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# The Psychological and Physical Effects of Sex Taboos

Ana Cetina

Commonwealth-Parkville School, Puerto RIco

ABSTRACT

The objective of this investigation was to find the physical and psychological effects sex taboos directly or indirectly cause in individuals. This investigation's importance is reflected in how sex taboos are such an integral part of everything, from culture, art, clothing, architecture, medical care, teachings, and language. Sex taboos are present in almost every person's life, and it is essential first to illustrate the effects it has on people to be able to take the first step into helping individuals and irradicating sex taboos. This investigation proves that sex taboos, or situations caused by the upholding of these norms lead to anxiety, depression, shame, guilt, risky sexual behavior, higher HIV infection rates, higher teen pregnancy rates, incorrect sex ed, damaged parent-child relationships, emotional distress, mistreatment and misdiagnosis of malnutrition, prejudice, isolation, medical professional perpetuating mis-information and myths, violent sexual behavior, and suicide.

## Introduction

The purpose of this research paper is to find out the emotional, psychological, and physical effects that happen to people because of sex taboos. This investigation is vital because sex taboos are projected in our education, beliefs, prejudices, media, religions, cultures, healthcare, and politics. They are reflected in how sex education is taught, how the media portrays bodies and sexual relationships and experiences, and how politics affect the reproductive and sexual health of individuals. Sex taboos affect everyone, but they are especially detrimental to children since their formative years determine the rest of their lives; growing up surrounded by a culture makes you internalize its norms into your conscious and subconscious. This investigation is essential to see the effects sex taboos have on people's physical and mental health, how these taboos shape our world and perception of reality, and how they may be used to control people. Through this study it has been found that sex taboos shape how institutions handle mental health, malnutrition, teen pregnancy, homosexuality, and masturbation. Sex taboos are harmful and can lead to many psychological and physical health problems in the people who experience them. These individuals are hurt by the internalized judgment they place on themselves, which can lead to suicide or shame and guilt, judgment that is learned from almost every aspect of their day-to-day lives. They are mistreated and injured by the institutions that base their treatment and methods on these sex taboos. They are also shamed, ostracized and hurt by the people who stigmatize and shame them because they believe in these same-sex taboos.

## Research Question

What are the physical and psychological effects of sex taboos?

## Literature Review

## The Connection Between Comprehensive HIV/AIDS Education and Outcomes of Different Demographics of Students

This study aims to determine the relationship between HIV/AIDS education and various student demographics and a descriptive assessment of the relationship between HIV/AIDS education and student results. Despite several studies demonstrating the significant risk reductions associated with HIV/AIDS education, relatively few schools offer it, and those that do are rapidly declining. Students, particularly those of color, are seriously threatened by this. The likelihood that members of various demographic groups will receive this education varies. How these different age, gender, and ethnicity demographics respond to it also varied greatly:

American high-school students have substantial morbidity and social problems resulting from unintended pregnancies and sexually transmitted infections (STIs), including HIV infection [1]. Students exposed to HIV/AIDS education were about 1/5 less likely to inject drugs (1%) and almost 1.5 times more likely to have HIV testing (13%) than those without HIV/AIDS education (7% and 10%, respectively). Students exposed to HIV/AIDS education were about 1.5 times more likely to use birth control (21%) and condoms (62%), and 1/3 less likely to drink alcohol or use drugs (21%) before their last sexual intercourse, than those without HIV/AIDS education (15%, 54% and 29%, respectively). (Ma et al., 2014)

The importance of this source within the investigation is demonstrating the effects HIV/AIDS education has on students, contrary to those who do not. It also shows the likelihood of different demographics to receive that education. Being able to have comprehensive sex education reduces the chances of using or injecting drugs before or after sex, increases the use of a condom, delays the age of first intercourse, reduces the number of partners, and reduces the likelihood of having "forced sexual intercourse" (rape) in both male and female students. It also shows that minority ethnic female students were more likely to have HIV testing, and white males were more likely to have higher GPAs. All these things given with HIV/AIDS sex ed are taken away with abstinence-only education, one born from sex taboo and stigma. This leads to psychological adverse effects that changing a curriculum could solve. This information helps advance the investigations by showing all the advantages comprehensive sex education gives them, an education that breaks some of the taboos and stigmas around sex.

## Correlation Between IGBT Inclusive Sex Ed and Bullying Against SMY

The study's goal was to determine whether including LGBTQ students in sex education curtails bullying and harassment of SMYs (Sexual Minority Youth). In a homophobic school setting, IGBTQ adolescents are very likely to face bullying or verbal, physical, and sexual harassment. In SMY, this harassment frequently results in lower mental health and increased rates of suicidality. Bullying in high school has been linked to increased rates of drug and alcohol abuse, adult suicide rates, and unsafe sex rates The goal of the experiment is to determine whether LGBTQ-inclusive sex education can improve the mental health, self-esteem, and general well-being of SMY youth while also reducing the rates of bullying and harassment against them:

Initial analyses indicated that after controlling for demographics and state level covariates (i.e. presence of IGBTQ anti-discrimination policies, median household income, and population density of same-sex couples), lesbian and gay youth in states with higher proportions of schools teaching LGBT-inclusive sex education had significantly lower odds of experiencing bullying in school (Odds Ratio: 0.83; 95% Confidence Interval: 0.71, 0.97). Bisexual youth had significantly lower odds of reporting depressive symptoms (OR: 0.92; 95% CI: 0.87, 0.98). While interactions were not significant, overall protective effects were significant for suicidal thoughts (OR: 0.91, 95% CI: 0.89, 0.93) and making a suicide plan (OR: 0.79; 95% CI: 0.77, 0.80).(Proulx, 2015)

The importance of this source for the investigation is reflected in the portrayal of all the psychological detriments students experience at the hands of non-comprehensive Sex ed.

Something stemmed from the stigma and taboo surrounding sex. In 2015, Alabama, Texas, and South Carolina had government-mandated sex ed, which ridicules and denies all LGBTQ education, calling it a choice and immoral, as well as blaming them for AIDS. Even after many studies have shown how bullying affects SMY, producing higher suicide rates and horrible mental health outcomes, this is complete oversight and ignorance on the part of the schools, an ignorance founded in taboo surrounding sex and reflected on the curriculum taught to children.

This study shows how a culture rooted in taboo really affects the children living in it. These effects can ruin or even end their lives.

## The Relationship Between Abstinence- Only Education and Higher Teenage Pregnancy and Birth Rates

Finding the corrigibility between adolescent birth rates, teen pregnancy rates, and curricula that promote abstinence was the aim of the study. Of all the first-world countries, the US has the highest rate of teenage pregnancies and STDs. The government launched an abstinence-only curriculum in 2009 to counteract this; it took a short break in 2010 before resuming with increased financing from 2015 to 2017. Whether this investment is profitable or even somewhat successful is much debated. Information has been gathered to show that abstinence increases the likelihood of becoming pregnant and giving birth:

In 2005, level O states had an average (6 standard error) teen pregnancy rate of 58.78 (64.96), level 1 states averaged 56.36 (63.94), level 2 states averaged 61.86 (63.93), and level 3 states averaged 73.24 (62.58) teen pregnancies per 1000 girls aged 14-19 (Table 3). The level of abstinence education... was positively correlated with both teen pregnancy (Spearman's rho = 0.510, p = 0.001) and teen birth (rho = 0.605, p,0.001) rates (Table 4), indicating that abstinence education in the U.S. does not cause abstinence behavior. To the contrary, teens in states that prescribe more abstinence education are more likely to become pregnant. (Stanger-Hall1 & Hall, 2011)

The importance of this source is to demonstrate how harmful a sex taboo culture can be, especially to children; abstinence-only programs are born from stigma and taboo surrounding sex. Instead of talking about the issue, people ignore sex altogether. As this study shows, abstinence-only programs do not teach people correctly and have damaging effects. An abstinence-only program teaches that having sex before marriage is immoral and will harm future marriages emotionally and psychologically. Now, the teens who get pregnant from unsafe sex will be in an environment that upholds standards that having sex out of wedlock is wrong. Not only do abstinence programs have higher teen pregnancies, but births, too. All these factors can cause significant psychological stress on students. Teen pregnancy is increased when there is abstinence education present in schools; not only can teen pregnancy and motherhood be detrimental to their learning and growth, but as another source shows, teen mothers are more likely to develop many psychological and mental issues then adult mothers.

## The Psychological Risks Teen Mothers Have and Effective Ways to Implement Solutions

This article aimed to draw attention to the psychological hazards that adolescent parents and pregnant women face and offer solutions. Adolescent parenthood or teen motherhood is strongly associated with mental health issues. Teenage moms are at an increased risk of developing substance misuse, PTSD, and depression. They are also more likely to be disadvantaged and reside in unsteady low-income neighborhoods. This impacts both the parent and the child and may cause behavioral problems for the latter:

Adolescent parenthood is associated with a range of adverse outcomes of young mothers, including mental health problems such as depression, substance abuse, and posttraumatic stress disorder. Teen mothers are also more likely to be impoverished and reside in communities and families that are socially and economically disadvantaged. These circumstances can adversely affect maternal mental health, parenting, and behavior outcomes for their children.

Medical providers often struggle to provide comprehensive care to young families, many of whom face a wide variety of barriers to optimal health and development. (Hodgkinson et al., 2014)

The importance of this source in the investigation is to amplify further all the harm sex taboo culture has on youth. The earlier source demonstrates how abstinence education, a curriculum born from sex taboos and stigma, produces increased chances of teen pregnancy. This source explains how teen pregnancy affects these parents and the children they try to raise. Teen mothers are at higher rates for depression, suicidal thoughts and attempts, substance abuse through and after pregnancy, and PTSD because of their higher likelihood of being exposed to trauma and abuse. Teen mothers often face other challenges, such as economic and social disadvantages, and are more likely to be African American and Latina, live in low-income homes, and experience child abuse. An earlier study reflected how racial minorities were less likely to have HIV/AIDS education, and when the education wasn't present, students were less likely to use condoms. This could be a small reason why many teen mothers are part of these ethnic groups. Low-income and racial minority families and communities are also less likely to have access to mental health resources. A mother's mental health dramatically influences her child, the relationship she has with it, and her ability to care for it properly. Teens may have trouble accessing mental health due to barriers and restrictions since they still must attend school. Depression in mothers has been found to have a significant effect on possible behavioral issues for the child. It may cause the child not to form a secure attachment since the mother lacks the emotional and social resources to act as a sensitive and responsible parent.

## Malnutrition and the Harmful Sex Taboo Explanation for It

To better battle child malnutrition in these communities, the investigation's goal was to gain an understanding of community members' perspectives on child development. The way that child malnutrition and growth are perceived and addressed in this community is significantly influenced by cultural norms and sex taboos. Postpartum abstinence is thought to be essential for your child's healthy growth. Mothers who have sex before their child is developmentally appropriate, for example, able to walk and talk, face stigma, and severe criticism, which can result in mental health issues. If a mother does have sex, she can wean her child too quickly, which could lead to malnourishment. Mothers may choose not to seek assistance or visit medical experts because of the stigma and guilt placed on them for this malnutrition. Many medical professionals believe in "Kubemenda," which is the harming of a child's growth due to breaching taboos around postpartum sex, and they will also criticize the mother. Additionally, the mother will likely only see a traditional healer for their child, or the healthcare worker will send her there:

In the study community, the early postpartum period is culturally constructed as the 'nurturing' period (kipindi cha kulea) during which a mother is expected to dedicate herself to the task of breastfeeding to ensure that her baby grows well. It is widely believed that sexual relations between couples during the lactation period can endanger a child's health/growth. Thus, sexual abstinence is a dominant traditional practice that has been adopted to promote healthy child growth.

[.] Most of the consequences attributed to kubemenda overlapped with the biomedical symptoms of malnutrition (tapiamla; see Table 1 for a full list). The parents frequently used schemas that referred to kubemenda in interpreting the etiology, the consequences. and the markers of poor growth episodes in both their own children and in the children of others. (Mchome et al., 2020)

The importance of this source within the investigation is demonstrating the effects sex taboo can have on people and how they deal with situations, in this case, a severe health one. The sexual taboo held over the mother influences how she is viewed for the suffering of her child, how the blame is placed on her, and the effects of that shame. This custom is also linked to higher STD infections from the father since he can engage in extramarital sex because of the belief men are sexually weaker than women and can spend less time with no sexual relationships.

The sexual taboo also affects how that child is ultimately treated for its growth since it is most likely prescribed traditional medicine, and professional help is not sought. Traditional medicine can slow the diagnosis and treatment of the child, and stigmatization can lead to worse health. The sex taboo also affects how the mother responds immediately to breaking the postpartum abstinence norm: weaning her baby, which can lead to more malnutrition. Mothers feel the strong need to adhere to their expectations since she has deeply internalized the cultural expectations from growing up with it around them; she feels shame. After the nurturing of the baby is finished, a woman is praised and honored for having adhered to the cultural norm. This sexual taboo leads to such prejudice and judgment that it influences how medical professionals handle the situation, the care administered to the child, and whether the mother even goes for help at all. The healthcare workers, to adhere to cultural norms, may promote this sex taboo in their teachings and educational materials. There is much unnecessary stress and blame added to the fact that a mother's child is not growing correctly; she is ostracized, gossiped about, publicly shamed, and usually forced into isolation. The baby is also judged and held in very low regard, thought to be socially unacceptable. This causes significant distress and shame for the mother and has effects on her mental health that will significantly affect the relationship the mother has with her child and her ability to care for it. The mother's challenges and issues will affect the child considerably on top of being malnourished and the psychological effects of that.

## Sexual Repression and Its Causes, Effects, and Treatments

This study sets out to investigate sexual repression and determine its causes, effects, and strategies for overcoming it in individuals. The suppression of sexual ideas, behaviors, or expressions — whether conscious or unconscious — is referred to as sexual repression, and it has many effects on individuals. Sexual frustration and sexual repression are not the same thing. Shame, guilt, dread, anxiety, decreased sexual desire, and problems with sexual function are a few symptoms. It can originate from a variety of factors, including personal beliefs, past traumatic experiences, and societal standards, some of which are related to religion. People may experience mental distress, difficulties in intimacy and relationships, low self-esteem, negative body image, and problems with sexual function. Since sexual repression is a very personal issue, there are a variety of approaches that can be used to overcome it. These include self-education and self-exploration, honest communication with partners, friends, or medical professionals, seeking professional support from therapists or sex educators, and engaging in self-care activities:

Sexual repression refers to a pattern of restricting sexual expression. This may occur through the conscious or unconscious suppression of sexual desires, behaviors, or thoughts. A person may experience sexual repression as a response to cultural norms, personal beliefs, or negative past experiences. For example, a person may tell a child that sex or masturbation is dirty or wrong or that a person should save sex for marriage. As a result, the child may grow up having learned to feel guilty about sexual desire or engaging in sexual behavior.

[…] The interplay of cultural influences with personal feelings can lead to internal conflicts. This may arise from conflicting beliefs, desires, or self-judgment, which can all contribute to sexual repression. Individuals may also experience difficulty accepting their sexual identity or desires due to a fear of societal judgment or internalized shame. (Medical News Today, 2023)

The importance of this source is that it demonstrates how sexual taboos can reflect on many aspects of people's lives and lead to other things. One of the major causes of sexual repression is sexual taboos and cultural

norms. A lot of cultural norms stem from practices in religion. Another major cause of sexual repression is a person's beliefs, internal conflicts, and self-judgment. All these ideas are influenced by the culture they grew up in and all the expectations it taught them. Sexual repression leads to many psychological and physical effects in people, such as emotional conflict, low self-esteem, and a negative body image. This article helps advance the investigation by showing another way that sex taboos and sex cultural norms can lead to conditions that can affect people psychologically.

## The Causes of the Taboo Gap and the Implication It Has on Girls' Safety and HIV Infections

The goal of the sources is to determine whether the taboo gap — which has its roots in damaging gender stereotypes and a reluctance to discuss sex with young people —is the cause of the discrepancy between professional attitudes and behavior in premarital sex, which is so strongly associated with an increased risk of HIV in adolescents, especially girls and why that is. Adolescent girls are at higher risk of contracting HIV due to discrepancies between professional opinions and measurements of behavior surrounding adult premarital sex, according to data from the Zambian Demographic and Health Survey. According to the study, this is caused by the taboo surrounding premarital sex and the unwillingness to discuss it, which is a result of damaging stereotypes that are reinforced in churches, schools, and other cultural settings. Teenagers are unable to obtain information on sex and reproductive health because of the taboo gap, which has sex a taboo subject. Increased infection rates can also result from food instability and financial hardship. Adolescents without permanent homes, particularly females, claimed to experience humiliation when visiting reproductive health clinics, which made them feel ashamed and discouraged from returning. An effective intervention involving gender transformative approaches that target the spaces where harmful gender stereotypes are being maintained is the answer to this taboo gap, which contributes to excellent infection rates among girls:

Inculcation of gender norms in homes, churches, schools, and cultural events can create a taboo gap wherein sex prior to marriage becomes a forbidden topic that leads to reduced access to sexual and reproductive health services (Fig. 3). This taboo is systematically reinforced and sanctioned, including by parents, peers, teachers, communities, development programmes and health systems, making it difficult for young people to learn how to practice sex safely (Kägesten et al., 2016) (Hay et al., 2019). Adolescents' concerns about patient privacy and being ridiculed or turned away when seeking care highlights that it is not enough to ensure that hospitals and clinics are fully stocked with contraceptives.

[.] Higher rates of discordance between their the attitudes and premarital sexual behaviours of boys than girls are a manifestation of underlying social norms that consistently direct girls to remain a virgin until marriage and to avoid initiating sex., while mixing messages for boys and ultimately engendered an expectation to dominate girls. Moreover, girls are likely to be blamed for the spread of HIV, as the community norms are restrictive for girls and permissive for boys, thus further discouraging girls from seeking sexual and reproductive health services, for fear of being shamed, blamed, and punished, thus widening the taboo gap. These factors must be considered in sexual health education programmes, and it must be acknowledged that change will be gradual rather than immediate. (Nesamoney et al., 2022)

The importance of this source in the investigation is to demonstrate another way sex taboo affects adolescents, both physically and psychologically. The source shows how the taboo of extramarital sex leads to silence in the field of sex ed. Zambian Demographic and Health Survey data shows that people who uphold the taboo and belief that premarital sex is immoral have discordance in measures of behavior; this poses a disproportionate threat to girls and leads to a higher chance of HIV infection. Many people who do have extramarital sex say they do not. Schools don't have the best sex-ed curriculum formulated for their environment, and they also further reinforce the taboo gap. Furthermore, the same taboo that led to the ignorance that may have caused these youths to contract HIV shames them for going to reproductive clinics and may impede them from seeking

vital help and services. There are many legal requirements (consent from family or husband) for a girl to be able to receive things for her sexual health, which impedes her from receiving them. Adolescents also reported being turned away and scolded when searching for condoms. Students have been taught that contraceptive use may lead to cancer and infertility; condoms are associated with prostitution. When youths are thought to have broken this taboo, they face shame and anxiety and experience bullying and stigmatization from teens. Boys are encouraged to have multiple partners and engage in sex by cultural norms; they are excused from promiscuity or even violent sexual behavior and are enabled to have transactional sex with girls. Younger girls usually use transactional sex to combat food and financial insecurity. It also leads to higher HIV and pregnancy rates since girls are unable to negotiate their contraceptive use, and transactional sex is usually had with older men who already have HIV from earlier sexual relationships. Many girls are in child marriage because their families hope it will stop them from having premarital sex and HIV and will not let them be ostracized from specific social settings. Child marriage, however, produces higher rates of HIV among girls since, because of the power imbalance, they are probably forced into sexual relationships before they would want to or are unable to ensure their partner is using contraceptives or getting tests for HIV. The cultural norms and taboos also make consent from girls a prize to be won by boys, which further impedes their ability to say no or to oversee contraceptive use, leading to more HIV infections. This means that a man with HIV is encouraged and influenced by the cultural norms and taboo gaps to have many extramarital partners in all the ways previously mentioned, leading to him spreading HIIV to other girls. The taboo gap also impedes the girl from going for healthcare for her HIV since promiscuity is such a taboo, and the girl would be blamed for both her and her partner's infection.

## The Experience of Sexual Stigma and Its Correlation with Suicide Rates in Youths

This study's goal was to determine the connection between low socioeconomic levels, sexual stigma, and suicide attempts among Brazilians aged 11 to 24. Comparing the variations in the frequency of suicide attempts between the data sets from 2004 and 2010 was another goal of the study. The study compared sexual stigma, low socioeconomic position, and suicide attempts among Brazilian teenagers using data from the Brazilian Youth Research Survey. Any stigma associated with homosexuality, same-sex urges, sexual practices, and relationships is referred to as sexual stigma. A questionnaire was filled out by participants between the ages of 11 and 24 throughout two data collection periods: 2004 and 2010. For those who had not suffered sexual stigma, there was a 20% reduction in suicide attempts. In contrast, there was a 60% rise in reported suicide attempts among individuals who had experienced sexual stigma, and there was a higher incidence of familial, physical abuse, molestation, and rape among kids who experienced sexual stigma. The article talks about how economic standing and methods of enacting policy changes are two examples of the social and historical elements influencing these dynamics:

Non-heterosexuals (or those perceived to be non-heterosexual) are often subject to a slew of prejudice and discrimination such as bullying (Poteat and Espelage, 2005), physical abuse (Saewyc et al., 2004), sexual abuse (Gold and Marx, 2007), and violence (Gruenewald, 2012). Those who had experienced sexual stigma also tend to have significantly worse educational level (Kosciw et al., 2013), earning (Blandford, 2003), employment (Pizer et al., 2011), physical (Hatzenbuchler et al., 2014a,b) and mental health outcomes (King et al., 2008). The internalization of sexual stigma among sexual minorities also manifests itself as a self-stigma: "a self-directed prejudice, whereby the self-concept is congruent with the stigmatizing responses of society" (Herek. 2016, p. 398). Of particular concern, sexual stigma have been shown to increase the risk of developing depression (Hatzenbuchler et al., 2008) and suicide risk (Ploderd et al., 2014).

[...] This study sought to compare changes in suicide attempt rates in young Brazilians between 2004 and 2012, focusing on differences between participants who had or had not experienced sexual prejudice. Whilst rates of suicide attempt decreased by 20% for those with no sexual stigma experiences (from 9.0 to 7.2%; 8 =

6.726, $p < 0.01$) between the two cohorts, rates of suicide attempt for those with experiences of sexual stigma increased by 60% (from 16.2 to 25.4%; 8 = 7.338, $p < 0.01$). (Brandelli et al., 2017)

The importance of this source in the investigation is demonstrating the effects of sex taboos on youths. Sexual stigma is born from the taboo that homosexuals and all that has to do with same-sex relationships are immoral and evil. This study showed the undividable relationship between experiencing sexual stigma and the psychological effects it has on teens, such as depression, which leads to higher suicide rates. Youth who stated they were experiencing sexual stigma also reported the increase, in 2010, of familial sexual and physical assault. This source also demonstrated that between 2004 and 2010, the years they conducted the surveys, there was an increase in suicide rates in teens who experienced sexual stigma. This may be because of the psychological effects growing up in this sexual stigma culture and world has on these young minds. Maturity is happening in a place where they are discriminated against, which, as an earlier study elucidates, growing up surrounded by a particular cultural belief makes it an integral part of how you judge yourself and others and may tie into their bones the belief that they are not good enough, leading to more depression and suicide rates.

## How Health Professionals and Health Students Perceive and Handle Masturbation

This study set out to find out how masturbation is treated as a clinical problem in Tanzania's Dar es Salaam. Masturbation is frowned upon in many African cultures. Interviews were conducted with 61 healthcare students and 58 healthcare professionals regarding a hypothetical situation and their proposed course of action. Views regarding the impact of masturbation and expertise about managing it were the two main themes. It was discovered that medical professionals would attempt to normalize masturbation by giving advice on how to stop it. They would advise you to see a psychologist for treatment and to keep an eye out for any adverse consequences following masturbation. A recurring theme was the belief that masturbation was clinically problematic and would result in a wide range of issues as an adult, including loss of sexual sensitivity, psychological reliance, erectile dysfunction, and sexual dissatisfaction with a spouse. Many of those questioned claimed they had never received any instruction on how to control masturbation in a medical context. These results highlight the necessity of thorough health education at Tanzanian colleges as well as the significance of providing information regarding the normalcy and health benefits of masturbation:

Most health professionals, especially medical doctors, perceived masturbation to be the result of hormonal changes that drive a child to masturbate to meet their sexual desires. The professionals indicated they would educate the father and the child about the physiological changes during puberty and reassure them to anticipate such behavior unless they misbehave during or immediately after masturbating. However, many students across professions believed masturbation to be unacceptable and an indication of a psychological problem that would need professional treatment by a psychologist.

Even though medical professionals Mushy et al. Page 8 J Sex Med. Author manuscript; available in PMC 2022 October 01. Author Manuscript Author Manuscript Author Manuscript Author Manuscript reported masturbation due to the physiological changes taking place during puberty, both students and health professionals had a similar misbelief that practicing masturbation would lead to negative sexual health consequences in adulthood.

[...] This study's findings show that even highly experienced health professionals and students still have several misconceptions about the effects of masturbation in adolescence on adult sexual health. Sexual dissatisfaction with a spouse, loss of sexual sensitivity in intercourse, loss of erection, psychological dependency, premature/early ejaculation, and penis size reduction were the most reported supposed side effects of practicing masturbation. Most participants believed masturbation might negatively affect early/premature ejaculation and sexual dissatisfaction in the marital relationship. In the absence of sexual health training of health professionals in Tanzania, professionals fall back on the population stereotypes that they have learned in the community. (Mushy et al., 2021)

The importance of this source within the investigation is demonstrating how the taboos and cultural norms placed around masturbation affect how medical professionals are taught to handle masturbation in a clinical situation and how they relay information back to the public as a supposed trusted source. The information these medical professionals are taught based on the taboo of masturbation further enforces the myths and stigmas in the communities surrounding self-pleasure and the people who practice it. The study states that although masturbation is preached to cause many health problems in adulthood and is viewed as an immoral activity, adolescents still report engaging in it. The study also said that there is a similar trend in the Brazilian health profession; most practice masturbation while believing it is detrimental to their health. The practice of masturbation, while upholding the belief that it is a wrong thing to do, causes shame and guilt to be placed on the individual (further sources elucidate this topic.) Especially if the people preaching that masturbation is wrong are the respected doctors of these communities.

## Psychological, Biological, And Relation Effects of Ego-Dystonic Masturbation

Finding out how ego-dystonic masturbation affects psychological and interpersonal wellbeing was the aim of this study. Most people view masturbation as a source of shame and remorse. This results in ego-dystonic masturbation (EM), which is the act of masturbating accompanied by guilt. To determine how severe EM was in relation to the frequency of guilt and masturbation following it, a total of 4,211 men in the clinic were studied. Higher levels of EM were linked to increased levels of depressive symptoms, relational issues, alcohol consumption, and freetloating anxiety in the subjects. Additionally, the study linked lower relational and intrapsychic domain scores to EM severity. Nonetheless, phobic anxiety and obsessivecompulsive behaviors were less prevalent in participants with more severe EW. This study provided evidence of the seriousness of EM and its detrimental effects on people's lives. It also demonstrated why medical professionals should be aware that patients pursuing treatment may disclose obsessive sexual practices:

In different types of hypersexuality referral, Cantor et al8 described cases of sexual guilt, with clients reporting distress related to sexual behaviors often sufficient to have warranted previous diagnoses of depression. Greenberg and Archambault9 found that guilty feelings connected with masturbation occurred in 40% of a sample of university students. More recently, the masturbatory experience of young Korean men in military service was examined. Feelings of guilt were reported by approximately 10.9% of the sample (132 of 1,212).10 In a previous study,11 a feeling of guilt after masturbation was reported by 274 patients (15.4%). For this study, we defined a masturbation activity followed by a sense of guilt as ego-dystonic masturbation (EM).

[...] To our knowledge, this is one of the few recent studies to consider the psychopathologic and biological correlates of EM. According to our main results, EM seems to be a psychological problem because it shows (i an almost 10% prevalence in clinical settings of sexual medicine; (ii) a clear association with psychiatric symptoms such as depression and anxiety and with psychological distress in general; (ifi) worse sexuality, with an impairment of successful sexual intercourse for the couple, leading to significant relational problems; and (iv) a tripling of the risk of EM from conflict between the patient and his partner. (Castellini et al., 2016)

The importance of this source within the investigation is demonstrating how EM affects people in psychological and relational ways. EM is the guilt felt right after masturbation. It is caused by masturbatory taboos and the continuation of this activity with an imponent sense of guilt and the feeling of wrongness and desire to punish or correct oneself. The earlier studies demonstrated how people were being taught by the cultural norms in their communities that masturbation is wrong. The source shows how the trusted medical professionals were also informing the public based on the taboos and all the myths that placed shame and guilt over masturbation. The narrative fed to these people, especially adolescents, will leave them with feelings of guilt since they believe that masturbation is wrong but continue to do it. This current source demonstrates how

the guilt they may feel will have different effects on them, leading to anxiety, depressive symptoms, and relationship problems. There must be a fundamental change in the misinformation fueled by taboos that cause harm to people.

## Methods

The investigation used a computer with an internet connection alongside an internet browser chrome. To find the documents required for this investigation, the Google search engine was paramount for pinpointing the necessary sources that would elucidate the research question. Although the internet connection was unstable at times, it proved sufficient to conduct all the required constituents of this investigation. Most of the sources were peer-reviewed, and even though some sources were not, the research advisor revised the sources and approved them by confirming their validity.

This investigation was completed utilizing a documentary analysis design. To populate this research, it was necessary to specify the purpose of each of the ten sources used. Furthermore, it was important to recognize the source's design and approach, indicate the target audience, highlight their limitations, and finally, determine the recommendations and findings contained in each. An analytical component outlining the significance of the data presented in the inquiry was generated, so a descriptive content analysis methodology had to be utilized for this investigation. All these components working in tandem created the optimal conditions for the consummation of this project.

## Results

Google Scholar and Pubmed were the best search engines for the sources used in this investigation. These findings will be organized by publication date, but the number assigned to each will be determined by the order in which they appear in the Literature Review (i.e., first source, second source, etc.). The third source was published in 2011, the first and fourth sources were published in 2014, the second source was published in 2015, the tenth source was published in 2016, and the eighth article was published in 2017; these sources can be considered not recent.

Regarding the findings of the previously mentioned order, the third source described the relationship between abstinence-only education and its correlation to higher teenage pregnancy and birth rates; the first source discussed the connection between comprehensive HIV/AIDS education and outcomes of different demographics of students. The fourth source outlined the psychological risks teen mothers have and delineated some practical ways to implement solutions, the correlation between LGBTQ-inclusive sex ed and bullying against sexual minority youth, the psychological, biological, and correlated effects of ego-dystonic masturbation, and finally, the eighth source delved into the subject of the experience of sexual stigma and its correlation with suicide rates in youths. Following the chronological order of the publications within this investigation's literature review, the fifth source was published in 2020, and it was able to discuss the topic of malnutrition and described harmful sex taboos and justifications for it; the ninth article was published in 2021, and it was able to synthesize how health professionals and health students perceive and handle masturbation; the seventh source was published in 2022, and it indicated the causes of the taboo gap and the implication it has on girls' safety and HIV Infections; and the sixth source was published in 2023, and it outlined sexual repression and its causes, effects, and treatments; these can be considered as very recent.

## Discussion

The following sources delineated some of the many psychological and physical effects sex taboos have on individuals. The first source explained the benefits that HIV/AIDS education has for students. It stated that students reported less risky behavior, higher GPAs, more HIV testing, more condom use, fewer sexual partners, and an older age of first intercourse. Sex ed, not including HIV/AIDS education, is born from ignorance around sex, and it is a taboo topic. This investigation demonstrates all the benefits that would be lost if sex ed did not include HIV/AIDS at all. This would cause many psychological and physical detriments to the students. The second source demonstrates how homophobic school environments, bullying, and harassment lead to higher depression and suicide rates in SMY. The source shows that IGBTQ inclusion in sex ed considerably brings down harassment, which in turn brings down suicide and depression rates. The exclusion of LGBTQ youth is produced by the upholding of the sex taboo of homosexuality. The following source illustrates the higher pregnancy rates that are made by abstinence-only education, a curriculum also born by the belief in sex taboos and the deflection of sex, and how that rate is lowered if sex ed is reasonable and understandable. This source goes hand in hand with the next one, which demonstrates the mental effects teen mothers experience and the effects of those mental conditions on their relationship with their children. The fifth source illustrates how postpartum sex taboos affect childcare for malnutrition and how mothers are blamed and shamed for their child's stunted growth. Mothers may be inclined not to take their children to healthcare centers, and if they do, they may be referred to traditional treatment over biological, which can further interfere with a diagnosis and healthy treatment for the child. The mother may also wean her child, which can lead to malnutrition or health complications. This shaming and isolation of the mother and child have significant psychological effects on both. The 6th source elucidates how sexual repression had psychological and related effects. Sexual repression is caused by the cultural influences that uphold sex taboos, as well as internal conflict formed from these internalized cultural norms and traumatic experiences. The 7th source explained what the taboo gap is and its perpetuation of gendered sex taboos and stereotypes. One of the taboos in the taboo gap is the moralization of sex before marriage. As reported by the study, the discordance in the people preaching, upholding this taboo, and their actions lead to high HIV infection for exclusive girls. This is caused by behavior encouraged by the taboo gap that lets specific individuals be excused from the conservation of a strict sexual lifestyle. This causes one person to spread HIV to multiple girls through child marriage, transactional sex, and the inability of girls to reject sexual advances or dictate on what terms those advances are realized. This taboo gap also enforces silence in the field of sexual health and produces institutions that teach misinformation about sex and prevent individuals from gaining contraceptives or exerting their human right to sexual and reproductive health. The taboo gap also places blame for the spreading of HIV on the girls, the demographic most affected. These cultural practices and beliefs also lead to psychological effects on the girls since they can be ridiculed, ostracized, and isolated for breaking the taboos. The 8th source reports the relationship between sexual stigma and suicide rates among Brazilian adolescents. Sexual stigma is enforced by homosexuality being taboo and all that has to do with same-sex attraction being stigmatized. This sexual stigma causes higher depression rates. Adolescents who report being stigmatized also reported more molestation rates. The 9th source stated that masturbation taboos had such deep roots in the Tanzanian community that it caused health professionals to teach and be taught many myths about masturbation and describe it as something that had to be fixed. This causes the community to amplify their upholding of sex taboos further since trusted medical sources are preaching the same. These masturbatory taboos also affected how health professionals treated masturbatory instances, and many were to be taught anything about masturbation in regards to a clinical setting. This teaching of masturbation as something wrong causes stress, blame, and guilt to be placed on a masturbating individual. The 10th source further elucidated the effects of masturbatory guilt on an individual. Ego-dystonic masturbation, the feeling of guilt after masturbating, is linked to higher free-floating anxiety, depressive symptoms, higher alcohol intake, and relationship problems. These sources have shown multiple effects, both physical and phycological, sex taboos or situations, curricula, treatment methods, and conditions caused by sex taboos.

## Conclusion

This study stated and went into a more profound analysis of the effects, both physical and psychological that sex taboos have on people. The presented sources were able to elucidate the correlation between HIV/AIDS education and outcomes in students in different demographics and LGBTQ youth's level of harassment in school in correlation with inclusive sex ed.

Moreover, this investigation delineated the relationship between abstinence education and its effect on teen pregnancy and birth rates. Additionally, evidence was provided that teen pregnancy and parenthood have adverse mental health effects. Notwithstanding this, further data also supported the investigation by stating that sex taboos have an undividable relationship with how malnutrition is handled and how mothers are blamed for it. This blame and treatment produce physical and psychological harm to both the child and the mother. Evidence was also provided to demonstrate how sexual repression, caused by cultural norms upholding certain sex taboos, can cause different emotional, psychological, relational, and physical issues to the individual experiencing it. Furthermore, a source was presented to show the causes and implications of the taboo gap and how it leads to more HIV infections in Zambian girls, as well as the psychological and social consequences it can have for them. Sexual stigma and its act in higher suicide rates and depression among Brazilian youths was also explained. The process revealed some limitations, which might be resolved by more investigation. Conclusively, sources were presented to illustrate how the sex taboo of masturbation affects the teachings and practicing of health care professionals, and the implications this had on the community, as well as the effects shame and guilt regarding masturbation brings to people. Generally, it would have been beneficial if the sources could outline more information on cause-and-effect relationships, provide a more in-depth look into these students' lives, and provide more information on specific topics that were only glanced over. In a general sense, the sources were able to present a vignette on the psychological and physical effects of sex taboo culture on individuals. For upcoming continuing research and data analysis, recommendations include securing more years of data and requesting more study resources. Ultimately, this investigation aimed to answer how our youth is affected by sex taboos physiologically, emotionally, socially, relationally, and physically. Sources converged to provide an answer, which is that these sex taboos lead to riskier behavior surrounding drugs and sex, adverse effects on LGBTQ youth's mental health from harassment at school, higher pregnancy and birth rates, negative psychological effects of this pregnancy and parenthood on the adolescent, mistreatment of HIV and HIV infected individuals, mistreatment of child malnutrition and blame on mothers, sexual repression and the emotional distress and relational problems it causes for people, higher suicide rates from sexual stigma experienced by adolescents, health professionals pushing biased and untrue information about masturbation, and anxiety and depression due to guilt from masturbation.

## Limitations

For the investigation to come to fruition, the scope of the research question had to be more encompassing to find more information on the subject, which permitted the optimal conditions to answer the research question. If the original research question had not been changed, perhaps the essay would not have been written as well, given that the research question would have been challenging to complete. The original research question was "What are the psychological effects on youths of growing up in a sex-taboo culture?" Only a few sources could apply to the effects of growing up surrounded by the culture. Sex taboo culture was also a particular statement that did not define my sources and purpose well. Even though there were excellent and plentiful sources regarding the effects of sex taboos on teens, it was a very restricting margin to have and blocked lots of good information. Finally, psychological effects are many, but they are tied to the physical effects sex taboos have on people. Therefore, a title change was needed to encompass the whole investigation completely. There was also

no source found on the effects of sex taboos on specifically female masturbation and both male and female body image.

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