

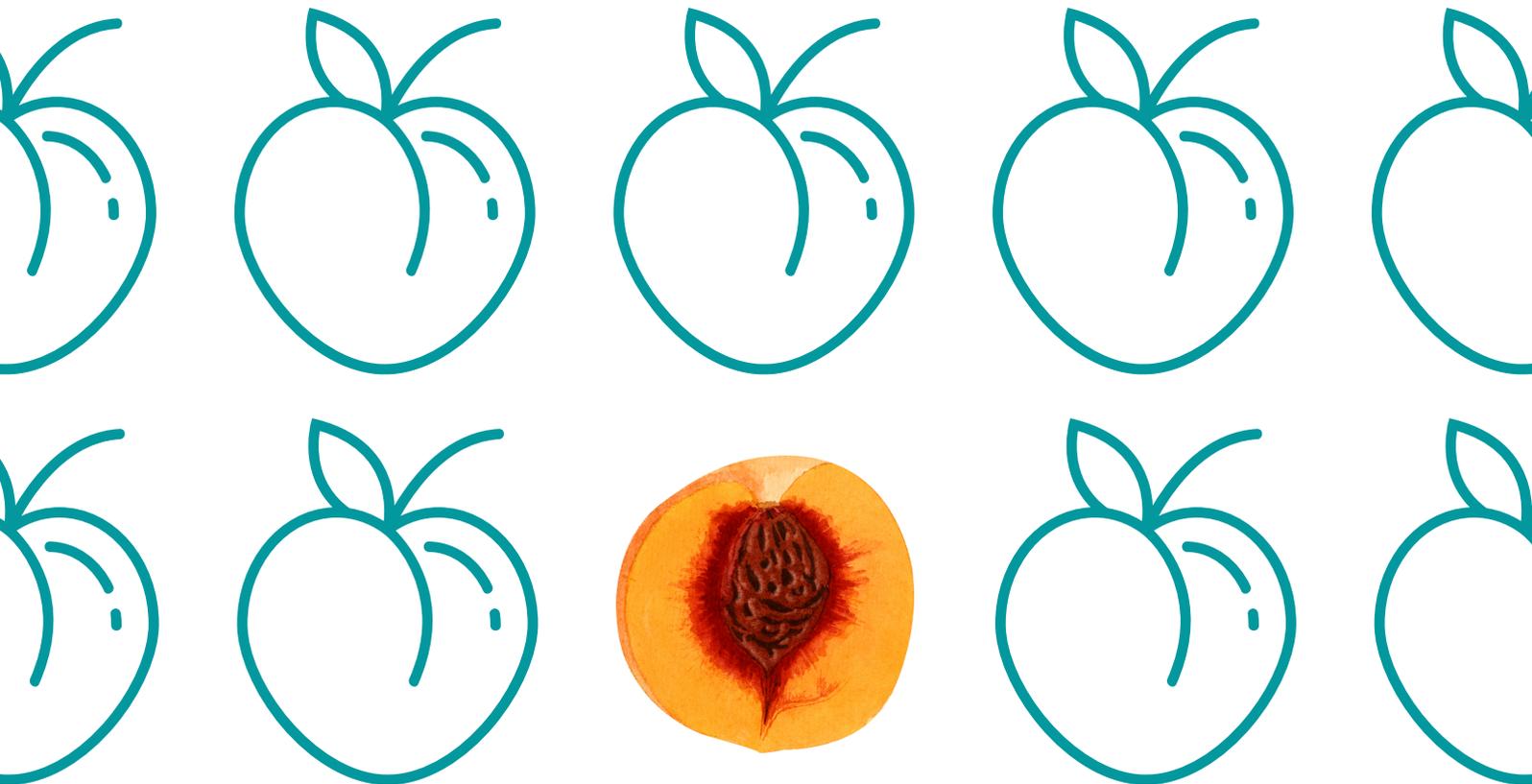
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SHAME, STIGMA AND COLORECTAL HEALTH FOR BOTTOMS

WORKING PAPER

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A

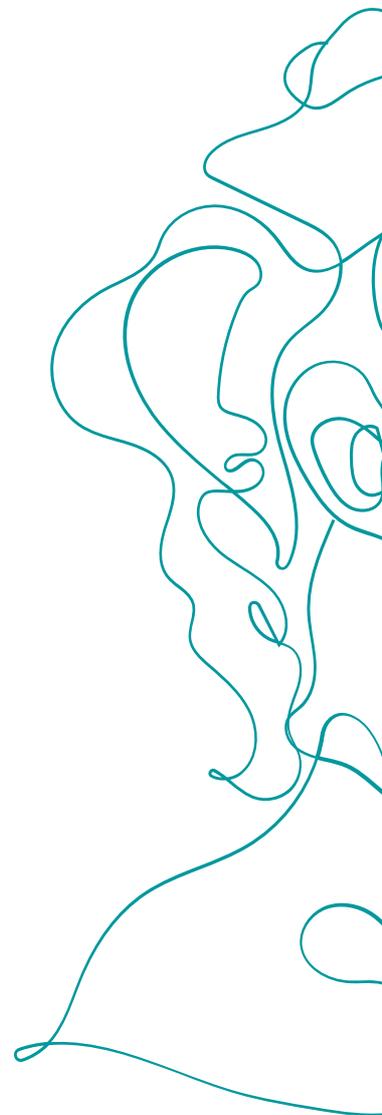
Introduction

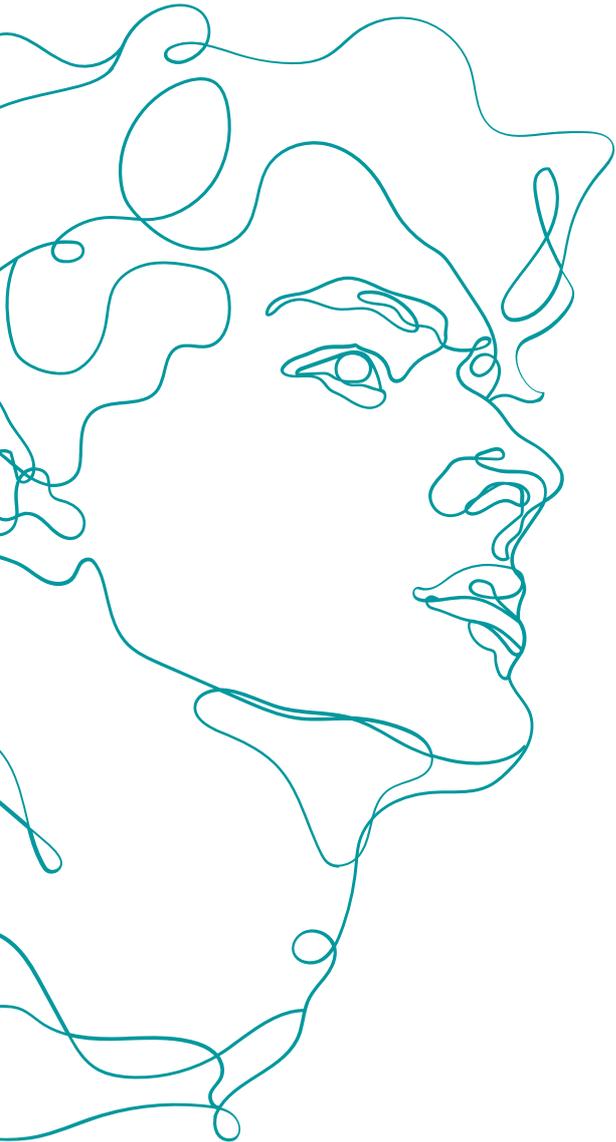
Context

**You're on your way here
but the water isn't clear.
Bottoming takes work.**
—@GrindrHaikus

The term bottom refers to men who prefer to engage in receptive anal intercourse (known as 'bottoming') with other men. This term, which has a long history among the communities of gay, bisexual, and men who have sex with men (GBMSM), points to multiple realities: while some men make being bottoms a key element of their sexual identity, others see it as one of the many sexual practices they engage in. In recent years, bottoms have garnered unprecedented attention from the media. Outlets and industry awards have sought to rank which adult entertainers are the best bottoms [1]. Even the lexicon of bottoming is constantly being updated with the birth of new terms such as power bottom (an energetic or dominant bottom). In more mainstream media, Troye Sivan's 'Bloom' was heralded as a 'bottoming anthem' on its release in 2018 – accompanied by the hashtag '#bopsboutbottoming' [2].

These discourses, however, coexist with deep-seated anxieties about bottoms and bottoming: even a cursory online search reveals that bottoming is marred by worries about how to 'prepare' for anal sex (that is, how to clean the rectum before sex, often via means of water enemas known as 'douching'), concerns about how to cope with pain, or anxieties the increased vulnerability to HIV transmission. In the words of Instagram poet @GrindrHaikus, 'bottoming takes work'. In addition, the bottom sexual position has long been associated with a lack of masculinity or submissiveness, revealing complex gender intersections which bottoms inhabit. Anxiety and shame are deepened when bottoms experience health concerns, particularly colorectal conditions, such as IBS (irritable bowel-syndrome) [3], haemorrhoids, or colon cancer - making it difficult to bottom.





This working paper reports on a Wellcome Humanities and Social Sciences Research Centres Collaborative Research seed award that sought to identify key stakeholders and issues around bottoms and colorectal healthcare. We are interested in exploring how bottoms navigate the anxieties and shame that surround bottoming when accessing colorectal healthcare as well as how those anxieties and fears influence their relationships to providers and on clinical outcomes. This is a preliminary project that sought to identify who the key stakeholders were for this research, what were their key concerns and questions, and what language should be used to represent these.

This project builds on our long-standing interests in cultural representations of bottoms' sexual and gendered identities and practices (Vytniorgu, 2022; 2021), and on the impacts of sexual pleasure and desires on health (Garcia-Iglesias, 2022).

We argue that quality colorectal healthcare requires a deep understanding of the cultural and social background of bottoming to support patients' sexual wellbeing.

In this project, we have focused on bottoming among gay, bisexual, and men who have sex with men (GBMSM). We did so because their practices are framed within specific gender dynamics of masculinity (or lack thereof) and cultural tropes. Nonetheless, there is a growing recognition that not only men engage in anal sex. Clinical practice should also appreciate that women have and enjoy anal sex - even more so in recent years (Gana & Hunt, 2022).

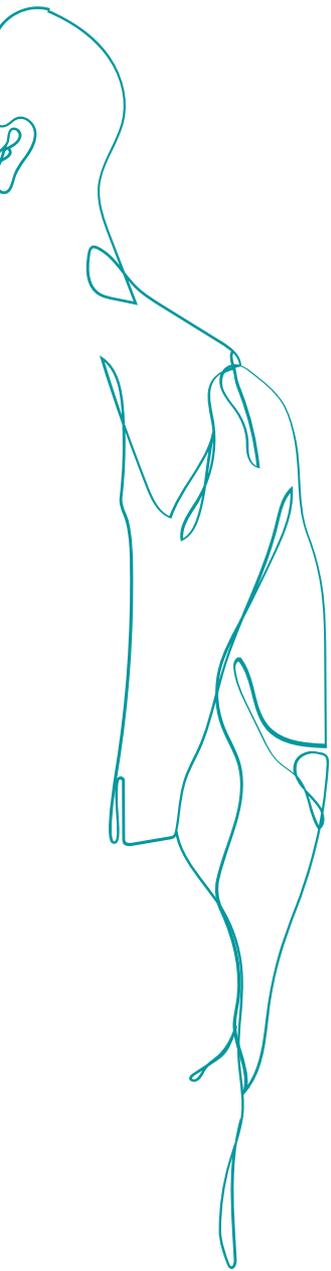
Literature review

The construction of narratives surrounding GBMSM experiences in healthcare has been mostly limited to the fields of mental health or sexual health (especially in terms of sexually transmitted infections).

This pigeonholing detracts from other equally important facets of GBMSM healthcare and sexual wellbeing. Research has evidenced that sexual minority groups are associated with negative health outcomes with respect not just to HIV transmission (Martin, 2005) and depression (Ferri, 2004), but also cardiovascular (Caceres et al, 2020) and respiratory health (Clausen & Morris, 2016). Thus, there are broader challenges associated with GBMSM health and wellbeing. These challenges also include heteronormativity in healthcare (Röndahl et al., 2006; Irwin, 2007; Rose et al., 2017), which impacts GBMSM engagement with health services due to fears of stigmatisation, homophobia, and effeminophobia (Neville & Henrickson, 2006; Annes & Redlin, 2012; Pennant et al., 2009).

Colorectal healthcare is a key aspect of GBMSM's health that has been frequently overlooked. While some studies exist that examine the experiences of GBMSM with conditions such as inflammatory bowel disease (IBD) [4] (Dibley et al., 2014), there is little research on the impact of such condition on gay men's sexual practices, including bottoming. Scholars have argued that GBMSM tend to be regarded as a homogeneous category in healthcare research, despite there being significant differences in sexual practices and identities (Ravenhill & de Visser, 2018, Swift-Gallant et al., 2021). This makes it difficult to generate nuanced approaches to the healthcare and wellbeing needs of men who have sex with men (MSM) and tailor healthcare systems to cater to the diverse spectrum of groups within this category of GBMSM.

In this literature review, we explore the effects of colorectal conditions in the sexual life and wellbeing of GBMSM bottoms, identify key barriers faced by them when seeking care, and indicate research directions.



The impact of colorectal conditions

Sexual practices

When considering the effects of a colorectal condition on a bottom's life, it is important to acknowledge the interactions between the biological manifestations of an illness and the specific lived experience of a bottom, with symptoms being experienced in ways seldom considered by mainstream healthcare. Even before anal sex, an individual can become anxious about rituals associated with bottoming, such as eating specific foods and or using enemas to reinforce a perception of anal hygiene.

In terms of sexual activity, a colorectal condition might affect a person's ability to bottom due to pain, the fact that bottoming may worsen existing symptoms, and due to anxieties surrounding anal incontinence. A study on the experiences of gay and lesbian patients with inflammatory bowel disease found that some MSMs required a period of adjustment with how they thought about and approached anal sex (Dibley et al., 2014). One participant mentioned no longer being able to be the 'bottom' to more 'dominant men' (that is, who may be 'rougher' during sex). This impacted them profoundly because, before living with IBS, the participant had used bottoming to adopt a more submissive role in sex. Another participant felt 'robbed of [...] flexibility' in their sex life (no longer having the option to bottom). This was an "enforced alteration to sexual practices' with possible knock-on effects on personal identity (Dibley et al., 2014, p. 25).

A study by Martin et al. (2017) on receptive anal intercourse in patients with IBS, and another by Kutner et al. (2021) on stigma towards anal sexuality in healthcare, found a general lack of guidance on non-heterosexual sexual activity, making it even harder for GBMSM to navigate this adjustment in their sex lives without a roadmap to do so.. Similarly, a study on MSMs' sexual communication with healthcare professionals after prostate cancer found that 'when sexual well-being was addressed by [healthcare professionals], participants described it as a "one-size-fits-all approach" that was "geared up for straight men", with little, if any, psychosexual support offered to cope with the impact of [prostate cancer] on gay sexuality and relationships' (Rose et al., 2017, p. 5).

Self-esteem (perceptions of desirability)

The effects of a colorectal condition, which may impact a bottom's ability to engage in receptive anal sex, have profound impacts on self-perceptions of sexual desirability. When coupled with body image issues from surgeries and/or scarring, this anxiety may have long-lasting effects on a bottom's self-esteem (Thomas et al., 2013). In one instance, a bottom '[decided] that they [weren't] even going to have any interest in relationships for the duration of the period that [they] had [a] stoma' (Dibley et al., 2014, p. 26) [5]. Hence, these conditions have unique effects on bottoms' social and sexual lives, requiring a more holistic and targeted treatment approach as well as a deeper understanding of bottoms' lived experiences when treating colorectal conditions.

Barriers faced in healthcare settings

The GBMSM label refers to a diverse group of people with a range of backgrounds and concerns. This diversity requires more research to thoroughly understand their multitude of experiences, so as to tailor healthcare approaches to their wide spectrum of needs. For example, a study on racism and homophobia in US healthcare found that young black MSM were even less likely to share their MSM status with clinicians owing to factors such as generations of medical mistreatment, distrust of the system, unconscious racial bias from healthcare providers and the fear of further stigma on top of that, as well as a lack of understanding from white clinicians (Quinn et al., 2019).

Disclosing one's sexual identity or preferred sexual practices to a healthcare provider, including a primary care one, remains a challenge for many GBMSM (Kutner et al., 2021). This is relevant given the fact that, in the UK, primary care providers such as General Practitioners (GPs) act as gatekeepers to specialist care, including colorectal care. Despite changing societal attitudes towards sexual minorities, homophobic attitudes are still perceived to linger in some healthcare settings. In a study by Rose et al. (2017), MSM participants mentioned that GPs would 'brush off' their sex lives as irrelevant or briskly change the subject when these came up, which made participants uncomfortable. Incidents such as these may be shared through patient's social circles, potentially cementing GBMSM's mistrust towards the particular providers or, even, whole health systems.

Hence, some GBMSM bottoms may opt to avoid disclosure of their sexual practices when seeking colorectal healthcare, 'motivated by "fear of rejection", "reservations as to whether HCPs [health care providers] are accepting or not", not wanting to be "lectured" [...] and being "too embarrassed" - with disclosure positioned as a "risk" for mistreatment (Rose et al., 2017, p. 5).

Barriers to GBMSM colorectal healthcare extend beyond the consultation room and even manifest in the wider clinical environment. Dibley et al. (2014) noted a reluctance among MSM to display affection for their partners in clinical settings, stemming from a 'desire to avoid causing offence' and its potential repercussions (p. 26). One of the participants in the study, who was preparing for high-risk surgery, mentioned that '[he and his partner] were not able to say goodbye to each other, [they] were not able to have a kiss and a cuddle when [they] were on a ward...[they] learnt a long time ago that people, although very accepting, they can become quite different if you start showing physical affection' (p. 26). When receiving support becomes a risk factor for bias and mistreatment, it is no surprise that some GBMSM may regard healthcare settings as unwelcoming environments.

Increasingly, researchers are beginning to recognise the multiplicity of practices and experience that are encompassed under the labels of 'bottom' and 'bottoming'. This is key because some of these practices have specific sexual and colorectal health implications. For example, sexual practices of breeding (receiving semen discharges in the rectum), fisting (anal penetration by a hand or fist), and the use of sex toys present unique implications within the 'bottoming' spectrum (Goddard et al., 2021).

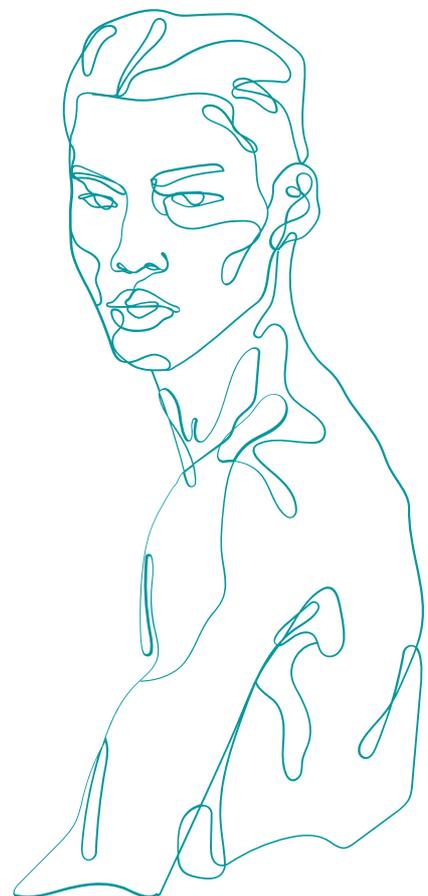


Research directions

Firstly, current research has focused on irritable bowel disease and colorectal cancer. Further research should expand into other conditions, exploring potential differences between acute conditions (such as anal fissures and haemorrhoids) and chronic conditions, as well as the differences between more visible and invisible conditions. At this stage, however, due to the sheer paucity of research in this area, it may be more productive to first raise awareness of colorectal conditions in general as a pressing health and wellbeing issue for MSMs as opposed to focusing on specific conditions themselves.

Secondly, while research has already somewhat explored the impact of stigma and shame related to non-heteronormative identities in healthcare, further work is needed that addresses the potential added layer of 'bottom shaming' that bottoms may face in clinical settings.

Thirdly, while briefly touching on race and ethnicity, research has evidenced little engagement with other demographic categories such as socioeconomic status, level of education, or cis/transgender status.



Methodology

Our key research questions were:

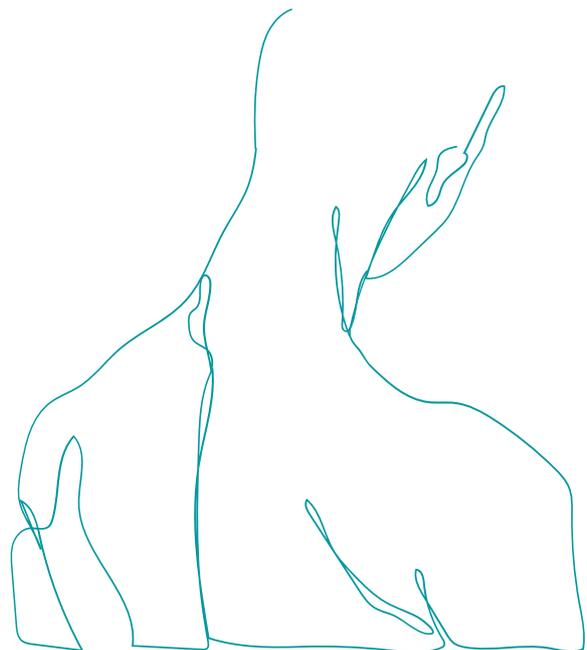
What are some of the recurring themes about bottoms and bottoming that arise in clinical and non-clinical practice?

To what extent do shame and stigma characterise bottoms' clinical encounters when the issue is connected to colorectal health?

How, if at all, have clinical and non-clinical stakeholders sought to tackle shame and stigma in their practice?

What are the key areas for further research and engagement in the area of shame, stigma, and colorectal health for bottoms?

We sought to answer these research questions by holding two focus groups – one with non-clinical stakeholders such as GBMSM counsellors, therapists, artists, activists, and influencers, and another with clinical stakeholders such as colorectal consultants, GPs, and nurses. It quickly became apparent that while a focus group workshop would work for the non-clinical stakeholders, one-on-one meetings would work best for busy clinical practitioners.



All of these meetings, including the non-clinical stakeholder focus group, were held online on Zoom. We were supported by a professional facilitator to conduct the non-clinical workshop, allowing the researchers to contribute to conversation and take notes. We also collaborated with a visual minutes artist who synthesised the non-clinical workshop discussion and created a visual infographic highlighting key themes and priorities for further work.

In both the workshop and the clinical one-to-one meetings we were joined by a student intern and research assistant, Azeem Merchant, recruited to our project via the University of Edinburgh's INSPIRE summer student internship scheme. The involvement of a current medical student proved especially useful to include the perspectives of existing medical students in this work.





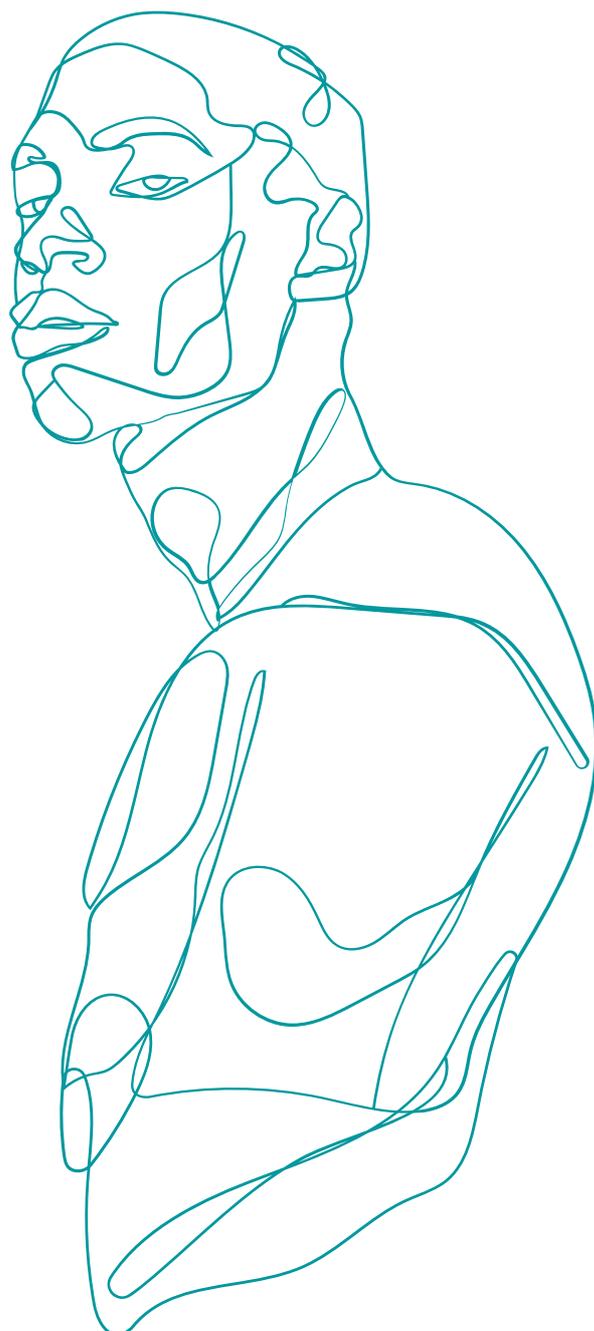
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Findings

Community views

Our eight non-clinical stakeholders were drawn from some of the leading gay men's therapy, counselling, and sexual health organisations in the UK. They all responded warmly to invitations to contribute to our workshop - feeling that discussions of bottoms' experiences were important because they are frequently ignored in healthcare settings. Most of these stakeholders were based in therapy and counselling. Within this context, they emphasised that sexuality and sexual practices – including but not limited to bottoming – were rarely discussed in therapeutic settings. In part, this is due to the scarcity of therapists and psychosexual counsellors who are knowledgeable and willing to engage in these conversations with clients, especially so with GBMSM ones. Thus, they highlighted the need for further training.

Stakeholders also noted that among patients there are persistent issues surrounding masculinity, which accords with the research to date, particularly in relation to anal sex. They also highlighted the difference between men who see bottoming as a sexual practice and those who identify as 'bottoms'. These represent different groups with differing needs. For men who bottom, bottoming is largely restricted to a sexual practice. For bottoms, bottoming is central to a sexual identity and may permeate other aspects of their lives and sense of self. Colorectal difficulties may therefore impact each group in different ways.

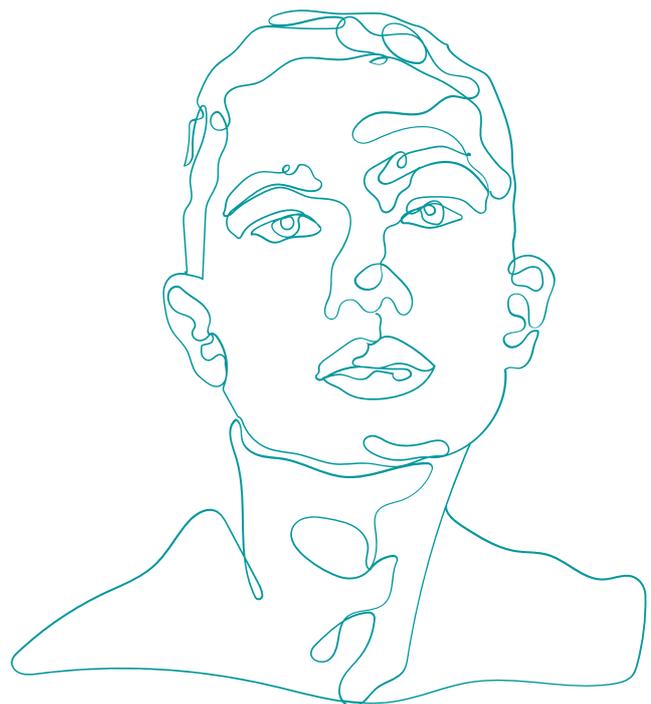


Impact of shame and stigma on bottoms' experiences of colorectal healthcare

When discussing shame and stigma in relation to bottoms' experiences of colorectal health, community stakeholders raised the following concerns.

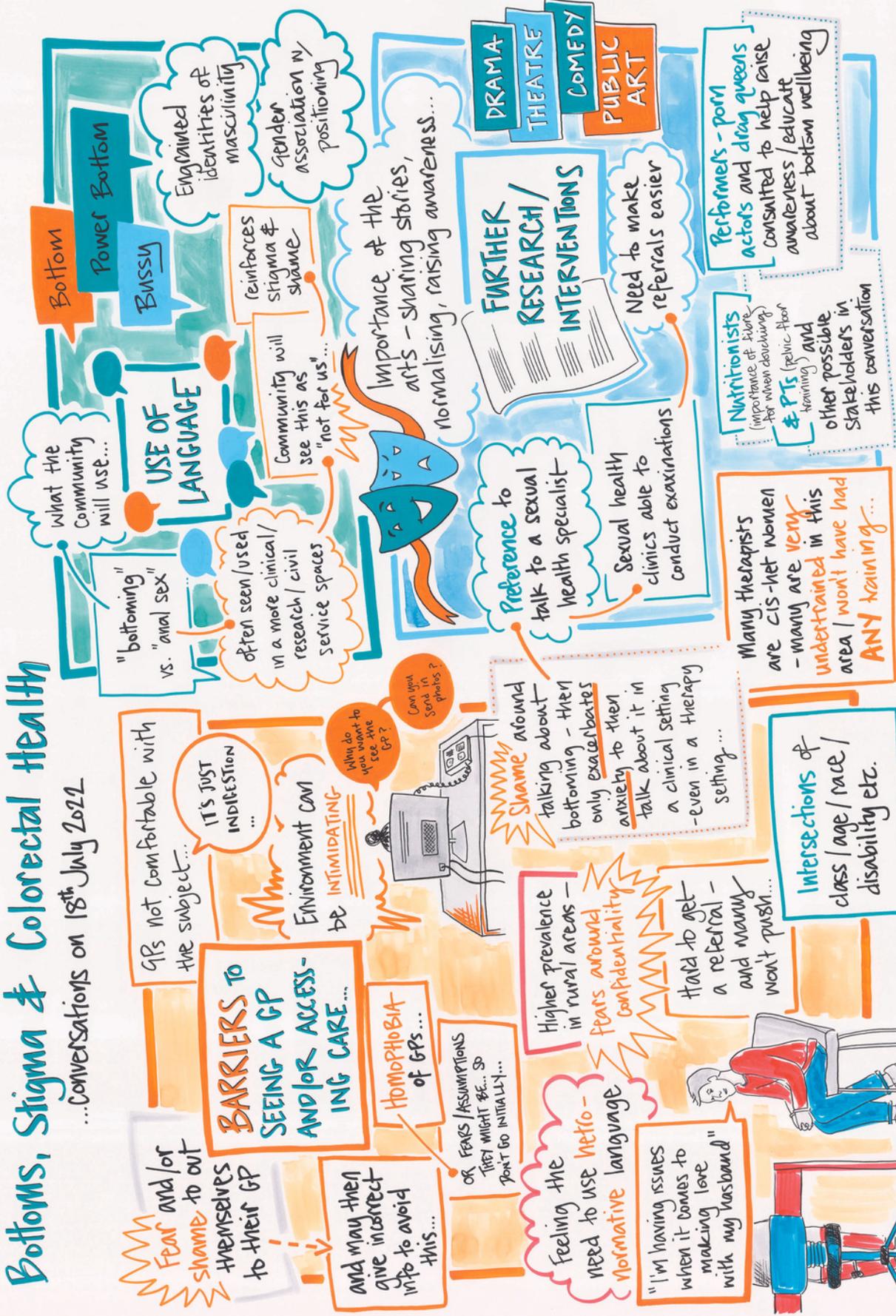
- The presence of language difficulties. Some patients may feel that they do not 'know' the 'correct' terminology or may assume a service does not cater to them because 'they are not using the right language'. Patients may also avoid talking about sex as a reason for a colorectal health problem. Moreover, a further difficulty lies in the fact that there can be a tendency among patients to frame sexual behaviour in heterosexual language, often at the prompting of GPs – for example, thinking of the anus like a vagina. However, for many GBMSM, the language they instinctively use to talk about their sexual practices—and which they find familiar—is be drawn from pornography. They are, however, unlikely to use this language with care providers due to the stigma surrounding pornography consumption.
- The difficulty of accessing primary care. Primary care environments may be seen as intimidating. Stakeholders highlighted how patients may struggle to speak about their conditions to non-clinical staff, such as receptionists. In light of this, some GBMSM prefer to directly access specialist sexual health services even for a colorectal health condition, as they see them as more welcoming.
- Discussing bottom sexual practices can be linked to performance and confidence. Due to pressure to 'be a good bottom', it can be humiliating to encounter difficulties in bottoming, which may lead to feelings of shame when experiencing colorectal health difficulties. Online LGBTQ+ health websites can indirectly further that undermining of confidence, through discourses about 'how to bottom' that ignore the challenges faced by those experiencing colorectal conditions. If a person cements their sexual identity on their being a bottom, this confidence and sexual self-esteem can be especially precarious.

- In clinical settings, providers may feel ashamed of talking about GBMSM sexuality. Not only might bottoms find it difficult to initiate a conversation about their sex life, but clinicians may be reluctant to talk about this. Finding a suitable clinician can be extremely challenging.
- Shame and stigma can be experienced intersectionally. Bottom sexual practices and identities are not experienced in isolation to other aspects of identity and experience, and there may be specific challenges faced by different kinds patients, including older patients, ethnic minorities, and patients with disabilities.



Bottoms, Stigma & Colorectal Health

...Conversations on 18th July 2022



Clinical perspectives

We spoke to four clinical stakeholders: three primary care providers (general practitioners or GPs) and one specialist colorectal surgeon. All of them agreed about some key themes affecting bottoms' experience of colorectal healthcare.

Shame anxiety and the clinical encounter

For some patients, specialist sexual health services are seen as a safer space in which to discuss their sexual health and wellbeing issues in comparison to primary care. Again, the issue of non-clinical staff was mentioned: disclosing personal details about one's sexual practices to a receptionist can be challenging. This leads to some patients avoiding discussing intimate concerns, ignoring them, or not bringing them up when they may be relevant.

Most primary care providers are not aware of the importance of sexual practices and identities and cannot address them adequately in a short appointment. However, this may be a gendered inequality: those providers who primarily see women may automatically assume their patients are sexually active and will therefore not be surprised to learn about sexual problems, including those related to anal sex.

For colorectal consultants, the nature of the clinical encounter may differ according to the patient. When seeing patients in relation to a cancer diagnosis, there may be little opportunity or desire to discuss anything other than the cancer diagnosis, treatment plan, and prognosis. This is even in those cases where surgical procedures may have significant impacts on patients' sex lives, including anal sex.

For those with acute problems that require 'quality of life' day surgery (such as a haemorrhoidectomy), it may be easier to discuss patients' expectations around anal sex. This can be especially important where a choice of treatment options might be available that have different implications for anal sex. It was noted that, while opportunities to talk about sexual wellbeing with consultants may be limited, specialist nurses play a bigger role in facilitating these important conversations about post-treatment sexual wellbeing.

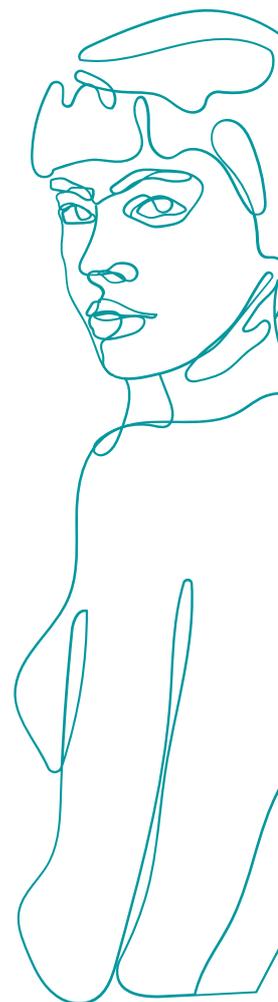
Women and diversity of bottoming practices and identities

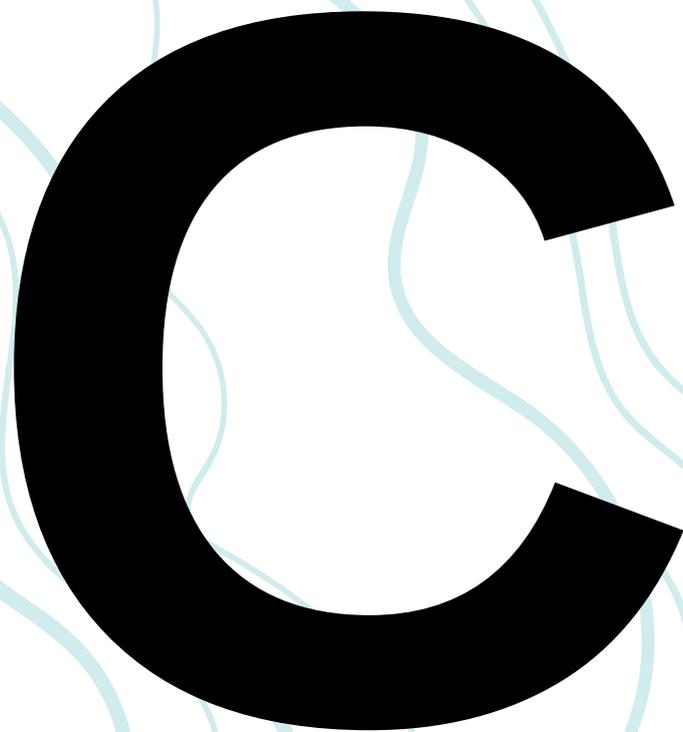
The primary care providers and the colorectal consultant agreed that any measures designed to further the sexual wellbeing of MSM bottoms would also have a positive impact on women who engage in anal play: specifically, measures designed around facilitating conversations about sexual wellbeing and avoiding shame anxiety in the clinical encounter. Moreover, our clinical practitioners recognised that patients who engage in receptive anal sex may do so in a range of ways and with a variety of sexual identities, including those that would ordinarily be kept private, even from a partner.

The need for education

All our clinical stakeholders emphasised the importance of raising awareness about anal sex through intervening in curricula for undergraduates and postgraduate medical teaching. Drawing on suitable patient case studies that are complex enough to be realistic but specific enough to have impact would be ideal. It also seems important to encourage undergraduate training to encompass sexual wellbeing as well as sexual health. However, it was noted that intervening in teaching curriculums is particularly challenging. Nevertheless, continuous professional development for already-practising providers may be particularly effective at raising awareness and delivering key messages and recommendations, especially if research-led.

Engaging with professional bodies such as the Royal College of GPs, Royal College of Physicians, Royal College of Surgeons, and the Royal College of Obstetricians and Gynaecologists is also important, but also focusing on specific bodies that engage in public and patient involvement, such as the Public Liaison Group (PLG) in the Association of Coloproctology in Great Britain and Ireland. The RCGP also has an LGBT+ Hub which is designed to raise awareness for people caring for LGBT patients.





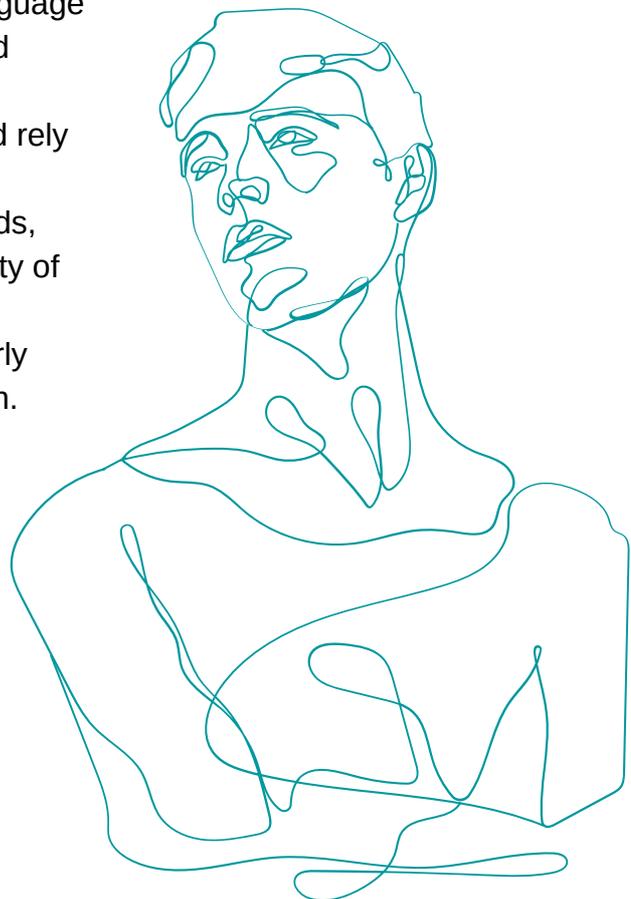
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Conclusions

Next steps

Through this project we have identified a number of key areas of interest for future research:

- The need to develop a language of 'sexual wellbeing' that encompasses sexual health but also psychosocial elements, such as self-esteem, to talk about colorectal health and anal sex.
- Involving non-clinical stakeholders within clinical settings (such as receptionists) in any future thinking and research, as they have a key role in patients' experiences.
- Future work should look at raising awareness of GBMSM sexuality, the diversity of experiences and sexual practices, and the specific language to be used to facilitate communication and make patients feel comfortable.
- Ensuring that any training tools developed rely on patients' lived experience, preferably through qualitative and arts-based methods, that represent the full depth and complexity of people's experiences.
- Engaging professional bodies from an early stage to ensure clear impacts for research.



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Notes

[1] <https://www.thesword.com/hottest-bottom-gay-porn.html>

[2] <https://www.buzzfeednews.com/article/alessadominguez/troye-sivan-bloom-new-era-pop-star-queer-bottom-anthem>

[3] Irritable Bowel Syndrome (IBS) is a common condition that affects the digestive system, causing inflammation of the gut. It causes symptoms such as stomach cramps, diarrhoea and constipation. These tend to come and go over time, and can last for days, weeks or months at a time

(<https://www.nhs.uk/conditions/irritable-bowel-syndrome-ibs/>)

[4] Inflammatory Bowel Disease (IBD) is a term used to describe conditions such as ulcerative colitis and Crohn's disease. They cause symptoms such as recurring or bloody diarrhoea, pain, cramps, or swelling in the tummy, and extreme tiredness.

(<https://www.nhs.uk/conditions/inflammatory-bowel-disease/>)

[5] A stoma is an opening on the abdomen that can be connected to either your digestive or urinary system to allow waste to be diverted out of your body and it looks like a small, pinkish, circular piece of flesh that may lie flat or protrude out.

