*Culturally Sensitive Sex Therapy:*

*The Need for Shared Meanings in the Treatment of Sexual Problems.*

*Mr. Li looked at me blankly. He had been referred by an infertility clinic for repeatedly failing (refusing?) to give a semen sample. Now he sat expectantly in my office, wondering what I was going to do to help him. I was wondering the same thing.*

Feeling incompetent in the role of sex therapist is an uncomfortable feeling. It is especially uncomfortable when you encounter this feeling midway through your career, when you have long ceased to feel the anxiety of a newly minted therapist. Whatever our level of experience, when we encounter clients, situations or problems that are alien to us, anxiety is a natural response. So it is for many ethnic minority clients who walk into a therapy office with little shared understanding of the process of sex therapy. Many of these clients, like Mr. Li, never return for a second appointment and remain an underserved population (Barrett et al., 2008; Moreira et al., 2005).

This chapter focuses on the need for cultural sensitivity in the practice of sex therapy. We begin with the premise that sexual problems are experienced by people worldwide, but we contend that the sexual concerns of diverse cultures do not necessarily mirror those of Western populations. Culturally sensitive sex therapy is required to meet the needs of people in other countries and cultures and also to address the needs of cultural minorities and immigrant populations in the Western world.

*Sexuality in a global perspective*

Sexuality is best understood as a biopsychosocial phenomenon (Bancroft, 2009). While the biological, psychological and social aspects of sexuality are clearly interrelated, the unique contribution of culture has been much neglected in the understanding of human sexuality and its problems and treatment.

 Culture is defined as the shared meanings and values of a group, which are passed on from one generation to the next or, as defined by Williams (1983), “the way of life for an entire society.” What constitutes ideal, acceptable and offensive sexual behavior is culturally defined. To illustrate, we can examine the cultural variations in what is considered appropriate for marital sex. While most, if not all, cultures sanction sexuality within some form of marital union, there is a great deal of variation in cultural dictates regarding how that sexuality should be expressed. In the West, marriage is presumably based on mutual love between two adults. There is a growing acceptance of same-sex marriage, with such marriages being legally recognized in Canada, Argentina, and some parts of the United States and Europe (Wright, 2006). Marital sex is expected to be pleasurable, intimate and consensual. In Western cultures, the standard is that sex should be desired by both parties rather than merely consented to, a fact that has likely contributed to Hypoactive Sexual Desire Disorder becoming the most common female complaint seen in sex therapy clinics in the Western world (Robinson, Munns, Weber-Main, Lowe, & Raymond, 2011). In many other parts of the world, however, marriage is the union of two families and is therefore often arranged by the families (Uberoi & Palriwala, 2008). It is always heterosexual, although there is a great deal of variation in what is considered a marriageable age for females. Sometimes the couple has met and consented to the union, but sometimes consent of the individuals is not seen as necessary given that the family has consented to the union. There is usually the expectation that the marriage be consummated quickly, often on the first night following the wedding. This presumes that what is required sexually in a marriage is a potent male and a willing and submissive (and chaste) woman. In many cultures the ability to consummate a marriage not only signifies the likelihood of offspring, but also that the union has been blessed by spirits or ancestors (Savage, 2012). Many anxious brides and grooms have taken to cutting themselves in order to show a bloodstained cloth to relatives who are often waiting just outside the door for proof of virility and chastity (Sungur, 2012;). So whether marital sex is expected to involve love, good communication, sexual desire, and the ability to give and receive sexual pleasure, or whether it requires male potency, female submissiveness, ancestral or spiritual blessing and ultimately offspring, depends upon the culture. Since culture defines ideals and norms it will also then define what is problematic and what treatments are likely to be effective (e.g., medical, spiritual, relational, or psychological). A good resource for the clinician interested in learning about sexuality in different cultures is the Continuum Complete International Encyclopedia of Sexuality (Francoeur & Noonan, 2004) available online at http://www.kinseyinstitute.org/ccies/index.php.

*Sexual Dysfunction in a Global Context*

Most epidemiologic studies on the prevalence of sexual problems come from the West (North American and Europe). With few exceptions (Laumann et al., 2005), most of what is known about sexual problems in other parts of the world is based on small numbers, clinical samples or case studies. Furthermore, what little research there is on ethnic minorities has often focused on issues of sexual health and risk for sexually transmitted infections (STIs) or unintended pregnancy, rather than on issues related to sexual pleasure (Hall & Graham, 2012; Lewis, 2004)

The first report of a large multinational comparison of sexual dysfunction was the Pfizer-funded Global Study of Sexual Attitudes, Beliefs and Behaviors (GSABB) (Laumann et al., 2005). Over 13,000 men and a similar number of women aged 40-80 years across 29 countries were surveyed. The most common sexual problems reported by women were lack of interest in sex (26-43%), inability to reach orgasm (18-41 %) and lubrication difficulties (16-38%). Early ejaculation was the most common complaint made by men (12 -31%) closely followed by erectile difficulties (12-28%). The incidence of all reported sexual problems were higher in East Asia and South East Asia than in other regions of the world. The authors of the study concluded that “…sexual difficulties are relatively common among mature adults throughout the world.” (p. 39).

 It is difficult to estimate the true prevalence of sexual dysfunction from surveys (Graham & Bancroft, 2006; Mercer et al., 2003). Epidemiological surveys have often resulted in inflated reports of sexual difficulties because both transient, short-term sexual problems (which are very common), as well as more persistent problems (which are less frequent) have been assessed (Hayes, Dennerstein, Bennett, & Fairley, 2008; Mercer et al., 2003). Although the criterion of “distress” is required for a clinical diagnosis of any sexual disorder (American Psychiatric Association, 2000), the cross-cultural GSSAB did not assess distress about sexual functioning, but only the presence of symptoms. More recent surveys that have assessed distress (Bancroft et al., 2003; Oberg, Fugl-Meyer, & Fugl-Meyer, 2004; Shifren, Monz, Russo, Segreti, & Johannes, 2008; Witting et al., 2008) show that prevalence estimates drop, usually by at least half, when distress is included in the determination of sexual problems (Brotto et al., 2010; Hayes et al, 2008).

To further illustrate this point we can look at the international prevalence data on premature ejaculation. In two multinational studies of intravaginal ejaculation latency times (IELTs), Turkish men had significantly shorter IELTs when compared to their counterparts in the Netherlands, United Kingdom, Spain, and the United States (Waldinger, McIntosh & Schweitzer, 2009; Waldinger, Quinn, Mundayat, Schweitzer & Boolell, 2005). However, whether these Turkish men were distressed by their relatively short IELTs was not determined in these studies. Yasan and Gurgen (2009) found that Turkish men referred to a sex therapy clinic (usually for fertility-related concerns) who met the DSM-IV criteria for PE were not distressed about their condition. This could be attributed to the fact that these men were more concerned about fertility-related issues, but it could also have reflected a genuine lack of concern about the duration of intercourse. Zargooshi, Rahmanian, Motaee, Kohzadi, & Nourizad (2012) reported that PE was the primary presenting sexual complaint seen at their clinic in rural Iran. Unlike their Turkish counterparts, men in rural Iran are distressed about the duration of intercourse, even when their IELTs far exceed the standard cutoff of 2 minutes. Zargooshi and his colleagues noted that with the high unemployment rate in rural Iran, sex was one of the few pleasures accorded to married men and they wanted it to last as long as possible. The opinion of Iranian wives was not solicited and therefore it is unclear whether they shared a desire for longer lasting vaginal intercourse. Furthermore, while the Iranian men were distressed about the brevity of intercourse, Western men are often more concerned about the fact that they lack control over the timing of their ejaculation, regardless of how quickly it occurs (Kempeneers et al., 2012). One might predict therefore that treatments that focus on extending the length of time before ejaculation (e.g., medications) may be more effective and welcomed in Iran, while cognitive-behavioral strategies to help men gain control over the timing of ejaculation will be the treatment modality of choice in the West.

 Cross-cultural research invariably raises concerns about the adequacy of translating language and concepts for use with populations other than the originally designated group. This issue was directly addressed by the investigators of the SWAN survey, a study of multi-ethnic midlife women living in the United States (Cain et al., 2003). Addressing the finding that Chinese and Japanese women were the least likely to report a desire to engage in sex, the authors note: “[d}espite careful translation, we cannot rule out the possibility that terms such as desire and arousal may have different meanings across cultures or that women will respond to them differently” (p. 275). Furthermore, as Ahrold and Meston, (2010) pointed out, the more different a culture is from the mainstream or comparison culture, the more likely it will be that differences will appear in assessment. Therefore, another conclusion regarding the GSSAB and the SWAN study dataset is that Asian sexuality differs significantly from Western sexuality and as such, when measured against Western standards will appear lacking.

 The tendency to compare other countries to the standards of the West plagues cross-cultural research (Meston & Ahrold, 2008). The GSSAB asked specific “Western-defined” questions about sexual difficulties. Different sexual concerns may be elicited when the question is broadened to ask “What problems bring men and women to treatment?”

For example, in a study of 1,000 consecutive patients attending a sex therapy clinic in India, apart from PE (the most frequent complaint, reported by 77.6% of men) nocturnal emission (71%). masturbatory guilt (33%); and concern about penis size (30%), were all more frequently reported than were complaints of erectile dysfunction (24%) (Verma, Khaitan, & Singh, 1998).

 Other evidence that the sexual problems of diverse cultures do not mirror those of North America or Western Europe comes from what are typically called culture-bound syndromes (CBS). Examples of CBS include Dhat syndrome (excessive worry about penis shrinkage due to masturbation) found on the Indian subcontinent and Koro or Koro-like syndromes in West Africa where men (predominantly), believe that their genitals have either been stolen, or have shrunk inside their body and will cause their death. This syndrome of shrinking genitals is also known as Suo-yang (Mandarin) or Shook-yang (Cantonese) in China. Unconsummated marriage, not due to any specific sexual dysfunction (Zargooshi et al., 2012), handkerchief stress (a term coined to reflect the anxiety of having to produce a blood stained cloth on the wedding night to prove virility) (Sungur, 2012) and concerns regarding having luck (good and bad) transmitted through sexual behavior (Savage, 2012) may represent real challenges to Western based notions of what constitutes a sexual problem. Hughes (1998) argued that instead of viewing CBS as a collection of bizarre or exotic sexual problems, they are best seen as examples of the way culture influences the manifestation of psychopathology.

Western definitions of sexual dysfunction highlight the performance aspect of sexuality, our linear view of sexual response (first desire, arousal, and then orgasm) and the individualism inherent in our culture (the individual nature of the diagnosis and the criterion that the person him or herself must be distressed about the problem) (American Psychiatric Association, 2000). The prevalence of Western defined sexual dysfunction in other areas of the world may indicate the extent to which values diverge or are shared. For example, while low sexual desire is the most frequent complaint of women in the West, in more male centric cultures, vaginismus is the primary sexual complaint for which women seek help (Yasan & Gurgen, 2009). The prevalence of vaginismus in these cultures has been attributed to the high premium placed on virginity and the fact that vaginismus interferes with intercourse (and therefore with male pleasure) and can significantly hinder reproduction (Sungur, 2012). Furthermore, as Yasan and Gurgen (2009) have pointed out: “It is understandable that women who have been forced to marry without consent and who know that they have to stay married for the rest of their lives, will have difficulties while experiencing sex unwillingly in their marriage.” (p. 73). We agree with these authors that while this is clearly a problem, it is not one best viewed as the problem of an individual woman but a reflection of a culture in which there is little or no autonomy for women.

 In summary, we find a paucity of good data regarding the experience of sexual problems in different cultures. While Western-defined sexual dysfunction may be found in other cultures, the rates of occurrence and the distress experienced vary across different countries (Laumann et al., 2005). The sexual problems that are significant for other cultures may be quite different from those found in the West. A good resource for the interested clinician regarding sexual problems and treatment options may be found in *The Cultural Context of Sexual Pleasure and Problems: Psychotherapy with Diverse Clients* (Hall & Graham, 2012).

*Acculturation*

Given that sexuality is at least in part, culturally determined, it follows that when the culture changes, so should sexuality. One of the most striking examples of this phenomenon involved a study of the interaction of two very different cultures: Iran and Sweden (Darvishpour, 1999). Iranian migrants to Sweden were found to have significantly revised their views about sexuality to more closely approximate the values of the host country. They went from a traditional, authoritarian and patriarchal orientation to a more individualistic and egalitarian approach to sexuality. People who immigrate to another country will often retain their values and traditions but will also, and to a greater or lesser extent acculturate (adopt the values and traditions of the host country) (Ryder, Alden, & Paulhus, 2000). It has been assumed that acculturation proceeds in a linear fashion, with immigrants increasingly assimilating the cultural values and mores of the mainstream culture. However, studies examining the effects of acculturation on the sexual attitudes and behaviors of immigrants have found conflicting results with some finding that acculturation predicts sexual behavior and others reporting no effect (Meston & Ahrold, 2008). While this may be due to the different measures of acculturation that have been used across studies (questionnaires, length of residency), it is likely that a linear assimilation model does not adequately capture the experience by which people adopt some or all of the tenets of the mainstream culture (Ahrold & Meston, 2010; Brotto, Chik, Ryder, Gorzalka, & Seal, 2005). Brotto and her colleagues found that the degree to which Asian women maintained aspects of their heritage culture influenced the effects of Westernization on sexual attitudes. Women who relinquished heritage ties adopted the more liberal sexual attitudes of the Western culture, while women who maintained strong heritage ties did not. Ahrold and Meston (2010) described two models of acculturation: In one the heritage and mainstream culture blend together and become a third entity – much like tea, “with one element blending into, and changing the original nature of the other” (p. 199). The other model is one in which the two cultures retain their retain their original elements while coexisting, like oil and water when combined. Mutual engagement in both the heritage and the mainstream culture has been found to be the most widely used practice of Hispanic youth who blend their two cultures into a unique cultural identity, whereas Asians tend to retain aspects of their heritage culture while adopting some elements of the mainstream (Ahrold & Meston, 2010). It is not yet known what the impact of age, gender and other personality variables is on the process of acculturation. Clinicians need to be sensitive to the dual allegiance to heritage and mainstream culture and to be aware that despite assimilation of some aspects of mainstream culture (clothing, occupation, language), clients may retain heritage values with respect to family and sexuality. The same may be true for first generation clients, who were raised with traditional values of the heritage culture but have greater exposure to mainstream culture. *Nina, a first generation Italian woman came to therapy depressed after having sex with a male friend in college, an occurrence that she deeply regretted. Nina explained: “I was taught that sex is very important, something sacred for marriage. But for me, it’s only right if I’m in a relationship that I could see leading to marriage. I feel pressure with American men. Most of my friends think sex is fun, and it is of course, but I just feel so pressured, I want to say ‘No I don’t love you! I would never marry you’ but then they would think I was some kind of freak, so I said okay when I meant no.”* Cultural sensitivity needs to extend to an awareness and appreciation of various patterns of adherence to the old culture and adoption of the new culture.

*Culture and Religion*

Religion is one way in which values and attitudes and rules regarding sexual behavior are transmitted within a culture. The degree to which a culture embraces religious prohibitions and sexual proscriptions varies. Religion is an important factor in determining sexual behavior in the Arab and Persian countries of the Middle East (Zargooshi et al., 2012), but is a less significant factor in many Western countries and Russia (Hall & Graham, 2012; Temkina, Rotkirch, & Haavio-Mannila, 2012). Gender may moderate the impact of religion and culture on sexuality. In Croatia, inconsistent and weak associations were found between religiosity and sexual behavior among women, while no relationship existed for men (Puzek, Stulhofer & Bozicevic, 2012). Sex guilt, defined as “a generalized expectancy for self-mediated punishment for violating or for anticipating violating standards of proper sexual conduct” (Mosher & Cross, 1971, p. 27), was found to mediate the relationship between religion and culture with sexual desire in women. Woo, Morshedian, Brotto, and Gorzalka (2012) found that the activation of sex guilt reduced sexual desire in Asian Canadian women but not in European-Canadians. Simply put, a strong identification with one’s heritage culture or religion will mitigate the liberalizing impact of Western acculturation on sexual attitudes and behavior. Strength of religious identification may explain within-ethnic group differences in sexual attitudes and is therefore an important issue to be addressed during assessment and treatment of sexual problems.

*How does culture influence sexual dysfunction?*

Hughes (1998) outlined three ways in which culture influences psychopathology, which we believe has relevance for sexual disorders. The first is on the phenomenology of symptoms; for example, culture influences the way distress is experienced. The second is in the syndromization of symptoms into patterns and the third is in the diagnostic process itself; for example, when the clinician does not understand or is unfamiliar with the culture of the patient, diagnostic errors may result (usually, but not always in the direction of over-pathologizing).

We believe that the diagnosis of low sexual desire in women illustrates the three ways that culture influences sexual disorders. While there is sometimes a biological basis for low desire, the prevalence of this disorder in North America indicates that there are multiple pathways for the diagnosis. The reduction in sexual desire for a loved partner is perhaps a very important way in which Western women manifest the stress, the unfair burden of housework, or other relationship unhappiness. Because refusing sex is a possibility accorded to Western women, a basic right not shared by women worldwide[[1]](#footnote-1), low sexual desire may be accompanied by avoidance of sex. Nevertheless, sex when it does occur may still be enjoyable. Since desire is deemed important and is often equated with love, North American and Western European women often feel distress about their lack of desire. In North American and Western Europe relationship distress may manifest in low sexual desire (culturally influenced expression of unhappiness); which will be experienced as a distressing lack of interest in sex, a high rate of refusing sex initiated by a partner, and a somewhat paradoxical enjoyment of the infrequent sex that does occur (the syndromization of symptoms into patterns). This clinical picture will be familiar to Western trained sex therapists and a diagnosis of low sexual desire is likely to result. Since female consent, and certainly sexual desire, is not deemed necessary in some other cultures (e.g., traditional Korean culture), unhappy or stressed women may engage in frequent, but unwanted sex, may experience disgust regarding sex and may come to manifest hostility towards their spouse and disdain for men in general (Youn, 2012). This symptom constellation may be unfamiliar to a Western trained therapist, who, upon encountering one Korean woman with this clinical presentation, may attribute her severe anger and hostility to underlying pathology (e.g., a mood or personality disorder).

*Culture and Issues Related to Diagnosis of Sexual Dysfunctions*

The assumption that there is a universal model of sexual response leads to the belief in a universal set of sexual dysfunctions. Although there were efforts to enhance the cross-cultural applicability of diagnoses in DSM-IV-TR, critics argued that these efforts fell short and that “the DSM’s underlying thesis of universality based on Western-delineated mental disorders is problematic and has limited cross-cultural applicability.” (Thakker & Ward, 1998, p. 501). While the sexual problems of individuals from other cultures may fit into some of the current Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnoses for sexual dysfunction, they may more often need to fall into the category of Sexual Dysfunction Not Otherwise Specified (NOS) (American Psychiatric Association, 2000).

In recent years there has been a growing awareness of the importance of culture in diagnosis and this has been reflected in the development work for DSM-5. The research agenda for DSM-5 included publications related to cultural issues in diagnosis (APPI, 2000) and experts on cultural issues have been appointed to some of the workgroups, including the Sexual and Gender Identity Disorders Workgroup (Dr. Jack Drescher). There was a study group on Gender and Cross-Cultural Issues, convened to “address gender, racial, and ethnic issues in mental disorders, including differences in symptoms, symptom severity, and course of illness” (American Psychiatric Association, 2012). As a result the descriptive text accompanying the DSM5 diagnostic criteria for sexual dysfunctions highlights the importance of considering cultural factors such as inhibitions related to prohibitions against sexual activity, attitudes toward sexuality, etc.

*Assessment*

Culturally sensitive assessment evaluates individuals and couples in the context of culture. Culture is viewed as essential to understanding sexual problems, not as something ancillary or exotic. Cultural values and ties may also be seen as strengths that can guide the treatment process, not solely part of the pathology (Ahmed & Bhugra, 2004; Hall & Graham, 2012; Kelly & Shelton, 2012).

 When encountering an individual or couple from another culture the clinician must try to understand the unique meaning of the sexual symptoms, rather than diagnosing them using the therapist’s own cultural lens. For example, Ramanathan and Weerakoon (2012) described their treatment of a young Indian man who presented with fears that he had damaged himself by masturbating. The man was concerned because he felt weak, he worried that his eyesight had been affected and that his acne was a manifestation of the damage caused by his masturbation. These concerns had not stopped the young man from masturbating, and now he worried that he could not control himself and that he would not be able to have sexual intercourse with his wife when he got married. If this young man had encountered a Western therapist, his symptoms might have seemed rather quaint and the impulse might have been to paternalistically explain that masturbation is not harmful and can indeed help a man prepare for marriage by boosting his confidence in his ability to get and maintain an erection and also to identify what arouses him. Instead the therapist in this case inquired about the meaning of the fears. The young man was indeed reaching the age where his parents would arrange a match for him. He was anxiously looking forward to marriage, but there was tremendous pressure on him to represent his family well, to please his new wife, and to be found attractive and desirable by her and her family. Indeed, the process that young Indian men and women go through in being evaluated by their potential in-laws is rather daunting and is brilliantly described in the novel *A Suitable Boy* (Seth, 2005). Ramanathan and Weerakoon did not try to dissuade the young man from his beliefs. Instead they addressed the meaning of the man’s distress – his concern about his suitability for marriage. The young man was sent for tests to determine the basis for the weakness, prescribed good nutrition to add strength, had his eyesight tested and was given a medication for the acne. He was also asked to refrain from masturbating for several days prior to the each of the several medical tests. This helped him realize that he could have control over his masturbatory behavior. The therapist also provided information about sex to alleviate anxiety about what to do in order to consummate the marriage.

As in the case described above, we advocate for an approach to assessment in which the clinician tries to understand the presentation of symptoms from the client’s perspective, recognizing that this perspective is strongly influenced by the culture in which that client was raised. At present, the best way to do a culturally sensitive assessment is to carry out a thorough diagnostic interview.

*Assessment Instruments: Tests and Questionnaires*

Many researchers have noted the limitations in regards to cross-cultural assessment instruments. As Rellini et al. (2005) pointed out, the majority of questionnaires used to assess sexual functioning in women were developed for, and standardized on, a Western, typically U.S., population. The lack of importance accorded to validation of measures in different cultures is grounded in the assumption that the constructs of sexuality that underlay the original questionnaire are unaffected by culture. Rellini et al. translated the McCoy Female Sexuality Questionnaire into Italian and attempted to validate it on an Italian sample. They found that of the five factors that were apparent on the original questionnaire, only two had relevance for the Italian sample: sexuality and partnership. These two factors differentiated women with sexual dysfunctions from those who did not have such issues, but the separate constructs underlying the phases of the sexual response cycle (i.e. desire, arousal, and orgasm) were not meaningfully related to sexual problems in the Italian sample. While these findings may have reflected translation difficulties, they may also reflect differences between Italian and American women in how they experience their sexuality. The Iranian validation of the Female Sexual Function Questionnaire (Quirk et al., 2002), also found a factor structure different from the original test (Khademi et al., 2006). Interestingly, the married women who responded to the questionnaire found a question on “enjoyment of non-penetrative sex” confusing and rarely responded to it. Other researchers have questioned whether the methods of assessing sexual desire and sexual enjoyment used in North American/European contexts are appropriate in different cultural settings (Graham, Ramos, Bancroft, Maglaya, & Farley, 1995). For example, in a study of the effects of oral contraceptive use on mood and sexuality carried out in women living in Edinburgh, Scotland and Manila, Philippines, there were striking differences between the two samples at baselines. The Manila women, whilst reporting a somewhat higher frequency of intercourse than the Scottish women, were less likely to initiate, had less sexual interest, less sexual enjoyment, and were less likely to feel “close and comfortable” with their partners during sexual activity (Graham et al., 1995). Although the interview and questionnaire measures had been translated and back-translated, and the Manila interviewers were trained, the authors questioned whether the method of assessment was appropriate for the Manila women. Personal pleasure for women and the individual (versus relationship) orientation of many interview formats and questionnaires may be seen as less relevant in collectivist and/or male-centric cultures (Hall & Graham, 2012)

Similar issues affect the assessment of male sexual dysfunction. The International Index of Erectile Function IIEF (Rosen et al., 1997) is the most popular measure of erectile dysfunction and it has been successfully translated into a variety of European languages and validated for use in many European countries (Rosen, Cappelleri, & Gendrano, 2002). The applicability of the IIEF to non-Western cultures has not been established. It was difficult to translate the IIEF into Malaysian because the language often referred to sex obliquely (e.g., intercourse is translated as “joining together in one body) or with moral undertones (sex organs are literally translated as “shame”) (Lim et al., 2003).

 Although there may be measures that are developed and validated for use with other cultures, it is difficult to find them, if they do exist. When seeing clients from non-Western cultures, we suggest using assessment measures developed in the West with caution – checking to see that the measure in question has been validated for use with a specific population and carefully looking at the answers to specific items, including following up with the client to ensure that the meaning of the question was clear. As Kelly and Shelton (2012) have observed, it is also important to keep in mind that an over-reliance on paper and pencil tests may be off-putting to certain cultural groups. A diagnostic interview may be the best way at present to gather a sexual history and to diagnose sexual problems.

The most important aspect of the diagnostic interview is the attitude of the interviewer. It is important to be flexible in our style and our openness to understanding problems from other perspectives. For example, an American patient of East Indian background was referred to one of us (KH) for a court-ordered evaluation regarding homicidal threats made to her husband. Her husband had succeeded in having her removed from the home and had a restraining order against her. She wanted to reconcile with her husband, but he feared for his life, and the judge was concerned that the woman was mentally ill. In the evaluation the woman readily admitted that she had told her husband (East Indian by birth and ethnicity) that she had put rat poison in some of his food and that she would tell him which food was poisoned if he asked. The background of the story was complex. The wife had recently undergone a hysterectomy for medical reasons and her in-laws came to visit shortly thereafter. She was required to cook and clean for her in-laws, despite medical advice to rest after the surgery. She also worried (correctly) that her in-laws were there to persuade her husband to divorce her since she could no longer have children. For weeks she cooked and cleaned and listened to her in-laws complain about her to her husband, who never stood up for her. He refused to listen to her worries or her complaints and refused to lift a finger to help her. He felt that the answer to the problem was to show his parents what a good wife she was so that his parents would leave and stop pestering him to divorce her. Instead, his wife was doing the opposite, and proving to them that she was not a fit wife for their son. The husband felt caught in the middle and did not know what to do. Ultimately he stopped speaking to his wife altogether. In desperation, she bought rat poison and displayed it prominently in the kitchen (she denied using it and no food was ever discovered to be poisoned). We believe this was not a case of individual pathology on the part of the wife, or the husband either, but rather an example of the tremendous stress and pressure that couples face and the apparently bizarre ways in which their distress is manifest. The judge and lawyers wondered *Why didn’t she leave him? Why didn’t they go to therapy?* Her physicians told her *You cannot keep doing this housework, you are making yourself sick, you have to stand up to your in-laws. Tell your husband that you cannot cook and clean for 6 weeks. Can’t you hire a cleaning lady?* All these are reasonable questions for Western born and raised couples, but they fail to understand the context of the distress of this couple.

*From Culturally Competent to Culturally Sensitive Sex Therapy*

Cultural competence “denotes the capacity to perform and obtain positive clinical outcomes in cross-cultural encounters” (Lo & Fung, 2003, p. 162). Successful treatment of sexual problems will require tailoring treatment to the unique cultural requirements of the individual or couple. In some cases traditional psychotherapy or sex therapy approaches can be modified (Ahmed & Bhugra, 2004; So & Cheung, 2005). Culture-specific modifications to the method of treatment may be most successful when the sexual problems are similar to those for which sex therapy was designed e.g., problems of sexual function, such as erectile dysfunction, ejaculatory problems and orgasm difficulties and when the clinician is familiar enough with the culture to make the necessary modifications. For example, So and Cheung outlined ways in which sex therapy could be modified for Chinese couples, including the admonition that sex therapists be directive and authoritarian. However, tailoring therapy in this way requires the therapist to be a chameleon, may modify the therapeutic relationship to the extent that it is no longer therapeutic, and requires that treatment approaches be adapted in ways that may alter the success of therapy (Sue & Zane, 2009). It also requires a breadth of cultural knowledge that most clinicians simply do not possess, and as the vignette at the beginning of the chapter illustrates, clients will often not return for the second appointment (when you have done your homework and understood a *little* about the culture). It is simply not workable to have a model of cultural competence that requires that treatments be modified for each culture. This approach also promotes overgeneralizing (Sue & Zane, 2009) or stereotyping, as clearly it is not feasible to understand the diversity and nuances of all cultures.

We believe that a culturally sensitive approach to sex therapy is one that recognizes the centrality of culture in shaping sexuality. Moreover, we argue that the importance of the therapist and client sharing meanings is central to the success of therapy, and that with sensitivity, a shared meaning can be developed between therapists and clients of different cultural backgrounds. Therefore, we prefer the term culturally sensitive sex therapy, which stresses a flexible attitude rather that the term “competent” which emphasizes knowledge and behavior.

*Case Discussion*

Suleman and Nasreen

Suleman and Nasreen were a married couple in their early 30s. Both were of Pakistani origin; Suleman was raised in the United Kingdom, while Nasreen was primarily raised in Pakistan and only spent two years in London prior to moving to the United States. At the time they came to therapy they had been living in the U.S. for two years. Nasreen made the initial request for therapy, stating on the phone that she had found me (KH) through an Internet search. She explained that her marriage was in trouble and that she wanted help to fix it. She confirmed that the problem had to do with sex.

When the couple presented together they seemed to be a bit of a mismatch. Suleman was tall, light-skinned, athletically built, and very attractive. He wore jeans and a t-shirt. Nasreen was short, plump, and rather plain with a dark complexion. She was dressed in a designer dress and high heels with a scarf loosely draped around her head and neck. (Her appearance bespoke her dual cultural allegiance as well as the fact that in all things she was trying very (too?) hard). Nasreen explained her worry that her husband had “problems” because he did not seem to want to have sex very often. The frequency of sex was once every three weeks or so, but it had been steadily declining since their move to the United States. When asked why this distressed her, Nasreen began to talk about all the hurts, slights, and insults she perceived coming from Suleman’s family. Of Suleman, she reported that he was a kind husband and a loving father to their three-year-old daughter. Suleman sat quietly and never interjected. He answered politely when asked questions. He said that the frequency of sex was not a concern to him. He explained that he was tired during the week from his long commute, that he often brought work home on the weekend because he wanted to be successful in his new job and get a promotion which would allow them to move into a house and have more children. Suleman agreed to come to therapy to make his wife happy. He was unsure as to whether there really was a sexual problem.

 Suleman was the middle of three sons born to a Muslim Pakistani family in East London, England. He had been married previously in a match arranged by his parents. Unfortunately, his first wife had been bullied by her family into the marriage and refused to have sex with Suleman in order to annul the marriage. The families got involved, with the bride’s family claiming that if Suleman could not have sex with his wife he must be impotent. Ultimately Suleman’s family agreed to a divorce with a monetary settlement in order to avoid further scandal. Suleman felt extraordinarily shamed by the failure of his marriage and betrayed by his parents who were supposed to vet the bride for him. He isolated from friends and family and spent his free time working out at a gym and watching pornography. He began to drink. As Suleman became increasingly estranged from his Islamic faith and his community he became depressed. In his isolation, Suleman went online to a chat room for Muslims, which is where he met Nasreen.

Nasreen was the only child born to her Pakistani parents. Her father had a business, which had been lucrative at one time, but her father’s health began to fail soon after she was born and after a series of failed financial transactions, the family moved in with her father’s eldest and more successful brother. Nasreen reported that although she was treated well, she was aware that her cousins had better clothes and more opportunities than she did. When Nasreen was in her late teens her father’s fortunes changed and the parents moved into their own flat and sent Nasreen to London to go to university. Nasreen was depressed and lonely in London and dropped out of university after her first term. She tried waitressing at an Indian restaurant for short period of time and she did not tell her parents that she had left school. Nasreen felt socially awkward and spent much of her free time on the Internet.

 After Nasreen and Suleman met in an online chat room for young Muslims, they began talking on the phone and then meeting for coffee. Both described a feeling of comfort and belonging with each other that they had not felt before. Suleman stopped drinking and going to clubs, and was welcomed back into his family. They ultimately accepted his decision to marry Nasreen as his divorce had negatively impacted his chances for a “good” match. Nasreen was Pakistani and Muslim, but she had several points against her, according to Suleman’s family: She was not educated, her skin was too dark, her father was not educated nor a professional and she had worked as a waitress. Soon after their marriage, Suleman was offered a good position at a financial services company on Wall Street. The couple settled in New Jersey in a Muslim/Pakistani community and lived close to Suleman’s older brother and his wife. Suleman began to drink again, although only in the privacy of his home and also returned to watching pornography and masturbating for his sexual pleasure. Nasreen also masturbated to orgasm, although she had never had an orgasm with partnered sex. The couple’s sex life had never been very satisfactory for either partner and had consisted of brief kissing and caressing followed by intercourse.

When asked in individual sessions about the reason for their infrequent sex, the couple had two very different interpretations. Suleman said that he loved Nasreen and that she was a good mother and a good wife. However, he did not find her very sexually appealing and it was easier for him to get his sexual needs met by masturbating to pornography, which he enjoyed a great deal. Suleman had been taught to masturbate by his older cousin when he was 12 years old. His cousin had masturbated him to orgasm and instructed Suleman how he could do this to himself. Suleman did not view this as sexual abuse despite the fact that his cousin was at 7 years older than him at the time. Suleman felt pleased to have received the information and instruction and he remained on good terms with his cousin. Suleman said that he wished someone had taught him how to have sex with a woman and he still felt very ashamed of the failure of his first marriage. To Suleman it was a good thing that he was not strongly attracted to his wife, as he felt that he needed to be more successful professionally in order to be happy and that the only thing lacking in his family life was a son. He was concerned about his wife’s unhappiness, however.

 When asked for her belief about the reason for her unhappiness, Nasreen could not stay on topic for any length of time. Instead of talking about her relationship with Suleman she digressed to discussing slights she perceived coming from his brother, or more particularly her sister-in law: *She doesn’t invite me over, she didn’t talk to me at this party or on that occasion, she did not thank me for the gift, she did not put out the food I brought over…*..Nasreen expressed the wish for Suleman to talk to his brother so that her sister-in-law would be better behaved towards Nasreen.

*An attempt at sex/couples therapy in the Western style.*

At first it appeared that Nasreen’s unhappiness about the frequency of sex was due to her unhappiness regarding the relationship. She wanted to have a closer relationship with her husband, who worked a lot and was somewhat withdrawn. Because she was relying on her sister-in-law to help her integrate into the community, she felt lonely and isolated. Also, it appeared that this situation mirrored the situation she was raised in, relying on an older and more successful brother for status in the community. Goals for therapy were to help Nasreen make more connections in the community (without having to rely on her sister in-law,) to increase the connection within the couple using their sexual relationship, which might increase in frequency, but which certainly could improve in the level of pleasure and connection experienced by both.

Suleman became very engaged in treatment and agreed with the goal of improving their sexual relationship. Nasreen also expressed interest in doing “homework” to improve their sexual relationship. Sensate focus I (touching and caressing the body without touching breast and genitals) was assigned with the goal of improving comfort and communication.

*Failure*

The next several sessions followed a similar path. Suleman made efforts to get home early to be able to spend time with Nasreen and to do the exercises. But there was always a reason Nasreen gave for why the exercise could not happen; she was too tired, their daughter was still awake, she had a stomach ache, she had to Skype with her parents in Pakistan. In session it was again hard to have Nasreen stay on topic; she continued to obsess and ruminate about slights from her sister-in-law. She did not make any efforts to reach out and make other connections in the community, even when it involved doing things she had expressed an interest in (play groups for her daughter, asking other mothers to come over, going to the library for children’s programs). *Was Nasreen a help rejecting complainer?* *Was she depressed and stuck in obsessive thinking about being slighted? Were her family of origin issues significantly interfering with progress?* Or was the problem that the therapist had not yet understood what Nasreen was desperately trying to tell her.

*Becoming Culturally Sensitive*

Amazingly, Suleman and Nasreen continued to come to sessions despite the lack of progress. I determined that I had not sufficiently understood the problem and needed to listen to Nasreen more closely (as she was the one presenting the obstacles). This time I listened to the meaning inherent in her story. Her meaning seemed clear: The problem was that Suleman’s family had never really accepted her or the marriage. She felt that this was holding Suleman back from truly loving her. The solution, she felt, was that the marriage needed to be sanctioned by Suleman’s family.

 I agreed with Nasreen that it was important for the two of them to have family approval for their marriage. When Suleman protested that his family had consented to the marriage, I stated: “Now Nasreen knows it is important that they *accept* the marriage”. Both agreed that they could do the sensate focus exercises to strengthen their intimate connection while they also worked on ways to increase familial acceptance. Increasing their intimate connection would help others to see them as a happily married couple and would help Suleman’s family see that the marriage was a good one. Nasreen was enthusiastic, but Suleman was pessimistic.

 The next week the couple returned and had done the first sensate focus assignment three times. It was very pleasurable for both and new in that Nasreen had been able to communicate her likes and dislikes to Suleman. Suleman felt very pleased with the exercise as well and found it enjoyable to touch and be touched without the pressure to have intercourse. He could tolerate what he would otherwise perceive as criticism as Nasreen was now the “teacher” he had wanted. Suleman reported that he felt sexually attracted to his wife. The two had also discussed ways in which they could address the family issue. They had decided to have a small gathering as the youngest brother and his wife were coming to New Jersey from East London for their annual visit. Last year they had not come to Nasreen and Suleman’s home – a slight Nasreen felt intensely. As they planned and discussed the party, they reported feeling close to each other. Nasreen felt optimistic about the marriage and both readily agreed to proceed to sensate focus II – caressing including breasts and genitals. This exercise again went well. Nasreen worked on communicating her pleasure more overtly, and guiding Suleman in constructive and positive ways. Suleman reported feeling more comfortable and confident and basked in his wife’s praise during the session. He also reported that he liked the way the Nasreen touched him and that he had an erection during times he was touched and also when he was touching Nasreen. This pleased Nasreen greatly and she reported feeling desired by Suleman for the first time in their marriage. Nasreen also felt certain that the party would be a success and that the oldest brother, who was the de facto head of the family in the United States would surely send his parents positive reports about Suleman’s wife.

Disaster struck however, and the next meeting was difficult. The couple did not discuss sex at all. Instead they reported on family events. The sister-in-law had taken exception to Suleman and Nasreen planning a party for the younger brother. She insisted that the party be held at her home, which is larger and a more appropriate venue since the eldest brother should host. Suleman accepted the situation and shrugged it off, saying that there was nothing to do. Nasreen felt deeply depressed and hurt. She expressed suicidal ideation. Nasreen did not see her reaction as too intense. Rather she felt it was an appropriate reaction to not being treated like a wife and sister (sister-in-law).

*Consulting Experts*

It was difficult in the session to help Nasreen gain a perspective on the situation that would help her feel less depressed. Suleman offered several options: he would talk to his brother, they would boycott the sister-in-law’s party, they would still host their own party; all to no avail. Nasreen continued to be despondent and Suleman was losing patience. I was unsure of how to proceed. It was time for the experts. My cultural sensitivity was failing me. I knew that Nasreen “skyped” with her family and felt supported by them, so I encouraged both Nasreen and Suleman to talk to their parents about the situation and ask for guidance. Suleman’s parents ultimately supported the older brother, but Suleman’s discussion with his parents became known to the younger brother and his wife. While in New Jersey, this sister-in-law reached out to Nasreen and the two found that they both had difficulties with the superior airs of their eldest sister-in-law. Finally Nasreen had found an ally in the family. Nasreen’s parents had been alarmed at the situation and alarmed by Nasreen’s depression. After speaking with her they decided that they needed to come to visit – for three months.

 For most Americans, a three-month visit from family, in a small one bedroom apartment, would be a disaster for sex therapy. In this case it was a bonus. Sex therapy, which had come to a standstill during this time was restarted anew. Nasreen’s parents knew that the couple were having sexual problems and knew that they had exercises to do. So they did what they could to make the exercises easier for the couple. They readily babysat their granddaughter, making dates possible. They cooked and cleaned, alleviating the household burdens from Nasreen. While they slept in the one bedroom in the apartment, the three year old daughter slept in their room and they agreed not to walk into the hallway during certain hours (necessary to use the bathroom) so that these hours would be available to the couple for working on sex. While his in-laws praised him and extolled Suleman’s virtues at every turn, Nasreen felt that their visit really showed their love for her and gave her a sense of family. It was Nasreen’s mother who provided the key to success. She told Nasreen: *You are the second wife of a very good man, who is the second son from a very good family. This family accepts you. It is you who does not accept your place in the family. If you don’t like it, you don’t have to stay here. This is America; you have choices here.”* In session Suleman and Nasreen agreed that they did not like the option of staying in a second-class place. They began looking for a community to move to, each weekend going to a different town within commuting distance from New York to check it out. These were pleasant family outings (complete with daughter and parents).

Sex therapy proceeded with renewed energy and at a faster pace. With his in-laws staying with them, Suleman had no opportunity to drink or watch pornography. Without his usual diversions, Suleman was more interested in having sex with Nasreen. Pleasing his wife sexually was culturally valued and also valued by Suleman, who genuinely cared for her. With the support of her parents, and the knowledge that *she* did not accept the marital family, not the other way around, Nasreen felt that she needed to attend to being a better wife. She made an effort to stay up at night and talk with Suleman about his work, she began to plan meals and fun outings for the family. It also meant doing the sex homework, which she came to enjoy very much. Nasreen had an orgasm for the first time with Suleman, which thrilled the two of them equally. At the end of three months the couple was nervous about the departure of Nasreen’s parents, but they were moving to an ethnically diverse town several hours away where they felt a sense of community was possible. Nasreen had already signed up for a “Mommy and me” class with her daughter and Suleman’s commute was considerably shorter so he anticipated being home earlier in the evening.

 The couple asked for a referral to continue therapy, which they felt was very helpful to them. However, they reported back after several months that they were doing well and were continuing to have regular and enjoyable sex. They declined a referral.

*Summary*

The important elements to the ultimate success in this case highlight some of the important elements for successful culturally sensitive treatment. It is imperative that therapy begins with a shared understanding of the problem. The way in which the individual or couple discuss their sexual problems provides important information about the meaning of the sexual problem. This will guide treatment. Embracing the culture, which means seeing the culture as a potential source of strength, rather than solely a source of problems allows the clinician access to factors that may further treatment progress. In this case it was extended family. As this case demonstrates, the sex therapy techniques themselves did not radically change, nor did the therapist radically change her therapeutic style, although the context was culturally unique.

*Future Directions*

Sex research, sexual medicine and sex therapy are either non-existent or marginalized professions in many parts of the world. As Stulhofer and Arbanas (2009) stated, “ The absence of tradition and lack of professional training programs, as well as financial and status-related disincentives for young aspirants, makes sexual problems and dysfunctions nobody’s business.” (p. 1044). We believe that bringing sex therapy to many parts of the world can raise awareness of sexual problems and can inform the public and related professions that treatment options are available.

It is important to note that while we advocate cultural sensitivity, we are not condoning cultural values and practices that we believe are intrinsically harmful. Gender inequality, which is often culturally entrenched and which affects sexuality is a case in point. Sexual wellbeing, as measured by emotional and physical satisfaction with one’s sexual relationship, satisfaction with sexual function and stated importance of sex, was higher for men than for women in all the countries surveyed in the GSSAB (Laumann et al., 2006). In many parts of the world, female sexual pleasure is not considered important, or it is considered dangerous. Female genital cutting, forced marriages of girls and women, and the sex trafficking of women and children are dangerous practices. There is a high rate of intimate and partner sexual violence, perpetrated primarily by men against girls and women (World Health Organization, 2005). Sex therapy promotes the equal right to sexual pleasure and safety for men, women and transgender individuals of all sexual orientations. The ubiquitous presence of sexual medicine, which at present has little to offer women in terms of enhancing sexual pleasure (Hall & Graham, 2012), may further this imbalance if it is also not practiced with sensitivity and augmented with at least some education and counseling. Sex therapy might not save the world, but it can do its part to improve the lives of the people in it.

Improving the lives and the sexual health and pleasure of women and men cannot wait for psychotherapy to be culturally accepted and practiced in communities in which it is not yet established. As Alain Giami (2012) asked, “Who in the culture is authorized or privileged to hear about the sexual problems and offer help?” Often it is the traditional healers. The explanations traditional healers give regarding sexual dysfunction often match the patient’s own understanding. They use a common language and their treatments are based on this mutual understanding, making for better treatment compliance. Perhaps even more importantly, in cultures in which there is no formal psychotherapy, traditional healers take the time to listen and this “therapeutic relationship” may be at the core of their effectiveness as healers (Ahmed & Bhugra, 2004). If psychotherapy is to be relevant to the treatment of sexual problems in an ever changing and varied cultural landscape, adaptation, innovation and flexibility will be necessary (Hall & Graham, 2012).

**References**

Ahmed, K. & Bhugra, D. (2004). The role of culture in sexual dysfunction. *Psychiatry*, *3*, 23-25.

Ahrold, T.K. & Meston, C.M. (2010). Ethnic differences in sexual attitudes of U.S. college students: Gender, acculturation, and religiosity factors. *Archives of Sexual Behavior, 39,* 190-202.

American Psychiatric Association (2000). *Diagnostic and statistical manual of mental disorders* (4th edition) (DSM-IV-TR). Washington, DC: Author.

Bancroft, J. (2009). *Human sexuality and its problems*. (3rd ed.) Elsevier, London.

Bancroft, J., Loftus, J., & Long, J. S. (2003). Distress about sex: A national survey of women in heterosexual relationships. *Archives of Sexual Behavior, 32,* 193-208.

Barrett, M. S., Chua, W-J., Crits-Christoph, P., Gibbons, M. B., Casiano, D., & Thompson, D. (2008). Early withdrawal from mental health treatment: Implications for psychotherapy practice. *Psychotherapy: Theory, Research, Practice, Training*, *45*, 247-267.

Brotto, L. A., Chik, H. M., Ryder, A. G., Gorzalka, B. B., & Seal, B. N. (2005). Acculturation and sexual function in Asian women. *Archives of Sexual Behavior*, *34*, 613–626.

Brotto, L. A., Bitzer, J., Laan, E., Leiblum, S., & Luria, M. (2010). Women’s sexual desire and arousal disorders. *Journal of Sexual Medicine*, *7*, 586-614.

Cain, V. S., Johannes, C. B., Avis, N. E., Mohr, B., Schocken, M., Skurnick, J., & Ory, M. (2003). Sexual functioning and practices in a multi-ethnic study of midlife women: Baseline results from SWAN. *Journal of Sex Research*, *40*, 266–276.

Darvishpour, M. (1999). Immigrant women challenge the role of men: Conflict intensification within Iranian families in Sweden. *Nordic Journal of Women’s Studies*, *7*, 20-33.

Francoeur, R. T. & Noonan, R. J. (2004). (Eds.) *The continuum complete international encyclopedia of sexuality.* Retrieved from http://www.kinseyinstitute.org/ccies/index.php.

Giami, A. (2012). The social and professional diversity of sexology and sex therapy in Europe. InK. S. K. Hall, & C. A. Graham (Eds.), *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients* (pp. 373-393). New York:Routledge.

Graham, C. A.,& Bancroft, J. (2006). Assessing the prevalence of female sexual dysfunction with surveys: what is feasible? In: I. Goldstein, C. Meston, S. Davis, & A. Traish (Eds.). *Women’s sexual function and dysfunction: Study, diagnosis and treatment* (pp. 52-60). London: Taylor and Francis.

Graham, C. A.,Ramos, R., Bancroft, J., Maglaya, C., & Farley, T. M. M. (1995). The effects of steroidal contraceptives on the well-being and sexuality of women: A double-blind, placebo-controlled, two centre study of combined and progestogen-only methods. *Contraception*, *52*, 363-369.

Hall, K. S. K., & Graham, C. A. (2012). *Introduction*. InK. S. K. Hall, & C. A. Graham (Eds.), *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients* (pp. 1-20). New York:Routledge.

Hayes, R. D., Dennerstein, L., Bennett, C. M., & Fairley, C. K. (2008). What is the ‘true’ prevalence of female sexual dysfunctions and does the way we assess these conditions have an impact? *Journal of Sexual Medicine*, *5*, 777-787.

Hindin, M. J., & Muntifering, C. J. (2011). Women’s autonomy and timing of most recent sexual intercourse in Sub-Saharan Africa: A multi-country analysis. *Journal of Sex Research*, *48*, 511-519.

# Hughes, C. C. (1998). The glossary of culture bound syndromes in DSM-IV: A critique. *Transcultural Psychiatry, 35,* 413-421.

Khademi, A., Alleyassim, A., Agha-hossein, M., Dadras, N., Asghari Roodsari, A., Tabatabaeefar, L. & Amini, M. (2006). Psychometric properties of Sexual Function Questionnaire: Evaluation of an Iranian sample. *Iranian Journal of Reproductive Medicine, 4,* 23-28.

Kelly, S., & Shelton, J. (2012). *African American couples and sex.* InK. S. K. Hall, & C. A. Graham (Eds.), *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients* (pp48-83). New York:Routledge.

# Kempeneers, P., Andrianne, R., Bauwens, S., Georis, I., Pairoux, J-F, & Blairy, S. (2012). Functional and psychological characteristics of Belgian men with premature ejaculation and their partners. *Archives of Sexual Behavior,* doi 10.1007/s10508-012-9958-y.

Laumann, E. O., Nicolosi, A., Glasser, D. B., Paik, A., Gingell, C, Moreira, E., & Wang, T. (2005). Sexual problems among women and men aged 40-80 years: Prevalence and correlates identified in the Global Study of Sexual Attitudes and Behaviors. *International Journal of Impotence Research*, *17*, 39-57.

Laumann, E. O., Paik, A., Glasser, D. B., Kang, J-H., Wang, T., Levinson, B.,…Gingell, C. (2006).A cross-national study of subjective sexual well-being among older women and men: Findings from the Global Study of Sexual Attitudes and Behaviors. *Archives of Sexual Behavior, 35,* 143-159.

Lewis, L. J. (2004). Examining sexual health discourses in a racial/ethnic context. *Archives of Sexual Behavior*, *33*, 223-234.

# Lim, T. O., Das, A., Rampal, S., Zaki, M., Sahabudin, R. M., Rohan, M. J., & Isaacs, S. (2003). Cross cultural adaptation and validation of the English version of the International Index of Erectile Function (IIEF) for use in Malaysia. *International Journal of Impotence Research, 15,* 329-336.

Lo, H. T., & Fung, K. P. (2003). Culturally competent psychotherapy. *Canadian Journal of Psychiatry*, *48*, 161-170.

Mercer, C. H., Fenton, K. A., Johnson, A. M., Wellings, K., Macdowall, W., McManus, S., …Erens, B. (2003). Sexual function problems and help seeking behaviour in Britain: National probability sample survey. *British Medical Journal, 327,* 426-427.

Meston, C. M., & Ahrold, T. (2008). Ethnic, gender, and acculturation influences on sexual behaviors. *Archives of Sexual Behavior*, *39*, 179-189.

Moreira, E., Brock, G., Glasser, D., Nicolosi, A., Laumann, E., Paik, A., Wang, T., Gingell, C. and for the GSSAB Investigators Group (2005). Help-seeking behaviour for sexual problems: the Global Study of Sexual Attitudes and Behaviors. *International Journal of Clinical Practice*, *59*, 6–16.

Mosher, D. L., & Cross, H. J. (1971). Sex guilt and premarital sexual experiences of college students. *Journal of Consulting and Clinical Psychology*, *36*, 27–32.

Oberg, K., Fugl-Meyer, A. R., & Fugl-Meyer, K. S. (2004). On categorization and quantification of women’s sexual dysfunctions: An epidemiological approach. *International Journal of Impotence Research, 16,* 261-269.

# Puzek, I., Stulhofer, A., & Bozicevic, I. (2012). Is religiosity a barrier to sexual and reproductive health? Results from a population-based study of young Croatian adults. *Archives of Sexual Behavior,* doi 10.1007/s10508-012-9924-8.

# Quirk, F. H., Heiman, J. H., Rosen, R. C., Laan, E., Smith, M. D., & Boolell, M. (2002). Development of a Sexual Function Questionnaire for clinical trials of female sexual dysfunction. *Journal of Women’s Health & Gender based Medicine, 11*, 277-289.

Ramanathan, V., & Weerakoon, P. (2012). Sexuality in India: Ancient beliefs, present day problems, and future approaches to management. InK. S. K. Hall, & C. A. Graham (Eds.), *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients* (pp. 173-196). New York:Routledge.

Rellini, A., H. Nappi, R. E., Vaccaro, P., Ferdeghini, F., Abbiati, I., & Meston, C. M. (2005).Validation of the McCoy Female Sexuality Questionnaire in an Italian sample.*Archives of Sexual Behavior, 34,* 641-647.

Robinson, B. E., Munns, R. A., Weber-Main, A. M., Lowe, M. A., & Raymond, N. C. (2011). Application of the Sexual Health Model in the long-term treatment of hypoactive sexual desire and female orgasmic disorder. *Archives of Sexual Behavior*, *40*, 469-478.

Rosen, R. C., Capelleri, J. C., Smith, M. D., Lipsky, J., & Pena, B. M. (1999). Development and evaluation of an abridged, 5-item version of the International Index of Erectile Function (IIEF-5) as a diagnostic tool for erectile dysfunction. *International Journal of Impotence Research*, *11*, 319-326.

Rosen, R. C., Cappelleri, J. C., & Gendrano, N. (2002). The International Index of Erectile Function (IIEF): a state-of-the-science review. *International Journal of Impotence Research*, *14*, 226-244.

Ryder, A. G., Alden, L. E., & Paulhus, D. L. (2000). Is acculturation unidimensional or bidimensional? A head-to-head comparison in the prediction of personality, self-identity, and adjustment. *Journal of Personality and Social Psychology*, *79*, 49–65.

Savage, N. (2012). The multi-cultural complexity of sexuality in Cameroon. InK. S. K. Hall, & C. A. Graham (Eds.), *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients* (pp. 113-134). New York:Routledge.

Seth, V. (1993). *A suitable boy*. London: Phoenix.

So, H. W. & Cheung, F. M. (2005). Review of Chinese sex attitudes and applicability of sex therapy for Chinese couples with sexual dysfunction. *Journal of Sex Research, 42*, 93-101.

Stulhofer, A. & Arbanas, G. (2009). Sex therapy in a cultural context. *Archives of Sexual Behavior, 38,* 1044-1045.

Sue, S., & Zane, N. (2009). The role of culture and cultural techniques in psychotherapy: A critique and reformulation. *Asian American Journal of Psychology*, *S(1)*, 3-14.

Sungur, M. (2012). The role of cultural factors in the course and treatment of sexual problems: Failures, pitfalls, and successes in a complicated case from Turkey. InK. S. K. Hall, & C. A. Graham (Eds.), *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients* (pp. 308-332). New York:Routledge.

Temkina, A., Rotkirch, A., & Haavio-Mannila, E. (2012). Sex therapy in Russia: Pleasure and gender in a new professional field. InK. S. K. Hall, & C. A. Graham (Eds.), *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients* (pp. 221-248). New York:Routledge.

Thakker, J. & Ward, T. (1998). Culture and classification: The cross-cultural application of the DSM-IV. *Clinical Psychology Review*, *18*, 501-529.

Uberoi, P., & Palriwala, R. (2008). *Marriage, migration and gender*. New Delhi: Sage.

Verma, K. K., Khaitan, B. K. & Singh, O. P. (1998). The frequency of sexual dysfunctions in patients attending a sex therapy clinic in North India. *Archives of Sexual Behavior*, *27*, 309-314.

# Waldinger, M. D., McIntosh, J., & Schweitzer, D. H. (2009). A five-nation survey to assess the distribution of the intravaginal ejaculatory latency time among the general male population. *Journal of Sexual Medicine*, *6*, 2888-2895.

# Waldinger, M. D., Quinn, P., Dilleen, M., Mundayat, R., Schweitzer D. H., & Boolell, M. (2005). Population survey of intravaginal ejaculation latency time. *Journal of Sexual Medicine, 2,* 492-497.

Williams, C. (1983). *Culture and society, 1780-1950*. New York: Columbia Press.

World Health Organization (2005). *Multi-country study on women’s health and domestic violence against women: Initial results on prevalence, health outcomes and women’s responses*. WHO: Geneva, Switzerland.

Witting, K., Santtila, P., Varjonen, M., Jern, P., Johansson, A., von der Pahlen, B., & Sandnabba, K. (2008). Female sexual dysfunction, sexual distress, and compatibility with partner. *Journal of Sexual Medicine, 5,* 2587-2599*.*

Woo, J. S. T., Morshedian, N., Brotto, L. A., & Gorzalka, B. B. (2012). Sex guilt mediates the relationship between religiosity and sexual desire in East Asian and Euro-Canadian college-aged women. *Archives of Sexual Behavior,* doi 10.1007/s10508-012-9918-6.

Wright, W. K. (2006). The tide in favour of equality: Same-sex marriage in Canada and England and Wales. *International Journal of Law, Policy and the Family,* *20*, 249-285.

Yasan, A. & Gurgen, F. (2009). Marital satisfaction, sexual problems and the possible difficulties on sex therapy in traditional Islamic culture. *Journal of Sex and Marital Therapy, 35,* 68-75.

Youn, G. (2012). Challenges facing sex therapy in Korea. InK. S. K. Hall, & C. A. Graham (Eds.), *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients* (pp. 156-169). New York:Routledge.

Zargooshi, J., Rahmanian, E., Motaee, H., Kohzadi, M., & Nourizad, S. (2012). Culturally based sexual problems in traditional sections of Kermanshah, Iran. InK. S. K. Hall, & C. A. Graham (Eds.), *The cultural context of sexual pleasure and problems: Psychotherapy with diverse clients* (pp. 136-154). New York:Routledge.

1. Interestingly there is evidence from a study in Sub-Saharan Africa that women who have greater autonomy in general household decision-making also have greater ability to choose the timing and frequency of sex (Hindin & Muntifering, 2011). [↑](#footnote-ref-1)