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The BODY Manual is addressed for adult trainers working in the field of health education, sexuality education, intercultural education, gender related education.

The Manual includes all BODY Products into a unique tool, complete of the main following components:

**Critical Incidents**

This section includes the research phase of the BODY project for each theme and explores the impact of cultural differences in the work of adult. In addition are included critical incidents analysed through Cohen-Emerique’s methodology, which implies that the cultural norms / expectations / values / practices.

**Best Practices**

Systematized compilation and promotion of innovative best practices in adult trainings that take into account cultural diversity in the domains of health education, sexuality training, gender-related training, and intercultural trainings.

**Anthology**

Collection of background-articles based on the disciplinary backgrounds of cultural anthropology, intercultural psychology and sociology addressing challenges related to different cultural practices and conceptions concerning, health, gender, sexuality, disability and body chosen by criteria related to the main sensitive zones identified.

**Working Tools**

The Tools sections include practical tools and exercises to be used in trainings related to the BODY Key topics: aim of the session, skills to develop, time need, suitable number of participants, material (technical devices) needs, preparation needed, procedure, debriefing, hints for facilitators and eventual suggested readings on the topic (background theory or methodology).
INTRODUCTION TO THE MANUAL

“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 Life-long Learning Programme, Grundtvig. The BODY project has the overall aim to explore how our perception of the body and body-related themes such as gender, age, sexuality, disability, health and disease are influenced by cultural differences and at the same time affects our intercultural communication.

Thus, the BODY project overall focuses on the interplay between cultural traditions, body image, body concepts and communication. All development activities in the project are carried out from the same approach that this triangle between culture, body and communication creates sensitive zones.

The concept of sensitive zones describes the situations and cultural encounters, where we find ourselves emotionally affected and spontaneously reacting with strong feelings like confusion, anger, surprise, disgust, sadness, embarrassment, irritation, insult, despair. We are in such cultural encounters surprised by our own emotional reactions – and at the same time puzzled by the other persons reactions. No matter how open we are to diversity, and no matter how accustomed we are to move and communicate in various environment – we are experiencing a culture shock, which we cannot immediately explain and understand rationally. The risk is that in such cultural encounters we tend to explain the difficulties and challenges in communication with the strange cultural habits and behaviour of the other person. In other words: we let cultural deadlock and differences be barriers that prevent us from communication, mutual understanding and furthermore the insight in other traditions and frameworks of human life.
This may be due to personal and private occasions. But it can also occur in many professional contexts as adult trainings and adult supervision being characterized by cultural encounters in a broad sense of the concept of culture. These professional encounters have been the focal point of the BODY project. Thus, the BODY aims at providing professionals with exemplary knowledge as well as practical methods to handle cultural differences linked to the body in an appreciative and respectful way, when being in contact with citizens and users. This may apply to adult teachers and trainers as well as counsellors, integration workers, health workers, social workers, job consultants, sexual supervisors and therapists, disability consultants and other professionals and frontline staff all over Europe.

Within the BODY project, based on the Margalit Cohen-Emerique methodology Critical Incidents, we 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. Furthermore, we produced an anthology and bibliography (Reader) presenting a variety of articles, each of which deals with the BODY themes, respectively the overall concept of body in culture and the cultural differences related to gender, sexuality, disability, health and disease.

With this manual we would like to convey the many valuable lessons about the interplay between culture, body and communications that we have learned and collected through interviews, workshops, training sessions and desk research within the project period. The manual is structured as follows:

- Initially, we introduce the analytical and conceptual approach and cultural understanding that has been the common thread through our working process. 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.

- Next, we present the key aspects of the methodology that we used as the guidance principles throughout our research and collection of critical incidents, best practices and theoretical texts. The methodology explains how each method has contributed to the overall goal of strengthening knowledge as well as tools around the interaction of culture, body and communication in adult training and other intercultural encounters in professional performance.

- Finally, follows the manual, which is divided after the recurring themes: the body as an overall concept, gender, sexuality, disability and health.

We refer, in addition, to the specific readers, where we have more elaborated presented the collections of critical incidents, best practices and theoretical articles.
Our concept of culture defines our handling of intercultural communication

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 multiethnicity, but also by multiculturality.

A broad concept of culture

In the BODY project we have distinguished between multiethnicity and multiculturality 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 multiculturality – goes far beyond national origins and traditions. At the same time, the growing multiethnicity in Europe is also an indicator that multiculturality will increase in most European countries, in everyday life as well as in working life, where professionals are confronted with multicultural perceptions, needs and expectations 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.

The danger of culturalizations of cultural differences

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 behaviour, politeness, greetings, physical contact, eating and dress have played a central role.

The checklist approach 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 behaviours 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.

When operating in professional fields, it is, however, necessary to have some guidelines for the intercultural encounter and communication. In the BODY project we aim at meeting this need through other methods than the checklist method as later described more detailed. Our general approach is 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. But, 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.
A static concept of culture divides people into us-and-them

Thus, the checklist method may, in the worst case, lead us to negative culturalizations, preconceptions and even prejudices about peoples, national and religious groups, sexual minorities etc. Thereby, we build our perception of other traditions and norms on a static and functionalist concept of culture, indicating that culture is associated with national origin. In accordance with the static and 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. 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 behaviour – on the verbal/linguistic level as well as the non-verbal/physical level. Culture is a binding and sometimes stigmatizing term that basically draws boundaries between "them and us" in hierarchical divisions.

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 be ethnocentricity – by distinguishing between so-called primitive peoples and civilized cultures. There are many examples to show how body language and bodily behaviour and forms of communication have been considered and rated from a culture-hierarchical scale.

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 often leads to robust generalizations about all ethnic minorities. The intercultural encounter and communication in this perspective may often be coloured by a negative and even suspicious approach against other concepts of pain and illness etc.

Culture from a dynamic, contextual and equal perspective

In the BODY projects we have considered culture as a dynamic, 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. This consequence of this approach is that 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.
From one culture to various cultural identities

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 labelled 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.

Intercultural communication from a democratic and resource perspective

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.

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

With the BODY project we have 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. The concept of an intercultural pedagogy appears in the wake of the realization that all forms of education, training, guidance and counselling 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, a keyword for intercultural competence and communication 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. The mutual exchange of perspectives and the ability to treat citizens and users in the multicoloured light of many simultaneous cultural identities is crucial for the cultural encounters and intercultural communication. Thereby, 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.

This approach is reflected in the methodology of the BODY project, as presented in the following sections.
The Methodology of BODY

If body-related themes as gender, sexuality, disability and health are especially sensitive zones in intercultural contacts, there are some areas of adult training or supervisor where they may be particularly relevant. Such are the trainings related to health issues, sexuality, parenting, gender issues, and all physical education as well as all intercultural trainings. These trainings also would have the potential of contributing to the mutual understanding of these differences and the recognition of special needs.

Self reflection and awareness – the first step to intercultural recognition

In adult training situations or in other professional settings, as trainers it is inevitable being aware of body signals and being able for self-reflection regarding our own emotions, reactions and our core values hidden behind. How we think, how we feel about the body, health, gender or sexuality is always present, even when we try to ignore them in the given context. Just because we don’t reflect on our attraction, our body responses, deep emotional reactions, we still live the situation, we react in a given way and so we affect the simplest social interactions as well. The ability of self-reflection offered by the intercultural approach enables us to examine ourselves in each and every situation like we often do without thinking with our partner – especially if we are ‘professionals’, trainers, teachers, care givers and the other is a client, customer, or a trainee. This method can help us to understand if a situation “gets stuck”, what causes a strong rejection, shock, resistance, why we get into conflicts even if we don’t want to.

The general need of methods and tools in the intercultural encounter

Apparently, there are few trainers’ trainings available that equip adult trainers with the skills and knowledge necessary to understand the impact of cultural representations and practices related to gender and body. The methodology we use in the BODY project aims to develop and strengthen intercultural competence focusing on concrete methods and tools to handle intercultural communication in the daily job performance among teachers, supervisors, educators, nurses, social workers and other professionals somehow involved in health, gender, sexuality or the body in general. Body, fitness and holistic approaches more and more popular, there are many adult trainings in European countries focusing on personality development or different body practices like dance, theatre, or yoga, this awareness of the relevance of the body is
rarely reflected in the professional level of adult trainers. Nonetheless, 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.

Professionals sharing experiences with other professionals

The participation of the target group in both research and methods used has been a focal point in the BODY project. Thus, our methodology is based on the experiences we gained through collecting critical incidents lived by adult trainers, collected through focus group sessions. We used the method of critical incidents developed by Margalit Cohen–Emerique: an action-research method developed for professionals of the social sector working with multicultural groups. The ultimate aim of the approach was to help solve conflicts and misunderstanding triggered by cultural differences. The approach is based on the recognition that conflicts / tensions are not the mere consequence of a ‘culturally different other’ but the results of the interaction between two occasionally conflicting cultural reference frames. As such, the approach is a unique way of dealing with cultural difference that does not generalise or essentialise the cultural difference but assumes its situational and interactional character.

In the BODY team we all share the broad definition of cultural diversity going beyond nationality, ethnicity, religion to encompass differences related to age, gender, sexual orientation, special condition related to health or handicap.

Our BODY training is built on extensive research, to make sure it answers critical situations and challenges that adult educators face during their practical work. It is based on a modular structure, which makes it possible to construct trainings from the building block according to the actual needs of the trainers to receive the training. Training modules focus on the body, non verbal communication, health, disability, gender and sexuality. Each module implies an overview on aspect of diversity found relevant: cultural, ethnic, religious, handicap, sexual orientation and it also makes easy to insert it into initial training curricula of the above domains. The training in its pedagogy relies on the approach on intercultural and non formal learning, with interactive tasks, the role of trainer approaching facilitation, based on the active participation of all. In the following sections we go in depth with the methods used.

Navigating between two types of ethnocentrism

One of the main challenges in the preparation of this handbook as well as in the whole project was to avoid two types of ethnocentrism:

- The ethnocentrism of enclosing others in fixed cultural (national, ethnic, religious, etc.) categories and generalizing, essentialising traits and characteristics ignoring the perpetual changes, dynamics and heterogeneity within each culture.
- The ethnocentrism of ignoring cultural differences and their impact, often referred to as the universalist bias, which usually hides the assumption that there are no real differences because our approaches, practices are universal.

To navigate between such an essentialist Scylla and a universalist Charybdis we used as a compass the intercultural approach developed by French social psychologist Margalit Cohen–Emerique. In this section we’ll describe what this approach implies and also how to read the different chapters, sections of the handbook.
Cohen-Emerique’s intercultural approach as compass

A first tradition of intercultural trainings focused on the transfer of information on specific cultures: how to understand Japanese use of space, Hungarian sense of humour, French gastronomy, Belgian identity etc. At the beginning of her career, Cohen-Emerique also delivered trainings for French social workers to be able to cater for the needs of their clients newly settling in France as part of the Jewish diaspora. However, she observed that her trainings based on history, cultural anthropology, identity psychology did not have a great impact on the practice of the social workers she trained: in some situations they did not apply the newly acquired knowledge on the specificity of this cultural group while in others they tried to stick to elements of the transferred information even when it did not seem to fit the context of the concrete client. Cohen-Emerique’s observations are in line with general critiques towards what is called a culture-specific approach:

- in one hand it is impossible to give valid and permanent information on cultural norms, values, behaviours that are generalizable across whole cultural groups and their members because of the dynamical nature and perpetual changes characterising each culture, and also the diversity of individual experiences of their members.

- in the other hand it seems tremendously difficult to apply well this type of information into concrete situations: somehow the anthropological knowledge is difficult to transpose into the everyday embodied interactions.

To respond to the challenges she identified Cohen-Emerique concocted an approach and a methodology that for the last thirty years has become widely used all over France in the training and supervision of professionals of the social and health sectors working with people from “other cultures”. Cohen-Emerique’s intercultural approach is based on three steps, each based on different training methods and tools and requiring the development of different competences from the professionals.

a) Decentration

The first step – decentration - is based on the recognition that if there is a conflict it is not the mere consequence of the culturally different other, but rather the interaction between two different cultural reference frames. Decentration thus invites to the exploration of the involvement of one’s own cultural – including professional - models, practices, norms and how they enter in interaction with the values / norms / expectations of the other.

The recognition that decentration is necessarily the first step stems from the observation that our cultural frames of reference act as filters – think of the metaphor of glasses as a representation of culture – biasing how we see the outside world. Decentration makes it possible for us to lift these cultural glasses just enough to be able to see their colour, their shape, i.e. to better understand how we filter our reading of the other person. Moreover, it is much easier to systematise and give meaning our knowledge on other cultures once we have acquired some perspective of our own. For instance it is easier to understand (which does not mean to accept) cultural taboos concerning meals - what is edible and what is not - once we have discovered that our own culture also draws such a line: maybe for us it is oysters and snails that are usually not categorised as food, maybe it is pork, maybe all beings that have eyes but there is usually such a line, and the question is merely where the line is. Finally it is our nature that we tend to consider ourselves – our own culture – in more complexity while easily accepting simplifications on others – other cultures. Gaining more awareness of our own culture first may help us become aware of this bias and maintain less simplistic
assumptions on others. This first phase implies the acquisition of tools helping self-awareness, self-perception. A core skill is the capacity to take a step back from a potentially delicate situation and try to resist the need of immediately looking for the answer and judgement in the other (“how can they oppress the women by forcing them to hide their face and body curves?”) and instead turn the attention to ourselves (“why is it so important for me to chose the way I want to dress? Why is it important that women show their face and body curves?”).

b) Reference frame of the other

Once we have gained awareness of our own cultural norms, values, patterns, we are ready to open our eyes on the other. The objectives of this phase are:

- Gaining a more elaborate idea on the cultural values, norms, patterns of people from other cultures, going beyond simplistic assumptions and stereotypes;

- Becoming aware of the multitude of factors that may influence the cultural reference frame of the other.

In this phase professionals acquire tools from cultural anthropologists to observe, interview, analyse cultural patterns, and create “grids” that facilitate the taking into account of contextual elements (e.g. for professionals working with immigrants a useful “grid” would help to determine to what extent the client is “integrated” or “acculturated” in the new society, so as to avoid pinning on her/him cultural values and patterns of her culture of origin which she does not follow anymore). Key skills in this phase are:

- Daring to be curious: Cohen-Emerique observed that often professionals stay with received ideas, assumptions on other cultures because simply they don’t dare to be curious and investigative by the fear of invading the other’s privacy and their right to be ‘invisible’ as a cultural entity different from mainstream. For this reason, professionals often do not dare to ask the client when they face a behaviour / norm that is strange for them, even when they would have had a chance to actually understand that behaviour or norm.

- Observation (e.g. being able to notice in Japan the lack of handshakes as a typical greeting ritual).

- Connecting the observations in a systemic way to our set of knowledge and practices (e.g. widening our representations of what a greeting ritual can be by slowly learning the delicate nuances of the bow).

c) Negotiation

The third step, negotiation implies finding a solution to a concrete problem in a way that respects as much as possible the identities of both parties. In this phase professionals acquire tools for communication and negotiation. A variety of attitudes and skills can be developed to improve our negotiation:

- Active listening, non violent communication: listening to the other, not just focusing on what we want to achieve and where our own reservation line is.

- Resistance to the need for closure: avoiding our genuine wish to close communication and end the relation in emotionally challenging, threatening situations.

- Awareness of non verbal communication (our own and of the others).

- Capacity to move between personal and professional spheres to maintain the relation: when there is a blockage in the process, realise that the shift between professional and personal registers can become a resource in maintaining the connection.
Our project we very much built on this intercultural approach proposed by Cohen-Emerique. Different phases of the project work correspond to the three steps of the intercultural approach. To ensure that we focus on issues relevant for adult trainers we entered the vast domain of cultural diversity through the collection of critical incidents from trainers, educators working in multicultural contexts. The incidents collected oriented our search for theories, in order to find answers to the questions raised in the field. This theoretical work is connected paves the way for the exploration of the reference frame of the other by bringing examples from a variety of cultural groups and highlighting dimensions of differences. The Best Practices and Tools offer inspiration, ideas and the development of competences that can serve as resource for negotiating common understandings and sustainable collaboration in the framework of adult training activities.

A mosaic of themes: five chapters on gender, sexuality, health, disability and body

For practical purposes we have dissected the great domain of BODY somewhat artificially into five themes: gender, sexuality, health, disability and body. This division should by no means suggest that these themes are independent, in fact the significant overlap is evident: for instance specific cultural practices for women who have their period could be tackled through the perspectives of health (e.g. how in health training women are prepared to handle the hygienic aspect of menstruation), gender (gender-specific practices), sexuality (specific practices on women’s sexuality), and even non verbal communication (do women with their period have to isolate, segregate, communicate differently etc.). Yet, this very simple separation proved useful for the work process, and also for the presentation of an inherently complex and organic domain. On a practical side, reflecting the overlap between the themes some critical incidents could be used to unveil cultural differences in several themes, and some best practices too could be adapted for several themes.

A kaleidoscope of approaches: critical incidents, anthology, best practice, tools

Each chapter is divided into four sections: critical incidents, anthology, best practices and tools. These four sections build on each other and together have the ambition to offer a dialogue between practice and theory, but also between the specific - concrete and the general approach. The four sections reflect four phases of our work in the BODY project.

Critical incidents

“I give French lessons every morning to 4 or 5 Japanese employees with different French levels. One morning, one trainee is missing when I start my lesson. He arrives a few minutes late, enters the room, walks up to me and holds out his hand to greet me. I take his hand to shake saying hello. To my surprise, he does not shake his hand up and down but rather twists it from left to right (as if he were playing babyfoot). I am embarrassed and do not know how to react: either I pretend that nothing strange happened (but it seems that other trainees saw this incongruous gesture) or I comment and explain what a handshake is, but I’m afraid of embarrassing the trainee. In the end, I decide to say nothing.”

The concept of critical incident, synonym to culture shock refers to concrete situations, narrated by professionals in which they experience a surprise, a challenge that they attribute to difference between cultural reference frames:
Culture shock is an interaction with a person or object from a different culture, set in a specific space and time, which provokes negative or positive cognitive and affective reactions, a sensation of loss of reference points, a negative representation of oneself and feeling of lack of approval that can give rise to uneasiness and anger (Cohen-Emerique 2011)

Cohen-Emerique’s method of critical incidents implies the collection and then analysis of the incidents with the participation of the people who experienced it. It is an action-research method developed for professionals of the social sector working with multicultural groups. The ultimate aim of the approach is to help solve conflicts and misunderstanding triggered by cultural differences. The approach is based on the recognition that conflicts/tensions are not the mere consequence of a ‘culturally different other’ but the results of the interaction between two occasionally conflicting cultural reference frames. As such, the approach is a unique way of dealing with cultural difference that does not generalise or essentialise the cultural difference but assumes its situational and interactional character.

A total of 88 critical incidents have been collected between February and July 2012, from professionals involved in adult education/accompaniment activities of a variety of fields including language training for foreigners, disability, international development, transgender support, health education etc. The incidents were either collected through workshops or through individual interviews or the combination of the two.

The advantage of this approach is that it acknowledges that in all cross-cultural conflict/tension there are two sides involved and that a conflict can never be reduced to or explained by the strangeness of the other, but rather the interaction of two differing cultural reference frames. The approach also offers us a possibility to uncover what further values, norms, practices and expectations lie behind culture shock incidents related to the body.

We considered it important to start each theme chapter with critical incidents referring to that theme, to keep the connection to the field, to ensure that the consecutive work phases (theory and tool development) are both relevant and practical for the professionals.

Anthology

The ambition of the anthology section is to give some introductory reference points for the discovery of the impact of cultural diversity in the BODY themes. These texts cannot pretend to be exhaustive reviews of all cultural diversity in each themes, but rather offer starting points on the range of cultural dimension that would have to be considered.

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 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 mem-
bers in order to conclude that the approach to disability varies and that there does’nt 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.

**Best practices**

We have collected practices which take into account cultural diversity in the domains of health education, sexuality training and gender-related training and that have already proven to have an impact in both inside and outside the EU. In order to ensure that the collection of Best Practices clearly meets learners/users needs, partners were asked- during the research phase - to use common indicators, or assessment criteria, to select and analyse Best Practices. The indicators were qualitative and organised in three categories: Content, Methodology, Transferability and Sustainability. These practices can serve as source of inspiration on how to tackle cultural diversity in the BODY themes through education programmes.

**Working Tools**

The last section of each theme offer examples from the trainings we have done locally and internationally. Most exercises were developed by the partners of the BODY project. Activities adopted from elsewhere are referenced.

Our trainings were based on a modular structure, which makes it possible to construct trainings from the building block according to the actual needs of the trainers to receive the training (modules focusing on: body, non verbal communication, health, gender, sexuality each module implying an overview on aspect of diversity found relevant: cultural, ethnic, religious, handicap, sexual orientation) and it also makes easy to insert it into initial training curricula of the above domains. In their pedagogy our tools rely on the approach on intercultural and non formal learning, with interactive tasks, the role of trainer approaching facilitation, based on the active participation of all.

The ultimate objective of these sections is the development of intercultural skills of the participants: a capacity to decentrate – become aware of how our own cultural baggage (our norms, our values, our communication habits etc.) influences our interactions, being able to decode and make elaborate hypothesis for understanding the others and a capacity to accommodate, negotiate, adjust to these differences and include them in training activities in a way that makes them a resource.
Shared concept – in a health perspective

With the BODY project we put a special focus on the professional competence to manage intercultural communication in the 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. all over Europe.

In the BODY project we seek to highlight the special intersection between intercultural and bodily, non-verbal communication. The concept of health is in this connection recognized as one of the most significant areas of intercultural differences – and thereby also a source of many interpretations, preconceptions and misunderstandings.

When health as well as illness and disease extensively are cultural-based concepts, we need to approach these phenomena from a holistic perspective that gives room for a broad understanding of peoples own perceptions of their health situation. Mental health may, for instance, be interpreted differently in different cultures. There may also be different rules and taboos for the articulation of the body and body parts. Such differences may influence a lot on adult training as well as the professional practice within most “human” professions.
HEALTH RELATED CRITICAL INCIDENTS

Full Reader of Critical Incidents related to HEALTH

Research results
Impact of cultural difference in the domain of HEALTH

For the theme of Health we collected 7 incidents from the five countries. All the incidents lead to point to a particular direction worth to explore.

The Drug habits (HU) situation questions how a family can deem acceptable the use of drugs, and support their daughter in this habit. The Wrapped babies (DK) situation is an example of cultural practices surrounding the handling and management of babies, and birth giving in general. The diversity in rituals and prescriptions abound concerning their freedom of choice (or its restrictions), the desire physical contact to maintain with them, the taboos and prescriptions concerning breastfeeding, and the sleeping habits just to name a few.

Sealed lips (IT) brings the question of how can we understand if the meaning behind an action is in the situation, in culture or psychological state triggered by trauma.

The incident entitled Water (FR) illustrates the debate between physical and spiritual needs: can a spiritual or religious prescription outweigh or have precedence over seemingly objective physical needs?

Adjacent to this the Abortion (HU) incident opens the question of what can a therapist do when pregnancy seems socially, financially, psychologically challenging, yet abortion is forbidden by the religion.

Similarly Contraception (FR) tackles the theme of contraception, which seems unacceptable from several religious positions. Finally, Accompanying death in the hospice (DK) gives an example of the rules that govern our behaviour facing illness or death.

Quick summary of critical incidents related to Health

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### CRITICAL INCIDENT: “Water”
[Collected by Élan Interculturel, France, 2012]

#### Sensitive zone
The contrast between: a scientific, materialist conception of the world, Cartesian conception of health and the primacy of individual physiological needs over all other needs on the one hand and a religious belief system on the other.

#### Culture of the person experiencing the shock
Female, 38-years-old, psychomotor/movement therapist (she helps clients dealing with issues related to movement, coordination and body awareness), working part-time in a hospital and part-time in private practice. In a relationship with a young physiotherapist, has lived in Paris for 10 years, the rest of life in Poitiers. Politically she describes herself as left-wing but non-militant. She comes from a family of health practitioners (mother a nurse, father a physiotherapist).

#### Culture of the person “causing” the shock
Young woman aged 18. Student. From Ivory Coast. Practicing Muslim. Comes from a relatively homogeneous cultural background (West African immigrants). Referred to the relaxation workshop by her doctor after experiencing back pains.

#### Describing the SITUATION
The situation took place at a first meeting in the context of a motor skills and relaxation workshop for a group of 5 women who all came for different reasons. It took place at my office and I led the group. It was very hot and there were two electric fans, but they did not provide much relief unfortunately. The participants were performing an exercise with gymnastic balls, which requires using bodily energy. Given the heat, I handed out water so that they would be kept hydrated and they all accepted except for one young woman who thanked me politely without further explanation. They continued with the activity and a few minutes later I noticed that the young woman was perspiring and pale, so I went over to her with a bottle of water telling her that this time she would absolutely have to drink to hydrate and refresh herself a little, or she would face a drop in blood pressure. The young lady refused, telling me that she could not because she was observing Ramadan and that I shouldn’t worry, that she was feeling fine and that she was used to withstanding high temperatures without drinking water. I was very concerned that she would grow faint so I suggested that she stop the exercise in order to rest a little. The young girl insisted on continuing, so I became stricter, telling her that if something happened to her I would be responsible professionally. I told her that I accepted her beliefs and ideas but that there were rules in my office, too, and that one of those rules was not to put oneself in physical danger. Faced with her insistence, I told her clearly that if she would not agree then she could leave the room. The young woman took her things without a word and just before she closed the door she said “You should know that this is discrimination and I will not tolerate it”.

#### 1. Elements of the SITUATION
Office of a psychomotor therapist in a town in the northern suburbs of Paris. The room is about 30m². There are no chairs, simply big and small balls to perform exercises and individual mats. There are 5 women: one is 18, two others around 30 years old and two more around 45. The group was originally heterogeneous with regards to ethnic origins (3 immigrants, 3 French, one of whom was originally from the Maghreb). The participants were in a circle, sometimes lying or sitting on the floor, sometimes on the balls, depending on the kind of exercise. The instructor walked around the room giving instructions and checking that the women understood. Sometimes she stopped with one or another of them to correct a position or to help with certain movements. The relationship between the ethnic groups of the people: the immigrant women and the participant with an immigrant background were from countries that had
previously been French colonies (Ivory Coast, Tunisia, Algeria).

### 2. EMOTIONAL REACTION

I felt very disturbed, a little worried because I had the impression that the participant had devalued my professional capacity and that my rules meant nothing. I experienced a kind of ambiguity between anger and anxiousness, anger at the contempt for what I was explaining and anxiousness that the participant might feel faint. Finally, rage at being accused of discriminating against participants. Troubled.

### 3. What norms / values / representations did the incident touch / threaten / question in the narrator?

For the narrator, while it is very important to have beliefs and a rich spiritual life, there is a limit: psycho-physical health. Physical integrity must take priority, it is the basis on which to have a fuller spiritual life. Also, if a training is being given or if you take part in any kind of workshop, the rules that exist must be respected, and the message and the arguments of the person in charge of the event must be taken seriously, otherwise there is no point in taking part. If religious beliefs are not compatible with the workshop, the workshop must be avoided.

### 4. Based on the analysis of question 3 what image does the narrator have of the other person?

The narrator had a negative image of the participant in question because of her disregard for the narrator’s rules and her accusation of discrimination. She viewed her as a fanatic capable of anything for her beliefs.

### 5. What could be the norms / values / representations of the other person / culture that led to the specific behaviour that caused the shock experience? (Hypothesis I)

Religion is the basis of all our actions, guiding and protecting us. It is everywhere all the time, it is our framework.

**Hydrating, drinking water** is important but it is not necessary to drink all the time. During Ramadan, it is possible to drink and eat sufficiently at night and that provides energy for the rest of the day.

**Perspiring** is a natural thing when it is hot and not a sign of faintness.

Not respecting the decision of the young woman to not drink and making rest and hydration as conditions (forbidden during Ramadan) for continuing with the exercises is **discriminatory**.

The young woman seemed to be strongly guided by religious doctrine and her superego.

### 6. Does the situation highlight any problem concerning the professional practice, or in general about the respect of cultural differences in intercultural situations?

It can be difficult to draw the line between respect for others and professional responsibility and to define the hierarchy of needs. Is it possible that spiritual needs take precedence over those of the body? Another issue in this situation is the border between the right of the trainer to determine what takes place during her training and to ensure the safety of the participants and the right of an adult participant to take responsibility for her own actions.

### OTHER RELEVANT INFORMATION

The young woman never returned to the workshop. The psycho-motor therapist stands by her position.
CRITICAL INCIDENT: “ACCOMPANYING DEATH IN THE HOSPICE”
[Collected by MHT Consult, Denmark, 2012]

Professional educational domain
Health / Gender

Sensitive zone
Professional versus private care of terminal ill family member; Conception of family responsibility; Attitude towards illness/death/body; Professional identity.

Culture of the person experiencing the shock
The narrator is a Danish female nurse, 38 years old at the time, working in a hospice. The narrator is part of a nuclear family herself, having 3 sons and a husband. Like many Danish families she has a Christian background, but is not an active believer in daily life.

Culture of the person “causing” the shock
The other protagonists are A) A Japanese female patient in the hospice, 72 years old – and B) the patient’s son believed to be same age as the nurse at the time, 38 years old. It is not known whether the son in the incident was the only adult child in the family, but apparently he was the only adult child living in DK at the time. Like many Japanese people they profess presumably to Buddhism or Shintoism. But similar to the Danish nurse they are apparently not very active believers.

Describing the SITUATION
I was working as a nurse in a hospice in the Metropolitan area in Denmark. One day a terminal ill Japanese woman was admitted to the hospice. As staff we expected to deliver the usual extensive, professional care. But we soon realized that the adult son of the woman had planned to stay in the hospice around the clock. The son actually insisted on doing everything for his mother. Even when we tried to persuade him to continue his daily life and let us do our professional tasks, he went on caring for the mother. As professionals we were only allowed to do those treatments, which were painful for her.

1. Elements of the SITUATION
The incident took place in a private hospice in the Metropolitan area in Denmark. Like most private hospitals and hospices in Denmark this hospice is very well equipped and with proper staffing. People pay, and the costs cover all necessities in palliative treatment and care. It is not known how many patients were in this hospice at the time for the incident, but usually the Danish hospices are rather small units. It is unknown why and for how many years the Japanese family live in Denmark. The Danish nurse telling the incident had other patients in her daily job.

2. EMOTIONAL REACTION
The nurse – as well as her colleagues - felt restrained and limited in her professionalism, since she was to some degree prevented from performing her professional duties and activities as usual. This also led to a feeling of being repudiated and distrusted in her professional identity and competence. She felt powerless, being a professional, but not able to support the patient in a proper way, seen from her own self-understanding.

3. What norms / values / representations did the incident touch / threaten / question in the narrator?
The nurse expressed the normative significance as a disrespect and limitation of her professional ethics. This is not at the least a very serious matter in medical world, where people are dependent on nurses and doctors professionalism. Thereby the incident gave rise to more normative dilemmas:
The professional identity: As a nurse, it is the narrator’s task to support the patient; she is part of the structure of the hospice here. By taking over her job, she felt that her expertise is not recognised, and her professional identity is questioned. The professional authority: Furthermore, the authority of both doc-
tors and nurses in the medical world is still quite strong. Even though there may have been many examples of medical carelessness, the authority is in general unbroken. Thus, the action of the adult son works as a degradation of the usual authority in the Danish context. This also works for female nurses, not only doctors. **The attitude towards illness, bodily decay and death:** In Western societies, many laymen are distant from illness, bodily decayed and death. These fundamental human matters have been institutionalized, so to speak. In accordance with this paradigm children - even adults – are not supposed to witness the dying process of a parent or other close relationships. Bodily decay and death are almost matters of taboo. **Concept of a family, role of children:** The Western/Danish family is in general nuclear, which also implicates that generations do not stick together as closely as in the former days. Generally spoken, family members are not so dependent as they used to be in a historical light. This is the other side of the institutionalization of illness and death. **Individualism:** Furthermore, the family structure and diminished responsibility and reciprocity implies that each family member has “a right” to follow her/his own needs foremost. Staying day and night by the mother’s side would in general be perceived as a sacrifice and not a wish to be close in the process of death.

### 4. Based on the analysis of question 3 what image does the narrator have of the other person?

Seen from the “Western” perspective the nurse and her colleagues got the impression that the Japanese mother somehow dominated her son. It seemed as if the mother wouldn’t allow the son to have his own life. The relationship between mother and son was interpreted as if the mother had excessive expectations and demands to her son. At the same time, the son seemed to be too considerate. The staff maybe looked a little bit down on the son, while he was so obviously given up his own life in this period of time. In their eyes he failed to fulfil his own needs, though he is a grown up man. Thus, the general view on the Japanese family was not entirely negative, but somehow sceptical and dissociative.

### 5. What could be the norms / values / representations of the other person / culture that led to the specific behaviour that caused the shock experience?

The interpretation of this incident may follow to directions: A family track and an economic track.

**According to the family track,** the Japanese/Asian family in general has other norms, values and traditions as for taking care of each other within the family. These are norms and values as: (i) Respect for elderly people and parents, (ii) Higher priority and primacy of collective family needs for individual needs. In addition, there may still be active hierarchies within the families in the way that elderly people enjoy a special respect and should be obeyed.

**According to the economic track,** Japanese citizens are used to a hospital system, where they pay for the care of family members hospitalized. This may represent high costs that the families may reduce by providing some of the daily care themselves. It is reasonable to believe that the Japanese son not only was acting upon family structures and cultural traditions. He may as well be acting upon the economic expenses by taking over the main part of the daily care of his mother in the hospice.

### 6. Does the situation highlight any problem concerning the professional practice, or in general about the respect of cultural differences in intercultural situations?

**Firstly,** there is a significant dilemma between the norms and traditions of the Japanese/Asian family and the Danish/Western welfare system, where “the state” has taken over both the responsibilities and the care of the traditional family in civil life. The incident shows the importance of being aware and conscious of different norms and traditions and expectations concerning care of ill family members.

**Secondly,** there may be important economic motivations behind the son’s behaviour. He may believe that he can reduce the costs by taking over as much as possible himself. Seen in this light the incident give reasons to wonder, whether the son and his mother were properly informed about the Danish subsidy system, also in a private hospice.
BEST PRACTICE on cultural diversity in the domain of HEALTH

The following Best practices are shortened; to read the full version download the Best practices Reader

Interactive ONLINE TOOL visually showing the Best practices in the domain of Health

Change for Chicks

Needle exchange only for women- Harm reduction programme- Intervision case discussion

Budapest, Hungary

The idea of regular case discussion sessions addressed to female colleagues working in “Women’s Day” program arose as a consequence of some considerations: (1) the special needs of female clients are more efficiently being handled if social workers give regular feedback about clients to each other. (2) it is necessary to discuss and analyze all the cultural specificities of the clientele (race, socio-cultural background, gender, family status, etc.) to provide a more efficient support to the clients – a special forum has been created for this purpose. (3) we realized how important it was to handle social workers’ emotions, and helped them to reflect on their own cultural, social and personal background which can have an effect on their daily work with clients.

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References: http://www.kekpont.hu/

Hadassah Ein Kerem Group of the Interfaith Encounter Association

Health equity for all people in Israel –Through promotion of cultural competences

Jerusalem, Israel

The Interfaith Encounter Association organized regular encounter, joint study and conversation session in particular topics. Cultural competence is a relatively new topic in Israel that has not been integrated into healthcare education. Most healthcare professionals don’t have cultural competence and will need to learn how to incorporate this care into practice. The Dr. Anita Noble founded the first interfaith group for health care professionals in Israel as a framework for joint study and conversation after approaching the Interfaith Encounter Association. The forum allows healthcare professionals to discuss cultural issues that occur in the healthcare setting and find culturally competent measures to address an issue.

Contact: Yehuda Stolov, yehuda@interfaith-encounter.org
Reference: http://interfaithencounter.wordpress.com/

Motivation to Improve Health Conditions

Elsinore, Denmark

Migrant women have many health problems, they see doctors and specialists, but do not always comply with the given advice. To encourage the women to understand and implement concepts related to health, Vitamin D is used as a catalyst for this process.

Contact: Elisabeth Vedel, eve@horsholm.dk
Reference: http://www.mhtconsult.dk
Light Speaking of Heavy Matter

Denmark

People with so-called overweight problems often feel guilty and stigmatized and cannot achieve loss of weight, even if they follow qualified professional advice. The training deconstructs the dominant discourses and narratives of “overweight” in our society.

Contact: S. Kaastrup, kaastrup@kaaberkaastrup.dk / Anne Kaaber, kaaber@kaaberkaastrup.dk
Reference: http://www.kaaberkaastrup.dk/profiler.php

Voices and Choices: Art Images on Breastfeeding

France

This activity facilitates dialogue between health professionals and soon-to-be/new mothers about the feeding method they will choose for their new babies. Using the photo-language method, a health professional presents participants with images related to breastfeeding in different cultures. These images are meant to spark discussion on common myths surrounding breastfeeding and to empower the women to make informed choices on how they will feed their babies.

Contact: Véronique Blouet, Veronique.blouet@valdoise.fr
Reference: http://www.codes91.org/content/heading1739/content19687.html

The Body is Also

Health promotion project for foreign non-accompanied minors and the professionals who work with these young people

Belgium

When they arrive in Belgium, young migrants are often in situations in which they are on their own to face the changes in lifestyles, norms, and conditions of their new country. Such a precarious situation can be damaging to their physical, psychological and social health, potentially leading to unwanted pregnancy, domestic accidents, sicknesses related to diet, etc.

This project serves as a springboard for health professionals working with these migrants and facilitates discussion on a variety of themes related to “the body”: emotional and sexual life, domestic accidents, hygiene, self-esteem, etc.

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

By 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.

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 – 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.”

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.

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 draw-
ing 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).

**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 differ-
ent, 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.

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, www.endlink.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 religious or theological questions, Richards and Bergin (ibid.) suggest involving a spiritual leader from the given faith. Experiences show that staff who understand 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 it 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 women 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 health-
care 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.

**Literature**


**Online**

Endlink.lurie.northwestern.edu (EndLink – Resource for End of life Care Education)

Ikas.dk/Den-Danske-Kvalitetsmodel.aspx (Den Danske Kvalitetsmodel, developed by Institut for Kvalitet og Akkreditering i Sundhedsvæsenet).
Depression, Women and Culture

By 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.

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.

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 a 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.
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 menstruations 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 lead to research into health maintaining factors. Seligmann has lead 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 or 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 counties – 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, i.e. people who are being examined to establish any actual gender differences. Initial results indicate that women, in all of the professional groups involved, 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.
## WHAT IS HEALTH?

<table>
<thead>
<tr>
<th>Aim of the activity</th>
<th>Introducing the participants to the intersection between culture and health – including differences in cultural concepts of body, health and disease.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills to develop</td>
<td>Creating awareness of cultural approaches, hierarchies and exclusive manners connected to health and disease.</td>
</tr>
</tbody>
</table>
| Procedure:          | **“What is health?” – exercise instruction**  
  - 2 (or more) large paper sheets are placed on the wall. One sheet is named “Health” and the other “Disease”.  
  - The participants are asked to write spontaneous key words for the word of “health” respectively the word “disease” on small post its to be put on the sheets.  
  - When the participants are ready, they are asked to stick the post its on each of the paper sheets on the wall. Everybody is having a look on the various keywords.  
  - The participants sits in a circle and are now asked to consider, which of the keywords are specifically connected with professional experiences. The participants briefly explains the concrete experiences for each other.  
  - The facilitator writes the professional keywords for “Health” and “Disease” on new paper sheets, marking them “professional concepts”.  
  - If all the keywords mentioned arise from a Western health system, the facilitator adds some keywords for “Health” and “Disease”, arisen from Eastern treatment traditions.  
  - The facilitator asks the participants to reflect on the feelings, values and ethics that they associate with the different cultural concepts and traditions for healthcare, disease pictures etc.  
  - The facilitator concludes on the fact that when “Health” and “Disease” are subjects of adult training, supervision and guidance, we may operate in a field of invisible concepts, tradition, ethics and values, which may inflict on the communication and the learning processes of the adult trainees. |
| Debriefing:         | Common evaluation in a group round as well as through a “warm evaluation”. |
| Hints for facilitators: | If the exercise is made in a heterogeneous group of participants, the facilitator should be much aware that the exercise is carried out in an inclusive and appreciative atmosphere and also that all participants are comfortable and are having... |
their voice in the discussions without being affected by “hidden hierarchies” in the group.

| Preparation needed: | The facilitator should have some knowledge of cultural approaches to health and disease to be able to respond to and perspective the inputs of the participants |

| Tool overview |
| This tool is for | A minimum number of participants to maintain some group dynamic |
| Materials needed: | • Large paper sheets  
| | • Markers, big and small  
| | • Post its |
| Duration: | 30-45 minutes |
Shared concept – In a gender perspective

The concept of Gender distinguishes between biological and social sex. This concept puts the accent on characteristics, attitudes and behaviours linked with femininity and masculinity. The roles linked to Gender change through times and cultures but also according to age, disability, class, political status, sexual orientation, etc.

Gender is traditionally defined by society in the simplest way (male and female OR male, female and “third gender”).

BODY seeks to go beyond these basic dichotomy or trichotomy as we believe that individuals don’t fit the opposite standards that do not respect their individuality as human beings. Thus, Genders are as many as humans on earth: “Gender fluidity is the ability to freely and knowingly become one or many of a limitless number of genders, for any length of time” (Kate Bornestein, Gender Outlaw: On Men, Women and the Rest of Us, Rutledge, New York, 1994).
GENDER related Critical Incidents

Research results
Impact of cultural difference in the domain of GENDER

A total of 22 incidents were collected in connection to gender issues (excluding those dealing with sexuality). Most of the incidents revolved around issues of separation of gendered roles: triggered by the fact that different cultures (national or even professional) prescribe different roles for women and men in a variety of domains of life, including everyday responsibilities, communication styles, dress codes.

- **Separation of gender roles.** It may be a widespread preconception in modern western societies the separation between gender roles tends to decrease. However, several incidents suggest that such differences may exist today not only in distant cultures. *Gendered grief (HU)* for instance points to gender differences when concerning expression of emotions and grief. The *Woman trainer (HU)* reveals the stereotypes and prejudice that a young woman had to overcome as trainer in the business sector.

- **Gender roles and hierarchy.** If the *Woman trainer (HU)* reveals a hierarchy existing in a professional culture, the incidents *Challenge (IT)* and *Lebanese father (DK)* reveal cultural positions where women are not supposed to occupy power positions, and in particular they are not supposed to be in power positions above men. In *Challenge (IT)* a young Palestinian student directly challenges a woman facilitator putting in doubt her competence explicitly because she is a woman.

- **Separation of roles in household.** *Husband, Women’s role, Men’s role (HU)* are three incidents whose protagonists are from Hungary’s most important cultural minority group, Roma. The incidents reveal the clash between a preference towards a balanced, fairly symmetrical division of tasks and responsibilities and the expectation towards traditional division, or even a non-traditional, but still clear division of tasks. In all three situations the men are in the dominant situation, having power on their partner’s autonomy, which is resented by the professionals representing a highly individualist culture.

- **Physical separation.** The division of gender roles is often marked by the clear demarcation of spaces for women and men. In *Theatre workshop (FR)* a French artist finds out that art workshops are not perceived as proper spaces for the African men living in the Parisian suburb. In *Meeting in the Turkish house (DK)* the narrator is shocked by discovering that the female audience is seated behind a curtain in the cultural centre. In *Homework Café (DK)* a 12 year old girl cannot benefit from educational resources because she ‘s not allowed to attend alone such a space, where boys are also present.

- **Femininity and children, young girls.** Children’s socialisation into gender shows a great cultural diversity, as to when and how children should start to become “gendered”. *Little girl with make-up (DK)* is the culture shock experience caused by a Palestinian mother bringing her three years old child to kindergarten wearing make-up. *Mixed playing (FR)* shows that in some Indian cultures the separation between boys and girls start very early. Finally, *Proposal (HU)* reveals the confusion of an educator asked for advice by a father whose 13 years old girl has been asked to marry into a Roma family. What is the right age to become woman, wife? To what extent is our conception of right age cultural?
• **To be gendered or not to be: issues of dress code.** If in some cultures there are clear prescriptions as to how women (and men should) be dressed in public (see Forearm, DK), several incidents lived by “natives” show how implicit expectations can create tension. In *Overdressed* (HU) a participant at a training is criticised for being too dressed up by her colleagues, while in *Sexually dressed in exam* (DK) and *Sexually provocative dress in library* (DK) are culture shocks between a preference for non-gendered dressing style and an explicit feminine dressing style preferred by some Bosnian women. All three cases testify of a search for how to handle and present femininity in the post-sexist societies: do all feminine dressing styles necessarily reflect internalised oppression?

• **Acculturation.** The incidents linked to dress codes already testify of difficulties to adjust for cultural preferences that are not clear and explicit. Nevertheless, several incidents reveal an expectation on behalf of western trainers and educators for the migrant women to embrace the western interpretation of gender equality and women’s emancipation. Acculturation in particular shows the surprise of two women trainers when they meet women from Maghreb countries having lived more than ten years in France, without acculturating to the French models of women’s roles.

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**Quick summary of critical incidents related to gender**

<table>
<thead>
<tr>
<th>Belgium</th>
<th>Denmark</th>
<th>France</th>
<th>Hungary</th>
<th>Italy</th>
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</thead>
<tbody>
<tr>
<td>Little girl with make-up</td>
<td>Acculturation</td>
<td>Husband</td>
<td>The challenge</td>
<td></td>
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<tr>
<td>Meeting at the Turkish home</td>
<td>Storytelling</td>
<td>Gendered grief</td>
<td>Introduction</td>
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<tr>
<td>Homework café</td>
<td>Seduction</td>
<td>Women’s role</td>
<td></td>
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<td>Forearms</td>
<td>Dressing up</td>
<td>Men’s role</td>
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<tr>
<td>Sexually dressed in exam</td>
<td>Theatre workshop</td>
<td>The proposal</td>
<td></td>
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<tr>
<td>Sexually provocative dress in library</td>
<td>Mixed playing</td>
<td>The woman trainer</td>
<td></td>
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<tr>
<td>Interruption</td>
<td>Transgender mirror</td>
<td>Overdressed participant</td>
<td></td>
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<tr>
<td>Lebanese father</td>
<td>Transgender authenticity</td>
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</tbody>
</table>
CRITICAL INCIDENT: “SEXUALLY PROVOCATIVE DRESS IN LIBRARY”
[Collected by MHT Consult, Denmark, 2012]

Professional educational domain
Gender / Sexuality / Body

Sensitive zone
Exposure of sexuality in the public sphere.

Culture of the person experiencing the shock
The narrator is a Danish female teacher, 58 years old. She is working at a language centre. She is used to work with students from other countries and cultures for many years. She is known to be a very professional and experienced woman with high standards of professionalism – also with experience from staying abroad in various countries for some years with her family. She may be characterized – and would certainly characterize herself – as a feminist or at least a woman with a strong sense of gender equality.

Culture of the person “causing” the shock
A Bosnian female medical doctor around her late thirties, learning Danish in the language centre.

Describing the SITUATION
In our Language Centre we have a special school library, where all our adult students have the opportunity to work with assignments on an independent basis. One or two language teachers – also being supervisors and consultants - are always present in the library to guide and support the students in their studies. One day I was on guard in the school library, where a group of about 10 adult students were working. All of a sudden I registered a certain unbalanced atmosphere. The source seemed to be a Bosnian female student, who was sitting at a table wearing a very low-necked dress. The female student was from my knowledge a Muslim.

1. Elements of the SITUATION
The incident took place in the library of a language centre. Present in the library was the female language teacher/consultant. Apart from the teacher were about 10 students present in the room, 8 male and 2 female students – all adult students. The male students circled around the table with the sexually dressed Bosnian woman.

2. EMOTIONAL REACTION
As the teacher and consultant in the school library the female teacher felt herself to have a professional responsibility to keep a certain calm, quiet and concentrated working atmosphere in the library. Thus, the teacher was annoyed by the behaviour of the Bosnian female student for obviously disturbing the concentration in the room. The teacher felt a little bit offensive, while this woman was so openly challenging the male students in a sexual way - and dressed up for a party.

3. What norms / values / representations did the incident touch / threaten / question in you?
The teacher expressed her own preference for a daily work dress code, being different from the way people dress up for parties. Actually, the language centre has some dress code among the teachers. It is not a very formal dress code. It allows the teachers and other employees in the centre to dress casually to some extent. The teacher herself was used to dress rather casually and not specifically feminine. Also, many of the adult students – both male and female – come from countries, where it would be rather offensive and even forbidden to dress up in a public institution in sexually challenging way. In addition, this incident also brings about more general reflections on the “backdrop” of the normative reactions in the situation:

Formal equality: The Danes emphasize equality in all spheres of life. The ideal is that everyone is equal and must have the same rights regardless of gender, social or ethnic background. This might transfer also in the
academic sphere. The dress code in Denmark is rather informal, but the students are still expected to adapt neat, modest and casual attire.

**Acculturation:** The narrator considers the adaptation as non conscious phenomena that takes place almost automatically as we learn the new lifestyles, rules, priorities of the new environment. She maybe expects that Bosnian women would adapt to Danish lifestyle and take up established cultural norms quickly but may not consider the fact that cultural adaptation is learning process that in most cases happens through a long period of time.

**Stereotype about a Muslim woman:** The Danish teacher’s surprise might also be caused by widely established beliefs and stereotypes about how typical Muslim women should look. Many times the image that first comes to our mind is that of a fully covered woman, in a traditional dress (‘burka’). We do not think that there might be women, who do not follow this dress code, but are nevertheless Muslim.

4. Based on the analysis of question 3 what image do you have of the other person?

The impression of the Bosnian female student was actually rather negative and offensive. The perception was that this woman did not distinguish properly between working life and private life with regard to the dress code. She allegedly attended the school and the library in order to do some serious language learning, being highly educated from her homeland, and therefore with a clear interest in learning Danish in order to promote her own employment opportunities in Denmark. Dressing up like this she seems to be inappropriate in the environment. This may surprise me even more as she is actually highly educated from her homeland – and also a Muslim.

5. What could be the norms / values / representations of the other person / culture that led to the specific behaviour that caused the shock experience?

**Display of femininity:** At scientific conferences in Eastern Europe, many female scientists appear very femininely dressed. It seems to be usual to stress your femininity in public, not to be as much a taboo as in many of the modern Western countries. One explanation for that could be that this trend of gendered dressing is a consequence of the forced emancipation during the socialist period. In general compared to Scandinavian cultures most Eastern European cultures are far more masculine in the sense of greater division between gender roles. **Multiple cultural references:** Each of us has several cultural identities, and our behaviours, values are negotiated between the different cultural positions. The woman in this case, is both Bosnian and Muslim, and her behaviour, dress code does not only reflect her religion (or our representation of it) rather the larger cultural era where she lives. Also, apparently there is no discrepancy between being a Muslim and being a woman dressed in a very female and sexual manner.

6. Does the situation highlight any problem concerning the professional practice, or in general about the respect of cultural differences in intercultural situations?

**Muslim/Religious beliefs:** Even though Islam is a prevalent religious belief in Bosnia, the country has been subjected to a lot of influence from the West, therefore the attitudes towards religious practice seems to be more flexible comparing to some other countries that are traditionally Muslim. Therefore it might not be unusual that a woman of Muslim beliefs dresses up in clothes that are not usually associated with Muslim practice. It may also be possible that other beliefs and values are more important to young Bosnian woman (e.g. such as fulfilling the role that is traditionally expected from woman in Bosnia). **Gender Hierarchy:** Bosnia is one of the countries which is still primarily patriarchal. Balkan family structure was traditionally based on a male-dominated system of regulations in which the worst position in the hierarchy was that of a young woman. Her most important role was seen as a mother and children breeder. Woman who failed to fulfil this role were often seen as worthless and faced discrimination from society, as ability to attract men audience was seen crucial to her identity. Even though nowadays women are gaining more power and in-

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**Adult Trainers’ MANUAL**  
www.bodyproject.eu
dependence and are taking up roles others that those connected to family life and structure, their inability to attract men might still be frequently looked down upon. The incident described by a Danish woman should therefore be seen in this socio-cultural context, in which women are still highly influenced by prescribed traditional roles. Although the incident described happened in Denmark, the cultural patterns are often internalized and the transition to more egalitarian society often does not bring the change in perception of women's own role and place in society. Many women still seek their acceptance by following the traditionally prescribed social norms. For a lot of them an exception from this existing socio-cultural model would have had much worse consequences than remaining in a subordinated position.

**Masculinity:** In addition to this, despite the fact that women are increasingly gaining access to higher education, higher position in society are still many times reserved for men and women often face – or touch – the so called 'glass-ceiling'. In conquering this obstacles women might sometimes try to use different strategies. Exposing body parts and dressing seductively could be one of the ways used for that purpose. The described behaviour of young Bosnian women could therefore also been seen as their way to earn a respect.

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**CRITICAL INCIDENT : “Transgender authenticity”**

[Collected by ARS Erotica Foundation, 13 April 2012]

<table>
<thead>
<tr>
<th>Professional domain</th>
<th>Gender / Body</th>
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<table>
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<tr>
<th>Sensitive zone</th>
<th>gender relations, body image, gender roles</th>
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<table>
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<tr>
<th>Culture of the person experiencing the shock</th>
<th>40-year-old, educated, middle-class woman, psychologist open to LGBT issues,</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Culture of the person “causing” the shock</th>
<th>Young transgender woman (a man with a female identity)</th>
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**Describing the SITUATION**

A lesbian film club plays films about the life of lesbians and the problems they have. Afterwards the films are discussed by the audience with the involvement of subject-matter experts. Last time I was moderator of the discussion as a psychologist. In the audience there was a transgender woman (a man with a female identity) who actively contributed to the discussion. In one of my interactions, when I wanted to pass the floor to her, I said: "Now let’s listen to a man’s opinion."

**1. Elements of the SITUATION**

1. (What happened?) Incident with a transgender man who has a female identity
2. (Who?) The narrator (psychologist but a moderator in a film club) and a transgender woman.
3. (What exactly happened?) The narrator made reference to the protagonist’s original gender, ignoring her self-image.
4. (where) It happened in an open discussion in a film club.

**2. EMOTIONAL REACTION**

I was embarrassed and wanted to correct my mistake so I called her female name.

**3. What norms / values / representations did the incident touch / threaten / question in the narrator?**

Acceptance of diversity, endorsement of claimed identities:

- Trainers working in the multicultural field are expected and expect from themselves the endorsement
the identity positions chosen by participants, be that cultural, sexual etc. This is a kind of occupational criteria.

**Professionalism:**
- As a psychologist intervening after films dealing with sexual orientations the narrator was embarrassed by her own reaction of not attributing the appropriate gender identity to the transgender participant. She may interpret this incident as a lack of professionalism.

**Gender is not biological, but social and can be changed:**
- Our societies have (to some degree) accepted the idea that people can freely chose their gender identity.
- Nevertheless, research has shown that we categorise the people we meet in a matter of seconds without conscious effort according to three criteria: age, ethnicity and gender. Although gender is cultural, making the difference between man and woman seems to be a very basic categorisation in our social perception. In this incident the basic categorisation according to some primary signs preceded the more elaborated learnt categorisation (whereby gender is not biological but chosen).

### 4. Based on the analysis of question 3 what image does the narrator have of the other person?

For the narrator the transgender woman was neutral.

### 5. What could be the norms / values / representations of the other person / culture that led to the specific behaviour that caused the shock experience? *(Hypothesis!)*

**Identity threat:** For any person being addressed as member of the other gender directly questions and threatens their gender identity. Most transgender women face that threat more often than other people due to some of their primary masculine characteristics (height, voice etc.). Furthermore whenever they are addressed as men they can never exclude the intentional re-categorisation and intentional refusing to accept them as women. **Gender identity is cultural not biological:** For transgender people gender is defined by culture, by subjective identification rather than the primary biological signs. This focus on the cultural aspect of gender is one of the reasons why transgender people do not necessarily opt for the biological transformation via surgery. **Between relativisation and essentialisation of gender:** The transgender position assumes that gender is always cultural. At the same time it also assumes a male/female binomial opposition, which is different from the contemporary tendency of conceiving gender as not just two extremes but a variety of nuances between the two and that each of us makes their own gender mix. Transgender people move from one gender identity to a precise other gender identity, and for the movement to make sense that other gender identity has to be well defined, not relativised. A male to female gender transition cannot take place of the destination position is a relativised feminine-masculine position, only if it is a somewhat traditional conception of femininity.

### 6. Does the situation highlight any problem concerning the professional practice, or in general about the respect of cultural differences in intercultural situations?

*"I had a cognitive dissonance: my slip of the tongue revealed that unconsciously I had a traditional gender conception. “* The narrator’s comment points to the fact that up to the present, most people in modern western societies could say the same, having deep down a traditional gender conception. This is reflected by the research on perception, which indicates that we categorise others in terms of gender automatically, without conscious effort and immediately. Whoever slips this categorisation stops the process of automatic perception and we find ourselves wondering: “is this man or a woman?” And though our conscious mind has learnt that gender is indeed cultural and that we would like to have and give the freedom to move between genders it takes time until this acquired freedom is reflected by our automatic perception functions.
**BEST PRACTICES ON CULTURAL DIVERSITY IN THE DOMAIN OF GENDER**

The following Best practices are shortened; to read the full version download the Best practices Reader

Interactive ONLINE TOOL visually showing the Best practices in the domain of Gender

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**Volunteer Training for “Melegség és Megismerés”**

Awareness raising program for teens and school teachers about LGBT issues

_Budapest, Hungary_

The aim of the training is to train volunteers who will work in the awareness raising programme whose final aim is to fight stereotypes and homophobic reactions against lesbian, gay, bisexual, transsexual and transgender (LGBT) people in schools. The training helps to overcome the stereotypes and to face questions about gender and sexual identity.

The training aims at challenging stereotypes by proposing new approaches in order to face questions about LGBT and gender within a non-formal educational context (in schools!), by using interactive exercises.

**Contact:** Zsolt Virág, info@szimpozion.hu, +36-30-5958274

**References:** [http://www.labrisz.hu/mm](http://www.labrisz.hu/mm)

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**Put this on the {MAP} / Reteaching Gender & Sexuality**

_United States_

The project has been developed to address educational, health, and wellness disparities experienced by queer* youth and young adults. The project resulted in a FILM – “Put this on the {MAP}”- and a WORKSHOP- “Reteaching Gender & Sexuality”- that fill gaps in training for professionals who work with young people in social services, mental health, education, employment services, arts and recreation programmes, and other community or cultural centres. The project addresses gender and sexual diversity across a spectrum of multi-cultural experiences, identities, and expressions.

**Contact:** Sid Jordan & Megan Kennedy, info@putthisonthemap.org

**References:** PUT THIS ON THE {MAP} [www.putthisonthemap.org](http://www.putthisonthemap.org)

Reteaching Gender & Sexuality, [www.reteachinggenderandsexuality.org](http://www.reteachinggenderandsexuality.org)
Accepting different gender identity

Copenhagen, Denmark

Parents are trained to accept and cope with children, whose behaviour does not match cultural gender expectations. The parents are gradually made to change their norms as they understand, that their children can perform normal actions.

Contact: Nicolai Ardal, nicopolitis@gmail.com

LUCIDE: Youth and Gender Module

Sexist-Discrimination: Learning to See; Acting for self and others

France

The goal of this training tool is to teach young people to identify sexist attitudes and behaviours, to understand the mechanisms that lead to discrimination and to become conscious of its impact on health (mental, social and physical well-being). It was developed by a group of professionals who were interested in the way sexist discrimination can have direct consequences on the health of men and women. In addition to the “Youth and Gender” training guide for health and social sector professionals, the LUCIDE program includes resources for teachers, students and professionals in the social and health sectors, as well as evaluation tools and guides.

Contact: Marielle Martinez, infos@lucide-contre-toutes-les-discriminations.org
Gender: Boundaries of Identity in a Multicultural Perspective

By Noemi De Luca

The concept of gender in its binary opposition male/female linked to characteristics, attitudes and behaviours 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 behaviours 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.

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. 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 exploring 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.

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

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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 behaviours 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 philosophy 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 androgyous 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 [...]”

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

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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. 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 describes the scheme that the “authority” (i.e. 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 behaviour. 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. Peripheral sexualities were therefore obscured in the discourse about sex, in order to silence a threat to economic productivity, which would be in turn favoured by forms of sex functional to procreation. 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”.

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.

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

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5 Foucault, Michel, La Volonté de Savoir.
6 Foucault, Michel, La Volonté de Savoir.
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. 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 Butler 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 θηλυκός (female), and that this binary scheme applies to gender, so that we have a masculine (ανδρικός) and a feminine (γυναικείος) 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/sesso 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”. 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 behaviour 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 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. By writing in a mixed style, using several languages and different literary genres, Anzaldúa directed her at-

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tention 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).11

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.12

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 particularly oppress all of us, lesbians, women, and homosexual men, are those which take for granted that what founds society, any society, is heterosexuality.”16 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

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 Deuxième 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.” 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?”14

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”.15 Monique Wittig, French feminist and novelist, author of several books (L’Opoponax 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”16. 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\textsuperscript{17} 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.\textsuperscript{18}

The term Queer theory was coined in 1990 by Teresa De Lauretis, initially to avoid all the confusing terminology to address gay and lesbians.\textsuperscript{19} 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 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.

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.\textsuperscript{20} 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.\textsuperscript{21}

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 behaviours and actions not related to the binary opposition male/female.\textsuperscript{22} 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”.\textsuperscript{23} 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”.\textsuperscript{24} 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 them\textsuperscript{25}, but the mere fact of re-enacting 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

\textsuperscript{17} Irigaray, Luce, Ce Sexe Qui N’Est Pas Un, Paris: Editions de Minuit, 1977.
\textsuperscript{18} Butler, Judith, Gender Trouble.
\textsuperscript{22} Butler, Judith, Gender Trouble, p. 140.
\textsuperscript{23} Butler, Judith, Gender Trouble, p. 138.
\textsuperscript{25} Butler, Judith, Gender Trouble, p. 137.
able to restore its analytical power for all sexualities.

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 damaging consequences for many individuals: intersexes, 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 behaviour 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.

Bibliographic References


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

By 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.

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 women. 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 im-
posed in a society that, mostly outside of the big urban centres, 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 the political success of the social conservatism can be used to revoke some of the acquired rights, although with a rigid top-down process, during the nearly ninety years of republican history.

**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 favoured 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 Gönlü, 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 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”.

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?
## WORKING TOOL

### Gender Roles

| Aim of the activity | • To understand and analyze gender role’s stereotyping and origins in different cultures.  
|                     | • To decrease stereotypical perceptions and actions towards the gender role behaviours that differ from our own reference cultural framework.  
|                     | • To challenge gender role stereotypes. |
| Skills to develop   | Self-cultural awareness, anti-bias |

### Procedure:

**Introduction:**
Persistence of dualisms in ideologies of gender: a particular view of men and women as opposite kinds of creatures both biologically and culturally, especially considering the ever-changing European socio-demographics.

#### Wo/Men
- nature/culture
- domestic/public
- reproduction/production

1. Divide participants into small groups (no larger than 5 members). Groups can be gender same or mixed groups.

2. Give each of the four groups a flipchart paper divided into two columns – the headings will be either:
   - 1. Different to your cultural framework “(Acting) like a Man”
   - 2. Different to your cultural framework “(Acting) like a Woman”
   - 3. Close to your cultural framework “(Acting) like a Man”
   - 4. Close to your cultural framework “(Acting) like a Woman”

   ![Each group will have a different heading]

3. Ask to draft on the left column (leave the second column blank) respectively a list of what it means to act like a man or woman in a different or a similar gender role behavior - relating to their own cultural framework and personal background and to refer meanwhile to practical examples related to their professional practice. (20 min.)

4. Ask participants to write down what people might "say" or "do" if someone does not act like a man or woman as defined in the left column. This portion of the activity can generate a lively and graphic use of words and discussion. (20 min.)

### Debriefing:

5. Assist participants with analyzing these lists. Possible questions for discussion
include:

- How and where do we learn our perception of male and female roles?
- Do these roles and descriptions limit or enhance us in life choices?
- Have you or someone you know in your work context ever acted differently from how your gender is "supposed" to act?
- What other conclusions/statements do you have about this topic?

Hints for facilitators:
You might refer to the Critical Incident examples of this Manual to provide participants with case studies so to easier come up with practical examples related to their professional practice of what people might "say" or "do" if someone does not act like a man or woman as defined in the left column.

Preparation needed:
Preparation of 4 flipchart papers divided into two columns, writing down the headings as in the procedure box above.

Suggested readings (background methodology and materials):
*BODY Critical Incidents Research, 2012
*BODY Critical Incidents Reader, 2013

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<thead>
<tr>
<th>Tool overview</th>
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<tr>
<td>This tool is for</td>
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</table>
| Materials needed: | 1. Four flipchart papers (divided into two sections).  
2. Markers |
| Duration: | 90 minutes |
Shared concept- In a sexuality perspective

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 of 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 able to understand why other people behave “differently”. This could help us - even in any professional setting - to go beyond stereotypes and biases and give us tools to get connected to others on various levels.
SEXUALITY RELATED CRITICAL INCIDENTS

Research results
Impact of cultural difference in the domain of SEXUALITY

We have collected nine incidents that were related to sexuality issues. They unveil sensitive zones of the separation of professional and personal life, issues linked to preconceptions, finally the question of taboos.

- Separation of personal and professional spheres. We had three incidents where the sexual position of the narrators became a source of conflict and tension. In Lesbian privacy (HU) and Coming out (HU) trainers who were themselves lesbian found themselves in situations where they felt compelled to come out, while at the same time for the sake of self-preservation and neutrality they usually put their own sexual orientation aside. In Lesbian Party (DK) the narrator finds herself involuntary deceiving a lesbian woman who interpreted their bonding far beyond the professional level and expected a sexual interest that the narrator could not reciprocate. Nudity on stage (FR) tells the story of an actor who has difficulties in performing a naked scene: his body remains well his body and not the professional body of the character.

- Gender transitions, crossings. Even if feminist studies have revealed long ago the socially constructed nature of gender, and true, that has been increasing freedom concerning how one lives, chooses one’s gender, often there is still resistance – sometimes on a non conscious level – concerning gender transitions. In Transgender (HU) a psychologist working on gender issues catches herself addressing a transgender woman as “man” and perceiving her as “not convincing”. Naked son in the garden (DK) revolves around the difficulties of a Philippine father – and the staff of a Danish school as well, facing a young boy who likes to go to class with make-up and in women’s shoes.

- Taboos. Sexuality is replete with taboos; in fact all societies regulate sexual behaviour by a wide range of prescriptions and prohibitions. The intimacy you are allowed to display in public usually has a clearly defined threshold. The Sleeping bag (BE) incident tells the story of breaking such a taboo where the protagonists are two men with mental handicap sharing a sleeping bag during an excursion. Nudity on stage (FR) touches the taboo of sexual behaviour of older people. Finally, the protagonist of Satisfaction (BE) breaks an even stronger taboo when she accepts to give sexual satisfaction to her handicapped son. A situation similar to the one depicted in the painting Roman Charity, which shows that the greatest generosity often implies going way beyond our own limits, and breaking our boundaries.

Quick summary of critical incidents related to sexuality

<table>
<thead>
<tr>
<th>Belgium</th>
<th>Denmark</th>
<th>France</th>
<th>Hungary</th>
<th>Italy</th>
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<tbody>
<tr>
<td>Sleeping bag</td>
<td>Lesbian party</td>
<td>Nudity on stage</td>
<td>Lesbian privacy</td>
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<tr>
<td>Satisfaction</td>
<td>Naked son in the garden</td>
<td>Transgender mirror</td>
<td>Coming out</td>
<td>Transgender authenticity</td>
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</tbody>
</table>

Full Reader of Critical Incidents related to SEXUALITY
**Describing the SITUATION**

I’m at a course concerning handicap and sexuality. There is a mother of a boy of 28 years old with a severe physical disability. They live together with the father and the two brothers. The mother says that her son a few years ago had a need to be sexually satisfied. They invited several people offering sexual assistance, specifically people with a disability. But the boy never felt at ease, because he didn’t know those women. They decided, after a consultation with the whole family (the family who lives together – so the brothers and the father), that the mother would carry out this task (hand job) and thus sexuality satisfy her son.

1. Elements of the SITUATION

We were with more than 200 people listening to the woman who told the story about her son. All of the participants were professionals. I just knew my colleague who was also there. I didn’t know the mother. She told the story in a large auditorium. She was sitting in front. It was a learning course for professionals. The audience didn’t know the woman in front, they just listened to the testimony. It was the start of the day, after this testimony, the audience was divided in groups to discuss and learn more about sexuality and disability. The audience didn’t have to give a solution or their meaning. They could ask questions to the mother, what happened. One of the questions was how she feels by giving the hand job to her son and what she thinks about these questions in institutions – if this kind of service is a part of the job of people who work in institutions.

2. EMOTIONAL REACTION

Surprised, uncomfortable.

3. What norms / values / representations did the incident touch / threaten / question in the narrator?

Respect and integrity of the body, respect of the boundaries of assistance. The taboo of incest: in most cultures having sexual relations with members of the family is one of the strongest taboos.

4. Based on the analysis of question 3 what image does the narrator have of the other person?

The mother wants to help her son no matter what, which one can only respect. The question here is whether this is a correct way of acting, even if the son also wants this and the rest of the family agree. The mother doesn’t cause a negative image, but it’s hard to accept.

5. What could be the norms / values / representations of the other person / culture that led to the specific behaviour that caused the shock experience?

Empathy, respect for the needs of the other. Sexuality is subordinated to human emotions and answering the needs for someone how is emotionally very close. Sexuality is treated as a body function, somehow independent from “romantic” emotions.
6. Does the situation highlight any problem concerning the professional practice, or in general about the respect of cultural differences in intercultural situations?

Sexuality and disability are still taboo. It’s a very hard to discuss the topic. Training /information evenings for family, friends and assistants of people with a handicap and for those with a handicap should ensure that the importance of this matter is seen and perhaps people would be more open to communicate about this. Especially, because the definition of sexuality is completely different for people with handicap – professionals, caregivers should pay more attention to each person and family, and be able to neglect the traditional social conceptions of sexuality. It also raises questions on how far assistance can go. What boundaries are there. What is a person prepared to do without crossing his/her own values.

**CRITICAL INCIDENT: “COMING OUT”**
[Collected by Ars Erotica Foundation, Hungary, 21 April 2012]

<table>
<thead>
<tr>
<th>Professional educational domain</th>
<th>Gender / Sexuality / LGBT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sensitive zone</strong></td>
<td>disclosure of one’s sexual orientation - where, when and how, professional versus private personal social roles</td>
</tr>
<tr>
<td><strong>Culture of the person experiencing the shock</strong></td>
<td>The reference frames of the two protagonists are more or less the same. The areas relevant to the incident include: sexual orientation, and how to disclose it; the limitations and framework of the disclosure. 34-year-old lesbian, middle-class, intellectual woman, LGBT activist, trainer, also a mother, living in a relationship</td>
</tr>
<tr>
<td><strong>Culture of the person “causing” the shock</strong></td>
<td>31-year-old lesbian, middle-class, urban, educated woman</td>
</tr>
</tbody>
</table>

**Describing the SITUATION**
The incident happened a few days ago at a sensitisation and communication training for social care professionals, during a session on minority groups, in the warm-up exercise. We played the “Take a step forward” exercise where each participant gets a role card and has to answer questions about minority-related stereotypes from the perspective of the minority-character indicated on the card. In the evaluation part, I asked the participant holding the “lesbian” card what context she placed her character into. And she said she did not have to use her imagination very much as she was a lesbian herself.

**1. Elements of the SITUATION**
The exercise is used to set the stage for the minority groups presentation and discussion. It serves to map out the relations (implicit or explicit prejudices) about minorities, where all the participants are asked (21 of them this time) what additional qualities she added to the 1-2 traits written in the role card to build up the character. And the trainer (the narrator) was asking them what they responded to the questions posed to their character. After the lesbian woman’s coming out the evaluation went on in the usual way. But later when we discussed lesbians, this woman left the room and came back when the topic was finished.

**2. EMOTIONAL REACTION**
Two participants got homosexual role cards (one lesbian and one gay card). First I was shocked for a moment. First I feared for me then for them. Then I went on asking questions in the usual way, raising the question “who else got a homosexual character card?” (because up to that point she was the first) and I told them that the subject would be discussed later in more detail. Fear, conflict. Why did I fear? I feared
because I started to feel the urge to come out (as an expression of empathy).

3. What norms / values / representations did the incident touch / threaten / question in the narrator?

**Empathy, empowerment of particular identities:** The question of the protection of privacy could be relevant. Is it part of the job description of a sex educator / intercultural trainer to unveil all aspects of their identity in an effort to promote those identities and contribute to their empowerment? Or should some level of privacy be preserved for the protection of the person of the trainer/researcher?

**Separation of professional / private spheres, preservation of personal identity:** It is an important principle that in a training situation the narrator doesn’t talk about his or her personal involvement in any minority groups, only about her professional involvement. A trainer should keep nearly equal distance from any minority group – we are outsiders / we must look outsiders. This is the only situation where to be an outsider is of value. In all the other walks of life, open disclosure is a positive value. These two approaches led to a serious conflict of values.

**Professionalism?** Reacting well to the “coming out” of the participant. The narrator talks about her own urge to come out as a means of empathy with the participant. However, there may have been other means of endorsing the coming out of the participant that does not necessarily entail her own coming out. The embarrassment of the situation kept her from being able to find such a solution and she went on with the debriefing as usual. She may have felt the need to do something.

4. Based on the analysis of question 3 what image does the narrator have of the other person?

She was brave. The narrator admired how simply she said it. Although the narrator had liked her (Gaydar phenomenon, based on mere stereotypes), at that moment the narrator started to respect her. She had seemed a confident and healthy personality from the beginning, but the incident even reinforced the narrator’s presumptions. Sense of community – not only because she was lesbian, but because she disclosed it.

5. What could be the norms / values / representations of the other person / culture that led to the specific behaviour that caused the shock experience?

**Mission to assume / promote particular identities:** The fact that the a participant “came out” in a training situation in a completely natural and simple way made the narrator conclude that they had shared values. As a participant of a training, the narrator also normally reacts in a similar way.

6. Does the situation highlight any problem concerning the professional practice, or in general about the respect of cultural differences in intercultural situations?

“This is primarily a professional issue. I was surprised by my own reaction: I saw a participant react in the same way as I usually do, and funnily - as a recipient - I was shocked by it. I’ve got to do something about it, but for now I don’t know what.”

In general professionals involved in action research / training in the domains of interculturality or sexuality would easily face the tension between different values, needs, such as

a) between the preservation of privacy and the promotion / empowerment of particular identities

b) between the need of neutrality / objectivity and the need for sensitization and their mission in general

c) between professional and personal spheres.

There may not be a general recipe, what’s more drawing a general recipe may not even be a good idea. In fact punctually, depending on the case some movement between professional / personal spheres can be a resource in the training / research activities. In each case the trainer / researcher has to evaluate the conflicting values, and be prepared for the possible identity conflicts – threats.
BEST PRACTICE on cultural diversity in the domain of SEXUALITY

The following Best practices are shortened; to read the full version download the Best practices Reader

Interactive ONLINE TOOL visually showing the Best practices in the domain of sexuality

❯ VOLUNTEER SEX EDUCATOR TRAINING
San Francisco, California, US

The aim of SFSI training is to train people to provide accurate, non-judgmental sex information to the public. At the end of training, a trainee should make significant progress in basic sex information, communication and education skills, and personal insight.

The training also helps to overcome the stereotypes related to sexuality and to facilitate links between different groups involved in these questions.

Contact: Michele Jones, tomichelejones@yahoo.com
References: www.sfsi.org

❯ IN BETWEEN US – SEXUALITY IN THE EU
Palermo, Sicily, Italy

The “In between us” workshop was funded by the Grundtvig sectorial programme (LLP). It gathered people from different European countries in the common aim of suggesting new approaches to tackle stereotypes and assumptions about sexuality and to create a space for self and group reflection about personal, national and European values related to sexuality.

The activities developed in an non-formal context were based on the promotion of tolerance and awareness raising about sexual identity thanks to the use of art as a pedagogical tools.

Contact: Maja Brkusain, maja.brkusain@cesie.org

❯ HUMAN LIVING LIBRARY
Palermo, Sicily, Italy

The Human Library is an innovative method designed to promote dialogue, reduce prejudices and encourage understanding. The books in the Living Library are people representing groups frequently confronted with prejudices and stereotypes, and who are often victims of discrimination or social exclusion. The aim of this best practice is to
create constructive interpersonal dialogue between people who would normally not have the occasion to speak to each other. People who act as living books, prepare a story about themselves – sometimes a life-long journey or maybe just an important period in their life. The one-day event was held on March 21st at the ArciBarcollo and involved 11 books telling their stories and who represented sexual orientation, ethnic minorities (LGBT and foreigner community in Palermo).

Contact : Ana Carla Rodrigues Afonso, afonso@ceipes.org

❖ Seks@Relaties.Kom
Sexual experiences of mentally disabled people
St.-Amandsberg, Belgium

SEKS@RELATIES.KOM is a workshop that focuses on sexual education for people with a mental disability. During the workshop, knowledge is shared and information is given, but the most important feature of the workshop is the sharing of feelings and experiences concerning sexuality and the body. To create an easy starting point, the trainer shows pictures about sexuality to the group. Because of the visual aspect and the openness of the trainer, the group feels free to talk about what they see in the pictures and what their experiences are regarding the subject. The workshop demonstrates to professionals and people with a mental disability that sexuality does not have to be taboo.

Contact: Greet Conix, vzwvmg@scarlet.com
Reference: http://home.scarlet.be/~vzwvmg/vmg_nieuw_werkboek%20seks@relaties%201%20en%202.htm

❖ Homophobia Awareness Training: Gay Continuum Activity
Belfast, Northern Ireland

WheelWorks develops art programs with some of the most excluded young people in Northern Ireland. Some of these art-based projects developed with arts facilitators focus on giving LGBT(Lesbian, Gay, Bisexual and Transgender) young people an outlet to “voice” their experiences. Eager to promote its expertise and resources on a wider scale, WheelWorks has partnered with professionals experienced in the issues of homophobia awareness to create a practical training program.

Contact: Lucy McCullagh, lucy@wheelworks.org.uk
Introduction to the intercultural approach of sexuality

By 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 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.

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.26

26 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.
‘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 marind amins. 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 intercourses 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).’

‘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).

What is sex? Definitions of sexuality

As it can be seen from the above examples, consensus is missing even in the same linguistic uni-
verse 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? Defencelessness, 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 increase 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.\(^{30}\) 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.

**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 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 rethink 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." 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 of 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, in as much 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.”

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 formally say, sexual paraphilia – and what is normal. This is how it becomes apparent for the

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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. 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. 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 privatise 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.”

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 sexuality. 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

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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?

What is culture?

‘The intercultural approach is built on the realization 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.

‘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 pantiliners tell us much about our concept of cleanliness. 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.’37 That is why the physical, emotional, behavioural, and social aspects of sexuality have no culture-independent meaning. Because what we consider sexual, erotically attractive or repulsive is also defined culturally.38

“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 part 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. 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.

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.’ 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 Malinowski and Margaret Mead 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 re-

39 L. Drummond 1981-2. “Analyse sémiotique de l’ethnicité au Québec” Question de culture, No.2, 139-153
40 Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation'

42 Margaret Mead: Sex and Temperament in Three Primitive Societies (1935), Male and Female (1949),

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fects 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 together, 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. Racial, ethnic, and national borders are sexual borders as well. One's national, racial, and ethnic identity is most often combined with ethnonsexual boundaries; every ethnicity carefully guards and watches over its own sexuality. Hungarian public life has recently been stirred by the case of MPs Ági Osztolykán (LMP) and György Gyula Zagyva (Jobbik) which happened in the corridors of the Parliament. 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’, 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 gipsy.’ 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 as abnormal, perverted, or unacceptable. This is the source of stereotypes like the lustful, amoral gipsy women, 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


44 http://osztolykanag.blog.hu/2013/02/20/sotetseg_a_tisztelt_hazban

45 http://vagabor.blog.hu/2013/02/21/nemcsak_taho_hanem_gyava_is_vagy

46 http://vagabor.blog.hu/2013/02/21/nemcsak_taho_hanem_gyava_is_vagy
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* has been re-published 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 Johnson 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 – 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.

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.\(^{50}\)

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)\(^ {51}\), 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.\(^ {52}\)

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,


\(^{51}\) 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).

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.\(^\text{53}\)

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.'\(^\text{54}\) 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.

### 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.\(^\text{55}\) 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 biological texts of sexuality are not at all


\(^{54}\) Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation’

\(^{55}\) Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation’
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’. 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* to point at the historical tradition according to 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 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. 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 pantiliners 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.

**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’etre. 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.”

**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 fulfil 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.  

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 civilized society demands of its members. 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.

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’s obligatory, because it’s an expectation, because of intimacy or emotional closeness,

61 Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation'
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 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 heteronormative 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 proxemic rules may easily fall victim to mutual misunderstanding if one of them considers a smaller distance

62 http://www.lelkititkaink.hu/testbeszed_terhasznalat.html
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.63 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.

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 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

63 Vera Várhegyi: The Intercultural Competence Approach; Artemisszió Foundation'
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. 64 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, 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.

64 Vera Várhegyi: The Intercultural Competence Approach; Artesmisszió Foundation’

English translation: Eszter Nádasi
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## "TOUCH"
### Discover your boundaries I.

| Aim of the activity | *To raise the awareness and tune participants for working with intimate issues*  
<table>
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<tbody>
<tr>
<td></td>
<td><em>To experience boundaries in physicality</em></td>
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<tr>
<td>Skills to develop</td>
<td>Awareness and sensitization on own body boundaries</td>
</tr>
</tbody>
</table>
| Procedure:           | Walk freely in the room - meet up anyone and make pairs - follow the instructions and switch partner after every instructions.  
|                      | For participants: If you don’t want to play one task, tell it to your partner!  
|                      | 1. shake hands  
|                      | 2. give a hug  
|                      | 3. kiss each other on the cheek  
|                      | 4. give each other a shoulder massage  
|                      | 5. wink at each other  
|                      | 6. massage the other person’s hand  
|                      | 7. caress each other’s face  
|                      | 8. kiss the other person on the ear  
|                      | 9. rub noses  
|                      | 10. tie up your partner’s hair  
|                      | 11. sit on each other’s lap |
| Debriefing:          | Discussion:  
|                      | • Was it difficult to set boundaries? Why, when?  
|                      | • How do you feel if the other is moving beyond your boundaries?  
|                      | Can you communicate it? How?  
|                      | • Was there a difference when the coach was part of the pair?  
|                      | • Were many tasks performed, or very few?  
|                      | • Was it difficult when one of the pair said no? How did this feel?  
|                      | Which task was the most difficult you? Why? |
| Hints for facilitators: | “Sexual boundaries 1- 2” exercises, which should build on each other. If you don’t have enough time, you can debrief the two exercises together.  
|                      | It is important as you conclude to refer to the objectives. |

### Tool overview

<table>
<thead>
<tr>
<th>This tool is for</th>
<th>8 – 10 participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials needed</td>
<td>Chairs</td>
</tr>
<tr>
<td>Duration:</td>
<td>20 minutes</td>
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</tbody>
</table>
### Aim of the activity
To facilitate reflection and personal feelings how difficult or easy to talk about sexual topics – how can you define and communicate your personal boundaries when you are somehow “forced” to talk about sexuality.

### Skills to develop
* awareness and communication skills  
* improving communication about sex  
* being able to set boundaries  
* overcoming embarrassment

### Procedure:
Facilitators put all the cards with sexuality questions into a big box in the middle of the room. Participants walk freely in the room - meet up anyone and make pairs – take one card from the box! One card per pair! You have 2 minutes answering each question, then switch: now your partner answering the same question. Altogether 4 minutes for pair discussion. Switch pairs 4 times. Facilitators show the time. Make sure there is enough space between the pairs to avoid that neighbors can hear the conversation.

For participants: If you don’t want to answer, tell it to your partner!

Questions on the cards:
1. Is sex important to you?
2. If you want to know something about sex, whom do you ask?
3. What do you do if you find out that you are in love with someone who is already in a relationship?
4. Would you be able to understand it if your boy/girlfriend had sex with someone else?
5. Tell the other person your most recent fantasy about sex.
6. What would you really not like your partner to do during sex?
7. What do you find beautiful about yourself?
8. What sex-related subjects can you talk about with your parents?
9. What do you think about masturbation? Do you masturbate?
10. Would you like to have sex with someone much older than yourself?
11. Would you like to have sex with someone much younger than yourself?
12. Do you know how an orgasm feels?
13. Would you like to have sex with someone of your own sex?

### Debriefing:
- How did you like talking about sex in this way?
- What made it more difficult and what made it easier?
- Was there a difference between the partners you talked with? What was the difference?
- What was it like for those who were paired with the coach? Is there a difference?
- Did you feel during the exercise that it became easier all the time? Why is that?
- During the exercise did you feel that there were a number of questions you didn’t want to answer? Was this difficult or easy?
- Do you regret having said certain things afterwards? Why?
- Which were the most sensitive topics for you? Why?

Hints for facilitators:
“Sexual boundaries 1-2” exercises, which should build on each other. If you don’t have enough time, you can debrief the two exercises together. It is important as you conclude to refer to the objectives.

Preparation needed:
Print the cards, get a box!

Tool overview

This tool is for 8-10 participants
Materials needed: chairs, big box with sexuality questions in it
Duration: 25 minutes

<table>
<thead>
<tr>
<th>DECENTRATION WITH PICTURES</th>
</tr>
</thead>
<tbody>
<tr>
<td>How we feel about sex?</td>
</tr>
<tr>
<td>Is it natural or it has anything to do with our cultural beliefs and values?</td>
</tr>
</tbody>
</table>

Aim of the activity
To facilitate how difficult to differentiate our emotions from our values. How deeply sex is an identity issue – our cultural reference frame determines our emotions and produces strong reactions.

Skills to develop
Awareness - how sexuality is deeply embedded in culture

Procedure:
Give 5-10 minutes for choosing one picture: Chose 1 (only one) picture which makes the strongest emotional reaction in you! Create small groups of 3 people. The groups can evolve according to the picture – people how chose the same picture. If they don’t have common picture they can merge by free choice. Discuss the pictures:
1. What are your emotions? What do you feel seeing the picture? What is the emotional conflict which causes the tension in you?
2. Set of your values. What do you think the values are according to you feel the conflict with the picture you see?
3. Possible values of the protagonist on the picture (hypothesis) – What kind of values do you think the protagonist belongs to?
Groups have 15 minutes altogether to discuss their pictures.

Debriefing:
Discuss it in the large group.
Was it difficult to chose? Each group is invite to chose one picture in their group and share it with the large group. Was it difficult to differentiate between emotions and values? How do you feel as a professional? To talk a bit about sexual cultures. What sexuality mean: erotica, procreation, intimacy, body issues, sexual identity, sexual habits? Where are our boundaries? How can we deal them? (15 min).

Conclusion and continuation to the next exercise: We have physical and emotional boundaries, taboos, which vary from person to person but it is important to be able to handle them if we can recognize the cultural component behind our often automatic reactions. The Decentration exercise shows that every time we cross those boundaries strong and deep emotions can came up and we may face difficulties controlling them. “Touching” our boundaries is a sensitive ac-
ization as it always influences our core emotions, core values, the basis of our identity (or identities).

Hints for facilitators:

It helps to mediate the discussions if facilitators knows that finally they want to discuss what is considered cultural if we talk about sexuality and how different everything (the body, body functions, beauty, concept of womanhood, manhood, motherhood etc., sexual practices) depending on a particular culture where they appear.

You can help the small group work with suggesting them to chose one person who is responsible for checking continuously the list of emotions, one is the instructions and one the time. Don’t bother the intimacy of the groups walking by, just in case they ask for assistance!

Preparation needed:

Put the pictures on the wall – volunteers help to facilitators. Give a list of emotions to each participants.

Suggested readings on the topic (background theory or methodology):

*Dora Djamila Mester, 2013. Introduction to the intercultural approach of sexuality - BODY anthology
*Margalit Cohen Emerique: The Methodology of Critical Incident - BODY anthology

Tool overview

This tool is for 10 participants

Materials needed:

1. Sensitively and carefully selected pictures in the theme of sexuality. The selection should reflect not just a wide variety of sexual cultures, habits, but also must show very natural, everyday images. They should be printed and put on the wall in a relative distance. The number of the picture should be no more than 10.
2. List of emotions

Duration: 40 minutes
Shared concept- In a disability perspective

The concept disability does not cover one type of person, but implies a great variety of disabilities that all have their own characteristics, needs and ways of approach. So we can already view these different groups from an intercultural perspective. Within a larger intercultural context changes in age, gender, sexuality, ethnicity, religion, etc. also cause changes in the way that disability is looked at.

The key to successfully dealing with disability lies in the understanding that the differences, within a smaller and larger intercultural context, have to be acknowledged before inclusion can be achieved.
We collected 27 incidents related to disability, out of which the majority (16) come from Belgium, where our partner organisation proposed workshops that focused specifically on disability. The cases offer a diversity of themes and situations, the most recurring being: the question of autonomy and reciprocity, representations of disability, issues of discrimination and inclusion, and finally taboos concerning intimacy and privacy.

- **Respect of autonomy** The incidents *Cooking lesson*, *Banking* (IT) and *Travel* (BE) revolve around the question of the autonomy of people living with disability. In all three situations, benevolent carers or observers assume that the handicapped person needs help to perform a certain action (whether it is crossing the street, participating in a cooking workshop or withdrawing money) and this takes them almost to perform the action instead of the handicapped person, who in fact were not in need of such support that is almost perceived as intrusion.

- **Reciprocity**: connected to issues of autonomy are those linked to the need of reciprocity – a powerful social rule in virtually all societies, regulating the equal engagement and respect of participants in an interaction. When people are restrained to the position of the permanent receiver, this takes away their opportunities to give back, thus to participate in the circle of reciprocity. It reinforces inequality, even when at the source it is a good willed, helping attitude (see the *Aunt*, BE).

- **Representation of handicap, of handicapped person.** Despite the (slowly) increasing integration of people living with disability, stereotypes and preconceptions still abound. Most of these preconceptions are connected to our expectations of what a person with disability can or cannot do. What’s more, even people whose daily work is connected to disability issues can possess some implicit attitudes, and when they suddenly surface they create embarrassment and shame, for instance in *new year’s speech* (BE), where the invited public speaker turns out to have a mutilation on her face, or in *theatre festival* (IT) where the narrator meets a theatre performer without arms. A strong preconception concerning connected to disability is the binomial opposition of *beauty* and handicap: what is handicapped cannot be normal and most of all cannot be beautiful. The incident *Beauty* (HU) tells the story of a woman who suddenly becomes aware of this powerful preconception when she finds herself admiring a young man who turns out to have a disability.

- **Discrimination, exclusion vs. integration.** Stereotypes sometimes give way to acts of discrimination, committed by more or less informed people with more or less intention. In the *Party* (BE) incident young people without disability ask the people with wheelchair to move away from the dance floor because they take too much space. Similarly in *Cinema* (BE) there are no wheelchair places in the theatre hall because they take too much space and thus reduce profits. The incidents *Article* (BE) and *Guilty* (BE) talk about persisting prejudice against people with disability. If there is consensus on the refusal of acts of
discrimination, how to reach inclusion and integration is not evident at all. The situation Icebreaking (IT) points to the risks of trying to anticipate too much the particular needs. Indeed, the trainer conscious of the inclusion of a participant in wheelchair reworks her series of icebreakers so that it includes sitting exercises, with which she painfully points out to the person with the handicap. What amounts for good inclusion? Changing the whole programme in accordance with the (perceived) special needs? Or should it be something else?

- Breaking taboos, rules of intimacy, privacy

  o Breaking taboos of intimacy and privacy: a key element in cultural socialisation is learning the taboos, in particular the taboos in social behaviour and contact. In several incidents people with light mental disability disregard such taboos, by slightly crossing privacy boundaries eating from a stranger’s plate (Restaurant, BE) engaging in intimate physical contact in public (Sleeping bag, BE) and wetting themselves in front of others (Toilet, BE).

  o Intimacy, crossing boundaries of professional and non-professional contact: the incidents Kiss and Touching (HU) show that the disrespect of boundaries of physical intimacy can happen also with respect to the carer. In both situations the person with disability goes beyond the physical contact permitted by a professional helping relationship into personal intimacy.

<table>
<thead>
<tr>
<th>Belgium</th>
<th>Denmark</th>
<th>France</th>
<th>Hungary</th>
<th>Italy</th>
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</thead>
<tbody>
<tr>
<td>Trip</td>
<td></td>
<td>Finger</td>
<td>Kiss</td>
<td>Cooking lesson</td>
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<td>Slap in the face</td>
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<td>Touching</td>
<td>Theatre festival</td>
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<tr>
<td>Article</td>
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<td>Martial arts</td>
<td>Icebreaking</td>
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<td>Cooking</td>
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<td>Beauty</td>
<td>Belly dance</td>
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<td>Shopping</td>
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<td>Bank</td>
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<td>Aunt</td>
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<td>Guilty</td>
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<td>New year speech</td>
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<tr>
<td>Restaurant</td>
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<td>Sleeping bag</td>
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<td>Toilet</td>
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<td>Party</td>
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<td>Cinema</td>
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<td>Fair employer</td>
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<td>Living isolated</td>
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<td>Satisfaction</td>
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CRITICAL INCIDENT: “ICEBREAKING”
[Collected by CESIE, Italy, 2012]

Professional educational domain
Disability / Interculturality / Arts (theatre, dance)

Sensitive zone
Disability, education, artistic expression, verbal and non-verbal communication

Culture of the person experiencing the shock
Sicilian / Female / Woman / Age 31 / Married / Heterosexual / Studies in theatrical disciplines / artistic theatre subculture.

Culture of the person “causing” the shock
Sicilian / Female / young adult / living with a disability / wheelchair driver.

Describing the SITUATION
In 2008 I taught theatre in a workshop for adults in Palermo. During the first lesson I met my students, among them there was Francesca, a woman in a wheelchair. I prepared various ice breaking and team building activities but at the beginning of the lesson I got into a panic because all the activities that I had prepared were in a standing position and Francesca would not be able to participate. The following lessons were terrible because I only gave my students activities in which they had to sit in order to let Francesca participate in the activities. I didn’t understand that this methodology caused discomfort in all participants and in particular in Francesca. I was convinced that remaining seated was the only solution to work together but I didn’t understand that I was emphasizing Francesca’s disability and I was creating a barrier in the creation of the team. Speaking to my colleagues, they helped me to understand that the problem was my perception of the disability.

1. Elements of the SITUATION
The critical incident occurred in 2008 in Palermo during a theatre lesson I was teaching adults. The protagonists were myself as the trainer, Francesca that brought in her wheelchair and the rest of the group they were indirectly involved in the situation. It was the first encounter for the whole group. I was not prepared and my proposed activities had not been thought through for the attendance of a differently able participant, that I was honestly not expecting.

2. EMOTIONAL REACTION
I felt uncomfortable – uncomfortable for not having thought of the possibility of attendance from a person living with disability. And I felt even more frustrated by seeing that my second attempt, of doing only seated exercise, was even a bigger flop given that the whole group was subject to my lack of experience with the specific target group. Later on I felt motivated to re-skill my pedagogical competences and to update and enrich my repertoire of activities with exercises that respect all kinds of bodies. Towards the end of the several months lasting workshop I felt empowered and more confident to ask the person about his/her needs on regards of activities, what the person can and can’t do. Relieved!

3. What norms / values / representations did the incident touch / threaten / question in the narrator?
I was struggling with my idea of verbal and non-verbal communication – I thought it was disrespectful to ask verbally what she could or couldn’t do, in terms of movement and participation. It also questioned my idea of social composition in society, I mean – The idea of having a disabled person in my class never crossed my mind. I wrongly thought they didn’t participate in theatre.
4. Based on the analysis of question 3 what image do you have of the other person?

I had a very positive image of Francesca – she is full of life even thought she in a wheelchair. I also found her very courageous and determined in her wish to be part of a group and to express herself through theatre.

5. What could be the norms / values / representations of the other person / culture that led to the specific behaviour that caused the shock experience?

Francesca is used to this kind of situation where people don’t expect her to be present and participative. Belonging to the subculture of disabled people, to her it was not shocking that I was not “prepared” for her presence in the group. To have a collaborative approach to all situations in life for her is a norm – she helps the able-bodied, like me, to feel comfortable in asking to what extent she can participate without feeling we are not politically correct or lacking respect. Francesca thinks it’s more respectful to ask then to just assume that she would like that everybody has to adapt to her. She also wants to adapt to others. She looks at it from situation to situation, it depends what is possible. But talking about it verbally, is the most important thing. Talking with her AND with the other participants.

6. Does the situation highlight any problem concerning the professional practice, or in general about the respect of cultural differences in intercultural situations?

Surely yes, I was so focused on Francesca that I was not really professional in her regards nor towards other participants. I have to see people living whit a disability like others, but also highlight the difficulties AND strengths of having them in a workshop. It’s not working to just ignore or find solutions yourself. I have to communicate these issues with the participants. Don’t see myself as the only professional, because sometimes other people know more what to do/say in some situations/about some subjects.

**CRITICAL INCIDENT: “NEW YEARS SPEECH”**

[Collected by KVG, Belgium in 2012]

<table>
<thead>
<tr>
<th>Professional educational domain</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sensitive zone</strong></td>
<td>Disability</td>
</tr>
<tr>
<td><strong>Culture of the person experiencing the shock</strong></td>
<td>Middle aged female, no disability, educator, Belgian, catholic</td>
</tr>
<tr>
<td><strong>Culture of the person “causing” the shock</strong></td>
<td>Woman, around 30 years old, with physical disability on her face, Belgian</td>
</tr>
</tbody>
</table>

**Describing the SITUATION**

We have an annual New Year’s reception at work. We asked someone of the Association of Equal Opportunities to give a talk. We’d frequently spoken on the phone and e-mailed, but then the woman came to the reception. Her face was mutilated. I hadn’t thought this when I heard her on the phone. I’d had a different image of the woman.

**1. Elements of the SITUATION**

There were around 15 people, most of them were volunteers (around 7). The other ones were professionals of our organisation or people of another organisation were we work with. And then there was the woman from the council. It was a reception at our working place. A place with 5 desks with computers, a kitchen and a little garden. We all know each other, except for the woman from the council that we invited.
2. EMOTIONAL REACTION

My very reaction was that I jumped. I hadn’t expected this. Afterwards I was ashamed of this reaction. That I, as an employee at an organisation for people with a handicap, respond in this way. The voice had given me a totally different physical image of the woman.

3. What norms / values / representations did the incident touch / threaten / question in you?

This made me realise that meeting someone with a disability at the most unexpected moments isn’t normality yet. Perhaps the image that people with a disability need to be helped by us and that they don’t often practise these types of professions. **Importance of the face:** In individualist societies (such as contemporary Belgium) the face has a great importance. It is meant to express our individuality, our uniqueness, reflect our personality and character. Scars, wounds, mutilation of the face can distort the image that other people form of us more than other body part for this relative importance of the face. Our representation of beauty creates the expectations towards symmetry, smoothness, harmony of shapes, in contemporary society also the freshness and youth of the face. In western cultures during interaction we usually look into the face of the other. Interacting with someone who has distortions, mutilation on the face is often a particular experience that teaches to look behind the scar, the mutilation to find the person. For the same reason there is an absence of contact with people whose faces are altered are different from the average. In particular there is a lack of representation of such people in the role of public speakers. **Implicit attitudes:** Everybody holds certain cultural beliefs and prototypical images of people that we interact with. Since probably most of us do not have contact with impaired people on a daily basis the image of them does not often comes to our mind when we first think of somebody whom we have not met yet. Even though the narrator works with impaired people that does not necessarily mean that she overcame the feelings of surprise when seeing another person with disability. She might not have been used to seeing them outside professional context, as even nowadays they are still marginalised. One can easily forget that disabled people do not exist in isolation.

4. Based on the analysis of question 3 what image do you have of the other person?

A normal, positive view of the woman. She was extremely pleasant and friendly.

5. What could be the norms / values / representations of the other person / culture that led to the specific behaviour that caused the shock experience?

**Fight against discrimination, full inclusion:** As a member of the Association of Equal Opportunities, the woman in the incident probably has a strong sense of mission toward the promotion of equal rights and opportunities, probably referring to a variety of minorities, people with disability included. **Empowerment to full participation:** In accordance with her mission she may consider it important to empower people with particular identities, as well as people with disability. She may feel it important to give an example to go against the stereotypes and show that people who have mutilations on their faces can be just as competent as others.

6. Does the situation highlight any problem concerning the professional practice, or in general about the respect of cultural differences in intercultural situations?

“"There is still an image of people with a disability as being ‘helpless’, not independent. There should be more of a focus on the capacities of this target group, instead of always concentrating on their limitations.” Although according to a Social Attitudes Survey 2009 published by the British Office of Disability people nowadays more likely think of disabled people as the same as everybody else (85 per cent compared with 77 per cent in 2005) there is still a belief that prejudice towards disabled people is widespread. Almost 8 out of 10 respondents felt that there is either a lot or a little prejudice towards disabled people. The reason for
these judgements might be that people with impairments may look or behave differently from other people. Although everyone looks different, most cultures have a model of ‘normal’ appearance and behaviour, reinforced through images in art and the media, and this can create unease when interacting with people who are different from this ‘normal’ model. Although the narrator was used to having contact with impaired people she still experienced a shock when the person with whom she had the conversation over the phone did not fit the image of the women that she created in her mind.
**Best Practices on Cultural Diversity in the Domain of Disability**

The following Best practices are shortened; to read the full version download the Best practices Reader.

Interactive ONLINE TOOL visually showing the Best practices in the domain of Disability.

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**Sexuality of Disabled People**

*Copenhagen, Denmark*

Parents are trained to accept and cope with children, whose behaviour does not match cultural gender expectations. The parents are gradually made to change their norms as they understand, that their children can perform normal actions.

**Contact:** Nicolai Ardal, nicopolitis@gmail.com

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**GIPS**

*Enter into the life of a disabled person*

*Leuven, Belgium*

The GIPS workshop shows school children how to experience the body when you have a disability. The workshop consists of two half-day sessions where they get to see a few movie fragments about disability, play a board game and ask questions to a disabled person. During the workshop, focus lies on raising awareness and experiencing disability. Because of the openness and the chance to ask questions, this workshop has been proven to have a positive effect on the children as well as on the person with a disability.

**Contact:** Paul Arnauts, paul.arnauts@kvg.be


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**Malus**

*Personal experience of a disabled person*

*Leuven, Belgium*

The workshop Malus uses a comic book, made by a well-known Belgian children’s book author, as a starting point. The comic book revolves around a little boy who has a disability and is read by a person with a disability to a class of school children. After reading the book, the disabled person shares his or her own experience and the children get the chance to ask every question they want. The workshop is a learning opportunity for the children, as well as for the workshop organizers.

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TABOO

Interactive personal statement
Roeselare, Belgium

The sharing of personal experiences has been proven to be an excellent tool to raise awareness and create openness around a certain subject. Taboo is a workshop where a person with a disability tells his or her personal story to a group of people. He or she tries to involve them in such a way that the story becomes tangible and not only didactic. For the participants it’s not only listening to a story, but also interaction that is important. It’s a story about the life of the disabled person, but also about the things that help people with disabilities in their daily lives. For this, he or she makes use of statements and a PowerPoint. The personal testimony is a positive experience for the participants as well as for the disabled person.

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WELLNESS

Experience the body
Leuven, Belgium

WELLNESS is a workshop that allows people with disabilities to get to know their own body and to relax. The workshop wants to point out that enjoying your body is human, important and necessary. There is one professional who shows massage techniques, relaxation tips and other exercises. The target group consists of people with approximately the same mental disabilities and their partners who don’t have a disability. They practice the exercises on each other. Therefore, trust between the partners is essential.

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

By 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 centres 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 physical illness. 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?

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, Vennix, 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.

**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 of 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.

**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; Vruggink 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 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; Vruggink et al., 1995).

Latrogenic 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 im-
possible 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).

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).

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; Iff, 1997).

Problems with the sexual experience

Case 5: A women 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 & Vansteenwegen, 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 surround 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.

**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; Iff, 1997).

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.
Literature


Islam and disability

By 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.

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.

Medical tratment

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.
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.
**TABOO**

*A story with an angle*

<table>
<thead>
<tr>
<th>Aim of the activity</th>
<th>To see the person, not the disability. To decrease our prejudices.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skills to develop</td>
<td>To raise awareness. Block perceptions</td>
</tr>
<tr>
<td>Procedure:</td>
<td></td>
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<tr>
<td></td>
<td>• Each participant takes place in the circle. He receives a red sheet of paper and a green sheet of paper.</td>
</tr>
<tr>
<td></td>
<td>• The person with a disability brings her testimony. During the story, he/she puts some statements to participants. Each participant must make a choice for or against the statement. Some participants are asked about their choice.</td>
</tr>
<tr>
<td></td>
<td>• Everyone is actively involved during this session.</td>
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</tbody>
</table>

The project Taboo brings a story of a person with a physical disability.

The person with a disability talks about his/her life. This is not much different than a person without a disability. However, it is for many people a revelation. The statements provide an open discussion about disability.

It's not just a classic listening and viewing experience. The person can use various methodologies to their story and bring it lively and interesting.

For the listener, it is not just listen to a story from her we also expect interaction. We want to inform people, sensitize and motivate the life of a person with a disability as positive, but none the less possible to see realistic.

It still is not easy to live with disabilities but each obstacle creates new possibilities and dreams.

Examples of statements:

- Should people with disabilities participate everywhere?
- I could start a family with a partner with a physical disability
- I would not want to live with a disability?
- People with physical disabilities should not receive financial support.
- I find people with disabilities pathetic.
- Gay or migrant is also a kind of disability.
- Should people with physical disabilities have children?
- Could you fall in love with someone with a disability?

Debriefing: We have a certain image of people with disabilities. Which is not always posi-
We fix our image on disability and do not look beyond the disability.

- Is our image culture-bound? Has our education forced a certain image up on us?
- Why do not we see each person as a person?
- Is it possible after this training to see the person and not the disability?

### Tool overview

<table>
<thead>
<tr>
<th>This tool is for</th>
<th>Any group size</th>
</tr>
</thead>
<tbody>
<tr>
<td>Materials needed:</td>
<td>Chairs</td>
</tr>
<tr>
<td>Duration:</td>
<td>120 minutes</td>
</tr>
<tr>
<td></td>
<td>*Introduction - Why taboo? History of the project [10 minutes]</td>
</tr>
<tr>
<td></td>
<td>*Testimony Taboo [1hr]</td>
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<tr>
<td></td>
<td>*Reflection [10 min]</td>
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S

hared concept - In a body perspective

When considered from a standard Western approach, the body is conceived as a “natural” or “fixed” structure. In this approach, scientific studies of the body are perceived as objective and habits surrounding embodied activities such as eating, sleeping or grooming are assumed to be universal. Conversely, viewing the body from an intercultural perspective illustrates the ways in which concepts of the body can differ from culture to culture. Furthermore, 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.

The BODY project aims at providing insight on 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. Ultimately, an intercultural approach to understanding the body makes it possible, not only to realize the ways in which concepts of the body are different in other cultures, but also to develop a certain relativity with regards to concepts of the body within one’s own culture.
Research results
Impact of cultural difference in the domain of BODY

Amongst the collected incidents 23 were connected to body issues beyond gender, sexuality, health and disability. This section takes under scrutiny these remaining incidents with a view to identify the recurrent sensitive zones.

- **Non-verbal communication codes.** All communication is embodied but the body has different roles in the interaction according to different cultures. In cultures that put the emphasis on direct and verbal communication, the body is meant to accompany the verbal message, highlighting it, moderating it. However in more “context rich” (Hall) communication styles, the position, arrangement of the body, the mimes, the gestures can take precedence over the verbal message. Beyond their relative importance and role, the gestures themselves can be very different (see Japanese Gesture, HU). A particular moment in interaction where such differences often have a dramatic effect is the greeting / parting rituals (e.g. Japanese handshake, DK, Handshake, FR or Nodding FR). The reason for this lies precisely in the meaning of these rituals: to confirm a mutual recognition and respect. One partners’ inability to properly reciprocate the other’s gesture breaks the symmetry of the interaction, breaks the reciprocity. Narrators of such critical incidents often feel disrespected and consider the one that commits the mistake as rude.

- **Movements, rhythms.** The cultural differences in the repertoires of movements go beyond the gestures used in interactions (politeness codes, rituals etc.). In fact they may concern very mundane activities such as walking, or bending down to fetch a dropped object (Bottom, FR). Such subtle differences can also become sources of misunderstanding and tension, because we automatically attribute intention to what we perceive as deviation from the “norm”. In Bottom (FR) for example the movement of bending down is interpreted as sensual, vulgar, while in Nodding (FR) the nod is understood as a wish to terminate interaction, whereas it was precisely the opposite: an encouragement to continue.

- **Privacy and integrity: the proper space of the individual.** A good deal of incidents are linked to differences in proxemics: the regulation of physical distance between people. This regulation tells us (without a conscious effort) what is the proper distance that we have to have with another person, taking into account our relationship. Usually intimate relationships allow smaller distance, while hierarchical relationships demand a larger distance. Breaking the rules of proxemics is usually interpreted as bad intention, either as aggression (for the one who stands too close) or dislike (for the one who stands too far). Hug (IT) is an incident where the rules of proxemics are topped with different prescriptions concerning physical contact: a British volunteer interprets the warm friendly hug of an Italian facilitator as invasive. Different proxemics and physical contact prescriptions can be alarming even when we are not personally involved. In Violent young refugees (DK) the narrator is shocked by the frequent and strong physical contact between the young men in the class. Similarly, witnessing Corporal Punishment (FR) is also often source of culture shock for Europeans, who cherish the physical integrity of individual as a primary value. A shift of formal and informal registers can also result in surprise and a feeling of threat. In Swimming suit (FR) for example,
the French facilitator feels invaded by the request of a participant to borrow her swimming suit. Beyond concerns of hygiene, the intimacy that such a demand supposes does not correspond to their relationship.

- **Taboos.** Each culture draws lines to delineate behaviour considered polite and acceptable from rude. We have seen some of these prohibitions and taboos in the sections dedicated to gender and sexuality. But there are also taboos beyond those two domains. A good deal of such taboos concerns eating (see Eating in class, IT) and hygiene (e.g. Blowing nose, FR). All prohibitions have a certain validity field: in some spaces we are allowed to perform certain actions, which we are not allowed to elsewhere. When the default setup is different, then again we find interesting incidents: in *Touching Art (FR)* Chinese visitors did not take into account that in Europe there it is usually forbidden to touch works of art in museums. Similarly *On the floor (FR)* is an incident triggered by the “unusual” behaviour of Indian visitors who sit down on the floor in the middle of a museum room.

<table>
<thead>
<tr>
<th>Quick summary of critical incidents related to body</th>
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<tbody>
<tr>
<td><strong>Belgium</strong></td>
</tr>
<tr>
<td>Violent young refugees</td>
</tr>
<tr>
<td>Japanese handshake</td>
</tr>
<tr>
<td>Soup and butter</td>
</tr>
</tbody>
</table>

Bottom

Japanese participant

Nodding

Swimming suit

Killing a bee

Silent students

Corporal punishment

Mixed role playing

Pakistani couple

Handshake

Nose blowing
**CRITICAL INCIDENT: “NOSE BLOWING”**
[Collected by Élan Interculturel, France, 2012]

<table>
<thead>
<tr>
<th>Culture of the person experiencing the shock</th>
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<tbody>
<tr>
<td>French woman in her early twenties working in South Korea as a French teacher in a military school. She already had experience living abroad having taught in both urban and rural contexts in India. She has a love for cultural exchange and at the time of the incident, she regularly contributed articles to an English newspaper about her cultural gaffes or shocks experienced while in Korea.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Culture of the person “causing” the shock</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Young students in a military school. The narrator did not have any individual background information on the students at the time of the incident, but they seemed to have a great respect for order, hierarchy and rules. While the school is mostly male, the French class had a more balanced number of male and female students because female students seemed particularly interested in the French language.</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Description of the situation</th>
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<tbody>
<tr>
<td>I was a French teacher at a military academy in South Korea. It was winter and I was giving my lesson as usual, but I couldn’t help noticing that most of the cadets had colds and quite a few had runny noses. None of them attempted to blow their noses and just continued to sniffle throughout my lesson. I was a bit annoyed by this as it made it difficult to concentrate on my lesson. Finally, I took out a packet of tissues and attempted to distribute tissues to the students with runny noses so that they could blow their noses. I was quite surprised when they all refused the tissues because they clearly needed them. After they refused the tissue, I continued my lesson as usual, but I remained confused by their reaction. Afterwards, I spoke to the commandant (the director of my department) about what had happened. He explained to me that in South Korea, it is considered rude to blow one’s nose in public. I was very embarrassed when I finally understood the reaction of my students.</td>
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</tr>
</tbody>
</table>

1. **Elements of the SITUATION**

   The incident took place in a classroom with 25-30 students. The room was set up with several rows of desks facing the front and the narrator standing in the front of the classroom. The narrator was roughly the same age as her students and had recently begun her position as French teacher. Around 30-40% of the students were female.

2. **EMOTIONAL REACTION**

   I experienced irritation when the students would not blow their noses, considering their behavior to be rude. After this initial reaction, I thought that my students maybe simply didn’t have tissues with them, so I assumed that offering them the tissues from my bag would solve the problem. But when the students refused, I was confused and a little embarrassed. I was even more embarrassed after speaking with my boss and learning why the students had refused my offer.

3. **What norms / values / representations did the incident touch / threaten / question in the narrator?**

   **Hygiene:** For the narrator, a runny nose can contribute to the spread of disease. Tissues offer a way to prevent this spread by providing a clean, discrete means of addressing a runny nose. She was not only annoyed by the act of her students’ sniffing, but also slightly disgusted.

   **Manners/Politeness:** In addition to hygienic concerns, blowing one’s nose in public is considered to be good manners in French culture. It allows the sick person to address a runny nose in a discrete manner so that they can continue with the task at hand.
4. Based on the analysis of question 3 what image does the narrator have of the other person?

Lightly negative. The narrator was initially a bit irritated by the behavior of her students.

5. What could be the norms / values / representations of the other person / culture that led to the specific behavior that caused the shock experience? (Hypothesis!)

In Korea, as the narrator later learned from her boss, it is considered rude to blow one’s nose in public. Thus, just as the narrator perceived the behavior of her students as rude, they considered it vulgar to blow their nose in a classroom setting. This politeness code could be related to the idea that natural bodily functions are to be removed from the public domain. In blowing one’s nose in public, Koreans may feel that they are drawing attention to, rather than discretely addressing their runny nose. For them, it may be best to ignore the runny nose while in public, or to sniffle without the use of a tissue and then to blow their nose once they are in private.

6. Does the situation highlight any problem concerning the professional practice, or in general about the respect of cultural differences in intercultural situations?

For the narrator this experience caused her to question a practice that she always considered to be “natural”. In seeing that when it comes to blowing one’s nose, the opposite idea of hygiene and politeness apply, she realized that how her own notions of hygiene are culturally influenced. For her professional practice as a teacher, she realized that it is important not to force things on her students, even that which may seem simple or unimportant to her and to be open to adapting to a new cultural context so as not to offend those with whom she works or interacts.

◆ CRITICAL INCIDENT: “THE HUG”
[Collected by CESIE, Italy, 2012]

Professional educational domain
Body / Interculturality

Culture of the person experiencing the shock
Sicilian / Female / Woman / Age 28 / heterosexual / unmarried / living with a Muslim-Bay Fall man / Catholic Christian worshipper but no churchgoer / Studies in Psychology / International NGO employee

Culture of the person “causing” the shock
British male / volunteering in Palermo, Italy / Age 24 / accustomed to respect the rules / being detached and undemonstrative / polite and reserved (not being accustomed to the confusion and disorganization have been the crucial elements at the base of the shock experience). Arriving in a country completely different in terms of habits, way of living, relation and contact with people etc.

Describing the SITUATION
A young man from UK came to Palermo for an internship in our institution. When he arrived he appeared really lost and frightened. I was the coordinator of his project and therefore I was worry about him and I tried to be warmly welcoming talking often with him. In those situations, our cultural peculiarities have met and crashed, especially relating the physical distance that I put between me and the man. The Sicilian people are really friendly and close each other, hugging each other so often, so I hugged him being attentive of him. My warm attitude towards him made him more shocked and it did not help him to overcome the feelings experienced. After some months, he was integrating to the city and he felt better, he was more opened and he told me to have felt uncomfortable at the beginning due all the differences experienced admitting me that also my close and warm attitude toward him made him embarrassed and not able to talk honestly about his intercultural shock. We discussed a lot and we finally clarified each other the cultural diversity that we carried and how it has created misunderstanding.
1. Elements of the SITUATION
The incident happened in Sicily, Italy. As I wrote above, the misunderstanding came up because, from my side I did not realise how much different was living in Palermo compared to UK. I was not really aware that starting from the traffic to the weather, passing people, relations, way of living, a new language could be really a shock. In particular I did not take into account, that my warm Sicilian attitude could have a strong impact to him. From his side, I can say that he was not really open minded at the beginning, he was fixed on the differences without appreciating the new things he was experiencing.

2. EMOTIONAL REACTION
I felt frustrated during this period. Later on when I resolved the misunderstanding, I found myself with more intercultural awareness. It helped me to analyze always how foreigners could live in a new country, the difficulties they could face and I understood that it’s really non functional assuming your point of view without putting it into questions, especially if you work with foreign.

3. What norms / values / representations did the incident touch / threaten / question in the narrator?
"It touched just my idea of the relation with people. I was used to be in a close contact with the people with whom I was working. I understood that people from other countries could have another relation style, being colder than me or not available to an immediate confidence. “Reciprocity – in cultural anthropology reciprocity is a way of defining people’s informal exchange of goods, labour and even non-material things, for example responding to a positive action with another positive action. Physical contact means hospitality and caring in Southern cultures. As reciprocity is an important value in society, the refusal of this (the welcome gesture of the hug) can cause frustration. Externalisation of emotions: showing emotions is accepted in Southern countries, and in general it is an important sign of recognition of the others. Proxemics (E.T.Hall): the required personal/social space between people is different in the different cultures. If you step too close to the other person, you can hurt his/her personal sphere. It is related to physical contact which is different in the different cultures, in the ‘warm, impulsive ‘cultures, physical contact and externalising emotions are important, while these can cause discomfort for other people.

4. Based on the analysis of question 3 what image do you have of the other person?
Rather negative and critical: I had an image of the other person as a strange person, not open minded and not enjoying live.

5. What could be the norms / values / representations of the other person / culture that led to the specific behaviour that caused the shock experience?
Many aspects of the new context made him live a shock experience. My approach to him, warmer than how he was used to experience in his country made him feel embarrassed and with some prejudices about me (the crazy coordinator, I supposed). “Non-verbal communication - proxemics – personal/social space: keeping a certain distance with unknown persons is necessary, especially with future colleagues. This is related to the fact that in certain cultures personal and professional sphere are strictly separated, and it cannot be mixed up (for example no hugging of a future colleague). Verbal communication has priority, it is more important to formulate the things in words, clearly, directly. Non-verbal communication – not showing emotions: instead of the externalisation of emotions, it is rather their hiding that is preferred in many cultures. Hiding emotions is understood as being able to master them, not being the victim of them; in interactions it is a sign of politeness. From this perspective, the externalisation of emotions can seem insincere or even childish.
6. Does the situation highlight any problem concerning the professional practice, or in general about the respect of cultural differences in intercultural situations?

“Both of us didn’t take into consideration or gave importance to the differences of culture and their peculiarities and the effects of these on the professional level. He never asked for further explanations regarding assigned tasks afraid of being hugged also in this kind of situation and I was not able to encourage him to be more active and participative.”

“These kind of misunderstandings happen but the important thing is to keep ourselves available for feedback by others or critiques which could make us more aware of ourselves and others behaviours and ways of approaching. We should understand that our point of view is not absolute and especially, if we are educators, it’s necessary to work on it.”

Reciprocity is a key issue in all interaction: it implies that we recognise each other as respectable interaction partners, while the lack of reciprocity implies precisely the opposite: a lack of recognition. It is for this reason that breaches of reciprocity has such an impact even in the most ordinary simple situations, such as not smiling back at someone, or not addressing the other with the proper politeness formula.
\textbf{BEST PRACTICES on cultural diversity in the domain of BODY}

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\textit{The following Best practices are shortened; to read the full version download the \textbf{Best practices Reader}}

\textit{Interactive \textbf{ONLINE TOOL} visually showing the Best practices in the domain of Body}

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\textbf{FORUM THEATRE FOR COMMUNITY BUILDING}

\textbf{As a part of a Community Building Project for Local Communities of Poor and Disadvantaged People in Small Hungarian Villages. Hungary}

In these villages, people are not organized into communities, they are highly isolated, and even neighbours are not connected in their daily life. A lack of communication, of dialogue, and of community needs increases the disadvantaged situation of those places and creates a barrier to development. As a part of a larger community building project, “Forum Theatre”:

- Assists residents in the village to build a community;
- Gives an opportunity for common problem solving and conflict resolution;

Gives the opportunity for those people to disconnect from their usual daily communication and helps them to find new self-expression methods.

\textbf{Contact:} Vera Szabó, veronika.szabo@artemisszio.hu

\textbf{References:} www.artemisszio.hu

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\textbf{EMOTIONAL DEVELOPMENT ACROSS EUROPE}

\textbf{Birmingham, England}

The aim of the workshop funded by the sectorial programme Grundtvig (LLP) is to gather participants from all over Europe to support them in the development of their emotional intelligence. The workshop foster awareness of how culture can impact upon people’s emotional development. Starting from the point that conflict between people often comes from a lack of understanding or poor communication skills, the workshop developed several techniques to support the cultural competences of the participants and overcome emotional situations.

\textbf{Contact:} Victor Allen, victor@mirrordt.co.uk

\textbf{References:} www.mirrordt.co.uk

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\textbf{QUÊTEURS DE GESTES / PASSEURS DE CORPS}

\textbf{Quimper, France}

The project is based on the method of “writing in movement”, which results from a 20 years research led by the contemporary dance Company “Patrick Le Doaré”. This project implies a work on body involvement and its possibilities of “personal writing”. The workshop consisted in a collection of bodies memory, ges-
tures, attitudes, movements brought by each participant in his country. Then, finding the sense, the meaning of each gesture, understanding the involvement, the repercussion, the intention, in order to transform it, giving it a specificity, a singularity. The everyday life movement becomes an artistic one. The body becomes a form of singular language, carried by an individualized writing.

Contact: T.E.E.M, teem@orange.fr
References: www.le-teem.fr/

❖ BODY AWARENESS

Denmark

The participants, who have an undeveloped body awareness and restricted linguistic competences, achieve a heightened body awareness and an intrinsic motivation for adequate actions through training based mainly on non-verbal exercises.

Contact: Susanne Lund Christiansen, info@SLC-trivsel.dk/
Reference: http://www.slc-trivsel.dk

❖ SPEAK WITH YOUR BODY: FASHION SHOW FOR MIGRANT WOMEN

France

“Speak with Your Body” is a fashion show for migrant women living in an Emmaüs shelter. The show is organized by the director of the Au bout du monde theatre, who leads an annual theatre course at the shelter. Realizing that a number of the women had trouble expressing themselves through their bodies and that some even took efforts to hide their bodies, the director created the show as a way for the women to liberate their emotions and celebrate their bodies.

Contact: Guerin Philippe, Philippe.guerin732@orange.fr
Reference: http://theatreduboutdumonde.fr/association_tbm.html

❖ FAIRY TALES AS A FRAME FOR DANCE

France

This workshop takes place over two days in a dance studio. It is open to any participant who wants to get involved in body exploration through storytelling/words and doesn’t require any particular dance level or technique. It deals specifically with the symbols and archetypes living within us all. Fairy tales are used to inspire the participants to express themselves, allowing them to improve self-confidence and have a more positive perception of their bodies through physical expression. Through dance, the participants explore the characters and universal themes relating to mankind, human relationships and different existential questions that exist in all cultures.

Contact: Iaro Rasoamiaramanana, iaroni@hotmail.com
Considering the Body from a Cross-Cultural Perspective
By Stefanie Talley

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.

Introduction

In his article "Body Rituals of the Nacirema," anthropologist Horace Miner explores the seemingly exotic and foreign body behaviours 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 behaviours 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 centred 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.

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 behaviour, 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 article, 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.

65Detailed literature reviews can be found in the texts of Lock, Turner (1997), Howson, and Morgan & Scott cited in the bibliography of this article.
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).

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 kamois 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” behaviour is grounded in cultural notions that assign gender traits to particular behaviours. 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.

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 imbalanced 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 eve-
ryday 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 behaviour 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 volume, it is worth noting how thoughts on the sexual attractiveness of different body parts and sexual behaviour can differ from culture to culture. In their book Patterns of Sexual Behavior, Clelland S. Ford and Frank A. Beach detail the sexual behaviours 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 honour 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 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.

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 *tuo*’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 behaviour 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.

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” (Classen 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 (cer-
tain 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, Kleinman 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). Ebigbo (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 behaviour 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 behaviour 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 particular 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 socio-historical 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 behaviour has been internalized on an emotional level.

Taboo

While manners may proscribe certain behaviours 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.

**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 an 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 traveller 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 exoticise or overempha-
size 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.
Bibliography


## WORKING TOOLS

### NON-VERBAL COMMUNICATION

<table>
<thead>
<tr>
<th>Aim of the activity:</th>
<th>To introduce to non-verbal communication</th>
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<tbody>
<tr>
<td>Skills to develop:</td>
<td>Awareness of own communication, understanding of the elements of non-verbal communication and cultural differences in communication</td>
</tr>
<tr>
<td>Procedure:</td>
<td>1) Walk in the room, then chose a person, then another, and then position yourself to the same distance from both of them.</td>
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<td></td>
<td>2) Walk, have eye contact with someone that person is going to be your partner. Take some space. One of you is going to be a subject, the other a mirror. Mirrors reflect everything the subject does. Make it so that outsiders don’t see who’s mirror and who’s subject. (give some minutes than instruct for changing roles). Find a last movement, thank your partner and walk.</td>
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<td></td>
<td>3) Rhythm machine: in pairs, count until three in an alternating repeating manner (one says 1, the other 2, the first 3, the second 1 etc..) Once this is practiced, each pair can replace the number 1 with a gesture and a sound. Then number 2. Then 3. Make it faster! Present your rhythm machine to the others.</td>
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<td></td>
<td>4) Find a new partner. One of you is leading, the other following. Your surface of contact is your forearm. The follower can close her/his eyes if s/he wishes. The guide can not.</td>
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<td></td>
<td>5) Blind car: in pairs, one standing in front of the other. The first one has eyes closed. Behind the driver can drive with the following movements: taping on the head move forward. Tapping on right shoulder move right. Tapping on left shoulder move left. Taping on the back move backward.</td>
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<td></td>
<td>6) The group is divided into two parts: those who seek and those who avoid eye contact. The speakers always want to have eye contact. Especially from the ones who avoid it... after a while: change of roles.</td>
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<td></td>
<td>7) Image. In pairs, starting from a handshake: one person remains in the image / position, the other goes away and comes back with a different position. Then she remains still and the other goes away and comes back.</td>
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<td>8) Speed gestures: one person stands in the center, the others line up. She does a gesture, then the others come one by one and do a response gesture. Once everyone is gone: in the next round, the response to the gesture can include a word/sentence to which the first person can reply with a gesture and sound.</td>
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<td></td>
<td>9) Chairs: two people sit side by side on two chairs. They can only communicate with moving head, arms, legs.</td>
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<td></td>
<td>10) Poet: a poet from kazaria comes to visit and recite one of her last poems. A translator translates it to English.</td>
</tr>
<tr>
<td>Debriefing:</td>
<td>- What aspects of non verbal communication have we touched?</td>
</tr>
</tbody>
</table>
| Hints for facilitators: | If there is time, make subgroups find answers to the questions above. If needed help participants to cover all of the elements bellow:  
- gestures  
- body positions  
- distance  
- facial expressions  
- expression of emotions  
- contextual communication: use of objects, furniture  
Para-verbal communication: intonation, loudness, silences, rhythm |
| Preparation needed: | handout on communication |

**Suggested readings on the topic (background theory or methodology):**

*Augusto Boal: Games for actors and non actors 2002 Routledge, New York*

*David Diamond: Theater for living: The Art and Science of Community-Based Dialogue 2007 Trafford Publishing*

**Tool overview**

| This tool is for | Any given number |
| Materials needed: | 4 flipchart papers, markers |
| Duration: | 1.5 hours |
What is intercultural competences?

- Competences for trainers
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 the 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. all over Europe.

Intercultural competence in a democratic perspective

The need for intercultural competence among frontline staff is not a new realization. The development of an intercultural pedagogy has been on the agenda since the beginning of the 1980s (Horst, C., 2006). The concept of an intercultural pedagogy appears in the wake of the realization that all forms of education, training, guidance and counselling should reflect the social, cultural and linguistic complexity and diversity. Both children, adolescents and adults should have access to educational environments and other public services that are capable of meeting them according to their own requirements and be 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. In 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. The 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 importance of the mutual perspective exchange and the ability to treat citizens and users in the multicoloured 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 the intercultural competence, there remains a need for concrete methods and tools to handle the intercultural communication in the daily job performance among teachers, supervisors, nurses, social workers etc. This may in particular 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-contextual, where messages and opinions are expressed very directly. Or the communication may be rather high-contextual, meaning that You have to seek for the real message “between the lines” etc. Sometimes “small talk” is an important part of creating a positive and trustworthy relationship. Sometimes this kind of communication may be confusing in a dialogue between a professional official and a civil client.

In the context of the body, the medical anthropology (Serschneider & Mølgaard, 2007) has identified how the distinction between illness and disease may facilitate the communication between physicians 'and patients' perceptions of sickness. Where 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 the intercultural communication physicians and other health workers should include both perspectives in order to recognize and respond respectfully to the patient’s own perceptions. This where illness refers to the patient’s way of describing his symptoms, describes the disease the medical and medical evaluation of a clinical picture.

❖ Competences for trainers

The general intercultural competences needed for functioning as trainers, educators in culturally diverse settings have been fairly well defined. Focusing on our five themes allowed us to observe in more precision what are the skills, knowledge, attitudes that can be helpful in our BODY-related domains.

a) Between anticipating and ignoring difference: negotiating the right attitudes facing diversity

There is no single rule pointing to the right direction concerning diversity. Our critical incidents showed us that sometimes it is trying too hard to adapt to particular needs that leads to a loss of autonomy, a loss of self-determination for the adults we work with (see for example Icebreaker (IT). At every moment the trainer must negotiate to what extent s/he can target specific needs, without closing the participants in their specificities.

b) Listening and observing

Without a general prescription the main resource at our disposal is observation, listening –sometimes limited to the non-verbal domain (see Banking, IT) if we work with people whose verbal expression skills are limited.
c) **Expectations of acculturation**

Be it migrants of members of cultural minorities, the adaptation or acculturation process they go through is not automatic nor linear, nor complete. Even values, norms that to us may seem practical, true and “developed”, for others may seem undesirable or simply non attainable. In any case we cannot expect others to display fixed levels of acculturation even after lengthy immersion in a given cultural environment.

d) **Preconceptions, implicit stereotypes**

Deconstructing stereotypes and preconceptions is hard work, and the end result would not bring a complete emancipation from preconceptions, rather the capacity to be aware of them. Trainers / educators working in diversity issues often assume they are through with preconceptions, and when certain situations bring those up (e.g. Transgender (HU), New Years Speech (BE), the disappointment and self-blaming can be exhausting. Researchers have shown that preconceptions and stereotypes are “natural” cognitive phenomena, automatisms. They operate without conscious effort, even in domains, which we do not suspect. To keep this in mind can prepare trainers to work through the stereotypes in the moment when they are activated.

e) **Own identity, authenticity, separation of personal and professional life**

Revealing aspects of our own identity can be a resource in intercultural work. It can also contribute to the recognition or empowerment of particular identities (e.g. migrant or minority identities). At the same time the preservation of personal identities would encourage us to keep parts of our identities covered. Without any general objective recommendations, the most that can be said is to keep the options open to negotiate in each situation where that boundary should be drawn, what are the risks and what are the gains of lifting or moving those boundaries.
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www.bodyproject.eu