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 behaviours.

This paper presents three young Black African women with perceived 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. They all were counselled and supported to accept who they were, two of whom made significant improvement.

The potential impact of body image concerns 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 gynaecologists need to be aware thereof, so that they may offer appropriate counselling, 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 behaviours [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 judgement there of [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 behaviour [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 spectatoring, the woman being more concerned about how her body might appear to her sexual partner. She is thus unable to relax and enjoy the relationship, has low self-esteem, less sexual satisfaction and tend to avoid body exposure during sexual intimacy [21-23].

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], with the initial ones looking at the body in one dimension i.e. as a whole. However, cognisant 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 [25-27]. 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 [28,29]. None has looked at otherwise healthy women. There is thus paucity of literature on body image concerns from sub-Saharan Africa.

This paper presents three 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 Reports

No. 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 odour from her genitalia. She would take baths up to four times a day at times to get rid of the odour 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 minor a protruding beyond the labia major. 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 other complaints. 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 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 counselled 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.

No. 3: 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.

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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 counselled 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 counselling continued whenever she was home on holiday. Attempts to involve her husband in the counselling sessions were not successful as he refused to honour 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

Body image experiences are considered integral to the quality of one’s life including sexual life [30]. 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 [23,31]. 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.

Woertman et al. [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 behaviours. There is also decreased sexual assertiveness [32].

A woman may have issues with her overall body configuration, or 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 often concerned about. Cash et al. [32] in their study involving college students (145 females and 118 males), reported that physical self-consciousness during sexual activity focused substantially on weight. They had poorer sexual pleasure, less desire, arousal and orgasms. The same was observed by Schwartz & Brownell [33]. Wierderman [31] reported that women who had poor body image with regards to their faces, mid-section and breasts, and 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 [34].

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 sexualised and considered an important feature of female attractiveness [25,35,36]. Studies have shown that majority of women are dissatisfied with their breast. Frederick et al. [36] 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 [26,28]. Women dissatisfied with their breasts may avoid sexual intimacy, undressing in front of their partner, having sexual activity with lights on or in the nude [18]. Such dissatisfaction has also been shown to be associated with heightened pursuit for cosmetic corrective surgery [37], all of which were evident in the presented case.

Genital perceptions have been reported to be related to sexual desire but not other aspects of sexual functioning in duding arousal, lubrication, orgasm, pain, enjoyment and satisfaction [38]. However, Braun [39] 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 & her colleagues [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 [40,41]. In their study on undergraduate students, Schinck et al. reported that those with poor genital satisfaction had low motivation to avoid risky sexual behaviours [16], as shown by one of the presented cases.

A number of factors have been shown to influence poor body image perception. Internalisation of social constructs of attractiveness as a part of female sexual socialisation 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 [41]. 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 [40-45], as well as increased popularity and publicity of cosmetic surgeries [16,40]. 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 practised in some parts of SSA [46], big breasts, buttocks, or hips 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 the 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 is 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 [47]. Involving both in a counselling 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 [48,49], they are not without side effects.

It is therefore imperative for health care providers and especially gynaecologists 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 counselling, care and support to women seeking their help.

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