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Sexual Therapy in Russia

Pleasure and Gender in a New Professional Field

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Editors: It is not surprising that the land that gave us Tolstoy, Dostoyevskysy, and Chekhov, Tchaikovsky, and Rachmaninoff, as well as Pavlova, Nureyev, and Baryshnikov, would give us a romantic view of sexuality. It is in this chapter, and no other, that the idea of love is discussed in connection with sex. Fate also makes an appearance in the discussion of the existence of a hard-wired sexual constitution. According to some Russian sexologists, all men and women have a sexual constitution, which is a relatively fixed and stable level of sexual desire (strong, medium, or weak). If a person happens to marry someone with a different sexual constitution, therapy is geared toward helping that person, or the couple, understand that this is “just the way it is.” This stands in stark contrast to the time and energy many American couples devote to trying to change or increase the level of sexual desire in the partner with less desire. While the notion of a sexual constitution may be foreign to many readers, challenging couples to find happiness together despite sexual differences is a treatment option that may be revisited upon reading this chapter.

Sexual dysfunctions in Russia are, however, often the focus of aggressive and multidisciplinary treatment including talk therapy, medication, and mechanical devices. The latter treatment is primarily geared toward resolving male sexual dysfunction, specifically erectile dysfunction. Awareness of the importance of helping women experience orgasm is a more recent phenomenon in Russian sex therapy

and in Russian culture.

The authors of this chapter interviewed eight sex therapists (physicians and psychologists), reviewed the vast treatment literature, and present two case studies in order to show a view of Russian sexuality and sex therapy with the history, politics, culture, and religion of the country providing the contextual but ever changing backdrop.

Introduction

Sexual morality and behavior have changed radically in Russia during the last two decades. In the Soviet period, there was strict public control over sexual information and a great deal of ignorance and discrimination regarding sexual matters. Today, Russia is characterized by a myriad of often conflicting views on sex and sexual morality. The media are very outspoken on sexual matters and often promote a liberal and hedonistic view of sexuality. On the other hand, the Russian Orthodox Church opposes sex education, abortion, and the rights of sexual minorities. The threshold to seek professional advice for sexual problems is lower today, while the forms of therapy, treatment, and advice offered to clients vary widely.

In this chapter, we first give an overview of the changes that have occurred in Russian sexual culture since the fall of the Soviet Union. We then turn to Russian sexual therapy and discuss two clinical cases, the first an example of problems with female orgasm in a young couple, the second an example of male erection problems in a middle-aged couple. We are especially interested in how gender equality and sexual pleasure are perceived in Russian sex therapy. The overview relies on previous research, including autobiographies and in-depth interviews on sexual issues conducted between 1996 and 2004 and two representative surveys in St. Petersburg conducted in 1996 and 2004. Parts of the chapter are based on interviews with eight experts that were conducted in 2009 and 2010 with practicing sexologists in different parts of Russia.¹

Historical Aspects of Russian Sexual Culture

Sexual Behaviors

During most of the Soviet period there was an almost phobic avoidance of the topic of sex (Kon, 1995). After the October Revolution in 1917 and into the early 1920s, the Bolshevik rulers briefly challenged traditional marital and familial relationships when they experimented with free love and communal living. This era was short-lived and under the leadership of Josef Stalin (from the late 1920s to the early 1950s), Soviet ideology sanctioned heterosexual sex solely within the confines of marriage. The higher value of working for the common good was touted over the pursuit of individual pleasure, further supporting the constraints on sexual behavior and knowledge about sexuality. For instance, male homosexuality was criminalized because it was deemed antisocial. These values remained virtually unchanged during the period after Stalinism. Soviet Russia was insulated from the symbolic and ideological changes of the 1960s that in Western countries were known as the sexual revolution. Public discussion of sexuality and reproductive health, consumption of erotica and pornography, sex research, and sex education were allowed only in the late 1980s. This change arrived with glasnost, the policy of transparency that characterized the perestroika era which was initiated by Mikhail Gorbachev in 1985

and ended with the collapse of the Soviet Union in 1991 (Goldman, 1993; Kon, 1995; Stites, 1985).

Although governmental ideology restricting sex remained throughout the Soviet era, there were important shifts in sexual behavior. Soviet legislation promoted equality between the sexes in all spheres of life and made it easy to both marry and divorce. The state provided free or inexpensive education, housing, health care, and child care; abortion was legalized in 1920. This was a fatal blow to the traditional, patriarchal Russian family. Wars, famine, migration, and political repression further destabilized traditional ways of life from the 1920s to the 1940s. Russian women entered the labor force earlier than in most other European countries and increased their professional and economic independence. Women were able to control the numbers of children they had (typically by induced abortion), the birth rate fell dramatically, reaching an average of two children per woman in the 1960s and only one child in the 1990s (Lapidus, 1978; Rotkirch, 2000; Zakharov, 2008).

After the Second World War, premarital and extramarital sex, as well as divorce, became more common. Urbanization and industrialization went hand in hand with earlier onset of sexual activity, more sexual partners, and more liberal attitudes. Especially during the comparatively prosperous times of late socialism in the 1970s and 1980s, many Soviet citizens enjoyed recreational sex. (Haavio-Mannila and Rotkirch 2010.)

Sexual behavior in Russia in many ways resembles Western countries with a time lag of 10 to 20 years. For instance, Finns in the 1970s and Russians in the 1990s reported similar ages of first intercourse and the same amount of variability in positions used in intercourse (Rotkirch & Haavio-Mannila, 2000). Russian sexuality is also characterized by many partners, extramarital relations, and by double morality or different standards for men and women (Haavio-Mannila and Kontula 2003.) . In St. Petersburg in 1996, one in two men and more than one in four women living in a sexual relationship reported having other sexual relationships in addition to their main one. A majority of these relations were casual, but 9% of the men and 4% of the women reported permanent sexual relations in addition to those in their main relationship. Men were much more ready to accept the infidelity of a husband than that of a wife (Rotkirch & Haavio-Mannila, 2000.)

Sexual culture in postcommunist Russia has undergone rapid changes. During the last two decades, access to sexual information and reliable contraceptives has greatly improved. Sexual behavior has become increasingly manifold, as manifested in the use of different sexual techniques and the numbers of lifetime partners. Homosexuality is no longer criminalized and homosexual subcultures proliferate in the big cities. However, hostility and discrimination toward homosexuals remains, especially in smaller urban centers and rural areas of Russia. Sexuality is also marked by geographic and socioeconomic divisions. The spread of poverty and social inequality have contributed to an increase in risky sexual behavior and sexually transmitted diseases (Regushevskaya, Dubikaytis, Nikula, Kuznetsova, & Hemminki, 2008). The growing affinity between the rulers of the Russian Federation and the Russian Orthodox Church has also affected sexual culture. The Orthodox Church supports a very strict sexual morality and condemns extramarital sex, abortion, and homosexuality.

Contraception

The lack of adequate contraception in Soviet Russia negatively affected women's health and sexual pleasure. Since the fall of the Soviet Union, Russian contraceptive culture has shifted from a high reliance on induced abortion to greater use of condoms. However, oral contraception is less popular than in many other European countries and unreliable methods are still widely used (Gerber & Berman, 2008;

Kontula, 2004; Perelman & McKee, 2009; Regushevskaya, Dubikaytis, Nikula, Kuznetsova, & Hemminki, 2009). In 2004, three in four women in St. Petersburg had used some contraception. The most commonly used method was the male condom, but other popular methods were coitus interruptus, the rhythm method, and douching (Kesseli et al., 2005).

Although abortions have become less common, rates are still higher than in many other European countries. In 2004, 55% of women of reproductive age living in St. Petersburg reported having had at least one abortion, compared to 36% of Estonian women, despite the fact that Estonia and Russia share the same Soviet legacy. The number of abortions a woman in St. Petersburg reported was typically one or two, but 6% had had at least five abortions. Women who had married several times and had many children were most likely to have undergone several abortions (Haavio-Mannila, 2007).

Sex Education

Sexual issues are discussed more openly than was once the case, both in public and at home. In 1996 as many as 57% of women reported that they had not received any information about sexual matters when growing up, and only one in 10 women thought the amount of sexual information received from their parents had been sufficient. By 2004, correspondingly, 42% had received no information at all, and one in five said they had received sufficient sex information during childhood.

A similar improvement can be seen in school sex education. In 1996, about 70% of the respondents had not received any sex education at school but this had dropped to 50% in 2004. However, sex education within the school system remains woefully inadequate with only 8% of respondents reporting a sufficient level of sex education. As a consequence, peer groups and haphazard information from diverse sources (e.g., television, religious groups, leaflets, books, Internet) shape the beliefs of young people, and the general level of sexual knowledge in Russia remains low (Kon, 2005; Snarskaya, 2009). As our first case description will illustrate, many young couples find it embarrassing to discuss sexuality and contraception with their partner (Meilakhs, 2008; Temkina, 2008).

The sex therapists we interviewed were critical of current approaches to sex education and family planning.² Some of the criticism centered on religious efforts that are in opposition to contraception and sex education. As one therapist expressed it:

Yes there is, constantly, propaganda against family planning. They come and leave booklets called *Abortion Is Death* or *Diary of an Unborn Child*. There is a fight going on. The church is against contraceptives. I'm not against the ideal that sex belongs to marriage, but life is richer than that and can't be fit into one single Bible.

However, another sex therapist was critical of family planning programs, which he perceived to be representing Western commercial and amoral interests. The quotation below also illustrates the emphasis put on romantic and spiritual love that is still common in Russian culture, and apparently also among some providers of sex therapy.

The family planning programs came to us from abroad and were related to the commercial activities of foundations. They include the exaggerated myth about AIDS and the myth about early sexual maturation. Children are taught not to love but to put on condoms. The best way to build a relationship is to know about moral and spiritual emotions, but in these programs there is not a single word about love. They talk about how to use contraceptives so as to not get infected by your partner. There are foreign brochures and booklets called *My friend the Condom*

or *How to Avoid Infections*. They distribute condoms to prostitutes, which are then sold in drug stores. This whole business is without any interest for me. But it does much harm. Some make a living out of it, the teenagers are suffering, because they have been taught how to fuck but not how to love.

Other sexual therapists deplored the lack of deep emotions in public representations of sexuality. Thus, the attitudes varied substantially as to what kind of sexual education young people need.

Generational and Cultural Differences in Sexual Attitudes

There are marked generational differences in sexual attitudes and behaviors in present day Russia. Soviet people born in the 1920s and 1930s and growing up after the Second World War belong to a generation of forbidden and silenced sexual culture. The next generation, born in the 1940s and 1950s, experienced rapid behavioral changes and had fragmented access to sexual information. A minority of the Soviet population had consulted the so-called sexopathological services that were established during the 1970s (see below). The term *sexopathology* illustrates the way in which Soviet medicine equated sexual problems with pathological diseases (Kon, 1995; Rotkirch, 2000).

Women of the older Soviet generations were usually not satisfied with their sexual life. Many had never openly discussed their sexual experiences. During in-depth interviews middle class women used evasive terminology when referring to sexual acts. They described themselves as cold or frigid and deplored this state of affairs. Women were not supposed to make sexual advances and sex for many was a “shameful marital obligation,” as a woman born in the 1930s described: “We were born in the Soviet times and thought that sex as such does not exist and it is shameful for a woman to...,” she continued, not wanting to complete the sentence. Russian women also often interpret sexuality through the needs and desires of their male partners; according to one respondent, “The man is most important, I always adjust myself to him,” (Temkina, 2008).

Soviet Russian men often told us how they suffered from lack of knowledge of the female body and of sexuality more generally. Men often feared the first intercourse as they did not always know what was supposed to happen. One couple had worried that their frequent intercourses as newlyweds was deviant and described their relief when 20 years later, during perestroika, the wife found a booklet about sex and realized that they had been “perfectly normal” (Rotkirch, 2003).

Sexual problems typical for the current Russian cultural context often arise in connection with infidelity, alcoholism, rape, and family violence. All of these are more frequent in Russia compared with most other European countries. Although alcoholism and family violence are now recognized as social problems, they are also often belittled or sidestepped. One sexologist we interviewed mentioned that several of his clients had suffered sexual violence in their youth. But another sexologist talked about marital violence only in passing, and seemed to imply that the woman was at least partly to blame for permitting violence: “Also women complain that their husband is fat and inattentive, that he may use violence. But if the woman’s attitude to herself is such that one may be violent with her, then what kind of love is that?”

Changes in Russian sexuality are perhaps best typified by the transformation in attitudes toward female orgasm. In the older Soviet generations, there was little information about female orgasm and it was not typically seen as a prerequisite for satisfaction. As one woman stated through an in-depth interview, “It is more important for a woman how much attention the man gives her, his passion, caresses, and his degree of desire” (Temkina, 2008, 289). A woman’s pleasure was seen to depend on

her male partner. Women either thought they had been lucky and found a great lover, or they complained about men who were indifferent and selfish during intercourse. In younger generations, by contrast, it is more common to know about the female orgasm and how to achieve it. The previous romantic and male-centered view of sexuality has shifted toward an emphasis on pleasure and female activity. Russian women born after 1970 tend to see themselves as responsible for their sexual pleasure and orgasm and it has become accepted for women to take the initiative sexually (Temkina, 2008).

The availability of information and contraceptives is generally seen as a blessing. However, some people consider the new emphasis on pleasure and orgasm as a stressful obligation. The huge media focus on sexuality has also left many Russians longing for more emphasis on love and spirituality. Russian culture has always been proud of its philosophical and spiritual values and this applies to love and sexuality as well.

The national borders of Russian sexuality are blurred. Many emigrants from Russia now live in the United States, Israel, and the former Soviet republics, and many people from the former Soviet republics have moved to Russia. These migrants often have interesting reflections on Russian sexual culture. Western Europeans often perceive Russians as more traditional and conformist in their views on sexuality and gender (Chernetskaia 2005; Watson, 1993). In contrast, in the southern post-Soviet republics, Russia is seen as a sexually liberal country with high gender equality. For instance, in Armenia premarital sexual relations for women were until very recently strongly condemned. Only today is female sexual activity, including female orgasm, recognized as existing, although it is linked to the woman's desire to satisfy her male partner. In another ex-Soviet republic, Tadjikistan, premarital relations remain prohibited for women. Questions related to women's pleasure and orgasm are raised only in the context of marriage (Temkina, 2008). For this chapter we interviewed a sex therapist working in Kazan, the capital of the autonomous republic of Tatarstan in Russia. There, traditional patriarchal behaviors have recently grown in importance, including more instances of bride theft (the kidnapping of a woman which forces her to marry the abductor).

A wonderful illustration of the existing geographic disparity is provided by Colette Harris (2004) in her research on sexual and gender relations in Tajikistan. Harris tells about a Tajik man who after 3 years of marriage is finally told by Russian colleagues what to do to arouse his wife.

One of the Russians explained what a man should do for his wife to enjoy sex.... [The husband] said that neither of them had known that a woman could enjoy sex.... This afternoon he came home and wanted to try out what he had learned. [The wife] became absolutely furious, accusing him of having taken a lover.... Then, a few days later she was talking with a Russian friend who explained that men discussed sex among themselves and that Russian men were much better informed than Tajiks. She realized that what her husband had told her was probably true and she went home and apologized for having misjudged him. Only then did she allow him to try what he had learnt and it was really great. (Harris, 2004, pp. 154–155)

Contemporary Sexual Discourse

Contemporary Russian public discourse is sensitive to questions of sexuality. It reflects a commercial and medical view of sexuality with pharmaceutical companies playing a prominent role. Sexual medical consultations have become more widespread and commercialized, and sexual experiences and problems are discussed on television talk shows. Famous sexologists such as Lev Shcheglov and the sociologist Igor Kon are asked for advice in the media and produce bestselling books (Kon, 1990, 1997a, 2002,

2005; Shcheglov, 1998, 2003). Various scientific, popular, and self-help books are translated from abroad and also written in Russia. The sex industry includes prostitution, striptease bars, gay clubs, pornographic products, Internet sites, and other sexual services. However, more neutral, pragmatic, and scientific approaches to sexuality remain scarce (Gessen 1995). There is also strong opposition to liberal views on sexuality, notably from the Orthodox Church and other religious groups, promoted through leaflets, actions, societies, and Internet sites.

Judging from popular medical discourse, male erection difficulties are the most common sexual problem. Women's orgasm problems are also often mentioned. There is a rapidly growing market for advice and help for sexual problems. Prescription drugs, special equipment, and specialist consultations are advertised in newspapers, radio, and TV and in drugstores. Take, for instance, this advertisement for Eli Lilly (manufacturers of the PDE5 drug Cialis) distributed in a Moscow drug store in 2009:

Be confident, 95% of erection failure cases may be treated! Eli Lilly is ready to help. 40% of men over 40 years old suffer from erection problems. Return confidence in your power! Ask in the drugstore or turn to a doctor. Learn more at www.bud-uvere.ru. Or consult a specialist at...3636, the call is free.

On the Internet, you may find the following announcement. We quote it at length, because it is an interesting example of prevailing discourses on sex, health, and gender:

There is currently an increase in the number of men in need of examination and treatment for sexual disorders such as erection failure, early (premature) ejaculation, and lack of libido or sexual desire. Until recently most sexual disorders were seen to have a psychological, functional origin. Sexual problems are almost always accompanied by neurosis, but in one case the neurosis may be the main cause of the disorder, in other cases its consequence. Views on the causes of the emergence of sexual dysfunctions have changed during recent years. About 80% of men's sexual problems have been shown to arise after illness in different organs and systems.

Therefore only a complex and individual approach makes it possible to diagnose and treat the different illnesses of men's sexual organs, as well as solve problems related to disturbances in sexual functioning.

It is really not easy to be a man in our times. You have to be the head of the family, that is, the breadwinner, in order to be respected and valued.... It is important not only to succeed socially, but also to maintain your health and an optimistic attitude to life.

Until they reach the age of 35, almost all men, notwithstanding their lifestyle, look rather attractive and do not experience health problems. After this age barrier has been crossed, many experience their first problems in intimate life. Here the advantage is on the side of those men who regularly undergo prophylactic examinations and carefully note even minor worrying changes in their well-being. (Andrological & Gynecological Clinic, Moscow, n.d.)³

The advertisement quoted above encourages men, especially those over 35 years old, to seek the new forms of sex therapy now available. Scientific authority ("80% of problems," "psychological, functional") is alluded to in a diffuse way and with no references. The advertisement promotes self-monitoring and early medical interventions. Interestingly, a man's sexual health is associated with psychological, medical, and social success. Having outlined the main changes in contemporary Russian sexual culture, let us now have a look at the field of sex therapy.

The Field of Professional Sexology

The roots of Russian sexology are found in Soviet sexopathology as established in the 1960s. Sexopathology views sexual problems as mainly a result of organic innate or acquired pathologies that require medical interventions. Medical education in sexology was under strong institutional and ideological control. One sexologist described the situation: "The Soviet Union was a repressive and totalitarian model which is why sexology appeared as sexopathology, it was allowed only within medicine."

The pioneering works in Russian medical sexology were published in the 1970s and include Svyadosh (1974), Vasilchenko (1977), and Isaev and Kagan (1979). However, access to these books and other sources on sexuality was restricted to specialists who consulted medical libraries. One sexual therapist remembered attending one of the very first lecture courses in sexology in Russia, held in Leningrad in 1977 at what is currently known as the Medical Academy of Postgraduate Studies and which established the first department of sexology in 1989. Igor Kon's pioneering *Introduction to Sexology* was also published in 1989, in a staggering edition of 250,000 copies, indicating the craving for reliable information during the perestroika era. Kon was also the author of a thorough overview (in English) of the first steps of Soviet sexology, which appeared in the *International Encyclopaedia of Sexuality* (Kon, 1997b, see also Kon, 2005).

After the fall of the Soviet Union in 1991, newly established nongovernmental institutions were allowed to give lectures and organize seminars related to sexual therapy and education. The Russian Family Planning Association was founded in 1991 with support from the Russian Government and the International Planned Parenthood Federation. It began training medical professionals and founded three youth centers that provided sex education and psychological and sexual counseling (Kontula, 2004). These new organizations also incorporated psychology into Russian sexology. For instance, the Institute of Psychoanalysis opened in St. Petersburg and offered training, seminars, publications, and consultations (Temkina & Rotkirch, 1996). Neurolinguistic training, feminist therapy, and many other psychological therapies were introduced. New training programs and centers in sexual therapy also emerged within universities and high schools. Today, the most respected training institutes are the already mentioned Medical Academy of Postgraduate Studies in St Petersburg and the Federal Research Center for Medical Sexology in Moscow, which trains only medical doctors. Recently, formal sexological training has become available also to psychologists and teachers.⁴

The experts we interviewed illustrate this institutional and disciplinary diversity. They refer to their discipline as sex therapy but also included doctors-psychotherapists (5 respondents), a family psychotherapist (1), a medical psychologist (1), and a feminist psychologist (1). Two experts worked at a center affiliated with a university, one at a center for teenagers' sexual and reproductive health, two at hospital medical centers, one at a commercial medical center, one at a maternity hospital, and one at a feminist crisis center for women. As for theoretical influences, our respondents mentioned Sigmund Freud, C. G. Jung, Eric Fromm, Karen Horney, Alexander, F. Pearls, Frigga Haug, Masters and Johnson, T. D. Kemper, Eric Berne, and literary masters such as Leo Tolstoy. They also mentioned Russian colleagues and clinicians as crucial professional advisors. By contrast, the international community of sex therapists was mentioned as an important influence by only one expert. Several experts referred to specific Russian research concepts and tradition such as sexual maps or the theory of sexual constitution. The latter is a typology of sexual personalities based on the strength of the sexual drive and other physiological and developmental characteristics, developed by Vasilchenko and Botneva. The

theory is well-known among lay Russians but not among Western sex therapists (see “Assessment and Treatment” section).

The field of sex therapy in Russia is thus hard to define. There is a core of doctor-sexologists trained in Moscow or St. Petersburg and an array of sex therapists with other kinds of training, which is often less rigorous and may be somewhat at the level of psychological couple therapy. Solid professional associations, international contacts, agreed criteria for sexological clinical work, and evidence-based practices in this area are often lacking.

Typically, Russian sexologists work both with individuals and couples. With teenagers and young married couples, the work often involves parent-child relations. The price for visiting a sexologist varies. A medical sexologist may charge R15,000 to 18,000 (about €300 to 400) for one course of treatment, including ultrasound, hormonal tests, and the consultation. This price is considered average. In private clinics or in Moscow, the price may be more than twice as high. Most clients are middle- or upper-class men and women. Poor and other less affluent people usually lack the financial means to consult a sexologist. However, in some cities some groups such as young people, drug users, and battered women may have access to inexpensive treatment for sexual problems. For instance, at one youth center 9- to 17-year-old clients receive all treatments for free, while clients over 17 years may get substantial student reductions.

When starting their practice, our experts had been oriented toward either young people or middle-aged clients but were now also treating elderly clients. Several sexologists noted that their own views had changed regarding sexuality in older age, and they were now more aware of it as an issue and were more approving of it.

All of the experts we interviewed agreed that there were two main approaches to sexology in Russia: the predominantly medical and the predominantly psychodynamic. In the medical approach, the central problems relate to erection and orgasm, while the psychological approach deals more broadly with personality and interpersonal sexual relations. For instance, the following quotation illustrates a predominantly medical approach to sexual therapy:

A sexologist is a doctor with a multidisciplinary specialty who works with the problems of sexual pathology, the disturbance of the copulative function in men and obviously in women also....Sexology includes sexual pathology, criminal sexology, endocrinology, psychotherapy, and urology.

Sexuality is biological by its very nature. Human beings are biosocial creatures, so probably doctors with medical training have the most comprehensive view of sexuality. By contrast, the psychological approach has a different emphasis:

I see myself as doing humanistic existential psychology. Sexology is the science of sexual relationships, not of the genital aspects but of the relationship between a man and a woman. The object of sexology is love.... All psychologists are sexologists. People may do it with the aid of a scalpel or the aid of chemicals. But there are authors who are experts on the sexual soul. The best book on sexology is *Father Sergey* by Lev Tolstoy! That's sexology for you. Or *The Kreutzer Sonata*. Sometimes it is more useful to read them than the contemporary advice booklets, "How to Get Married and What to Do with that Swine Afterwards."

Nevertheless, the divide between psychologists and medical doctors is a question of emphasis and most experts see sexual therapy as a multidisciplinary endeavor. Medically oriented sexologists also

provide psychotherapy while psychologists may hold a medical degree and prescribe drug treatments.

Our eight experts espoused different attitudes toward homosexuality. For example, three disapproved of homosexuality (and one of these did not treat homosexual patients at all), one strongly approved of homosexuality, while four had neutral views. Several sexologists said homosexuality results from the childhood environment, especially because of an absent father, or due to hormonal influences or a single traumatic event. The current homosexual “fashion” in the media also provoked unease among some therapists. The following quotation by a politically liberal sex therapist blamed the way some single mothers bring up their children:

Recently we have many similar cases. Homosexual or transsexual tendencies. They are terribly unhappy girls. Why? We have always had it, but we have noticed more girls with homosexual and transsexual orientations during the last years. Because of the sexual revolution. Before, these topics were taboo.... We see a tendency to behave like the other sex. The mother wanted a boy, but had a girl. There is a sex role identification lacking. This is especially in a single-mother family, where the mother is bringing the child up to “be what I want you to be like.”

Assessment and Treatment of Sexual Problems

Most of the therapists we interviewed agreed that erection and orgasm problems constitute the main focus of their work. They also often mentioned combinations of marital and sexual problems, especially women who consult a therapist because their partner is having extramarital affairs or has left her for a younger woman. The comparatively high number of extramarital affairs in Russia is reflected in their clientele. Therapists also mentioned the special needs of different social groups, such as homosexual couples, transsexual people, elderly people, teenagers and teenage pregnancies, victims of violence, people who are HIV-positive, drug addicts, and sex workers.

What kind of diagnosis and treatment will couples with sexual problems receive in Russia? We provide an overview of assessment and treatment based on expert interviews and a review of the most influential scientific literature.

The leading sexologist Lev Shcheglov (2001) divides sexual disorders into two main types (a) sexual dysfunctions in men (such as arousal, erection, and ejaculation problems) and in women (arousal and orgasm problems), and (b) sexual disharmony” (pp. 257–261). There are five categories of sexual disharmony: (a) social and psychological dysfunction/maladaptation; (b) lack of sexual and psychological adaption in the couple; (c) lack of information and accurate knowledge; (d) sexual disharmony following sexual functional problems and typically leading to problems with erection and duration of intercourse in men; and (e) anorgasmia in women. The experts we interviewed often provided information that was consistent with Shcheglov’s classification. Additionally, they mentioned couples’ communication problems.

Most sexologists saw their task as defining the problem and making a diagnosis, then treating the problem. A few regarded the definition of the problem as part of the treatment. Krishtal and Grigorian’s (2005) textbook on sexology states that clinical sexology makes a diagnosis of the breach in sexual health, corrects it, and provides preventive measures. Another recent textbook for medical students emphasizes four demands for sexological work: to take into account the large number of different specific etiological factors; to adopt a systemic approach; to compare sexual indicators with the corresponding age-specific norm; and to take into account individual traits in sexual constitution (Vasilchenko (2005).

Diagnostic Tools

Among the various means used for making a diagnosis, Krishtal and Grigorian (2005) mention sexological studies and assessment of the spouses' psychological, social-psychological, and sexual-behavioral adaptation. Many therapists use sexological maps⁵ that depict formal indicators of sexual problems and so direct the therapist to ask questions designed to elicit the relevant information. As one expert said: "Following that map I ask him questions relating to sex and his personality only.... But the discussion is more important. We can talk for an hour, an hour and a half, about what happens and when. This serves to enable a differentiated diagnosis to be made."

Other therapists mentioned discussion as a diagnostic tool and as a method of treatment —these two phases are not always easy to separate. They conducted discussions with each individual and then both members of the couple. Some traced the patient's life history since childhood, sometimes including the marital and sex life of his parents, while others focus on the here and now.

The therapist's perspective affects the definition of the problem. While medical doctors may focus on physical factors, a psychologist may emphasize other issues. One psychologist noted that "sexual problems are not problems of genital contact, but of relations and interaction." Most therapists, however, take into account both medical and psychological aspects, and their interaction.

The clear majority of experts used age, psychosexual types, and the type of sexual constitution as key references in diagnosis. Vasilchenko (2005) has claimed that both age and individual characteristics influence the intensity of human beings' sexual activity, which is also related to the individual's constitution. Lev Shcheglov also stressed individual differences in sexual constitution (2001). Individuals' sex drive may be divided into three groups: strong, medium, or weak. These groups are considered to relate to physiological, developmental, and behavioral factors. The male sexual constitution is considered to be related to age of sexual interest and first ejaculation, as well as degree of hairiness; women's sexual constitution is related to her age at the onset of menstruation and how easily she becomes pregnant and gives birth.⁶

This strong emphasis on personality and on psychophysiological sexual traits appears to be typical of contemporary Russian sexology. For instance, a medical doctor in Kazan mentioned that the main tool for preventing sexual problems would be to teach people how to find the right partner.

You should look at the genetically based component, like the sexual constitution—if a man has a strong sexual constitution he may want it daily, maybe several times daily, until he is 80, and if he marries a woman with a weak sexual constitution, whose menstruation started after she turned 13 and who has not matured hormonally and maybe never will, it is clear that it will be pure violence to her.

Genetic and physiological factors may also contribute to constitutional sexual differences. In addition, sex therapists also referred to the impact of socialization. Single mothers were especially seen as detrimental to male and also often to female sexual development.

Assertive female sexuality may still be a problem in some Russian social circles, but this does not appear to be the case for sex therapists. On the contrary, one therapist was openly dismayed at how a male client reacted to his wife's sexual activity.

"Why did you come to see us? I ask. The client said, 'My wife has become more self-confident, more active and free. Somehow it's worrying.' When a woman becomes more active and confident men start worrying, that is a reason to go to psychotherapy!"

Sexologists may thus promote gender equality in sexual life and encourage men to be accepting of women's sexual demands. On the other hand, our interviews also featured examples of how sexologists reproduce gender inequalities. Men are often seen as more controlled by their biology and hormones than women, a view which assigns women the responsibility for changing and controlling the situation. As one expert put it, "We know that the man is biologically determined, he is active, hypersexual." We also detected a tendency to define male problems as more concrete (lack of erection), while more general problems are attributed to women such as being either uninterested or too demanding. In a few cases, the therapist discussed his female clients in a derogatory way.

Take the wife; she has such a puritanical attitude to everything. To put it bluntly, she can't even touch the male organ with her hands; it can only be put in with a fork.... There is a lack of sexual literacy, education, and information that leads to a lack of harmony between the two of them.

In the above quote, the sexologist was harsh in his comments about his female patient's reluctance to touch the penis, making a rude and aggressive comparison to a kitchen utensil. However, he did also stress a general lack of knowledge as contributing to the couple's misery.

The therapists noted that marital conflict can arise due to different levels of sexual desire and a lack of understanding. Crises in communication may be due to broader social issues, such as difficulties in combining work and family, and responsibilities toward other family members and kin. Several therapists mentioned work-related stress as a common source of Russian men's sexual problems. One of them talked about the "manager syndrome" in a way which reminded us of the advertisement for urological treatments quoted previously:

My younger male patients often have problems with erection and ejaculation...they have nervous crises over the situation at their workplace and lose interest in sex itself; there is that kind of manager syndrome. People work too much and don't wish to enter a relationship, they have no energy left: "I'd rather sleep a little or do something else, but absolutely no sex."

Treatments and Outcomes

Depending on the expertise of the sexologist, the patient is offered psychological help, medical treatment, or both.⁷ If a sexologist provides mainly psychological counseling, she or he may consult with or refer the patient to a urologist, endocrinologist, or neuropathologist. Medication may include hormones in order to cure erectile problems. Although Viagra is much advertised and used in Russia, no prescription and therefore no medical appointment is needed. None of our experts mentioned Viagra as a treatment option. Physiological treatment may include massage and the use of mechanical devices. Treatment of anorgasmia predominantly includes education and information, taking into account individual characteristics, and therapeutic work with couple communication. Many therapists said that lack of knowledge was the principal reason behind women's orgasm problems. As one put it:

Our young women are so little educated, it is tragicomic.... And not only the young. A woman came to me and cried here in my office, she was about 45 years old. Her first husband had died; she met another man 2 years ago. She said she had discovered orgasm. And she cried and cried that her life had been wasted. I said, but you should be happy, how many women live their whole lives without knowing anything at all.

The therapist may advise the client to acquire sex toys in order to have orgasm. One sexologist

actually owned a sex shop and advised her clients to purchase items. Another therapist stressed that "You cannot work just on achieving orgasm, because there is no such point, no such pill, instead you must talk to your husband, restore family relations, solve problems on a purely psychological level." A medical psychologist described the need for communication within the relationship thus: "Women say, 'Where is that prelude? Where are the ways to arouse me? My husband doesn't know that I have a clitoral orgasm.' I ask them, so why don't you tell him about this! Not everybody knows these things." A third therapist mentioned that women may enter extramarital relations to express the desire and satisfaction they have lost in their marriage. "The husband comes to me and says she cannot reach orgasm. When you start sorting things out you learn that she has a third person on the horizon."

Fatigue and marital conflicts are also given as important reasons for lack of female orgasm, especially among older women. As one sexologist commented,

Women often suffer anorgasmia. I have had cases with dysfunctional families, the husband started drinking, stopped earning money, a conflict situation, much to do at the workplace, two children, it is clear that although everything was fine until now, and sexual life was enjoyable, for such a woman sexual relations have begun to feel like something forced on her. She has lost all desire for intimate relations.

All therapists said therapeutic discussions individually and with the couple were a main component of treatment. Some sexologists also used group discussion (either for women only or men only, or with several couples together). In the therapeutic discussions, the therapists distinguish between interpretations and recommendations. Interpretations are one way of suggesting to the patient what may be happening to him or her. Some sexologists stress reflection and "active listening" over practical advice: "I can recommend them to listen to themselves, not to lie to oneself.... I do not give them tasks, like read erotic literature, buy some tablets, or have sex three times a day." Other sexologists do give specific advice. Recommendations include books to read, films to watch, breathing exercises, or simply instructions to caress each other. Specific suggestions can also relate to the lifestyle as a whole, to physical activities and nutrition, and to self-reliance and self-esteem.

The type of recommendations often appears to vary by gender. For instance, the influential Shcheglov (2001) gave specific recommendations in the case of male erection problems due to marital disharmony. According to him, the woman should know the needs of her partner, she should affect his erogenous zones when they prepare to have sex, help him to become aroused, and take care of contraception. The main responsibility of restoring couple harmony is assigned to the woman.

We now provide two case descriptions in order to further illustrate the values, treatment, and techniques employed in Russian sex therapy.

Case 1. Lack of Female Orgasm in a Young Couple

Our first case describes a young married couple who sought sex therapy because the wife did not experience pleasure from intercourse. It illustrates the lack of basic physiological knowledge and couple communication skills that may still be found among young Russians. VB, a family psychologist, tells us:

I had an incredible couple last week. She was 22 and he was 23 years old. Their joint sexual life began 7 years ago when they moved in together. They consulted me because of the wife's lack of sexual satisfaction. She had never experienced orgasm. She says she loves her husband, they are married, she feels pleasure thinking about him, feeling him, his scent, and his touch. But still

there is no satisfaction. They told me that during these 7 years nothing had changed in their sexual relations, they repeat the same habit. We found out that he knows very little about her. I asked him:

What does she like to read?

I don't know.

What food does she especially like?

I don't know.

Well, what do you think?

He mentions one kind of food, but she says she likes another. He doesn't know her tastes or interests. He doesn't know her body. I ask him:

What part of your wife's body is the most intensive erogenous zone?

He mentions one part, let's say the breast. She says, "No." He says, "Really?" The same can be said about her. For them, working with me meant exploring each other.

VB diagnosed the couple's lack of intimate communication and knowledge of each other as the basic problems. He further defined the problem as relating exclusively to their stereotypic relations with each other and the "lack of creativity, lack of self-assurance, the uncertainty, the lack of ability to accept the other and yourself." In this case, VB said that in a couple of sessions the couple solved their main problem (lack of female orgasm) after learning to discuss their erotic and sexual preferences.

Which traits typical of the Russian context can we detect from our first case? The early start of sexual relations is related to the liberalization of sexual norms that took place in the 1980s. Additionally, in Russia, a couple who had dated for so long would typically not be only cohabiting and married but also be the parents of at least one child (Zakharov, 2008). We also note the importance nowadays paid to female orgasm. The couple knew about its existence, although they could not achieve it. We also see how the psychologist does not blame one of the partners for the problems. He starts working with the husband but asks the same questions of the wife. He found that both were equally ignorant about the needs of each other. Female sexual pleasure is seen by both the therapist and the clients as a mutual concern for both spouses. Finally, the reader should not miss a very culturally specific trait in the first question: the therapist asks about reading habits, not pop stars or television sitcoms!

Case 2: Erection Problems in a Couple Relationship

This is how a doctor and sexologist, here called JJ, described his experience with a married heterosexual couple.

A couple saw me for a long time. They are married and have a big age difference: He is about 45 years old and she is 28. The relationship had deteriorated. He is a businessman, he works and is tired. He has a family from his first marriage. There is a conflict because he has to go and visit his children and provide them with money. His young wife criticizes him. They have started quarreling. She is an independent, beautiful woman. He has unpleasant feelings from sexual intercourse, he has lost sexual desire. Naturally, the wife does not understand that the reason for these problems is due to their conflicts. She has started accusing him of seeing his first wife or

some other woman, and thus puts oil on the fire. They have a huge age difference. Her sexual type belongs to a category of strong personalities, she needs quite frequent and satisfying sex. When she married him she didn't think about this. After they had been married for some time, twice a week was enough for him, because he belongs to the middle type in terms of psychosexual development. He also has episodic relations with lovers. On the basis of these conflicts she has also begun to worry, she can't relax during intercourse. She has difficulties achieving orgasm although she previously reached orgasm almost every time. After their disputes she sleeps badly and is in an unstable mood. Sex has a bitter taste to him and he has lost his erection a couple of times. Such a bunch of complications: it's a classical case. Someone advised him to take a Viagra pill. He took it the wrong way⁸ and it didn't work. He got even worse."

In this case, J J followed a complex, multidisciplinary approach in his treatment of the couple. First, he interviewed the wife, then the husband, and defined their psychological and psychosexual traits. According to J J, the husband was found to be "shy, emotional, and easily hurt. If he doesn't manage [to have an erection] he is on the verge of despair." Thus, he was considered to belong to the middle psychosexual type, who does not want sex more than twice a week after the age of 40. By contrast, the wife's "sexual type belongs to those with strong personalities. She needs quite frequent and quite good sex."

J J described his work as paying attention to age and to the personalities and sexual needs of his clients. In the above case, he eventually defined the root of the couple's problem and predicted future developments based on the theory of sexual constitution. "The reasons for their problems became clear. I had to explain to her that when she married she chose a husband who was 17 years older than she was. After a couple of years he will need sex only once in two weeks, while she will need it every other day.

We note that neither the strong sexual appetite of the woman, nor the shyness of the man, was seen as problematic by the therapist. The couple's social situation (e.g., the man's relations to his children and ex-wife, the couple's economic decision making) was not mentioned except in passing. With another sexologist, these could be seen as the main problem. J J worked two months with the couple and used all three main treatment methods: couple and individual psychotherapy, medication, and physiological treatment. In this case, the latter meant physiotherapy with an electrical device (the Iarilo) deemed by the therapist to have been quite effective in order to restore erection. This machine aims to improve erectile function of the penis by affecting the blood vessels by using air massage and laser treatment.⁹ J J reported that the machine is effective both in itself and as a placebo, as the mere sight of an erection can have a positive psychological impact. In this case the husband had restored confidence in himself and in his ability to get and maintain an erection.

This therapist also made specific suggestions to the wife and the husband regarding ways of reacting and acting towards each other: "So I also had to explain to him how to behave, what he needed to do, so as not to suffer so violently and to satisfy his woman. And to her I explained what she should feel, see, and say and how to manage her emotions. That is routine work."

Above, we noted that J J acknowledged the uneven levels of sexual desire of the spouses and did not judge the woman for having high sexual demands. However, he occasionally talked as if the couple's sexual incompatibility was something the woman should have taken into account to a larger extent than the man. Thus, he mentioned twice that the wife does not see the reason for their problems. By contrast, the wife's suspicion and concerns about her husband having an extramarital affair is not mentioned,

although they turned out to be realistic.

Overall, JJ was positive about the outcome of this case and his method of combining different kinds of treatment. JJ said that in this case as in other cases, he rarely expects radical changes in couple behavior and aims at gradual improvement. He also pointed out that everything (the discussions, the medical treatment, and even the cashier) are located in the same place, so that the patient is not forced to “run from one doctor to the other” (which is not uncommon in Russian medicine; see Temkina & Zdravomyslova, 2008).

Preventive Advice and Morality

What kind of advice would Russian sexual therapists give to promote sexual health and well-being in the future? We asked our eight interviewees what prophylactic and preventive measures they recommended to enhance sexual well-being. Their approaches varied. We noted above that finding a partner with a compatible constitution and sexual appetite that matches your own was recommended by some therapists. One sexologist advocated regular sex, as well as a balanced diet, “in order to have enough testosterone in the blood,” and an active way of life. Some recommended that after turning 40, a man should visit an urologist-andrologist and a sexpathologist once every year. Several sexual therapists emphasized the need for people to take care of their health (broadly defined) and to take into account age-specific influences in order to have realistic expectations about sexual functioning.

According to one medical psychologist, the crucial thing is to prevent young people from having intercourse at a young age: “I directly aim to prevent early sexual relations. That is clear. This correlates with a healthy lifestyle, with psychological and sexual health: abstinence, mainly, and reducing the popularity of early sex.”

Another psychologist wanted to enhance marital harmony. Quite another approach was adopted by a doctor and psychotherapist, who said: “The best prophylactic model is to sleep with whomever you want to sleep with.... If it is your wife, perfect! If it is not—that is your problem. But it’s not good if a person sleeps not with whom he wants to but with the one he is obliged to sleep with, because of his career, his family duty, or out of pity.” For this therapist, normal sexual relations are exclusively built on love and attraction, and they do not always entail monogamy. When another therapist included among his recommendations to “take a second wife and do with her everything you wish to do,” he seemed to accord men greater liberty and less responsibility. Again, although many sexologists wanted to restore the importance of love in sexual relations, at least some of them did not confine love to marriage.

Prolonged alcohol use is related to sexual dysfunction, including problems with arousal, erection, and vaginal lubrication (Peugh & Belenko, 2001). Nevertheless, not one of the experts we interviewed specifically discussed alcoholism in connection with sexual problems. They mentioned regular sex, love, special balanced diets, an active way of life, seeing a doctor in time, being careful about whom you sleep with, preventing marital conflicts, and enhancing harmony. Perhaps the problem with alcoholism is seen as too self-evident? Neither does the public and commercial sexual discourse in Russian society connect alcohol use with sexual health.

Therapists working with drug users or women who have been abused stress that the sexual life of their clients was very poor or nonexistent, and that these clients typically did not raise sexual topics. “Few of our clients report a satisfying sexual life. One group of clients says that they don’t have any sexual relations at all; the other group says that ‘I am forced to do it because everybody does it.’”

One therapist emphasized that due to economic hardship, women’s economic dependence, and family

violence, poor men and women are in no position to concentrate on their sexual pleasure.

The sexuality of Russian women is often secondary to questions of economic and social survival. Especially elderly women are often ready to stand discomfort related to male sexual problems... There are more urgent things than women's sexual pleasure: economic and social factors, to have a husband and a father for your children.

Economic dependence fosters sexual corruption and "*blat*," a Russian expression for informal exchanges of services and access to goods. In some cases poor or disadvantaged women may offer sex in exchange for services or goods, but the reverse also happens. One case involved a client in her 50s who had boyfriend 20 years younger than herself. This partner beat her, had relations with other women, and took advantage of her having a good apartment. The woman was aware of being exploited, but stated that the sexual pleasure of having a young lover made her continue the relationship.

The prophylactic advice offered reflects the liberalization of sexual behavior and norms in Russia during the last several decades. Sex therapists acknowledge the increase in pre- and extramarital sex and both men's and women's quest for sexual pleasure. However, their moral attitude to this development differs. One deplored this development and wanted to partially restore the old traditions. For another, there was no going back to the old morality, but neither has the current form of liberating sexuality outweighed the social and economic difficulties:

I have been working with women since the early 1990s. Although the word *sex* has suffered this incredible proliferation in various texts, pictures, discussions, and TV programs, I can't see that my clients have begun to respect themselves more as women.

How is treatment success evaluated? It is not easy to find evidence of this either in the scientific literature or on Internet sites nor from our interviews with experts. The continuation of a normal sexual life is often seen as the main general criterion, but more detailed evaluations are hard to make. One doctor simply said, "Either there is [clicks his tongue, imitates an erection with his hand] or there isn't." Others mentioned the difficulty of patients who have recurrent problems or who finish treatment too early. One sexologist saw the lack of ways to "tie the patient to the doctor" as her main professional challenge; the attitude of the spouse, such as lack of support or sexual interest, may also weaken treatment results. One sexologist described restoring a man's erection, but "the wife did not need that...so the work of the sexologist was in vain."

Several sexologists criticized those Russian men who are not ready to work with either their own issues or the relationship, but blame their female partners for all of the problems. One expert noted:

It's worse when one of them wants to change the situation but the other couldn't care less. A husband who sees himself as a psychologist and sex pathologist tells his wife: "The problem is that you are so ugly, you need to lose weight. Go to fitness class, learn how to do a striptease, then you can come to me...."

In sum, our cases represent typical types of marital conflict and sexological diagnosis in contemporary Russia. The first case described one psychological approach among many others, the second a medical approach combined with psychotherapy. In itself, these kinds of married couples would not have been unthinkable during the Soviet 1970s, but they would rarely have sought professional help and it would probably have been unusual for a woman to complain of lack of orgasm to the doctor in the presence of her husband. Neither would the kind of gender conflict evident in our

second case, with the sexually demanding wife, have been described by the sexologist as “classical.” The articulation and approval of female desire by both female clients and therapists is a novel phase in the development of sexology in Russia. This said, sexist attitudes may persist, where the woman is assigned more responsibility than the man for restoring the couple’s harmony.

Many Russian sexologists stress that they are not moralists. However, in any society, sexologists’ personal views on gender roles, normalcy, and illness may influence the diagnosis and recommended treatment. The contemporary morality of many Russian sexologists is tainted by liberal hedonism, stressing the right to individual sexual pleasure for all. Especially among the male doctors we interviewed we heard little about partnership, mutual help and support, negotiations, and compromises. Not surprisingly, the only feminist psychologist we talked to presented a stark contrast to this picture.

Conclusions

This chapter has dealt with Russian sexual culture and encounters in the field of Russian sexology, its diverse practices, and socioeconomic context. In sharp contrast to the official secrecy and sexual puritanism of the Soviet era, sexual issues are expressed and discussed in manifold ways in contemporary Russia. Liberal, commercial, and medical approaches to sex are in competition with religious and traditional sexual morality. The public and commercial discourse about sexual health focuses on erection and orgasm problems. Consulting a specialist for treatment of sexual problems has become an accepted and legitimate behavior. Treatment is typically not covered by national health insurance but has to be paid for by the patient or client, making it more accessible to the middle and upper classes. However, free or affordable treatment is often available to young or marginalized people.

Russian sexology was founded two decades ago and expanded throughout the 1990s. While the field is being institutionalized, there is little if any consensus about terminology, clinical practices, or ideological views. Sexologists use different methods and approaches and support different sexual moralities. Alongside the officially certified sexologist-physicians trained in St. Petersburg and Moscow, there exist a variety of psychologically trained therapists providing sexological services. Most sex therapists appear to combine both psychological and medical treatments. Treatment is multidisciplinary and not always evidence-based. Diagnosis often applies theories, diagnostic tools, such as sexual maps, and sometimes devices such as the Iarilo. The theory of sexual constitution, relating personality and the levels of sexual interest to physiological and developmental factors, is widespread among both sexologists and lay Russians.

We suggest that there are currently four important developments related to questions of pleasure and gender in Russian sexological encounters. First, Russian sexology has adopted a generally liberal and permissive view of sexual pleasure at all stages of the life cycle. Teenage sexuality and premarital sex is accepted, and also the sexual problems and pleasure of elderly people have recently received more attention and recognition. Second, there is a growing acceptance of sexual practices outside of heterosexual activities. Homosexuals and transsexuals are identified and recognized as a type of client, although there is also evidence that at least some sex therapists lack understanding of and discriminate against homosexuals. Third, women’s sexual desire and sexual activity is broadly acknowledged. A recent development is the emphasis on female orgasm and sexual initiative. Male sexual problems are also being discussed, including work-related stress, allowing for a more vulnerable and health-oriented perception of Russian masculinity. This is not to say that Russian sex therapists always espouse gender equality. We also detected signs of double morality and of putting the responsibility for change in a

heterosexual couple more on the woman than on the man. Finally, the scientific understanding of sexuality is strongly influenced by the theory of sexual constitution, which relates a person's level of sexual desire to genetic and developmental traits. This theory appears to be little known in Western countries but widely accepted in Russian-speaking communities.

Our analysis was based on two surveys and a small number of interviews that are not necessarily representative of the whole field of Russian sex therapy. Nevertheless, the diversity even among this small number of experts is apparent. One can detect varying and ambivalent attitudes to issues such as gender equality, sex education, and sexual orientation among Russian sexologists. Gender equality is present and encouraged, but not totally integrated, in Russian sexology. A person turning to professional help would have a hard time knowing what kind of approach to expect from his or her sex therapist.

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Notes

1. The interviews were conducted by trained sociologists between April 2009 and May 2010 in the cities of Moscow, St Petersburg, Samara, Archangelsk, and Kazan. We interviewed three women and five men who were 45 to 60 years old (three psychologists and five medical doctors). We refer to these respondents as "experts," "sexologists," or "sex therapists." The research is part of the project "Gender Arrangements in Private Life in Russian Regions" at the European University of St. Petersburg and has received financial support from the Ford Foundation and Novartis International AG.
2. Here and below all excerpts are from our research data unless otherwise indicated, see note 1.
3. <http://www.lclinic.ru/content/view/1/2/>
4. Information provided by Dr. Yuri Zharkov to Dr. Osmo Kontula by e-mail, May 2009, quoted with permission.
5. 6. Sexological maps for studying men include questions about complaints made, libido, first ejaculation, orgasms, masturbation, dynamics of sex life, alcohol, living conditions, personality traits and the objective facts of treatment (Vasilchenko, 2005, pp. 277–279). Women's maps also include information on pregnancies and menstruation (Vasilchenko, 2005, pp. 402–407). The maps were developed at the sexopathological department of the Moscow Psychiatric Institute of the Ministry of Health of the Russian Federation. Krishtal and Grigorian (2005, pp. 384–386) add a map for sexological studies of the couple.
7. For an informative overview of the theory of sexual constitution, see <http://big-archive.ru/med/sex/79.php>. The theory is frequently mentioned in Russian language blogs (*polovaia konstitutsiia, seksual'naia konstitutsiia, seksual'naia sovmeštmost'*) and "ask-the-doctor" Internet pages in Russia and abroad.
8. A textbook in sexology distinguishes between six types of corrections to problems with sexual health: psychotherapy, corrections of the psychological and social-psychological maladaptation between the spouses, medical treatment of sexual disorders, physiotherapy of sexual disorders, gymnastics, and different methods, including surgical operations, to treat impotence in men (Krishtal & Grigoryan, 2005.)
9. Often men do not understand that they need to take Viagra about an hour before they plan to have sex. Also, after eating a high-fat meal, it may take even longer for Viagra to take effect.
10. Iarilo was developed by the company Iarovit on the basis of research carried out in the department of biotechnical medical systems at the Moscow State Technical University and appears to be quite widely used in Russia and other CIS countries. The Internet site of Yarovit is <http://www.yarovit-med.ru>.

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