



Body Image and Female Sexual Functioning: Impact on Health Service Delivery in a Developing Country Context

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Abstract

Female sexuality is complex and highly contextual, influenced by among others one's body image and self-esteem. Body image experiences are integral to the quality of an individual's life including sexual function. Research findings have linked evaluations and cognitions interference with sexual responses and experiences during sexual activity. They may lead to sexual dysfunction, sexual aversion, avoidance and risky sexual behaviors. This paper presents four young Black African women with poor body image of different parts of the body namely the breasts, weight and configuration and external genitalia, and impact thereof on their sexual functioning. One had reconstructive cosmetic surgery and was subsequently satisfied with the results. The others were counseled and supported to accept who they were, two of whom made significant improvement. The potential impact of body issues on reproductive health care delivery in the context of a developing country is discussed. With the changing socio-cultural, demographic, lifestyles as well as increasing information dissemination due to technological advances, these concerns are likely to increase, compounded by an increase in sexual functioning problems, with an inevitably heightened demand on health service delivery. Health care providers and in particular gynecologists need to be aware thereof, so that they may offer appropriate counseling, care and support to women seeking their help. Women need to be assured that their bodies are fine the way they are, and their male partners appraised on the need to appreciate and respect their female partners and not deride them on account of body or body-part appearances.

Introduction

Human sexuality is often defined to include sexual activity and experiences which affect how an individual views oneself, one's body and sexual relations [1]. People engage in sexual relations for various reasons including self-pleasure, love, affection, desirability, acceptance by the partner and procreation [2,3].

Female sexuality is a complex phenomenon and highly contextual. It is individually defined and experienced, encompasses women's sexual knowledge, beliefs, attitudes, values and behaviors [4]. It is influenced by previous sexual experiences, relationships, biological factors, socio-cultural context in which the activity occurs, her body image and self-esteem [5,6]. Physical attractiveness is particularly important for young women who are especially concerned about their appearances and other people's judgments [7,8]. It is an important component of experiences of women's sexuality [9]. The way in which one experiences her body is highly subjective, a product of her perception, thoughts, feelings about her body size, shape, competence and function [10,11].

Body image is the mental picture one has of his/her body, an attitude about the physical appearance, state of health, normal functioning and sexuality [12]. It comprises cognitive and emotional meanings about the body [13]. Female body image is dynamic and fluctuates over time and across different experiences [14]. Research has linked body image to various important aspects of female sexuality such as sexual functioning, sexual schemas, sexual esteem and sexual behavior [15-17]. Body image issues can affect all domains of sexual functioning [18]. A positive feeling about the body is an essential element of sexual body esteem and is associated with a pleasurable sex life [19,20]. Negative body image leads to cognitive distractions or spectating. The woman becomes more concerned about how her body might appear to her sexual partner and is thus unable to relax and enjoy the relationship. She has a low self-esteem and less sexual satisfaction and tends to avoid body exposure [21-23].

Women are socialized to view themselves as objects to be viewed, evaluated and consumed by others [7]. As a result they learn that perceptions of their personal worth are dependent on their

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appearance and regard their own bodies or parts thereof as objects to be viewed and, evaluated by other. Most of the literature on body image and its impact on female sexuality has been on women of European descent, majority from the USA and have focused on weight concerns [24]. Others have involved ill-health such as HIV/AIDS, breast and cervical cancers, genital prolapse and urinary incontinence [25-31]. A few have looked at healthy individuals [32,33]. The initial studies looked at the body in one dimension i.e. as a whole. However, cognizant of the importance women attach to specific body parts they consider critical for attractiveness in a sexual context, more recent studies have looked at the impact of various parts of the body such as the face, breasts, hips, buttocks and external genitalia on sexual functioning [34-36]. There have been very few publications on body image and sexual functioning from the sub-Saharan Africa (SSA). These have been in relation to the effects of HIV/AIDS, breast cancers and their treatments [37,38].

This paper presents four young healthy and sexually active Black African women who presented with various sexual problems as a result of poor body image perception of different body parts, in Nairobi, Kenya.

Case Presentation

Case 1

A 28-year-old single lady, nulliparous, has been under my professional care for about five years now. She initially presented with recurrent malodorous vaginal discharge which had affected her social as well as sexual life. She felt uncomfortable being near or in the company of other people as she imagined they smelt the odor from her genitalia. She would take baths up to four times a day at times to get rid of the odor with no respite. She had also been avoiding sexual intimacy. She was successfully treated and for over a year she had no complaints.

She presented two years later complaining that she felt her external genitalia (the labia minora and clitoris) were abnormal compared to what she had seen on the internet. She felt they were abnormally prominent, with the labia minora protruding beyond the labia majora. She was uncomfortable undressing in front of her sexual partners or having sex with lights on. She often tried to avoid receptive oral sex. She had never experienced orgasm during penile-vaginal intercourse or oral sex. The only times she had been able to was during solo masturbation and after watching a lesbian pornographic movie, which she found these particularly arousing, but did not have lesbian orientation herself. She also felt inadequate in bed and could not satisfy her partners. She had no other complaints. She had been changing partners fairly regularly hoping to enjoy sexual intimacy, with no respite. She was afraid of insisting they use condoms even though she was aware of the risk of contracting HIV infection among other risks, as she feared rejection. She wanted to have corrective cosmetic surgery so that she would be able to enjoy sexual intercourse.

She was counseled and explained that each woman has her own external genitalia and there was a big variety in shape, size and color and that each was normal. She was told hers was very normal. This point was emphasized with the aid of several pictures of external genitalia and she was encouraged to appreciate her body, be happy and comfortable with what she had. She was followed up on scheduled visits over the next one year and made steady progress over time, was much more comfortable with her sexual partners, could now undress in front of them and having sex with lights on. She however had not

managed to achieve an orgasm during heterosexual relations.

Case 2

A 29-year-old health professional, para 2+0, married to a lawyer, was seen three years after her second childbirth, complaining that she was not enjoying sexual intercourse with her husband. Both pregnancies had been uneventful and deliveries were normal. She had an episiotomy during the first delivery, which was repaired and healed well. She did not require an episiotomy nor did she have a perineal tear during the second childbirth. They had been married for six years and had a good sex life before the second childbirth. She had no sexual problems at all. She would easily get aroused, had good lubrication and would achieve orgasms on a regular basis. However this had changed rather abruptly after the second childbirth. She felt her introitus was wider and the vagina more lax with poor grip on her husband's penis than before. She had very poor arousal and lubrication and was not able to achieve orgasm during penile- vaginal intercourse. Her sexual desire was not affected though. She often had to masturbate after intercourse with her husband to achieve orgasm. She found this very frustrating. She had tried to explain this to her husband but he always assured her that he had not noticed and difference, that it felt the same as before the second childbirth. Despite the assurances she felt that he did not want to hurt her feelings.

Upon gynecological examination the only positive finding was a minimal laxity of the vaginal introitus consistent with after-effects of normal vaginal delivery. There were no old tears and the episiotomy had healed very well. There was no evidence of vaginal wall prolapse or anal sphincter damage.

She was counseled, appraised on the findings and advised to continue with Kegels' exercises which she had been doing to improve the vaginal tone. During the scheduled review visit six months later she reported no improvement. She requested vaginal reconstructive surgery. After counseling and explanation of the procedure to be performed, with advantages and potential pitfalls thereof, she was scheduled for the surgery. A posterior colpo-perineorrhaphy was carried out and she healed well.

A year after the surgery she was very happy with the results. She was enjoying her sexual relationships with her husband.

Case 3

A 32-year-old university graduate working with an international organization based in Nairobi, presented at my clinic about two years ago. She complained of poor arousal and inability to achieve orgasm during sexual intercourse with her husband of 8 years. They had two living children. Both pregnancies and deliveries had been normal. The problem started after delivery of the second child. She had gained a lot of weight during the pregnancy much more than the first one and had been unable to shed it off. She felt her mid-torso was too round and larger compared with the rest of the body. She is short and has generally small lower limbs. She was embarrassed to undress in front of her husband or have sex with lights on or during the day. Her husband made matters worse by constantly reminding her how unsightly she looked. He would often refer to how beautiful his friends' wives were. He had also changed a lot with regards to sexual activity with her. He rarely touched or caressed, kissed her as he used to do before. Sexual activity was very infrequent and often a hurried affair. He blamed these on her changed body which made matters worse for her. She felt rejected and vilified.

She had contemplated having extramarital affair on a number of occasions in revenge and for her own sake, but was afraid of being rejected or judged by another man as well. She thus had resorted to regular solo masturbation with the aid of sex toys especially during her numerous travels for duty. She did not have history of medical illnesses such as diabetes or hypertension. She had no other complaints. On examination apart from a high BMI and obesity especially mid-torso region, she was in a general good condition.

She was counseled and advised to do exercises and dietary changes to aid weight loss. A year later, there wasn't much change in her physical appearance and body image perceptions. Likewise there was no change in her sexual functioning. In fact it had worsened as her husband had told her he was contemplating marrying another woman. Sexual intercourse between them had been even more infrequent and often emotion-less.

Case 4

A 26-year-old para 1+0 programme officer, married to an IT specialist, has been my patient for the past four years. I looked after her during the pregnancy, delivery and postnatal periods. These were all uneventful, with a normal vaginal delivery. An intrauterine contraceptive device (CuT 380A) had been inserted at three months post-delivery for contraception.

She presented three years after the last delivery, asking to have the IUCD removed. She felt she did not need it as she was working outside the country and would be with her husband for two to three weeks twice a year when she comes home. She had requested posting outside the country from her employer for social reasons. She no longer enjoyed sexual relations with her husband. She had no sexual desire and did not look forward to sexual intimacy with her husband. She was ashamed of her breasts which according to her had shrunk significantly in size after breastfeeding her son. Her husband had on a number of occasions made disparaging comments about her breasts, comparing them to other women's. This had damaged her self-esteem even further. She felt inadequate as a woman and was ashamed to undress in front of him or have sexual intercourse with the lights on or in the nude.

She was desperate to have breast enhancement cosmetic surgery or medication that would do the same. She was worried that her marriage may be irreparably damaged if the situation continues.

She was counseled extensively and continues on the inevitable bodily changes following pregnancy childbirth and breast feeding, including alteration of breast size and shape. She was reassured that there was nothing wrong with her breasts. She was shown several pictures of different breast sizes and shapes. Was encouraged to accept her body as it was and dissuaded from corrective cosmetic surgery. This counseling continued whenever she was home on holiday. Attempts to involve her husband in the counseling sessions were not successful as he refused to honor the appointment. She finally relocated back home after two years and is currently pregnant expecting their second child. She has learnt to accept who she is and is now enjoying sexual relations with her husband.

Discussion

Female sexuality is a complex phenomenon, individually and socially constructed and defined by socio-cultural factors. A woman's active participation in a sexual activity is essential for her enjoyment. Sexual enjoyment and satisfaction serve as motivators for future

sexual relations with the same or different partner. Her perceived physical attractiveness and satisfaction with her own body or parts thereof she considers essential for attractiveness in a sexual context may greatly influence that [9,39].

A growing body of literature links perceived physical attractiveness i.e. body image and sexual functioning. Body image experiences are considered integral to the quality of one's life including sexual life [40]. It includes the physical appearance as well as psychological feelings one has about adequacy and competency of her body as a whole or specific parts thereof such as the face, breasts, thighs, hips, buttocks and genitalia [23,41]. These body parts may be evaluated separately and unequally as shown by the four presented patients. Each placed higher premium on a different part of her body.

Women who are satisfied with their bodies i.e. have positive body images, have high self-esteem and assertiveness. They reportedly have more frequent sexual activity, engage in various sexual behaviors such as receptive oral, achieve orgasms regularly and generally enjoy sexual relations with their partners. They are comfortable undressing in front of their partners and having sexual intercourse with lights on or in the nude [42-44]. Positive body image is also associated with increased sexual desire [44,45], elevated arousal and lubrication [46], better and more frequent orgasms [42,44], enjoyment and sexual satisfaction [44,47-49]. On the other hand those who are dissatisfied with their physical appearances i.e. have poor body images, report the opposite experiences with regards to their sexual functioning [44,45,50].

Woertman and van den Brink [18] in their review of 57 studies from 25 countries on body image and sexual functioning concluded that body image issues can affect all sexual function domains. They noted that body evaluation and cognition during sexual intimacy due to poor body image interfere with sexual response and experiences thereof and that they may lead to sexual aversion, avoidance as well as risky behaviors [18]. There is also decreased sexual assertiveness [51].

All the four presented cases reported sexual problems related to or as a result of their poor body images. A woman may have issues with her overall body configuration, weight as the third presented case, who felt that she had put on too much weight during her second pregnancy, more so around mid-torso. This is one of the areas of the body many women are concerned about. Cash et al. [41] in their study involving college students (145 females and 118 males), reported that physical self-consciousness during sexual activity focused substantially on weight. These individuals were more anxious and reported more avoidant body focus during sex. They had poorer sexual pleasure, less desire, arousal and orgasms [41]. The same was observed by Schwartz and Brownell [52]. Wierderman [53] reported that women who had poor body image with regards to their faces, mid-section and breasts that had cosmetic surgeries, those who had issues with their mid-section and breasts reported improvements in sexual functioning and were more willing to try new sexual practices with their partners than those with issues with their faces.

One of the presented cases was dissatisfied with her breasts. The breast is often referred to as the body part most strongly associated with a woman's femininity and sexuality. It is a salient feature of the ideal female body. Breast size in particular is highly sexualized and considered an important feature of female attractiveness [34,54,55]. Studies have shown that majority of women are dissatisfied with their breast. Frederick et al. [35] in a large on line survey (n=60,000)

reported that 70% of women were dissatisfied with their breast. Studies of college women showed that majority preferred large breasts [26,37]. How large it was not defined though!

Women dissatisfied with their breasts may avoid sexual intimacy, undressing in front of her partner, having sexual activity with lights on or in the nude [18,42]. Such dissatisfaction has also been shown to be associated with heightened pursuit for cosmetic corrective surgery [56,57], all of which were evident in the presented case.

The remaining two presented cases had issues with their genitalia. One was dissatisfied with the anatomical development of her labia minora and clitoris, which she felt were too prominent. This had affected her sexuality in that she was ashamed of exposing her genitals during sexual activity. She avoided receptive oral sex as a result thereof and felt sexually inadequate. She kept changing partners frequently hoping to get satisfaction, which she did not. She also did not want to insist on protection despite the frequent change of partners for fear of losing a lover. The last one felt her vagina was too lax after delivery as a result of which she was not enjoying sexual relations with her husband. She eventually had corrective surgery and was satisfied with the results.

Genital perceptions have been reported to be related to sexual desire but no other aspects of sexual functioning including arousal, lubrication, orgasm, pain, enjoyment and satisfaction [58]. However, Braun and Tiefer [59] opined that the external genitalia, namely labia majora and minora, clitoris, mons pubis and vestibule may be critical for some women during sexual encounters. Schinck et al. [16] stated that despite equivocal findings on the impact of genital self-image issues on sexual functioning, the general consensus is that it impacts female sexuality and overall sexual experience. A positive genital perception is associated with greater sexual esteem, lower sexual distress and anxiety and less self-consciousness during sexual activity, leading to better overall sexual functioning [60,61]. In their study on undergraduate students, Schinck et al. [16] reported that those with poor genital satisfaction had low motivation to avoid risky sexual behaviors, as shown by one of the presented cases.

The mechanisms through which body image impacts female sexual functioning, include cognitive distraction or spectating during sexual activity. As a consequence one is unable to relax and focus on her own pleasure [22,49,62,63]. She also may have poor or low self-esteem, and lack of assertiveness [32], fear of body exposure and anxiety [41].

A number of factors have been shown to influence poor body image perception. Internalization of social constructs of attractiveness as a part of female sexual socialization may compel an individual woman to aspire to those ideals and view anything different as undesirable. Female bodies are socially constructed as objects to be watched, admired and evaluated [61]. This is compounded by exposure to media images especially pornographic materials depicting the "ideal" female body and its different body parts such as hips, external genitalia, breasts, thighs [59,64], as well as increased popularity and publicity of cosmetic surgeries [16,59]. Partners' comments about their bodies and especially if they compare with those of other women may have devastating effects on a woman's ego and self-esteem and sense of worthiness. Societal pressures on women to conform to culturally prescribed and acceptable feminine and sexually appropriate features such as pulling of the labia to elongate them as practiced in some parts of SSA [65], big breasts, buttocks,

may make those with different features feel they are less feminine and attractive. Peer pressures from female colleagues or friends real or subtle may also play a part. Many young girls have concerns about the normalcy of their genitalia especially labia and clitoris. I see a number in my clinic wanting to know if they are normal.

The presented four patients are neither isolated cases nor do they represent a population based pattern on body image issues in the country or region. However it is not far-fetched to state that body image concerns and their impact on sexual functioning are significant, based on what we see in our clinical practices, as well as what is disseminated through print and electronic media locally and regionally. With the changing socio-cultural, demographic, lifestyles as well as increasing information dissemination due to technological advances, these concerns are likely to increase, compounded by an increase in sexual functioning problems, with an inevitably heightened demand on health service delivery. Body image plays an important role in sexual well-being as well as safety of an individual/couple. These two are critical especially in the context of unplanned pregnancies and the HIV/AIDS epidemic. There is therefore need to create awareness among women as well as men who are their partners, that women's bodies differ in size and shape, on the changes which occur with age and biological functions such as pregnancy, delivery and breast feeding, encourage and support those with concerns to accept who they are or what they have. Women need to be assured that their bodies are just fine the way they are, and their male partners appraised on the need to appreciate and respect their female partners and not deride them on account of body or body-part appearances. Body-image concerns may affect marital satisfaction [66]. Involving both in a counseling session may greatly benefit by addressing women's body esteem. They should also be made aware of the fact that even though surgical interventions to correct what they consider abnormal may lead to satisfaction with new appearances as well as sexual function [67,68], they are not without side effects.

It is therefore imperative for health care providers and especially gynecologists [69], and those involved in sexual and reproductive health care be aware of the foregoing and equipped to adequately and appropriately discuss such issues with their patients. They need to be able to offer appropriate counseling, care and support to women seeking their help.

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