KAROLINSKA INSTITUTE
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Female genital self-image affects women's sexual function

A cross-sectional study

Genital självbild påverkar kvinnors sexuella funktion

En tvärsnittsstudie

MSc Dissertation in Sexual, Reproductive and Perinatal Health, 15 credits (Advanced studies), 2019

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TO ALL WOMEN.

MAY WE KNOW THEM.

MAY WE BE THEM.

MAY WE RAISE THEM.

- UNKNOWN

To our amazing families,
The Dupo Kjellin's, Ria and the Ylipää's

We are forever grateful for your endless love and support – thank you (for sticking by us)!

A very special gratitude to Suzann Larsdotter - An eternal advocate for all the vulvas out there.
Thank you for your inspiration and support throughout this work!

- Gabi and Vanne

ABSTRACT

Background: Female genitalia (i.e. the vulva) is inadequately pictured. Therefore, women are often insecure of their genitals, increasing the interest in genital surgery to fit norms. Midwives could empower women's bodily perception to improve sexual health. There is a knowledge gap in the relationship between female genital self-image and sexual function.

Aims: The aims of this study were to (1) explore the relationship between genital self-image and sexual function among women and (2) investigate predictive factors of genital self-image.

Method: A cross-sectional research design was implemented using an online survey with validated measurements; Female Genital Self-Image Scale (FGSIS), and Female Sexual Function Index (FSFI). Participants were acquired through social media. Data was analyzed using the Chi-Square test, t-tests and Mann-Whitney U-test.

Results: A total of 378 women were included in the study. Most participants were 25-34 years old, heterosexuals in steady relationships, and had a college education. Associations were found between FGSIS and FSFI domains; desire, arousal, lubrication, orgasm, satisfaction and pain. Most women had a medium- or high FGSIS. Age and sexual impairments were predictive factors.

Conclusion: In this study, there was a relationship between female genital self-image and sexual function. The empowerment of women should be standard in midwives' work to enhance genital self-image, sexual function, and a societal change of gender equality.

Keywords: *Female Genital Self-Image, Female Sexual Function, Empowerment*

SAMMANFATTNING

Bakgrund: Kvinnliga könsorgan (vulvor) beskrivs ofta ofullständigt, vilket riskerar att skapa missuppfattningar om de normala könsorganens utseende. Kvinnors osäkerhet kring sina könsorgan kan vara en anledning till att könskirurgin ökar. Barnmorskor kan sprida kunskap och stärka kvinnor för att förbättra deras sexuella hälsa. Kunskapsluckan gäller förhållandet mellan kvinnors genitala självbild och sexuella funktion.

Syften: Studiens syften var att (1) utforska förhållandet mellan genital självbild och sexuell funktion bland kvinnor och (2) undersöka prediktiva faktorer för genital självbild.

Metod: En tvärsnittsstudie utfördes genom en online-enkät med de validerade mätinstrumenten (FGSIS och FSFI) för att utvärdera kvinnlig genital självbild och sexuell funktion. Deltagarna rekryterades genom sociala medier. Chi-Square-test, t-test och Mann-Whitney U-test utfördes vid dataanalysen.

Resultat: Totalt 378 kvinnor inkluderades i studien efter inlämnad online-enkät. Majoriteten av deltagarna var 25–34 år gamla, heterosexuella, i en stadig relation och hade högskoleutbildning. Samband påvisades mellan genital självbild och sexuell funktion. De flesta kvinnorna hade medel- eller hög genital självbild. Ålder och sexuell funktionspåverkan var prediktiva faktorer.

Slutsats: Resultaten indikerar en relation mellan kvinnors genitala självbild och sexuell funktion; lust, upphetsning, lubrikation, orgasm, tillfredsställelse och smärta. Empowerment borde ingå i barnmorskans arbete, för att förbättra kvinnors genitala självbild och sexuella funktion.

Nyckelord: *Kvinnlig Genital Självbild, Kvinnlig Sexuell Funktion, Empowerment*

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INTRODUCTION

Sexuality is linked to power and manifested physically, emotionally and cognitively throughout life (UNESCO, 2018). There is a common agreement that women undertake the societal stress of having an ideal female body (Braun & Wilkinson, 2001; Moreno-Domínguez, Raposo & Elipe, 2019). The level of satisfaction or dissatisfaction concerning body image often transfers to how women perceive their genitals, i.e. their genital self-image (Gomes et al., 2019; Komarnicky, Skakoon-Sparling, Milhausen & Breuer, 2019). Furthermore, women's sexual health may be affected due to currently inadequate and negative representations of the vulva.

Midwives play a key role in women's sexual and reproductive health and meet women through different stages in life, in various health care settings (Swedish Midwifery Union [Svenska barnmorskeförbundet], 2018). Reasonably, midwives could empower women into improved sexual health and overall wellbeing, through women feeling comfortable with- and in charge of their bodies. There is, however, a knowledge gap regarding how women perceive their genitals (i.e. genital self-image) and, moreover, if their sexual function is affected by this perception. Therefore, the current study aims to explore the relationship between genital self-image and sexual function among women in a Swedish context and to investigate predictive factors of genital self-image. With this insight, midwives could gain a greater understanding of the importance of empowering women and their bodily relationship. Consequently, this would strengthen the basis for further development of how the empowerment of women can be implemented clinically.

BACKGROUND

SEXUAL HEALTH AND RIGHTS

According to the World Health Organization (WHO, 2002), the definition of sexual health consists of different factors; the state of mental, physical and social well-being concerning sexuality. Therefore, a person's sexual health is not just the absence of dysfunction or illness, but rather encompasses a positive perception and respectful attitude towards sexuality and sexual relationships for sex to be safe and enjoyable (WHO, 2002).

The Guttmacher-Lancet Commission on Sexual and Reproductive Health and Rights is a collaboration by Starrs et al. (2018) who are experts from Europe, Asia, Africa, the Middle East, North and South America. They explain sexual rights as the right for all people to decide what happens to their bodies and sexuality. This includes the right to: (1) have safe and enjoyable sexual

experiences, (2) defining your sexuality, (3) determine if and when to be sexually active and (4) to have bodily integrity and self-determination (Starrs et al., 2018). These rights are recognized by the WHO, motivated by its centrality, for people to live healthy lives in their full potential. Healthcare should provide information, resources, services, and support needed to achieve these rights throughout a person's life (Starrs et al., 2018; WHO, 2002).

WOMEN'S SEXUALITY

Women's sexuality is often explained through the concordance of the subjective (psychological) and objective (physical) arousal (Velten, Margraf, Chivers, & Brotto, 2018). A psychological way to explain women's sexual arousal is the personal experience of being sexually excited (Velten et al., 2018), whereas the physical aspect includes genital response as a neurovascular process where the blood flow to the genitals increases. The levels of concordance vary among women and are considered an important component for obtaining healthy sexual functioning among women (Brotto et al., 2016; Velten et al., 2018).

SEXUAL FUNCTION

Sexual function is a clinical definition of human sexuality from both a physical, psychological and social perspective (Woertman & Van den Brink, 2012). According to Braun and Kitzinger (2001a), definitions of the vagina's function are left out and the vagina and its uses are not further explained. To achieve satisfying sexual health, a lack of sexual dysfunction is desired among other aspects (Brotto et al., 2016; Starrs et al., 2018).

When discussing female sexual function or dysfunction, six domains are frequently used (Rosen et al., 2000). Lundberg and Löfgren-Mårtenson (2010) explain the definitions:
Desire refers to sexual fantasies, thoughts, reactions and/or the desire for sexual activities such as masturbation or intercourse. *Arousal* is the subjective feeling of being sexually excited, and/or the physical reactions (i.e. lubrication) to any kind of sexual stimuli. *Lubrication* is often connected to arousal, whereas increasing secretion is a genital response of arousal. The female *orgasm* can theoretically be described as what happens in the body during climax and how individuals experience it: often a heating sensation and/or vaginal contractions. There are at least three types of orgasms among women: clitoris- or vulva orgasm, vaginal orgasm or mixed orgasm (a combination of the first two types). Sexual *satisfaction* is often independent of orgasmic frequency for instance, it is, however, the overall feeling of being pleased or content with one's sexual life. Finally, genital

pain in conjunction with sexual activities is often a consequence of lacking sexual response (i.e. absent lubrication and/or sexual desire) which often negatively affects people's sexual lives (Woertman & Van den Brink, 2012).

When suspecting a sexual dysfunction concerning one of the domains, health professionals need to discuss the broad picture of a person's sexual relationships, stress, beliefs in sexuality, as well as cultural and religious aspects (Neijenhuijs et al., 2019). If the woman is satisfied with her level of sexual function despite, for instance, the lack of sexual desire, arousal or orgasm; then there is no dysfunction and no diagnosis should be made (Neijenhuijs et al., 2019).

THE VULVA AND CLITORIS

The female genital anatomy has only since the beginning of the 21st century been mapped in its entirety (O'Connell, Sanjeevan, & Hutson, 2005). The vulva consists of structures that extend from the pubic arch and can be divided into erectile and non-erectile parts (Yeung & Pauls, 2016). The erectile parts are the clitoris, the clitoral bulbs, and labia minora. The non-erectile parts are mons pubis, labia majora, and vestibule. The anatomy is represented in the figure below.

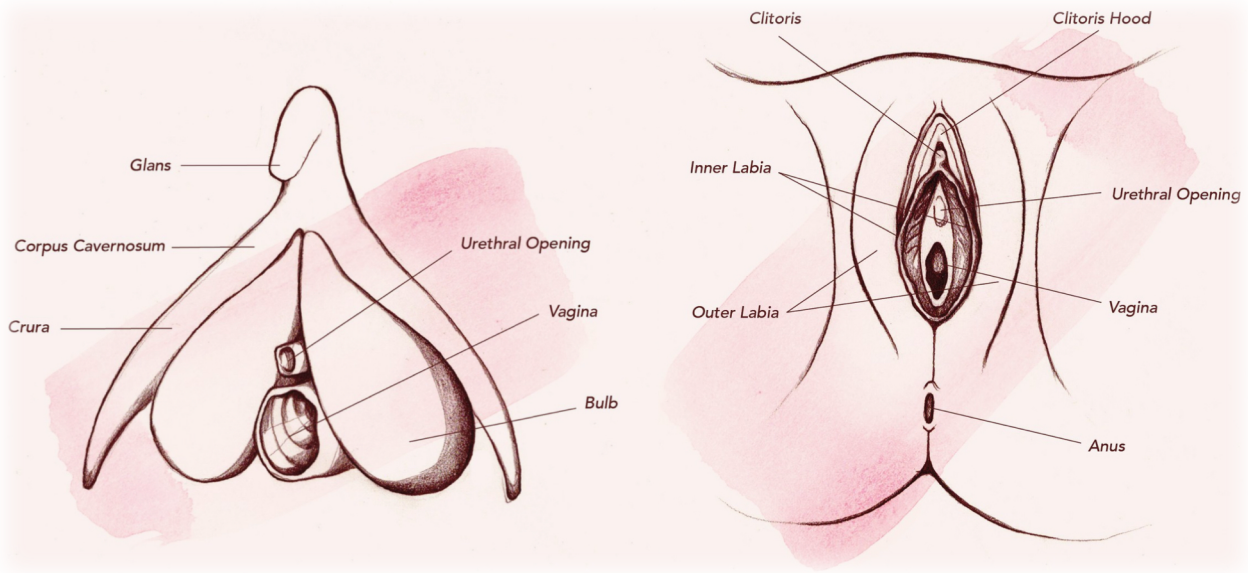

Figure 1. Anatomy of the internal and external genitalia (Han [Teen Vogue], 2019)

The clitoris is included in the vulva but usually discussed separately. Throughout history, the clitoris has been described as a button located below the pubic bone, where the labial folds meet (Braun & Kitzinger, 2001a). Today there is an accurate medical description of the clitoris; that consists of a glans, attached to a shaft (3-4 cm), which transitions to a body that is up to nine centimetres long. Next to the clitoral body are also erectile tissue (O'Connell et al., 2005).

Figure 2. Diversity in vulvas (Willcox [The Vagina Museum], 2019)

There are few descriptions of normal female genitalia in the medical literature, which is confirmed by Lloyd, Crouch, Minto, Liao and Creighton (2005). Furthermore, there are a few reports on the clitoral size and vaginal length, but lacking information on labial size or aspects such as colour and rugosity of the vulva. Lloyd et al. (2005) studied Female genital appearance among 50 women and found that women varied widely in genital dimensions. The length of the labia majora varied between 7–12 cm. Also, labia minora varied from 2–10 cm in length, and 0.7–5 cm in width. The colour of the genital area was most often darker compared with the surrounding skin, however, some were the same colour. Regarding labial rugosity, some were smooth while most were moderately marked.

SOCIAL CONSTRUCTS OF FEMALE SEXUALITY

According to the United Nations Educational, Scientific and Cultural Organization (UNESCO, 2018), sexuality is a social construct which, in addition to the biological aspects, refers to the individual experience of interpersonal and sexual relationships in a variety of beliefs, behaviours, practices, and identities. The socio-cultural aspect is important to consider when describing women's sexuality because of the way women see themselves as a result of general representation (Braun & Wilkinson, 2001). Braun and Wilkinson (2001) stated that the female genitalia (i.e. the vagina) is depicted throughout western society and history as something negative, derogatory and/or lesser than the genitalia of a man. This negative representation and construction of women's bodies continue to be a struggle for control and are often reduced to isolated parts. It is a common topic of

myth, ridicule, and susceptibility to violent abuse (Bramwell & Morland, 2009; Braun & Wilkinson, 2001; Crann, Jenkins, Money, & O'doherty, 2017).

The combined notion of the female genitalia being correlated with negativity and a subject for discussion inhibits women from taking control of their bodies (Braun & Wilkinson, 2001). Like so many other parts of the female body, the vagina is socially constructed as an area for beautification (Braun & Kitzinger, 2001b). As such, women are often ashamed of their genitals, leading them to seek healthcare to surgically modify their genitalia to fit the norm (Bramwell, 2002; Bramwell & Morland, 2009; Braun & Wilkinson, 2001; Laan, Martoredjo, Hesselink, Snijders, & van Lunsen, 2017).

BODY IMAGE

Before discussing genital self-image as the focus in this study, it is important to describe general body image; since the level of satisfaction or dissatisfaction concerning body image often transfers to the genital self-image (Gomes et al., 2019; Komarnicky, Skakoon-Sparling, Milhausen & Breuer, 2019).

Although body image is often described as simple as "how one perceives one's own body", Woertman and Van den Brink (2012) proposes a multidimensional way to describe the construct. This is through three dimensions: *evaluation*, *investment* and *affect*. Body image *evaluation* refers to feelings of satisfaction or dissatisfaction with one's appearance. Body image *investment* refers to the valuation of physical appearance and how important it is to achieve one's desired physical appearance. Body-image *affect,* is to what extent one is emotionally affected by body-focused evaluations.

Feelings about one's body reflect general feelings about the self and the sexual self (Berman et al., 2003). Physical appearance is a key component of women's perceived sexuality, therefore sexuality and body image are connected (Berman et al., 2003; Seal & Meston, 2018; Woertman & Van den Brink, 2012). According to Woertman and Van den Brink (2012), a positive body image correlates with a greater extent of pleasurable sex life, positive attitudes toward sex and more frequent sexual encounters (Berman et al., 2003). A woman's confidence in her body, and how it appeals to a sexual partner, is an important factor when sexually interacting with someone (Woertman & Van den Brink, 2012). Woertman and Van den Brink (2012) further describe that women often adopt an observer's perspective on their body; therefore, it is relevant to discuss body image among women where media plays an important role. They often present an unrealistic ideal

of women's bodies, which makes it difficult for many women to be satisfied with their bodies (Bramwell, 2002; Laan et al., 2017; Woertman & Van den Brink, 2012).

GENITAL SELF-IMAGE

Genital self-image is a definition of people's feelings and beliefs of their genitals (Herbenick et al., 2011). Various studies have measured women's genital self-image, which is important because of the range of ways that people make choices or interact with their genitals (Herbernick et al., 2011).

Many women are brought up in western society's deficient representation of female genitalia in mainstream media and pornography (Braun & Wilkinson, 2001; Smith, Butler, Wagner, Collazo, Caltabiano, & Herbenick, 2017) as described under social constructs. Women are often concerned about their labial size, colour, shape, and symmetry (Smith et al., 2017). This might be the reason why labiaplasty, which is surgically changing the labial structure and appearance, is one of the most rapidly growing cosmetic surgeries among American and British women (Smith et al., 2017). This also reflects a society where many women are still unaware of the diversity of normal genitals (Bramwell, 2002; Braun & Wilkinson, 2001; Laan et al., 2017). However, studies show that young women who have been exposed to pictures of "natural" vulvas have a more positive genital self-image (Laan et al., 2017).

Komarnicky et al, (2019) as well as Herbenick et al. (2011) state a correlation between women's genital self-image, sexual activity and sexual satisfaction. Positive genital self-image correlates with high sexual satisfaction and sexual activity. A negative genital self-image would, in turn, lead to lower sexual satisfaction and sexual activity. This indicates that experiences and perceptions about the physical self, affect people's sexual lives (Berman et al., 2003). Research has found that a positive perception of one's genitals correlates to better sexual functioning (Herbernick et al., 2011). Few studies have yet discovered genital self-image in a Swedish context, whereas much remains to be investigated regarding genital self-image.

EMPOWERMENT

Empowerment theory connects individual strengths and competencies as well as proactive behaviours to social change and social policy. Empowerment is a complex concept to explain, for this reason, it is often seen as a contradiction to powerlessness and helplessness. In theory, research and intervention, empowerment conjoin individual well-being with the larger socio-political environment. Empowerment aims to identify opportunities instead of risks (Perkins & Zimmerman,

1995). Empowerment theory is often used in social work, though it has been increasingly used in health care and among midwives for the last three decades to strengthen women (Hermansson & Mårtensson, 2011). This theory will, therefore, be used in this study as a theoretical framework (Hermansson & Mårtensson, 2011).

Wijma, Smirthwaite, and Swahnberg (2010) describe "empowering pelvic examinations" as an opportunity to change the uneven power balance between women and caregivers, where caregivers have more knowledge in their profession. The empowering pelvic examination should be in collaboration with the woman, aiming for increased knowledge of her vulva. Mirrors can be used throughout the examination, naming all parts of the vulva and make the woman aware of how it feels when these parts are touched. The woman is encouraged to ask questions at any time, and also quit the examination at any time; she has full autonomy. She should also be assured that everything appears "normal".

Furthermore, the International Confederation of Midwives (ICM, 2014), states in their ethical code that midwives should empower women to actively participate in decisions about their care and to speak for themselves regarding issues of their bodies and health. This is confirmed by the United Nations Educational, Scientific and Cultural Organization (UNESCO, 2018) who internationally strive for positive health behaviours and empowerment in decision-making, self-care, and control.

THE MIDWIFE'S SIGNIFICANCE

The Swedish midwifery union ([Svenska barnmorskeförbundet], 2018) describe the role of the midwife is to promote women's reproductive and sexual health. They further describe that within the area of expertise is promoting sexual health by preventing sexual illness. More specifically being able to identify needs, inform and advise on sexuality and contraception, as well as provide care for gynaecological illness and disease (Swedish midwifery union [Svenska Barnmorskeförbundet], 2018). Midwives meet women in different ages and stages of life in different settings such as; maternal health care-, midwifery-, sexuality-, abortion-, and youth clinics. They also meet women with varying degrees of sexual function, which may lead to conversations about desire, sexual arousal, lubrication, orgasm, satisfaction, and pain. Therefore, they may have an opportunity to make a difference in terms of women's genital self-image through increased knowledge of the functioning of the vulva and representation of its appearance.

RESEARCH PROBLEM

Female genital self-image and sexual function may be key factors for the quality of sexual health among women. Women's sexual health is often discussed as complex and largely affected by socio-cultural factors, which may affect their genital self-image as it affects their body image. Midwives play an important role in enhancing women's knowledge and empowering their perception of their own body. Since women seek healthcare for impaired or low sexual arousal, orgasmic dysfunction, dyspareunia, and vaginismus; it is important for midwives to know about the mechanisms of genital self-image and whether they affect sexual function among women.

AIM

The aims of this study were to (1) explore the relationship between genital self-image and sexual function among women and (2) investigate predictive factors of genital self-image.

METHODS AND MATERIAL

DESIGN

This study used a quantitative cross-sectional research design, which allowed for an investigation into the relationships between female genital self-image and sexual function among women in a Swedish context. According to Polit and Beck (2016), cross-sectional studies are applicable for describing relationships between different aspects of a population, at a short time interval.

SURVEY

A survey was created and published online through the software SUNET Survey by Artologik Survey & Report. The current study was part of a bigger mindfulness-intervention study. The current study, however, was using baseline survey data that included an introduction to the study, followed by 43 items: ten demographic items, 11 Female Genital Self-Image Scale (FGSIS) items, 19 The female sexual function index (FSFI) items, and three items on attitude (Appendix 2). The time required for completing the survey was 5-10 minutes. Participants consented to participate by first being shown an information letter and consent form. The form ended by telling the participant that by clicking "next", they were consenting to participate (Appendix 1).

The survey introduction presented a brief background and instructions for participation in the greater study that this study was part of. The instructions were to show what was necessary for the study to be conducted and that it would not implicate any participant's anonymity or integrity

(Polit & Beck, 2004). The survey introduction also came with a caution asking the participant from refraining participation in the study if triggered by questions about sexuality, as the questions dealt with sensitive information. Contact information to the authors of the study was presented at the very bottom, with their full names and professional titles provided. Once accepting the terms of participation, the opening items contained the selection of a code that could not be linked to the participant and ten demographic items including their gender identity, sexual orientation, age, level of education, current employment status, relationship status, given birth, sexual impairment and migration (Appendix 2).

The demographic items were followed by two self-report instruments: "Female Sexual Function Index" (FSFI) and "Female Genital Self-Image Scale" (FGSIS), which both have high reliability and validity in a multicultural context (Herbenick & Reece, 2010; Rosen et al., 2000).

FEMALE GENITAL SELF-IMAGE SCALE (FGSIS)

Female Genital Self-Image Scale (FGSIS) is commonly used (DeMaria, Hollub & Herbenick, 2012; Herbenick et al., 2010). FGSIS assess female genital self-image through an 11-item questionnaire (Herbenick & Reece, 2010). As a part of the 11 items, a quick definition of the female genitalia was presented. The 11 items focused on attitude and perception towards one's genitalia and could be divided into interpersonal and interpersonal factors. Intrapersonal factors were the personal perceptions of feelings, function, smell, and appearance of their genitals. Interpersonal factors were the perceptions of the genitals in interaction with sexual partners and healthcare providers (DeMaria et al., 2012; Herbernick et al., 2010). The initial 11-item FGSIS in the original research was reduced to a 7-item FGSIS with a Cronbach's alpha of 0.89 (Herbenick & Reece, 2010). Consequently, the 7-item FGSIS was used in this study which was also recommended according to Herbenick and Reece (2010).

I feel positively about my genitals.
I am satisfied with the appearance of my genitals.
I would feel comfortable letting a sexual partner look at my genitals.
I think my genitals smell fine.
I think my genitals work the way they are supposed to work.
I feel comfortable letting a healthcare provider examine my genitals.
I am not embarrassed about my genitals

Responses were assessed using a four-point scale, strongly agree to strongly disagree with higher scores indicating a more positive genital self-image (Herbenick & Reece, 2010). Instead of the

typical Likert-scale, normally ranging from 5-7 points, the FGSIS four-point scale in this study applied Radio buttons for convenience in examining the data in the analysis (Polit & Beck, 2016).

The total FGSIS score ranged between 7-28 with no definition for high or low, except that a higher score indicates a more positive genital self-image (Herbernick & Reece, 2010). Since the answer options 1-2 were negative (strongly disagree, disagree) and 3-4 were positive (Strongly agree, agree), the authors made cutoffs as following;

- *High FGSIS:* total score between 21-28, where the average response would be 3 or 4.
- *Low FGSIS*: total score between 7-14, where the average response would be 1 or 2.
- *Medium FGSIS*: total score between 15-20, which consisted of the remaining participants whose average were somewhere in between the high and the low group.

The data in this study was analyzed after these cutoffs to better understand the differences between the participants' level of genital self-image.

FEMALE SEXUAL FUNCTION INDEX (FSFI)

The female sexual function index (FSFI) assessed female sexual function through a 19-item questionnaire (Rosen et al., 2000). FSFI is an instrument to evaluate sexual function in women e.g. sexual desire, arousal, lubrication, orgasm, satisfaction, and pain. It does not deal with aspects as sexual experience, attitude, knowledge or interpersonal functioning of women (Rosen et al., 2000).

As a part of the 19 items, the FSFI initiated definitions of sexual activity, sexual stimuli, and sexual arousal or sexual interest. The definition of sexual activity was adjusted after consulting sexologist Suzann Larsdotter. Since the authors aimed to include participants no matter sexual orientation, definitions of sexual activity and intercourse were adjusted, and the word "foreplay" was excluded because of the heteronormative assumption. The response options varied depending on the field of the item but were either scored from 0-5 or 1-5 with the use of Radio Buttons (Polit & Beck, 2016; Rosen et al., 2000). The scoring for the analysis was made according to the table in the original research of the FSFI (Appendix 3). The minimum and maximum total scores ranged from 2.0 to 36.0, where a higher score indicated a better sexual function.

During the coding of the Female Sexual Function Scale-data in SPSS, an extra answer option was detected. Item 15 in FSFI (Appendix 2) had another answer option "no sexual activity" which the original FSFI scale did not. Because of this, a Cronbach's alpha was conducted to test the internal consistency. The Cronbach's alpha of the validated Swedish version of FSFI ranged from 0.90-0.96 (Demaria et al., 2012; Ryding & Blom, 2015), whilst the Cronbach's alpha for the total FSFI with the unaccounted answer option became 0.96. If that item would have been deleted, the

Cronbach's alpha would have been equivalent. The participants who had chosen the option "no sexual activity" were re-coded from group 0 (No sexual activity) into group 1 (Very dissatisfied). This was after testing the Pearson correlation coefficient between items number 14 and item 15.

PILOT STUDY

Before the online survey was available to the public, a pilot study was conducted to examine their credibility and applicability (Polit & Beck, 2016). This was done to eliminate any possible questions that might arise while answering the survey. Pilot studies are, according to Polit and Beck (2016), almost essential to test the study itself and its effectiveness. Four people were recruited, where two of them corresponded to the target group. The recruits for the pilot study gave direct feedback to the authors on the contents of the introduction to the survey and the survey itself. The pilot study participants had trouble with some academic phrasing in the FGSIS and FSFI. Changes were made according to the feedback; words and descriptions were rephrased to be more easily understood by the general public.

SELECTION

A convenience network sampling was used for this study, which according to Polit and Beck (2016) was used to reach the most conveniently available people for the study as participants. The network sampling relies on people referring the study to another, it takes advantage of social networks and is also convenient since friends tend to have the same characteristics. This sampling method is suitable for small-scale research as they tend to be simple and is often limited in time and cost. To be able to collect as many willing participants as possible, using a convenience snowball sampling through online outlets was the most effective way to collect participants for the study due to the limitation in time. When discussing the selection, the authors have chosen to use the term convenience network sampling (Polit & Beck, 2016).

INCLUSION- AND EXCLUSION CRITERIA

Inclusion- and exclusion criteria were used to define the target group (Polit & Beck, 2016). Participants in the study had to be individuals that defined themselves as a woman and who had a vulva. Because the study was limited in terms of time, resources and specificity, the authors chose to focus on this population. The participants also had to be over 18 years of age (i.e. adults).

DATA COLLECTION

Data were collected from 12 September 2019 to 23 September 2019. It was desirable to collect as many participants as possible, to get a sufficiently large amount of data to produce reliable results (Polit & Beck, 2016). Participants were recruited through eight different social media outlets as seen in Figure 3. These platforms were chosen because of the large number of members that were mostly women, to be able to reach the target group conveniently.

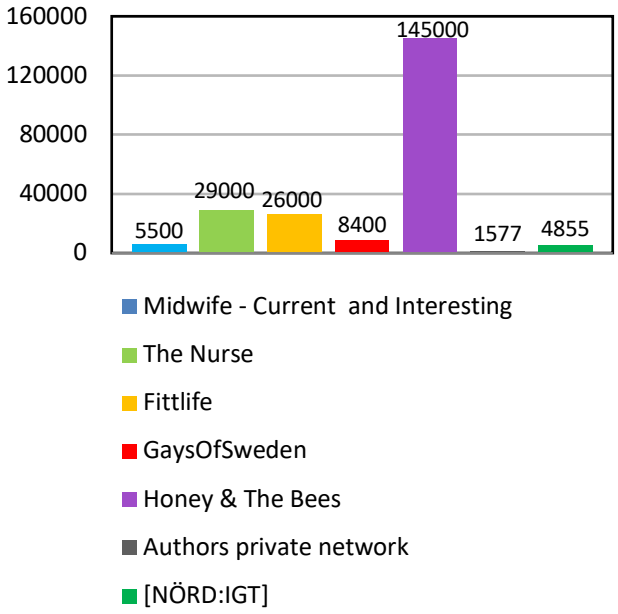

Figure 3. Social media outlets and groups

DATA ANALYSIS

Statistical Package for the Social Science (SPSS) version 25, a software by IBM was used during the analysis of the survey results. SPSS is frequently used for statistical analysis of quantitative data in medical research (IBM Corp, 2017). Various statistical analyses were conducted when analyzing the data. Descriptive- and frequencies analyses, cross-tabulation, independent sample t-tests' and Pearson's chi-square tests were used to study sample dimensions and demonstrate differences in socio-demographic characteristics; Female Genital Self-Image and domains in sexual function.

Some of the variables were merged for the analysis, a process of combining two or more variables into one (IBM Corp, 2017). The age dataset was adjusted after a means testing in the different levels of female genital self-image by the demographics (Table 1). There was a difference in means after the age of 40 compared to the lower age groups. The data was, for this reason, adjusted into two groups, ≤39 and ≥40. Regarding sexual orientation, bi- and homosexual was combined into one variable whereas heterosexual remained. However, others/do not know/would not disclose was not in the analysis because the group was heterogeneous and small-sampled. Education levels ≤high school were merged into one group because of the low number of participants, resulting in the dichotomized groups, ≤ high school, and ≥college or university. For the same reason, those with no employment, retired and on sick-leave were excluded from the analysis.

After a contingency table of demographics was created, a Chi-Square test (χ^2) was calculated to demonstrate a possible relationship between the genital self-image and the demographic variables (Polit & Beck, 2016). Because the Chi-Square test has a high sensitivity

level in sample size, cells in SPSS with small frequencies <5, were grouped together as mentioned above (Polit & Beck, 2016).

Independent sample t-tests compare the means of two independent groups to determine whether their means are significantly different (Polit & Beck, 2016). T-tests were conducted to evaluate potential differences between; the two FGSIS groups by the FSFI domains, and to compare age- and sexual impairment groups by the individual FGSIS items. Non-parametric Mann-Whitney U-tests are sometimes preferred over the independent sample t-test in an analysis where the assumptions of a normal distribution in the t-tests' were not met by the data. Therefore, a Mann-Whitney U-test was conducted when comparing mean ranks on the individual items in Female Genital Self-Image in relation to specific dichotomized variables of interest. The Mann-Whitney U-test did not show any difference in the level of significance. Therefore, only the t-test was presented in the result as done in other studies, when there was no difference in the level of significance (Ryding & Blom, 2015).

RESULTS

DEMOGRAPHICS

The demographics of the 378 participants were reported in Table 1. These descriptive statistics show that half of the participants were between 25-34 years old and were working full time, the majority had a college education. The majority were heterosexual, while one-fifth of the study population were bi- or homosexual. Most were in steady relationships (cohabiting, married or registered partnership), and did not have a sexual impairment (medication, disease, dysfunction). There was an even distribution of whether the participants had given birth or not. Only a small amount of the participants had migrated from their birth country. The table further shows the demographic sample by three groups; "high", "medium", and "low" genital self-image. More than 40% of the women in this study sample did not have a high genital self-image score. Overall, most women felt positive about their genitals, and their genital self-image tended to increase by age. Regarding sexual orientation, homosexual women had the highest genital self-image, followed by bisexuals and heterosexuals had the lowest proportion of genital self-image.

Table 1. Descriptive socio-demographic background factors for the total sample, as well as high, medium and low FGSIS scores**.**

	Total Sample n = 378 n (%)	**High n = 224 n (%)**	**Medium n = 136 n (%)**	**Low n = 18 n (%)**
Age				
20-24	39 (10.3)	20 (51.3)	15 (38.5)	4 (10.3)
25-29	105 (27.8)	56 (53.3)	45 (42.9)	4 (3.8)
30-34	95 (25.1)	54 (56.8)	35 (36.8)	6 (6.3)
35-39	55 (14.6)	32 (58.2)	22 (40.0)	1 (1.8)
40-44	37 (9.8)	26 (70.3)	9 (24.3)	2 (5.4)
45-49	17 (4.5)	13 (76.5)	4 (23.5)	-
≥ 50	30 (7.9)	23 (76.7)	6 (20.0)	1 (3.3)
Sexual orientation				
Heterosexual	282 (74.6)	169 (59.9)	98 (34.8)	15 (5.3)
Bisexual	63 (16.7)	39 (61.9)	21 (33.3)	3 (4.8)
Homosexual	15 (4.0)	11 (73.3)	4 (26.7)	-
Other/Do not know/Would not disclose	18 (4.8)	5 (27.8)	13 (72.2)	-
Education				
Elementary school	1 (0.3)	1 (100.0)	-	-
High school	41 (10.8)	23 (56.1)	15 (36.6)	3 (7.3)
College/University	335 (88.6)	200 (59.7)	121 (36.1)	14 (4.2)
No education	1 (0.3)	-	-	1 (100.0)
Employment				
Full time	211 (55.8)	132 (62.6)	70 (33.2)	9 (4.3)
Part time	52 (13.8)	32 (61.5)	16 (30.8)	4 (7.7)
Student	99 (26.2)	51 (51.5)	44 (44.4)	4 (4.0)
Unemployed	4 (1.1)	2 (50.0)	1 (25.0)	1 (25.0)
Retired	1 (0.3)	1 (100.0)	-	-
Sick leave	9 (2.4)	6 (66.7)	3 (33.3)	-
Sickness- or activity subsidy	2 (0.5)	-	2 (100.0)	-
Marital status				
Single	97 (25.7)	60 (61.9)	31 (32.0)	6 (6.2)
In a relationship	62 (16.4)	39 (62.9)	20 (32.3)	3 (4.8)
Cohabiting /Married/Reg. partnership	219 (57.9)	125 (57.1)	85 (38.8)	9 (4.1)
Given birth				
Yes	188 (49.7)	111 (59.0)	69 (36.7)	8 (4.3)
No	189 (50.0)	112 (59.3)	67 (35.4)	10 (5.3)
Sexual Impairment				
Yes	84 (22.2)	35 (41.7)	42 (50.0)	7 (8.3)
No	294 (77.8)	189 (64.3)	94 (32.0)	11 (3.7)
Migrated from birth country				
Yes	28 (7.4)	16 (57.1)	8 (28.6)	4 (14.3)
No	349 (92.3)	208 (59.6)	127 (36.4)	14 (4.0)

*p-value ≤ 0.05, ** p-value ≤ 0.001, *** p-value ≤ 0.0001

DEMOGRAPHICS AND GENITAL SELF-IMAGE

The medium and low groups were combined into one, due to the small number of participants that scored a low genital self-image. Table 2 demonstrates the demographic sample by two groups; “high” and “low-medium” genital self-image. In looking at the descriptive data in Table 1, there were variations in genital self-image found amongst two of the demographic categories: age and sexual impairment. One's genital self-image tended to increase with higher age but especially increased at age 40 and older compared to those 39 and younger. Therefore, this variable was dichotomized into two groups: 39 and younger verse 40 and older. Also, in Table 1, participants who did not have a sexual impairment descriptively scored higher on their genital self-image compared to those with an impairment.

A Chi-Square test ($\chi 2$) was calculated to demonstrate the relationship between genital self-image and the demographic variables. The test showed a significant association between genital self-image and age, as well as non-impairment on sexual function. Which means that genital self-image increases with age, as well as with the absence of sexual impairment. However, there was insufficient evidence to reject the null hypothesis at the 0.05 level for the other demographic variables. For this reason, no relationship was found between genital self-image and sexual orientation, education level, employment, marital status and whether one had given birth or migrated from one’s birth country.

Table 2. Demographics and genital self-image

Female Genital Self-Image Score	**High n (%)**	**Low-Medium n (%)**	χ^2
Age	**224**	**154**	**0.002***
20-39	162 (55.1)	132 (44.9)	
≥ 40	62 (73.8)	22 (26.2)	
Sexual orientation	**219**	**141**	**0.504**
Heterosexual	169 (59.9)	113 (40.1)	
Bi- or homosexual	50 (64.1)	28 (35.9)	
Education	**224**	**153**	**0.750**
≤High school	24 (57.1)	18 (42.9)	
College/University	200 (59.7)	135 (40.3)	
Employment	**215**	**147**	**0.172**
Full time	132 (62.6)	79 (37.4)	
Part time	32 (61.5)	20 (38.5)	
Student	51 (51.5)	48 (48.5)	
Marital status	**224**	**154**	**0.593**
Single	60 (61.9)	37 (38.1)	
In a relationship	39 (62.9)	23 (37.1)	
Cohabiting/Married/Reg. partnership	125 (57.1)	94 (42.9)	
Given birth	**223**	**154**	**0.966**
Yes	111 (59.0)	77 (41.0)	
No	112 (59.3)	77 (40.7)	
Sexual Impairment	**224**	**154**	**0.000***
Yes	35 (41.7)	49 (58.3)	
No	189 (64.3)	105 (35.7)	
Migrated from birth country	**224**	**153**	**0.799**
Yes	16 (57.1)	12 (42.9)	
No	208 (59.6)	141 (40.4)	

*p-value ≤ 0.05, ** p-value ≤ 0.001, *** p-value ≤ 0.0001

Table 3 demonstrates the means and standard deviations of individual items within female genital self-image for the total sample, by age groups “below 39” and “above 39” as well as “sexual impairment” and “no sexual impairment”. This was done to find out how women experience the different aspects of genital self-image. For the total sample, women had a generally positive perception of their genitals except for the items regarding smell and embarrassment where women scored below 3 in means. Which means that women are more negatively attuned to their smell and tend to be embarrassed of their genitals. The highest mean score was on item six which was letting a healthcare provider examine one’s genitals.

AGE

An independent sample t-test was conducted to compare the differences between the age groups ≤39 and ≥40 concerning genital self-image at the item level. There was a significant difference in six out of seven items. However, there was no significant difference concerning genital examination in healthcare. These results suggest that age affects most items in the female genital self-image. More specifically, women over the age of 40 were more positively attuned to their genitals regarding their feelings, appearance, interaction with sexual partners, smell, function, and embarrassment, compared to the women under 39 years old.

SEXUAL IMPAIRMENT

The two groups; sexual impairment and no sexual impairment, were also compared through an independent sample t-test concerning genital self-image items. There was a significant difference in three out of the seven items. However, there was no significant difference concerning either appearance, interaction with sexual partners, smell or embarrassment. Accordingly, having an impairment affects some aspects of the female genital self-image. More specifically, women without sexual impairment are more positively attuned to their genitals regarding feelings, function and genital examinations in healthcare.

Table 3. Female Genital Self-Image Items by Age and Sexual Impairment

	Total Sample M (SD)	**Age ≤ 39 M (SD)**	**Age ≥ 40 M (SD)**	**t-test**	**Sexual impairment M (SD)**	**No sexual impairment M (SD)**	**t-test**
1. I feel positively about my genitals.	3.20 (.706)	3.14 (.701)	3.39 (.695)	2.89*	3.01 (.752)	3.25 (.685)	2.77*
2. I am satisfied with the appearance of my genitals.	3.04 (.816)	2.99 (.799)	3.23 (.855)	2.27*	2.99 (.857)	3.06 (.805)	0.69
3. I would feel comfortable letting a sexual partner look at my genitals.	3.08 (.870)	3.00 (.853)	3.39 (.865)	3.75**	2.94 (.869)	3.13 (.867)	1.73
4. I think my genitals smell fine.	2.65 (.732)	2.54 (.713)	3.01 (.685)	5.47***	2.52 (.784)	2.68 (.715)	1.77
5. I think my genitals work the way they are supposed to work.	3.19 (.733)	3.13 (.740)	3.42 (.662)	3.25**	2.89 (.850)	3.28 (.673)	4.32**
6. I feel comfortable letting a healthcare provider examine my genitals.	3.25 (.730)	3.22 (.718)	3.35 (.768)	1.34	3.01 (.829)	3.32 (.686)	3.46**
7. I am not embarrassed about my genitals	2.97 (.854)	2.91 (.832)	3.17 (.903)	2.40*	2.86 (.880)	3.00 (.845)	1.39

*p-value ≤ 0.05, ** p-value ≤ 0.001, *** p-value ≤ 0.0001

Table 4 shows the descriptives of sexual function by the different levels of genital self-image: high and low-medium. An independent samples t-test was conducted to compare sexual function domains between the groups: high and low-medium genital self-image score. There was a highly significant difference in the total score of the female sexual function index in the high genital self-image group compared to the low-medium genital self-image group. Consequently, genital self-image may affect sexual function. These results suggest that when women have a high genital self-image, they have a high sexual function. This was true for the total sexual function score, as well as for all of the domains; desire, arousal, lubrication, orgasm, satisfaction, and painlessness.

Table 4. Sexual function domains by genital self-image groups.

	High M (SD)	**Low-Medium M (SD)**	**t-test**
FSFI total score	26.92 (7.59)	21.78 (8.71)	5.87***
Desire	3.67 (1.16)	3.01 (1.25)	5.27***
Arousal	4.80 (1.54)	3.79 (1.83)	5.59***
Lubrication	5.03 (1.61)	4.19 (1.99)	4.31***
Orgasm	4.60 (1.72)	3.74 (1.89)	4.51***
Satisfaction	4.25 (1.67)	3.43 (1.59)	4.74***
Painlessness	4.64 (2.20)	3.62 (2.41)	4.21***

*p-value ≤ 0.05, ** p-value ≤ 0.001, *** p-value ≤ 0.0001

DISCUSSION

This study explored the relationship between genital self-image and sexual function among women, as well as investigated which women had a positive genital self-image. This cross-sectional study of 378 women found that women's genital self-image significantly affected all of the sexual function domains. The analysis also showed that women at the age of 40 and older, had significantly higher genital self-image scores than the women under 40. Women's genital self-image scores were also significantly higher among women without sexual impairments.

GENITAL SELF-IMAGE AND SEXUAL FUNCTION

Women who had a high genital self-image scored higher on all of the sexual function domains; desire, arousal, lubrication, satisfaction, orgasm, and painlessness than those with a low genital self-image. These results align with previous studies who looked at similar domains (Berman et al.,

2003; Berman & Windecker, 2008; Herbernick et al., 2011), as well as with research showing associations between women's genital self-image, sexual activity, and sexual satisfaction (Herbernick et al., 2011; Komarnicky et al., 2019). Berman and Windecker (2008) had similar findings and concluded that poor genital self-image could affect women's overall sexual health and that it could have harmful consequences through unnecessary genital surgeries.

In the current study, women with a sexual impairment such as sexual dysfunction, medication or disease affecting sexual function, perceived their genitals more negatively than women without any sexual impairment. Consequently, this relationship cannot be further discussed, given that the results do not show what specific impairment the women had: medication, dysfunction or disease. There is, however, research supporting these findings regarding both dysfunction (Sarhan, Mohammed, Gomaa & Eyada, 2016), disease, and medication (Hawighorst-Knapstein, 2004).

GENITAL SELF-IMAGE INCREASES WITH AGE

This study's results showed that the genital self-image score increased the older the women were, with a significant increase after the age of 40. These results are supported by other studies, finding that also body satisfaction- and appreciation increases with age (Tiggemann & Mccourt, 2013). The mechanisms behind these results might be explained through other studies on women's sexuality and body image, suggesting that ageing often entails a decreased valuation of appearance in favour of self-worth (Tiggemann & Lacey, 2009), decreased sexuality-related distress (Hayes, Dennerstein, Bennett & Fairley (2008) and lesser concerns of appearance during sex (Richters, Grulich, Visser, Smith & Rissel, 2003).

SEXUAL ORIENTATION MAY AFFECT GENITAL SELF-IMAGE

Although this study did not show any significant differences regarding sexual orientation, tendencies were shown that the level of genital self-image seemed to differ between women depending on their sexual orientation. Means were the lowest among heterosexual women, increased among bisexuals and even higher among homosexual women. This tendency is strengthened through studies by Moreno-Domínguez et al. (2019) stating that, in comparison to heterosexuals, homosexual women have a more satisfying sex life and their satisfaction is less affected by body concerns. Moreover, the male gaze seems to increase women's concerns about physical appearance during sex, which homosexual women might not have to contend with

(Mcdougall, 2013). Furthermore, it is plausible that homo- and bisexual women have seen more natural vulvas than heterosexual women have, indicating that if heterosexual women saw more vulvas, it might make them more comfortable with their own. This result might also strengthen the need for representation of the diversity of vulvas (Laan et al., 2017). Further research should explore how sexual orientation and sexual practice affect female genital self-image.

PROFITABLE GENITAL SELF-IMAGE

The means in the total sample, when it came to genital smell and embarrassment, was considerably lower than the rest of the individual items (Table 3). More than 40% of the women in this sample had a medium-low genital self-image, which put them at a higher risk of consorting to labiaplasty or other modification due to their vulnerability (Braun, 2009; Eftekhar, Hajibabaei, Deldar Pesikhani, Rahnama & Montazeri, 2019; Fahs, 2014). Since there are negative outcomes associated with these beautification techniques (Braun, 2009), as well as general feelings of lower self-worth (Fahs, 2014; Laan et al., 2017; Mcdougall, 2013), it could be beneficial to focus on normalizing vulvas and improving women's genital self-image.

The notion that a woman's genitalia needed modification to fit into an ideal is what women have been taught and led to think of as a "normality" (Mcdougall, 2013). Images of the vulva are more easily accessible through pornographic media than in medical literature (Lloyd et al., 2005). This poses a problem where porn creates an ideal for what women's genitals should look like. The pursued ideal is, conceived through pornographic media, which sends women multiple messages of unattainable ideals (Mcdougall, 2013). The lesser a woman feels satisfied with herself the more likely she will consume products for beautification (Braun, 2009; Herbenick et al., 2013; Mcdougall, 2013). Women's insecurities and vulnerability have long been a great source of exploit and profit (Bramwell, 2002; Bramwell & Morland, 2009; Braun & Wilkinson, 2001; Braun & Kitzinger, 2001b; Fahs, 2014; Herbenick et al., 2013; Laan et al., 2017; Mcdougall, 2013).

MIDWIVES' CLINICAL OPPORTUNITY TO EMPOWER WOMEN

Regarding genital self-image, the women in this study had great confidence in letting health care professionals examine their genitals. This points to midwives as professionals with a great opportunity to enhance genital self-image among women in healthcare settings. This could lead to increased sexual function when women are less troubled by physical appearance during sex (Richters et al., 2003). Hermansson and Mårtensson (2011) described midwifery empowerment as a

process of supporting women to take control of factors that affect their health; gaining knowledge and learning to appreciate one's body and genitals might be one aspect. As previously mentioned, empowering pelvic exams could enhance women's knowledge of their bodies concerning anatomy as well as knowledge of the diversity of the vulva concerning looks and function (Wijma et al., 2010). Knowing that women have uncertainties regarding their genital odour, midwives have the opportunity to clarify the normal variations as well as deviant genital odour.

Furthermore, midwives could indeed empower women to appreciate their bodies as it is, and also for what it can do (Robbins & Reissing, 2018). Regarding representation, midwives could offer a diverse representation of natural vulvas in direct contact with patients, during pelvic examinations as mentioned, and indirect in the waiting room through picture books such as *101 Vagina* (Werner, 2013) or *I'll show you mine* (Robertsson, 2011). Midwives could also recommend Instagram pages such as *The vulva gallery*, or websites as *labialibrary.org* to help normalize the differences in vulvas.

EMPOWERMENT OF WOMEN, SOCIAL CHANGE

By using empowerment theory, women's sense of their sexual self may be powerfully influenced, leading to enhanced autonomy (Hermansson & Mårtensson, 2011). The study results present that women in this sample were highly confident of their genitalia. This positive outcome suggests an undergoing societal change for the benefit of women, which needs to be pursued. The female genitalia is often regarded, as shameful, smelly or something that constantly needs "fixing" (Mcdougall, 2013). This is what women encounter about the female genitalia, when it is a topic of discussion. According to Braun and Wilkinson (2001), women are being told to dislike themselves which is why there is a need for a further social change. They further encourage challenging society in the way discussions are held in schools, demand a wider representation in educational purpose and empower women to create a social change in how the female genitalia is represented.

Female genital self-image is an important component of women's sexual and overall health (Berman & Berman, 2003). When women get to know their body, they learn to know their sexual preferences, which in turn leads to better sex with others. An enhanced genital self-image can affect women's amount of depression and sexual distress (Berman & Berman, 2003), as well as sexual function (Eftekhar et. al., 2019; Berman & Windecker, 2008). When healthcare providers can empower women (Wijma et al., 2010), it will also challenge the socio-cultural constructs that exist today, which can lead to multiple positive changes (Braun & Wilkinson 2001). As seen in studies, representations of the vulva have the ability to affect women's genital self-image (Braun &

Wilkinson, 2001). In the same manner, empowerment of women's genital self-image should, in turn, affect socio-cultural aspects such as gender equality.

METHOD DISCUSSION

DESIGN

There are multiple advantages to using a cross-sectional study. This study aimed to explore the relations between female genital self-image and sexual function, which is why a cross-sectional design was chosen. It can capture multiple variables at a specific point in time, and the findings can be analyzed to create new in-depth research (Polit & Beck, 2016). Although a cross-sectional study cannot help determining cause and effect, it is a design that can be used to confirm assumptions (Polit & Beck, 2016). The disadvantages of a cross-sectional design are the challenges of acquiring a varied selection in the population that is being studied, which can also be seen in this study (Polit & Beck, 2016).

SELECTION AND SAMPLE

The current study used convenience sampling through internet-based social media sites. When using convenience sampling, there is a risk of sampling error, meaning that the study sample might not be representative of a larger population (Polit & Beck, 2016). A considerable part of the total sample were heterosexuals in steady relationships, although variations did exist, as in Swedish society. A majority of the study sample had a college education, which is not representative of the Swedish population, whereas it may have affected the generalizability of the results (Polit & Beck, 2016). This study may have resulted in selection bias, which is a term that is used to describe a group of prejudices and effects that result in a sample that is consistently disparate from the population it intends to represent (Polit & Beck, 2016).

The Facebook groups from where the participants were recruited, were chosen due to a large number of members that would fit the inclusion criteria. The total number of people who may have been reached through social media was around 260 000, yet the number of participants were 378 women. This may be due to the fact that many members were found in most of the groups or some did not meet the inclusion criteria. Large groups on Facebook tend to have a high flow of posts which could result in a limited focus on the specific post about study recruitment. The short time frame for recruitment of participants for this study may also have contributed to a low number of participants.

The members were almost exclusively women, a large part with potential interest in the subject; midwives, nurses. The latter may, however, have resulted in having women with higher education, as to become a nurse or midwife, they would need to have a university education. However, since no difference was found between the levels of schools and genital self-image, this factor may not undermine the findings of the current study.

The online survey was accessed through a link, distributed across the different social media platforms (e.g. Facebook, Instagram). This was a strength considering that most of the Swedish population have internet access and social media is commonly used among all age groups as a means of communication. Participants were able to share the link and re-distribute it as they saw fit. This made it undistinguishable as to how many participants were recruited from which groups. Having specific links to the online survey, for each individual group, would have been useful to see the demographics of a specific social media group. However, spreading the survey online was important for anonymous participation as well as the recruitment of a larger sample size that would strengthen the generalizability of this quantitative study (Polit & Beck, 2016).

SURVEY - FGSIS & FSFI

The definition of sexual practice was adjusted from the original FSFI, after consulting sexologist Suzann Larsdotter. Since the researchers aimed to include participants no matter their sexual orientation, definitions of sexual practice and intercourse were adjusted, and the word “foreplay” was excluded because of the heteronormative assumption. This was done to make the language less heteronormative and suitable for more people rather than affecting the validity of the measuring instrument. It could not be confirmed whether this alteration did or did not affect the validity of the instrument. However, the internal reliability was highly acceptable (α=0.96).

A validated Swedish translation of the FGSIS does not yet exist as it does with the FSFI. Nonetheless, it is transferable to a Swedish context. The internal consistency was assessed via Cronbach’s alpha, on the Swedish version of the translated items in FGSIS. The Swedish version showed a relatively high internal consistency. Furthermore, the FGSIS purposely utilized a 4-point response scale, ranging from strongly disagree to strongly agree. This is, due to the nature of the questions that otherwise may result in neutral responses, the participants are forced to take a stand (Herbenick & Reece, 2010).

PILOT STUDY

As Polit and Beck (2016) emphasize, it is always good, if not necessary, to conduct a pilot study to strengthen the validity of the survey and to see if changes are needed before finalizing the result for the participants. The advantages of having a minor pilot study made the researchers aware of the written language. Information was modified into non-academic writing to be easier to understand, after gaining direct feedback from the pilot study participants.

DATA ANALYSIS

Participants who were under 20 years of age were excluded from the analysis, due to the uncertainty of whether or not they were minors. This was considered important, as research on minors must have ethical approval (Ethical Review Agency [Etikprövningsmyndigheten], 2019). Consequently, the final sample consisted of only adult women.

The 15:th item that was re-coded in the Female Sexual Function Index, might have affected the distribution in the data material. However, this was corrected by calculating the Pearson correlation between item number 14 and 15. The test showed that the participants who answered "no sexual activity" were likely to have answered "very dissatisfied" if the first answer option was not available, concluding that this re-coding did not affect the validity of the survey.

ETHICAL CONSIDERATIONS

Because the study needed participation from people, ethics as part of the study remained constant and was therefore taken into consideration. The principle of beneficence, more specifically the do no harm was greatly reflected upon while formulating the questions for the survey (Polit, 2016). The survey questions, therefore, emanated from established self-report instruments; "Female Sexual Function Index" (FSFI) and "Female Genital Self-Image Scale" (FGSIS) (Herbenick & Reece, 2010; Rosen et al., 2000).

Participants were informed before participating in the study that they could, at any given time, decide to withdraw themselves from the study, which according to Greaney et al. (2012) is important so that the participants will always make an informed decision.

Asking sensitive questions about one's preferences was at a certain point debatable, whether or not the survey questions could inflict or trigger a certain psychological trauma in the participant. This uncertainty was quickly corrected by informing the participants before they entered the first online survey about what type of questions the survey would ask of them and then asking the

participants to reconsider their participation in the study if they felt unsure (Polit & Beck, 2016). The participants were further given contacts to RFSU and 1177.se to provide them with healthcare if needed.

A research study of this size and the academic level was limited and did not, therefore, need official approval from an ethics committee (Ethical Review Agency [Etikprövningsmyndigheten], 2019). However, an information letter and consent form were included in the study (Appendix 1). The data was also collected anonymously to protect the participants' integrity.

CONCLUSION

In this study, a relation was found between female genital self-image and the total sexual function score, as well as all the different domains in sexual function such as desire, arousal, lubrication, orgasm, satisfaction and pain. These results propose that women's perceptions of their genitals have an effect on how they function sexually. There are, however in this sample, predicting factors influencing a woman's genital self-image, such as age and sexual impairment. More than 40% of the participating women had a medium or low genital self-image, suggesting that more could be done to improve women's genital self-image. Midwives should empower women in regard to their genitals, as well as educate in the diverse normal range of genital looks and odour, chiefly about the labia, to break myths and enhance sexual health. The empowerment of women, through education and representation, should be a standard part of the midwife's work. This could, in turn, enhance genital self-image and contribute to a better sexual function, and in the broad aspect to a societal change of gender equality.

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APPENDIX 1
INFORMATION AND CONSENT

MEDVERKAN I EN STUDIE OM SEXUELL HÄLSA

Vi är två barnmorskestudenter som gör ett examensarbete om huruvida fokuserad mindfulness (clitfulness) har effekter på kvinnors sexuella funktion och genitala självbild (känslor och tilltro till sitt könsorgan). **Vi söker dig som identifierar dig som kvinna och har vulva (klitoris, blygdläppar, venusberg) och vill delta i studien.** Med ditt deltagande ökar vi förhoppningsvis kunskapen om kvinnors sexuella hälsa.

Mindfulness är en välkänd meditationsmetod för ökad medveten närvaro. Metoden har visat positiva effekter på sexuell hälsa, framför allt hos kvinnor med sexuella dysfunktioner som samlagssmärta, bristande lust och utebliven orgasm. Många kvinnor har generellt en bristande kroppsuppfattning vad gäller sitt könsorgan. Vi vill därför undersöka om Clitfulness kan vara en metod som genom ökad kroppsuppfattning bidrar till en förbättrad sexuell funktion och/eller genital självbild.

"Clitfulness" är ett nytt begrepp och fenomen, myntat av sexologen Suzann Larsdotter med kollegor. Det är en form av mindfulness med fokus på känslan i genitalierna: i detta fall vulvan. Programmet du kommer följa bygger på detta. Clitfulness behöver ej leda till onani eller sex men kan göra det om så önskas.

GENOMFÖRANDE

Ett komplett genomförande innebär att du:

1. Fyller i en inledande enkät (nr 1) nu, om sexualitet och kroppsuppfattning. Frågor kommer att ställas om din generella bakgrund, sexuella funktion, genitala självbild och attityd till mindfulness.
2. Genomför Clitfulness (fokuserade mindfulnessövningar) under en vecka, enligt instruktioner du får tillgång till när du besvarat denna enkät.
3. Fyller i en avslutande enkät (nr 2) för att ditt deltagande ska bli fullständigt.

DELTAGANDE

- **Deltagande i studien är helt anonymt. Du kommer att välja en kod för din anonymitet.**
- **Du kan när som helst avbryta ditt deltagande genom att inte fullfölja studien.**
- **Inskickad enkät innebär att du ger samtycke till deltagandet i studien och godkännande för insamling av datamaterial genererat från dina svar.**
- **Tidsåtgång för ditt deltagande under veckan är ca 3-5 min/dag i en vecka.**

Då frågorna behandlar känslig information är det viktigt att du avstår om du triggas av frågor och/eller övningar gällande sexualitet.

Om du har frågor om studien är du välkommen att kontakta oss.

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APPENDIX 2

ONLINE SURVEY ON DEMOGRAPHY

1. VIKTIGT!
För att säkra din anonymitet - välj en kod (BOKSTÄVER + SIFFROR) som inte går att härleda till dig.
Kom ihåg din kod genom att skriva ner den alt. ta en screenshot.
Samma kod ska användas i enkät nr 2.

2. Vilket kön identifierar du dig själv som?

- Kvinna
- Man
- Ickebinär
- Annat
- Osäker
- Vill ej uppge

3. Vilken sexuell läggning har du?

- Heterosexuell
- Bisexuell
- Homosexuell
- Annat/Vet ej
- Vill ej uppge

4. Hur gammal är du?

5. Vad är din högsta utbildningsnivå?

- Grundskola
- Gymnasium
- Högskola/Universitet
- Har ingen utbildning

6. Vad är din nuvarande sysselsättningsgrad (Välj det alternativ som passar bäst)?

- Heltid
- Deltid
- Student
- Arbetslös
- Pensionär
- Sjukskriven
- Sjuk- eller aktivitetsersättning (förtidspensionär)

7. Hur ser din relationsstatus ut idag?

- ◯ Singel
- ◯ I ett förhållande (med en eller flera)
- ◯ Sambo / Gift / Registrerat partnerskap

8. Har du fött barn?

- ◯ Ja
- ◯ Nej

9. Om du har fött barn, hur avslutades förlossningen?

- ☐ Har ej fött barn
- ☐ Vaginalt
- ☐ Instrumentellt (sugklocka, tång)
- ☐ Kejsarsnitt

10. Har du något som påverkar din sexuella funktion (t.ex. psykologiska faktorer, fysiska funktionsnedsättningar / sjukdomar, medicinering)?

- ◯ Ja
- ◯ Nej

11. Har du migrerat från det land du föddes i?

- ◯ Ja
- ◯ Nej

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ONLINE SURVEY ON FGSIS ITEMS

FGSIS = Female Genital Self Image Scale

Följande frågor behandlar hur du känner för ditt könsorgan (vulva och vagina).
Ordet **vulva** syftar till yttre könsdelar (de delar som du kan se från utsidan som klitoris, venusberg och blygdläppar).
Ordet **vagina** syftar till den inre delen av könsorganet.

Ange i vilken grad du håller med eller inte håller med om varje påstående.

12. Jag känner mig positivt inställd till mitt könsorgan

- ◯ Instämmer inte alls
- ◯ Instämmer inte
- ◯ Instämmer
- ◯ Instämmer fullständigt

13. Jag är nöjd med utseendet på mitt könsorgan

- ◯ Instämmer inte alls
- ◯ Instämmer inte
- ◯ Instämmer
- ◯ Instämmer fullständigt

14. Jag skulle känna mig bekväm med att låta en sexpartner titta på mitt könsorgan

- ◯ Instämmer inte alls
- ◯ Instämmer inte
- ◯ Instämmer
- ◯ Instämmer fullständigt

15. Jag tror att mitt könsorgan luktar gott

- ◯ Instämmer inte alls
- ◯ Instämmer inte
- ◯ Instämmer
- ◯ Instämmer fullständigt

16. Jag tror att mitt könsorgan fungerar som det ska

- ◯ Instämmer inte alls
- ◯ Instämmer inte
- ◯ Instämmer
- ◯ Instämmer fullständigt

17. Jag känner mig okej med att låta en vårdgivare undersöka mitt könsorgan

- ◯ Instämmer inte alls
- ◯ Instämmer inte
- ◯ Instämmer
- ◯ Instämmer fullständigt

18. Jag är inte generad över mitt könsorgan

- ◯ Instämmer inte alls
- ◯ Instämmer inte
- ◯ Instämmer
- ◯ Instämmer fullständigt

19. Jag gillar utseendet på mitt könsorgan

- ◯ Instämmer inte alls
- ◯ Instämmer inte
- ◯ Instämmer
- ◯ Instämmer fullständigt

20. Jag kan se hur en sexpartner skulle blir upphetsad av mitt könsorgan

- ◯ Instämmer inte alls
- ◯ Instämmer inte
- ◯ Instämmer
- ◯ Instämmer fullständigt

21. Jag kan se hur en sexpartner skulle njuta av smaken av mitt könsorgan

- ◯ Instämmer inte alls
- ◯ Instämmer inte
- ◯ Instämmer
- ◯ Instämmer fullständigt

22. Jag är bekväm med lukten från mitt könsorgan

- ◯ Instämmer inte alls
- ◯ Instämmer inte
- ◯ Instämmer
- ◯ Instämmer fullständigt

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ONLINE SURVEY ON FSFI ITEMS

FSFI = Female Sexual Function Index

Dessa frågor handlar om dina sexuella känslor och reaktioner under de senaste fyra veckorna. Besvara följande frågor så ärligt och tydligt som möjligt. Vid besvarande av frågorna gäller följande definitioner:

Sexuell aktivitet kan omfatta smeksex, oralsex, gnuggsex, eller vaginalt/analt samlag med annan/andra eller dig själv (onani). Samlag kan definieras som penetration i slida/anal.

Sexuell stimulering omfattar situationer enligt ovan eller sexuell fantasi.

Sexuell lust eller sexuellt intresse är en känsla som omfattar lusten att ha en sexuell upplevelse, känslan av att vara mottaglig för en/flera partners sexuella initiativtagande, samt tankar och fantasier om att ha samlag.

23. Under de senaste fyra veckorna, hur ofta har du känt sexuell lust eller sexuellt intresse?

- ◯ Nästan alltid eller alltid
- ◯ Större delen av (mer än halva) tiden
- ◯ Delar av (ungefär halva) tiden
- ◯ Några gånger (mindre än halva tiden)
- ◯ Nästan aldrig eller aldrig

24. Under de senaste fyra veckorna, hur skulle du bedöma din nivå (grad) av sexuell lust eller sexuellt intresse?

- ◯ Mycket hög
- ◯ Hög
- ◯ Måttlig
- ◯ Låg
- ◯ Mycket låg eller ingen alls

Sexuell upphetsning är en känsla som innebär både fysiska och mentala aspekter.
Det kan innebära känslor av värme eller pirrande i könsorgan, fuktighet eller muskelsammandragningar.

25. Under de senaste fyra veckorna, hur ofta har du känt dig sexuellt upphetsad (“kåt”) vid sexuell aktivitet eller samlag?

- ◯ Ingen sexuell aktivitet
- ◯ Nästan alltid eller alltid
- ◯ Mer än hälften av gångerna
- ◯ Ungefär hälften av gångerna
- ◯ Mindre än hälften av gångerna
- ◯ Nästan aldrig eller aldrig

26. Under de senaste fyra veckorna, hur skulle du bedöma din nivå (grad) av sexuell upphetsning vid sexuell aktivitet eller samlag?

- ◯ Ingen sexuell aktivitet
- ◯ Mycket hög
- ◯ Hög
- ◯ Måttlig
- ◯ Låg
- ◯ Mycket låg eller ingen alls

27. Under de senaste fyra veckorna, hur säker var du på att bli sexuellt upphetsad vid sexuell aktivitet eller samlag?

- ◯ Ingen sexuell aktivitet
- ◯ Väldigt säker
- ◯ Mycket säker
- ◯ Måttligt säker
- ◯ Ganska osäker
- ◯ Mycket osäker eller fullständigt osäker

28. Under de senaste fyra veckorna, hur ofta har du varit tillfredsställd med din känsla av upphetsning vid sexuell aktivitet eller samlag?

- ◯ Ingen sexuell aktivitet
- ◯ Nästan alltid eller alltid
- ◯ Mer än hälften av gångerna
- ◯ Ungefär hälften av gångerna
- ◯ Mindre än hälften av gångerna
- ◯ Nästan aldrig eller aldrig

29. Under de senaste fyra veckorna, hur ofta har du blivit fuktig ("våt") vid sexuell aktivitet eller samlag?

- ◯ Ingen sexuell aktivitet
- ◯ Nästan alltid eller alltid
- ◯ Mer än hälften av gångerna
- ◯ Ungefär hälften av gångerna
- ◯ Mindre än hälften av gångerna
- ◯ Nästan aldrig eller aldrig

30. Under de senaste fyra veckorna, hur svårt har det varit att bli fuktig ("våt") vid sexuell aktivitet eller samlag?

- ◯ Ingen sexuell aktivitet
- ◯ Extremt svårt eller omöjligt
- ◯ Mycket svårt
- ◯ Svårt
- ◯ Lite svårt
- ◯ Inte svårt

31. Under de senaste fyra veckorna, hur ofta har du bibehållit din fuktighet till dess att sexuell aktivitet eller samlag har fullbordats?

- ◯ Ingen sexuell aktivitet
- ◯ Nästan alltid eller alltid
- ◯ Mer än hälften av gångerna
- ◯ Ungefär hälften av gångerna
- ◯ Mindre än hälften av gångerna
- ◯ Nästan aldrig eller aldrig

32. Under de senaste fyra veckorna, hur svårt har det varit att bibehålla din fuktighet till dess att sexuell aktivitet eller samlag har fullbordats?

- ◯ Ingen sexuell aktivitet
- ◯ Extremt svårt eller omöjligt
- ◯ Mycket svårt
- ◯ Svårt
- ◯ Lite svårt
- ◯ Inte svårt

33. Under de senaste fyra veckorna, hur ofta har du fått orgasm genom sexuell stimulans eller samlag?

- ◯ Ingen sexuell aktivitet
- ◯ Nästan alltid eller alltid
- ◯ Mer än hälften av gångerna
- ◯ Ungefär hälften av gångerna
- ◯ Mindre än hälften av gångerna
- ◯ Nästan aldrig eller aldrig

34. Under de senaste fyra veckorna, hur svårt har det varit att få orgasm genom sexuell stimulans eller samlag?

- ◯ Ingen sexuell aktivitet
- ◯ Extremt svårt eller omöjligt
- ◯ Mycket svårt
- ◯ Svårt
- ◯ Lite svårt
- ◯ Inte svårt

35. Under de senaste fyra veckorna, hur tillfredsställd har du varit med din förmåga att få orgasm genom sexuell stimulans eller samlag?

- ◯ Ingen sexuell aktivitet
- ◯ Mycket tillfredsställd
- ◯ Måttligt tillfredsställd
- ◯ Lika tillfredsställd som otillfredsställd
- ◯ Något otillfredsställd
- ◯ Mycket otillfredsställd

36. Under de senaste fyra veckorna, hur tillfredsställd har du varit med den känslomässiga närheten mellan dig och din partner vid sexuell aktivitet?

- ◯ Ingen sexuell aktivitet
- ◯ Mycket tillfredsställd
- ◯ Måttligt tillfredsställd
- ◯ Lika tillfredsställd som otillfredsställd
- ◯ Något otillfredsställd
- ◯ Mycket otillfredsställd

37. Under de senaste fyra veckorna, hur tillfredsställd har du varit med ditt sexuella förhållande med din partner?

- ◯ Ingen sexuell aktivitet
- ◯ Mycket tillfredsställd
- ◯ Måttligt tillfredsställd
- ◯ Lika tillfredsställd som otillfredsställd
- ◯ Något otillfredsställd
- ◯ Mycket otillfredsställd

38. Under de senaste fyra veckorna, hur tillfredsställd har du varit med ditt sexliv i allmänhet?

- ◯ Mycket tillfredsställd
- ◯ Måttligt tillfredsställd
- ◯ Lika tillfredsställd som otillfredsställd
- ◯ Något otillfredsställd
- ◯ Mycket otillfredsställd

39. Under de senaste fyra veckorna, hur ofta har du upplevt obehag eller smärta vid vaginalt samlag?

- ◯ Inga försök till samlag
- ◯ Nästan alltid eller alltid
- ◯ Mer än hälften av gångerna
- ◯ Ungefär hälften av gångerna
- ◯ Mindre än hälften av gångerna
- ◯ Nästan aldrig eller aldrig

40. Under de senaste fyra veckorna, hur ofta har du upplevt obehag eller smärta efter vaginalt samlag?

- ◯ Inga försök till samlag
- ◯ Nästan alltid eller alltid
- ◯ Mer än hälften av gångerna
- ◯ Ungefär hälften av gångerna
- ◯ Mindre än hälften av gångerna
- ◯ Nästan aldrig eller aldrig

41. Under de senaste fyra veckorna, hur skulle du bedöma din nivå (grad) av obehag eller smärta vid eller efter vaginalt samlag?

- ◯ Inga försök till samlag
- ◯ Mycket hög
- ◯ Hög
- ◯ Måttlig
- ◯ Låg
- ◯ Mycket låg eller ingen alls

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ONLINE SURVEY ON CLITFULNESS

Clitfulness

Mindfulness är en välkänd meditationsmetod för ökad medveten närvaro som visat positiva effekter på sexuell hälsa.
"Clitfulness" är ett nytt begrepp och fenomen, myntat av sexologen Suzann Larsdotter med kollegor.
Det är en form av mindfulness med fokus på känslan i genitalierna: i detta fall vulvan.

42. Hur ofta utför du Mindfulness eller någon form av meditation?

- ◯ Aldrig
- ◯ En gång om året
- ◯ En gång i månaden
- ◯ En gång i veckan
- ◯ En gång om dagen
- ◯ Mer än en gång om dagen

43. Välj det alternativ som passar dig bäst. 1= Mycket negativ, 7= Mycket positiv

	Mycket negativ						Mycket positiv
Vad är din inställning till Clitfulness?	◯	◯	◯	◯	◯	◯	◯

44. Välj det alternativ som passar dig bäst. 1= Nej, inte alls, 7= Ja, definitivt

	Nej, inte alls						Ja, definitivt
Tror du att Clitfulness kan förbättra din sexuella hälsa?	◯	◯	◯	◯	◯	◯	◯

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APPENDIX 3

SCORING

FSFI DOMAIN SCORES AND FULL SCALE SCORE

The individual domain scores and full scale (overall) score of the FSFI can be derived from the computational formula outlined in the table below. For individual domain scores, add the scores of the individual items that comprise the domain and multiply the sum by the domain factor (see below). Add the six domain scores to obtain the full scale score. It should be noted that within the individual domains, a domain score of zero indicates that the subject reported having no sexual activity during the past month. Subject scores can be entered in the right-hand column.

Domain	Questions	Score Range	Factor	Minimum Score	Maximum Score	**Score**
Desire	1, 2	1 – 5	0.6	1.2	6.0	
Arousal	3, 4, 5, 6	0 – 5	0.3	0	6.0	
Lubrication	7, 8, 9, 10	0 – 5	0.3	0	6.0	
Orgasm	11, 12, 13	0 – 5	0.4	0	6.0	
Satisfaction	14, 15, 16	0 (or 1) – 5	0.4	0.8	6.0	
Pain	17, 18, 19	0 – 5	0.4	0	6.0	
			Full Scale Score Range	2.0	36.0	