



BODY Culture, Body, Gender, Sexuality in Adult Trainings

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BODY IN CULTURE – CULTURE IN BODY

An anthology about the interface
between culture, body and communication

May 2013



open kijk op handicap



cesie
the world is only one creature

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The influence of cultural perceptions of the body in intercultural communication

An introduction to the Anthology

Margit Helle Thomsen

1.1 Preface

“The body brings the first impression in a social encounter. It bears the visual markers based on which we categorize each other automatically (age, gender, ethnicity, disability etc) and sometimes judge accordingly. The body also performs the rules of communication and respect – rules that show great diversity across cultures...” (From the description of the BODY project, 2011).

BODY is a two-year Grundtvig project which is funded by the European Commission under the Lifelong Learning Programme, Grundtvig. The BODY project has the overall aim to explore how our perception of the body and body-related themes such as health, disease, gender, age, sexuality and disability are influenced by cultural differences and at the same time affects our intercultural communication. Furthermore, the goal is to provide exemplary knowledge and experience on how professionals can handle cultural differences linked to the body in an appreciative and respectful way, when being in contact with citizens and users. It may apply to adult teachers and trainers as well as counselors, integration workers, health workers, social workers, job consultants, sexual supervisors and therapists, disability consultants and other professionals and frontline staff all over Europe.

Based on the Margalit Cohen-Emerique methodology Critical Incidents, the partners in the BODY project have described and analyzed a large number of concrete examples of how professionals in many different contexts have experienced and handled "culture shock" in reference to cultural perceptions of the body and body-related themes such as disability, sexuality, etc. We also collected a wide range of examples that illustrate how people around Europe through professional cultural encounters have developed best practices to accommodate cultural differences anchored in the body. The best practices all operate in the intersection between culture and body where intercultural empathy and respect have overcome the communication challenges and barriers that traditionally are known to be linked to the specific communication of the body.

The present anthology aims to supplement and complement the many practical experiences with a selection of articles and texts, which from different angles present a general analytical

view of the crossroads of culture and body, highlighting the importance of the body for intercultural encounters between people. The anthology is expanded to include a bibliography containing numerous references to texts that have put culture and body-related topics on the agenda.

This general introduction outlines our approach and framework of understanding in relation to the intersection between culture and body. The selected texts in the anthology reflect this approach in various ways. The introduction is organized as follows:

- Initially, we outline the background for the BODY project and address as a starting point the general question of how to define and conceptualize multiculturalism.
- Next, we explain our analytical and conceptual approach and cultural understanding. We describe how the general concept of culture has a strong influence on our concept of cultural differences in terms of the body and body-related issues such as sexuality, disability, gender, health, age etc.
- Thirdly, we define the concept of intercultural competence and communication. We give examples that illustrate the need for intercultural competences among professionals in the job performance.
- Finally, we conclude with a short presentation of the articles in the anthology.

1.2 The background: a multicultural and diverse Europe

Well over 72 million migrants are currently living in Europe. This is equivalent to almost 15 per cent of Europe's total population of more than 500 million. These figures also illustrate that Europe as a whole is characterized by multi-ethnicity, but also by multiculturalism.

We distinguish between multi-ethnicity and multiculturalism in order to emphasize that culture is not to be confused with ethnicity or different national origins. The concept of culture covers a much wider diversity, which also includes the cultural diversity that is the result of differences in living conditions, lifestyles, needs and affinities based on variables such as age, gender, socio-economic classes, sociocultural life, education and professions, sexual orientation, state of health, physical and mental resources, faith and religion, political beliefs, etc.

Thus, culture – and multiculturalism – goes far beyond national origins and traditions. At the same time, the growing multi-ethnicity in Europe is also an indicator that multiculturalism, increasingly, must be seen as a familiar feature of everyday life in most European countries. This applies to society in a broad sense as well as to the working life, where professionals are confronted with multicultural perceptions and expectations regarding the quality of service they provide when meeting with citizens and users. This goes for frontline staff in the

educational sector as well as the healthcare sector, employment sector, social sector, etc. It also implies expectations that the professionals have knowledge and understanding regarding the body-related needs of the individual citizen or segments of citizens. This may be expectations concerning body language, treatment of the body, or how to properly deal with the body in cultural encounters, where the body as well as nonverbal communication plays an important role in mutual understanding and respect between professionals and citizens and users.

Previously, such needs and expectations led both researchers and practitioners to point out the need for cultural “checklists.” Using these lists, professionals could check the specific cultural traditions, values and codes of conduct that were considered to be innate characteristics of citizens from a particular ethnic background. Such lists included body-related standards, where norms surrounding behavior, politeness, greetings, physical contact, eating and dress have played a central role.

The “checklist” approach and method has in recent years been rejected or at least been countered by the argument that it is based on a static conception of culture which does not take into account the mutual cultural adaptation that actually takes place in multicultural societies over time. The “checklist” approach can in the worst case also lead to culturalizations and ethnifications, meaning that certain attitudes, values and behaviors are automatically linked to a specific affiliation. Be it ethnic/cultural identity or affiliation with certain sexual minorities, disabilities etc.

The famous - or rather infamous - headscarf worn by many Muslim women is an example of how a particular item of clothing can lead to generalizations about women's capacity to join the labour market.

The seed of doubt that has been sown about the “checklist method”, should not be taken as a statement against the need for knowledge about other cultural contexts. It is both valuable and important to gain knowledge about other cultural values, norms and practices. The view is, however, that we may never be able to form a complete picture of other people's perceptions and individual management of cultural traditions and norms. We may perceive the woman wearing a scarf as suppressed by the sexual and gender-related norms of a patriarchal culture in the Middle East. In reality, we do not know, if this interpretation is relevant for this particular woman. The scarf itself does not tell the whole story, neither about the culture or about the individual person.

1.3 From a static to a dynamic concept of culture

"Spaniards are proud and conceited. Englishmen are affected. Germans are strict and disciplined, and the French are arrogant ..." Lots of stereotypes are continuing from generation to generation or are in vogue. They often show just how ignorant the person is. Different ethnic origins and religious beliefs enhance the mutual lack of understanding beyond the boundaries of Europe or in relation to immigrants. How often do you not see that Europeans cannot distinguish between Islam and Islamism? The best way to combat prejudice is to allow for Intercultural dialogue.. " (The European Commission, 2008).

The quotation from the European Commission was presented on the occasion of the European Year of Intercultural Dialogue in 2008. It gives a clear message that culturalizations are negative expressions of how we may ontologize notions and have preconceptions about peoples, national and religious groups, sexual minorities etc. The answer to prejudices is dialogue, which may in itself strengthen a more dynamic understanding of cultural expressions in constant movement and motion. This leads us to the actual concept of culture, which shows how the concept of culture itself is both historically and structurally determined.

1.4 The functionalist concept of culture

Thus, culturalizations are linked to the so-called functionalist and static concept of culture, indicating that culture is associated with national origin. In accordance with the functionalist concept, culture is viewed as a common symbol system that all people in a given society or a given group of citizens are socialized to carry and continue from generation to generation. The view is that cultural background totally corresponds with ethnic and/or national origin (Thomsen and Moes, 2002, Thomsen, 2004).

It also indicates that people, who originally come from the same country or belong to the same community or religious group, are expected to basically be similar through these formal affiliations that are perceived as a common, unchanging cultural foundation. Culture is in this understanding a specific, irreversible "coding". It is a programming in which cultural identity is seen as a collective and homogeneous phenomenon that controls the individual's psychosocial behavior – on the verbal/linguistic level as well as the non-verbal/physical level.

The functionalist concept of culture is based on a descriptive approach, where the classical anthropologist observes and describes how foreign cultures function, seen from the outside. Thus, the classic conception of culture has emerged as neutral and objective. But the fact is that the observer always looks upon and interprets "the others" through a subjective and value-based filter. This becomes especially clear when the classic cultural research tend to distinguish between so-called primitive peoples and civilized cultures. There are many examples to show how body language and bodily behavior and forms of communication have been considered and rated from a culture-hierarchical scale. One example is the differences in health and illness

perceptions. The typical western health and illness perception has traditionally been based on biological "device error" model. The general idea has been that people can be considered as biological machines, and disease may be treated as faults in the machinery – in the human organism. This approach to illness and health, has become increasingly supplemented by more psychosocial explanations of disease and healing form – by other things influenced from classic Eastern traditions (Rashid, I., 2006).

Intercultural communication in the functionalist and relativistic perspective

In the functionalist cultural understanding, intercultural communication has been a matter of mastering certain cultural codes and communicative tools, such as checklists. The meeting of cultures has been seen as a minefield, where professionals must learn to avoid the worst pitfalls In a communication that takes place between essentially different cultures and cultural premises. This very much indicates body-related codes of conduct such as standards for greetings etc.

The functionalist concept of culture has since been replaced by a cultural relativism and a framework of understanding, aimed at avoiding the most ethnocentric, hierarchical and discriminatory notions of "foreign cultures". But cultural relativism does not represent a complete break with the ontological notion that cultures in their roots are essentially different, and furthermore, that people are born and grow up with a particular cultural identity. Culture is a binding and sometimes stigmatizing term that basically draws boundaries between "them and us" In hierarchical divisions.

The culture-bound identity is, both in the functionalist and relativistic understanding, also embedded in the body and bodily expressions. This occurs for instance in the healthcare sector, where the culturalization of the perceptions of illness and health among some ethnic groups continuously leads to robust generalizations about all ethnic minorities, regardless of ancestry, lifestyles and ways of dealing with hospitalized family members, etc.

Therefore, Intercultural communication in this perspective may often be a somehow negative colored matter of being vigilant, critical and suspicious against certain reaction patterns, for example, migrant women´s perception of pain and body-related labour incapacity. It may well have dialogue form, but the intention is rather detection than clarification.

1.5 The complex and contextual concept of culture

In the last decades, several cultural researchers have instead focused on highlighting the complexity, ambiguity and dynamics of the concept of culture and cultural phenomena (Liep, J. and Olwig, K. Fog, 1994, Jensen, I., 1998, 2001.2007). This more complex understanding of culture does away with the idea that culture is a value-based coding that people automatically inherit from previous generations and carry on as fixed values, rules of conduct and behavior.

Instead, the core of the complex concept of culture is that culture first and foremost is an expression of the interactions and relationships that continually arise in a dynamic interaction between people. Therefore, culture is an ever-changing process of negotiating across traditions and values. Thus, culture is also a contextual concept, where the importance of cultural differences needs to be examined and assessed in the specific context where people meet.

Seen in a BODY perspective, this means in practice that many body-related "cultural chocks" should be analyzed in more detail in the context, before being interpreted as an expression of cultural differences or even cultural contradictions. For example, when a female adult student with Arabic background will not be alone with a male teacher without being totally covered, it cannot automatically be interpreted as an expression of a general Muslim maxim and gender perception. It is necessary to uncover the woman's individual family context and gender hierarchy and division of labour, before we form a "Muslim culture" rule that women in Muslim societies must not be physically alone with other men without being completely covered. Although we can demonstrate numerous examples of Muslim women covering up outside the home, we must be aware that at the same time, an increasing number of Muslim women do not cover up the body in the public domain. Culture is characterized by ongoing negotiation, change and normative breaks. Without a thorough understanding of the context, we can easily tend to generalize and draw erroneous conclusions about the importance and determination of culture.

1.6 Cultural identities a resource perspective on human beings

*Sometimes you would think that only women have a gender, only elderly people have an age and only black-haired people have an ethnic background. We all **are** both a gender, an age, a social background, an ethnic background, etc. No one wants to be reduced to a mere representative of a group. Because then the individual differences disappear, and you will be labeled from just a single dimension of your identity ... "(Elisabeth Plum, 2004).*

The quotation reflects a current trend in introducing the notion of cultural identities. Using a humorous tone, the author points to the obvious fact that we as human beings in a social context juggle with multiple identities which cut across many other dividing lines.

- New mothers may have a close community across age boundaries and ethnic divisions, because it is neither age nor ethnicity, but motherhood that currently determines the mothers' common values.
- A woman of North African origin may have a strong community with a group of Danish men by virtue of their common relation to the same workplace culture. From a traditional cultural point of view, an Arabic woman and a group of Western men would have nothing in common, and all cultural expectations and preconceptions would automatically speak against such a relationship.

- Similarly, a man with a physical disability may be closely connected in values and points of view to a number of sporty young women, because they share a professional and educational environment.

- A young Muslim woman may have a different gender identity and position, depending on whether she is at home in the family or with fellow students at the educational institution.

- A Muslim academic migrant family from the Balkans may have more in common with a Swedish academic family than another family from the same areas of the Balkans, as far as lifestyle, hobbies, socialisation standards, gender roles and sexual norms etc. are concerned. The professional community may take precedents over ethnic and geographic roots, etc.

Seen from the perspective of cultural identities, cultural encounters require the ability to move across different environments characterized by differences in values and views on gender, sexuality, disability, age, sickness and health, etc.

Thus, the concept of cultural identities depends on a resource perspective, which tells us to look for and be aware of other people's individual resources and to avoid any a priori generalization, culturalization and negative preconceptions.

1.7 From risk perspective to resource perspective

"By constantly focusing on risk of disease, we risk that resources of the individual person are dimmed and displaced. When we are looking with medical glasses upon a group of elderly people, we see people who are physically disabled, stooped and thin-haired. If we change to the existential glasses, we see, instead, people with life experience, strength and joy. The glasses, or rather the language we use, determine how we look at the future and upon our own ageing..." (Hvas, Lotte et al 2009).

In summary, classical culture research highlights the significance of the body as cultural medium in a literal sense. Through a variety of field studies, it has shown that notions of bodily beauty and strength as well as notions of bodily impurity and contempt may have multiple expressions, which, in the course of time, have given rise to contradictions, violent clashes and assaults.

The dynamic, complex and context-related cultural understanding has provided us with tools to recognize cultural differences on an equal basis, but also to articulate differences that we as individuals or professional groups do not understand. It has shown that culture is a relative term, which derives its dynamics from the meeting and interaction between different traditions, values and practices. We may, in a Western context, distance ourselves from birth

rituals used in distant places. But we may also choose to open our eyes to the inherited methodological experience that a distant ritual represents, and which may contribute to innovative thinking in the Western context.

This is the essence of intercultural competence and intercultural communication, where we express ourselves through verbal/linguistic as well as nonverbal/bodily sensations and expressions.

1.8 From multiculturalism to interculturality

UNESCO has in the Convention of Cultural Diversity from 2005 defined the concept of interculturalism as an equitable interaction of diverse cultures. Interculturality requires that, through this interaction and through a respectful dialogue, we create a foundation for new common and "hybrid" cultural expressions. Although the Convention is particularly aimed at artistic expressions, the definition can rightly be transferred to general human interactions and relationships in a multicultural society.

The basic idea is that a multicultural society can exist in the presence of a wide range of parallel cultures without any interaction or mutual exchange occurring between these cultures. The multicultural society will not be intercultural in its heart, however, until we reach and maintain a dialogue - and added value - across cultural differences with the clear aim of creating mutual insight, understanding, respect, recognition and appreciation, synergy and reorientation.

Dialogue of the body

From the BODY perspective it is important to emphasize that the concept of dialogue should be extended to cover all forms of communicative expressions and situations. Experiences suggest that intercultural communication in many cases manifests itself nonverbally and also unconsciously. Indeed, exploratory research (Nann, Varhegyi 2010) has shown that the body, gender, and sexuality become "sensitive zones" in intercultural contact, which means that differences tend to have a strong impact, felt as difficult to adjust to or accept, and sometimes thought of as proofs of incompatibility.

1.9 What is intercultural competence and communication?

"If body, gender and sexuality are "sensitive zones" in intercultural contact there are some areas of adult training where they may be particularly relevant. Such are the trainings related to health issues, trainings focusing on sexuality, parenting, gender issues, and all physical education as well as all intercultural trainings. These same trainings would have the potential of contributing to the mutual understanding of these differences and the recognition of special needs..." (From the description of the BODY project, 2011).

With the BODY project we put a special focus on the professional competence to manage intercultural communication in job performance. This competence is seen as a growing need among professionals and frontline staff in the educational and pedagogical sector as well as in social work, healthcare, guidance etc. throughout Europe.

A core point of an intercultural pedagogy is an approach that unleashes the pedagogical thinking and teaching practices from the national framework and from the tendency to naturalize national references and even idealizations in education, whether it concerns adult pupils or youngsters.

Intercultural competence in a democratic perspective

The need for intercultural competence among frontline staff is not a new discovery. The development of an intercultural pedagogy has been on the agenda since the beginning of the 1980s (Horst, C., 2006, Thomsen, 2010). The concept of an intercultural pedagogy appears in the wake of the realization that all forms of education, training, guidance and counseling should reflect existing social, cultural and linguistic complexity and diversity. All children, adolescents and adults should have access to educational environments and other public services that are capable of meeting their needs and able to respond to different socio-cultural positions from a democratic point of view and in the name of equality for all citizens.

Thus, intercultural competence in society is not merely a question of accommodating cultural diversity and inclusiveness. Inclusiveness only exists by virtue of the simultaneous occurrence of an **otherness** in society. At its core, inclusiveness reflects itself in exclusion, in individuals living excluded from the prevailing concept of normality (Thomsen, 2006).

This applies not only to the social level. Seen from the BODY perspective it is worth noticing that citizens may have a respected socioeconomic position, and at the same time belong to a sexual minority with a marginalized and even excluded status. This duality reflects that intercultural competence among professionals as well as in society in general is not just a matter of knowing other bodily expressions and norms. Basic recognition is an integral part of the competence.

Intercultural competence as human perspective exchange

A keyword for intercultural competence is the human perspective exchange, which denotes the ability - and willingness - to build human contact and interaction across the diversity of traditions, experiences, values and cultural identities (Thomsen, 2009). The mutual exchange of perspectives and the ability to treat citizens and users in the multicolored light of many simultaneous cultural identities is crucial for the cultural encounters and intercultural communication.

Thus, intercultural competence on a societal level is a question of ensuring democratic access to equal and worthy citizenship, regardless of gender, age, ethnicity, sexual orientation, physical and mental habitus etc.

Intercultural communication in everyday work

However, even when realizing the democratic importance of building up intercultural competence, there remains a need for concrete methods and tools to handle intercultural communication in the daily job performance among teachers, supervisors, nurses, social workers etc. This may particularly be the case in relation to bodily issues. The wide range of examples of critical intercultural incidents in our BODY project testify the need for both affective and cognitive reflections to avoid negative preconceptions and maintain the open minded and explorative approach to attitudes and norms we do not immediately understand.

It can be useful to be aware of bodily signals, for instance standards of physical distance and contact not being expressed directly, but somehow demonstrated. It may also be useful to pay attention to differences in language structure. For instance Danish and Italian differ not only as spoken languages, but also as communicative norms and standards for formal and informal approaches. Some communication norms are low-context, where messages and opinions are expressed very directly. Conversely, communication may be high-context, meaning that one must “read between the lines” to get the real message. Sometimes “small talk” is an important part of creating a positive and trustworthy relationship. In other instances, this kind of communication may be confusing in a dialogue between a professional official and a civil client.

In the context of the body, medical anthropology (Sperschneider & Mølgaard, 2007) has identified how the distinction between illness and disease may facilitate the communication between physicians' and patients' perceptions of sickness. While the concept of illness refers to the patient's way of describing her or his own symptoms, the concept of disease describes the medical assessment of a clinical picture. The conclusion has been that in intercultural communication, physicians and other health workers should include both perspectives in order to recognize and respond respectfully to the patient's own perceptions.

1.10 Short outline of the articles in the anthology

The articles in the BODY anthology illustrate the interaction between culture and body from various angles. The articles are ordered according to the themes dealt with in the BODY project:

- Body as overall concept
- Sexuality
- Gender
- Disability
- Health

Under the title **Considering the Body from a Cross-Cultural Perspective**, **Stefanie Talley** provide us with a general introduction to the interaction between culture and body through a broad range of historical and contemporary examples.

In the following article **Introduction to the intercultural approach of sexuality** **Dora Djamila Mester** analyzes how human sexuality is often considered to be universal and treated as a natural phenomenon, although it is, in fact, deeply determined by culture.

The article **Gender: Boundaries of Identity in a Multicultural Perspective** by **Noemi De Luca** focuses on the understanding of gender and body-related issues across time and space. The author discusses the necessity to rely on a reformulation of the gender category as it is understood by queer theorists.

The article **A veil on power - women on the verge of an identity crisis (because of men): the case of Turkey** by **Christoforo Spinella** deals with the intersection between gender, identity and culture in Turkey from the point of view that Turkish women may today be caught between modernity and traditionalism.

In **Sexuality, Chronic illness and physical disability: can sexuality be rehabilitated?** **Jim Bender** puts focus on the sensitive zone of how physical disability and chronic illness affect sexuality, and the need and possibilities of rehabilitation.

The article **Islam and disability** by **Inge Huysmans** gives examples of various patterns and coping strategies in Muslim families with disabled children and family members in order to conclude that the approach to disability varies and that there doesn't exist a special Muslim approach to disability.

In the article **Intercultural care in hospitals** **Naveed Baig and Stephanie Torbøl** introduce us to the use of religious assessment and patients own religious resources as potentials in the healing process.

In **Depression, women and culture** **Birgit Petersson** finally reflects on the cultural as well as gender-related differences in the depression rate and draws attention to the fact that the Western diagnostic manual of mental disorders, DSM, does not include cultural differences.

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Considering the Body from a Cross-Cultural perspective

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This article provides a general introduction to the interaction between culture and body through a broad range of historical and contemporary examples. The article addresses major cultural differences in the perception of the body, and how we may move towards a cross-cultural approach to understanding the body. Ultimately, the article seeks to demonstrate that when it comes to the body, notions of what is “natural” can change according to the cultural context.

2.1 Introduction

In his article "Body Rituals of the Nacirema," anthropologist Horace Miner explores the seemingly exotic and foreign body behaviors of the Nacirema, a people he describes as “magic-ridden.” Miner gives a detailed presentation of their rituals and ceremonies, which involve the use of household shrines to ward off disease and regular visits to “holy-mouth-men”:

“...The Nacirema have an almost pathological horror of and fascination with the mouth, the condition of which is believed to have a supernatural influence on all social relationships. Were it not for the rituals of the mouth, they believe that their teeth would fall out, their gums bleed, their jaws shrink, their friends desert them, and their lovers reject them. They also believe that a strong relationship exists between oral and moral characteristics. For example, there is a ritual ablution of the mouth for children which is supposed to improve their moral fiber.

The daily body ritual performed by everyone includes a mouth-rite. Despite the fact that these people are so punctilious about care of the mouth, this rite involves a practice which strikes the uninitiated stranger as revolting. It was reported to me that the ritual consists of inserting a small bundle of hog hairs into the mouth, along with certain magical powders, and then moving the bundle in a highly formalized series of gestures.

In addition to the private mouth-rite, the people seek out a holy-mouth-man once or twice a year. These practitioners have an impressive set of paraphernalia, consisting of a variety of augers, awls, probes, and prods...” -Horace Miner (1956)

It is only at the end of Miner’s article that we learn that the “Nacirema” are in fact 20th century Americans. In presenting an anthropological study of teeth brushing and dentist visits, which have been normalized in Western cultures, Miner shows how these behaviors are just as culturally influenced as the rituals and practices of the “remote tribes” that are typically the focus of

such anthropological studies. No matter the culture, that which is considered normal or strange, forbidden or taboo is often relayed through the body. As sociologist Anthony Synnott illustrates in his book *The Body Social*, the body is both the symbol of the self and the society. He describes it as “something we have, yet also what we are, it is both subject and object at the same time...The body is both an individual creation, physically and phenomenologically, and a cultural product; it is personal, and also state property” (Synnott 2).

This article proposes a discussion on how cultural norms are developed and expressed through the body. We affirm that culture is central in determining the ways in which the body is understood and acted upon. Through an exploration of practices and behaviors related to the body across cultures, we seek to reflect on the following questions:

- What are some of the major cultural differences in how the body is perceived and used?
- How are these differences influenced by dominant societal norms and how can these differences affect cross-cultural interactions?
- How can we move towards a cross-cultural approach to understanding the body?

Through a review of the scholarly literature on the body, we present four main themes of research that have appeared in theoretical discussions of the body: definitions of the body, the body across life stages, the body in action, and the regulation of the body. Moving beyond theory, we will give concrete examples from ethnographic studies on how perceptions of the body have differed across cultures and time periods. This presentation will include both Western and non-Western examples and will be centered on questioning taken-for-granted assumptions surrounding the body. Ultimately, we seek to explore how culture influences the ways in which the body is perceived, used and even defined.

2.2 Brief overview of the literature

Though the body serves a central role in communicating individual and cultural identities, it has often been neglected in social research. Seeking to go beyond biological and physiological explanations for human behavior, classical social theorists often turned their attention away from the role of the body in human interactions, focusing on more abstract themes such as class, nationality, and power (Turner 33). Theories on religious traditions, social customs and cultural beliefs thus gave peripheral or sometimes even no attention to the role of the body in the manifestation of these acts (ibid).

Starting in the 1970s however, the body became a central point of interest in the social sciences. This growing prominence of the body in scholarly literature is due to a variety of factors. The politicization of the body first rose to prominence as part of the feminist movement’s efforts to end exploitation of the female body. The AIDS crisis of the 1990s and ethical debates surrounding issues such as abortion and euthanasia have also contributed to the growing attention given to the body in the social sciences. Similarly, changing demographic factors related to aging and increasing ethnic diversity have played an important role in the development of research on the body. Consumer culture and the marketing of goods and services to maintain the body have sparked a growing interest in the “body as project” in a number of industrialized

countries. Finally, the emphasis on technology in these societies and the ways in which this affects traditional notions of the body and the boundary between technology and the body also inform research on the body (Turner 1987: 228).

While limits of space make it impossible to give a detailed review of the existing scholarly literature on the body within the limits of this article¹, a number of scholars who have shaped research on the body are worth mentioning. French scholars have been particularly influential in the development of the sociology of the body. The notion of “physical capital” developed by Pierre Bourdieu, relates to the symbolic value of the body and how physical characteristics can be used to improve one’s social status (Bourdieu 1978: 832). The control of populations through the subjugation of bodies is a central theme in the research of Foucault (1979). Philosopher Maurice Merleau-Ponty is known for his interest in everyday embodiment (1962), while sociologist David le Breton has written extensively on the sociology of the body, tracing its development and presenting new areas of research (2002). Other notable French authors who have contributed to research on the body include Françoise Loux, Georges Vigarello, and Jean-Michel Berthelot among others.

In the English speaking world, British-Australian sociologist Bryan S. Turner has played a key role in the development of the sociology of the body during the 1980s and 1990s. His book *The Body and Society: Explorations in Social Theory*, is considered a foundational work. Published in 1984, it was the first contemporary book to focus entirely on the body as a theme of research. Similarly, with his book *The Body and Social Theory*, British sociologist Chris Shilling provides a critical survey on research on the body, tackling such themes as health, sexuality, and diet. He presents the body as a “project,” which is transformed by its participation in society (Shilling 1993).

Though the body has rarely been a central focus in classical sociology, it has appeared in important ways in the work of a number of notable scholars. One of German sociologist Georg Simmel’s most famous works is his essay “The Sociology of the Senses.” According to Simmel, the senses have a purpose that goes beyond their physiological usage. His description of the function of the eye illustrates this argument: “The eye has a uniquely sociological function...The eye of a person discloses his own soul when he seeks to uncover that of another” (Simmel 1921: 358). Similarly, Erving Goffman, who is famous for his research on social interaction, gave particular attention to the role of bodily performance in the presentation of self (Goffman 1959). In another classic work, *Balinese Character*, Margaret Mead and Gregory Bateson present a photographic analysis of gestures and body movements based on field research conducted in Bali. Finally, British anthropologist Mary Douglas, who traces how concepts of “dirt” differ from culture to culture in her book *Purity and Danger*, has argued that the body is a symbol of the social structure (Douglas 1966).

¹ Detailed literature reviews can be found in the texts of Lock, Turner (1997), Howson, and Morgan & Scott cited in the bibliography of this article.

2.3 Defining the body

One central theme in the scholarly literature on the body is what has come to be known as the “mind-body problem”. In modern Western philosophy, the reflection on this dilemma can trace its origins to French philosopher René Descartes, whose famous dictum (“I think, therefore I am”) has become a fundamental principal of philosophy. According to *Cartesian dualism*, the mind and the body act as two distinct yet interacting entities. Monism, on the other hand, holds that it is possible to reduce the mind and the body to a single entity.

Questions of personhood and the self are central to any study of the body. As Hallam et al. note in the book *Beyond the Body: Death and Social Identity*: “Not all bodies are synonymous with self and not all selves have an embodied corporeal presence” (Hallam et al. 1999). Anthropologist Linda L. Layne argues that conceptions of personhood can be divided into individualistic conception and social/relational perceptions. In “structural-relational” personhood, the individual is defined by his social roles and responsibilities. Layne notes that this system is particularly present in Asia (Layne 273). Margaret Lock, describing the notion of personhood in Japan says: “Individuals...are conceptualized as residing at the center of a network of obligations, so that personhood is constructed out-of-mind, beyond body, in the space of ongoing human relationship” (Lock 169).

The Kanak of New Caledonia offer another example of a relational conception of personhood. While researching the Kanak, ethnologist Maurice Leenhardt discovered that the word *kamo*, which indicates humanity, is not only used to refer to human being. According to Leenhardt, depending on the context: “Animals, plants, and mythic beings have the same claim men have to being considered *kamo*, if circumstances cause them to assume a certain humanity” (Leenhardt 24). The division between humans and nature and even between the human body and its external environment are flexible for the Kanak. Leenhardt writes:

“The Melanesian is unaware that the body is an element which he himself possesses. For this reason, he finds it impossible to disengage it. He cannot externalize it from his natural, social and mythical environment. He cannot isolate it. He cannot see it as one of the elements of the individual” (Leenhardt 22).

For the Kanak, who have a broad representation of what is human, the *kamo* is able to undergo continual metamorphosis. Even a simple glance is enough to transform an animal into a human (ibid).

The Wari Indians of Rondônia, Brazil provide another example of how the social production of personhood is influenced by cultural models of the body. For the Wari, the body is a social creation (Conklin and Morgan 671). The Wari ascribe to a relational personhood in which it is defined as an interactive process rather than a fixed event that takes place at birth. For the Wari, personhood is created through social ties. The body plays a key role in this process, as it is the exchange of bodily fluids such as blood, sweat, and breast milk that is central in creating social ties. Thus, a non-Wari person can undergo a blood transformation (when a non-Wari woman conceives a baby with a Wari man, for example) and become fully Wari, even if she has not yet mastered the language. Conversely, Conklin and Morgan cite two recent cases of Wari women

who, upon being impregnated by non-Wari men, were no longer considered Wari by their neighbors.

Most Western cultures are based on an individualistic perception of personhood. The functioning of the body is thought to be controlled from within through a natural, asocial, biological process. Western scientific explanations for the functioning of the body are not without cultural influence, however. In their article “The Limits of Biological Determinism,” Eleanor Miller and Carrie Yang Costello argue that the idea that “sex hormones” influence “masculine” and “feminine” behavior is grounded in cultural notions that assign gender traits to particular behaviors. Similarly, in her article “Egg and the Sperm,” anthropologist Emily Martin affirms that “scientific” discourse on the human body is culturally shaped. She takes the example of the egg and the sperm to show how stereotypes on what is male and female inform scientific accounts of how biological processes work. Whereas the female body is said to undergo a process of “shedding” during menstruation, the male body is described as “producing” sperm in medical texts. This rhetoric, Martin argues, supports the notion of the male role as being active and forceful and the female being weak and wasteful. In revealing the cultural influence on a number of scientific descriptions, the above articles serve as an example of how truly blurred the line between biology and culture is in the “scientific” understandings of the body and its functions.

2.4 Conceptions of the body across stages of life

While all humans undergo the same biological life cycles, culture plays a major role in how these cycles are perceived and dealt with. In examining the stages of birth, childhood, mating, adulthood, aging and death, a number of societal differences can be observed.

Birth and babies

The position in which a woman gives birth, the actors involved in helping her deliver, and what takes place after birth can all differ between cultures. For example, in some cultures, the birthing process is considered to be “unclean” and thus women need to be isolated before, during and after childbirth for varying periods. In China for example, as part of a traditional custom known as “doing the month,” a woman who has recently given birth is confined to her home for one full month. There, she must follow a number of strict rules, including abstaining from washing and from all contact with water. She must also follow a “hot diet” to remedy the hot-cold imbalance believed to be caused by pregnancy (Pillsbury 1978).

Conversely, in her ethnographic research, Columbian anthropologist Virginia Gutierrez found that the Jara women of South America gave birth in a passageway or closed space that was fully visible to everyone around, including small children, as childbirth was considered to be a normal process of everyday life (Newton 16). While most Western women give birth while lying on their backs with the assistance of a medical doctor, in a transnational study on cultural difference in the birthing process, it was found that elderly women play a central role in assisting a new mother during childbirth in 58 out of 60 cultures (Newton 22). A cross-cultural survey of 76 non-European societies catalogued in the Human Relations Area files found kneeling to be the

common birthing position in 21 cultures, followed by sitting in 19 cultures, squatting in 15 cultures, and standing in 5 cultures (Newton 23).

Childhood

After birth, the childhood experience continues to be shaped by cultural factors. Societies differ significantly when it comes to childcare practices and what is expected from children. In Japan, for example, physical contact is considered essential to child development and co-sleeping between children and care givers is common (Ben-Ari 1997). Co-sleeping is also practiced in Sweden, where children (especially girls) sleep with their parents until they are school-aged (Welles-Nyström 2005). In the United States, on the other hand, separate sleeping arrangements are standard.

During research for his now famous study on the inhabitants of the Trobriand Islands, anthropologist Bronislaw Malinowski was shocked by the parenting behavior of Trobriand adults. In the Trobriand Islands, Malinowski explains:

“[Children] soon become emancipated from a parental tutelage which has never been very strict. Some of them obey their parents willingly, but this is entirely a matter of the personal character of both parties: there is no idea of a regular discipline, no system of domestic coercion...A simple command, implying the expectation of natural obedience, is never heard from parent to child in the Trobriands” (Malinowski 45).

If authoritarian parenting is eschewed by Trobriand Islanders, other societies may adopt vastly different approaches, with authoritarian parenting styles or corporal punishment being the norm.

While the process of biological maturation is standard among humans, cultural differences can vary concerning when one is socially considered an adult. Arranged child marriages, for example, though increasingly uncommon, particularly in urban areas, have existed in parts of southern Europe, India, China and Africa. For Hausa girls in Nigeria, for instance, marriage traditionally took place at the age of ten (Helman 6).

Adulthood and Mating

New behaviors, responsibilities and freedoms are acquired as children grow into adulthood. One area in which cultures tend to differ is in how and when young people are introduced to sexual activity. While the appearance and simulation of sexual activity at an extremely young age in the Trobriand Islands shocks most westerners, other cultures adopt an opposite approach. For example, during his fieldwork among the Kuna of the islands in the Panamanian Caribbean, anthropologist David B. Stout discovered that they sought to postpone all knowledge of the sex act and child birth as long as possible, preferably until the last stage of the marriage ceremony. Childbirth was referred to as “to catch the deer” and children were told that babies were found in the forest between deer horns or left on the beach by dolphins (Newton 12).

The age at which a person marries or enters into a relationship can vary as can the duration and nature of that relationship. While sexuality will be the subject of another chapter in this vo-

lume, it is worth noting how thoughts on the sexual attractiveness of different body parts and sexual behavior can differ from culture to culture. In their book *Patterns of Sexual Behavior*, Clelland S. Ford and Frank A. Beach detail the sexual behaviors of 191 different cultures. They found that breasts are only considered attractive in 13 cultures, while homosexuality is accepted in 49 of 76 cultures for which data was available.

Aging

Old age can be a time of extreme vulnerability or honor depending on the culture. In parts of South Asia and Africa, for example, most older women are widows and are among the poorest populations (Newton 11). On the other hand, in some male-dominated cultures in which young women have very limited power, older women are able to acquire positions of importance and power that allow them to overcome the constraints usually placed on women.

The Tiwi, an indigenous people in Australia, offer one example of a culture where the elder members of the community have great power. According to anthropologist Jay Sokolovsky, male Tiwi elders wield great power:

“Regarded with a mixture of fear and reverence, the oldest males sit at the top of a generational pyramid, authoritatively dominating society by the exclusive possession of key cultural knowledge” (Sokolovsky 2009).

In other societies, respect for age may translate into a family-based system of care for the elderly.

Death

The concept of death cannot be separated from its biological implications, but a simply biological definition of death would be inadequate in most cultural contexts. The meaning and significance of death is also culturally defined. The variety of taboos surrounding contact with dead bodies and differences in funeral rituals and beliefs about what happens after one dies illustrate that this universal human experience can be interpreted in a number of ways. For the Tiwi, for example, death is not seen as an end, but as one step in a cyclical process. Ancestors are believed to regularly influence on the lives of the living and can be reborn in a future generation (ibid). In North America, the medical diagnosis of “brain dead,” in which a patient has lost all functioning in the brain, but may still have a heartbeat, has sparked ethical debates on the limits of personhood and biological life.

Concepts of Time

While the stages of birth, childhood, adulthood, and death have been used to describe experiences that are similar across cultures, it is important to note that not all cultures view time in the same way. Research on Ju/'hoansi communities in Botswana found that they did not keep track of chronological age, practiced no age segregation, and did not mark or celebrate birthdays or anniversaries (Rosenberg 35). Concepts of time can also differ drastically on a day-to-day basis. The Western practice of sleeping in the same place every night for 7-8 hours without interruption is not universal. For some, it is rare to consolidate sleep into one long interval. The

!Kung san of South Africa and Efe of Central Africa, for example, have no fixed times for sleeping and waking up and do so several times a day when it is most convenient (Worthman and Melby 2002).

Rituals and Rites

Despite possible differences in the perception of time and life stages, all cultures mark the moments and stages they consider to be important with a number of rituals and rites. French ethnographer Arnold Van Gennep was the first to note that rituals surrounding hallmark events differ only in detail from one culture to another. He developed this concept as a theory of socialization in his book *The Rites of Passage*:

“The life of an individual in any society is a series of passages from one age to another and from one occupation to another...Transitions from group to group and from one social situation to the next are looked on as implicit in the very fact of existence, so that a man’s life comes to be made up of a succession of stages with similar ends and beginnings: birth, social puberty [Van Gennep distinguishes between social and physiological puberty], marriage, fatherhood, advancement to the higher class, occupational specialization and death. For every one of these events there are ceremonies whose essential purpose is to enable the individual to pass from one defined position to another which is equally well defined...Thus we encounter a wide degree of general similarity among ceremonies of birth, childhood, social puberty, betrothal, marriage, pregnancy, fatherhood, initiation into religious societies and funerals. In this respect, man’s life resembles nature, from which neither the individual nor the society stands independent (Van Gennep 3).

Besides his argument that rites of passage are relatively similar across cultures, what is interesting to note in Van Gennep’s description is the fact that he distinguishes between social and biological passages. Thus social birth and death do not necessarily correspond with their biological homologues.

2.5 The body in action

Techniques of the Body

Having examined cultural differences in how the body is defined and perceived across life stages, let us now turn our attention to the everyday life of the body. On a day-to-day basis, the body is the interface through which humans interact with their external environment. In his article “Techniques of the Body”, sociologist Marcel Mauss presents a catalogue of how everyday activities such as sitting, sleeping, eating and even walking are governed by societal codes of conduct. “In every society, everyone knows and has to know and learn what he has to do in all conditions,” Mauss argues (Mauss 85). Things as simple as the standard gait adapted when walking or the method used for cleaning the body can be shown to differ across cultures. While it is normal to sit at a table or use a fork to eat in some cultures, Mauss gives examples of societies where eating on a rug or using a different utensil or even one’s hands is common. Mauss

finds that within societies, techniques differ according to age and gender and that techniques are ingrained into individuals at a young age so that by the time they are adults, they seem natural.

In his book *Death and the Right hand*, Robert Hertz also examines a characteristic that has been taken as natural in most cultures: the predominance of the right hand over the left. Hertz questions if this tendency has cultural rather than just biological origins, evoking the commonly believed biological argument that we are right-handed because we are left-brained. Because the left hemisphere of the brain is usually larger and the major nerves of the brain are crossed, it thus controls the right side of the body. Hertz wonders if in fact the opposite could be true: we are left-brained because we are right-handed.

Though he ultimately concedes that the predisposition for right-handedness has biological origins, Hertz notes a treatment of the “left” across cultures which goes beyond natural characteristics. He finds that “right” is not only contrasted with “left”, but also with “wrong” and “immoral”. Thus, we speak of “defending our rights” and the term “sinister,” which originally just meant “left” gradually developed a more negative meaning. This contrast can be found across languages, from the French concept of *droit* to the word *tu’o* in the Berawan language of central Borneo. Hertz concludes that culture is in fact central to the dominance for the right hand. “If organic asymmetry had not existed, it would have had to be invented” he affirms.

Physical Appearance

The Muslim veil has been a source of great debate in contemporary cultural discourse. Some argue that it is a means of oppressing women. For others, it is a sign of religious devotion. Whatever it may mean for the women who wear it, the veil is imbued with cultural significance, illustrating to what level dress and the physical presentation of the body are communicators of cultural norms. As Linda B. Arthur explains: “Dress provides a window through which we might look into a culture, because it visually attests to the salient ideas, concepts and categories fundamental to that culture” (Arthur 7).

Dress and outer appearance can also serve as a space of resistance to cultural norms. In the book *Embodied Resistance: Challenging the Norms, Breaking the Rules*, the contributing authors analyze such acts of resistance, with examples ranging from overweight women who challenge dominant beauty norms in the West to transgender women negotiating heteronormative spaces. According to Rose Weitz, every action contains both resistance and accommodation to cultural norms. “At times, resistance is a clever and complicated dance of negotiation, and it is rarely a zero-sum game,” she affirms (Weitz 2001). Resistance and accommodation can be practiced on the individual level, but also within sub or minority cultures.

Nonverbal Communication

Cultural differences are at the origin of a number of nonverbal communication problems. Just as spoken language can differ from culture to culture, the use of gestures, touch and eye contact is culturally regulated. As linguist Walburga Von Raffler-Engel explains:

“Nonverbal behavior symbolizes more than specific meanings—it is expressive of entire cultural viewpoints...The nonverbal sign becomes a symbol within the culture of its sender. Its receiver, in any particular situation, may or may not attribute the same or similar value to it; the receiver may not attribute any symbolism to that sign at all” (Von Raffler-Engel 96).

To prevent the potential cross-cultural miscommunication Von Raffler-Engel describes, it is important to be cognizant of potential differences in nonverbal communication.

Anthropologist and cross-cultural researcher Edward T. Hall was a leader in the field of nonverbal communication research. Hall distinguished between high context cultures, in which many things are left verbally unsaid, allowing for nonverbal clues to determine meaning and low context cultures in which verbal communication is more direct. Hall also coined the term “proxemics” to describe the use of physical space in nonverbal communication. Haptics (touch), chronemics (the use of time), and kinesics (body movement) are also key aspects of nonverbal communication.

2.6 Regulation of the body

The Senses

Culture plays an important role in how humans perceive the functioning of the human body. One example is the cultural variation that exists in the perception of the five senses. Proposing a “sociology of the senses,” German sociologist Georges Simmel argues that “it is through the medium of the senses that we perceive our fellow-men” (1969). Similarly, Anthony Synnott affirms that: “Odors define the individual and the group, as do sight, sound and the other senses; and smell, like them mediates social interaction” (Synnott 183).

Each sense is not given the same level of importance in all societies, however. In his article “Ruminations on Smell as a Sociocultural Phenomenon,” Kelvin Low gives attention to the low status of smell in the hierarchy of the senses in Western culture, which can be traced back to Aristotle’s hierarchy of the sensorium. Sight, on the other hand, has great importance in the West. For the Andaman Islanders, on the other hand, smell has a practical role. As fragrant flowers from the jungle bloom, it is possible to differentiate the aromas. Each season is thus marked by an “aroma force” and the year is organized according to a “calendar of scents” (Clas- sen et al. 7).

Pain

The feeling of pain is one natural function that allows humans to recognize bodily threats or problems in the body. Still, while pain is a universal sensation, according to Kleinman et al., pain is also a cultural experience. They affirm that how individuals perceive and respond to pain,

both in themselves and others is greatly influenced by their cultural background. They also argue that cultural factors influence how people communicate their pain to others. For the Chagga people of Tanzania, for example, pain during childbirth is not to be expressed:

“The Chagga are told from childhood that it is man’s nature to groan like a goat, but women suffer silently like sheep...She also knows that screams would shame her mother and make her mother-in-law critical of her. Thus most Chagga women are stoic during labor, suppressing loud cries” (Kleinman et al. 17).

Reactions to pain do not only differ according to national or ethnic groups. Feelings of pain can also be mediated by specific social contexts. In an early study of the importance of cultural meaning on the perception of pain, American physician Henry Beecher found that combat soldiers who had experienced severe tissue trauma reported little or no pain associated with their injuries. After determining that the soldiers were not in shock and that they were capable of feeling pain, he concluded that their motivation to return home altered their perception of pain (Bendelow and Williams 211). It is not difficult to find a number of cultural contexts in which pain is tolerated and even encouraged because of a particular cultural or social reason (certain rites and beautification procedures, for example).

Health

In a related theme, the description and treatment of a variety of health issues can also differ from culture to culture. In a survey of descriptions of symptoms given in different cultures, Kleiman et al. show how culturally specific idioms and notions can influence how a concept as simple as the headache is expressed:

Ohnuki-Tierney, for example describes complaints among Sakhalin Ainu of Japan as including ‘bear headaches’ that ‘sound’ like the heavy steps of a bear: ‘deer headaches’ that feel like the much lighter sounds of running deer; and ‘woodpecker headaches’ that feel like a woodpecker pounding into the trunk of a tree” (O-T 1981:49). Ots (1990) describes a common experience of headache among Chinese characterized by a painful dizziness or vertigo—a complaint that is an embodiment of the traditional Chinese medical category of imbalance as the proximate cause of ill health. Abad and Boyce (1979: 34) report that Latinos in North America distinguish *dolor de cabeza* (headache) and *dolor del cerebro* (brainache) as two distinctive experiences and disorders. Headache is a common complaint of Latino patients who suffer *nervios*, a core idiom and syndrome of distress in Latin American cultures (Guarnaccia and Farias 1988). Ebigo (1982) indicates that Nigerians complain of a wide range of specific pains, using language that would be considered potential indicators of psychosis in this country: ‘it seems as if pepper were put into my head,’ ‘things like ants keep on creeping in various parts of my brain,’ or ‘by merely touching parts of my brain it hurts (Kleinman et al 1).

As these examples show, pain is not simply a biological response to a physiological stimulus. Its interpretation is a culturally informed reaction to and perception of the world. Responses to pain and illness thus depend greatly on cultural and social contexts.

Emotions

The body is directly connected to the expression of emotions. According to Michelle Rosaldo, emotions are “embodied thoughts” which are somehow “felt in flushes, pulses, ‘movements’ of our livers, minds, hearts, stomachs, skin” (Rosaldo 143). In many Western cultures, the repression of emotions serves as a means of clearly defining the “outside” and the inside.” The expression of emotion, particularly by men, is thus compared to a “leaky body.” As Lupton explains, the control of emotions is never guaranteed, however: “Like body fluids, emotions ‘flow, they seep, they infiltrate; their control is a matter of vigilance, never guaranteed’ ” (Lupton 97). At the same time, too much repression of emotions can cause them to become “blocked” or “stuck” in the body and lead to ill-health. In this culturally specific model, the self resides in a sort of “body-container” that requires constant monitoring to control the ebbs and flows of emotions (ibid).

Grief is one example of an emotion whose expression is culturally shaped. For example, while anthropologists tend to agree that “grief” is shown at funerals in most societies, “grief” is widely defined in this context and can include a range of emotions. Furthermore, the appropriate expression of grief can vary greatly between societies. In some cultures, the externalization of emotions is seen as taboo. While studying the Javanese, Geertz found that a young girl was chastised for crying during a funeral because tears were said to make it hard for the deceased to find his path to the grave and were thus negatively viewed (Huntington and Metcalf 60). In contrast, during his research on the indigenous people of the Andaman Islands, anthropologist Radcliffe-Brown found seven different occasions in which it is considered necessary to weep as part of ceremonial custom (Huntington and Metcalf 44).

Manners

In his book *The Civilizing Process*, Norbert Elias explores how a number of habits and customs have become formalized into the codes of manners and good behavior in Europe. Elias argues that as people began to live together in new ways, they were more affected by the actions of others and more cognizant of their own behavior during interactions, thus adopting new forms of controls. What is interesting to Elias is how these norms have become internalized with each generation.

One example Elias gives to support his argument is the development of the use of the fork. He thus examines the cultural controls of conduct that led to the contemporary practice of using the fork:

“The suppression of eating by hand from one’s own plate has very little to do with the danger of illness, the so-called ‘rational’ explanation. In observing our feelings toward the fork ritual, we can see with articular clarity that the first authority in our decision between ‘civilized’ and ‘uncivilized’ behavior at table is our feeling of distaste. The fork is nothing other than the embodiment of a specific standard of emotions and a specific level of revulsion...The social standard to which the individual was first made to conform by external restraint is finally reproduced less smoothly within him, through a self-restraint which may operate even against his conscious wishes. Thus the sociohistorical process of centuries, in the course of which the standard of what

is felt to be shameful and offensive is slowly raised, is reenacted in abbreviated form in the life of the individual human being.” (Elias 53).

For Elias, the “fork ritual” has been implanted into Western society not only because generations of parents have taught their children that it is best to eat with a fork, but because with time, the rightness of this behavior has been internalized on an emotional level.

Taboo

While manners may proscribe certain behaviors when it comes to interacting with others, culturally demanded restrictions and controls can also be applied to the natural functioning of the body. British anthropologist Mary Douglas has written extensively on concepts of purity and taboo, most notably in her book *Purity and Danger: An Analysis of Concepts of Pollution and Taboo*. For Douglas, there is an intimate relationship between the social body and the physical body:

“The human body is always treated as an image of society and...there can be no natural way of considering the body that does not involve at the same time a social dimension...Strong social control demands strong bodily control...Social intercourse requires that unintended or irrelevant organic processes should be screened out...Socialization teaches the child to keep organic processes under control. Of these, the most irrelevant and unwanted are the casting-off of waste products. Therefore, all such physical events, defecation, urination, vomiting and their products universally carry a pejorative sign for formal discourse” (Douglas 74).

Though the above processes are natural, Douglas argues that there is a tendency in certain cultures to try to distance humans from the “baser” processes of nature. Social interaction is believed to take place between “disembodied spirits” and all functioning that belies this reality must be repressed. Thus, we find that one should never blow one’s nose in public in South Korea or that in a number of societies, it is considered rude to eat in front of others.

2.7 Conclusion

By drawing upon a number of ethnographic studies, this article has given an overview of the ways in which perceptions of the body can differ from culture to culture. When considering the body from a cross-cultural perspective, it is essential to remember three things. First, ethnographies not only provide information about other cultures, but can also facilitate the development of a certain relativity with regards to one’s own culture. In her book, *Coming of Age in Samoa*, anthropologist Margaret Mead highlights the importance of cultural relativity. According to Mead:

“As the traveler who has once been from home is wiser than he who has never left his own doorstep, so a knowledge of one other culture should sharpen our ability to scrutinize more steadily, to appreciate more lovingly, our own” (quoted in Dettwyler 115).

A comparison of different ways in which the body is perceived and acted upon across the globe calls into question assumptions regarding what is “natural” or “fixed” when it comes to the body. Secondly, though written accounts serve as a window into the customs and traditions of other societies, it is important to not exoticize or overemphasize cultural differences. No society is static and prevalent practices and beliefs should not be seen as monolithic. As Conklin and Morgan put it:

“While there is heuristic value in drawing the cross-cultural contrasts starkly, this runs the risk of overstating differences between societies while overemphasizing consensus within a society. Cultural ideologies of personhood are rarely shared uniformly by all members of a society, and people invoke different interpretations to suit different purposes” (Conklin and Morgan 1996).

In other words, within each society, sub-cultures based on social class, ethnicity, religion and other factors can influence how individuals perceive their own bodies and those around them. For example, in the West, despite dominant norms regarding the human life cycle and conceptions of personhood, bodily issues such as abortion and euthanasia continue to be hotly debated.

Finally, ethnographic descriptions of the body can also serve as a means of identifying cultural outliers and rebels. The idea of contested identities and Lock’s notion of “bodily dissent” draw attention to the ways in which individuals reject and reinterpret cultural standards related to the body. What is considered to be dissent is greatly dependent on the particular cultural context. For example, tattoos, piercings, and body modifications may be normalized in one culture while seen as extreme in another.

The body and culture interconnect in a number of ways in a number of ways that we were not able to develop in this text include sports, dance, and fitness among others. While it is not possible to describe all of the ways in which the body is culturally influenced in one text, the goal of this article has been to demonstrate the differences and the similarities that can exist across cultures. From the shape shifting *kamo* of New Caledonia to the practice of “doing the month” in China, the above examples serve to illustrate the ways in which the body is culturally constructed. Ultimately, by using a cross-cultural approach, we hope we have shown how the body can serve as a cultural canvas, reflecting the values and norms of a society, yet able to be redefined and repurposed by the individual.

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Introduction to the intercultural approach of sexuality

Dora Djamila Mester

Human sexuality - as deeply connected to the body and its biological functions – is often considered to be universal and treated as a natural phenomenon. Nevertheless, if we start to deconstruct the different elements of sexuality – from gender, emotions, social interactions, relationships, sexual habits, sexual orientations, different sexual practices even to the interpretation of erotic desire, the meaning or use the body - it turns out that everything around human sexuality is deeply determined by culture. To understand the complexity of various cultural identities, the overlaps and the fluidity of sexuality we can get closer not just to our own sexuality as individuals but we will be able to understand why other people behave “differently”. In this article the author follows the different meanings and social functions of sexuality from culture to culture and even in different historical times to understand that beyond ethnic differences what else “culture” means in the context of human sexuality and to reveal the mechanisms how sexuality is deeply embedded in our societies and culture.

3.1 Introduction

The world-famous anthropologist Margaret Mead writes that homosexual men were frowned upon in the Trobriand Islands but in cases involving women, such relationships were tolerated (although interestingly, the same word, *lubaygu*, was used for both a strong friendship between a man and a man, and a romantic relationship between a man and a woman). It was also observed by Mead that adult homosexuality is universal among men in the Makassar Islands, and among women in the Lau islands before marriage, while it was perceived as a game in Samoa. In the latter place, a separate word, *soa* is used for the institutionalised homosexuality between boys. Boys are circumcised in pairs. They choose an older man for themselves who is reputed to be adept at doing such things and they ask him to carry out the operation on them. The relationship between the two boys who are circumcised together seems to be a cause and effect, logical relation in such cases. The boy to be circumcised picks a mate for himself who often is his relative. This sharing of an important life event with each other, is believed to bind two boys tightly to each other later in life. Many such pairs of boys can be seen in the village who have been circumcised together and who have maintained the closest friendship for a very long time after the operation. Such pairs often sleep together, and friendship sometimes turns into a homosexual relationship. – writes Mead. However, they not only sleep together but they also

work together, eat together, dance together in the evening, and, what is more, they also court girls together. The friend, the 'soa' acts as a mediator between the other boy and the girls. The only thing considered to be an abnormality in Samoa is the 'moetotolo', i.e. the night 'love-theft'. The boy who approaches a girl this way is mocked by the village.²

'Marriage among banars includes some socially sanctioned sexual relationships. When a woman gets married, she has her first sexual encounter with one of the kins of the father of the bridegroom. She starts having sex with her husband only after bearing a child for this man. She also has an institutionalised relationship with one of the kins of her husband. The partners of the husband include: his wife, the wife of one of his kins and the wife of the son of the wife of the kin (Thumwald, 1916). Having sex with several partners one after the other is also a well-known custom among marindamins. During the time of holding the marriage the wife copulates with all the members of the clan of the husband, and the bridegroom comes last. All major festivities come with the custom of otiv-bombari when semen is collected for ritual purposes. Some women copulate with many men and the semen is collected in a coconut shell. Marind men participate in multiple homosexual intercours during their initiation (Van Baal, 1966). Heterosexual intercourse among etors is a taboo for 205-260 days of the year (Kell, 1974). In many parts of New Guinea, men are afraid of copulation because they think that without magical preemptive measures they would die after copulation (Glasse, 1971; Meggitt, 1964.)'³

Another country, another story. Recently, I met an approximately twenty-five year-old girl from Sicily, who – as we found out – had also come to live in Amsterdam. Now she works for a Dutch company. We talked about how it feels to live here. She had a story about how strange it is that Dutch people are naked in the sauna, and how much it frustrates her. They have a sauna at the company which is used by practically everyone working there. The first time she went, she realised she could not even wear a bikini but when she saw men and women naked in the same place she was completely stunned. She cannot get used to the idea of working with the same people during the day and then seeing your boss in the evening completely naked in the corridor. She could never get used to this. Back at home, she says, this could only be imagined in the most intimate situations. It is not allowed at all for a 'decent' woman to appear like this before strangers if they are men.

'I went to a religious school and keeping your virginity until marriage was a constant topic there. We girls talked a lot about this among ourselves, whether it is important or not. Still, most of us got through this barrier when we were eighteen or nineteen. I did, too. But this was a struggle for me for a time as well. This is probably the reason why I felt remorse and shame the first time I had sex.' (Éva, 32 years old, hairdresser, mother of one, Budapest, Hungary, 2010)⁴

² Eszenyi Miklós: The man with the man, the woman with the women. pp. 68.

Original text: Coming of age in Samoa- a Psychological Study of Primitive Youth for Western Civilization.

³Rubin, Gayle: The traffic in women- Notes on the „political economy”. (Note four from the Hungarian translator.)

⁴ Interview. Dóra Djamila Mester: Woman, Mother, Lover- Motherhood and Sex, Jaffa Kiadó, Budapest, 2013.

'As a matter of fact I was introduced to sexuality by my grandfather when I was ten. My first sexual experiences are connected to him. But this was not negative. When my grandfather came over to us or I went over to their place, we would sleep together in the afternoon. And I remember that my grandpa would reach for me and fondle my clitoris. And that it was good for me. But when he pulled my hand towards himself and wanted me to stroke him as well, I already found it disgusting. That is why I did not tell anyone, because it was good for me. Maybe I had some sense of guilt because I felt it was awkward that I wanted this from my grandfather. That I would keep pushing him, saying come on, come on, but he would tell me we should not do it yet because we had just gone to bed and my granny was still awake. I definitely wanted this. This was really good for me. And I felt it was awkward that I was pushing for it so much. I knew what was happening and that I should not talk about it. What would I tell my mom? It is not that I have to be protected here. Instead, something is happening which should not.'

(Teodóra, 41 years old, mother of three, white-collar freelancer, Budapest, Hungary, 2010)⁵

3.2 What is sex? Definitions of sexuality

As it can be seen from the above examples, consensus is missing even in the same linguistic universe concerning the meaning of the concept of sex, sexuality. Since it affects the everyday life of everybody, the word 'sex' is often used without asking what one thinks of when hearing this notion. Indeed, what is the first thing that comes to mind when we hear the word 'sex'? What moves, what images flash before our eyes? A woman's erotic décolletage, the nude body of a man or a woman, a detail from lovemaking, a flirt, a secret workplace affair, an unfulfilled desire, a trauma, a porn scene, an obscene memory? Sex has a different meaning for everyone. Forbidden, secret or compulsory, or maybe the natural, joyful part of life? Desired images, fantasies, a concealed tingle, suppressed feelings? Spirituality, love, self-awareness, sport? Defenselessness, work, submission? Or rather does it not mean anything? And what are the social and institutional norms which we all take for granted in our own reference frame? Which mark the cultural context of our individual, subjective feelings? Sex is only allowed in a marriage. You can only make love with someone you are in love with. Sex is intimacy. Treating and handling your partner with erotic overtones is forbidden in public places. You cannot appear naked even in front of your husband. The erotic physical interaction of men with men is forbidden under any circumstances. And we could continue. How deep can we get if we try to define what human sexuality really means? Could there really be a standardised answer lurking in human nature, hiding behind the different social cultures? The explanations from (natural) sciences tend to define sexuality as the reproductive activity of the human race, in which coitus has a distinguished place. But even if we limit ourselves to nature, we can find many animal species for whom sexuality is more than a simple activity with the goal of preserving the species. Perhaps the most spectacular example is that of the bonobo, a great ape for whom sexual interaction has been proven to have a social function: it helps to defuse conflicts inside the group, to in-

⁵ Interview. Dóra Djamilá Mester: *Woman, Mother, Lover- Motherhood and Sex*, Jaffa Kiadó, Budapest, 2013.

crease cooperation, to decrease aggression, and it is a defining component of social cohabitation independent of reproduction. What is sex, then? When defining human sexuality it seems to be justified to look for a definition which conveys the complexity of sexuality.

The English word 'sex' refers to the biological gender that is mostly used for the physical and genetic peculiarities of sexuality. The existence of only two genders is only a myth even in a biological sense. Today, man and woman are placed at the two ends of a horizontal axis, emphasising the manifold transitional phases between them since the sexual anatomy of men and women go through the same developmental path. Male and female genital organs resemble each other in their tissues and functionally as well. Concentrating solely on the physical aspects of our sexuality, it can be said that the genitals, the hormones or the chromosomes can be placed on a very wide spectrum in fact. That is why it is difficult to talk about 'pure' men and women even on a biological basis in most cases. If sex as a sexual activity is mentioned, most people understand it as the copulation of a man and a woman. According to the results of the survey of Kinsey Institute published in the February 2010 edition of the journal *Sexual Health*, based on the answers of 486 randomly selected heterosexual adults, the insertion of the penis into the vagina is considered to be sexual activity in a narrow sense by most people but three out of ten would already dismiss oral sex as a sexual intercourse, and half of the respondents thought that stimulating the genitals by hand had nothing to do with sex.⁶ These results suggest that not only in the past but in the present as well, the definition of sexuality has been dominated by a heteronormative and biologising approach according to which the primary goal of sex is procreation. However, since many people cannot relate their own practices and personal experiences to this approach, why not assign a definition to sex that is based on the real life situations of people? Based on the above examples, looking for an open and inclusive sex definition seems to be justified. Just like our sexual identity, orientation varies quite much based on our culture and individuality. The meaning of eroticism, sexual desire and attraction can be very diverse as well. Sex may or may not include emotions. Though strict definitions tend to limit sexuality exclusively to the genitals in a physical sense, there are also people for whom a kiss or a handshake may carry just as much of a sexual meaning as playing with the genitals does for others. Sexuality is so manifold and variable that the ratio of cultural and biological components in our individual sexuality becomes questionable.

3.3 Man and sexuality: nature or culture?

No matter how much sexuality is perceived as a subjective, intimate state of being, all our personal desires and opportunities are defined by the given society, macro- and micro-culture we are born in, grow up in or live in at the moment. The perceived personal freedom, self-determination (how we feel, think, how we see, live our body), and how our sexual life is realised on a daily basis is framed by the norms of the society. Even the often self-explanatory ideas

⁶ http://www.kinseyinstitute.org/newsletter/win2010/researchwin2010.html#sex_meaning

of sexuality are in fact created by institutions like ethics, laws, education, psychological theories, medical definitions, social rituals, pornographic or romantic stories, popular culture, and different professional and amateur discussions on the Internet. In fact, this draws the borderlines that mark our opportunities and determine our desires.

According to historian-sociologist Jeffrey Weeks, who specialises in work on sexuality, "No universally acceptable codes of appropriate behaviour have been elaborated despite all the heated debates. But something much more valuable has happened. We are being forced to re-think what we understand by sexuality because of a growing awareness of the tangled web of influences and forces - politics, economics, race, ethnicity, geography and space, gender, morals and values - that shape our emotions, needs, desires and relationships."⁷ Our 21st century sexuality is very far from the 'natural' world of instincts even on the level of desires. Still, in the public thinking – whatever we mean by it – images still appear hinting that deep inside we are instinct beings and our sexual motivations are basically focused on mate choice and race preservation. This is supported by the essentialist understanding of sexuality according to which sexuality is a biologically determined, eternally changeless entity independent of society and history. The main components of this understanding are: 1) man is either male or female in a biological and a historical sense as well, these appear as binary opposites, which at the same time delineates the boundaries of the normality of sexuality, inasmuch as the only 'natural', in other words 'normal' form of sex (as we have already pointed out previously, the English word 'sex' means biological gender and sexual intercourse at the same time) is the lovemaking of a man and a woman; 2) sexual desire appears as an overwhelming natural force piercing through civilisation and culture; 3) the definition of sexual instinct whose only goal is reproduction.

Opposite to this understanding stands the constructivist understanding of sexuality which relates the definitions and forms of expression of sexuality to the appropriate historical and social context. It does not mean that human sexuality could not be viewed as a clearly biological phenomenon. As Gayle Rubin, cultural anthropologist of Berkeley University in California says: 'Human organisms with human brains are necessary for human cultures, but no examination of the body or its parts can explain the nature and variety of human social systems. The belly's hunger gives no clues as to the complexities of cuisine. The body, the brain, the genitalia, and the capacity for language are all necessary for human sexuality. But they do not determine its content, its experiences, or its institutional forms. Moreover, we never encounter the body unmediated by the meanings that cultures give to it.'⁸ Ethics, law, institutionalized pedagogy has always defined what is forbidden, tolerated and allowed in a given society for people regarding their sexual practices. The achievements of modern civilization, medical science, psychiatry, psychology, and then sexology created the science of sexuality, classified, categorized the people practicing different sexual habits. It taught us what is perverted – as experts today

⁷ Jeffrey Weeks, *Sexuality*, Routledge 1986 and 2003, page 9.

⁸ Rubin, Gayle: *Thinking Sex- Notes for a radical theory of the politics of sexuality*. In: *Sexualities- Critical Concepts in Sociology*. Edited by Ken Plummer. Volume II. Routledge, London, 2002. pp. 197.

formally say, sexual paraphilia – and what is normal. This is how it becomes apparent for the members of a society in the civilising process of different cultures how they should ‘appropriately’ regulate their physical and mental processes, social interactions in order to meet the norms of our closer and wider social environment.

With this in mind, it is interesting to observe that introducing younger generations, children to sexuality poses a problem in many European countries. As if the sexual education in families did not treat sex as a ‘natural’, biological event. As if it resulted from some biological cause that the child is unaware of the relation of the genders, and it were an especially delicate and difficult task to enlighten the developing young girl or boy about himself and about everything that happens around him. We only realise how much this situation is not self-explanatory and how much it is the result of a civilisation process when we observe the specific behaviour of the people of another era or culture different from ours. Sociologist Norbert Elias shows a 16th century example in his book *The Civilizing Process* when children lived in the same social space as the adults from quite an early age on; and adults did not yet demonstrate such a strong self-control in sexuality, neither in speech nor in action, as they would in later eras.⁹ In his work ‘History of sexuality’, Michel Foucault arrives at the same conclusion. At the beginning of the 17th century the practice of sexuality did not need to be hidden; the code regulating roughness, obscenity, and indecency left a much wider space for people than it did in the 19th century.¹⁰ Before the 17th century it was indeed strange for adults to hide the manifestations of instincts before each other and the children, to banish them to the sphere of intimacy or to lock them away tightly. All this decreased the distance between the expected behaviour of adults and children already. The biological development of humans did not differ much from today; only in connection with this social change can the whole problem of ‘adulthood’, as it presents itself today, become understandable for us. As in the course of the civilizing process the sexual drive, like many others, is subjected to ever stricter control and transformation, the problem it poses changes. The pressure placed on adults to privatize all their impulses (particularly sexual ones) the „conspiracy of silence”, the socially generated restrictions on speech, the emotionally charged character of most words relating to sexual urges- all this builds a thick wall of secrecy around the adolescent.”¹¹

Some days ago I went to a baroque concert. The melodies born many centuries before came to life ‘among the walls of the past’ in a wonderful, elegant building of Amsterdam. On the open cover of the cembalo there was a renaissance painting with a naked Venus lying lazily with her left hand resting upon her Venus hill which would later be named after her. In the hall, the orderly, elegantly dressed citizens, all decent, listened to the baroque music; no one would have dared to think that the naked woman grasping her groin would radiate eroticism or any sexual-

⁹ Elias, Norbert: *The Civilizing Process- Sociogenic an Psychogenetic Investigations*. Volume 1. *The History of Manners- IX. Changes in Attitude Toward Relations Between the Sexes*. pp.169. Basil Blackwell Publisher, 1978, England- Worcester.

¹⁰ Foucault, Michel: *The history of sexuality*. Vol. 1. *An introduction*. New York, Vintage Books : Random House, 1990

¹¹ Elias, Norbert: *The Civilizing Process- Sociogenic an Psychogenetic Investigations*.

ity. I was thinking how different it would be if the same image were a contemporary photograph. Just like an erotic photo that simply displays a naked woman with tits and a pussy, this painting awakened the same curiosity in my five year-old son. He has 'not yet learned' that acknowledged artworks painted in the past 'do not count' as erotic, arousing in a different cultural context. What is considered normal and 'perverted', what is desired or uninteresting always reflects the expectations and system of norms of a given era. In sexuality, just like in every other aspect of being a human, it is absolutely necessary for a society to create a system of rules. This is the reason why it makes no sense to put the biological, natural explanations 'hiding at the bottom of everything' forward and in the meantime forget the social, cultural peculiarities forming our lives in reality. The cultural aspects of sexuality get a bigger emphasis at the moment we interact with somebody. Let it be a love, a gynaecological examination, a family conflict, a school or a workplace affair, suddenly what the participants in the situation think about the definition of sex, what gender identity, eroticism, and desire means to them and how they relate to their own or the other person's body becomes very important. Our key concepts surrounding sexuality and often thought of as basic and self-explanatory – let it be our social or biological gender, our body, our sexual identity or sexual practices – are not universal at all. Even the seemingly most basic and most similar physical processes may carry a different meaning in every culture. But where do the boundaries of cultures lie?

3.4 What is culture?

'The intercultural approach is built on the realisation that we (everyone else as well) are all part of some culture, or rather cultures. The aim of collecting knowledge about culture is just to understand what this statement means and to realise how deeply culture intermingles with our behaviour, way of thinking, and emotional life. The Western man likes to overestimate his independence, autonomy, and freedom of choice: essentially, the notion of free will is a very important part of our cultural heritage. That is why we tend to underestimate the effect of culture. This can lead to an attributional mistake when judging others: we attribute intention to an act behind which there is actually no intention. The goal of knowledge about the expression, consequences, and mechanisms of culture is to decrease the incidence of such errors.'¹² 'Everything we see around us is the product of culture: not only the pictures on the wall or the books but everything else as well: the tools of work, the walls, and even the house plants. Furthermore, the furniture also bears witness to the development of the furniture industry: a desk or a bookshelf reflects the concept of knowledge and learning, just like a bathroom or feminine pantliners tell us much about our concept of cleanness. The workplace, the given institution, the function it provides, and the way the fulfilment of this function is organised are all cultural phenomena. Let us take a look at ourselves, what we wear, what posture we sit in, how we step up to others, how we are physically 'prepared' for interaction with others. 'Culture surrounds us; it is written in our body, our soul, we cannot step out of it.'¹³ That is why the physical, emotional,

¹² Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation

¹³ Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation

behavioural, and social aspects of sexuality have no culture-independent meaning. Because what we consider sexual, erotically attractive or repulsive is also defined culturally.¹⁴

“Culture refers to the total way of life of any society, not simply to those parts which the society regards as higher or more desirable. Thus culture, when applied to our own way of life, has nothing to do with playing the piano or reading Browning. For the social scientist such activities are simply elements within the totality of our culture. This totality also includes such mundane activities as washing dishes or driving an automobile, and for the purpose of cultural studies these stand quite on a par with the ‘finer things of life’. It follows that for the social scientist there are no uncultured societies or even individuals...every human being is cultured in the sense of participating in some culture or other.” Ralph Linton (1945:30)

Despite all this, there is no unified scientific answer to the question: what is culture? No wonder no consensus has been reached in the matter since practically irrespective of what approach we would choose, it is hard to get hold of it. We may get closer to the answer to the question of where the boundaries of cultures lie in the case of sex if we consider the definition of culture which, instead of using the common values, language or customs to draw the boundaries of a culture, asks whether there is any kind of common language with the help of which we can share our differences with each other.¹⁵ If there is, then we are still part of the very same culture. Maybe we think differently about whether gay people can adopt a child, or whether anal sex is acceptable in a relationship but if we are able to even argue about it, if we have a common system of concepts, then we still belong to the same cultural group. The same cannot be said about the mutilation of the female genitalia for religious causes which is customary in several Islamic countries, or about sentencing homosexual people to death. Indeed, in case of these traditions insurmountable boundaries seem to lie between culture and culture.

¹⁴ Much of the ambiguity surrounding the concept of culture results from the etymology of the word 'culture'. Our word 'culture' is derived formally from Latin 'colere' which was an agricultural expression originally, meaning taking care of the soil and the animals. Cultivating the soil was a metaphor for cultivating the human mind, that is how the new meaning of this expression could spread by the 16th century. In its first canonized definition on the pages of the 1719 edition of Dictionnaire de l'Académie Française it includes the arts and the sciences, and embodies humanity's parting from the natural, the animalistic. In the century of light, culture and civilization signify the path on which humanity leaves dark era of irrationality and darkness behind. Therefore, only one kind of human culture could be imagined which had to be approached by every people gradually. The first contesting was formulated by Herder in 1774. Herder claimed not less than that every people is worthy of acknowledgement for their own individuality. Thus, Herder can be seen as the forerunner of modern cultural relativism. (Vinsonneau:19-20)

Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation'

¹⁵ L. Drummond 1981-2. "Analyse sémiotique de l'ethnicité au Québec" Question de culture, No.2, 139-153

3.5 Does culture define sex or does sex define culture?

The above definitions of culture agree that culture is related to some kind of group of people. Nonetheless, it is hard to determine what kind of grouping we mean. Because we can 'talk about Hungarian culture but about Gothic culture as well, and what is more, lately about the culture of the mobility-impaired, or gluten-sensitive people, gender culture, or cultures defined based on sexual preferences. The latter ones deserve the title of culture not less than the previous ones. In other words, for the forming of a cultural group, common territory, imaginary or real blood or genetic relationship, or ethnicity are not needed objectively because any of the previous may be the basis of the idea of culture.¹⁶ That is why, concerning the cultural aspects of sexuality, it is important to make a clear distinction between talking about a group of people belonging to a given ethnicity, nation or religious group, living in a given district of a given city whose sexual culture is necessarily defined by their national, ethnic, religious, ethical cultural tradition, and talking about social groups, or say subcultures, who were explicitly formed based on a given sexual attribute (gender identity, sexual practices, fetish, custom). Naturally, these mostly overlap with each other multiple times, and that is the reason why it is hard to discern how such segments of culture appear in the sexual identity and practices of a given person. This also explains the importance of the long introduction above about whether we can consider human sexuality a universal characteristic intrinsically linked to human nature. Since we cannot, it is worth analysing and consciously reflecting on how our own cultural environment determines our sexuality. How we, too, depend on the culture we live in and how we, too, create and form everything (through our sexuality) we call sexual culture.

When culture defines sex: sex and ethnicity

Western philosophers have long considered their own world universal. The first big wave of cultural anthropology, the work of Bronislaw Malinowski¹⁷ and Margaret Mead¹⁸ was the first to call the attention of the West to the fact that seemingly natural human phenomena, physical and emotional processes, social relations and sexuality, sexual culture, which integrates them, is far from universal, and rather varies nation by nation, ethnicity by ethnicity. Their findings are still profound even today; just think about Europe where many ethnicities live close together with different traditions, customs, and cultural patterns. Roma children go to school with non-Roma children, Muslim women and men work in Dutch workplaces, students from the Far East sit in the halls of Western universities, so we may as well say that the European Union itself reflects this phenomenon. Day by day we interact with people of different ethnicities; we work, study, make business, fall in love, yearn, flirt, found a family. However, whatever we do to-

¹⁶ 'Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation'

¹⁷ Malinowski, B. (1927). *Sex and Repression in Savage Society*. London: Kegan Paul, Trench, Trubner & Co.; Malinowski, B.; H. Ellis (1929). *The Sexual Life of Savages in North-Western Melanesia. An Ethnographic Account of Courtship, Marriage, and Family Life Among the Natives of the Trobriand Islands, British New Guinea*. London.

¹⁸ Margater Mead: *Sex and Temperament in Three Primitive Societies* (1935), *Male and Female* (1949),

gether, our body, soul and the cultural traditions written in them are there with us. We differ on what we think about our body, intimate hygiene, what is beautiful or repulsive in a man or woman, what we are allowed to talk about in the family, in company or what is considered a 'delicate' topic. How we show our emotions, get to know new people, or what is allowed in sexual intercourse and what is forbidden for a man or a woman.¹⁹

Racial, ethnic, and national borders are sexual borders as well. One's national, racial, and ethnic identity is most often combined with ethnosexual boundaries; every ethnicity carefully guards and watches over its own sexuality. Hungarian public life has recently been stirred by the case of MPs Ági Osztoykán (LMP) and György Gyula Zagyva (Jobbik) which happened in the corridors of the Parliament.²⁰ The MP from Jobbik happened to say to his colleague: 'Just because you are Roma, I would still do you!'. In itself, this sentence can be seen as a 'simple' racist, sexist comment – which tells us a lot about how racist and sexist ideology is blurred together, but the rest of the story teaches us a lot as well. The above-mentioned MP tried to deny having made the comment saying 'because of course these are just the type of people I get aroused by'²¹, and then simply attributed the comment to another one of his colleagues. That colleague in turn, in an open letter, managed to put the sexually and culturally relevant moral of the story into words, saying: 'You are afraid what your bulldog comrades you usually simply call 'cannibals' would think if they hear you would date a gypsy.'²² In other words, the aforementioned MP wanted to deny his comments made in the corridors of Parliament only partially on the grounds that it had been simply indecent for a politician of a European country to say such a thing. Rather, he was trying to deny it much more out of fear that his comrades would brand him for committing a sexual transgression.

Normative heterosexuality is a defining component in most racial, ethnic, and nationalist ideologies; sticking to the generally accepted sexual identities and behaviours, and treating the deviations from it contribute to the regimes sustained on a racial, ethnic or national basis. In this context, sexuality signifies an element of power, sexualisation is one of the defining components of constructing and maintaining an ethnic, racial 'queerness'. These ideologies are built on a given society considering the sexuality of the dominant racial, ethnic, national or political group to be the norm, i.e. natural, and any 'queerness', deviation from it as abnormal, perverted, or unacceptable. This is the source of stereotypes like the lustful, amoral gypsy women,

¹⁹ 'A collection of essays published not long ago deals with the sexuality of gypsies living in countries based on the Western culture and with the narratives of sexuality of gypsies and non-gypsies (Gypsy sexuality: Romani and Outsider Perspectives on Sexuality, edited: Jud Nirenberg, Clambake Press, 2011), but a number of social scientific analyses, studies have also been born looking for correlations between sexuality and ethnic differences. Just to mention a few: , Joane Nagel: Ethnicity and Sexuality, Annual Review of Sociology, Vol. 26 (2000), pp. 107-133; Paloma Gay-Y-Blasco: „A Different Body?""- Desire and Virginity among Gitanos, The Journal of the Royal Anthropological Institute, Vol. 3, No. 3. (Sep., 1997), pp. 517-535; Lorena García: „Now Why do You Want to Know about That?" – Heteronormativity, Sexism, and Racism in the Sexual (Mis)education of Latina Youth, Gender & Society Vol. 23. No. 4. (2009), pp.520-541.; Amy C. Wilkins: Stigma and Status: Interracial Intimacy and Intersectional Identities among Black College Man, Gender & Society Vol. 26. No. 2. (2012), pp.165-189.

²⁰ http://osztolykanagi.blog.hu/2013/02/20/sotetseg_a_tisztelt_hazban

²¹ http://hvg.hu/itthon/20130220_Attol_hogy_cigany_vagy_meg_ledofnelek_j

²² http://vagogabor.blog.hu/2013/02/21/nemcsak_taho_hanem_gyava_is_vagy

the coloured women and men who are shown as naturally highly sexualised. This type of (hetero) normativity is the basis of homophobia and intolerance towards any kind of sexual difference. That is why we have to make ourselves conscious and sensitise ourselves towards the ethnic aspects of sexuality, however, if we focus the cultural differences of sexuality on ethnicity, we may lose many other aspects of the peculiarities of sexual cultures. As a practicing sex educator, I find that it is quite different to work with gipsy teens in schools in the central and the more peripheral districts of Budapest. Many nuances are added to the same ethnic characteristics if we take into account every detail of the socio-cultural, social, family, school, and institutional background.

Sexual cultures, when sex defines the boundaries of culture

As the concept of culture got more and more refined, the attention of cultural anthropologists turned to the different social groups of their own countries. It turned out that customs abound and it is almost impossible to describe the sexual habits of people only along ethnic, religious, national lines. Since it was initially released in 1983, British social anthropologist Sheila Kitzinger's popular book *Woman's Experience of Sex*²³ has been republished several times. Kitzinger, a natural birth activist has written many world-famous books about pregnancy, birth and female sexuality. In her books she voices the real-life experiences of real women, which contradicted the social myths of the era. In their extensive social survey, the legendary American pair of researchers Masters and Johnson²⁴ arrived at the conclusion that most American mothers – unlike the cultural expectations of the era – were not indifferent towards sex; on the contrary, they showed a much higher sexual activity than those without children. In the world-famous survey of A. C. Kinsey, eight thousand American women were asked about their sexuality. From this study, many facts that had until then remained hidden came to light about the desires and sexual practices of everyday women, showing a much more varied picture than what would have been possible if they had been categorised as a single group just because they belonged to the same nation.

In her article “The Intercultural Competence Approach”, Vera Várhegyi writes that 'man and culture are bound together by cultural identity. We can think of cultural identity as the imprint of our social belonging we carry with us continuously, and our keeping alive the respective emotions, values, behaviours, and beliefs. For instance: I can imagine that I belong to the community of Hungarians (even when I am not with them, or perhaps then even more so). My heart aches when a Hungarian competitor falls behind the German one in a hundred meter swim (emotion). I am sure I am part of a country having a history of a thousand years (value). I believe the bloodline of the people who settled in Hungary runs in me (belief). Last, stunning many foreigners, I insist on eating pasta with ground poppy seed and sugar (behaviour). However, this simple image is complicated by many details. First, cultural identity is not a static or uniform phenomenon: everyone chooses a different way to incorporate his culture into himself

²³ Kitzinger, *Women's Experience of Sex*.

²⁴ Masters, W.H; Johnson, *Human Sexual Response*

– Hungarian identity can also mean something completely different for the individual Hungarians. Second, everyone is part of several communities, cultures and his cultural identities reflect this diversity: we are the unique combinations of professional, national, perhaps ethnic, religious, gender, musical, etc. identities. As a result of this diversity, our identities dynamically react to our social environment, more precisely, it is always the given environment that decides which one of our identities is activated. When we work, our professional identity comes to the forefront most probably, although it happens that our belonging to another group becomes dominant, for example when our colleague tells a sexist joke discriminating women negatively. What group the people that surround us belong to also influences whether we momentarily consider ourselves a woman, a professional, or black. Typically, we relate the most to the least represented group in a community, i.e. to the most outstanding identity. Karim, who has Arabic origins, will consider himself an Arab in Budapest, but a Hungarian in Tunisia. And a psychologist will impersonate his male identity if there are only women in a conference except for him, but his psychologist identity will be stronger once surrounded by anthropologists.²⁵

Opinions are divided concerning whether sexuality can mean the basis of our identity in any form and whether sexual identity can be a bond between people, whether it can be the basis of a subculture. As we could read above, cultural identity is dynamic and relational in nature; therefore the answer to this question depends mostly on an individual's social, cultural context. I remember the feeling I felt in San Francisco, California at the introduction of the sex educator training of San Francisco Sex Information. Twenty of us future participants were sitting in a circle. Everyone had to say her name, who she was living with, what her sexual identity and sexual orientation was. I did not even know then that the latter is not the same as sexual identity. By the time it was my turn to introduce myself, I managed to realise how relatively I could categorise my sexuality. While I was maybe sticking out a bit at home in my own social environment by living in an experimenting, 'open' relationship, here, in this sexually more colourful, diverse medium, my introduction definitely 'stuck out' from the others with its conservativeness. Just like when looking at the gay rights movements of different countries we can see that homosexuality as a sexual identity always appears against the heterosexual social groups in majority, or to be more precise, the hegemonic heteronormativity. Nothing shows this better than the fact that the sexual relationship between members of the same gender remained without a name for a long time in Western culture. We all have a sexual identity, but what we fill this category up with is absolutely a function of the historical, political, social, and cultural environment; when and what it means, and where its importance lies.²⁶

²⁵ Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation

²⁶ Many ethnographic, sociologic and psychologic studies have been written about examining and understanding sexual identity, for instance Paula C. RUST "Coming out" in the Age of Social Constructionism: Sexual Identity Formation among Lesbian and Bisexual Women, *Gender & Society* (1993) vol. 7 no. 1 50-77; Ramona Faith Oswald: Who am I in Relation to Them?: Gay, Lesbian, and Queer People Leave the City to Attend Rural Family Weddings, *Journal of Family Issues* (2002) 23: 323-348; Jessica F. Morris and Esther D. Rothblum: Who Fills out A "Lesbian" Questionnaire?: The Interrelationship of Sexual Orientation, Years "Out," Disclosure of Sexual Orientation, Sexual Experience with Women, and Participation in the Lesbian Community, *Psychology of Women Quarterly* (1999) 23:

There are communities formed explicitly based on sexuality. They may be organised according to sexual identity (gay rights and social activist communities, events, parties) but it also happens that members of the community do not identify their sexual identity based on this and the driving force behind the organisation remains their sexual orientation. It may be a virtual community or connected to a specific physical space like adult playgrounds created for BDSM sex (dungeon)²⁷, the swinger clubs for the fans of group and pair switching sex, night clubs or sex parties in costume, and according to some views, commercialised sexual services also belong to this category, just to mention a few. Similarly, certain forced communities can form a sexual subculture, like in prisons or in the army.²⁸

Here we have to mention the role of the Internet and technology in the changes of sexual cultures. Today, the internet can allow many people preferring many kinds of 'unusual' sexual desires to find each other without physical proximity, to create a virtual community, or to access sexual, erotic content according to their interest. Just like it can also provide us with information about the existence of sexual cultures that are different from ours, thus influencing the cultural reference frame we thought to be stable. It not only has a role in widening our perspective and increasing our awareness, but technology also provides space for many new sexual, erotic games, like producing home-made porn films (home porn), sexting (sending erotic profile pictures by phone), looking for a mate or a sex partner on the Internet, just to mention a few. Thanks to this, the Internet provides opportunity and space for people having similar passions to find each other reaching beyond country and language borders to form a community, or at least considering themselves to belong to the given subculture. This virtual connection can assist in recognising (even going public with) our particular identities in a certain sense as much as it can justly pose the question of how much an identity born in a virtual space can be 'real', or at least how vulnerable it is outside the Internet.²⁹

537-557, Diamond, Lisa M.: Sexual identity, attractions, and behavior among young sexual-minority women over a 2-year period. *Developmental Psychology*, Vol 36(2), (2000), 241-250. Dubé, Eric M.; Savin-Williams, Ritch C.: Sexual identity development among ethnic sexual-minority male youths. *Developmental Psychology*, Vol 35(6), (1999), 1389-1398.

²⁷ Bondage, Discipline (B&D vagy B/D); Dominance és Submission (D&S or D/s), Sado- Masochism or Sadism and Masochism (S&M or S/M).

²⁸ Numerous social scientific analyses have been prepared about sexual subcultures, just to mention a few: Carole S. Vance: *Anthropology rediscovers sexuality: A theoretical comment*, *Social Science & Medicine*, Volume 33, Issue 8, 1991, Pages 875–884, Gates, Katharine *Deviant Desires: Incredibly Strange Sex!*, Juno Books, 2003, 1999.; Walshok, Mary Lindenstein: *Emergence of Middle-Class Deviant Subcultures: The Case of Swingers*, 18 *Soc. Probs.* 488 (1970-1971); Laura María Agustín: *New Research Directions: The Cultural Study of Commercial Sex, Sexualities* (2005) vol. 8 no. 5 618-631; Dawne Moon: *Culture and the Sociology of Sexuality: It's Only Natural?*, *The ANNALS of the American Academy of Political and Social Science* (2008) vol. 619 no. 1 183-205; *Introduction to the Cultural Study of Commercial Sex: Guest Editor Sexualities* (2007) 10: 403-407; Andreas Spengler M.D.: *Manifest sadomasochism of males: Results of an empirical study*, *Archives of Sexual Behavior*, (1977), Volume 6, Issue 6, pp 441-456.

²⁹ The topic has a comprehensive literature as well, from which to mention a few Keith F. Durkin and Clifton D. Bryant: "Log on to sex": Some notes on the carnal computer and erotic cyberspace as an emerging research frontier, *Deviant Behavior*, Volume 16, Issue 3, (1995); *Mobile Cultures: New Media in Queer Asia* edited by Chris Berry, Fran Martin, Audrey Yue, Duke University Press (2003); Michael W. Ross: *Typing, doing, and being: Sexuality and the internet*, *Journal of Sex Research* Volume 42, Issue 4, 2005; Jane D. Brown: *Mass media influences on sex-*

As we can see, the Internet's role in our sexual identity seems to be very complex and diverse: 'Our identity defines our values, thoughts and behaviour, but what unique way our identity chooses to grasp the cultures of the groups we belong to and in a given environment which of our identities we feel most accessible is the function of the interplay of countless personal and environmental factors. The relation between culture and identity is not a one-way relation, however. Just like we ourselves and our environment can be considered the product of culture, so can we find the opposite to be true as well, namely that individuals continuously participate in reproducing, forming, and changing culture.'³⁰ This is just as true about the sexual components of our identity. One of my friends recently told me about one of his adventures. As a Hungarian, heterosexual, white, atheist man with a family he got into an affair at a North American University with a dark-skinned, religious catholic, lesbian female colleague living in the US but originally from Sri Lanka. In this story, the differences between the ethnic, national, religious characteristics, and also sexual identity of the two of them were present at the same time.

3.6 The dimensions of our sexual differences

If every culture embodies unique answers, then it is natural that these answers differ from each other. In the case of sex it is further complicated by which aspect of sexuality is at the centre of the intercultural dialogue in question: the body, some sexual practice, or our gender roles. Discovering what these differences constitute and what scale of our activities they affect is an unending task for which applied anthropologists and cultural (comparative) psychologists bring newer and newer data bit by bit. 'Culture signifies the historically conveyed patterns of meanings embodied in symbols, the system of inherited concepts expressed symbolically with the help of which people can communicate with each other, perpetuate, and develop their knowledge and attitude towards life.' (Geertz 2001:74) Based on this, we can say that the extent of cultural differences by far surpasses the differences between values, religions, everyday habits, etc.³¹ If we try to enumerate what subcategories sexuality might have at all, we already find a number of dimensions that simply 'offer' cultural differences.

The sexual body

Sex, considering its everyday aspects, has many points of connection with the flesh and the body. Since the relation between body and culture constitutes a separate article in the BODY anthology, here I would rather stick to the questions of body especially related to sexuality. But even so, examples abound. Discussions about sex are dominated by viewpoints restricting it to medical, natural scientific, and bodily functions. And this is not only misleading because sex is just the topic for which it is especially important to thoroughly observe the soul, the psyche, and the social and cultural environment of the 'owner' of the body, but also because the bio-

uality, Journal of Sex Research Volume 39, Issue 1, 2002 Special Issue: Promoting Sexual Health and Responsible Sexual Behavior.

³⁰ Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation'

³¹ Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation'

logical texts of sexuality are not at all value-neutral. The assertions, the language, the symbolic system of science, too, always reflect the cultural norms (expectations) of the given era. Historian Thomas Laqueur, whose work deals with sexuality, analysed the medical texts of many centuries starting from the classical age and came to the conclusion that it is not our anatomy that takes form in our fate, but it is rather our fate that takes form in our anatomy. That is, the place men and women hold in society is not determined by our biological characteristics, instead on the contrary: culture defines how we perceive the anatomical and physiological build-up of women and men, and what follows from all these biological 'facts'³². For instance, it was a scientifically 'proven' fact that the female orgasm is just as necessary for conception as is that of the man. Although there has been no change in the anatomy of women during the centuries, this scientific standpoint has still come off the agenda. Laqueur also states that until the mid-eighteenth century, the so-called 'one-gender' model had been predominant both in science and in the public thinking, which had positioned man and woman on a vertical scale where the woman was of a lower rank. According to this, only one biological gender existed in a more or less perfect form: more in the case of men, and less in the case of women. The basis of this theory was supported by drawing parallels between the male and female genitalia, while the physiological explanation was provided by the theory of common human bodily fluid. On the contrary, from the mid-eighteenth century onwards a new, 'two-gender model' transferred man and woman to the two ends of a horizontal axis as a creature of two, fundamentally different biological genders. Feminist anthropologist Emily Martin used this as a basis in her book *The Woman in the Body*³³ to point at the historical tradition according to which women are closer to nature, to bodily processes, to the family, to taking care of children. Let's just think of the simple everyday expressions such as 'she must be on her period, that's why she is upset', or the male version of the biologising argument in the topos 'a man always follows his cock'. But this can be just as well seen in the natural scientific descriptions of the sexual body, as conception has long been depicted as an act in which the female body is passive and receptive, while the man is active, dominating, intruding.

The things considered erotic on the body, or the body parts seen as more or less sexual have differed a lot with every historical age and cultural environment. Let's think of the European cultural history of the female breast. The breast of women – compared to other parts of the body – has always been depicted with a distinguished erotic content, irrespective of the real experiences of real women. We cannot detach ourselves from the beauty ideal and expectations of our age, they are all part of how we perceive our own body, let's say, how we experience our own breasts. A certain hegemonic normativity is present in every culture concerning which bodies are considered sexually acceptable. It includes expectations about beauty, sexual attractiveness as well as what the given culture considers healthy, complete, whole. Looking at the depictions of the body in Western culture, a certain heteronormativity can be observed in the definition of the sexually attractive female or male body as young, fertile, heterosexual,

³² Laqueur, Thomas: *Making Sex- Body and Gender from the Greeks to Freud*. „Of Language and the Flesh”. Pp.1. Harvard University Press, USA, 1990.

³³ Emily Martin: *The Woman in the Body: A Cultural Analysis of Reproduction*, Beacon Press, Aug 1, 2001

healthy, and whole. Child sexuality is not part of it, nor any kind of disability, or sexuality in old age. Attributing a special sexual meaning to the genitals is also a cultural concept, while it can be proven from personal accounts that the erogenous zones is different in every person. The bodily processes that differ with age and for people living with different disabilities indicate the relativity of sexual tactility and sensuality. Inversely, it is worth taking a look at how much different cultures differ on the handling of nudity for instance. In some places the skin, the flesh has to be invisible, while in other places everything can be shown without any concern. But the same is true for the processes of treating and caring for our body; for example, whether a woman is allowed or explicitly expected to remove body hair, whether pantliners are in use, whether she can touch her own genitals, or for instance whether touching herself or her bodily fluids are considered acceptable or outright disgusting also differ from culture to culture.

3.7 Sexual desire

However strange it may sound, sexual desire itself is determined culturally. Drawing a simple parallel may help understand it. The carnal desire of sexuality can be compared to the tastes that motivate what foods we want to eat. What may seem to be an intrinsically physical desire is actually acquired. Our preferences for olives, Brussels sprouts, or ground poppy with sugar have been learned; the same is true about the way we perceive different types of touch. If I do not know, if I have never even heard about it, maybe I would not have thought about trying it, 'wanting it'. Just like we have to 'learn' that we have the right to desire, we often have to learn what forms of desire are acceptable. For example, although seemingly everything is about enjoying life and consumption in Western culture, some forms of desire seem to remain illegitimate. Sexual desire is especially problematic. Whichever official sexual educational program for young people we look at, sexual anatomy is solely restricted to the reproductive functioning of our body, as if experiencing pleasure through our bodies had no *raison d'être*. Michel Foucault uses this viewpoint to compare the different concepts of sexuality in Western and Eastern cultures. On the one hand, there are the societies- and they are numerous: China, Japan, India, Rome and Arabo-Moslem societies- which have endowed themselves with an *ars erotica*. In the erotic art, truth is drawn from pleasure itself, understood as a practice and accumulated as experience; pleasure is not considered in relation to an absolute law of the permitted and the forbidden, nor by reference to a criterion of utility, but first and foremost in relation to itself, it is experienced as pleasure, evaluated in terms of its intensity, its specific quality, its duration, its reverberations in the body and the soul."³⁴ We, in our Judeo-Christian culture talk about sexuality in the language of science and imagine it based on universal norms. Doctors, sexologists, psychiatrists, psychologists, sexual-therapists treat our sexual dysfunctions, analyze the problems of our souls, the perversions of our psyche. Desire has to be explained in every case: I want him, I am in love, because I want to have a child with him, because I have the right to

³⁴ Foucault, Michel: *The History of Sexuality*. pp. 57.

want him, or just because it is forbidden. The secrecy of desire, eroticism is rooted in its forbidden, sinful nature.

The social contexts of sex and gender

The people considered to be man or woman based on their social and biological characteristics and the existence of other social gender roles differs from culture to culture, just as what these identities mean, their power dynamics, hierarchical relationship, or simply what social role they fulfill can vary. Social gender roles constitute one of the pillars of the BODY project, with an entire article dealing with the intercultural aspects of the concept of gender. I would simply mention how norms regarding the kind of sexual, erotic, corporal or virtual relations we can establish are culturally dependant. It always depends on the given culture where the limits of normality are drawn and what their regulatory functions or their selfish cultural traditions are. In sexuality this is illustrated by the notion of *taboo*, or *that which is considered* explicitly or implicitly prohibited. The taboo of incest or the prohibition of sexual intercourse between relatives has a totally different function in each society and different patterns lie behind their apparent universality. Family systems vary on a wide scale from one culture to another.

They contain jumbled and complex rules about who can and cannot marry whom. Anthropologists have been pondering the question of family systems for decades in order to find an explanation for the taboo of incest, marriages between cousins, the conditions of inheritance, the relationships to be avoided, the compulsions of intimacy, the taboo of names, the wide scale of real family systems. Anthropologist Gayle Rubin of Berkeley University in California citing Lévi Strauss – comes to the following conclusion:

“Lévi-Strauss adds to the theory of primitive reciprocity the idea that marriages are a most basic form of gift exchange, in which it is women who are the most precious gifts. He argues that the incest taboo should best be understood as a mechanism to insure that such exchanges take place between families and between groups. Since the existence of incest taboos is universal, but the content of their prohibitions variable, they cannot be explained as having the aim of preventing the occurrence of genetically close matings. Rather, the incest taboo imposes the social aim the social aim of exogamy and alliance upon the biological events of sex and procreation. The incest taboo divides the universe of sexual choice into categories of permitted and prohibited sexual partners. Specifically, by forbidding unions within a group it enjoys marital exchange between groups.”³⁵

Studying the process of civilization, Norbert Elias argues that the super ego, just like the psychic structure of man or our whole individuality, strongly correlates with the system of rules of social behaviour and with the structure of the society. The pronounced division in the “ego” or consciousness characteristic of man in our phase of civilization, which finds expression in such terms as “superego” and “unconscious”, corresponds to the specific split in the behavior which

³⁵ Rubin, Gayle: *The Traffic in Women*. pp. 173.

civilized society demands of its members.³⁶ Today, prohibition is so deeply rooted in us that we don't necessarily reflect on its causes, and we cannot handle the ensuing turmoil in many cases. If the relation between parent and child starts to include the slightest hint of eroticism it becomes suspicious immediately, the fear of abuse appears. But it varies from culture to culture – as shown by the quotations at the beginning of this article - that sexual intercourse itself within a group has a defined and strictly controlled social meaning for many ethnicities. Similarly, the organisation of the family also varies between cultures.

“Types of marriage and marriage rules”: marriage can mean commitment between a man and a woman (monogamy), between a man and more women (polygamy) or between one woman and more men (polyandry). We know types of marriages that don't fit into any of the above categories. For example the “mosol” girls in China never get married. With the help of their brothers they build their houses where then mothers, daughters, uncles and brothers live together. In the evenings men visit the house where their darling lives. These are totally legitimate relationships, they often last for years and of course children are born from these relationships. But these children have a father concept which is completely different from that of a Hungarian, German or Russian child growing up in a nuclear family. Besides, deciding who can marry each other is also defined by cultural norms. For example the marriage of cousins is frowned on in many places. From the perspective of the Western Judeo-Christian culture it can seem weird that in many societies marriage between cousins is not only possible but outright preferable. But we can find differences even in this. For example in the Arabic marriage system the ideal wife for a boy is the daughter of the mother’s sister or the father's brother. A marriage like this would cause a strong uproar in Amazonia, where it goes the other way around: the daughter of the father’s older sister or the mother’s brother should be chosen. In the family system known to us it's difficult even to distinguish between these relationships, because we are not used to differentiating between our cousins this way.³⁷

Sex as an activity

As it came up previously the things we consider erotic, attractive, arousing, or the reasons we have sex with someone or alone varies from culture to culture as well. The goal and the content of sexual activity are also culture-dependent. We have sex because we find great pleasure in it, because it is obligatory, because it's an expectation, because of intimacy or emotional closeness, because it gives security, because it alleviates stress, reduces distress, because we need company, because it has spiritual content, because it is a means of earning money or because we consider it to be good physical exercise.

In simply thinking about the history of masturbation we see that different eras have considered

³⁶ Elias, Norbert: *The Civilizing Process- Sociogenic and Psychogenetic Investigations*. IX. Changes in Attitude Toward Relations Between the Sexes. Volume 1. *The History of Manners*. Basil Blackwell Publisher, 1978, England- Worcester. pp.190-191.

³⁷ Vera Várhegyi: *The Intercultural Competence Approach*; Artemisszió Foundation'

it reprehensible (Thomas Laqueur: *Solitary Sex*, a cultural history of masturbation, Zone Books, 2003) for different reasons, that it has had different religious and sanitary approaches, and that it has had different meanings in the case of boys and girls. As it was mentioned in the definition of sexuality, many people consider sex the insertion of the penis into the vagina (PV sex). It's not only a hetero-normative definition related to reproduction but it also narrows the opportunity of the sexual playing field for heterosexual people. But whether we play with our own body or with our partner's, how we handle - even unrelated to our body - eroticism not only depends on our fantasy (that is also framed by our cultural traditions), but also on what the closer-wider social environment surrounding us considers acceptable, tolerated or expressly prohibited. As a practicing sex educator, I find it quite interesting to keep this in mind when listening to the negative feelings people have about different sexual practices. In Hungary I often get letters from readers, questions for example in connection with anal sex. For many heterosexual couples it is a natural act, but there are men who consider receiving anal sex (from the female partner) unimaginable because they associate anal reception with homosexuality. I often hear similar reservations about oral sex when working with Roma young people. If a woman gives pleasure to a man orally, it is considered unacceptable and disgusting by boys and girls alike because 'only bitches do that'. But it is also culturally determined whether we consider taking the lead, being active, passive, or submissive in sexual intercourse and whether we assume a traditionally masculine or feminine role.

In San Francisco, California professional sex workers told me they would have no job if their culture allowed wives to be completely free in bed. From this perspective, we can look at the activities preferred by sexual subcultures or at the usage of different tools and the attitude those outside of these communities have of such practices. It's enough to think about binding or experimenting with pain and how these acts generate repulsion or incomprehension from those who can only imagine pain as a negative human feeling and cannot imagine linking it to pleasure in under any circumstances. And we could continue by examining cultural differences in relation to bodily fluids, to tasting them, to the erotic usage of different objects, "tools", and toys. To close the list, I would like to mention the following example: I, myself, as a sexual educator often see and experience a lot as a result of my profession but I distinctly remember the first time I saw Japanese girls addicted to octopus and fish sex on the Internet. For me, seeing the tiny fish splashing in and out their vaginas and mouths, their completely naked bodies, and the jerking tentacles of the living octopuses was like crossing a cultural border. On the other end of the spectrum, sex does not always mean moist nudity. A handshake or a love letter can also carry an erotic message. In the novel "Midnight's Children" by Salman Rushdie, Adam Aziz falls in love in Kashmir, India as a result of having to examine his client through a white bed sheet for months. Just as the body has its own symbolic and cultural meanings, so does sexual intercourses. It can be the confrontation with authority (marquis de Sade), it can mean the expression of hierarchy in our gender or social roles, but it can also carry other dynamics of power and force, just like it can embody belonging to a community.

The spaces of sex

“Space and time are not only relative concepts in Einsteinian physics but in human behaviour as well. The usage of space and time are coordinated by cultural rules that remain completely invisible until two individuals following different expectations meet. The users of different proxemic³⁸ rules may easily fall victim to mutual misunderstanding if one of them considers a smaller distance appropriate for dialogue in the given relationship or situation, while the other prefers a bigger one. These differences can lead to funny situations even in Europe, for instance when an Italian and a Swede try but cannot find the distance suitable for both of them. The alternative approaches to time also first become tangible (sometimes painfully so) during cooperation and interaction. Differences cannot only be seen in ‘how late’ people are for a meeting, although this is the most frequent observation.”³⁹ To what extent a culture organises our sexuality along the dimensions of space and time is very much visible, tangible in some aspects, while in others it remains almost completely unseen, or at least unreflected by the individuals. However, the spaces of sex have always been well regulated. Just think about which sexual activities are allowed for whom and how in our own culture and which are those that remain confined to the private space. Let’s take a Western European capital where kissing is allowed in bus stops, but a woman can’t show her breast and a same-sex couple can’t kiss. It is no coincidence in most Western cultures breast-feeding in public places is a controversial question because we can’t forget about the sexual meaning of the female breast even if it shows up only to feed the mother’s baby. For example, in Budapest such a regulation applies to how far a shop with sexual content can be from a school or a church. But in some towns the same meaning is carried by where red-light houses can and cannot be found, or where the bedroom of the parents is located in the space of the family house : open, together with the children’s room or at an intimate distance from the common family spaces. The legitimate and illegitimate spaces of sex tell us much about how the given culture handles sexuality.

3.8 Intercultural competence and sexuality

But why is the knowledge that everything around our body and sexuality is defined by culture (cultures) interesting in itself? The answer is because cultural features are often very difficult to perceive regarding bodily issues and sexuality. We think they come from nature and that they are universal, so we cannot even imagine in most cases that the things which are absolutely natural for us could provoke adverse feelings in others. Similarly, we also forget to think about why we feel such strong emotions when we come across things which are strange for us. If we do not consider our values and understanding of our body, gender roles, social relations, or sexual practices as universal but rather believe that they are as diverse as we are many, it can bring us closer to seeing them point towards connection points and understandability instead of representing insurmountable obstacles in our social interactions. We all carry everything laid out in the previous pages within ourselves. Unreflected or consciously, we keep dragging along

³⁸ http://www.lelkititkaink.hu/testbeszed_terhasznalat.html

³⁹ Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation'

the complex tissue of our sexual culture and identity in ourselves with a constantly changing, expanding and renewing content and quality. But several times this package doesn't make our situation easier at all. The cultural differences in the case of sex address primary senses (smells, tastes, touches); they activate deep feelings, desires, and attitudes and touch our basic values.

In some cases this means a quick, natural reaction, in which we immediately feel, think, and tell something about the "other". We feel that the other is "strange", unusual, disturbing or even irritating, scandalous, or shocking. If someone makes us blow a fuse or simply surprises us by being tattooed, by missing one of her breasts, by being untidy, by falling in love with people from the same gender or by having sex for money, then the first thing we will do is surely not to think over what may have caused our feelings of contempt. Are we afraid? Are we unsure? Do we judge him or her because we grew up in a totally different value system? The differences can easily (and even invisibly) build an impenetrable wall and several times they don't point towards dialogue at all.

As Várhegyi Vera writes in her article 'The Intercultural Competence Approach; Artemisszió Foundation,': "The intercultural approach was called into being by the realisation of the fact that the coexistence or the co-operation of different cultural groups might cause difficulties. We can arrive at the same conclusion ourselves if we try to count how many years there were in the history of humanity without wars, or how many violent conflicts are going on between different groups of people at the moment. But there is more to it than just the above. Because the conflicts transmitted in the media and the tensions that seemingly verify Huntington's 'clash of civilizations' thesis come to life along fault lines of economic policies and power, while the problems of co-operation with others may show up irrespective of all this, even in the most banal daily interactions. That is, even without any special manipulation for power and material difference of interests, it may be difficult to understand and accept cultural differences and we can get into a conflict relatively easily just because the programming of our human nature is not based on accepting the different, the other but rather on defending, keeping and preferring our own culture. Despite the several obstacles, the meeting of different cultures and confrontation with the cultural differences can mean a resource as well".⁴⁰

But why do we have to be tolerant of every kind of sexual difference which is unlike ours? Why should someone whose profession is not related to sex still care about sex? In the case of sexuality intercultural competence does not necessarily mean we should 'speak' all kinds of sexual culture or diversity 'languages', nor does it mean we should be tolerant of all kinds of difference. It rather means that the ability to self-reflect can be useful in numerous situations. Because sexuality is not only present, it is explicitly the subject of discussion – it is also in sexual education, counselling, dating or family life, and every human interaction, even in the seemingly most professional and most eroticism-free situations. We cannot "put away" our body,

⁴⁰ Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation'

gender, attraction, sexual orientation, we cannot forget about them. They are present even when we try to ignore them in the given context. It is not good or bad. It is an absolutely natural and unavoidable characteristic. What happens if we don't notice them? Just because we don't reflect on it, we still live the situation, we react in a given way and so we affect the simplest social interactions as well. Our different identities are present in parallel at the same time, and it is difficult to find the balance between them all, especially if the interaction is characterised by some asymmetry. Such can be a parent-child, doctor-patient, teacher-student, helper-client, local administrator-migrant relationship, where the hierarchy between the parties isn't necessarily present openly but implicitly, without any reflections. A supporting expert can look at himself or herself in a professional situation as a neutral expert, while as a man or a woman he or she is present with body and soul, with all his or her emotions, values, prejudices. The identity provided by the professional culture can put a hat or a mask on us in which we do not even think about considering ourselves the equal of the other party, because it is the other one who needs help, counsel, healing, answer. 'We', professionals are open, inquisitive, empathic while the 'other party' will be, wanted or not, client, sick, child, patient. The ability to self-reflect offered by the intercultural approach enables us to examine ourselves in each and every situation like we often do without thinking with our partner - whether he (she) is our future love, the conductor or our customer. This can help us to understand why a situation "gets stuck", what causes a strong rejection, shock, resistance, why we get into conflicts even if we don't want to. Of course this approach is no guarantee for the avoidance of conflicts and misunderstandings, but it helps us to mark and understand our own limits, helps us to say *yes* or *no*, and reduces our uncertainty in situations caused by not understanding why the other is so different.

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**Gender:
Boundaries of Identity
in a Multicultural Perspective**

Noemi De Luca

The concept of gender in its binary opposition male/female linked to characteristics, attitudes and behaviors associated, appears to be the result of social and cultural construction. Indeed from a multicultural perspective and through history for instance in Ancient Greek culture, the traditional boundaries of gender concept are not sufficient to include the large variety of sexual behaviors and identities of the individuals. Feminism movement and Queers theory participate to enlarge gender's conception and especially since this reductive classification exclude several people from civil rights and lead often to social exclusion.

4.1 Introduction

Gender issues are a crucial theme for all societies and for those who lead and make policies for them. They are pivotal in the explanation of social roles and relational processes within every community, in that they set many of the rules for social interaction. These roles are very often based on the sexual difference between individuals, and are defined as “gender roles”, term coined in 1955 by John Money.⁴¹ In order to understand the processes that occur and the dynamics at work in all societies, body-related themes need to be explored from the point of view of cultural differences. Despite the fact that culture has always been important in the analysis of gender issues, examining its role nowadays has become particularly central: the present world is characterized by increasing interconnectedness which requires us to take a close look and research the elaborated way in which gender differences are apprehended across varied spaces.

Keeping this investigative goal in mind, this paper is intended to report on the understanding of gender and body-related issues across time and space, with the ultimate aim to offer a (hopefully unbiased) conclusion on the necessity to rely on a reformulation of the gender category as it is understood by Queer theorists. In the attempt to do so, a brief account of the history of gender will be outlined in the first section of the essay, presenting an insight on the processes that have led to the idea of gender as we conceive it nowadays. The following section will critically engage with uncovering the cultural origins of the binary gender classification, by explor-

⁴¹ Money, John and Ehrhardt, Anke, *Man and Woman, Boy and Girl: Gender Identity from Conception to Maturity*, Baltimore: John Hopkins University Press, 1972.

ing the implications that cultural differences have had on gender in their general trend to create a correspondence with the female and male sex. Before concluding, the author of this writing will describe the appropriate theories that have shaped the ideas around gender identity and sexuality, from Second-Wave Feminism to Queer theory, particularly reflecting on the possibilities opened up by the queer.

4.2 The Making of a Category: a Short History of Gender

A good part of the world population is brought up with a mindset that assumes that only two sexes and two genders exist: male/female and men/women. Their behavior throughout their lives is deeply affected by this axiom. As a consequence, we see that homosexuality, bisexuality and transsexualism are still a taboo in several cultures and religions, where people have to live hiding themselves and their feelings both from their communities and authorities. Why is this status quo? How did this become the way we conceive gender diversity? And, most important, do we find the binary system of gender in all cultures? The first step to understanding the issue at stake is to outline a definition of what gender, and sexual orientation are. Sex can be defined as a set of physical characteristics determined by the presence of specific chromosomes. As it is well known, XX chromosomes give birth to a girl, whereas XY bring about the essential characteristics of a man. Defining gender and sexual orientation can be slightly more challenging, as the two ideas are often confused with one another. If we go by the definition we can find in dictionaries, gender is “the state of being male or female” (Thesaurus). This certainly entails that having two sexes to choose from, an individual can either feel that they belong to one or the other, hence adopt those behaviors that are prescribed specifically for a man or for a woman. In this sense, gender can be meant as the feeling of belonging to a sexual category. It is necessary to contribute further to the definitions outlined above by including a perspective. Understanding the two dimensions of gender is a pressing issue: on the one hand, gender is a feeling of belonging that every individual experiences; on the other hand, a whole other dimension needs to be considered, which is the idea that society perceives individuals as being part of a specific gender or another. The inner dimension of gender, or gender identity, may or may not correspond to the sex of a person. The lack of correspondence between the two unveils the cultural origins of the gender category. A look at the way that the ideas of gender roles and sexual orientation have developed throughout history may assist us in the difficult endeavor of showing how gender is a classification of identities and roles created and “cultivated” by people, a mere trait of some cultures.

The earliest documents about gender and homosexuality can be found in the history of ancient Greece. Same-sex relationships were tolerated within that society, and seen as ordinary practices. Frequently, this kind of relationship occurred between master and student (pederasty had no negative connotation and was integral part of the education of a child). Ancient Greece also presented some examples of transsexualism and cross-dressing: the goddess Cybele, for instance, was worshipped by those who were castrated and wore female clothes. Greek phi-

losophy itself engaged with the theme of intersexuality. In his myth of the androgyn, Plato described the existence of a third sex, a synthesis of man and woman, and used it to explain the origin of love:

“The original human nature was not like the present, but different. The sexes were not two, as they are now, but originally three in number; there was man, woman, and a union of the two, having a name corresponding to this double nature, which once had a real existence, but is now lost, and the word androgynous is only preserved as a term of reproach. In the second place, the primeval man was round, his back and sides forming a circle; one head with two faces looking in opposite ways, set on a round neck and precisely alike; also four ears, two privy members, and the remainder to correspond. He could walk upright as men do now, backwards or forwards as he pleased, and he could also roll over and over at a great pace [...].”⁴²

The Roman copy of a Greek statue from the 2nd century BC is exhibited at the Louvre museum in Paris: Sleeping Hermaphroditus depicts a hermaphrodite, an intersexual individual showing characteristics of a female and a male body at the same time. Biologically, combinations of the sexual chromosomes different from XX and XY do exist, and can give birth to various types of intersexuals, called “true hermaphrodites”. Moreover, intersexuals can also present a regular XX or XY set of sexual chromosomes, without manifesting the physical characteristics dictated by their genes (they are defined as “pseudohermaphrodites”). Despite being accepted and accounted for in ancient civilizations, to the point that, as we have seen, an intersexual goddess existed in ancient Greek culture, nowadays intersexuality acquires a cultural connotation in the term “disorders of sex development” (DSD), which is the technical jargon to describe what is understood to be a medical condition by many professionals. What is negatively described in some societies, compared to the “orderly” development of sexual characteristics that we can find in female and male individuals, is fully recognized by other societies. The Indian government was prompted in 2009 to give recognition to the hijra community, by giving third-sex individuals the choice to define themselves as “other sex” in the official voter rolls.⁴³ This news from 2009 reinforces the viewpoint that a binary system of gender is not necessary, nor is it essential to maintain a two-sex system.

Michel Foucault’s *History of Sexuality*⁴⁴ describes the scheme that the “authority” (ie. those who can exercise their power over society) put in place so as to control the productivity of people through the prescription of accepted sexual behavior. Contrary to what we might think, it was Foucault’s opinion that the discourse on sexuality and sex was not suppressed, but it was rather implicitly censored through the creation of codified and accepted channels to discuss those issues.⁴⁵ Peripheral sexualities were therefore obscured in the discourse about sex, in or-

⁴² Plato, *The Symposium*, Benjamin Jowet (trans.), Great Books of the Western World, Chapter 7, p. 157.

⁴³ Singh, Harmeet Shah, *India’s Third Gender Gets Own Identity in Voter Rolls*, CNN, November 12th, 2009.

⁴⁴ Foucault, Michel, *La Volonté de Savoir*, Paris: Gallimard, 1976.

⁴⁵ Foucault, Michel, *La Volonté de Savoir*.

der to silence a threat to economic productivity, which would be in turn favored by forms of sex functional to procreation.⁴⁶ Thus, Foucault's understanding was that the censorship of some manifestations of sex was utilitarian, because the conception of women as individuals engaged in marriages and functional to procreation made it possible for the rising bourgeoisie to be reassured that their wealth would be passed on to their heirs. Robert Nye echoed Foucault's theory when he stated: "The rather sudden appearance of a "two-sex" system essentially locked men and women into a form of biological determinism that experts, and, increasingly, individuals throughout society believed to be their sexual destiny"⁴⁷.

This part of the essay has dealt with the history of how some societies have adopted a two-gender/two-sex system and have managed to keep the lid on some individuals and their characteristics with the intention to foster an easily controlled order. Whether it be the conscientious decision of the authoritarian power, in Foucault's view, or the outcome of a cultural process, as it will be discussed in the next section of the article, a binary gender system brings about issues of justice and equality that are better exposed when a multicultural point of view is adopted.

4.3 Gender-Related Differences in Diverse Cultures and Societies

Gender perception constantly changes according to time and space. Just like every cultural aspect of life, gender is a concept that has developed throughout the history of humanity, as it has been outlined in the previous section of this essay, and across countries, cities, and spatial realities. The evolutionary characteristic of gender is evident when different ideas and perspectives about it are analyzed comparatively, be it, for instance through the observation of the way it was understood in the past in comparison with how it is conceived nowadays in Western societies, or through the examination of the different ideas about gender that coexist at the present day in culturally or spatially distant societies. This section of the article will deal with different spatial and thus cultural values that gender can assume. It is important to bear in note that the use of the term "evolutionary" is not intended to show any positive prejudice nor bias by the author towards the changes that gender has gone through, but it is a way to refer to the process of diversification of this category tout court.

It is most probably safe to state that there is no cross-cultural understanding of gender unchallenged of any contradiction. In what we refer to as Western societies, for example, a piece of garment in the shape of a skirt would be deemed appropriate if worn by a woman. And yet those same people that are part of Western societies would not stick up their noses at the sight of a Scotsman elegantly wearing a kilt on the street, in a pub, or at a wedding in Edinburgh. Nor would they feel that gender boundaries have been crossed if a man wore a dress on Halloween. It can be then rightly assumed that gender roles are not the same in all societies, and therefore that gender norms and value undergo reinterpretation, both during time and across spaces.

⁴⁶ Foucault, Michel, *La Volonté de Savoir*.

⁴⁷ Nye, Robert, "Sexuality," in T. A. Meade, M. E. Wiesner-Hanks (eds), *A Companion to Gender History*, Oxford: Blackwell, 2004, p. 16.

This statement makes itself self-evident when the three-sexes, three-genders systems of some Indian cultures (with their Hijra) and Native American societies of North America (with their Two-spirit people) are taken in consideration.

The discursive element of gender, highlighted by Judith Butler⁴⁸ in her *Gender Trouble*, reveals and underlines its cultural origin and bias. The recurrence to a variety of gender norms in different languages further demonstrates its cultural aspect. In their essay on the linguistic construction of gender identity through lexical choices in Greek publications, Dionysis Goutsos and Georgia Fragaki pointed out the way that female and male genders can be shaped by the choice of words to refer to men/women and boys/girls. What is of particular interest for our discussion is the fact that in modern Greek, as it was in Aristotle's ancient Greek, sex can be αρσενικός (male) or θηλυκος (female), and that this binary scheme applies to gender, so that we have a masculine (ανδρικός) and a feminine (γυναικειος) gender. Therefore, gender moves along the lines of sex, encouraging the implicit understanding that gender is as natural and given as sex, and not man-made as the theories discussed later in this essay will point out. This characteristic of gender can be traced also in the use that French speakers make of the words genre and sexe (or the use of genere/sexo made by Italian speakers): the latter is used interchangeably to signify both gender and sex in everyday and non-professional speech; whereas genre, outside of the literature realm, is only used in the academia to refer specifically to gender. Contrasting the trend that we have outlined here, Kamla Bhasin discussed the pertinence of most South Asian languages in differentiating between sex and gender by qualifying the basic term linga (sex) with the adjective for "biological" or "social".⁴⁹ In this sense, the cultural origin of gender is easily exposed in South Asian languages. And yet, this mere fact does not make the category "gender" any more fair to the people who do not conform with the expectations of behavior that society envisages for them. A transvestite, a transsexual, a butch (a masculine lesbian), or a gay man exceed and cross the boundaries neatly set for male and female gender roles, thus creating and occupying a grey area in the gender system. If it is the case that gender roles only exist to mirror the sexes that are conceived as natural by many societies, including the Western ones, we are left with the impending task to make up our minds on whether admitting to the cultural origin of gender and to the pretence of the binary system of sexes, or otherwise leaving a good percentage of the world population out of the possibility for analysis, justice and inclusion.

Uncovering the cultural essence of gender was a necessary step to approach the issue of understanding gender from an intercultural point of view. Nowadays, in a global and multicultural world, where everything moves, mingles, changes and develops at a faster pace, uncovering the cultural aspects of gender becomes crucial in order to be able to promote a flowing and smooth exchange and contact among different societies and people. Of particular interest is Gloria Anzaldúa's perspective on the intersection between gender, ethnicity and the self. Already in

⁴⁸ Butler, Judith, *Gender Trouble, Feminism and the Subversion of Identity*, New York: Routledge, 1990, p. xxv.

⁴⁹ Bhasin, Kamla, *Understanding Gender*, New Delhi: Kali for Women, 2000.

1987, the Mexican feminist author of Indian origins put forward in *Borderlands/La Frontera* her conception of the self marked by the fact of being a mestiza (mixed-race Latina) who crossed the US-Mexican border several times, repeatedly mediating between different cultures.⁵⁰ By writing in a mixed style, using several languages and different literary genres, Anzaldúa directed her attention to “threshold” people like herself, who challenge categorizations of identity with their mere existence from many points of view (especially that of the sexuality and ethnicity).⁵¹

The lack of a homogeneous comprehension of gender identity and roles also creates legal confusion: the existence of a plethora of laws discordantly regulating gender-related issues is once again evidence of the cultural feature of gender and synonym of unfair and unequal treatment that people from and in different countries can incur into.⁵²

4.4 Critically Thinking About Gender: from Feminism to Queer Theory

Gender as we know it is a limited concept: since it cannot include and explain non-heterosexual non-mainstream practices, it becomes an invalid key to understand reality. Social justice and civil rights are still nowadays deeply affected from such limitation forced onto people by the binary system. Women and LGBTI (Lesbian, Gay, Bisexual, Transsexual and Intersexual) people have suffered because of unequal laws and misconceptions throughout history, treated as inferior beings even to the point of being dehumanized. Historically, mainstream culture has given a minor role to women, even when in theory promoting equality. With the Declaration of the Rights of Man and the Citizen of 1789 for instance, “man” was conceived as the overarching category, which would include all human beings, creating an imaginary unity that disregarded differences and distinctive qualities. In 1793, moving the first steps towards what would have become known as Feminism, Olympe De Gouges wrote Declaration of the Rights of Woman and the Female Citizen. Man as the neutral category was an idea strongly opposed by Second-wave Feminism, which underlined the “universality of female subordination”⁵³.

French existentialist philosopher Simone de Beauvoir laid down already in 1949 the basic arguments that would be brought forward later on by Second-Wave Feminism. In her book *Le Deuxieme Sexe*, she examined the causes of the inferiority and submission of women to men:

“When an individual (or a group of individuals) is kept in a situation of inferiority, the fact is that he is inferior. But the significance of the verb to be must be rightly understood here; it is in bad faith to give it a static value when it really has the dynamic Hegelian sense of “to have become.”

⁵⁰ Anzaldúa, Gloria, *Borderlands/La Frontera: The New Mestiza*, San Francisco: Spinsters-Aunt Late, 1987.

⁵¹ Sellar, Anne, “Gloria Anzaldúa,” in L. Code (ed.), *Encyclopedia of Feminist Theories*, London and New York: Routledge, 2000.

⁵² On this topic, Ottoson, Daniel, *State-Sponsored Homophobia. A World Survey of Laws Prohibiting Same-Sex Activity between Consenting Adults*, May 2008, ILGA.

⁵³ Ortner, Sherry, “Is Female to Male as Nature is to Culture?,” in M.Z. Rosaldo and L. Lampere (eds), *Woman, Culture and Society*, Stanford, CA: Stanford University Press, 1975, p. 67.

*Yes, women on the whole are today inferior to men; that is, their situation affords them fewer possibilities. The question is: should that state of affairs continue?"*⁵⁴

Elaborating on de Beauvoir's idea that men and women should be equal, French philosopher Luce Irigaray exposed the injustice suffered by women as philosophical subjects always defined in relation to the male individual as "the other".⁵⁵ Monique Wittig, French feminist and novelist, author of several books (*L'Opoconax* and *The Lesbian Body* among others), strongly opposed the heterosexual discourses in her *The Straight Mind*: "the discourses which particularly oppress all of us, lesbians, women, and homosexual men, are those which take for granted that what founds society, any society, is heterosexuality"⁵⁶. At the end of the 20th century a qualitative shift occurred, from strictly feminist theories and politics of difference towards a more holistic approach to gender, which took the critiques of social reality to a new level of acknowledgment of diversity. Feminism had first highlighted the importance of equality between men and women, then moved on to analyze woman as a separate philosophical and political entity, a full individual not defined in relation to man. However, the binary gender category was left in place by Feminism as it was, based on the two sexes, thus leaving a whole set of individuals without the possibility to fully be part of society and to enjoy their civil rights. If with *Ce Sexe Qui N'Est Pas Un*⁵⁷ Irigaray underlined the need for two sets of individuals to be recognized, it was Queer theory that, some years later, concluded that the equal inclusion in society of two sexes was not enough to promote justice for all individuals. In fact, Queer theory, and specifically Judith Butler, exposed gender as an empty category, unable to analyze all sexual practices.⁵⁸

The term Queer theory was coined in 1990 by Teresa De Lauretis, initially to avoid all the confusing terminology to address gay and lesbians.⁵⁹ Queer had already been in use for a long time: meaning diagonal or transverse, it acquired the connotation of sexual deviance only in the 18th century. With more recent theory on sexuality, queer became an overarching term, capable to grant inclusion to all different sexualities, accepted with the same equal status. Instead of flattening all differences, Queer theory understands and acknowledges all forms of sexual diversity; with its ability to contain all shades of meaning in the realm of sex and sexuality, queer represents a solution against societal violence suffered by those individuals who exceed gender boundaries.

⁵⁴ de Beauvoir, Simone, *Le Deuxième Sexe*, Gallimard: Paris, 1949; H. M. Parshley (trans.), London: Jonathan Cape, 1953, p. 23.

⁵⁵ Irigaray, Luce, *Speculum. De L'Autre Femme*, Paris: Editions de Minuit, 1974. And also, Irigaray, Luce, "The Question of the Other," in *Yale French Studies. Another Look, Another Woman*, no. 87, 1995.

⁵⁶ Wittig, Monique, "The Straight Mind," in R. Ferguson, M. Gevert, T. T. Min-ha, and C. West (eds), *Out There: Marginalization and Contemporary Cultures*, London: MIT Press, p. 58.

⁵⁷ Irigaray, Luce, *Ce Sexe Qui N'Est Pas Un*, Paris: Editions de Minuit, 1977.

⁵⁸ Butler, Judith, *Gender Trouble*.

⁵⁹ De Lauretis, Teresa, "Queer Theory: Lesbian and Gay Sexualities", in *Differences: A Journal of Feminist Cultural Studies*, 3:2, 1991.

Late scholar Eve Kosofsky Sedgwick perfectly described in *Epistemology of the Closet* the lack of visibility that affects the “deviant identities”, by using the metaphor of the closet. The space in which these identities are forced to act and live their sexual desires was compared to the closet, a private space where any gay, lesbian, transsexual person can hide and spare themselves other people’s judgments.⁶⁰ On the same lines, professor of Biology and Gender Studies Anne Fausto-Sterling denounced the practice of performing corrective surgery on intersexual babies in order to force them into belonging to a sex or the other. The author of *Sexing the Body* criticized those operations to the point of comparing them to female genital mutilation of some African societies, as in both cases human beings are deprived of the ability to experience sexual pleasure.⁶¹

The first theory that can be considered “queer” is the theory of performativity by Judith Butler, who introduced the idea that individuals are relational subjects in continuous development, and therefore in need of a fluid category able to include all their different stages. In her renowned book *Gender Trouble*, the American philosopher and feminist described gender as a repetition of behaviors and actions not related to the binary opposition male/female.⁶² These performance are the imitation of behaviors which give the impression of pre-existent gender patterns and are the outcome of a social construction: “gender identity can be conceived as a personal/cultural history of received meanings subject to a set of imitative practices”⁶³. Drag is also described by Butler as an imitative performance: “Drag constitutes the mundane way in which genders are appropriated, theatricalized, worn and done. It implies that all gendering is a kind of impersonation and approximation”⁶⁴. The pleasure of drag can be found in the deconstruction of the heterosexual paradigm and this performance needs an audience in order to be recognized. However, the performativity of gender roles is, in a sense, a double-edged sword: parody and subversion can be a way to challenge them⁶⁵, but the mere fact of reenacting them poses a threat in that it can also consolidate them as they are. In Butler’s theory lies the possibility to manipulate and rebuild the gender category so as to make it more inclusive and able to restore its analytical power for all sexualities.

4.5 Conclusion

The analysis of the development of the meaning of gender throughout history, as well as the examination of the different connotations that this same category has in varied societies has led to the clear conclusion that gender as a binary classification of human beings is not necessary. Even more so because its existence as a female/male scheme applied to reality has dam-

⁶⁰ Sedgwick, Eve Kosofsky, “Epistemology of the Closet,” in H. Abelove, M. A. Barale, D. M. Halperin (eds), *The Lesbian and Gay Studies Reader*, London and New York: Routledge, 1993, pp. 48-49.

⁶¹ Fausto-Sterling, Anne, *Sexing the Body. Gender Politics and the Construction of Sexuality*, New York: Basic Books, 2000, p. 79.

⁶² Butler, Judith, *Gender Trouble*, p. 140.

⁶³ Butler, Judith, *Gender Trouble*, p. 138.

⁶⁴ Butler, Judith, “Imitation and Gender Insubordination,” in D. Fuss (ed.), *Inside/Out: Lesbian Theories, Gay Theories*, London and New York: Routledge, 1991, p.21.

⁶⁵ Butler, Judith, *Gender Trouble*, p. 137.

aging consequences for many individuals: intersexuals, like homosexuals until not long ago, are diagnosed with a medical condition and often forced into changing their body so as to conform with the female or the male sex; moreover, people whose behavior crosses the boundaries neatly set for men and women are outcast, negatively judged by the society they live in, and denied even the basic civil rights, usually due to the impossibility of having their relationships officially recognized. Differences among societies in this matter are overabundant, thus increasing the complexity of the exchange and movement of people in a globalized world. This is especially true if other differences, apart from gender diversity, are taken into account: the combination of the cultural construction of gender with other factors, such as different ethnicity, age, religion, etc. represent a whole new set of challenges for the citizens of the world today, which can be better put into perspective and overcome with the help of a multicultural approach.

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**A veil on power.
 Women on the verge of an identity crisis (because of men):
 the case of Turkey**

Cristoforo Spinella

Womanliness and gender identity in Turkish culture is complex. Turkey was a precursor in the protection and recognition of women individuality and rights in the public and political sphere even before European countries for instance concerning the universal woman suffrage. However, recent political declarations, the high rate of domestic violence, the lack of women representation in the decision-making process and media representation of the women tend to maintain their role in the Turkish society from a traditional and patriarchal state of mind. Identity of Turkish women are caught between modernity and traditionalism.

5.1 Gender policies in Turkey

*“It is certain that the reason of the suicide of these our girls is their excessive misery, there is any doubt, - said the sub-prefect in Ka. – But if misery was the real reason of a suicide, in Turkey half of women would suicide...”
 (Orhan Pamuk, “Snow”)*

“All women should give birth to at least three children”. It is with this hope that on the 8th March 2008 the Turkish Prime Minister Recep Tayyip Erdoğan celebrated the International Women’s Day. Speaking to an audience that was expecting the guidelines of the gender policies of his Islamic inspiration government, in power for six years yet, he did not leave space to any ambiguity. A concept reaffirmed several times during the years, and made stronger by the initiatives that in the plans of its government should further encourage the birth rate. The last in order of time is the law, passed in the last summer, which prohibits caesarean births unless medical necessity to avoid reducing the women fertility. But even before this law – designed together with a plan still under discussion to reduce from 10 to 4 weeks the maximum time limit for abortion, making it almost impossible – there had been measures and suggestions to frame the Turkish women into the roles in which still today lots of people want to see them locked up: those of wives and mothers. It is certainly not just a political issue *stricto sensu*. Indeed, historically the “controlled democracy” of Turkey has brought with it a significant protection of the women role in the public dimension, and not just compared to the rest of the Muslim world. Just to make some instances, the universal women suffrage began in 1934, a decade earlier than in France and Italy, and already in the next year elections the 4,6 percent of those elected were woman. In the mid-nineties, then, it arrived

the time for the first woman premier, Tansu Çiller: a result that still today many European countries are waiting for. The effect of the reforms of radical secularism imposed by the founder of the Republic Mustafa Kemal Atatürk since the Twenties have guaranteed to Turkey a very advanced legislation with respect of women rights, often at the cost of a violent break with the traditions.

The above mentioned example of the ban of the Islamic veil in public places and university remains paradigmatic. Largely modified by the monochrome government of the Akp (Justice and Development Party) – heir of the Islamic parties tradition long banned or suppressed - , which has been leading the Country unceasingly for ten years now. This law which in the legislative intension wanted ensure that women have the “Western freedoms” discouraging some presumed religious constraints became surely a discrimination tool. Creating those that Merve Kavakçı, still today the veiled woman elected in the parliament history of Ankara, has defined as «second-class citizens», the prohibition *ex lege* imposed in a society that, mostly outside of the big urban centers, remained culturally and politically traditionalist, has effectively split into two Turkey. Even here dip the roots of dichotomies such as city/province, élite/people and modernity/tradition on which is installed the actual profile of the Country.

The result is the fear that the reorganization of the social balances in a direction that is more in line with the requests expressed in the ballot boxes by most of the Turkish becomes an anew “dictatorship of the majority” in the power bodies. The alarm bell sounds strong on the basis of factual and symbolic initiatives launched in these years by a government that after a decade continues to enjoy of a large popular consent. The references range from above mentioned invitations to the social use of women’s body – the exaltation of fertility adheres to religious precepts as well as to a deliberate policy of demographic expansionism that Turkey encourages massively – to the symbolic redefinition of sexuality in literature, cinema and television (a good instance could be the success of the recent video transposition of the best-seller novel of Şule Yüksel Şenler “Huzur Sokağı”, published for the first time in 1970 and model of “novels for salvation” which defines the passage from the Western “libertine” life style to the acceptance of chaste precepts of Islamic religion). In this context, makes its way the fear that that the political success of the social conservatism can be used to revoke some of the acquired rights, the some of the acquired rights, although with a rigid *top-down* process, during the nearly ninety years of republican history.

5.2 Reality and representation

The representation of womanliness is, in Turkey more than anywhere else, a complex aspect. Considering for example a couple of recent episodes well deep-rooted in the popular culture. As the controversy exploded during the recent Olympics Games of London when Yüksel Aytuğ, editor of the conservative daily *Sabah* (The Morning), accused the athletic competition of “killing womanliness”: an opinion, his one, which considers that the costumes and the uniforms used by the women athletes would distort the charm, and for this reason should be favored those who manage to preserve it, until getting points for beauty. Moreover: in his article, Aytuğ launched an

invitation to women's associations in order that they protest against the Olympics, explaining that it was enough "looking at the swimmers" to realize it:

"Women with large shoulders, flat breast, small hips: totally indistinguishable from men. Their breasts – the womanliness and motherhood symbol – flattened as they were mere obstacles to speed. And I do not even speak of the javelin throwers and shot putters, of the weight lifters or the wrestlers. More you look like a man, more you are successful..."

Beyond the immediate and inevitable criticism coming from half world, this grotesque representation resends, however, to an image of the woman that in Turkey still conserves a place: the exclusive mean of the men taste satisfaction and the perpetuation of the family institution.

Another important effect in the definition of the female figure in the public space comes from, as often happens, the imaginary conveyed by the television. In these years, dramas and sit-coms produced in Turkey have lived a real boom in terms of commercial and audience success, even outside the Country's borders. However, in some cases, it appears to be controversial the representation of gender identity offered by these mass productions in which women are depicted as weak and generally victimized, like in the case of famous soap opera "Fatmagül'ün Suçu Ne?" (What is the Fatmagül's fault?). "Turkish women are so impressed by these characters to take them as model. But then they face the ones of globalized society and this causes confusion. To this must be added that Turkish men are still too reluctant to share their power and responsibility", already suggested some years ago by the researcher Sengül Hablemitoğlu, professor at Ankara University dealing with gender studies.

Power is perhaps the real key for change that is still lacking. As Sibel Gönül, Akp deputy leader of the Commission on Equal Opportunities and therefore part of the present ruling class, explains:

"For me, the main area in which Turkey needs to improve is the role of women in decision-making mechanism..."

The Judicial power, for example, is too much in the hands of men. According to data of judiciary, only 25% of 7600 judges and hardly 8% of prosecutors are women. In the Parliament, the women representation does not reach 15%. It does not astonish, then, that the Country is in last places (126th on 131) of the World Economic Forum classification on gender gap. Actually, there is a lack of basis. The percentage of female employment is still below 30% and consequently the dependence from man – husband, brother or father – still remains too strong. According to latest UN Human Development index, only 24% of women work and only 27% had completed at least upper cycle of secondary school (compared to 47% of men). The Turkish Organization for employment (İşkur) has repeatedly raised the issue by launching a campaign aimed to increase the number of women at one third in the total workforce, by 2015. Certainly, progress has been noticed. Since 2001, for example, the number of mothers under 15 years fell to 87%. But the rate of juvenile

marriages for women is at 32% (compared to 7% of men), a fact that makes of Turkish “children brides”, the largest group in Europe after Georgia. They seem too many, but it astonishes less if we consider that a third of them could not complete even the primary school.

There is then another problem at There is then another problematic issue. The dependence from man is fed also by cultural assumptions, thus it continues to exist. All the surveys show that not only the majority of Turkish men, but even of the women consider the carrying out of domestic activities as the main women task. In the most reactionary contexts, the work has almost the character of social wound since it takes them away from their “function”.

5.3 The Turkish femicide

It is here that the femicide, that in silence devastates the Country, dips its roots: in the idea that women choices cannot be free, nor contrary; in the said “no” or even just assumed. Almost a victim at day: according to “Bianet” observatory, 257 in 2011, 217 in 2010, and many other dozens in the still partial count of 2012. A massacre that is consumed mostly within the home walls, and however, generally, by hand of husbands or relatives. A tragedy that last year brought Turkey to be the first Country to ratify the Council of Europe Convention on the prevention of violence against women and to move forward a series of campaigns on the theme by the Family and Social Policy Minister Fatma Şahin. *“If statistics are not improving despite the legislative developments, then we need to reconsider our policies starting from scratch – reflected last months the president of the Parliament of Ankara Cemil Çiçek – The laws are certainly important to reverse the negative trends, but it is obvious that at the basis of the problem there is an inadequate education”.*

Here it is. Even in 2005 the new Criminal Code had predicted more severe penalties for the crimes of violence, but the deterrence was not enough. The number of shame: the Turkish police speak of 78.488 episodes classified as domestic abuse or violence against women in a year and half, between February 2010 and last August. More clearly: one every ten minutes. And for the same authorities the number is underestimated, since that only one-tenth of the cases effectively recorded joins these statistics, and probably many others are unreported. Therefore, the data of NGOs dealing with the issue say more: 4 Turkish women out of ten suffered a physical violence at least once, 15% sexual abuses. In the house it is even worse: according to a research of the Bahçeşehir University of Istanbul, between 50% and 70% of the Turkish brides had suffered abuses within the domestic walls. And 15% of them even feels to *“had deserved it”*. Then, where does the path of Turkish women lead, caught between ideas of modernity and calls of a severe tradition with those who break it, between emancipation and segregation? On the shoulders of optimists there is the weight of contradictions. «Abortion is a murder», says one day the Prime Minister Erdoğan, and the next one exalts the women role in the Turkish society development. But if «All women should give birth to at least three children», how does he insist saying, who will look after them?

Sexuality, chronic illness and physical disability: can sexuality be rehabilitated?

Jim Bender

People living with a chronic physical disability have often problems in the sexual functioning and the sexual experiences. Sexual problems that appear to this target group are very divers and there are biological, psychological and social factors that can explain sexual problems. Sexological assistance for people living with a chronic physical disability is in many cases not accessible. Rehabilitation centers don't frequently have a sexology treatment and sexologists in the private sector don't often see these group of people. Yet also these people have the same right on a good sexual health.

Sexuality in our society appears to be almost absent of taboo. This is very much connected to the idealized image of being sexy, young, beautiful and wild. Even though the majority of the population does not fit this description, they do consider relationships and sexuality to be an important part of their lives. Why would people with chronic illnesses and physical handicaps feel any differently?

In light of this, the observation that sexuality is almost structurally avoided in the health care system in Holland is rather disconcerting. It is only coincidences of patient and caregiver variables that determine whether or not sexuality ever gets discussed in the context of a chronic illness or disability. This article focuses on the following issues. What is the impact of chronic physical problems and disabilities on sexuality? What does this mean to those who are confronted with them? What can a sexologist do to help and what are the important themes a sexologist should be aware of?

6.1 Introduction

Sexuality is being discussed more and more openly in society. In particular, this seems to be the case among those who fit the description of being young, beautiful and wild: "Millennial Generation," in other words. Experience has shown that the majority of the population, who do not exhibit this so-called ideal image, consider sexuality part of their lives and relationships. So why should people with chronic illness or physical disability feel any differently? Yet sexuality is one area of life that seems to be systematically excluded from the broad scope of the healthcare system. It is only coincidences in patient and caregiver variables that determine whether or not sexuality ever gets discussed in the context of a chronic physical illness.

This article will focus on a number of key questions. What is the impact of chronic physical problems and disability on sexuality? What does this mean for the people who face them? What can sexologists do to help and what are the important themes they need to be aware of? Last but not least, this article will review the options for assistance in this area.

Sexuality gets a lot of attention these days, be it sex on TV and in advertising, sexual violence, AIDS, STDs, unwanted pregnancies, erectile dysfunction pills, contraceptives, etc. And that is just the tip of the iceberg. Yet what does sexuality have to do with people who are chronically ill or who have a physical disability? Is it not a contradiction in terms?

Physical illness, serious accidents and chronic illness are often quite extensive. People are faced with pain, injury, oftentimes with serious disabilities, disfigurement and occasionally with a risk to their lives. The way their bodies let them down can come as a shock. Healthcare is primarily aimed at helping these people survive. Then they go home and try to make the best of it. In serious cases they receive “follow-up care” in the form of rehabilitation. As part of this, people are supervised in order to minimise the physical disabilities as much as possible and, if necessary, to learn to live with the lasting disabilities. The purpose of all this is to maintain the best quality of life possible.

The fact that serious changes will affect sexuality and relationships is unsurprising. Scientific research in this area is revealing more and more indications of a high prevalence of sexual problems in the case of various somatic diseases. Multiple sclerosis, arthritis, diabetes, heart and vascular diseases and kidney diseases are linked to a high prevalence of sexual problems: between 50% and 75% (Vruggink, Kornips, van Kerrebroeck, & Meuleman, 1995; van Berlo, Venix, Rasker, van Rijswijk, Taal, Weijmar Schultz & van de Wiel, 1999; Diemont, Vruggink, Meuleman, Doesburg, Lemmens & Berden, 2000; Bancroft, 1989). The impact is even more far-reaching in the case of paraplegia (Sipski & Alexander, 1997).

This data is in stark contrast to the clinical attention for any sexual issues/problems experienced by people with a chronic illness or physical disability. During information meetings for people with chronic illness the audience (on average, 50 to 100 people) was asked how often a caregiver discussed sexuality with them, in relation to their illness, of their own accord. There were rarely more than two affirmative responses (Bender, 2002 communication).

On a regular basis people did not receive any information on the illness or disability, with respect to sexuality, and people cannot discuss it with anyone, not even with their own partner. They often feel guilt and shame in relation to their partners and themselves. The result of this complex dynamic is often unnecessary chronic sexual problems.

This article will try to answer a number of questions. What is the impact of chronic physical problems and disability on sexuality? What does this mean for the people who face them? What role can sexologists play in this respect and what do they need to pay attention to? Last but not least, the options for assistance in this area will be reviewed.

6.2 The biopsychosocial approach to the sexuality of people with chronic illness and physical disabilities

The biopsychosocial model of sexuality represents a framework for understanding people's sexual functioning and sexual experiences. This is the best context in which to address the sexual satisfaction and sexual problems of people with chronic illness or physical disabilities. In the case of this group of people both the explanation of and the treatment methods for sexual problems seem to be determined by a biological disorder. However, assessment errors can be made by failing to involve psychosocial factors in the diagnosis and as a result, the caregiver may be wide of the mark. The three factors (biological, psychological and social) will be explained in succession, using concise practical examples.

6.3 Biological aspects

Case 1: a young couple of which the male partner, who had serious dystrophy in his legs, could no longer perform active sexual acts. Their request for assistance was as follows: how can we adapt to this seemingly impossible sexual change and how can we ever realise our wish to have children, if we can no longer have sex?

The sex therapy focused on expressing their sexual intercourse more by way of shared eroticism, for example by using sexy clothing and telling each other erotic stories).

Artificial insemination using the man's sperm proved feasible, once they had accepted this as the best alternative. Careful referral proved essential to the subsequent fertility treatment.

Direct influences

- Neurological disorders can have a direct impact on sexuality. Multiple sclerosis and paraplegia are examples of neurological disorders that often lead to problems with erections/lubrication and orgasm (Bancroft, 1989; Sipski, 1997; Vrugink et al., 1995).
- Vascular disease can have a direct impact on sexual problems as it decreases circulation to the genitals, leading to dysfunction. Serious vascular disease – for example, as caused by diabetes or high blood pressure – often causes sexual dysfunction (Bancroft, 1989).
- Hormonal disorders can lead to problems with libido. This rarely occurs in adults with an otherwise normal physical development. Some congenital anomalies will lead to problems in this area, and they often appear during puberty. One example of this is Klinefelter's syndrome (Bancroft, 1989; Kaplan, 1979).

Indirect influences

Indirect influences on sexuality are physical complaints that disrupt sexual functioning and the sexual experience, albeit not because they directly affect the “sexual system.” There are numerous complaints that can lead to sexual disabilities and dysfunction. Paralysis, fatigue, loss of strength and energy, pain and stiffness, incontinence, dizziness and sensory disturbances are all examples of common complaints that have a big influence on one's general quality of life, including one's sex life. There are few illnesses that do not entail these kinds of complaints. The more intensive the experience of these complaints, the greater the impact they will have on sex (Bancroft, 1989; van Berlo et al., 1999; Diemont et al., 2000; Sipski, 1997; Vrugink et al., 1995).

Iatrogenic influences

These are medical treatments that are necessary and which (prove to) have an unintended negative effect, in this case on sexuality. The side effects of drugs such as antidepressants, beta blockers and cytostatics are known iatrogenic influences. Damage to the sexual system from operations on the pelvic region, for example, can lead to serious sexual dysfunction. Prolonged and intensive medical treatments, such as long-term rehabilitation treatment, can lead to problems. The “disownment of body and mind,” mentally distancing oneself from one's body, in order to cope with the treatment, can result in physical estrangement, which in turn can lead to sexual problems (Diemont et al., 2000; Moors-Mommers, 1994; Sipski, 1997).

Psychological aspects

Case 2: A woman in her thirties presents for sexological assistance, together with her partner. The stated problem was that the woman was less interested in sex. She was an attractive woman who had suffered a foot injury a few years earlier. Two operations did not provide any improvement.

The woman in question knew why she was no longer interested in sex. Previously, she only wore high heels and sexy clothes to go with them. Due to her foot injury she could no longer wear high heels and therefore, she was forced to dress in a completely different fashion. This was so difficult for her sexual self-image that she was no longer open to sex. The therapy focused on processing this loss and investigating how she could feel sexy and desirable once again.

Psychological aspects always play a role in human sexuality, in the case of both healthy and ill people.

Impact on body image

An illness or physical disability always has a direct influence on how a person experiences his or her body. For many people, the first time they experience a far-reaching disease is a shocking experience. Your body lets you down. As opposed to proper control over basic bodily functions, a loss of control can arise. Urinal or faecal incontinence is one poignant example of this. Many people with these kinds of complaints are scared to death of having an “accident” during sex

and they avoid sexual activity. Sexual problems can arise the moment the body looks different. Scars, amputations, paralysis, muscle atrophy or cosmetic disfigurement are traumatic events with respect to the experience of physical integrity. "My body is different, which means it is no longer mine." For people who have a lot of difficulty with this, it can become almost impossible to imagine their partner still finding them sexually attractive. This estrangement usually leads to avoiding sexual activity with a partner, which is often labelled as a "loss of libido" (van Berlo et al., 1999; Diemont et al., 2000).

Impact on self-image

The way people look at and value themselves determines their self-image. A solid self-image will emerge if someone is happy with his or her roles in life. These roles are the pillars of one's self-image. One's self-image will be greatly affected as soon as one is made unhappy due to unattainable ideals or as soon as one is limited to fulfilling those roles. Anyone who suffers from chronic illness or serious physical disability will automatically struggle with the major loss of his or her life roles. The basic roles in life such as mother and father, spouse, employee, lover, etc. are often radically changed due to a physical condition. One can discuss most of the losses within these roles with those in one's environment. However, due to the taboo surrounding sexuality, discussing the changes in this area is by no means a given. If the losses are not processed and no new roles are defined, then broadly speaking, the impact on the person, including their sexuality, cannot be underestimated (Bancroft, 1989; Meihuizen de Regt, 2000; Sipski, 1997).

Ability to adapt

Physical conditions put a person's ability to adapt to the test, to varying degrees. The initial reaction, namely denying or playing down the need to adapt, is almost standard. Most people would rather hold on to the familiar and they cannot stand their lives changing in this way due to their physical problems. This detail plays an important role in terms of sexual adjustments. Chronic physical disabilities require adjustments in all areas of one's life. Sexuality is no exception. In addition to sexual dysfunction, problems such as pain, stiffness, paralysis, loss of power and energy can lead to sexual adjustments (van Berlo et al., 1999). In comparison with other areas of adjustment, sex is affected due to the difficulty most patients and their partners have in discussing it, the lack of professional attention to this and the general taboo surrounding sexual aids.

Significance of sexuality to the individual

Everyone interprets and defines sexuality in his or her own way. For example, one's age, stage of life, gender, personality, education and culture all play a role in a person's understanding of sexuality. This will be an important factor in determining when, how and even if a person is capable of adjusting himself to his new situation, sexually speaking (Meihuizen de Regt, 2000; Sipski, 1997).

6.4 Social aspects

Case 3: A couple, both in their forties, consulted me a year-and-a-half after the man had an operation for a tumour in his back. The man was ready for sexual contact with his wife. However, his naked body evoked in her intrusive images of how she saw him taken care of in the hospital after the operation. As a result, she avoided all possible situations that came close to sex.

By placing and understanding her aversion in this context, she was able to disregard her misconceptions in this regard. As a result, it was possible to gradually build on the amount of physical contact they shared.

Relationship skills

Communication and social skills, as well as the ability to deal with problems and conflicts are examples of relationship qualities that partly determine how a couple will deal with the chronic illness or disability of one of the partners. (In this article, a “couple” may be of a heterosexual or homosexual orientation; Hawton, 1995; Lange, 2000; Schnarch, 1991).

Role reversal and role confusion

If a physical condition results in serious disabilities, there is often a forced change of roles. Depending on how the roles are defined and divided in life, this will also co-determine the consequences of that change. Many of the roles are specifically determined by gender and can lead to bigger problems the more one's gender-specific roles are affected. This phenomenon can also play a role, from a sexual perspective. If a man is unable to play the leading and active role in sex due to his physical disabilities, then in the case of a traditional couple, both partners may become sexually disordered. In this situation rigid roles can make adjustment very difficult. Another example of how role patterns can result in problems is the assumption of the role of patient and caregiver. For example, dependence and (over-)anxiety can place a label on a relationship and as a result, the equal role of lovers may become almost impossible (Sipski, 1997; Jans & Vansteenwegen, 1999). One poignant example of this is the situation in which a partner may have to wipe a partner's bum, then lay the person in bed and then sexual contact is supposed to take place.

Stage of life and significance of sexuality to the relationship

What is the place of sexuality in a relationship? People who focus on sex and who do not feel bonded to one another in many other ways are at a greater risk of divorce, in the event of major changes to their sex life. Physical problems can change their appearance in such a way that the partner may lose his or her attraction to the other. The gravity of these changes and the importance the partner attaches to these may determine the viability of a relationship. The stage of life in which a couple finds themselves at such time as an illness or disability arises will be significant to their expectations in relation to sexuality after the illness. In addition, in some

cases – for example, in the event of non-congenital brain injury – changes in character may arise which cause the person to lose his or her attraction to the other. A couple that has been together for 40 years will experience the sexual changes differently than a couple who only know one another for 1 year or 5 years (Schnarch, 1991; Sipski, 1997).

6.5 What sexual problems are experienced by people with physical illnesses?

Sexual dysfunction

Case 4: A young man, around 30 years of age, who presented with an image of a cauda [equina] lesion caused by a hernia, had lost his erection during sex a month after the lesion arose. Both his urologist and his rehabilitation doctors confirmed his major anxiety (without having actually performed a diagnosis in this area) that the erectile dysfunction was caused by his hernia. Since his nerves had had relatively little time for any recovery and the effect of a partial lesion on sexuality can remain unpredictable, he was able to give himself the benefit of the doubt – under psychological supervision. It was only after a few months and following conclusion of his clinical rehabilitation that he was confident enough to perform a masturbation test which evidenced that he was able to achieve an erection and ejaculation.

The four-phase model of sexual functioning by Kaplan forms the basis of the subdivision of sexual dysfunctions (1979). Disorders during the phase of desire; arousal disorders that lead to erection and lubrication problems; and problems during the orgasm phase. The sexual problems that most often occur due to these concepts include a lack of interest in sex and problematic differences in the partner's respective levels of interest in sex. Reduced lubrication and erectile dysfunction can be problems during the arousal stage and may lead to dyspareunia. Difficulty with orgasm occurs more frequently among this target group. In particular, greater difficulty achieving orgasm occurs more frequently in the event of somatic problems (Bancroft, 1989; Moors-Mommers, 1992; Luyens & Smits, 1996; Sipski, 1997).

Sexual dysfunctions are very discomfiting. Sexual activities proceed differently than expected. Some people are not disturbed this. However, many people react with shock and occasionally panic. Shame and communication issues always lead to a deterioration in the complaints and can often lead to chronic problems.

Since the somatic aspects should not be overestimated and certainly not underestimated, a proper diagnosis for people with chronic illnesses and physical disabilities is indispensable. A sexological history investigating the complaint in relation to the illness should form the basis of this diagnosis. This history should take serious account of any psychosocial problems related to illness or other factors. As opposed to somatic suffering, the stress of being ill often causes these sexual difficulties. Asking simple questions, e.g. as to when the problems started, will often provide more information than expensive technical diagnoses (Bancroft, 1989; Hawton, 1990; Lange, 2000; IJff, 1997).

Problems with the sexual experience

Case 5: A woman with MS suffers from lipedema. The sensitivity of her genitals is dramatically reduced. She has stated that she no longer wishes to have sex with her husband, as she no longer enjoys it. They soon stop having any sexual contact altogether. Her husband feels that their sex life is incomplete without intercourse. Her difficulties with sexuality forced both partners to examine their norms and values, especially in relation to intercourse. It was only when they were able to investigate this in an open and equal manner that they resumed physicality and, ultimately, intercourse with renewed motivation.

Sexual dysfunction often occurs in this case. However, sex is experienced differently. Occasionally, there are significant changes in the physical experience such as in the case of paraplegia or other sensitivity issues. In addition, sexuality can be experienced differently, from an emotional perspective. Having sex can evoke feelings of sadness or grief, instead of lust (Jans & Vansteenkoven, 1999). Understandably, a man or a woman with an amputation above the knee having sex for the first time since the amputation will experience sex differently than before. As long as a person experiences sex as an area of loss, the experience will be considerably less positive.

Sexual relationship problems

Case 6: The male partner of a woman suffering from chronic pain constantly loses his erection when attempting to have sex. Although his wife states that she wants to have sex with him, her pain is so visibly present that losing his erection seems to be more socially acceptable than having successful intercourse. This detail soon became even more complicated when his wife's response to his loss of erection was to feel extremely rejected. The misunderstandings surrounding his loss of erection needed to be clarified before they could investigate their options for sex.

Illness and physical disability influence not only patients' lives but also the lives of their partners. Their partners are largely overwhelmed, certainly during the acute phase of an illness. The partner can be traumatised if there is an acute danger to the patient's life or, for example, if there is a serious accident or operation. Since patients are given priority in the context of caregiving, it may so happen that the partner does not receive enough attention, if any, for his or her experience. Depending on the severity of the illness, life will have changed dramatically for both people in the short-term and the long-term.

What effect does this have on sex in a relationship? Due to excessive stress the partner may not be interested in sex or experience sexual dysfunction. Fear of a relapse, e.g. in the case of a CVA or a heart attack, a partner may be hesitant when it comes to having sex, even if the patient is ready for sexual contact. Physical contact may bring back the experience of the trauma and as a

result, the partner will avoid sex. Certain actions in sexual behaviour may have become impossible for the partner due to the physical disabilities, which in turn can seriously affect the experience (Lange, 2000; Sipski, 1997). Chronic illness or physical conditions always put a relationship to the test. Most people do not reflect on the fact that the sexual relationship is also put to the test.

Problems with sexual adjustment

Case 7: A single, 35-year-old homosexual man was left almost fully blind due to his illness. He said that he did not know how to cope with the new situation, including in the area of sexuality. How was he supposed to come into contact with men now? In addition, all of the qualities that he found attractive in a man were of a visual nature.

Problems with sexual adjustment are present if a person or couple fail to achieve a new sexual balance after a period of processing the situation. Communication issues in this area and oppressive norms and values often play an inhibiting role. To more limited and rigid a couple's repertoire of sexual behaviour, the more difficulty they will have in making adjustments to their sexual behaviour on their own. Adjustments may be required in terms of the type of actions or who should take the initiative. Sex will almost always become less spontaneous and require greater preparation if physical disabilities play a role. People find it more difficult to adjust to this fact than they do to change their behaviour (Sipski, 1997).

Practical sexual problems

Case 8: A woman who can only achieve orgasm by way of manual stimulation.

Due to the consequences of her partner's CVA, namely paralysis on one side of the body and overwhelming fatigue, he is no longer capable of satisfying her in this manner. They successfully overcame these two limitations by purchasing a vibrator.

Practical problems require practical solutions, and this also applies to sex. Unfortunately, many people cannot summon such a matter-of-fact attitude in the area of sexuality. Physical conditions and illness entail a lot of practical inconvenience, and this also applies in the area of sexuality. Fatigue and a lack of energy may force a person to take a nap or to have sex in the morning time. Incontinence occurs quite frequently and most people do not experience this as erotic. Practical measures such as a protective cover for the mattress and drinking less before sex seem obvious and yet people largely fail to conceive of them (Jans & Vansteenwegen, 1999; Sipski, 1997).

Sexual integration problems

Case 9: A young woman, aged 31, who was born spastic due to a birth trauma, has never

had a sexual experience, neither with herself nor with another. She becomes curious about her own sexuality after watching erotic programmes on television. She notices all kinds of feelings within herself when watching these programs but she does not know what to do with them. Nor does she know what the images on television have to do with marriage (sexual relations). Her confusion was largely resolved by adequate education about sexuality. Furthermore, she started exploring her own sexuality by talking to girlfriends about their experiences, by reading erotic literature and by learning to masturbate. She used discussions with a sexologist to discuss her experiences and doubts.

Problems with sexual integration can include all five of the above-mentioned problems, albeit in another context. In particular, problems with sexual integration arise in people who became chronically ill or physically disabled during or prior to puberty. This fact played a disruptive role in the person's sexual development. As a result, these people must often develop their social sexual skills at a later stage.

Many factors play a role in this. Young people with a congenital condition or a condition they acquired at an early age often miss the boat, in terms of socialisation. As a result, they often fail to form relationships and experiment sexually during puberty. Information on sexuality which focuses on *their stories* is a rarity. The image people form of these young people is that they are "sexless" or that sex is "not for them." Parents often adopt a protective stance with respect to sexuality and relationships. The short-sighted attitude of some parents/caregivers is still, "Let sleeping dogs lie." These young people receive far too little education for the purpose of identifying sexual abuse and promoting safe sex. Due to the lack of acknowledgement of this group's sexuality, they are extra vulnerable to sexual difficulties and sexual abuse (Meihuizen de Regt, 2000; Sipski, 1997). Practical experience with this group has shown that these facts can lead to delayed relationship and sexual development, whereby people only address these issues in their twenties, thirties and forties.

6.6 What can a (rehabilitation) sexologist do to help people with chronic illness and sexual complaints?

Most sexologists, including those without formal medical training, have a lot to offer people with chronic physical disabilities with respect to any sexual problems, perhaps more than they realise. The first and often most important thing is being able to discuss sexuality openly with another person. Unfortunately, the sexologist is often the very first person with whom a person can discuss sexual concerns (in enough detail). An open, inviting attitude on the part of the sexologist during the first meeting is often liberating for those people who are surrounded by care but who have no-one to talk to about their sexual concerns (Bancroft, 1997; Hawton, 1990; IJff, 1997).

The biopsychosocial model of sexuality is often the basis of the sexological history for people with a physical condition. It is essential for the sexologist to maintain this. Direct causal connections are often incorrectly made between chronic physical conditions and sexual problems. Sometimes it is the patient or the referring party who has not looked beyond the somatic context. In addition to investigating the biopsychosocial impact of the chronic physical condition in connection with the sexual complaint, it is also necessary to gather sexologically relevant information that is separate from the somatic complaints. For example, one must also have a clear picture of a patient's premorbid sexuality, in order to make a proper assessment of the current issues and treatment topics (Bancroft, 1989; Lange, 2000; IJff, 1997).

It may be useful to provide the patient with adequate information about sexuality in general and in connection with the illness or disability in question, and this may lead to a more clear understanding of what is going on in this area. People in the general population are often taken in by societal sexual perceptions of ideal beauty, the need to perform and all kinds of potential sexual "shoulds," and these perceptions hit people with physical problems even harder (Hawton, 1990; Hengeveld & Brewaeys, 2001; van Lankveld, 1999; IJff, 1997).

A proper analysis of the sexual problems can lead to practical interventions that often prove to be surprisingly simple. Examples of this include other positions in the case of difficulties with balance, the use of a vibrator if it is difficult to achieve orgasm and having sex in the morning time in the event of fatigue issues. Many people come up with these on their own, while others do not. Putting one's heads together and figuring it out together are often the first interventions. The sexologist must use the power of his or her imagination more often than in the case of other clients, in order to imagine the impact of physical limitations on sexual behaviour. This is often required, in order to help them in the adjustment process.

Targeted referrals or pronounced problems may require a more intensive therapy. Although the somatic details are important, often they are not the starting point for adequate guidance. The partner's involvement in these therapies is usually indicated, even if this is only during the diagnostic phase (Annon & Robinson, 1978; Hengeveld & Brewaeys, 2001; Sipski, 1997).

The timing of the interventions is determined by the grieving process that surrounds being ill or disabled. Sexual losses are rarely recognised by the person in question or by healthcare providers and this is precisely why it is essential that they can be discussed. Caregivers that offer solutions such as erectile dysfunction pills while a person is grieving his/her losses, are regularly wide of the mark.

The starting point in sexological rehabilitation assistance is to achieve the most *satisfactory level of sexual functioning* within the limitations defined by the somatic limitations (Rol & Bender, 1996). Usually, adults who are seen as chronically ill or disabled individuals have already developed a sexual frame of reference and almost always suffer losses in this regard. Sexual adjustment is the process encouraged and guided by the (rehabilitation) sexologist. The therapy is aimed at processing losses and, subsequently, investigating what can be achieved. Processing psychosocial obstacles that stand in the way of a positive new balance is essential to this process.

In the case of people with sexual integration problems no sexual basis has been developed. They need to start from scratch. In that case the therapy will comprise more than a “coaching” process, in which respect the therapist will encourage the person in question, make suggestions and provide information, and help create the prerequisites to enable the person to start their sexual development. In Israel this process is sometimes accelerated (in the case of young, single soldiers who have become disabled) by using surrogate sexual partners for this therapy (Aloni, Dangur, & Chigier, 1994).

Other disciplines are used for all forms of therapy at the rehabilitation centre. This has an added value in terms of the quality of the responses to any specific sub-issues. For example, an ergotherapist can provide handy tips for adjusting devices and, if required, the rehabilitation doctor can explain complex questions from a somatic perspective.

A sexologist who is not working in a rehabilitation setting would do well to build up a network that can offer supplemental expertise. Physiotherapists, ergotherapists, medical experts, e.g. experts on neurological problems and incontinence nurses can be found in rehabilitation centres and hospitals and they often have their own practices. An increasing number of teams specialising in specific illnesses have been created in hospitals. Examples include teams specialising in MS, arthritis, renal disease, diabetes, non-congenital brain injury. There is an almost structural lack of sexological expertise within this range of specialists.

Many interventions from the arsenal of standard sexological interventions can be used. They often require a creative twist, in order to match the somatic story in question. Sensate focus exercises are a good example of this. A person with a sensory disorder must literally look for

new erogenous zones and sensate focus is a suitable method for doing so. Many people struggle with strict norms and values, as well as a lot of myths and misinformation in relation to how things should be when it comes to sex. The techniques used in cognitive behavioural therapy are frequently indicated for helping people adapt their blocked cognition to the new reality of an often radically changed body. Communication issues and the ensuing misunderstandings are often addressed during treatment. For couples, this is often the cause of problems with adjustment. Holding up a therapeutic mirror to patients gives them the opportunity to make more conscious choices in terms of how they wish to act on their sexuality under these changed circumstances (Hawton, 1990; Hengeveld & Brewaeys, 2001; van Lankveld, 1999; Luyens, 1996; Schnarch, 1991; IJff, 1997).

6.7 Discussion

People with chronic illnesses and/or physical disabilities are extra vulnerable to difficulties with sexuality, for a variety of reasons. Caregivers often fail to identify these difficulties. Prejudice may play a role in this omission. As a result, it regularly happens that before a patient starts seeing a sexologist, he/she has already unsuccessfully turned to other caregivers with the same questions. Having no partner, being too old, not needing to procreate and having no opportunity for sex are all examples of reasons why these people are sent away none the wiser. When asked, most people can clearly articulate why sexuality is so essential to them that they wish to discuss this delicate subject with a caregiver.

At present only 4 of the 25 rehabilitation centres in the Netherlands have a modest range of sexology treatment. Sexological outpatient clinics in hospitals offer this target group assistance on a regular basis. Presumably, it is only by coincidence that sexologists in the private sector (the largest group of sexologists) see patients with a disability or chronic illness in their offices. One can also presume that the scope of these services is insufficient for the more than 2 million people in this highly diverse target group.

The question is whether people with chronic conditions have sufficient access to sexological assistance. This access is determined by physical and financial factors, and by one's attitude. Sexologists can do a lot for these people by adapting and applying their expertise. If a caregiver is open to this, then he or she can make a contribution to this particularly human area of life, which is often difficult to discuss. This will give patients a better chance of good sexual health, even if their general health lets them down.

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ISLAM and disability

Inge Huysmans

In different cultures there are different ways to think about disability. One culture can see a person living with a disability as a person who is weak and needs help. Also there are cultures that approach these people as a “divine gift” or contrary, as a shame. Other cultures then will approach people with a disability as a normal person with the same rights and duties as others. But every culture has to take into account that the way a culture thinks about people living with a disability, determines the manners to this target group.

7.1 Disability and the value of an individual

In those families that view disability as a ‘divine gift’ children with a disability are considered so valuable that they are often rather spoiled. However, this in turn can impede the rehabilitation process and as a result, the child is not given the opportunity to learn to live as independently and autonomously as possible. Children with a mental disability can learn to dress themselves, to eat and to play. However, those children who are so spoiled that they don't have to do anything themselves will not learn these things.

Islam states that people with a disability should be surrounded by love. This falls under the scope of the general rule which states that people who are weak because they are ill, a child or an elderly person should receive more love and assistance than those who are strong and healthy. However, this love should not go so overboard that the person becomes entirely dependent on others. Independence is a very precious commodity in Islam.

In other families children with a disability are viewed as some kind of shame. Some parents would rather that no-one outside the family know they have a child with a disability. This attitude is partly related to the misconception that someone with a disability is inferior. In Islam, however, neither health nor physical strength nor wealth plays a role in determining a person's value. The most important factors for doing so are a good heart and good deeds.

7.2 Medical treatment

Some Muslims are more focused on the use of traditional remedies which they call, “Islamic cures.” In such cases healing prayer and Quran recitation are used, amulets are made and exorcism rituals are performed. Some people refuse medical treatment because they feel it is contrary to their beliefs. This includes the belief that everything is in the hands of Allah and that He is the Healer. That is also the reason some Muslims do not wish to avail themselves of the available mainstream healthcare facilities. According to Islam, however, the term “Islamic cures” is much broader than its current definition. In fact, what is currently defined as mainstream healthcare also comes under the scope of Islamic cures.

On the other hand, some Muslims have very high expectations of mainstream healthcare. They expect that it is always possible to resolve any limitations. This is mainly based on the belief among Muslims that nothing is impossible for Allah.

The Prophet said, “Allah has not sent down an illness without sending down a cure for it [...] that is known by some people and unknown to others.” Therefore, the fact that some illnesses or limitations cannot be cured at present does not affect the belief that Allah is the Healer. The therapy is simply not yet known.

7.3 Marriage

Research among Moroccan and Turkish families who have a child with a mental disability reveals that there is a high frequency of blood relationship between the parents. Half of the parents are related to one another, and a third of these parents are full cousins. If generations have been married within the family for a long time, the chances of having a child with a serious disability increase by almost 20%.

Marriage within the family was a point of discussion within Islam from the outset. People agree that any marriage which could endanger the health of the spouse(s) or any children they may have should be discouraged. From a religious perspective, medical investigation prior to the endogamous marriage (marriage between relatives) .

Another situation involves marrying off persons with a disability. The family of a man or woman with a limitation will sometimes want the person to get married and a partner is arranged in their country of origin. They believe that the marriage will heal the person with the disability. “Everything will be alright if you get married,” their family members and friends often say. Furthermore, their future partner will also help out with caring for and supervising the person with a disability, thereby relieving the family to some degree.

However, Islamic sources do not proscribe any absolute decision about marrying off persons with a disability. This depends on a variety of factors. The most important factor is the nature and severity of the disability. This mainly has to do with the term 'equality' which is central to Islamic jurisprudence, when determining whether a marriage is acceptable. The consent of both partners is also decisive in this case. The man or the woman must be clearly and honestly informed of the medical condition of the future partner and agree to the marriage in advance.

The story of Mohammed Ghaly shows how in certain situations some Muslims act on the basis of popular beliefs that are not always in agreement with the authoritative Islamic sources. Due to the lack of Islamic sources that address medical ethical issues, sometimes it is difficult for caregivers to work with Muslims with a disability or Muslim families with a child who has a disability. After all, our starting point in the healthcare profession is to respect every faith as much as possible. Professor Ghaly recommends that caregivers seek advice from a well-educated imam or islamologist who has specialist knowledge in this field.

Experiences from ethnic resource team – inspiration for health and social care services

Naveed Baig and Stephanie Torbøl

Not all cultures and societies in the world have a tradition of organized pastoral counselling. In many countries crises and grief in connection with illness and death is handled within the family's own ranks. However, in line with changes in family and community structures as well as the general secularization of society, a lot of citizens are actually living without a strong network to family members and other social relations as for instance local religious communities. This situation is reflected, when professionals in hospitals and other parts of the healthcare sector no longer have the possibility to call for family members or other close relations when patients and relatives have a need for support in connection with illness, death and grief. In many cases, the need for pastoral support and counselling is particularly evident among ethnic minorities, whose social and religious needs have traditionally been somehow invisible in public institutions and services. This article passes on experiences from the Danish model of establishing a special Ethnic Resource Team with the purpose to systematically make human and voluntary resources available to patients and families in need of grief work in their own language and / or on their own religious and cultural grounds. This also indicates the intercultural guidance of hospital staff.

8.1 Experiences from Ethnic Resource Team – inspiration to social and health services

There is a common understanding that ethnic minorities have a large network, and therefore do not need interlocutors or volunteer befriending services. Despite the fact that most do have a social network, it may well be that individuals have a need to speak to a neutral person, who can listen and understand, concerning subjects which they may prefer not to discuss with for example family members. Even if a network can be hugely important for dealing with crises, rehabilitation, caring roles etc., it is not always possible for family members and others to be present with the patient in hospital, in a care home or at home. The nine-to-five work pattern in society affects everyone, and it may therefore be difficult for family and friends to allocate time for visiting their relatives.

Since mid-2008, Ethnic Resource Team (ERT) has received an increasing number of enquiries from the target group. This has in particular been concerning long visits with patients and families. These may originate from the social worker who wants his or her female client to develop a new network following a suicide attempt, as her family has ostracized her - or from the nurse

who thinks it would be useful for the lonely man in frequent dialysis to benefit from a volunteer visitor. ERT have had increasing enquiries from parents, who have children with prolonged illness, and have a need for care and support – often from someone with a similar background to their own.

A doctor contacts ERT in relation to a young patient, who for the second time in less than a year has tried to take her own life. The doctor wishes for the patient to have someone to talk to, who could possibly also help with practical matters. A resource person is dispatched to see the patient. The patient has no other visitors – the ties to the family have been severed, and she has nowhere to live. The resource person comes to see her twice in hospital and makes contact with her social worker. The social worker is not aware of either suicide attempt. The resource person therefore initiates contact between the social worker and the psychiatric department. When the patient is discharged three days later, the resource person accompanies her to a crisis centre selected by the social worker. Following a conversation with centre staff, for safety reasons, the decision is made to transfer the woman to another centre, with 24 hour staff, where she is allowed to remain.

Imam role

The imam role forms a central part of the work of the ERT, as it addresses the existential, religious and spiritual needs of patients, families and staff. The imam role is a counterpart to the hospital chaplain role. In addition, staff has an interest in receiving training from a hospital imam. The two functions (the general visitation services and the imam role) overlap, but a distinction is made between an enquiry or request for a standard conversation/volunteer visitor and an enquiry specifically concerning an imam. The majority of imam enquiries relate to terminal patients. Quran reading to acutely ill patients and practical help concerning funeral arrangements are the most common causes for enquiries. Further, the role also entails conversations about existential/religious topics and advice on bioethical concerns. ERT has developed a call list of Hindu, Buddhist and Jewish representatives, who can be called upon when needed. The list also includes Shia imams.

At present, the regional authorities or hospitals have no guidelines for employment of hospital imams. Some departments make use of imams on an ad hoc basis, bringing in external representatives (typically from a local mosque) when the need arises. A few major hospitals have a hospital imam on staff, with set office hours and involvement in the running of the organisation on an equal footing with other staff.

The imam role has led to the following positive results:

- Increased confidence among staff, as they have the opportunity to consult and/or involve the imam in particular in relation to religious matters and differences in disease perceptions. Demystification of the imam role through for example explanation of the role in the hospitals at

staff introduction. The imam as a colleague. The imam is involved in multidisciplinary team meetings, committees etc.

- A feeling of recognition and safety for patients and families – that their religious representative is visible and available in some of life’s most difficult moments.
- Potential for bridging. Patients/families listen when the imam is involved in the patient pathway. For example, the imam can explain pros and cons of a stay in a nursing or care home to a family who may have a very biased view of care homes and the care home culture, and may lack an understanding of why they are being referred from the hospital to a care home.

Example of interdisciplinary cooperation: a psychologist involves a hospital imam in conversations in the clinic with a mentally ill and suicidal Arabic head of a family in his mid-forties. The three gather in the psychologist’s office, and after the psychologist’s introduction, the imam talks to the patient about his existential problems and his view of God. The man is feeling isolated and has lost his will to live. He feels distanced from the rest of the family, and feels guilt at not being able to be there for them in the way he feels he should. The patient is very introverted. The man expresses the sentiment that “if Islam did not forbid suicide, he would have taken his own life a long time ago.”

8.2 Tangible tools for staff

We have to treat people the same, and therefore we have to treat them differently, because people are different. Staff wants practical tools for solving practical tasks relating to all aspects of their work – including the challenges they may face when interacting with ethnic minorities. At almost every training session for health and social care workers, a need for tangible tools has come up – specific methods or tips, which can help staff in their day to day work. Sometimes, staff members ask culture specific questions, such as “How would you deal with this in Somali or Turkish culture?” Overall, generalisations should be avoided. However, there are some areas where it is possible to draw some general conclusions (for example that Turkish people do not eat pork because they are Muslims), but there are also areas where it would be professionally indefensible and unethical to generalise (such as Somalis are addicted to khat). Intercultural communication is, in our view, the best approach for successfully dealing with misunderstandings and misconceptions which can arise in a department. This avoids any unnecessary generalisations.

There is more than one reality

Two people, who share the same experience in the same time and place, will not necessarily experience this in the same way. Our perceptions are filtered through different filters, such as our senses, experiences, beliefs, prejudices, knowledge, faith etc. All these filters combine to draw our personal map of the world and of life. As such, two patients admitted to the same hospital and treated for exactly the same condition by the same staff members, may well have widely differing views of the treatment pathway, and may therefore react in different ways. If communication is to be equally successful with both these patients, it may be useful to recognise and use as a starting point the experiences of the individual, and to examine the map which is the foundation for this experience.

A nurse enters the room of a female patient about to undergo surgery, to explain the procedure. The patient's husband is present. The nurse initially greets the patient by shaking her hand, but as she turns towards the husband he retracts his hand and states that he does not greet women. The nurse explains that in her culture, this could be taken as a sign that he does not respect her as a woman. The husband and the patient then explain that it is an element of their culture and tradition that a man does not greet a woman by shaking her hand, and that in their country of origin it would in fact be viewed as a sign of lack of respect for the woman if he were to do so. They end up sharing a laugh over the matter.

What the nurse did in this situation was in fact to explain to the couple how she interpreted the husband's reaction from her own world map (her cultural codes) without attributing to him an intention to offend her, but leaving it open to him to explain the reasoning for the act based on his map. All in all, this communication may have taken three minutes, but the result is that the treatment can be initiated in the best possible way, with a shared understanding and laughter. There may not always be time or energy to have such a chat, but if nothing else, this mindset can contribute to avoiding unnecessary judgement or offense on the wrong basis, sparing the participants (patients and staff) the negative mood which this could cause.

Treatment culture

One of the filters which often shape our perception of a situation is, of course, culture. If we examine specifically treatment culture, there is no need to travel far to discover marked differences in the way in which a doctor treats patient symptoms, or in the expectations people have of the doctor. At a doctor's visit in France for example, it is almost guaranteed that the patient will leave with prescription, whether the complaint is a minor cold or some type of infection: nasal spray for blocked sinuses, throat spray for throat problems, powder for stimulating a cough etc. As such, a French patient may well feel let down or not taken seriously, when a Danish doctor sends him home empty handed with an advice to drink chamomile tea or go to bed, or worse, with advice to exercise more.

Neither is necessarily right or wrong. Both are acting and reacting from their respective cultural maps, and based on what this tells them about good treatment in their respective cultures. Again, it is therefore important that the doctor investigates what may be causing the patient to feel unsatisfied, and explain why she is choosing a different treatment path. In this way, the patient can avoid drawing the conclusion: “The doctor is sending me home with no medication – as such she has let me down and considers me a hypochondriac” or “Danish doctors are incompetent”, and the doctors avoids thinking “the patient is unhappy, so I must be a bad doctor” or “French patients are arrogant”. Instead, they are able to develop a joint understanding of the issues, using dialogue.

Ethnic pain

Other cultural filters which may be relevant in communication with ethnic minority patients, is disease perception, body perceptions and the way in which pain is described. How can pain be expressed verbally?

The “ethnic pain” is an expression which has spread in hospital culture – especially in departments under significant time pressures. Typically, it is an issue of patients who express and describe their pain in a way which the staff are unaccustomed and are unable to interpret – either because they are viewed as being very demonstrative in their suffering, or because they verbalise it in a language which is less clinical than staff are accustomed to. For example, the expression “a burning sensation in the body” has surfaced on several occasions during training sessions held by ERT – primarily from hospital staff.

In actual fact, this is an issue of communication, which is apparently difficult to solve – partly because staff lack the time, tools and energy to tackle it, and partly because the weakness and alienation increases the fear and lessens the communication skills of the patient.

“Personally, I do not like the expression ‘ethnic pain’, but I use it because we know what we are talking about then”, a nurse honestly admits during a training session. She most likely feels that she can then put words to what she does not understand, at that being able to verbalise the incomprehensible gives a sense of control, because it provides an opportunity to minimise it and thereby prevent it from affecting one’s work too much. This is a natural defence mechanism, which protects against being overwhelmed by frustration and paralysed by impotence, and can be the first step on the way to addressing the problem. Having a word or an expression for something, means you can begin to discuss it and make the problem visible. The most important thing is for the problem to actually be addressed. Otherwise, such expressions may act as blinkers, covering up the core of the issue. Ethically, this is unworkable in a hospital – the patient is weak and alienated, and as such, it is the responsibility of staff to tackle any communication problems.

It is crucial to move the focus from “it is the unfamiliar which is causing problems” to “we lack communication tools”. From the subject to the relation and from the identity (he is that way) to

the behaviour (he acts that way), instead of jumping from behaviour to identity (he is evil because he never smiles).

8.3 Intercultural communication

Intercultural communication is a term for the communication which takes place between people with differing cultural backgrounds in a given social and cultural context (Jensen, 2001, p. 45).

Culture is a very broad and flexible concept. Culture includes habits, faith, art and other results of human activity in a specific group of people during a specific time period. As such, culture is something we all possess – even if we are not always conscious of it. The reason why there is a need to focus on communication is partly that staff themselves feel that a lack of language skills is the main challenge in their interaction with ethnic minorities (and as such, non-verbal communication can be necessary) - and partly that there is a tendency in the health and social care sector to view communication related problems and uncertainty as caused by the cultural and religious background of the individual. For example, if there are some individuals in the patient's family who speak in a certain tone or have a different kind of eye contact than staff are accustomed to, this will often be attributed to an unfamiliar or distant culture – as if one has never before encountered individuals with a different tone, different gesticulations, different facial expressions etc. There is a tendency to forget that people are different, and that their education, childhood, networks, experiences and so on can affect the way in which they address staff.

Intercultural communication provides staff with the confidence to engage in an “equal dialogue” and to tackle difficult topics, allowing them to get to know the patient better and provide higher quality care and treatment. This also means that – once the trust has been established – it is possible to relate difficult messages without anxiety. It is the uncertainty and anxiety, which may disrupt communication to an extent where attempts at communication are abandoned altogether. The Roman philosopher Seneca (ca. 4 BC – AD 65) said: “It is not because things are difficult that we do not dare; it is because we do not dare that they are difficult”. Making an effort and paying attention to things which may be different (such as a different disease perception), and an appreciative world view can all help enhance communication – even if sometimes people do not even speak the same language. This does not mean that you have to agree with the lifestyle, behaviour etc. of the other person, but that the process, exchange and dialogue are the main points of interest in the encounter. Culture and the unfamiliar are part of the framework around the communication, but the individual as a unique human being must be at the centre, not culture or religion – even if this can hold significant importance for the individual.

8.4 Religious assessment

“Religious assessment” relates to questions about spiritual needs and concerns for patients/families. Religious assessment is common in the psychological/therapeutic field – in particular in the US – and is becoming more and more widespread in other Western countries. The purpose of a religious/spiritual assessment is to help counsellors to decode the possible relation between the spirituality and the patient’s problems (Frame, 2003). Staff is encouraged to employ a neutral and inclusive language when undertaking this type of assessment, for example “religious community” instead of “church”, “religious/spiritual leader” instead of “priest”, “higher power” instead of “God” etc. Religious assessment is not about agreeing with all life views/ religions, but rather concerned with ensuring that staff discovers and makes use of the spiritual resources of the patients themselves, in order to promote their appetite for life – without judgement and stereotyping (see also the website about palliative care, end-link.lurie.northwestern.edu, developed by the Cancer Centre and Northwestern University (US); this is a resource page, which provides a multidimensional introduction to topics relating to dying patients and their families – primarily for hospital staff who work in this important area).

Other purposes may include:

- That religious and spiritual questions are used as a resource for patients.
- To establish the degree of health and pathology in the patient’s beliefs, as religion and spirituality may well be linked to improved physical health, emotional wellbeing and so on (Frame, 2003). Religion and spirituality may also have a negative influence, and can harm the patient. This can involve – according to Richards and Bergin (1997) – demonic possession, overly focusing on one’s sins, spiritual depression, panic over religious themes, constant repetitions of specific religious acts etc.
- To uncover religious and spiritual concerns, which may be causing psychological problems for patients, for example if children whose relations have subjected them to abuse and isolation may question a caring and protective God later in life.

Richards and Bergin (ibid.) suggest nine dimensions of religiosity, which should be covered with patients with mental illness, in order to build up a picture of the religious and spiritual domains. The domains which are of relevance to health and social care staff to work on in interactions with ethnic minorities are set out below. This assessment should not necessarily be employed therapeutically, but can also be used as an icebreaker – in interactions with somatic and psychological patients and their families – allowing staff to have open conversations with the individual about faith and life. It is important that staff is clear beforehand about their own beliefs.

- **World view.** Is there a belief in a God or higher power? What is the view of the world, of evil and how much free will individuals have to influence their destiny? If there is a belief in a

higher power, what type of power is this, and what does it mean for the individual? Patients who believe in a merciful and forgiving power often have a higher sense of self worth (Richards & Bergin 1997). Patients who for example have a belief in a punishing, vengeful or impersonal power may have less hope, and this can be useful for staff to be aware of when interacting with patients.

- **Degrees of faith.** Is the faith practised actively, or passively? Which religious aspects are taken seriously? An answer from a Muslim may be that he or she abstains from alcohol and pork, but only attends prayer a few times a year for holidays. There will be others who do not practice their religion at all and do not wish to discuss religion. These patients will therefore not be able to make use of religion as a resource or support.
- **How do patients solve their problems?** It is important for staff to know what approach patients take to problem solving. If this relates to specific religions or theological questions, Richards and Bergin (ibid.) suggest involving a spiritual leader from the given faith. Experiences show that staff who understands the religious beliefs of their patients finds it easier to enter into dialogue and ask detailed questions. A young couple who had a stillborn daughter in a Danish hospital (where they were visited by an Imam), were very pleased to discover that the nurse knew that according to Muslim faith, their daughter was to be interred, and that the nurse was aware of the rituals involved therein. As such, the nurse was able to have a caring and supportive conversation with the couple, discussing the burial and the coordination and arrangements. Assessment of terminal patients is of a different character, but is highly important: is it ok to discuss death? Do you believe that the moment of death is predetermined? What is your relationship with death? What happens after death? Do you wish to discuss the details with someone from your own faith community?
- **Values and lifestyle balance.** When “values” do not align with “lifestyle”, this may also lead to feelings of shame and guilt. In his book, Frame (2003) provides an example of a Christian-Mormon woman aged 23, who sought help for depression with a therapist. After some general questions about her life, the therapist queried her religious and spiritual life. The woman explained that she was a practising Mormon, and used to be involved in missionary and other church work. However, when she started university, she felt a sense of guilt that she did not have enough time for church work. As she could not live up to her self-imposed demands, she became ill. The therapist alerted her to the fact that her need to be “perfect” was related to her depression. If the therapist had not queried her religious life, the main cause of her suffering would have been much more difficult to determine.

The position of individuals and families, membership of a faith community, the role of faith in one’s life (past and present), the role of God (or a higher power) in illness processes, the degree of joy and peace from religious and spiritual practices etc are questions which are brought to the forefront by religious assessment (Frame, 2003). If the individual observes religious holidays such

as Ramadan, Yom Kippur etc, then it would be straightforward to discuss these holidays and their significance to the individual.

Other detailed questions could be: are you aware of any religious or spiritual resources in your life which you may be able to draw on to overcome your problems? Do you believe that there may be religious or spiritual causes which have contributed to your conditions? Do you wish for your representative from the institution to contact your religious/spiritual representative, if you feel it may be beneficial to speak to him/her? Do you want to consider discussing religious and spiritual issues with your representative in the institution, if this may be helpful?

In the future there will be a need – as experiences have illustrated – for resources and guidelines concerning ethnic minorities in hospitals and healthcare institutions in Denmark and the other Nordic countries. These guidelines can provide security and strength in vulnerable situations, where all may appear lost. For this group, there is a real care need, which does not just relate to admission and treatment, but also to the time of discharge, where the patient will be returning to their everyday life.

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Depression, Women and Culture

Birgit Petersson

In different cultures great differences are found in the depression rate and women report about depression 2-3 times more often than men. There has been an increased extension of especially the American diagnostic manual of mental disorders, DSM, which does not include cultural differences. The historical differences, the change in the diagnostic manuals and the consequences of these, are discussed. The knowledge from research has changed in such a way that the importance of social factors have been more obvious. The research methods have become more valid, even though these still do not, or only to a small extent, include the cultural differences. There are, among other things, great cultural differences in the societies about which feelings that are accepted socially for men and women.

9.1 Introduction

There is an increasing need for awareness of the cultural differences when people from different cultural backgrounds request support for psychological or somatic problems. This is a need which has grown in line with the internationalisation which has taken place over the last few years. In fact, this need has existed for many years in societies with high immigration rates, such as the US and UK, but it has often been ignored or there has been a lack of willingness to acknowledge the importance of cultural differences for the development of illnesses.

There is now also a growing recognition that it is not possible to transfer a Western diagnosis system to other, non-Western cultures without issues. Still, not least the American diagnosis system DSM seems to be going from strength to strength across the world. Why? I will not examine the deeper underlying explanations in this context, but will point to the pharmaceutical industry and their overwhelming interest in a Western diagnosis system. With such a system, the doors are opened for the medicalisation which has taken place in Western psychiatry since the 1950s to be expanded to the rest of the world. This is illustrated, amongst other things, by medical conferences, which are often financed by the pharmaceutical industry, where they also often invite groups of psychiatrists from third world countries, which would never be able to finance travel and lodging themselves.

There are, of course, also advantages to having a joint diagnosis system. In research for example, it can be very difficult to compare studies, because different diagnostic tools have been employed. As such, it would be an advantage if we could be sure we were referring to the same concepts when for example discussing the frequency of depressions. But what if this is an illusion, and we were in fact not referring to the same thing? Or are merely discussing a minor part of the problem, because it has different modes of expression? Thus, the important question is: Is it really that important what the culture in question is? Are the major disease types, for example depression and schizophrenia, not the same no matter where in the world they occur? If not, what influence do cultural differences actually have?

In this connection depression is a good example for illustrating cultural differences and their importance, which can be used in both research, prevention and treatment contexts.

9.2 Diagnoses

There are significant cultural differences in the American and European diagnosing practices. The World Health Organization WHO has selected the European diagnosis system ICD for its use, while the research community to an increasing extent are using the DSM system. The European system has its roots in the work of the German psychiatrist Emil Kraepelin during the late 1800s. The American system is based on the work of the Swiss psychiatrist Adolf Meyer. He emigrated to the US, where he worked as a professor in Baltimore. His overarching view was that depressions were caused by the individual being maladjusted in the environment, while Kraepelin felt that development of for example depression was due to endogenous factors.

Even though there has since been a partial alignment of the two diagnosis systems' criteria for example for depression, there are still marked differences. In DSM, it is required that the diagnosis of depression can be applied no sooner than two months after a serious loss such as a bereavement. Until then, it should be treated as a grief reaction. Comparing the diagnosis criteria, there is also a tendency to a more condemnatory attitude in ICD, for example illustrated in the criteria for mania. Whether there is a difference in how the diagnoses are employed in practice, and whether this also reflects a more humanitarian attitude in American psychiatry, is uncertain.

Western psychiatrists are aware of the difficulties relating to diagnosing. In an overview of the modern disease classifications, The Danish psychiatrist Bech (1993) points to the difficulties of the depression diagnosis by quoting Wing: "to diagnose is first to observe a condition, and then to create a theory of it".

In the latest edition of DSM, DSM-IV, American Psychiatric Association (1994) emphasises that there are cultural differences in the expression of depression, while this is not the case in ICD. The increasing degree of somatic symptoms the closer you get to the Mediterranean countries,

the Middle East and Latin America, is mentioned. As is the understanding of depression as being caused by demons, present in for example some African countries.

Taking a historical view of the development of diagnosis systems, it is possible to identify distinct phases based on experiences from clinical work and later on from research projects. Originally, diagnoses were developed based on clinical observations, and not until the mid-1900s did population studies begin to become included. This meant that diseases in the psychiatric “infancy” were described from severe clinical and often hospitalised cases. Only later less debilitating diagnoses outside of hospital were identified.

Research projects which can be referred to as phase I studies include clinical studies with structured diagnostic systems (Petersson and Kastrup (1995), Prior (1999), Romans (1998)). Amongst the best known are Stirling County and Manhattan-Midtown studies, but the Samsø study from Denmark can also be counted amongst them. In these studies, one finds a high frequency of mental illness on the population, but very few were in contact with the treatment system. In the majority of studies there were marked differences between the genders. In the Stirling County study for example, 66% of women versus 45% of men reported psychological stress.

In phase II studies, diagnostic interviews were employed with different scales, such as the semi structured PSE. These studies have been undertaken in a large number of countries, and show marked differences in symptom reporting between countries and between genders. Examining interview schedules, it is often apparent that there are far more questions relating to symptoms which are more common in women, for example anxiety, phobias and depression, while the more externalised and antisocial symptoms are underrepresented. As such, there is an inherent gender bias. Correcting for example for alcoholism and psychopathy, gender differences overall are far less marked. However, examining differences between countries, then these remain significant, for example 7.5% of Dutch women have mental health problems judged against PSE compared with 22.6% in Greece and 27% in Uganda. It is important to keep in mind that national differences in accepted modes of expression are not accounted for here, and as will be illustrated based on varying acceptance of expression of emotions, these differences are not due to actual illness. Holland is interesting in this context, as there is only a very small gender difference. 7.5% of women versus 7.2% of men report mental health problems. In Greece the figures are 22.6% and 8.6% respectively.

Phase III studies are larger epidemiological studies such as the ECA study, which also employs diagnostic interviews, but where these have been adapted to ensure a better balance between the number of symptoms for men and women respectively. The study still shows an overrepresentation of anxiety, depression and phobia in women, and antisocial behaviour and abuse in men. The frequency of depression is two or three times higher in women, but in the overall level of symptom reporting, the gender differences have been almost completely eradicated.

A large number of such studies are now underway around the world, but even though some rating scales have been validated in different cultures, it is important to question what is actually being measured. For example in Arabic countries depression is used exclusively for bereavement, while what we may refer to as depression is described for example as an “oppressive mood” (Hamdi and associates 1997). In other countries the differences in modes of expression are even greater, not least when considering psychosomatic symptoms.

Gender differences and prevalence

Almost all studies indicate that women, when ignoring the manio-depressive diagnosis, develop depression two or three times more frequently than men. Some studies indicate that the gender ratio may be somewhat different amongst the very young, for example a seven year follow-up study by Ernst and Angst (1992) showed that young men developed depression almost as frequently as women. But while the depression rate among the men dropped with age, the rate among the women remained high. In the younger age group mental illness in women is often characterised by eating disorders, and the depression is often a reaction to the eating disorder. The proportion of women with depression in Western countries peaks in the 30-45 age group, contrary to what might be assumed, as the use of antidepressants increases with age.

In an observational study of 18 years old men and women, Gjerde and associates (1988) found that men with depression were more aggressive and expressed a sense of alienation, while the women were more introspective with feelings of guilt and low self esteem. Interestingly, a concurrent self-reporting study showed that the men experienced guilt feelings and low self esteem, while the women reported aggression and alienation. Taking account of the gender socialisation patterns present in Western countries, this reflects the gender role manifestations and expectations for men and women respectively. Several authors have pointed to the fact that women in many ways can be said to be brought up to be depressed. Where boys to a larger extent are taught to be independent and extroverted, women are taught to be intimate and dependent. Despite the fact that these are gender role stereotypes, there is no doubt that the image of “the rational man” and “the emotional woman” are expressed in a number of studies.

Based on this observation it is possible to question whether depression in men and women should be expected to express itself in the same way, given the different expectations of the behaviour of men and women. If depression for example is caused by a strain, would it then take the same form of expression in men and women? Would “depression” in men not be characterised by greater aggression or even violence, in contrast with that of women which is characterised by a more internalised behaviour? Today, some researchers believe that antisocial behaviour, violence, abuse and criminal behaviour in men should be viewed as an expression of depression, caused by the differences in socialisation.

For me, this perception means that in future, it will be necessary to examine reactions to strains and tensions rather than actual disease – and possibly separate some disease related issues, for

example the manio-depressive psychosis – while other issues can more advantageously be considered reactions to life events and strains, even if this has different manifestations depending on the strength of the individual prior to the event. The expansion of the diagnoses which has taken place in particular in the DSM system in the latest editions is certainly not appropriate.

9.3 Hypotheses on the development of depression

Explanations of why depressions arise have taken varying forms across the last centuries. As with the large population studies, they follow a historical development which is parallel to the research tradition prevalent in the different periods. There are two major questions: Why are depressions developed at all, and why are they more frequent among women?

Among the earliest explanations for the overrepresentation of depression in women are the biological, where depression in women is attributed to hormonal differences. An example of this is the myth of the accumulation of depressions in menopause, which has never been confirmed in population studies. On the contrary, a decrease in depression with increasing age has been found. The myth was so persistent that it was only removed from teaching materials and diagnosis lists during the 1990s. Another is the myth of depression prior to menstruation. Whether these exist or not has caused great disagreement, most recently in connection with the development of DSM-IV. This disagreement resulted in menstruation problems being included in the diagnosis descriptions as Premenstrual Dysphoric Disorder (Gold and Severino 1994). Depression is one of the main criteria for this diagnosis.

Post natal depression is also controversial. That some women develop depressions cannot be disputed, but there may be good reason, as I will discuss in more detail later on, to question the prevalence and the causal factors.

More recent hypotheses which have caused a great deal of interest includes Seligmann's hypothesis of learned helplessness. Seligmann proposed this hypothesis after showing that rats (and later other test animals) developed apathy when they were exposed to a number of challenging strains, such as obstacles to obtaining food. This apathy persisted even after the obstacles had been removed. Later on, Seligmann and associates have continued this research, and have shown that resignation in relation to tasks is more often present in the behaviour of women than that of men, leads to depression. In recent years this type of research has been developed further, and has led to research into health maintaining factors. Seligmann has led some of this research, but perhaps the best known is Antonovsky (1991).

The third explanatory model is the psychosocial. It has long been known that the worse the socioeconomic conditions, the greater the risk of mental illness. However, in relation to depression, for a long time the view was taken that conditions were different, in that admissions were often of women in higher socioeconomic classes.

Perhaps for this reason, the study of conditions among groups of English women, but Brown & Harrison (1978), came as a shock to some, and a revelation to others. Brown and Harrison (1978) found a number of risk factors in relation to the development of depression: low social status and young children living at home, loss of a parent in childhood etc. However, they also established, by comparing conditions in an island community with those in the urban setting that social networks can act as a protective aspect against some of these risk factors.

Jack Bryø Jensen and I (1982) undertook a corresponding study at almost the same time, only this was focused on pregnant women, who were followed through their pregnancy and until six months after birth. Half of the women lived in Copenhagen (the Capital area, edit.), the other half in Holbæk (a smaller urban society, edit.). There were marked differences in the development of mental health problems including depression. Again, the social networks and good living and working conditions in the smaller town acted as protective forces. The conclusion, which may be surprising to few people today, was that social factors were and are of great importance in the development of mental illness.

Social psychiatric research has pointed to the differences between the social lives of men and women as possibly the main explanatory factor for the gender differences in prevalence of depression. Almost regardless of how men and women are compared, their different life conditions are apparent. For an example, female doctors tend to be far more strained than male doctors, and they have a high suicide rate compare with society in general (Korreman 1994). The fact that the majority of male doctors are married to a partner with a shorter education than themselves, and that a proportion of these partners either work at home or have reduced work hours, affects the overall strain on the families. It could be argued that everything seems to indicate that men and women come from two different cultures, no matter where in the world we turn our eye. More recent studies, where the social experiences of men and women are approaching one another, do appear to even out the differences in the prevalence of depression. And prevalence of depression also increases in groups which are socially vulnerable (Romans 1998).

Cultural differences

One of the criteria for depression in Western countries is a feeling of guilt. However, there are indications that this is specifically related to Christian culture, which can also be described as a highly individualistic culture. Being raised in a Muslim culture, this is characterised by shame, and the external prestige in interrelations between people is highly conspicuous. These societies are therefore much more affected by ideas and perceptions about honour and shame (Benedict 1979). This must be included in our understanding of mental health problems - as well as our understanding of the problems which can occur within families, where some may feel or be let down and/or betrayed, and in the way in which one may seek to solve such conflicts (Petersson 1999).

This is not just the case in Muslim culture, many Eastern cultures, such as the Japanese, are also highly affected by shame. This can lead to hiding the illness of a family member, or rearticulating it with other, non-stigmatising, concepts. This may be a contributory factor in the greater reporting of psychosomatic symptoms in relation to depression, as these psychosomatic symptoms to a lesser degree lead to judgements from society. In such cultures, one may also be less likely to report on any issues, as the external perception, not just of oneself but also of the entire family, is being endangered. Hamdi and associates (1997) mention expressions such as “my heart is poisoning me”, “as though boiling water is poured on my back”, as examples of expressions of depression in their study of Arabic people.

In Buddhist culture, the fate of the individual is the defining factor for illnesses, including depression. Depression is not an illness, but an occurrence caused by previous bad actions. This belief is closely related to the belief in reincarnation. Examinations of people from Buddhist cultures show that this belief in destiny appears to protect people, so that they can attribute a meaning to events which does not lead to feelings of guilt or shame, contrary to what we find in Western cultures. Studies of for example Tibetan torture survivors show that, despite symptoms of strain such as flashbacks, there is a distinct lack of depression, avoidance and repression (Lützer and Mathiasen 1998). The belief that the individual is merely being affected by fate is also present among Muslim groups, and some elements can also be found in European culture, for example on the idea of hubris and nemesis.

In certain African cultures, depression in people is attributed to external causes, and this reasoning appears to counteract internalisation of feelings which could lead to guilt and shame. In other cultures grief is viewed as a spiritual experience (Eisenbruch 1990), and in some countries it is common to experience hallucinations in connection with severe losses, symptoms which in our culture will mostly be regarded as signs of a serious mental illness. This does occur as a temporary consequence of strains in our culture, for example many people may experience that a loved one is still in the room, long after they have passed away. One of the women I followed for the pregnancy study experienced a period of about a week’s duration (roughly a month after the birth), where she heard the child crying constantly, despite the fact that it was not crying and was often sleeping soundly when she checked on it.

Cultural differences in permitted feelings

If it is viewed as very shameful to express certain feelings in a given culture, these feelings may not be present, or only present themselves very rarely. Some feelings are experienced but not expressed. As such, as Kirmayer and associates (1998) state, it is not possible to conclude that these feelings are not in fact present. For example, it is far easier for Vietnamese people to express feelings in anonymous questionnaires and especially in a foreign language. This is a problem I have often encountered in a slightly different incarnation, in that I have for a number of years participated in interpreter training sessions, where a new interpreter would translate for me, while a practised interpreter listened in and corrected any mistakes. Without fail, shameful events were not translated, and even the experienced interpreters would admit that they often found it difficult to translate items which were straining for their own culture.

Not least in Japanese culture, there is a ban on expression unkind feelings, at least in the public space, something which does not go away, even when people move to a Western country. Otherwise, there are great differences in the feelings which are permitted in different cultures. Fischer and Manstead (2000) have examined gender differences in feelings in different cultures, and found that, in line with the issues previously discussed, there is a connection with whether the culture concerned is individualistic or more collective. As such, fear seems to be less prevalent in men in collective cultures, both when compared to women from the same culture or with men and women from less collective cultures. The same is the case for shame and guilt. With regards to melancholy and disgust, women from individualistic cultures score the highest. It appears that men in Western cultures are encouraged to avoid settings which can undermine their status as individual men, men with “control over their emotions”. The authors also show that these differences are greater, the more individualistic a country is. Even within the Western world there are significant differences, and as such, the US, Sweden and Holland score highly in relation to individualist, while for example Poland, Portugal and former Yugoslavia score lower. In other continents too, it is not possible to simply transfer norms from one country to another; there are significant cultural differences in the “permission” to express emotions and the freedom to be independent. This does not involve a judgement of which is best, but is simply to point out that there are differences. Even if we in the Western world believe that individualism provides great freedom, there are advantages and disadvantages to both. Madden and associates (2000) have examined depression and anxiety in relation to gender, and found that when comparing these with the “permission” to express emotions, that this in the individualistic countries – that is, primarily North America, Western Europe, Australia and New Zealand – is a contributory factor to keeping women in inferior positions, even if they are otherwise able to participate actively in the economic and political spheres. Whether these gender differences will change, as there are indications they may, when men and women are analysed based on the same social conditions, is an interesting issue to follow in future. At present, I am analysing - as well as possible - stress among men and women with identical professional groups and same social conditions, ie people who are being examined to establish any actual gender differences. Initial results indicate that women, in all of the professional groups in-

volved, report experiencing more stress than men. However, men with partners who have longer educations than themselves are the most stressed. This may indicate that it is difficult to be socialised to being a real man, when one's female partner all of a sudden possesses and represents the traditionally masculine values within the family: high status, high income etc. But it may also show that the care for the family, which women traditionally undertake through double working, is now becoming double work for the man, with the accompanying increased risk of development of depression and other illnesses, and the latest research appears to show.

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