

Trends in Andrology and Sexual Medicine

Series Editors: E.A. Jannini, C. Foresta, A. Lenzi, M. Maggi

David L. Rowland

Emmanuele A. Jannini *Editors*

Cultural Differences and the Practice of Sexual Medicine

A Guide for Sexual Health Practitioners



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Trends in Andrology and Sexual Medicine

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*To special friends (they know who they are);
to my family past, current, and future
vintages; to really helpful colleagues who
are not really friends, and to those dedicated
to transcending cultural differences*

David L. Rowland

*To my students and my fellows, to boldly go
where no sexologist has gone before*

Emmanuele A. Jannini

Preface

Few human behaviors are governed more profoundly by the complex pathway of rules, thoughts, and ways of life—what we call culture—than sexuality, rendering the “science of sex” a matter particularly engaging but also immensely complicated. What is a symptom or a disease in one culture may be considered normal in another; what is largely accepted in one society is forbidden in another; what is assumed as universal (within the Western paradigm) is discovered to be local and transient. For such reasons, a transcultural perspective—although largely neglected in sexual healthcare—is an indispensable tool for understanding human sexuality.

We thus invite you to take a compelling journey into a realm of sexuality that has been under-discussed, under-researched, and often invisible to the practitioner, or even to experts in sexual medicine or sexual psychology. This journey will transport you not only around the world but deep into aspects of various cultures and subcultures. You will find it, as we have, highly educational and both inspiring and disheartening at the same time.

We view this volume as an initial attempt to provoke greater sensitivity to and discussion of cross-cultural issues within sexual healthcare, this book representing a meager though important step in a very daunting process. We are proud of the variety of topics and perspectives offered in the various chapters, of the authors who accepted our often vague challenge to bring their cultural perspectives to the fore of sexual medicine and healthcare, and of the overall tone of cultural humility and sensitivity without sacrificing principles of good practice. Various chapters will sometimes impart a sense of urgency and even desperation, though always mixed with at least a glimmer of hope—that as a community of scholars and practitioners, we have an important role to play, that we can make meaningful differences in the lives and experiences of people suffering from sexual disorders and oppression, that we can advocate on their behalf, and that we can help change policies that stigmatize and do damage.

As with any edited book, we needed to balance control and standardization of text with creativity and idiosyncrasy that emanates from various world regions and cultures. We tried to respect those variations while ensuring conformity that helps readers orderly progress through ideas and text. So expect variation in writing style as well as type of and approach toward content across chapters, yet standardization in that all authors had been tasked with drawing conclusions and suggesting practical steps/applications based on their review.

We regret that, in our first attempt, some world and cultural viewpoints are omitted or covered all too sparsely—particularly in Asian, South American, and sub-Saharan African regions, or with respect to particularly vulnerable subgroups. Be assured, it was not from lack of trying. We repeatedly found that faculty, clinicians, educators, and healthcare practitioners (especially in many less developed regions) were so overburdened in their responsibilities that adding one more commitment to their logbook was just not feasible, especially when for some it meant the added burden of working and thinking in a non-native language. We can only express our deepest appreciation to all our authors who *did* accept our bid and hope that a future volume will not only add other perspectives but also develop clinical and research models to guide ongoing efforts regarding this critically important topic.

The scientific approach to sexual health, both from a medical and a psychological perspective, is extremely young, but also rapidly maturing. We hope this volume will help students of sexual medicine and psychology, sexual healthcare givers, and researchers approach human sexuality through a fresh, transcultural kaleidoscopic lens that illuminates differences and similarities and that makes clinical practice increasingly sensitive to and aligned with patients' needs.

While each chapter was carefully reviewed and revised, the ideas, content, views, accuracy, originality, and attribution of sources for each chapter are the sole responsibility of its authors. They do not necessarily reflect those of the editors and/or the publisher, and they are neither endorsed nor given validation by the editors and/or publisher.

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Part I

Introduction: Editor's Notes

These initial chapters provide an overview of relevant issues and challenges faced by healthcare professionals as they adopt a cross cultural perspective—both are worth a quick read so as to acquire a broad understanding of the topic. The first chapter provides an introduction to the topic, first explaining why—now more than ever before—cultural competence is important in healthcare practice, and then illustrating how cultural variations impact the health and healthcare of individuals. Issues encountered in the clinic setting such as alternative worldviews of health and illness, communication and language barriers, and practitioner–patient relationships are briefly discussed, with specific examples from the literature affording deeper understanding. The importance of cultural competence in dealing with sensitive issues surrounding sexuality—where culture often has a strong vested interest—is introduced, and a final section on strategies for developing cultural sensitivity rounds out the chapter.

The second chapter introduces the reader to the field of medical anthropology—the discipline that seeks to understand cultural-medical intersections and to generate new knowledge and insights within the field. As authors Wentzell and Labuski note: “Expectations of sexuality reflect the gender norms of a specific time and place...” and these differ greatly across cultures. The authors then proceed to discuss “how healthcare providers can employ anthropological insights in order to responsively treat sexual problems without causing harm.” Medical anthropologists provide an intuitive understanding into the ways that the medicine of a specific place and time erroneously defines “normal” versus “pathological” by attending to medical practices as themselves parts of culture. Using two research projects to illustrate their points, they cogently demonstrate how sexual “problems” are culturally couched, and end with specific guidelines to help practitioners reflect on ways that their own ideas and actions have been shaped by particular cultural or structural influences and settings.



Culture and Practice: Identifying the Issues

1

David L. Rowland

1.1 Diversity and Healthcare: The Idea Is Not New

The conversation regarding cultural diversity and healthcare has been happening in earnest for over half a century. As far back as the 1970s, medical anthropologist Arthur Kleinman described the phenomenon of “illness without disease,” the idea that negative emotional states such as unhappiness and depression may be somatized in many cultures—not in the manner of our current conceptualization of psychosomatic illness but rather as a vaguely defined physical discomfort that has no clear underlying physical symptoms. Kleinman further noted that people in different parts of the world often have their own conceptual model of disease and along with it, how disease should be treated [1–3]. Undoubtedly, medical missionaries dating back to the nineteenth century (think David Livingstone, the British physician, explorer, and medical missionary in Africa in the 1800s!) had been well aware of such cultural differences. However, only more recently has the need for understanding diversity and cultural differences become paramount for the average practicing clinician, and only in the past 30–40 years has the issue become a topic of concern needing to be addressed at both the individual and institutional levels within the healthcare enterprise. Quite interestingly, anticipating just such a forthcoming need, back in 1978 Kleinman himself [1] suggested a set of eight standard questions that every physician needed to ask the patient (see Box 1.1).

Diversity has two elements to it. Many nations/states have historical and existing racial and ethnic populations that subscribe to their own unique set of cultural values—thus, what we might consider *domestic diversity*. And many nations/states experience an influx of non-natives who may be in transit or hoping to resettle within the host country—thus what we might consider *international diversity*. Some

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Box 1.1 Kleinman's questions [2]

- What do you think has caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you?
- How severe is your sickness? Will it have a short or long course?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?

countries are dealing mainly with one or the other types of diversity; others are having to deal with both. And in some instances, because of the lack of health care workers in isolated parts of the world, trained practitioners may volunteer (or be assigned) to treat patients abroad who hold very disparate views about health and illness. Both types of diversity—domestic and international—present a challenge.

1.2 Diversity Is Increasing

In the USA, the impact of domestic diversity has been poignantly felt over the past several decades (even though it has actually existed for many preceding decades), particularly in some areas of the country. Hispanic and Latino ethnicities make up 17% of the US population, African Americans 13%, and other non-white races about 12%, with such groups growing substantially over the past three decades [3, 4]. Compare the 5-year growth rate from 2005 to 2010 of Caucasian whites at 5% with the much faster growing rates of 40% for Asians and Hispanic/Latinos [4]. In fact, 2050 will presumably represent the point at which the Caucasian white population becomes a minority in the USA. For some US states, that future is now, in Texas, Hawaii, California, and New Mexico.

Cultural diversity is much the status quo around the world. In Europe, for example, ethnic groups have for centuries been spread widely across various regions and nations, and with the recent influx of migrants and refugees, the impact of cultural diversity has taken on new dimensions, urgency, and repercussions. To cite examples, in Sweden in 2017 [5], about 17% of the population was foreign born, and of these about 65% were born outside the EU. In France in 2008, nearly 12 million foreign born immigrants and their immediate descendants were residents in the country, or about 19% of the total population of the time—and that population has undoubtedly grown since that census. In the Netherlands in 2017, about 22% of the population was ethnic/foreign born non-Dutch or non-Frisian. Diversity is, of course, defined by more than racial, ethnic, and non-native background, with religion, tradition, and subculture values often assuming the stronger role in

contributing to diversity of thought, feelings, and attitudes. Indeed, clinical interactions are often complicated by a range of differences: linguistic, sociocultural, religious, and ethnic factors.

But even within the European Union, different values and traditions can impact medical practice [6]. For example, some parts of Europe have held a tradition that assumes the patient has a duty to maximize his/her own health and follow physician's instructions, with the physician guided more by professional norms than by patients' rights. Thus, when relatives disagree with a physician's decision (say, regarding end-of-life decisions or treatment for a handicapped child), the physician may feel obliged to proceed to ensure compliance even when contrary to patient or family wishes. Other parts of Europe subscribe to a more patient-centered social welfare model than a professional standards model. Such models give the patient the right to override medical opinion (even when mental competency may not be guaranteed), as the approach focuses on the patient's positive rights and entitlements to healthcare, with the appointment of patient advocates being a norm when disputes arise.

Consider further the diversity existing within many non-Western countries. Some of the most culturally diverse nations are found in sub-Saharan Africa, and East Central and Southeast Asia, where cultural differences are the product of colonial histories combined with the formation of nation states based on geographical landmarks rather than homogenous peoples. The result is often a patchwork of regional and ethnic variations. Such is the situation in Pakistan, a country having eight major ethnic groups, two minor ethnicities, and some 74 living languages. Furthermore, because education often improves as people migrate to urban areas, an important demographic in healthcare attitudes and beliefs in Pakistan is that of the person's origin *and* current place of residence—rural or urban.

Beyond the anticipated, predictable societal diversification—typically characterized by changing demographics resulting from expanding subpopulations within nationally defined societies—the less predictable *international* diversification is becoming more common. Specifically, migrant health is becoming an ever-increasing issue in many parts of the world, as populations—increasingly mobile—are displaced by war, persecution, famine, economic privation, and desire for an improved lot. Such changes and their challenges—either from changing populations within or migrating populations from outside—have not gone unrecognized. In many situations, both patient and practitioner are acutely aware of and able to articulate the shared problems of diversity in healthcare.

Superimpose upon the changing demographics of national populations the fact that the physician workforce itself is also changing, and another layer of complexity is added to the situation [7]. In the USA, in 2010, medical school graduates were about 75% Caucasian, 13% Asian, 6% Black, and 6% Hispanic [8], percentages that hardly represent the current or trending demographics of that country. Patient preferences for race/ethnic concordance with the practitioner are well known [9], and given the disparity in percentage and distribution of ethnicities (patient and practitioner), the implications are significant, as outlined in the next section.

1.2.1 Subcultures Within Dominant Cultures

Cultural differences extend beyond those of geopolitical, ethnic, and national identities. Within many national cultures, subpopulations having special characteristics sometimes establish their own cultural identity. For example, in the USA and Pakistan, transgender communities have developed their own subcultures, as have members of many sexual minority groups. There are cultures of aging, cultures of disability, cultures of the homeless, cultures surrounding drug use, regional cultures, political cultures, and so on, many of which have established their own views, values, and attitudes regarding sexuality and gender. While some of these cultures have long existed, others have become more visible as societies become more open and tolerant about diverse lifestyles and beliefs. Although it will never be possible for practitioners to understand people of every subculture, having awareness of such diversity within the population enables healthcare providers to be more intentional in their efforts to be more inclusive in both their verbal and non-verbal communication.

1.3 How Do Cultural Differences Impact Health Care?

The reality is that it is becoming increasingly unlikely that health care professionals will *not* encounter patients (or families of patients) who hold values and ideas about sickness and health different from their own, or from the ones into which they have been indoctrinated through their health care education. Culture, once viewed as an explanation for ways of life and forms of understanding of distant societies, now refers to the “dominant values, symbols, social practices, and interpretive categories of any community,” communities that often exist in our very midst [10]. Aspects of culture such as beliefs about the cause of diseases, pain relief, truth telling, religious beliefs and practices, the organization of social units, decision-making, and moral codes can impact interactions between patients and practitioners [10, 11]. The “clinical” realities for the patient and health care provider may, literally, be worlds apart [12].

Thus, “culture” can have a major impact on the healthcare of individuals [12]. However, often the rules of a culture are not overt or even discussed, and therefore such differences may be well hidden from view for both patient and practitioner, in some instances appearing insignificant or irrelevant. In fact, cultural norms/rules often do not become apparent until they are broken—often when it is too late. For example, most clinical environments assume that the patient will heed the physician’s advice. But such an assumption may be far from the reality. Medical training—whether intentional or not—typically positions the doctor as the expert/teacher, so within a doctor-centered sphere, the naïve/unknowing patient would obviously comply with medical instructions. But a patient may be reluctant to disclose all the relevant details of the illness, may not agree with or understand the physician’s diagnosis, may believe the treatment would not be sanctioned by his family or is inconsistent with religious beliefs, and/or may misinterpret the

treatment as being unrelated to the condition, all factors that would result in low or no compliance. Thus, while the practitioner—consistent with his training—sees and treats specific diseases as being similar across people [13], patients experience illness differently, often with their understanding of the disease at odds with that of the practitioner's.

1.4 Kinds of Issues Encountered

Cultural differences typically revolve around half a dozen predictable issues [11–13]: (1) the construct or meaning of disease, (2) the role of authority and who possesses it, (3) the manner and extent of communication, (4) the appropriateness of physical distance and contact, (5) the role of the family in decision-making, and (6) issues surrounding gender and sexuality. Beyond these “in-clinic” concerns, cultural differences may also impact who has access to healthcare, due to the status of certain patients within the social system (e.g., citizen or refugee), their tradition of health seeking behavior within the subculture, and the level of comfort the individual/family has with the specific health care system of the dominant culture or host country.

Although not all the concerns listed above are addressed in this chapter, discussion of several key issues offers insight into the kinds of problems encountered by patients and practitioners alike when values and traditions regarding health, illness, and remedy are disparate. These include the meaning of disease, communication issues, and patient–practitioner relationships, this last category serving as a proxy for any number of factors including physical distance and contact, family roles, and gender/sexuality.

1.4.1 Views of Health and Illness

Every culture has dealt with issues surrounding health and disease since the beginning of time, and each has developed its own explanations for those conditions [11]. Over the centuries, these ideas have become deeply engrained. The introduction of Western medicine, which until only the past century has made credible progress, represents but a small and recent chapter in the understanding of disease within cultures that may have longstanding views and traditions regarding illness and its treatment. For example, traditional Chinese medicine, which has a history of somewhere between 2300 and 5000 years, is based on the need to maintain a balance between two complementary forces, yin (passive) and yang (active), that influence the human body (as well as the universe as a whole) [14]. Health ensues when the two forces exist in harmony, and illness when that harmony is disrupted. Even though most medical training in China currently follows a Westernized approach to illness, traditional Chinese medicine remains a vibrant part of the health care system, is practiced professionally, and carries substantial street credibility, not only in China but in other Asiatic regions as well [15].

As a result of such traditions, it is often advantageous to conceptualize the patient through two lenses: that of his/her personal experience of disease, and that provided by the framework of his/her culture. Every patient—independent of cultural similarity or dissimilarity—will have probably formulated a cause for his/her health problem and tried some type of remedy prior to approaching a practitioner. The patient's purported cause and treatment are typically embedded in his/her personal experiences with health and sickness—the patient learns specific ways of being ill, and these will often differ across individuals even within a single culture. But these interpretations are further informed by the person's cultural values and beliefs. For example, if the prevailing cultural understanding of health and illness subscribes to systems of balance (e.g., the yin and yang in Oriental perspectives, the “hot” and “cold” in various Latin perspectives), then cause will focus on events or situations that have disrupted balance, and remedies will depend on steps that restore balance. For many individuals utilizing health care systems based on modern medicine, the traditional approach often serves as a “backup” strategy, especially when there is some skepticism regarding the Western medical approach.

Many patients, particularly those with roots outside North America and Europe, do not share the Western biomedical view of disease; or they accept only those elements that do not clash with their more deeply embedded traditional views. Views of health and illness often have strong religious overtones (being blessed, being cursed), and when the medical vs religious interpretations of health and illness are at odds, the religious view may well prevail. Patients may, for example, identify the origin of disease in both physical and spiritual terms (depending partly on the nature of the disease), which then may lead them to seek solutions that include spiritual mediators. In some cultures, diseases are seen to require both a physical and spiritual remedy. In a now classic account by Fadiman [16], a Hmong refugee family living in the USA in the 1980s ascribed the origin of their infant daughter's disease (epilepsy) in part to spiritual causes, leading the family to consult spiritual sources to address the spiritual causes of the disease while also consulting a physician to treat the physical issues. Due to cultural misunderstandings and mistrust, the parents failed to properly medicate their daughter, Lia, as prescribed: in part thinking it might interfere with the process of spiritual healing and in part because the concept of adverse side effects of medication was unfamiliar to them and so they were distressed by their daughter's negative reactions to medications that were supposedly healing her. At the same time, the treating physicians interpreted the family's lack of compliance as abusive and, within the purview of the best interests of the child, had the child removed from the home. The saga ends in tragedy for Lia, and the book, written in 1997 when long-term fallout from the Vietnam War was yet fomenting, was a major wake-up call in the USA about how cultural misunderstanding could wreak disastrous effects on the patient–physician relationship, destroy patient's trust in a health care system, and jeopardize the health of individuals.

Perhaps equally alarming to the practitioner of Western medicine, cultural (or subcultural) values may sometimes lead to behaviors that negatively affect the health of the larger community, such as parents refusing to vaccinate children on the

belief that the vaccines will sicken them. Some cultures have very specific anxieties, for example, related to fluid loss (e.g., blood, semen) or to the cold (that may prevent people, e.g., new mothers, from venturing outside on cold days to see the doctor). And sometimes cultural interpretations may lead to treatments that are actually harmful: The hot–cold dichotomy of Latino and Asian cultures may result in the use of noxious lead salts or mercury [11]. For such reasons, practitioners need to understand that parallel, often competing systems exist, and that although in some instances, they may be harmless, in others they may have significant and serious repercussions for the health of the individual and community. In still others, the content of the treatment may in all likelihood be harmless, but the method of delivering the treatment may inflict damage, as is the case of burns and scars resulting from acupuncture or the application of burning herbs to the skin. Clearly, as demonstrated in Fadiman’s [16] account, dismissal, stern warnings, or other countermeasures are often ineffective in managing the situation. As Juckett [11] indicates, and as is further discussed in Sect. 1.4.2 of this chapter, a critically important step is beginning with a conversation that explores the patient’s (and/or his/her family’s) understanding of the cause of the disease and the remedies that have been undertaken thus far. Such information can aid the practitioner in obtaining a sense of the patient’s social construct of health, illness, and treatment.

1.4.1.1 Stigmatization and Mental Illness

In most cultures—including yet many Western nations—illnesses that are viewed as mental or psychological (including those involving sexual issues) may present a special problem in that they are considered shameful and bring dishonor to the family. Furthermore, because symptoms are typically behavioral rather than physical, the origin of the illness may be attributed to unnatural or supernatural causes rather than to an actual disease. For example, within some groups, sadness and depression may be viewed as challenges from God, with prayer and penance being the appropriate response. Or those with dissociative or schizophrenic symptoms may be deemed possessed or even gifted (e.g., when they speak nonsensically), and so on. Indeed, according to the DSM-5 [17], personality states may be seen as an “experience of possession” as the ailing individual experiences “discontinuity in sense of self and sense of agency, accompanied by related alterations in affect, behavior, consciousness, memory, perception, cognition, and/or sensory-motor functioning...,” signs and symptoms that may be observed by others or reported by ailing individuals themselves. Other persons with mental illness may show somatization disorder, where symptoms may not always be traceable to a physical cause but may nevertheless cause pain and/or neurologic or gastrointestinal disorders, symptoms that are real even though not directly related to the actual problem. Thus, descriptions of the symptoms related to mental illness may often make no sense within a Western interpretation. For example, Vietnamese patients have reported “feeling tired in the chest” when in fact they are referring to feelings of hopelessness, depression, and mental exhaustion [11]. Such symptoms may require translation and interpretation.

1.4.2 Issues of Language, Expression, and Communication

Among the more significant challenges for staff of health care facilities is that of the language barrier. The patient may not speak the native language, or speaks it without understanding specific terms related to health, disease, and medicine, or speaks it without understanding nuance. Language barriers present significant risk for adverse outcomes, with effects on health, safety, and future access [18, 19]. The patient may misinterpret the diagnosis, especially if it is not consistent with his/her own interpretation; may not fully understand medical instructions; and/or may feel embarrassed by that lack of understanding. Translation is not always the answer—in Sweden in 2015, 17% of the population had a foreign background, and within that 17%, 150 different languages were spoken. No systematized translation efforts could accommodate such great need. Furthermore, refugees or undocumented individuals may not have access to traditional healthcare systems or may avoid them for fear of deportation, and therefore they may seek help only when emergencies arise, a time when full “intercultural” services may be less available, yet a time when clear communication is more crucial than ever. Some studies suggest that under conditions of illness and emergency, an individual’s ability to communicate decreases even further.

Even under less dire circumstances, treatment is affected by what the patient chooses to disclose to the practitioner [20], and the content of much of this disclosure is culturally driven: potentially shameful or embarrassing elements may be omitted or not explained in detail. Furthermore, not only might the patient’s terminology be limited (e.g., where English may be one of the several official languages as occurs in former colonies such as India, Nigeria, and Pakistan), but disclosure depends in part on what family members deem acceptable (and not dishonorable), with relevant factors including race, age, immigrant status, sex, language, and education of the patient, as well as the language, race, and sex of the practitioner.

The use of a language interpreter is one strategy that makes sense when a specific ethnic group dominates within a specific region (e.g., Spanish translation in US enclaves of California, Florida, regions of major cities, the Southwest, and so on). But where resettlement intentionally integrates ethnic and language groups into mainstream communities, for example, in many smaller municipalities in the USA or other countries, the problem of language interpretation is not so readily solved. Furthermore, in European countries where waves of refugees speaking many languages are entering the country (legally or illegally), translation services can only partially meet the needs of the system.

Furthermore, the general consensus is that language interpretation is *not* best served by those who may be most expedient, for example, family members—particularly husbands speaking on behalf of their wives. Using family members—parents, spouses, or offspring—may only compound the problem. Relatives may prevent objective and sincere representation of the problem and interfere with confidentiality protection—in the worst case scenarios the patient may actually become somewhat “invisible” in the process as the family interpreter takes center stage. A professional interpreter will, on the other hand, be trained to build bridges, maintain

an unbiased perspective, demonstrate emotional constancy, and even consider spatial/seating arrangements, placing the patient closest to the practitioner or maintaining equal distance from patient and practitioner.

Ideally, the interpreter would work side-by-side with the practitioner, understand medical and health care terminology, and be available for subsequent visits so as to ensure continuity. Seldom, of course, do community healthcare systems have resources to ensure such optimal circumstances. In some instances, having an interpreter who mirrors the ethnicity of the patient may help minimize apparent cultural differences between patient and practitioner, thereby leading to greater self-disclosure. Indeed, such interpreters can assist in interpreting non-verbal communication, including manner and tone, whether the culture is high touch vs. low touch, and the appropriateness of certain types of gestures [11]. However, interpreter–patient or patient–practitioner concordance can also lead to problems, for example, when the patient/interpreter/practitioner triad makes erroneous assumptions that cross-cultural issues have largely been addressed because of a presumed shared cultural background (consider a Latino patient visiting a Latino physician).

Assuming that communication is fairly open, to ensure accuracy, the practitioner should ask the patient (through the interpreter if necessary) to repeat back the key elements of the conversation along with any information and instructions in his/her own words. As simple as the task seems, the process can help ensure that the communication has been clear.

1.4.3 Relationship Between the Patient and Practitioner

For successful health care delivery, the practitioner and patient need a positive working relationship. Key to this relationship is a sense of trust [21, 22]. The development of trust depends partly on the perception of competence—that the practitioner has sufficient expertise to benefit the patient—and the perception of good will—that the practitioner will act only in a manner that serves the best interest of the patient.¹ Cooper [23] notes two aspects of this trust within the patient–practitioner relationship: (1) fiduciary trust, in which the power disparity between physician and patient assumes that physicians and their institutions will do the right thing with regard to providing effective medical care, and (2) trustworthiness, demonstrated through humanistic qualities such as compassion, altruism, empathy, honesty, and so on. Ultimately, patients want and need to be treated with dignity and respect [24], and such treatment is essential for developing trust.

The nature of the relationship between patient and practitioner weighs most heavily on the practitioner. The practitioner can promote a positive trusting relationship with the patient by recognizing the importance of cultural differences,

¹You can imagine the issues of broken trust in health care systems that resulted when the US CIA deceptively used a vaccination program in Pakistan to learn the whereabouts of Osama bin Laden in 2011. As a result, legitimate vaccination programs in Pakistan suffered serious setbacks, with the effects still being felt today, nearly a decade later.

by taking the patient's problem seriously even when symptoms and explanations do not seem readily apparent or plausible, and by engaging in friendly and open dialog, sometimes difficult given the physician's time constraints and the patient's resource constraints.

The above approach is best characterized as "patient-centered care." And even though this approach is already the mainstay bedside manner for many physicians, its projection by the practitioner is even more critical when patient and physician share little common ground in terms of class, culture, ethnicity, religion, values, and biases [25]. The patient-centered approach, often characteristic of general practitioners, is perhaps even more important in medical situations requiring high technical skills, such as those in oncology or neurosurgery. Yet this approach is sometimes overshadowed in situations where technical skills and language pre-empt other aspects of patient-practitioner interaction.

Attempting to learn specific behaviors that convey respect is often an endless and futile task—this culture avoids eye contact, that one imparts decision-making to a family representative, another requires permission for physical contact from either the patient or a family member, and so on. Such tasks are further complicated as signs of respect undergo change as patients assimilate into a new culture. In contrast, adopting a patient-centered approach characterized by compassion, understanding, and care that is obvious to the patient and family generally leads to consistently greater patient satisfaction and better health outcomes [26]. The patient-centered approach, discussed further in Sect. 1.6, involves a number of broad principles that drive communication and interaction, as delineated in Box 1.2 [27].

A patient-centered approach never implies that the practitioner retreats from professional standards and principles of ethics. The concerns of the practitioner always need to be addressed, for example, obtaining complete and accurate information even when the patient/family is reluctant to share, conveying risk even when posing the possibility of patient misinterpretation, and ensuring compliance even when the patient's decision-makers may object to aspects of the treatment. However, treating patients as we ourselves would want to be treated during crisis or times of vulnerability encapsulates the essence of patient-centered care.

Box 1.2 Association of American Medical Colleges (AAMC) cross-cultural skills (see Epner paper [26])

- Knowledge, respect, and validation of differing values, cultures, and beliefs, including sexual orientation, gender, age, race, ethnicity, and class
- Dealing with hostility/discomfort, as a result of cultural discord
- Eliciting a culturally valid social and medical history
- Communication, interaction, and interviewing skills
- Understanding language barriers and working with interpreters
- Negotiating and problem-solving skills
- Diagnosis, management, and patient-adherence skills leading to patient compliance

Finally, many practitioners have learned the lesson that in some cultures, a relationship with a patient (even when a mature adult) means having a relationship with his/her family. Elders in a family (often men/husbands) may decide when someone is sick, what the cause is, and who should be sought out for treatment [3]. They may also play an important role in deciding what treatment is acceptable or preferred for the patient. Parents may be particularly protective regarding the sexual health of their daughters. Thus, giving advice that is contrary to a family member's way of thinking (husband, elders, parents, etc.) may lead to non-compliance and ineffective outcomes. As a result, practitioners may need to seek out those family members responsible for decision-making, query them about their goals regarding the afflicted family member, and include them in the decision-making process when possible. When family members realize that they and the practitioner both share the common goal of doing what is best for the patient, the likelihood of achieving a desirable outcome is greatly enhanced.

1.5 Cultural Diversity and Sexual Medicine

As mentioned in Sect. 1.4, gender and sexuality constitute major areas of concern regarding cultural differences and health care [28, 29]. Sexual issues represent highly sensitive topics, but not just to patients. Recent analysis has suggested that a high percentage of general practitioners feel uncomfortable raising issues about sexuality during the typical office visit [30] and these findings do not take into account situations involving cultural differences between patient and practitioner. Imagine the discomfort for both practitioner and patient when a cultural divide adds to the lack of confidence and awkwardness of the conversation. Anthropologists learned early on that an understanding and sensitivity to cultural values was critical to effective efforts and policy-making in the field of sexual and reproductive health, as seen in attempts to encourage contraception through sterilization in India, a program that led to long-term distrust of family planning in a country having a strong pro-natalist orientation [31].

Cultural differences in sexuality—what is accepted, what is expected, and how these differ for men and women—are both significant and, in some domains, well documented. For example, in some Asian countries, sexual well-being falls short relative to other populations, on measures of sexual satisfaction, relationship functioning, and the importance of sex [32]. In many regions of the world, women's roles are not only rigidly defined, women themselves are often viewed as a weaker sex whose sexuality needs to be protected (and controlled) by men/husbands [33], or whose sexual desire needs to be thwarted through genital cutting. In still other cultures, men and manhood are associated with sexual aggression, competitiveness, and philandering [34, 35], a perspective that not only places great sexual pressure on men, but also places women at risk for sexual assault. In nearly all cultures, the inability to perform sexually in a manner consistent with sexual scripts creates anxiety, shame, and stigmatization.

In this section, we provide several snippets attesting to the kinds of challenges that arise when an individual's cultural perspective about sexuality is not fully aligned with the assumptions of the health care system or provider.

- The social construction of what it means to be a “couple” is deeply embedded in culture. In Western culture, a couple is typically considered the conjugal/sexual pairing that forms the basic family unit [36, 37]. But in various Western subcultures (e.g., transgender) [38] and other parts of the world (e.g., where polygamy is accepted), the Western concept of “couple” may have little relevance. For this reason, the healthcare practitioner/clinician may need to explore the meaning of “couplehood” when issues of sexuality are encountered, including in some instances, how the couple relationship is related to the rest of the family.
- In research on cultural differences and health care in Latina women, both foreign and US born, sexual topics emerge as the most sensitive of all issues [20]. Most difficult are problems surrounding self-disclosure, and particular concern occurred when there were perceived differences in the culture, language, sex, age, and birthplace of the healthcare provider. Women indicated discomfort mentioning genital problems because they wanted to avoid examination, and they indicated they would even avoid reporting partner abuse for this same reason. Their level of disclosure was generally related to physicians' patient-centered communication style, and for these Latina women, this included the perception of caring, concern, and compassion on the part of the practitioner.
- Sexual health in many countries is taught through a Eurocentric/Western biomedical framework [39] that views humans as sexual agents within an individualistic society. For children born in one country whose parents have migrated to another, messages about sexuality at home may be radically different from those at school, from peers, or from the media; that is, the parents' culture and that of the host country conflict. Zimbabwean women—largely the product of a distinctly African Christian culture—who have migrated to Australia had typically learned that their sexuality provided a means for pleasing one's (future) husband and that their role as women involved being a gentle and obedient wife. Thus, a woman's sexuality in Zimbabwe was defined largely in terms of how it might benefit men. Discussions about sex were largely taboo, as sex was considered secretive and, once openly discussed, it lost its power. These Zimbabwean women struggled to communicate issues of sexual health to their own children in their host Australian culture, where communication about sexuality is a parental expectation, yet is counter to the African expectation that another family member assumes responsibility for sex education. Without other family members nearby, these women often deferred to Church-sponsored education in Australia, which typically espoused abstinence and sometimes circumvented discussions about contraception. The authors of this report noted the inadequacy of sex education materials and guidance in Australia for providing migrants with tools and strategies essential to navigating cross-cultural and intergenerational differences regarding discussions, expectations, and information about sexuality.

- In Australia and Canada, migrant and refugee women show low use of sexual and reproductive health services, and therefore are at significant risk for negative outcomes [40]. The low use is explained by these women's general lack of knowledge regarding available services, restrictions imposed in previous location/culture, and the assumption that such services for unmarried women are unneeded or inappropriate. Talking about sex is sometimes taboo for women from certain cultures, and therefore using sexual and reproductive health services places women in a compromising situation that requires them to engage in a forbidden (i.e., sinful) behavior. The consequences of avoidance of sexual and reproductive health services were significant. Some women lacked basic knowledge about sexuality, showing naiveté about menstruation (which was thus frightening or shocking), or menopause, viewing the latter as the result of illness. Women often had little say in or control over their own reproductive health. For example, cervical screening and HPV vaccination were sometimes seen as a threat to virginity, the use of contraception was often considered a family/husband decision, and women were not permitted to ask their husbands to be tested for an STI. Yet, within the safe space of the interview, many women showed interest in receiving information about sexual health, contraception, HIV testing, STI prevention, HPV vaccine, painful sex, educating their children, and even negotiating sex within their own marriages—as well as wanting to educate their husbands about many of these issues.
- Changes in gender role often present a major challenge, particularly for women, as non-natives transition from one set of cultural values to another. In an interview with Iranian-American women, Rashidian [41] noted their highly conflicted situations, as these women experience feelings of disloyalty to their culture and religion, along with guilt, self-doubting, and shame as they, with apprehension, want to explore and in some instances embrace an identity more accepted in the Western tradition. They often continue to experience strong pressures from their family/husband to retain the traditional female role of their native culture, sometimes feeling as controlled in the USA as in Iran, by both family and tradition. For these women, who felt a sense of entrapment by patriarchal rules which placed on them the burden of upholding the family's honor, life was often viewed as a balance between being the passive, resigned, and family-dependent self of the old world and the independent, assertive, professional, and competitive self in the new culture once outside the Iranian-American community.
- Male circumcision and female genital cutting are areas where strong cultural differences occur, and where even Western medical experts disagree, at least regarding circumcision. This topic, discussed in detail in Chap. 17 of this book, demonstrates quite persuasively the power of culture in shaping medical practice [42, 43]. Female genital cutting shares some common roots with circumcision in boys, although the devaluation (or worse, barring) of female sexual pleasure has also served as a rationalization for female genital cutting in strong patriarchal societies. In such social systems, not only was control of women's sex lives by men considered standard procedure, but the clitoris was recognized as unnecessary for successful reproduction in women [44]. In some cases male

circumcision has been justified on the basis of good hygiene (a benefit) with little or no cost, as it does not interfere with male functioning in terms of orgasm and ejaculation. In contrast female cutting can interfere with female orgasm (presumably a high cost to the woman, but not necessarily the woman's partner) with no obvious benefit. The topic of female genital cutting has a plurality of perspectives, for example, with not all women who have experienced genital cutting reporting negative effects [16, 42]. Contentiousness occurs because some believe that different standards and scrutiny are applied to male circumcision vs female genital cutting, without objective consideration of the data—which, as might be expected, both sides seem to claim. For further discussion of the issues, refer to Chaps. 14 and 19.

The above issues/studies highlight the need to broaden and deepen our understanding of cultural diversity as it relates to the practice of sexual medicine. Not only do differences occur across cultures and religions, but different approaches and values are entrenched within similar cultures (as seen with male circumcision). And within nearly every culture—whether overt or hidden—various *sexual* subcultures exist. For example, within the USA, many alternative and non-traditional sexualities are found among those seeking health care, including those who subscribe to open marriage, consensual non-monogamy, polyamory, kink, transgender identification, or other less conventional behaviors [45]. Thus, assumptions regarding sexuality sometimes held by the practitioner may have little connection to the assumptions of sexuality of those seeking help.

A number of journals already attend to cultural differences related to sexuality, *Culture, Health, and Sexuality* perhaps being the most clearly identified by title. However, the translation of reported differences into clinic settings and practice is often not the focus of these reports. The goal of this book is (1) to bring an awareness of cultural differences to the practicing health care provider in sexual medicine, and (2) to demonstrate how such differences can be relevant to the health care and treatment of clients having sexual issues.

1.6 Developing Cultural Competence in Medical Practice

Many articles, reports, and programs have addressed the issue of developing cultural competence among health care practitioners in the clinic [46, 47], a trend initiated half a century ago by Kleinman's [2] list of suggested questions that every practitioner should ask the patient (Box 1.1). Since then, many sages, experts, and writers have offered advice regarding ways to handle situations involving cultural disparities between patient and practitioner.

For example, Juckett [11] identifies the need to possess knowledge, awareness, and respect for other cultures, as opposed to taking an ethnocentric stance where one assumes the superiority of the methods and values of one's own culture. Misra-Hebert [12] cautions that it is important for physicians to be cognizant of their own biases; for example, Western culture operates on a number of culturally based assumptions regarding health care and clinic interactions such as the expendability

of privacy in the doctor's office; the value of being forthright about disease, prognosis, and treatment; and the emphasis on individualism and control of our destinies—placing responsibility on the patient for actions that contribute to his/her recovery. Taking another approach and realizing it as the exception to the rule, Deagle [13] lauds the idea of practitioners living within the communities they treat so as to enable “careful observation of cues, becoming culturally aware as a means to discovering that we too have a folklore of culture with myths and metaphors that are often no more valid or real than the folklore of other cultures.” Others speak to being attentive to our own situatedness [34], although some, wanting to add balance to the conversation, warn that although multiculturalism requires respect for cultural diversity and that we approach other cultures non-judgmentally [48, 49], tolerance does not necessarily imply acceptance of their values. Stated more broadly, the fundamental underlying principles of good medical practice, particularly those involving basic human rights, should not be compromised. While the concept of human rights (and perhaps more controversially, women's reproductive rights) “may have originated in the West, this does not make it innately Western” [50] and when specific religious traditions or cultures deny such rights, they undermine fundamental principles of Western medicine.

Most practitioners understand that family medicine requires appreciation of the psychosocial aspects of health [3, 11]. So, what is it exactly that health care professionals need to know or should do in order to become culturally competent? Should the practitioner develop awareness of the verbal and non-verbal idiosyncrasies of various major cultures, learn to avoid certain gestures, understand differences in personal space requirements, or develop awareness of the differing interpretations of direct eye contact? Most would argue: “not necessarily.” The basics of working across cultures are perhaps best learned not by exhaustive review of attitudes and behaviors but by reflection, both on one's self and on patients' lives, beliefs, and actions [51]—in other words, the first tenet is that there is need to be intentional about the process and not merely assume one can improvise his/her way through the patient–practitioner discourse.

Programs devised to improve cross-cultural interaction stress a variety of approaches. As an example, the LEARN program (Box 1.3) delineates a sequence of steps that can be used to guide the practitioner through a clinical session with the patient. Most such programs recognize the tripartite process of increasing knowledge, adopting a particular attitude, and skill-building, with the more prominent elements of most programs being those of attitude and skill-building [24].

Box 1.3 LEARN Program [42]

- *Listen* with sympathy and understanding to the patient's perception of the problem
- *Explain* your perceptions of the problem
- *Acknowledge* and discuss the differences and similarities
- *Recommend* treatment
- *Negotiate* treatment

Attitude is perhaps best characterized by practicing, adopting, and refining—as mentioned previously—a patient-centered approach, even in situations demanding high technical competence where person-based skills may seem less important. *Skill-building* generally focuses on verbal and non-verbal communication strategies with the patient. In other words, being aware of the need to be culturally sensitive (rather than trying to learn the details of many different cultures), paired with a person-centered attitude and effective verbal and non-verbal communication skills, is often sufficient to ensure positive practitioner–patient interactions in cross-cultural settings.

Fortunately, practitioner training programs that emphasize these two aspects of patient interaction—attitude and communication—appear quite effective in improving *patient satisfaction*, particularly when all healthcare staff are trained, including receptionists, practicing staff, assistants, and so on [19]. No particular characteristics of various training programs have stood out as being most effective, that is, whether long vs short, experiential or not, or specific vs general cultural information.

Several other aspects of training programs have been noted. First, although patient satisfaction has generally improved with practitioner cross-cultural training, actual patient health outcomes are not consistently assessed, making it nearly impossible to evaluate the overall health benefits of such programs. Second, a concerted approach to cross-cultural medicine is likely to require resources/funding, and sometimes such resources (e.g., as that necessary for interpreters) are not easy to secure.

1.7 Conclusion

The practice of medicine emphasizes the importance of cross-cultural competency, and sexual medicine could benefit from an understanding of how cultural differences can impact the sexual health and well-being of individuals. Many resources are available to clinicians to help them develop a positive and effective attitude in the treatment of patients from disparate cultures—an example of one such resource is the *Pocket Guide of Culturally Competent Communication* (Fig. 1.1) [51]. Specific to sexual medicine, the chapters of this book address cultural differences related to gender, sexual identity, and sexual response that have implications for clinical practice.

1.8 Resources

Additional resources are readily available for developing cross-cultural skills, including programs, tip sheets, and online training modules. Visiting one of the following websites may provide a helpful starting point:

<https://www.ceh.org.au/cultural-competence-communication/>

<http://sph.umd.edu/department/epib/cross-cultural-clinical-skills>.

https://pdfs.semanticscholar.org/8140/4335016cdc110d3b75f058dfe41a412d247c.pdf?_ga=2.261315341.1055063370.1548449477-136238883.1548449477.

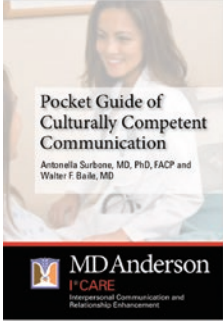
 <p>Pocket Guide of Culturally Competent Communication Antonella Sorbone, MD, PhD, FACP and Walter F. Balfe, MD</p> <p>MD Anderson I-CARE Interpersonal Communication and Relationship Enhancement</p>	<p>Fundamental Principles</p> <ul style="list-style-type: none"> • Cross-cultural medical encounters are increasing in multi-ethnic societies. • Cultural factors influence cancer survival rates and patient/family quality of life. • Cultural competence is a set of attitudes, skills and knowledge that can be acquired. • Respecting cultural diversity is key to delivering comprehensive cancer care across the illness trajectory. • Cultural competence promotes patient-centered care through sensitive negotiation of therapeutic goals. <p style="text-align: right;">1</p>	<p>The following vary across cultures:</p> <ul style="list-style-type: none"> • role of autonomy in decision making. • support available to help patients cope. • role expectations of sick persons. • beliefs about cancer causation. • EOL preferences (AD, DNR, hospice). • patient/clinician/institution relationships. <p>Why Cultural Competence Can Help You Plan the Patient's Care</p> <ul style="list-style-type: none"> • Discussion of cancer is a taboo in some cultures where the word "cancer" is still associated with death or guilt & shame. • Patients from diverse cultures rely on different healing practices that can often be incorporated into care plans. • Ethnic/genetic/cultural differences can affect treatment response directly or through lifestyles. <p style="text-align: right;">2</p>	<p>Where You Need Cultural Competence Most</p> <ul style="list-style-type: none"> • Truth-telling about diagnosis, prognosis and risks • Discussion of death and EOL choices • Issues related to: <ul style="list-style-type: none"> - family involvement in information and decision making - use of alternative and complementary cancer treatments - reliance on spirituality and religion for healing - attitudes toward psychological and behavioral counseling - concerns regarding clinical trials <p style="text-align: right;">3</p>
<p>7 Areas to Cover in Taking a Cultural History -"BALANCE"</p> <p>B Beliefs & Values (that influence perceptions of illness)</p> <p>A Ambience (living situation and family structure)</p> <p>L Language & Health Literacy (role of interpreters, accuracy of translation, metaphorical meanings)</p> <p>A Affiliations (community ties, religious & spiritual beliefs)</p> <p>N Network (social support system)</p> <p>C Challenges (cancer-related risks of home, work & life conditions)</p> <p>E Economics (socioeconomic status & community resources)</p> <p style="text-align: right;">4</p>	<p>Pearls of Wisdom</p> <ul style="list-style-type: none"> • Sensitivity to cultural issues enhances trust between patients and doctors. • Initial time investment avoids later misunderstandings and/or bedside ethical conflicts. • Personalized cancer care incorporates patients' and families' culture and draws on community resources. • Learn about the cultural groups most frequently treated at your institution. • Incorporate cultural into social history. • Be prepared to briefly describe your own cultural background. <p style="text-align: right;">5</p>	<p>Pearls of Wisdom (cont'd.)</p> <ul style="list-style-type: none"> • Always clarify your institutional and ethical norms in matters of truth-telling and decision making. • Recognize your own biases toward some cultural attitudes and practices. • Be aware how different families involve themselves in decision making. • Be sensitive to different cultural meanings of suffering and caregiving. • Open your mind to different ways to promote health and cope with illness. <p style="text-align: right;">6</p>	<p>Resources</p> <p><i>Cancer, Culture, and Health Disparities: Time to Chart a New Course?</i> Marjorie Kagawa-Singer, Annalyn Valdez Dada, Mimi C. Yu & Antonella Sorbone, CA Cancer J Clin 2010; 60: 12-39</p> <p>For more information visit: www.mdanderson.org/icare</p> <p>Antonella Sorbone, M.D., Ph.D., F.A.C.P. Lecturer in Bioethics Professor of Medicine New York University Medical School I-CARE Program Faculty</p> <p>Walter F. Balfe, M.D., Professor of Behavioral Science Director, Interpersonal Communication And Relationship Enhancement (I-CARE) Program Department of Faculty Development The University of Texas MD Anderson Cancer Center</p> <p>Cathy Kirkwood, MPH I-CARE Project Director</p> <p><small>*The University of Texas MD Anderson Cancer Center, 2011</small></p> <p style="text-align: right;">7</p>

Fig. 1.1 Example of pocket guide used at MD Anderson. Reprinted with permission of the author WFB

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