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Invited Editorial

Ancient South Asian traditions and the cultural foundations of sexual medicine: from kāma to clinical care

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Abstract

Introduction: **Contemporary sexual medicine increasingly recognizes the need to move beyond a narrow biomedical model and incorporate culture, dignity, pleasure, relationships, and patient context.**

Methods: **This editorial reflects on ancient South Asian traditions, including kāma, the Kāmasūtra, epics, temple art, Ayurveda and culturally embedded sexual beliefs, and interprets their relevance to modern clinical care.**

Results: **South Asian traditions historically framed sexuality as relational, moral, social, reproductive, spiritual, and pleasure-oriented. These traditions remain relevant because many patients continue to experience sexual distress through ideas of shame, masculinity, fertility, marital duty, semen anxiety, and family expectation. Clinical examples include unconsummated marriage, masturbation myths, Dhat syndrome, and misuse of traditional claims by social media influencers.**

Conclusion: **Ancient traditions should neither be romanticized as medical science nor dismissed as mythology. Their greatest value lies in promoting culturally literate, evidence-based, compassionate, and patient-centred sexual medicine.**

Keywords South Asia, unconsummated marriage, dhat syndrome, ayurveda

Ancient South Asian traditions and a broader sexual health lens

Modern sexual medicine has achieved remarkable progress in the diagnosis and treatment of erectile dysfunction, ejaculatory disorders, androgen deficiency, infertility, female sexual dysfunction, and genital pain. However, as recent editorial commentary in *Sexual Medicine Reviews* has emphasized, sexual medicine must move beyond a narrow biomedical "repair model" and embrace a broader sexual health framework that includes dignity, pleasure, justice, rights, culture, and human flourishing.[1]

Ancient South Asian traditions offer a useful cultural lens for this broader view. South Asia has preserved diverse religious, literary, artistic, philosophical, and medical traditions related to sexuality. These traditions should not be read as modern clinical guidelines. Rather, they show that sexuality was historically understood as a multidimensional human experience involving desire, pleasure, duty, fertility, restraint, relationship, family, morality, gender, and social belonging.

In classical Indian thought, human life was often described through four broad aims, known as the four **puruṣārthas**: ***dharma,*** meaning ethical duty and social order; ***artha***, meaning material security and livelihood; ***kāma***, meaning desire, pleasure, affection, aesthetic enjoyment, and erotic fulfilment; and ***moksha***, meaning spiritual liberation. Within this framework, kāma was not treated as shameful or merely reproductive. It was a legitimate part of human flourishing when balanced with ethical and social responsibilities.[2,3]

Kāma and the Kāmasūtra are related but not identical. Kāma refers to the wider concept of desire and pleasure, whereas the **Kāmasūtra** is a classical Sanskrit text that discusses aspects of kāma in social and relational life. Although many readers associate the Kāmasūtra only with sexual positions, it is better understood as a broader treatise on attraction, courtship, partner selection, erotic communication, marital life, pleasure, and social behavior. Its contemporary value is not as a clinical manual, but as an early recognition that sexual satisfaction is relational, psychological, cultural, and communicative.[4]

Epics, temple art, Ayurveda, and cultural models of sexuality

The **Ramayana**[5] and **Mahabharata**[6] are two major Sanskrit epics that have deeply influenced South Asian moral, religious, literary, and cultural imagination for centuries. They are not medical texts, but their stories have shaped social ideas about marriage, fidelity,

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fertility, masculinity, celibacy, gender roles, desire, shame, and family duty. For readers unfamiliar with these traditions, the characters mentioned below should be understood as culturally influential narrative figures through whom societies have reflected on sexuality, morality, and reproduction.

In the **Ramayana**, **Rama** and **Sita** as a couple symbolize marital fidelity, separation, sacrifice, and public morality. **Ahalya**, a female figure in the Ramayana, is often used to discuss themes of desire, deception, transgression, punishment, stigma, and eventual restoration.[5] The **Mahabharata** presents even more complex sexual and reproductive narratives: **Kunti** invokes divine fathers to obtain children; **Pandu** is unable to engage in intercourse because of a curse and yet **Madri** (second wife of Pandu) becomes a mother within this unusual reproductive setting; **Draupadi** has a polyandrous marriage; **Bhishma** takes a vow of celibacy; **Shikhandi** reflects gendered complexity; and **Arjuna** lives for a period as Brihannala, a gender-variant identity. **Gandhari'**s account of 101 children developing in earthen pots in the Mahabharata may be viewed, cautiously, and symbolically, as an ancient narrative imagination of assisted reproduction or extra-uterine incubation, rather than as evidence of modern in-vitro fertilization.[6] These stories remain clinically relevant because many patients still interpret sexual concerns through morality, family obligation, masculinity, shame, honor, and fertility expectations. The cultural reach of the Ramayana extends beyond South Asia; **Thai culture** is deeply influenced by the Ramayana epic through the **Ramakien** tradition, visible in classical dance, temple art, royal symbolism, place names, and even roads such as Bangkok's Rama I Road and Rama IX Road.

Erotic temple sculptures at sites such as **Khajuraho** and Konark in India are also often misunderstood through a modern lens of embarrassment or sensationalism. These carvings were not merely decorative or obscene. They may be interpreted as symbolic acknowledgements of kāma, fertility, auspiciousness, worldly life, tantric influence in some contexts, and the integration of human desire within a larger spiritual and social order (Figure 1). Their presence on temples suggests that sexuality was not always hidden from public cultural expression.

Ayurveda is a traditional South Asian system of medicine that remains widely practiced in modern life through dietary advice, lifestyle regulation, herbal preparations, wellness practices, and fertility or vitality-related therapies. Within Ayurveda, **Vajikarana** (similar to Andrology and Reproductive Medicine) refers to the branch concerned with virility, libido, semen quality, fertility, vitality, and healthy progeny. Classical Ayurvedic traditions linked sexual function with diet, sleep, age, mental state, lifestyle, and systemic health, an approach that partly overlaps with the modern biopsychosocial model. **Ashwagandha** (*Withania somnifera*) is a traditional plant used for vitality and reproductive health. Recent studies have explored its potential effects on stress, testosterone, semen parameters, and well-being.[7] However, traditional use should not be confused with automatic safety or proven efficacy. Herbal and herbo-mineral products, including the widely marketed traditional substance **Shilajit**, have been promoted for vitality, testosterone, and male reproductive health; however, their composition may be variable, and concerns regarding contamination, heavy metals, adulteration, inadequate standardization, and insufficient regulation require caution before routine clinical recommendation.[8] Traditional knowledge should generate research questions, not bypass evidence, dose standardization, pharmacovigilance, and patient safety.

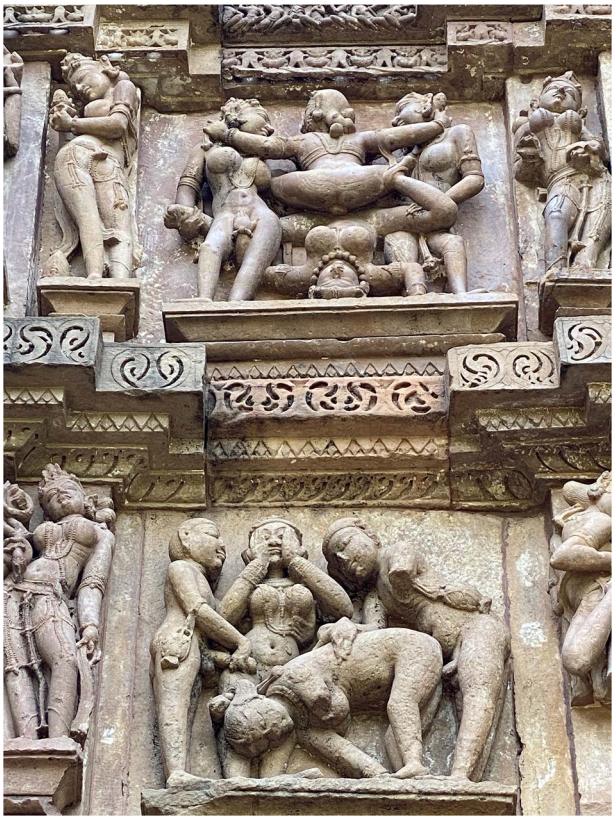

Figure 1 Erotic sculptures on the Khajuraho temple facade in Madhya Pradesh, India, part of a UNESCO World Heritage-listed group of Hindu and Jain temples renowned for Nagara-style architecture and intricate erotic sculptures.

Contemporary clinical relevance: Culturally shaped distress, myths, and misinformation

Unconsummated marriage remains a relevant example of culturally shaped sexual distress in South Asia, in which contemporary couples may experience anxiety and delayed help-seeking because sexual expectations are still influenced by older norms surrounding marital duty, virginity, modesty, family honor, and fertility. Its medical causes are usually multifactorial, including vaginismus, erectile dysfunction, premature ejaculation, performance anxiety, fear of pain, religious guilt, poor sexual education, and limited knowledge of genital anatomy.[9] Management requires a non-judgmental, couple-centered approach. Education, reassurance, psychosexual counselling, graded intimacy, pelvic floor therapy, and appropriate medical treatment are often more effective than blaming either partner. Ancient traditions remind us that sexuality has always existed within relationships, family, and society; modern clinicians must therefore treat the couple and their context, not merely the organ or symptom.

Masturbation myths, semen anxiety, and **Dhat syndrome** provide another example of the continuing interaction between culture and sexual health. Many young men in South Asia believe that masturbation or semen loss causes weakness, infertility, erectile dysfunction, memory loss, loss of masculinity, or permanent damage. These beliefs may lead to guilt, anxiety, depressive symptoms, and Dhat syndrome-like presentations.[10] Clinicians should correct such myths respectfully. Masturbation can be discussed as

a normal sexual behavior unless it is compulsive, distressing, injurious, or interfering with life. Counseling should separate cultural beliefs from biological facts while reducing shame and avoiding ridicule of the patient's background.

In the **social media** era, ancient traditions are also frequently misused by influencers to sell unverified aphrodisiacs, semen-retention programs, masculinity courses, "natural testosterone boosters," or exaggerated claims linking every modern sexual problem to ancient wisdom. Such exploitation misleads the public, delays appropriate medical care, increases guilt, and commercializes cultural heritage. Respect for ancient traditions should not become a vehicle for misinformation. Clinicians and researchers must distinguish cultural history from scientific evidence, and heritage from health claims.

Conclusion: From tradition to evidence-based cultural care

Ancient South Asian traditions should neither be romanticized as ready-made medical science nor dismissed as irrelevant mythology. Their value for contemporary sexual medicine lies in cultural literacy. They remind clinicians that sexuality is not only a matter of organs, hormones, or performance, but also of desire, duty, relationship, fertility, shame, morality, identity, and social expectation. A culturally informed sexual medicine must therefore respect tradition while remaining firmly evidence-based, resisting both colonial dismissal of indigenous knowledge and modern commercial misuse of heritage through unverified aphrodisiacs, semen-retention claims, or "natural testosterone" marketing. The most useful path is not tradition instead of science, but tradition interpreted through compassion, clinical evidence, regulation, and patient-centered care.

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Conflicts of interest

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