

Ethical and Sociocultural Aspects of Sexual Function and Dysfunction in Both Sexes



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ABSTRACT

Aims: This study aimed to highlight the salient sociocultural factors contributing to sexual health and dysfunction and to offer recommendations for culturally sensitive clinical management and research as well for an ethically sound sexual health care, counseling and medical decision-making.

Background: There are limited data on the impact of sociocultural factors on male and female sexual function as well as on ethical principles to follow when clinical care falls outside of traditional realms of medically indicated interventions.

Methods: This study reviewed the current literature on sociocultural and ethical considerations with regard to male and female sexual dysfunction as well as cultural and cosmetic female and male genital modification procedures.

Results: It is recommended that clinicians evaluate their patients and their partners in the context of culture and assess distressing sexual symptoms regardless of whether they are a recognized dysfunction. Both clinicians and researchers should develop culturally sensitive assessment skills and instruments. There are a number of practices with complex ethical issues (eg, female genital cutting, female and male cosmetic genital surgery). Future International Committee of Sexual Medicine meetings should seek to develop guidelines and associated recommendations for a separate, broader chapter on ethics.

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Key Words: Sociocultural; Culture; Ethics; Cultural Sensitivity; Sexual Dysfunction; Religious Beliefs

The biopsychosocial paradigm recognizes that sexual difficulties may have multifactorial etiologies related to physical, psychological, and social factors.¹ In this model, however, factors related to the “social” and cultural components as contributors to sexual dysfunction often do not receive adequate attention. Sociocultural

factors are significant because they bear upon what every individual brings to the clinical setting. Not only can culture impact on how an individual communicates his/her sexual complaint but also which sexual problem s/he is more inclined to report. Political correctness, lack of knowledge of various cultural mores, or a micro rather than macro view of sexual dysfunction often prevent adequate investigation of the possible role of culture, religion, and social norms that may influence sexual behavior and functioning.

Furthermore, sexual health is a basic human right regardless of culture. The principles of biomedical ethics permeate all aspects of sexual medicine and include respect for autonomy, nonmaleficence, beneficence, and justice. However, sexuality and sexual behavior vary widely across differing sociocultural spheres, necessitating that health professionals provide a culturally informed approach to care within an ethical framework that imbues respect, understanding, and tolerance as foundational elements. Honing in specifically on traditional female genital surgeries and the rapid rise in the popularity and commercialization of both female and male genital cosmetic surgical procedures, which fall outside the traditional realm of medically indicated interventions, provides a unique lens through which complex moral and ethical concepts surrounding sexuality can be explored. Moreover these procedures illustrate the controversies surrounding health and human rights that providers grapple with as

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RECOMMENDATION	LOE/GRADE
1. Evaluate patients and their partners in the context of culture.	4/Grade C
2. Evaluate distressing sexual symptoms regardless of whether they are a recognized dysfunction.	4/Grade C
3. Develop culturally sensitive assessment instruments.	4/Research Principle
4. Conduct a culturally sensitive interview that acknowledges cultural factors and language barriers and includes agreement on what language and style would feel most comfortable for the client or couple.	4/Grade C
5. Assess heterosexual couples presenting with unconsummated marriage for the presence of female (vaginismus) or male sexual difficulties (eg, premature ejaculation) and impact on each other.	4/Grade C
6. Develop culturally and religiously sensitive assessment skills.	4/Grade C
7. Suspend preconceptions about clients' race/ethnicity/gender/sexuality and that of their family members.	4/Grade C

FEMALE GENITAL CUTTING: RECOMMENDATIONS AND ASSOCIATED LEVELS OF EVIDENCE (LOE)	LOE/GRADE
1. Providers should approach FGC-affected populations in a sensitive and professional manner. Education on FGC should be integrated into postgraduate health professions training curricula and Continuing Medical Education.	4/Grade C
2. FGC classification and counseling discussions should be documented in the medical records. Efforts should be made to limit attendants in the room to those directly involved with the care of the patient, ensuring privacy and patient confidentiality.	4/Grade C
3. Comprehensive care for FGC-affected women should also encompass reproductive, sexual health and psychosocial counseling.	4/Grade C
4. Address language barriers by incorporating trained medical interpreters and visual aids/diagrams. The woman's partner/spouse may play an important role in decision-making.	4/Grade C
5. An <i>adult</i> woman desiring elective vulvar genital modification of prior FGC should undergo a detailed history and physical examination using culturally appropriate terminology.	4/Grade C
6. Engage in community partnerships with FGC-affected communities and social service agencies that build trust, enhance community health literacy, and dispel fears while addressing: gender equity, economic empowerment, intimate partner violence, and stigma-reduction.	4/Grade C
7. Evidence-based clinical and ethical guidelines on the care of women with FGC should be developed that incorporate validated measures and quality improvement metrics.	4/Grade C
8. The performance of primary FGC among minors is illegal. Discussions on the legal ramifications of performing FGC on minors should be incorporated in patient counseling and education. Reporting to appropriate child welfare protection services is mandatory when a minor has recently been subjected to FGC or is at risk of undergoing this procedure.	4/Grade C
9. Consensus does not yet exist on what constitutes reinfibulation, and in what settings it can be condoned when requested by an <i>adult</i> woman. Future efforts must aim to further classify and distinguish traditional FGC from female genital cosmetic surgery (FGCS) procedures, distinguishing informed <i>adult</i> requests for partial reinfibulation for cosmetic/aesthetic reasons and hymenoplasty as distinct from primary FGC on minors.	4/Grade D
10. Women's empowerment through education and economic gain will influence women's reproductive health choices and healthy behavior, and accelerate progress towards the eventual abandonment of FGC.	4/Grade C

FEMALE GENITAL COSMETIC SURGERY: RECOMMENDATIONS AND ASSOCIATED LEVELS OF EVIDENCE (LOE)	LOE/GRADE
1. Professional societies and credentialing bodies must establish guidelines and monitor standards of practice regarding media portrayal or advertising for FGCS that is evidence-based and reflects normative anatomy.	4/Grade C
2. Avoid the use of such commercialized terminology that is nondescript, groups several procedures together, and does not reflect the body of scientific literature on well-established procedures.	4/Grade C
3. Physicians have an obligation to ensure patient safety and transparency regarding FGCS procedures.	4/Grade C
4. Women requesting FGCS should undergo a thorough clinical and psychological evaluation for sexual dysfunction using validated measures; distinguishing underlying major sexual or psychological dysfunction, and ruling out any possibility of coercion or exploitation.	4/Grade C
5. Counseling on FGCS should avoid using language that implies that the vulva are abnormally misshaped or deformed, or that through surgery the vulva can be “restored” to a more appealing size and shape.	4/Grade C
6. Physicians performing FGCS should have a clear understanding of the patient’s desires and expectations, including her goals for surgery. The risks and benefits of FGCS should be discussed and the specific technique used should be based on patient anatomy, patient preference, and the desired aesthetic.	4/Grade C
7. Patients must be able to distinguish FGCS from therapeutic surgical interventions. Surgeons should convey accurate information on the sexual, social, and/or functional outcomes.	4/Grade C
8. Physicians desiring to perform FGCS should undergo additional formal training and skills development in FGCS post-residency through hands-on supervised learning and continued medical education to assure quality and patient safety in practice.	4/Grade C
9. Physicians have an obligation to ensure that women have access to medically indicated gynecologic procedures, which takes precedence over access to FGCS.	4/Grade C
10. Commercial advertisement for FGCS must avoid conflict of interest and maintain a medical professional model of care that benefits and protects patients.	4/Grade C
11. Physicians who see adolescents requesting FGCS require additional expertise in counseling adolescents.	4/Grade C

MALE GENITAL COSMETIC SURGERY: RECOMMENDATIONS AND ASSOCIATED LEVELS OF EVIDENCE (LOE)	LOE/GRADE
1. Most men complaining of a small penis are actually normal in size without anatomical or functional penile anomaly.	4/Grade C
2. Approaches to treatment should be informed by rigorous evidence-based research and incorporate structured counseling and management protocols.	4/Grade C
3. Penile augmentation surgeries to increase penile girth and length have not been proven safe or efficacious for men with normal penile size.	4/Grade C
4. Patients considering penile enhancement procedures should be clearly counseled on the risk of complications and adverse outcomes.	4/Grade C
5. Regulations prohibiting false and unsubstantiated advertising claims concerning penile enhancement procedures should be enforced by government agencies and medical regulatory bodies.	4/Grade C

they seek to provide quality care amid differing moral and ethical worldviews and limited available safety and efficacy data to inform evidence-based best practices. Guidelines and policies of professional medical societies and multinational bodies play a critical role in defining what constitutes genital modification procedures that

improve benefit, minimize harm, advance human rights, and protect vulnerable populations. This paper highlights culturally informed approaches to sexual health care while illustrating nuanced controversies through the lens of genital modification procedures and provides guidance on how to apply principles of medical ethics.

SOCIOLOGICAL CONSIDERATIONS

The Role of Culture and Society in Sexual Dysfunctions

A variety of social and cultural factors may affect individual and couple's sexual functioning. Cultural messages include moral or religious beliefs regarding sex, as well as media messages that in many cultures act as a primary source of sexual education. Social construction of gender and sexuality may affect functioning in both men and women.² For example, women with dyspareunia exhibited more mate-guarding and duty/pressure motives for engaging in intercourse and had more maladaptive penetration-related beliefs than women without sexual pain.³ Factors related to the societal role of sexuality influence expectations, such as that women must allow vaginal intercourse for satisfactory sex to please her partner or fulfill his/her need for sex or that men must always initiate, perform, and provide a firm erection. These social and cultural messages often influence the psychological presentations as they translate to feelings of anxiety, guilt, responsibility for the lack of intimacy, and lack of autonomy and control in intimate relationships.⁴

Another method of approaching the impact of sociocultural factors upon sexual function and behaviors, and a valuable way to address the needs of cultural minorities and immigrant populations in a Western context, is to explore the phenomenon of acculturation. Acculturation explains the process of behavioral and cultural adaptation that occurs when an immigrant raised in one culture arrives in another country with a different culture.⁵ In the specific context of international migration, acculturation refers to adjustment along 2 dimensions: (1) adoption of ideals, values, and behaviors of the receiving culture and (2) maintenance of ideals, values, and beliefs from the immigrant person's culture of origin.⁶ As sexual response and roles are at least in part influenced by sociocultural factors, it is reasonable to expect that acculturation, depending on its degree, affects to a certain extent sexual health and behavior. Recent studies have increasingly emphasized the importance of attending to both dimensions of acculturation.^{7–11} Despite the paucity of relevant data regarding the role of acculturation in sexual dysfunction, a culturally sensitive approach in a clinical setting should take into account the degree of acculturation¹² and not assume that length of time in a new culture corresponds with one's adoption of the new culture's sexual values, given that one might hold strongly to the customs and values of their heritage culture.

Additional sociocultural factors to consider in assessing possible contributors to sexual dysfunction include religious beliefs. Values and traditions regarding sexual meaning, ritual, and practice vary across religions. Traditional values and rituals that may restrict access to knowledge about sex and emphasize restricted and limited sexual behaviors, as well as ejaculatory restrictions, may impact sexual functioning through their influence on emotions, including guilt and anxiety.¹³

Culture-bound syndromes (CBS) are another manifestation of sociocultural influence on sexual dysfunctions. Furthermore,

both culture and society weigh on whether individuals even seek treatment to start with, what kind of treatment they seek and how much stigma and meaning they attach to their sexual problem.

What follows are illustrative but not exhaustive examples of sociocultural factors that impact on the prevalence of sexual difficulties. However, the following examples should not be generalized and applied as stereotypes to individual members of a racial, ethnic, religious, or cultural group.

Culturally Defined Sexual Dysfunctions vs Universal Sexual Dysfunctions

The Pfizer-funded Global Study of Sexual Attitudes, Beliefs and Behaviors (GSSAB)¹⁴ studied 13,618 men and 13,882 women aged 40 to 80 years from 29 countries. This crosscultural study showed significant diversity in sexual prevalence, with eastern countries having much higher rates of sexual problems. This discrepancy in the results might be an artifact of using Western definitions of sexual dysfunction and measures.

Indeed, male and female sexual dysfunctions do not always have similar and recognizable symptoms throughout the world. CBS distinctive to certain ethnic groups reflect this variability. Research has not yet established whether CBS are different from recognized sexual disorders, are variants of them, or whether both sexual dysfunctions and CBS reveal different means by which sociocultural factors interact with genetic background to provoke impairment. Experts' views on Dhat syndrome and Koro syndrome illustrate well this dilemma.^{15–18} Dhat syndrome was first described as a CBS of the Indian subcontinent.¹⁹ Over the years, many authors have recommended categorizing Dhat syndrome as a "culture-related" disorder rather than a CBD.^{20,21} Nowadays, Dhat syndrome is classified by ICD-10 as both a neurotic disorder (code F48.8) and a culture-specific disorder (Annexe 2) caused by "undue concern about the debilitating effects of the passage of semen."^{16,20,21} Grover et al²¹ even designed a comprehensive questionnaire to help clinicians assess Dhat syndrome.

The sociocultural context influences also the way a patient describes their sexual complaint and what symptoms he/she will report. Sometimes these symptoms and concerns are not considered as sexual problems by Western standards. For example, Verma et al²² evaluated the complaints of 1000 consecutive patients attending a sex therapy clinic in India. Premature ejaculation (PE) was the most common problem (77.6% of men). However, semen concerns, masturbation, and size issues were all reported more often than complaints of erectile dysfunction (24%).²² These concerns are less likely to be reported in Occidental populations and are less frequently assessed by clinicians following Western guidelines. Even when some authors^{23,24} recommend the assessment of masturbatory habits, they do not describe masturbation as a potential concern by itself but as a pleasurable and natural behavior that could lead to sexual dysfunctions if abnormally practiced.

Other illustrations of the cultural gap between Western-defined sexual dysfunction and sexual difficulties as described and reported by other populations are unconsummated marriages due to social pressure, religious beliefs, and lack of appropriate sexual knowledge without any underlying specific sexual dysfunction.²⁵

Moreover, it is difficult to adhere to the concept of a universal set of sexual dysfunctions when some cultures consider certain Western-labeled sexual dysfunctions as a norm to attain. For example, in many Asian, African, and Latin American countries, but especially in sub-Saharan Africa, women carry out a variety of modifications to their genitals.^{26–28} One of these practices is called “dry sex” and involves the insertion of natural and/or synthetic products into the vagina in order to dry up the normal lubrication fluid created by sexual arousal. This practice is believed to increase sexual satisfaction of 1 or both partners. The clinician may have opposing views about certain practices and their “benefits” for patients. Unfortunately, the only available data on these ethnic minorities focus on issues of sexual health and risk rather than on concerns related to sexual satisfaction.²⁹ A “single umbrella” classification of sexual dysfunctions free of sociocultural contexts is quite impossible to obtain,³⁰ as these minorities do not fit inside this classification.

Cultures also vary with respect to the meaning they impart to sexual problems, their way of comprehending the subjective experience of dysfunction and distress. The meaning attributed to a sexual problem is, in part, dependent on sexual motives. Sexual motivation varies according to cultures. When a person considers sexuality as a way of expressing love and of experiencing intimacy and pleasure, a disruption of the normal course of sexual function is not only considered as a threat to the relationship equilibrium but also as a lack of quality of life and satisfaction. However, when motives include reproduction and marital duty, sexual dysfunction has a completely different meaning and individuals will complain of different sexual problems. For example, for French men and women,³¹ sexual activity is more synonymous with pleasure and love than with procreation. According to Bangladeshi men, both quick ejaculation and erectile difficulties are perceived as a shameful failure endangering their masculinity.³² For Muslim men living in the U.K., premature ejaculation was referred to as a punishment.³³ Women also differ in the meaning they attach to sexual difficulties. According to Yasan et al,³⁴ in a conservative culture, women suffering from vaginismus are under great social pressure to engage in sexual intercourse on the first night of marriage or soon thereafter. An unconsummated marriage would expose these women to traumatic experiences and loss of social status as a consequence of their dysfunction.

In summary, individuals with CBS require more than a dismissal that nothing is wrong (based on Western cultural ideals). Clinicians should be aware that some forms of sexual distress might not correspond with Western classifications of sexual dysfunctions and might consequently need a separate and different category of representation (Recommendation: Grade C/Level 4.). Hence, clinicians need to carefully assess sociocultural

factors in patients presenting with sexual distress (Recommendation: Grade C/Level 4.) and work on developing culturally sensitive instruments, both quantitative and qualitative, that would measure sexual distress (Research principle).

Global Prevalence of Sexual Dysfunctions: How Does Culture Impact Available Prevalence Rates?

Cultural and social factors contribute to sexual dysfunction, yet evaluating such contributions correctly is difficult due to the lack of reliable data regarding the prevalence of sexual difficulties in different cultures.²⁹

The majority of epidemiologic research assessing sexual dysfunction prevalence was conducted in Western countries (North America and Europe). Apart from the GSSAB,¹⁴ most of the data collected in non-Western countries are based on small numbers, clinical samples, or case studies.³⁵ Recent prevalence studies of the various types of premature ejaculation were conducted in both Turkey and China.^{36,37} According to both studies, a relatively high proportion of men (20.0% in Turkey and 25.8% in China) reported a concern with ejaculating too rapidly. Furthermore, the reported prevalence of sexual problems by available studies varies widely across cultures and ethnic backgrounds but it is not clear whether this variation is really related to cultural and racial differences or simply to differences in study designs and measures.^{38,39}

For example, the prevalence of sexual problems differs across studies depending upon various elements including definition of disorders and the classification system used for diagnoses, time frame of the study, and use of particular criteria such as distress.^{40,41}

Another bias characterizing both crosscultural and ethnic groups research is systematic use of Western standards to measure sexual function and dysfunctions.¹⁰ Keeping in mind that sexual concerns of diverse cultures do not necessarily correspond to those of Western populations, it is difficult to analyze the results of these studies and to determine with accuracy a global prevalence of sexual dysfunctions.

A 2-year U.K.-based survey of men’s sexual concerns conducted via e-mail and telephone helpline identified significant correlations between the types of sexual dysfunction and ethnicity of the men who presented with them.⁴² A large number of men, especially young Muslim men from the Middle East and the Indian subcontinent, reported premature ejaculation and masturbation worries as being significant concerns. Shaer and Shaer⁴³ additionally reported that premature ejaculation, low desire, concerns over penile size, and penile curvature were common worries among Arabic-speaking men in the Middle East that should be considered in the evaluation of men with erectile dysfunction. Moreover, Zargooshi⁴⁴ suggests that men in arranged marriages are significantly more likely to have concerns regarding premature ejaculation. Among the causal factors suggested for this association were the absence of sexual activity before marriage, anxiety related to first sexual experiences, religious beliefs, and family pressure.^{44,45} It is, however, important

to point out that most of these surveys employ self-report and do not assess distress or chronicity. In other words, a man's belief that he ejaculates too quickly may not be congruent with the DSM-5 objective diagnostic criteria of premature ejaculation. Higher reported complaints of rapidity of ejaculation are not necessarily equivalent to an actual higher prevalence of premature ejaculation (whether lifelong or acquired).

The impact of sociocultural factors on sexual dysfunction is not the exclusive domain of non-Western populations. In a cross-cultural study conducted on more than 5000 men from 3 European countries (Portugal, Croatia, and Norway)⁴⁶ the odds of reporting a distressing lack of sexual interest were significantly associated with sociocultural contexts. Moreover, men indicated masturbation and use of pornography as a reason for their decreased desire and speculated that guilt and religious beliefs may have mediated these effects.

The prevalence of female sexual concerns also varies across cultures but the literature reveals several contradictory results. For example, while low sexual desire is most prevalent in Western women,^{14,31} in India,⁴⁷ Iran,⁴⁸ Nigeria,⁴⁹ and China,⁵⁰ orgasmic problems were the most prevalent sexual problem. According to Lo and Kok,⁵⁰ these differences in prevalence between the East and the West can be explained by their understanding that Asian wives are not entitled to have sexual desire, hence lack of sexual desire was considered to be not a problem but a norm. On the other hand, not reaching an orgasm quickly and easily was the sign of a physical problem that should be fixed. In other words, reporting orgasm difficulties was legitimate as opposed to desire problems.

In the Middle East, results were also contradictory. Oksuz⁵¹ came to the conclusion that sexual desire problems were the most common among Turkish women; however, other data⁵² suggest that vaginismus is the primary sexual complaint for which women seek treatment. According to Dogan,⁵² Turkish women seek help for vaginismus and not for sexual desire concerns because the first problem prohibits intercourse whereas the second does not. The high prevalence of vaginismus within conservative and religious populations has been attributed to numerous cultural factors such as restrictive premarital sexual activities and the sacralization of virginity.⁵³ Western authors⁵⁴ agree with this theory and suggest that high conservative morals, along with restricted sexual standards, are involved in the development of vaginismus.

It is important to mention that unconsummated marriages—or the incapacity to achieve successful penile-vaginal penetration between newly wedded couples—is a major issue in traditional Middle Eastern societies and in some developing countries, where premarital sexual practices are prohibited by religious beliefs and cultural taboos. Vaginismus has been reported as the leading cause of unconsummated marriage followed by ED or “honeymoon impotence.”^{44,53}

Clinicians should carefully assess couples presenting with unconsummated marriage for the presence of female (vaginismus) or male sexual difficulties (eg, premature ejaculation,

erectile dysfunction) and their impact on each other (Recommendation: Grade C/Level 4.).

Culture and Treatment Seeking

In North America, research indicates that racial and ethnic minorities are less likely than Caucasians to seek help for sexual difficulties.⁵⁵ False sociocultural beliefs about available treatments lead individuals to delay seeking help until symptoms are more severe.^{56–58} Interestingly, one study disagreed with the assumption that non-Western populations turned more often to primary care and to informal sources of care such as religious men, traditional healers, and family and friends. Indeed, according to Tan et al,⁵⁹ although the majority of Asian men have never sought help for their erectile dysfunction, those who have, consulted, Western doctors rather than from traditional Chinese medicine practitioners.

Conversely, in comparison with men and women from Western regions involved in the GSSAB (including Europe and North America), the responses from Asian subjects indicate that they were less likely than Caucasians to seek help for sexual difficulties.¹⁴ Overall, the lack of awareness or the belief that the problem is not a medical concern were the most common reasons cited by men and women for not consulting a health practitioner about their sexual problem.⁶⁰

Many ethnic minorities also prefer drug therapy to counseling. These patients often expect a physical explanation for their dysfunction and are unreceptive to psychological assessment.⁶¹ It is important to recognize and explore patients' expectations to avoid misinterpretations and offering culturally “unacceptable” care. Moreover, when they fail to comprehend the concept of psychosexual management, many of these patients do not come back for a follow-up appointment and remain an underserved population.^{62,63}

Cultural Sensitivity in Sex Therapy

The culturally sensitive sexual health interview must consider that perception of pathology and distress related to certain presentations may be influenced by the client's social, cultural, or religious perspective. Cardemil and Battle⁶⁴ provide excellent guidelines for clinicians to follow (Table 1) (Recommendation: Grade C, Level 4). In addition to the recommendations in Table 1, clinicians should consider the following additional and fundamental points in their culturally sensitive assessment.

1. Assess personal values and attitudes

Cultural sensitivity does not necessitate agreement with client's values but does require respect for and acceptance of their limitations without judgment. Honest self-reflection and awareness of the personal feelings and reactions that become aroused in treatment and processing of these feelings in supervision or workshops assist in creating acceptance and understanding.

2. Ask about culture

Awareness and acknowledgment of cultural differences are first steps in “breaking the ice” of cultural diversity. Race and ethnicity, especially in Western societies such as North America where political correctness may inhibit questioning, can be the proverbial “elephant in the room.” For example, Hansen and colleagues⁶⁵ reported that in their study of 149 psychologists, 39% rarely or never sought culture-specific case consultation and 27% rarely or never referred a client to a more culturally qualified therapist. Clinicians should attempt to increase their awareness of sexual mores in various cultures through education and access to informative resources.^{13,66,67}

Sexual functioning assessment, whether in the context of medical or mental health services, should include questions, raised in a sensitive manner, about culture and religion, and how those factors may impact on the presenting condition, or the perception of that condition. Clients do not expect all practitioners to be expert on the values, rituals, and practices of all cultures and faiths, and are generally willing and happy to provide this information. Rather than make assumptions based on clients’ outward presentation, simply staying curious and respectful allows clients to be engaged in meaningful discourse that provides important information regarding the presenting condition.

3. Acknowledge and addressing culturally based challenges in discussing sex

The extent to which individuals and couples feel comfortable discussing sex varies among people, but cultural factors and language barriers may certainly influence comfort. Many faith-based cultures value modesty in dress and language and open discussion of sex may be discouraged.

A culturally sensitive interview should acknowledge cultural factors and language barriers and include agreement on what language and style would feel most comfortable for the client or couple (Recommendation: Grade C, Level 4).

4. Clarify the triangle of love

Sternberg⁶⁸ developed the triangular theory of love, which involves 3 major components: passion, intimacy, and

Table 1. Guidelines for Clinicians Carrying Out a Culturally Sensitive Assessment of Individuals and Couples Presenting With Sexual Concerns

- Suspend preconceptions about clients’ race/ethnicity/gender/sexuality and that of their family members.
- Recognize that clients may be quite different from other members of their racial/ethnic/gender/sexual group.
- Consider how racial/ethnic/sexual and other differences in background and experience between therapist and client might affect therapy.
- Acknowledge that power, privilege, racism, and sexual prejudice might affect interactions with clients.
- When in doubt about the importance of race, ethnicity, gender, and sexuality in treatment, err on the side of discussion; be willing to take risks with clients.

commitment. Most Western relationships are created based on these components, generally beginning with initial passion and idealization, falling into intimacy and attachment, and finally reaching a stage of commitment culminating in marriage. In many traditional cultures, family or community arranges marriages and couples may have established only an acquaintance, a friendship, or perhaps an intimate but not sexually consummated relationship. Often commitment precedes intimacy and passion and the expectation of “falling in love” is a variable concept. The radical shift from sexual (or relative sexual) abstinence to complete sexual intercourse as a source of cognitive dissonance has been addressed in the literature.⁶⁹ Additional cultural considerations include the expectation to function sexually without prior establishment of intimacy, and the level of communication between the partners regarding sexual expectations.

5. Assess Sexual Knowledge and Preparation

The ability to commence a healthy and satisfying sexual relationship depends on receiving accurate sexual information and preparation. For example, one population study on marital preparation in the Jewish Orthodox population revealed that only 40% reported having been well prepared for their wedding night, and 64.5% did not know the “basics of intercourse.”⁷⁰ Particularly in cases of unconsummated marriage, assessment of sexual knowledge is critical as often a simple lack of information, insufficient premarital education, and a cultural context strongly proscribing sexual behavior contribute to this phenomenon.⁷¹

6. Be mindful of religious conflicts

Sexual expression and behaviors reflect one’s personal sense of self and, to that extent, one’s religious beliefs may directly influence sexual functioning. Although it is not within the scope of this manuscript to provide a summary of the sexual mores of the major religions, there are resources that have been recently provided to address this need.¹³ Religion plays a fundamental role in prescribing and proscribing sexual values and in regulating sexual activities, practices, and behaviors. Clinicians should be aware of specific religious influences, such as restrictions on premarital sex, masturbation, extra-vaginal ejaculation, and sexual positions and practices, though not assume that the presenting couple practices them. It is always best to err on the side of caution and ask the couple directly about religious factors that may be relevant. Sex therapy practices can be modified for couples to conform to religious restrictions.^{72,73} Although the literature has reported that factors such as religious shame, guilt, and conflict around sex may affect sexual functioning,^{72–74} the extent to which religious beliefs and practices directly affect sexual functioning is unknown.⁷⁴ Sensitive practice assumes the ability and willingness to confer with client’s clergy when appropriate.

7. Sociological considerations in practice

To adequately address the contribution of sociocultural components to sexual functioning, the clients’ social world must be understood. Sociological theory offers an additional dimension to treatment that examines the significance and of the presenting

condition within the clients' social interactions. Sociological theories are theoretical frameworks that sociologists use to explain and analyze how social action, social processes, and social structures work. A key concept in sociological theory is role identity. Role identity is defined as the role (or character) people play when holding specific social positions in groups. Individuals are committed to a particular role identity and are motivated to act according to their conception of the identity and to maintain and protect it, as their role performance implicates their self-esteem. For a woman in a faith-based society, for example, whose self-concept and self-esteem has been socialized and defined by a culture that values chastity and virginity, taking on a new role as a married woman and a new identity as a sexual human being, may be a source of cognitive dissonance. Furthermore, a woman's reflected appraisal may be wrapped up in how she perceives that others, who may see or know that she is sexually active, see and judge her. This contributes to how she sees herself, and if her self-image is negatively affected, her sexual problems will be perpetuated. Likewise, social messages to men linking masculinity with sexual performance may act as a source of anxiety, possibly triggering and maintaining the sexual problem.

ETHICAL CONSIDERATIONS

The controversies surrounding female and male genital modification procedures illustrate the nuances of culturally informed care that health care providers may face wherein applying principles of medical ethics may have important implications on guiding approaches to ethically sound sexual health care, counseling, and medical decision-making.

Female Genital Cutting

Health care providers increasingly grapple with traditional cultural practices that impact sexual health and well-being. Global migration patterns have broadened ethnocultural diversity in the West; adding unique challenges to providing quality, ethical and culturally sensitive care. Providers must become cognizant and respectful of the varying perspectives their patients bring regarding their bodies, their health concerns, as well as customs and practices from different regions around the world⁷⁵ (Recommendation: Grade C/Level 4).

One such cultural practice is female genital cutting (FGC), otherwise known as female genital mutilation or female circumcision, which is an ancient cultural tradition that has come under intense international scrutiny due to immigration from FGC-affected regions of the world. FGC is defined as any procedure that involves partial or total removal of external female genitalia or other injury to female genital organs whether for cultural or nontherapeutic reasons⁷⁶ (Table 2). Although often understood as a form of gender-based violence and a violation of a woman's basic right to health, FGC is anchored in a complex sociocultural context, often being performed as a ritual initiation into womanhood which imbues psychosocial benefits of social acceptance and marriageability, and preserving virginity while instilling pride, honor, value, and esthetics.⁷⁷

FGC affects up to 140 million women worldwide. Each year 3 million girls are at risk of undergoing this practice.⁷⁶ FGC is documented in 28 countries throughout sub-Saharan Africa and in regions of Southeast Asia and the Middle East. Prevalence rates vary between and within nations, with some regions possessing rates higher than 90%. Educational campaigns against FGC have led to a significant decline in its prevalence over the last 25 years, although support for its continuation varies widely among and within countries. Although complete abandonment of FGC has yet to be attained, increasing medicalization as a harm reduction strategy has led to declines in the more severe forms of the practice among younger generations of women and girls in recent times.⁷⁸

Despite the availability of clinical care protocols, a growing body of evidence indicates persistence of significant gaps in the training of providers on caring for FGC-affected populations^{79–89} (Recommendation: Grade C/Level 4). As these populations integrate into Western society, complex sociocultural challenges present themselves as providers consider their own personal identity and culture while caring for communities that uphold contrasting values and identities ascribed by this practice.⁹⁰ Consequently, FGC raises a number of ethical considerations. Intense controversy persists surrounding genital modification procedures performed on minors (whether male or female) who are unable to provide informed consent,^{91,92} the Western media's portrayal and over-generalization of FGC without attention to rigorous evidence-based research and balanced public policy debates,⁹³ and the confluence of double-standards around female genital cosmetic surgery and an adult woman's ability to choose genital modification procedures.⁹⁴

Table 2. 2007 WHO Classification

Type	Definition
I	Partial or total removal of the clitoris and/or the prepuce. (clitoridectomy) <i>Type Ia</i> – removal of the clitoral hood or prepuce only. <i>Type Ib</i> – removal of the clitoris with the prepuce.
II	Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (excision). <i>Type IIa</i> – removal of the labia minora only. <i>Type IIb</i> – partial or total removal of the clitoris and the labia minora. <i>Type IIc</i> – partial or total removal of the clitoris, the labia minora and the labia majora.
III	Narrowing of the vaginal orifice with creation of a covering seal by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris (infibulation). <i>Type IIIa</i> – removal and apposition of the labia minora. <i>Type IIIb</i> – removal and apposition of the labia majora.
IV	Unclassified: All other harmful procedures to the female genitalia for nonmedical purposes, (i.e., pricking, piercing, incising, scraping, and cauterization).

Reinfibulation

Primary FGC on minors is universally criminalized throughout the Western world^{95,96} (Recommendation: Grade C/Level 4), whereas repair of FGC (in the form of defibulation to open the vulvar scar in Type III FGC to facilitate penile-vaginal intercourse or childbirth) is generally an accepted medical indication. However, variation in prohibition exists for reinfibulation procedures (reapproximation of the Type III FGC vulvar scar). An ethical conflict for providers may arise if they receive requests from women to have their scars reinfibulated to varying degrees after delivery to restore their sense of beauty, normalcy, and genital self-image⁹⁷ (Recommendation: Grade D/Level 4). The procedure of reinfibulation entails the reapproximation of the vulvar scar that was opened to facilitate vaginal birth, to resemble the original circumcision scar (or variation thereof) post-delivery.⁹⁸ Providers may perform *partial* reinfibulation (restoration of only the most superior aspect of the vulvar scar above the level of the urethra) without creating new harm. There is evidence that the clitoral glans remains intact beneath the vulvar scar in nearly 50% of cases.⁹⁹ However, empirical studies are lacking on the psychosexual outcomes and impact on genital self-image among women requesting reinfibulation. Further clarification of what constitutes reinfibulation is necessary, in terms of specific tissues involved. Moreover, professional guidelines and policy recommendations for providers should include guidance on how to counsel women who request a form of reinfibulation, particularly partial reinfibulation^{100,101} (Recommendation: Grade D/Level 4).

Another concern is the sociocultural repercussions on women residing within immigrant ethnic enclaves who are at risk of being ostracized and face psychosocial harm if they do not abide by cultural mores on reinfibulation.⁹⁰ Evidence indicates that women emigrating from communities where FGC is normative live in a sociocultural context within which this tradition is viewed as an important aspect of life even after immigration to the West.⁷⁷ Due to how deeply rooted this cultural practice is embedded within immigrant communities, a woman may lack autonomy in decision-making regarding the management of her scar at delivery and may be unduly influenced by pressure from her family and/or community^{94,100,102–104} (Recommendation: Grade C/Level 4).

Genital Cosmetic Surgeries

Female Genital Cosmetic Surgery (FGCS)

There has been a significant growth in requests for female genital cosmetic surgery (FGCS) over the past decade which has raised a number of ethical concerns as the evidence-based literature on clinical outcomes has not kept pace with the demand for these procedures. The increasing popularity of these procedures has been attributed to increased exposure to female nudity in the media, increased pubic hair grooming, and vulvar images on the internet, print magazines, and video pornography, which has skewed societal perceptions defining a very narrow ideal for the appearance of the female genitalia and imposed pressure on women to alter their appearances to achieve perfection, beauty,

and/or enhanced function.^{105–108} This has become a source of controversy worldwide due to the ethical and human rights concerns raised that extend beyond the risks of the procedures themselves to promote certain cultural views of women.¹⁰⁴

FGCS represents a variety of nontherapeutic procedures performed on women whose genitalia are physically healthy, within the normal range of variation of human anatomy, and are sought out to change the appearance or to impact function of genitalia to achieve an individual cosmetic goal.¹⁰⁹ FGCS is an umbrella term encompassing multiple procedures that are distinct from one another. Terminology such as “laser vaginal rejuvenation,” “designer laser vaginoplasty,” “revirgination,” and “G-spot amplification” reflect commercialized and even trademarked phrases used to market enhanced genital appearance and sexual performance.¹¹⁰ Hence, ambiguity and inconsistency exist in terms of what these commercialized terms actually mean.¹¹¹ Among the most popular forms of FGCS is “vaginal rejuvenation,” which is a term synonymous with vaginoplasty and/or perineoplasty.

There were more than 5000 vaginal rejuvenation procedures performed in the U.S. in 2013, an increase of 44% from 2012.¹¹² However, due to its nondescript nature, there is wide disparity among plastic surgeons and gynecologists as to what constitutes “vaginal rejuvenation” and what the procedure actually entails, which results in miscommunication among providers as well as unclear patient education and counseling^{111,113–118} (Recommendation: Grade C/Level 4).

There is no consensus on techniques for FGCS procedures, and very limited outcome data have been published to date. The various forms of FGCS have varying degrees of evidence, safety, efficacy, indications, and ethical considerations. The evidence on FGCS is often retrospective, lacking in controls or comparative data. Furthermore, there have been no large prospective clinical outcome trials to date, and current practice lacks uniformity and remains poorly described.¹⁰⁷ Women request FGCS procedures for a variety of functional and esthetic reasons including changing the appearance of normal vulva to a desired shape or size, increasing sensation during intercourse, decreasing interference with intercourse, relieving pain and discomfort with clothing and exercise, and improving self-image.^{105,119} Moreover, the appearance of the vulva can create significant psychological distress, particularly among adolescent populations.¹²⁰ Despite the controversy surrounding these procedures, overall patient satisfaction rates are high.¹²¹ Complications occur in 4% to 18% of women^{122,123} and include problems with wound healing, pain with sex, vulvar vestibulitis, excess bleeding, infection, and overtightening of the perineum.¹²³

Male Genital Cosmetic Surgery (MGCS)

Penile augmentation procedures have increased in global popularity in recent years as advertisements target men concerned about their penile size, offering a wide range of procedures and devices claiming to enhance penile size.¹²⁴ Procedures for penile enhancement remain highly controversial due to the wide

variety of procedures, lack of standardization, and absence of safety and efficacy outcomes data. Research examining normal penile size note differences between objective physician-standardized measurements and patient self-reporting, which may be influenced by measurement techniques as well as mode of achieving an erection.^{124–126} Studies indicate that the majority of men requesting surgical penile enhancement have a normal-sized and fully functional penis^{124,127} (Recommendation: Grade C/Level 4). Although some men may be uninformed about the range of normal penile sizes, others may have a condition known as penile dysmorphophobia, which is a subset of body dysmorphic disorder (BDD), not amenable to surgical interventions but rather psychotherapy, education, and counseling.

Surgical approaches to penile enhancement include a variety of procedures to augment length (ie, suspensory ligament release, prepubic liposuction or surgical lipectomy, correction of ventral chordee or scrotal web, penile disassembly and cartilage transplant), and/or girth (ie, lipoinjection, dermal graft, temporalis fascia transfer, saphenous vein grafts, and injection of synthetic materials).¹²⁴ Indications, patient selection criteria, and outcome measures are poorly defined due to the absence of standardized measurement tools, validated survey instruments, and independent review panels. Moreover, an accurate assessment of complication rates is difficult to discern and may include penile deformity, paradoxical penile shortening, scarring, granuloma formation, migration of injected material, and sexual dysfunction.¹²⁷

Currently there are no randomized controlled trials or meta-analyses examining outcomes of surgical and interventional procedures for penile enhancement. Little consensus exists to guide the development of best practice guidelines to manage patients who present with distress about their penile size and for penile enhancement surgery. In 1996, the first guidelines advised that only men with an erect length of less than 7.5 cm be considered candidates for penile augmentation.¹²⁸ Wylie and Eardley proposed normalizing patient education and the inclusion of psychotherapy in the form of cognitive behavioral therapy (CBT), as well as physical treatments using vacuum devices, penile extenders, traction devices, and rings (although the evidence on efficacy is limited). Furthermore, medications such as selective serotonin reuptake inhibitors (SSRIs) can be incorporated in the treatment of BDD.¹²⁹ A structured management and counseling plan has been proposed for the initial evaluation and counseling of physically normal patients with a complaint of a small penis involving empathic understanding, conveyance of the facts, and advice about true options. If the patient still insists on surgery, then consultation with a plastic surgeon should be included to optimize the best surgical approach¹³⁰ (Recommendation: Grade C/Level 4).

Penile enhancement surgical procedures remain a highly controversial and experimental practice due to the lack of rigorous outcomes data and validated objective measurement tools, as well as high rate of complications and patient dissatisfaction. Until long-term safety and efficacy data are available,

nonsurgical treatment modalities and appropriate patient education and counseling should be employed^{131,132} (Recommendation: Grade C/Level 4).

Female Genital Cutting vs Female Genital Cosmetic Surgery

On a fundamental level, FGC and FGCS share some commonalities, as both entail modification to female genitalia for nontherapeutic reasons to either reduce or enhance (depending on the culture and surgical procedure) sexual function, desire, and attractiveness. Although based on cultural norms and expectations, these procedures are not without inherent risks. However, it is argued that FGC and FGCS are distinct entities with FGC being performed mainly on girls without consent under unsanitary conditions and largely by untrained, nonmedical personnel and to curb female sexual function in many circumstances, whereas FGCS is performed on consenting adult women in sterile operating suites under skilled surgical precision to enhance female sexual function and partner satisfaction. There is great variation in the extent of tissue excised in both types of genital modification including pricking the genitals to draw a drop of blood, hymen reconstruction,^{92,133} labiaplasty, and infibulation (Type III FGC); however, the primary difference between these procedures is the ability to provide informed consent.

There is international consensus denouncing all forms of genital modification on female minors as a human rights violation⁷⁶ (Recommendation: Grade C/Level 4). Focusing on the rights of children anchors the debate on children's right to bodily integrity until they have reached an age at which they may give informed consent.⁹⁴ However, what is often neglected in this debate are the ethical considerations of consenting adults who choose to alter their genitalia as part of their basic human right to control their own bodies, whether to comport with a specific tradition, custom, or esthetic, or to promote their mental and social well-being. The controversy around genital modification among adult women lies in the performance of medically unnecessary procedures to conform one's appearance to a prevailing or personal standard of beauty, which may vary by culture and era and by various pressures: whether social or community, societal ideals, the beauty industry, mainstream media, or one's own insecurities.^{134,135}

Further ethical complexity enshrouds the condemnation of FGC as a human rights abuse juxtaposed against Western acceptance of male circumcision and the recent rise in requests for FGCS as well as MGCS. A double standard exists which forbids elective genital modifications on consenting adult women with FGC who elect to undergo culturally motivated cosmetic genital alteration, whereas accepting elective FGCS, MGCS, and male circumcision.^{94,136} For providers, the challenge lies in disentangling the influence of ethnicity, migration, sex, and gender on sociocultural attitudes towards FGC among immigrant communities that have already undergone FGC upon arrival to the West.^{90,100}

Genital modification procedures are not purely about anatomy and physiology, but are intertwined within cultural norms and ideology. The unifying voice between the contrasting discourse on FGC and FGCS lies in a woman's ability to make a voluntary and informed choice and to be the ultimate decision-maker on what is done to her own body.⁹⁴

Principles of Medical Ethics

Genital modification procedures of any kind have inherent risks and benefits, which include not only the potential physical and physiological impact, but also psychological and sociocultural consequences. Discerning what value the patient ascribes to personal autonomy, self-actualization, social acceptance, and culturally specific esthetics are important factors to elicit during counseling.

Autonomy and Informed Consent

Respect for autonomy is rooted in the principle that adult patients without mental impairment have the right to make informed choices about their health care without interference from others.⁷⁵ Implicit within autonomy is possessing knowledge and understanding to provide informed consent with a thorough understanding of the nature and purpose of surgery, its benefits and risks, available alternative options, and likely consequences.⁷⁵ Autonomous decision-making and the right to self-choice may be compromised by insufficient education, personal or cultural coercion by a partner, or by an individual's inability to make one's own health choices. This can be further exacerbated by a lack of economic independence.

Providers who encounter requests for genital modification should first assess whether the patient is competent to make medical decisions, taking into consideration one's ability to communicate a choice that reflects understanding of the procedure, and that one's choice remains stable over time, and is consistent with one's values and best interests.¹³⁴ An assessment of baseline sexual function using validated measures should be employed. The patient should be able to engage in a dialogue on informed consent expressing an understanding of the immediate and long-term risks, benefits, indications, and alternatives of the procedure (Recommendation: Grade C/Level 4).

Autonomy also denotes the ability to make choices without undue coercive influence from other individuals or society. Restrictive commercial agreements that allow a surgeon to claim unique skills, tests, and/or treatments should be disclosed to avoid giving the public the deceptive impression that experimental or unstudied procedures are of proven value or accepted practice¹³⁷ (Recommendation: Grade C/Level 4). When these circumstances are present, a patient may not be in a position to make an informed, educated choice.

Nonmaleficence

The ethical principal of nonmaleficence admonishes to "do no harm." Harm reduction strategies in FGC (ie, requests for partial

reinfibulation) enable the patient to choose the type and degree of genital modification and have procedures performed in a controlled environment with skilled surgical technique, anesthesia, and postoperative care. Although Anti-FGC activists may argue that provider acquiescence to requests for genital modifications counters international efforts against human rights violations in girls, providers also must consider the ethical implications of protesting the existence of an objectionable practice they do not endorse while refusing to turn away an *adult* patient who seeks help and makes an informed choice.¹³⁴

Nonmaleficence in FGCS allows a surgeon to refuse to perform genital modification procedures if he/she feels that it is not in the best interests of the patient.¹⁰⁶ The patient should be informed of the potential risks and benefits of the procedure without underestimating the possible adverse effects or overselling the benefits¹⁰⁵ (Recommendation: Grade C/Level 4). Consequently, any procedure that has a greater chance of harming a patient than helping her is unethical.

FGCS may inherently attract patients who may have underlying psychological concerns such as depression, anxiety, and/or body dysmorphic disorder, perceiving their anatomy as abnormal when it is in fact normal. Consequently women may be misled to believe that normal variations in genitalia are pathological concerns. Failure to recognize a psychological disorder creates long-term harm to patients, by exposing them to the risks of surgery (ie, infection, wound separation, bleeding, altered sensation, dyspareunia, adhesions, and scarring) for monetary incentives and by neglecting to recognize and treat an underlying psychological condition.¹⁰⁹ In addition, providers may experience a conflict of interest between their patients' interests and their own entrepreneurial and monetary benefits, prioritizing their interests over those of their patients by inducing patients to believe that they need treatments that are not necessary.¹⁰⁵ Furthermore, long-term clinical trials are lacking that would allow the validation of clinical outcomes, clarification of short and long-term risks and benefits, as well as the impact on sexual health, social, physical, and mental well-being (Recommendation: Grade C/Level 4).

Beneficence

The principle of beneficence denotes any action that is done for the benefit of others and to prevent/remove harms or to improve the situation of others. It also includes defending the rights of the patient impartially.⁷⁵ Although FGCS procedures show high patient satisfaction rates,¹²¹ long-term outcome data demonstrating improved relationships and sexual function is scarce. Surgeons performing FGCS must gain requisite surgical training and skills through experience and sufficient patient volume regardless of techniques employed. Given that most residency training programs do not provide specialized training in FGCS, it is imperative that the surgeon obtain adequate hands-on training under direct supervision before performing such surgeries on one's own¹⁰⁶ (Recommendation: Grade C/Level 4).

Justice and Equity

The ethical principle of justice implies equity in access and the provision of care, including fair allocation of resources and equivalence of treatment across individuals, while considering the legal principles of adult autonomy, privacy in medical decision-making, and equal protection of men and women under the law.¹³⁴ The personal decision to undergo a genital modification procedure should be individualized and grounded in informed consent in competent adults who voluntarily choose to alter their bodies.

Many of the surgical techniques of FGCS have become proprietary such that they cannot be shared among professional colleagues, hindering the ability to replicate techniques, allow independent peer review, and validate outcomes.¹⁰⁹ Furthermore, a market-driven business model seeks to control the dissemination of clinical and scientific knowledge.¹³⁸ Disputes over equity in access to health care are most pronounced in low resource settings, where FGCS is not a priority against life-threatening illnesses. Furthermore, concerns regarding inequity in global health needs remain unmet as essential gynecological services are inaccessible in many regions while skilled gynecological surgical talent are being diverted towards FGCS¹⁰⁹ (Recommendation: Grade C/Level 4).

CONCLUSION

Culture influences many aspects of sexual functioning, including how patients from a given culture express and manifest their symptoms, their distress, and their willingness to seek help. Sexual dysfunctions are highly prevalent across all populations, regardless of race, religion, culture, or ethnicity. Cultural and social factors contribute to the causation of sexual dysfunction, yet that contribution can be stronger or weaker depending on the level of acculturation.

On another level, the right to self-choice regardless of culture is a basic human right. An adult individual has a right to make a choice on whether or not to undergo a form of genital modification without the influence of what society, one's culture, one's partner, or family deems as desirable or acceptable.

There remains a critical need for increased provider cultural competency in caring for FGC-affected populations, formal training to enhance knowledge and technical skill on the care of circumcised women, and an improvement in communication between women and their providers (Recommendation: Grade C/Level 4).

In regards to FGCS and MGCS, media-driven characterizations of sexually desirable genitalia are a disservice to the wide anatomic variation of normality and can exert a coercive influence on vulnerable women and men who seek to be desirable to their present or future partners¹⁰⁵ (Recommendation: Grade C/Level 4).

Providers must consider their patient's individual psychosocial circumstances and have a responsibility to provide culturally

appropriate and ethically grounded counseling and education on normative anatomy so that patients can make informed decisions regarding their care. Longitudinal studies are needed to examine genital cosmetic surgeries on multiple levels: how and where surgeons are trained, the use of proprietary techniques, ethical issues associated with marketing strategies, quality of care, cost, impact on physical, mental, social, and sexual quality of life and relationships, role of partners, influence of the media, documentation of safety and effectiveness, as well as monitoring and reporting of adverse outcomes (Recommendation: Grade C/Level 4).

Western medical ethics respects the choices of informed adults in medical decision-making. It is the obligation of providers to mitigate harm while maximizing benefits for patients who make an informed choice to modify their genitals whether for personal, cultural, psychological, religious, or esthetic reasons. Applying principles of medical ethics may have important implications on informing approaches to ethically sound sexual health care, counseling and medical decision-making.

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