

EPIDEMIOLOGY & RISK FACTORS

Sexual Complaints and Ethnicity: Ethnic Differences in a Help-Seeking Sample

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ABSTRACT

Background: Sexual complaints are a widespread problem around the globe. Ethnicity and culture play a vital role in sexual complaints, in terms of presentation, treatment, etiology, meaning, help-seeking behavior, and treatment preferences.

Aim: This study investigates whether there are differences in the type of sexual complaints among Dutch people with various ethnic backgrounds, using a help-seeking sample from 16 outpatient clinics based in different regions in the Netherlands.

Methods: Differences in sexual complaints between various ethnic groups were analyzed separately for women and men, using logistic regression, controlling for age.

Main Outcome Measures: The primary outcome measures included sexual complaints determined as per the registered details of the Dutch Registry for Sexology Outpatient Clinics.

Results: Both similarities and differences were found between ethnic groups. Dyspareunia was an important complaint among women from all ethnic backgrounds, as were erectile problems among men. For most complaints, however, modest yet significant ethnic differences were found.

Clinical Translation: Health practitioners need to be aware of this ethnic and cultural variation, while acknowledging variety within groups as well.

Strengths & Limitations: This study is the first to include a help-seeking sample large enough to investigate ethnic differences in sexual complaints in this level of detail. An important limitation is the fact that this study pooled together diverse groups of people into ethnic categories.

Conclusion: The differences found were significant, yet modest. We can state that ethnic background does play a role in etiology and/or help-seeking in patients with sexual complaints, as long as we maintain an open stance and acknowledge similarities between ethnic groups as well. **Tjldink S, De Graaf H, Hehenkamp L, et al. Sexual Complaints and Ethnicity: Ethnic Differences in a Help-Seeking Sample. J Sex Med 2020;17:1676–1686.**

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Key Words: Sexual Problems; Sexual Complaints; Ethnicity; Sexology; Culture; Sexuality

INTRODUCTION

Sexual complaints are a widespread problem around the globe,¹ with 40–50% of women and 20–30% of men having 1 or more sexual complaints.^{2,3} These sexual complaints impact people's quality of life.^{4,5}

Cultural factors have been found to significantly affect presentation, etiology, and treatment of sexual complaints, as well as help-seeking behavior and treatment preferences.^{6–8} For instance, in the United Kingdom, therapists' communication about sexual complaints was found to be characterized by an explicit style, which was not always sensitive to the specific needs of patients with other cultural backgrounds.⁶ In line with these findings, treatment success is enhanced by the patient and therapist sharing a similar explanatory model underlying the presentation of problems.⁸ Successful explanatory models for sexual problems are likely to be culturally sensitive.⁹

Previous studies demonstrated ethnic differences in the types of sexual complaints among help-seeking samples. Differences by ethnic background were found in the proportion of patients presenting with dyspareunia, vaginismus, sexual desire, and

Received January 16, 2020. Accepted May 15, 2020.

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<https://doi.org/10.1016/j.jsxm.2020.05.022>

ejaculation problems. For example, among women, dyspareunia appeared to be far more common among Dutch (42%) than Turkish/Moroccan (21%) or Surinam/Antillean (25%) patients,⁷ whereas vaginismus was found to be more common among Turkish/Moroccan (34%) than Dutch (16%) patients.^{7,10} Richardson and Goldmeier¹⁰ found that 60% of patients presenting with premature ejaculation at a London outpatient clinic originated from an Asian or Islamic country, despite Asian and Islamic men making up only 12% of the local population.

Differences in seeking help for sexual complaints may be related to ethnic or cultural differences in gender role expectations with respect to sexuality. For example, in many African countries, being able to successfully accomplish vaginal penetration is considered to be the most important sexual duty of men.¹¹ This cultural pressure to perform was found to be associated with premature ejaculation and erectile problems,^{6,12} suggesting that problems with achieving and maintaining an erection might be the chief presenting male complaint in such countries. Meanwhile, in some African cultures, sexuality is characterized by reciprocal sexual pleasure and fulfilment for both sexes.¹³ Some women have been reported to attach great value to sexual pleasure and orgasm,¹¹ which could indicate that women of African descent are inclined to seek help for orgasm complaints. On the other hand, some African countries are marked as high-risk for female genital cutting, which is associated with sexual pain complaints, such as dyspareunia and vaginismus.¹⁴ In Western countries, sexual norms are on the one hand characterized by male dominance and female subjugation,¹³ whereas on the other hand, the Sexual Revolution during the 1960s has made way for more (pre-marital) sexual freedom and pleasure for both men and women.¹⁵ This is often a cause for low sexual desire leading to feelings of abnormality and distress.¹⁶ In Islamic cultures, various ideologies about female sexuality are disseminated as well,¹⁷ with religious texts promoting pleasurable sex for both men and women, and encouraging foreplay and female orgasm on the hand, and yet on the other hand granting more sexual privileges to men. During the past decades, restrictive fundamentalist Muslim ideals characterized by female chastity, male dominance, and a disregard of female pleasure have gained influence in several Muslim countries.¹⁷ The subsequent lack of sexual knowledge and experience as well as the ideal of female virginity have been associated with a higher prevalence of vaginismus.¹⁸ Familial pressures to consummate marriage and reproduce have also been associated with a higher prevalence of erectile complaints and premature ejaculation among men.¹⁹ These same pressures request couples to be able to have sexual intercourse, and are therefore associated with seeking help for erectile complaints and vaginismus.^{19,20}

The present study investigates whether there are differences in the type of sexual complaints among Dutch people with various ethnic backgrounds, using a help-seeking sample of patients who presented with sexual complaints between 1996 and 2016 at outpatient sexology clinics based in different regions in the

Netherlands. Greater insight into ethnic differences in the types of sexual problems for which help is sought, combined with what is known about cultural and religious differences, can help doctors and other caregivers to enhance the culture sensitivity of their communication and treatment. This is especially important in an ethnically diverse country such as the Netherlands, where one-eighth of the population has a first or second generation non-Western immigrant background.

We hypothesized that Dutch women of Turkish or Moroccan descent, who are more likely to adhere to Islamic cultural standards, will present with vaginismus more often than other ethnic groups, whereas native Dutch and other Western (European, North American, and Australian) women were expected to be more likely to present with complaints of low sexual desire, anorgasmia, and dyspareunia than other ethnic groups. Relatively more women with an African background were expected to seek help for orgasm complaints, dyspareunia, and vaginismus. For men, we expected that the ability to have an erection is important in men of all ethnic backgrounds. However, due to specific cultural pressures for men to perform well sexually in African and Islamic cultures, we expected that relatively more men with these backgrounds present to sexologists with erectile problems. Furthermore, although men's sexual endurance is respected in many different regions of the world, we expect that men who originate from African countries are a little more likely to seek help for premature ejaculation, as some African cultures have been shown to idealize it more profoundly.^{11,20}

METHODS

Sampling Method and Criteria

Data were collected by registered sexologists working at 1 of 16 Dutch sexology outpatient clinics located in general or academic hospitals, united in the Dutch Registry for Sexology Outpatient Clinics. This Registry platform was founded in 1995 to facilitate systematic registration of care provided in these outpatient clinics. Complaints rather than dysfunctions are registered, because Diagnostic and Statistical Manual of Mental Disorders definitions and criteria for sexual dysfunctions tend to change throughout the years, rendering registration of dysfunctions unsuitable for registries designed to span several decennia. Over the years, between 5 and 16 clinics participated, with the number of participating clinics increasing over time. Patient records that did not include registration of gender, country/region of birth of both parents, and at least 1 sexual complaint were excluded from the study. Ethnic background of the patients was registered using 8 categories, with the most prevalent ethnicities within the Dutch population having their own categories, and less prevalent ethnicities being grouped into one. The categories were (i) native Dutch, (ii) Turkey, (iii) Morocco, (iv) the Netherlands Antilles, Aruba, and Surinam, (v) Central and South America, (vi) rest Western (rest of Europe, Australia and Oceania, and North America), (vii) rest Africa (all African countries besides Morocco), and (viii) Asia.

Measures

As part of the registration, care providers are required to keep a record of each patient seeking treatment for 1 or more sexual complaint(s), using a structured form (see Table 1). The form assesses background characteristics (ie, age, gender [male or female], country of birth, parents' country of birth), (romantic) partner status, gender of partner, discipline of referrer (eg, gynecologist or urologist, psychologist, physical therapist), type of sexual complaint, comorbid physical or psychological complaints, number of treatment sessions, duration of treatment, and whether treatment was completed or whether the patient ended treatment prematurely. Data were registered on paper, digitally via an Excel form, or with the use of the electronic medical record software used by the particular hospital. For the present study, gender, ethnic background characteristics (eg, country of birth of patients' parents), and type of sexual complaint were used.

Ethnic background was determined on the basis of the countries of birth of a patient's parents. A patient was categorized as having a Dutch background, if both parents were born in the Netherlands. If 1 parent was born in another country/region, that country/region was considered to be the ethnic background. If both parents were from different countries/regions other than the Netherlands, the mother's country/region of birth was leading. These criteria are based on those utilized by the largest national survey organization in the Netherlands, the Central Bureau of Statistics.²¹

For each patient, a maximum of 3 sexual complaints was registered. All registered complaints were used for analysis, regardless of whether they were registered first, second, or third. Sexual complaints were recorded by the care provider in coordination with the patient. If, for example, a presenting complaint of low sexual desire appears to be accompanied by, or turns out to be secondary to, dyspareunia, both sexual complaints are registered.

Statistical Analyses

For each gender, age differences between ethnic groups were tested with one-way analysis of variance. Second, logistic regression analyses were used to investigate ethnic group differences in sexual complaint prevalence, controlling for age. Deviation contrasts were used, with odds ratios (OR) greater than 1 indicating the likelihood that patients with a certain ethnic background would report a specific sexual complaint more often than the overall sample. The presence of ethnic group differences was investigated for each sexual complaint separately. A significance level of 0.05 was used.

RESULTS

Sample

A total of 26,135 patient records were entered into the Registry between July 1996 and December 2016. Overall, 2,406 patients (9%) were excluded due to missing data on key variables (eg, sexual complaint(s) and/or birth country of the patient's

parents). The final sample included 21,352 patients: 13,112 women (61.4%) and 8,240 men (38.6%). Of the female patients, 83.2% had an other-sex partner, 2.1% had a same-sex partner, and 11.6% had no partner. Of the male patients, 74.5% had an other-sex partner, 4.3% had a same-sex partner, and 18.3% had no partner.

Small but significant differences in age were found between ethnic groups. Women of Turkish, Moroccan, or other African countries descent were, on average, younger (between

Table 1. Classification of sexual complaints in the registration form, as used by the outpatient clinics for sexology

Sexual desire problems
Diminished sexual desire (lack or loss of sexual desire)
Sexual aversion (anxiety for or aversion to sex)
Hyperactive sexual desire (obsessed by or addicted to sex)
Other sexual desire problems
Sexual arousal problems
Subjective arousal problem (no, less-intense, or short-lasting feeling of sexual arousal; erection/lubrication unimpaired)
Erection/lubrication problem (penis/vagina not, not sufficiently, or too shortly erected/lubricated)
Other sexual arousal problems
Orgasm problems
Orgasm problem (no or delayed orgasm)
Premature orgasm
Anhedonia (physiological reactions belonging to an orgasm intact, but no or not an intense feeling of orgasm)
Ejaculation problem (orgasm intact, but no or less powerful or retrograde ejaculation)
Other orgasm problems
Sexual pain problems
Dyspareunia (pain in genitals before, during, or after sexual activity)
Vaginismus
Pain in other body parts (before, during, or after sexual activity)
Diminished sensitivity in genitalia (little or no sensitivity in genitals before, during, or after sexual activity)
Other sexual pain problems
Paraphilia
Gender identity disorder
Sexual abuse/sexual violence
Problem of the perpetrator
Problem of the victim
Other sexual abuse/sexual violence problems
Sexual dissatisfaction (concerning)
Frequency of sexual contact with partner
Sort of sexual contact with partner
Sexual contact with third party
Sexual orientation (gay/bisexual)
Own appearance
Absence of a partner
Other sexual discontentment
Sexual problem NOS

NOS = not otherwise specified.

Table 2. Demographics: age, presence of partner, and second generation descent

Characteristics	Women		Men	
Age, mean (range) years	34.5 (11–87)		47.3 (10–89)	
Partner	N	%	N	%
Yes, other-sex partner	10,903	83.2	6,138	74.5
Yes, same-sex partner	277	2.1	356	4.3
No	1,515	11.6	1,505	18.3
Unknown	417	3.2	241	2.9
Second generation descent				
The Netherlands*	10,647	81.2	6,440	78.2
Turkey†	398	3.0	308	3.7
Morocco	370	2.8	151	1.8
Netherlands Antilles and Surinam	442	3.4	362	4.4
Central and South America	122	0.9	31	0.4
Rest Western	525	4.0	340	4.1
Rest Africa	148	1.1	208	2.5
Rest Asia	460	3.5	400	4.9
Total	13,112	100.0	8,240	100.0

*Patient and his/her parents were born in the Netherlands.

†At least one of the patient's parents was born in that country/region.

29.4 and 31.1 years of age) than women from other ethnic groups, with ages ranging between 34.5 and 36.1 years ($F(7, 13,047) = 17.36$). Dutch men, with a mean age of 48.7 years, were older than any of the other ethnic groups, whose ages ranged between 38.9 and 45.2 years ($F(7, 8,182) = 39.60$). For a complete overview of the sample composition, see Table 2.

Prevalence of Sexual Complaints

Tables 3 and 4 present an overview of ethnic differences in sexual complaints presentation. Among help-seeking women, dyspareunia was the most prevalent sexual complaint (51%), followed by complaints of diminished sexual desire (24%), vaginismus (16%), sexual dissatisfaction (14%; for the various types of sexual dissatisfaction see Table 1), low or no feelings of sexual arousal (7%), anorgasmia, and sexual complaints related to having a history of sexual violence (both 5%). Dyspareunia was the most prevalent complaint in almost all ethnic groups, except for women of Turkish or Moroccan descent, for whom vaginismus was, respectively, equally or more prevalent than dyspareunia. Difficulty in obtaining or maintaining an erection was the most prevalent sexual complaint among the men, in the whole sample as well as in each ethnic group, with a total prevalence of 62%. This complaint was followed by sexual dissatisfaction (20%), diminished sexual desire (13%), premature ejaculation (12%), delayed orgasm or anorgasmia (9%), and low or no feelings of sexual arousal (7%). ORs representing ethnic differences are presented for those sexual complaints that have a prevalence of at least 5%, for women and men separately (see Tables 5 and 6).

Ethnic Differences in Women

Dyspareunia was more often reported by Dutch (OR 1.71) and other Western (OR 1.36) women relative to the overall sample. Women of Turkish (OR 0.67) and Moroccan (OR 0.49) descent were significantly less likely to report this complaint. Central and South American (OR 1.47), Dutch (OR 1.26), and other Western (OR 1.29) women were more likely to present with diminished sexual desire compared to the overall sample, whereas women of Moroccan descent (OR 0.43) were significantly less likely to present with this complaint. Vaginismus was most often reported by Turkish (OR 2.07), Moroccan (OR 3.36), and Asian (OR 1.33) women and least often by native Dutch women (OR 0.76), and women descending from the remaining Western countries (OR 0.58), Central and South America (OR 0.52), and Africa (OR 0.51). Sexual dissatisfaction was most prevalent among women with a Turkish background (OR 1.43) and least prevalent among women with a Dutch background (OR 0.67). No significant ethnic differences were found with regard to complaints of low or no feelings of sexual arousal. Relatively many women originating from Africa (other than Morocco) and the Netherlands Antilles, Aruba, and Surinam sought help for complaints related to having a history of sexual violence (OR 1.84 and 1.48, respectively), whereas relatively few women originating from the Netherlands (OR 0.77) and from Turkey (OR 0.48) reported these complaints. Anorgasmia was more prevalent among women with a (non-Moroccan) African background (OR 2.26), and less prevalent among women with a Moroccan background (OR 0.35) relative to the overall sample.

Table 3. Women's sexual complaints by second generation ethnic descent

Sexual complaint	The Netherlands	Turkey	Morocco	The Netherlands Antilles, Aruba, and Surinam	Central and South America	Rest Western	Rest Africa	Rest Asia	Total
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)
Dyspareunia	54 (5,715)	33 (130)	27 (101)	42 (186)	44 (54)	48 (252)	42 (62)	42 (193)	51 (6,693)
Diminished sexual desire	25 (2,666)	18 (70)	9 (33)	19 (85)	28 (34)	25 (132)	25 (37)	19 (87)	24 (3,144)
Vaginismus	14 (1,480)	33 (132)	45 (165)	16 (71)	9 (11)	11 (57)	11 (16)	22 (101)	16 (2,033)
Sexual dissatisfaction	13 (1,371)	22 (86)	17 (62)	18 (80)	20 (24)	15 (78)	16 (23)	19 (89)	14 (1,813)
Subjective sexual arousal problem	6 (680)	8 (30)	5 (18)	7 (32)	7 (9)	7 (38)	10 (15)	7 (32)	7 (854)
Sexual violence: victim	5 (556)	3 (13)	6 (21)	10 (42)	9 (11)	5 (28)	11 (17)	7 (31)	5 (719)
Orgasm problem	5 (522)	7 (26)	2 (7)	8 (34)	8 (10)	6 (30)	11 (17)	4 (17)	5 (663)
Sexual aversion	3 (352)	4 (16)	2 (8)	4 (17)	3 (4)	5 (25)	3 (4)	4 (19)	3 (445)
Lubrication problem	2 (265)	2 (9)	2 (6)	4 (18)	1 (1)	2 (11)	6 (9)	2 (11)	3 (330)
Pain in other body parts	1 (63)	0 (0)	0 (0)	0 (2)	0 (0)	1 (5)	1 (1)	0 (1)	1 (72)
Diminished sensitivity in genitalia	0 (39)	1 (4)	0 (0)	1 (5)	2 (2)	0 (0)	0 (0)	1 (4)	0 (54)
Hyperactive sexual desire	0 (28)	0 (0)	0 (0)	0 (1)	0 (0)	1 (3)	1 (1)	0 (1)	0 (34)
Gender dysphoria	0 (21)	0 (0)	0 (0)	0 (0)	1 (1)	0 (2)	0 (0)	0 (0)	0 (24)
Premature ejaculation	0 (12)	1 (4)	1 (2)	0 (0)	0 (0)	0 (0)	1 (1)	0 (1)	0 (20)
Anhedonia	0 (16)	0 (0)	0 (0)	0 (1)	0 (0)	0 (2)	0 (0)	0 (0)	0 (19)
Paraphilia	0 (10)	0 (0)	0 (0)	0 (1)	0 (0)	0 (1)	0 (0)	0 (0)	0 (12)
Sexual violence: perpetrator	0 (7)	0 (0)	0 (0)	0 (1)	0 (0)	0 (1)	1 (1)	0 (0)	0 (10)
Ejaculation problem	0 (1)	0 (1)	0 (0)	0 (0)	0 (0)	0 (0)	1 (1)	0 (2)	0 (6)
Total N	10,106	380	345	409	111	492	136	430	13,112

Table 4. Men's sexual complaints by second generation ethnic descent

Sexual complaint	The Netherlands	Turkey	Morocco	The Netherlands Antilles, Aruba, and Surinam	Central and South America	Rest Western	Rest Africa	Rest Asia	Total
	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)	% (N)
Erection problem	62 (3,985)	60 (168)	57 (86)	69 (251)	52 (16)	57 (195)	71 (148)	54 (216)	62 (5,083)
Sexual dissatisfaction	20 (1,294)	19 (58)	19 (28)	17 (61)	19 (6)	19 (63)	18 (37)	18 (73)	20 (1,620)
Diminished sexual desire	13 (856)	7 (21)	11 (17)	12 (43)	6 (2)	15 (51)	5 (10)	12 (47)	13 (1,047)
Premature ejaculation	8 (496)	36 (110)	26 (40)	17 (61)	19 (6)	17 (59)	28 (59)	29 (116)	11 (947)
Orgasm problem	10 (622)	4 (12)	4 (6)	8 (28)	6 (2)	7 (25)	4 (9)	6 (24)	9 (728)
Subjective sexual arousal problem	6 (414)	8 (24)	5 (8)	8 (30)	3 (1)	8 (27)	5 (11)	6 (25)	7 (540)
Dyspareunia	4 (239)	2 (7)	5 (7)	3 (12)	10 (3)	4 (14)	3 (6)	5 (20)	4 (308)
Ejaculation problem	2 (144)	2 (6)	2 (3)	3 (10)	3 (1)	2 (7)	4 (8)	2 (8)	2 (187)
Hyperactive sexual desire	2 (116)	1 (3)	1 (1)	1 (3)	3 (1)	2 (8)	1 (2)	2 (7)	2 (141)
Anhedonia	1 (91)	1 (3)	0 (0)	1 (4)	0 (0)	2 (7)	0 (1)	1 (3)	1 (109)
Paraphilia	1 (77)	0 (1)	0 (0)	1 (3)	0 (0)	2 (7)	0 (0)	1 (3)	1 (91)
Sexual violence: victim	1 (53)	0 (1)	1 (1)	0 (1)	0 (0)	1 (2)	1 (3)	1 (3)	1 (64)
Sexual aversion	1 (42)	0 (1)	1 (2)	0 (1)	0 (0)	1 (4)	0 (0)	1 (2)	1 (52)
Gender dysphoria	1 (41)	0 (0)	0 (0)	1 (4)	0 (0)	1 (2)	0 (0)	1 (2)	1 (49)
Pain in other body parts	0 (29)	0 (1)	1 (2)	0 (1)	0 (0)	1 (2)	0 (1)	1 (3)	0 (39)
Diminished sensitivity in genitalia	0 (31)	1 (2)	1 (1)	1 (2)	0 (0)	1 (2)	0 (0)	0 (0)	0 (38)
Sexual violence: perpetrator	0 (13)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	0 (13)
Total N	6,275	303	149	358	29	334	205	394	8,240

Table 5. Most prevalent sexual complaints among female patients by ethnic background $\geq 5\%$ (controlled for age)

Country of descent	Dyspareunia	Diminished sexual desire	Vaginismus	Sexual dissatisfaction	Subjective arousal problem	Sexual violence: victim	Orgasm problem
	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)	OR (95% CI)
The Netherlands	1.71 (1.56–1.87) [‡]	1.26 (1.13–1.40) [‡]	0.76 (0.66–0.86) [‡]	0.67 (0.60–0.76) [‡]	0.86 (0.73–1.02)	0.77 (0.65–0.92) [†]	0.84 (0.70–1.02)
Turkey	0.67 (0.54–0.81) [‡]	0.90 (0.70–1.15)	2.07 (1.66–2.58) [‡]	1.43 (1.14–1.81) [†]	1.11 (0.78–1.59)	0.48 (0.29–0.80) [†]	1.23 (0.84–1.82)
Morocco	0.49 (0.40–0.61) [‡]	0.43 (0.31–0.59) [‡]	3.36 (2.70–4.17) [‡]	1.08 (0.83–1.40)	0.71 (0.46–1.10)	0.87 (0.58–1.31)	0.35 (0.18–0.68) [†]
The Netherlands Antilles, Aruba, and Surinam	1.07 (0.89–1.29)	0.88 (0.70–1.11)	0.94 (0.72–1.21)	1.03 (0.71–1.62)	1.00 (0.70–1.41)	1.48 (1.08–2.03) [*]	1.37 (0.96–1.94)
Central and South America	1.15 (0.83–1.58)	1.47 (1.02–2.10) [*]	0.52 (0.30–0.90) [*]	1.07 (0.71–1.62)	1.01 (0.55–1.86)	1.40 (0.80–2.45)	1.46 (0.81–2.63)
Rest Western	1.36 (1.15–1.61) [‡]	1.29 (1.05–1.57) [*]	0.58 (0.44–0.76) [‡]	0.81 (0.64–1.03)	0.99 (0.72–1.38)	0.79 (0.55–1.14)	0.96 (0.66–1.39)
Rest Africa	1.00 (0.75–1.35)	1.38 (0.98–1.94)	0.51 (0.32–0.81) [†]	0.93 (0.63–1.39)	1.52 (0.93–2.47)	1.84 (1.16–2.93) [†]	2.26 (1.41–3.62) [‡]
Rest Asia	1.07 (0.89–1.28)	0.91 (0.72–1.14)	1.33 (1.06–1.68) [*]	1.14 (0.91–1.44)	0.97 (0.69–1.37)	1.03 (0.72–1.46)	0.64 (0.41–1.01)

OR = odds ratio.

^{*}P value < .05.[†]P value < .01.[‡]P value < .001.

Ethnic Differences in Men

Among the help-seeking men, erectile complaints were relatively more prevalent among men of African (OR 1.75), and the Netherlands Antilles, Aruba, and Surinam descent (OR 1.39). This complaint was less prevalent among men of Dutch (OR 0.86) or Asian (OR 0.76) descent. There were no ethnic differences in sexual dissatisfaction. Dutch and other Western men were 1.71 and 1.43 times more likely, respectively, to present with complaints of diminished sexual desire compared to the overall sample. Men from African countries other than Morocco had a 2 times smaller likelihood to present this complaint. Premature orgasm was the least prevalent among men with a Dutch background (OR 0.36), and the most prevalent among men originating from Turkey (OR 2.02), the rest of Asia (OR 1.51), and Africa (OR 1.40). Complaints of delayed orgasm or anorgasmia were most prevalent among men with a Dutch background (OR 1.77). Similar to the women in our study, no significant ethnic differences were found with regard to complaints of low or no feelings of sexual arousal. Finally, men originating from Morocco and Central and South America did not differ from the men belonging to other ethnic groups on any of the sexual complaints.

DISCUSSION

This study examined whether patients with different ethnic backgrounds from Dutch outpatient sexology clinics differ with respect to the type of sexual complaints they report, which complaint is most prevalent, or is quite similar for patients with different ethnic backgrounds. Among women, dyspareunia is the most commonly reported complaint in all ethnic groups, except for Moroccan women, whereas for men, erectile problems form the most prevalent complaint, without any exceptions. However, when examining the most prevalent complaints separately, we found several significant ethnic differences among women as well as among men.

Sexual Complaints and Ethnicity in Female Patients

Dyspareunia

As hypothesized, dyspareunia was the most prevalent among women with a Dutch or Western background. An explanation for this result can be found in the normative paradox that emerged during the Sexual Revolution in the 1960s, in which women were expected to enjoy sex, while still privileging the sexual needs of their male partner.^{22,23} A U.S. study found that about half of the women who experienced pain during their last sexual encounter did not inform their partner about their pain.²⁴ Continuing intercourse while a woman is experiencing genital pain, which may result in tissue damage, fear of pain, and (increased) pelvic floor muscle tension, maintains the complaint of dyspareunia.²⁵ The cultural norm for women to be able to have vaginal intercourse may explain why women seek help for dyspareunia. This same cultural norm may also explain that

Table 6. Most prevalent sexual complaints among male patients by ethnic background $\geq 5\%$ (controlled for age)

Country of descent	Erectile problems		Sexual dissatisfaction		Diminished sexual desire		Premature ejaculation		Orgasm problem		Subjective arousal problem	
	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)	OR	(95% CI)
The Netherlands	0.86	(0.75–0.97)*	1.10	(0.94–1.28)	1.43	(1.13–1.81)†	0.36	(0.30–0.42)†	1.77	(1.36–2.30)†	1.11	(0.81–1.50)
Turkey	1.09	(0.86–1.38)	1.02	(0.76–1.36)	0.65	(0.41–1.03)	2.02	(1.57–2.60)†	0.66	(0.38–1.15)	1.25	(0.78–2.01)
Morocco	0.86	(0.63–1.17)	1.00	(0.68–1.19)	1.22	(0.75–1.99)	1.33	(0.94–1.90)	0.67	(0.32–1.42)	0.87	(0.44–1.73)
The Netherlands Antilles, Aruba, and Surinam	1.39	(1.10–1.75)†	0.90	(0.68–1.19)	1.26	(0.88–1.80)	0.82	(0.62–1.09)	1.28	(0.83–1.95)	1.43	(0.93–2.22)
Central and South America	0.79	(0.42–1.50)	1.05	(0.48–2.30)	0.67	(0.19–2.36)	0.77	(0.35–1.70)	1.09	(0.31–3.85)	0.50	(0.09–2.89)
Rest Western	0.86	(0.68–1.07)	1.01	(0.76–1.33)	1.71	(1.21–2.40)†	0.77	(0.58–1.03)	1.29	(0.84–1.99)	1.35	(0.86–2.12)
Rest Africa	1.75	(1.31–2.34)†	0.96	(0.68–1.35)	0.49	(0.27–0.89)*	1.40	(1.03–1.89)*	0.73	(0.39–1.36)	0.86	(0.47–1.57)
Rest Asia	0.76	(0.62–0.94)*	0.99	(0.76–1.39)	1.26	(0.89–1.78)	1.51	(1.19–1.92)†	0.99	(0.63–1.54)	0.99	(0.62–1.57)

OR = odds ratio.

*P value < .05.

†P value < .01.

#P value < .001.

women continue to have vaginal intercourse, even when this sexual activity has become painful. We had also hypothesized that women with an African background would present to the clinics with dyspareunia. This was, however, not the case. Perhaps, this is due to large variations between the women of African descent, with cultures either promoting^{11,13} or ignoring pleasure.¹⁴

For women with a Turkish or Moroccan background, dyspareunia was significantly less prevalent compared to the overall sample. Possibly these groups seek help for vaginismus instead of dyspareunia, because it is more important for them to be able to have sexual intercourse for reproductive purposes,²⁶ irrespective of whether it is painful or not. And for lay people, vaginismus is a genital pain complaint that may be difficult to differentiate from dyspareunia.

Diminished Sexual Desire

Diminished sexual desire was relatively common among women originating from Central and South America, followed by women from the Netherlands and other Western countries. Indeed, since the Sexual Revolution introduced the new cultural norm of female sexual desire,¹⁵ we had hypothesized that relatively many women of Dutch and other Western descent would seek help for this sexual complaint. Our findings are in accordance with findings of several earlier studies that found diminished sexual desire to be the most important sexual problem among women in South American countries^{27–30}. These earlier studies did not offer cultural explanations for diminished sexual desire specific to their study populations.

Vaginismus

The relatively high prevalence of vaginismus among women with a Moroccan or Turkish background was in accordance with our hypothesis. Several culture-specific factors may explain why in these ethnic groups vaginismus was so often a reason to seek help. First, lack of sexual knowledge and experience, related to virginity being a religious imperative for women in Islamic cultures, may be underlying this finding.¹⁸ Also, young women are prepared for the occurrence of pain and excessive bleeding during their first intercourse.¹⁸ This could induce fear, which is a risk factor of vaginismus.⁷ In addition, within marriage, Islam attaches great value to consummating a marriage as well as to pregnancy and childbearing.¹⁷ Vaginismus prohibits intercourse and sometimes pregnancy,¹⁸ which is considered shameful.¹⁹ Relatively few women with an African background sought help for vaginismus.

Sexual Dissatisfaction

Sexual dissatisfaction was most prevalent among women with a Turkish background, and relatively low among Dutch women. Abdolmanafi et al²⁶ studied negative automatic thought patterns associated with sexual dissatisfaction in Islamic women and found that their beliefs were strongly determined by religious and

traditional teachings. Examples of thought patterns that led to sexual dissatisfaction include “sex is meant only for procreation” and “experiencing pleasure during sexual activity is not acceptable in a virtuous woman.” However, women with a Moroccan background did not seek help for sexual dissatisfaction more often, although their cultural backgrounds share the same religion. It seems therefore that other, yet unknown, cultural factors are at play.

Sexual Victimization

A history of sexual victimization was most prevalent in women with an African, Surinam, Antillean, or Aruban background. A former population survey in the Netherlands³¹ found no differences between ethnic groups when it came to the prevalence of sexual violence. There are many potential explanations for this finding, including the reluctance to acknowledge sexual victimization in patients in other groups, therapists not systematically investigating patients’ sexual violence history, and ethnic differences in the actual prevalence of sexual violence. We have no additional information that would help us to explain this finding.

Anorgasmia

1 in 20 women in our sample sought help for anorgasmia. Seeking help for anorgasmia requires a woman to attach significant value to sexual pleasure and not take anorgasmia for granted. Considering Western norms for women to enjoy sex, we had hypothesized that native Dutch and other Western women were more likely to present with anorgasmia. This was, however, not the case. We also expected relatively many women of African descent to seek help for orgasm complaints, due to the reciprocal sexual pleasure reported in African societies,¹³ as well as the importance that women in some African tribes attach to sexual pleasure.¹¹ Indeed, we found that relatively many women with a (non-Moroccan) African background sought help for anorgasmia.

Sexual Complaints and Ethnicity in Male Patients

Erectile Problems

Among all ethnic groups, erectile problems formed the most important sexual complaint. Relatively more men originating from Africa and the Netherlands Antilles, Aruba, and Surinam sought help for erectile problems. This finding was expected for men with an African background, due to the cultural emphasis on erectile performance and vaginal penetration.¹¹ This focus may inflict performance anxiety, in turn leading to erectile problems.¹² Additionally, this cultural emphasis could also explain why these men find erectile problems sufficiently distressful to visit a clinic. These same explanations, maybe less pronounced, may apply to the other ethnic groups. Sex through penetration is for men of various backgrounds an important aspect of their masculinity. It should not be surprising, therefore, that erectile problems are omnipresent in all ethnic groups in our sample.

Diminished Sexual Desire

Relatively more men originating from the Netherlands and other Western countries sought help for diminished sexual desire. Literature on the role of ethnicity on sexual problems persistently omits the cultural values of men of Western descent, as researchers often focus their explanations on cultures of non-Western countries. Cultural explanations for the occurrence of sexual problems among Western men are therefore scarce. Generally, ideals about masculinity are thought to include men having unwavering and constant levels of sexual desire, supported by evolutionary theory,³² as well as by social messages about what men and women “should” be.³³ Only in recent years more attention in research has been devoted to Western men increasingly reporting sexual desire problems.³⁴ Perhaps in recent years Western men have become somewhat freer from masculinity norms such that they feel less restricted to seek help for low sexual desire.

Premature Ejaculation

A little more than 1 in 10 men sought help for premature ejaculation. Premature ejaculation was more prevalent among men originating from Turkey, Asia, and Africa. Premature ejaculation in the context of Muslim marriages was suggested to be related to abstinence of sexual activity before marriage, anxiety surrounding sexual debut, and pressure of the family to consummate the marriage.¹⁹ Many Muslim communities reside in Asia, which may explain the higher prevalence among men with an Asian background. It is difficult, however, to determine which cultural factors may be at hand among men who originate from Asia, since Asia is particularly culturally diverse. The importance of penetration for African men¹¹ may lead to men, who originate from African countries, being more concerned about premature ejaculation, as there is more cultural pressure for durable erectile performance.

Strengths and Limitations of This Study

This study is the first to include a help-seeking sample that is large enough to investigate ethnic differences in sexual complaints in this level of detail. For over 2 decades, all those seeking help at the outpatient clinics that participated in this study were included. Clinics were located in all regions of the Netherlands. Furthermore, all sexual complaints were registered by certified sexologists who applied the same criteria to all patients.

This study also has several limitations. First, to obtain groups of adequate size, we pooled patients who may be culturally diverse in ethnic categories based on geographical location. Within ethnic groups, we did not differentiate between first- and second-generation immigrants or between patients with 1 or 2 parents with an immigrant background. We also did not take into account the number of years that patients or their parents had been living in the Netherlands, nor their age when they migrated.³⁵ Furthermore, the extent to which patients identify with their Dutch and/or non-Dutch cultural background was not

measured either. In order to do better justice to variations in ethnicity, an even larger sample is required.

Secondly, many potentially relevant factors were not assessed. For instance, patients' type of religion and the level of religiosity were not registered. This would have helped to understand the role religion plays in the presentation of sexual complaints among patients of various ethnic backgrounds.

Finally, interpretation of the findings should be done with caution, as differences may represent differences in help-seeking behavior or differences in actual prevalence.

CONCLUSION AND RECOMMENDATIONS

This study found ethnic similarities as well as differences in the type of sexual complaints within a large sample of help-seeking patients seen in outpatient clinics for sexology. Dyspareunia for women and erectile problems for men were the most common complaints, irrespective of ethnic background. For most complaints, significant but yet modest ethnic differences were found, suggesting that patients' ethnic backgrounds do play a role in etiology and/or help-seeking concerning sexual complaints. These findings can help caregivers to become aware of cultural differences in their patients' presentation of sexual complaints and to enhance the culture sensitivity of their communication and treatment. Nevertheless, caution is also required. Intergroup differences tend to obscure intragroup differences. It is therefore recommended to have an open stance with regard to ethnic background and sexual complaints.

ACKNOWLEDGMENTS

We would like to thank Landelijk Overleg Poliklinieken Seksuologie (LOPS) for financing this study, and their adjoined sexologists who collected all of the data for this study. Furthermore, we are grateful to Elske Marra (Rutgers) for her critical reading, editing, and suggestions, and Ciel Wijsen (Rutgers) for her advice and support during the writing process.

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Conflict of Interest: The authors report no conflicts of interest.

Funding: This study was funded by Landelijk Overleg Poliklinieken Seksuologie (LOPS).

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