

Female Genital Cosmetic Surgery

Psychological Aspects and Approaches

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Background: Women and Cosmetic Surgery

According to the 2016 report of the American Society of Plastic Surgeons [1], the number of people seeking cosmetic surgery continues to rise, with an increase of 3% from the previous year. The majority (92%) of the consumers were women. This amounted to a total of 17.1 million cosmetic surgeries performed in the United States. Breast augmentation remains the most popular and common cosmetic procedure, with more than 290,000 American women receiving breast enhancement in 2016, up 4% from 2015 and up 37% since the year 2000.

Empirical research on psychological factors in the uptake of breast augmentation is sparse. Some research has studied background psychological and personality characteristics. A review of 65 studies found that in general, women who sought cosmetic surgery were more likely to have a narcissistic personality (25% of those seeking surgery vs. 1% of the general population) defined by an unexplained grandiosity and need for admiration [2]. The review also found those seeking cosmetic procedures are more likely (10% of the patients vs. 1.8% of the general population) to have a histrionic personality, defined in terms of attention-seeking behaviour and extreme emotionality.

Women seeking breast augmentation are more likely to be Caucasian, in the age range of 20s to mid-40s, thin and tall, well educated, and have a higher likelihood of a history of depression and anxiety [3]. They are also more likely to be a smoker, to regularly consume alcohol, and to have had a psychiatric hospital admission in the past [3]. A study by Moser and Aiken [4] applied the Theory of Planned Behaviour to explore intentions for seeking breast augmentation, from both positive and negative cognitive and emotional perspectives. Through a combination of 11 focus groups and subsequent questionnaires administered to

400 women who were considering breast augmentation, they found that women's intentions were significantly predicted by anticipated regret (i.e., women expecting to regret the surgery were less likely to seek surgery), and subjective norms and attitudes (i.e., women attuned to the approval from others were more likely to seek surgery). Women's indirect attitudes, such as expectations for better self-image, enhanced sex appeal, and better perceived appearance were associated with lower levels of anticipated regret over having the breast augmentation. The findings from this study suggest that psychosocial factors can predict cosmetic surgery uptake and outcome. Psychosocial research could therefore usefully inform psychological assessment and interventions.

Psychological Factors and Female Genital Cosmetic Surgery

Although female genital cosmetic surgery (FGCS) was not among the top five most popular cosmetic surgeries in the 2016 report of the American Society of Plastic Surgeons [1], it was notable that FGCS was up 39% in 2016 from 2015, an increase that was greater than in every other type of cosmetic surgery. Though systematic reviews have yet to be conducted on the characteristics of women seeking FGCS, insights into personality types and motives for surgery may be drawn from the literature examining other individuals who seek cosmetic procedures. Some argue that women seeking breast augmentation share similar traits to women seeking FGCS given that both entail alteration to parts of the body associated with female sexuality, although the surgical procedures are clearly different, with different possible complications. Indeed, among women seeking FGCS, previous breast augmentation was the most common prior cosmetic procedure obtained by this group [5].

Among the different types of FGCS, labiaplasty, or surgical alteration to the labia majora and minora, has become the most popular surgery, founded on widespread denigration of female genitalia. Often described as a passive receptacle for the penis, female genitals have been depicted as disgusting, sexually inadequate, vulnerable/abused and even dangerous [6]. The problem-saturated views of female genitalia have undoubtedly impacted on how women view female genitals including their own [6]. A study with young adult women showed a clear relationship between women's perceptions of female genitalia and their own genital self-perceptions [7].

Anxiety associated with perceived vulvar anomalies has undoubtedly increased over recent decades. Hairless, undefined vulvas that have no protruding labia minora have been increasingly emphasised in Western culture and media [8–10]. Women have become more self-conscious of their genitals as a result of these depictions [3,11,12]. Pubic hair removal has thus become popular if not normative and further draws attention to vulvar appearance details [13], in private and public spaces (e.g., communal showers). Women's preference and perception of 'normal' is now the 'Barbie doll ideal' [8]. For example, women will rate vulvar images as more 'normal' and 'representative of society's ideal' with digital and surgical modifications [14].

In reality, the notion of 'normal' is a fallacy given that, like snowflakes, no two vulvas look the same. Their size, shape, texture and colour vary enormously; these variations are not reliably predicted by differences in ethnicity, hormone use, sexual history and other personal and demographic dimensions [15]. Sexualising media have helped to construct a 'designer vulva' that minimises naturally occurring normal variations [16].

Given the subjectivity in the perception of what is 'normal' when it comes to vulvar appearance, there is a critical need to consider the key role for psychological factors in women's genital self-perceptions, dissatisfaction and the desire for cosmetic alteration. However, the literature on psychological predictors of FGCS is not only sparse, but biased, owing to the expectancy of patients and the surgeon carrying out costly assessments. For example, women may downplay any negative or judgemental attitudes that could be perceived as contributing to their requests. Among the existing studies that have examined psychological characteristics of women seeking FGCS, there is

evidence for the influence of personal negative judgements and evaluations, perceived partner-related dissatisfaction and perceived negative evaluations by others. In order to adequately consider each of these domains in the context of a psychosocial assessment of women seeking FGCS, it is important to explore each of these in turn.

Personal Factors

A Google search of 'labiaplasty' in 2018 produced 1.32 million hits. Google analytics keep track of such searches generated by high-risk women, and increase direct-to-consumer marketed advertisements that offer low-cost procedures, feeding the consumer market that thrives off self-conscious women [17–20]. In a general sample of women, self-esteem is significantly and negatively associated with satisfaction with genital appearance, suggesting that women with low self-esteem may be particularly vulnerable to appearance schemas (defined as cognitive structures that organise one's experience and actions related to their appearance) [21], though in another study there were no significant differences in self-esteem between women who were and those who were not seeking FGCS [3]. There is significant pressure on women to meet impossible and unrealistic beauty standards. These findings suggest that women with low self-esteem are especially at risk, leading to a vicious cycle such that women's insecurities about their body lead to more exposure to, and vulnerability of, FGCS practices that promise to quell anxieties and raise satisfaction. Indeed, aesthetic dissatisfaction is the leading reason for seeking FGCS and supersedes functional reasons such as vulvar discomfort or pain [22].

In the only controlled study of women seeking FGCS ($n = 55$) versus those who were not ($n = 70$), the surgery seekers had a lower overall quality of life and body image, although they were no more likely to experience anxiety and depression than the control group [23].

Some women may seek FGCS as a means of improving sexual function. Sexual difficulties affect up to a third of women across ages [24], and psychological factors, such as depression, anxiety and body image, are strong predictors of women's sexual response and satisfaction [25]. Some advertisements for FGCS promise to improve sexual function, and according to a short-term retrospective study conducted by the surgical providers, 92% of their patients and their partners reported satisfaction and improved sexual responses with vaginal

tightening and labiaplasty [26]. In the only prospective study to evaluate the effects of FGCS on sexual response, only 18 of the original 33 women evaluated at pre-surgery completed post-surgery measures of sexual function, and even fewer completed the follow-up 6–9 months later [27]. Most measures of sexual response did not significantly change post-FGCS. Thus, whereas sexual satisfaction improved at immediate post-surgery, rates fell back to baseline levels when women were assessed at follow-up.

The lack of a control group and the bias inherent in having the treatment team conducting the assessments means that the reliability of these findings is questionable (see Chapter 6, this volume). Given how common relationship and sexual difficulties and dissatisfaction are for women, including younger women [24,28], the promise of positive sexual outcomes would be a compelling motivation to seek cosmetic genital procedures. However, women are not likely informed that the impact of these surgical procedures on the underlying vascular and neural pathways that contribute to sexual response and pleasure is totally unknown (Chapters 2 and 9, this volume).

In summary, although women may seek FGCS to increase sexual desire and/or improve sexual response, at present there is no evidence to suggest that these expectations are met, especially over the long term. The implications for counselling women seeking FGCS are considered in a later section.

Perceived Partner-Related Dissatisfaction

As a group, women seeking cosmetic labiaplasty are more self-conscious, believe that they are less attractive to their partner, and tend to be less satisfied with their lives overall [3,29]. Being in a relationship seems to buffer somewhat against these negative psychological attributions [3]. Although women seeking labiaplasty are concerned that partners do not find them attractive [29], there is evidence that partners themselves have more favourable views than the women might expect [7]. Given women's distorted views about their partner's perception of their genitals, it can be useful for women who are in relationships to be accompanied by their sexual partner at the pre-surgery assessment. This has the advantage of allowing a clinician to identify partner-related perspectives and to gauge whether outcome expectancy is realistic. In a controlled comparison of one group of women seeking and another not seeking FGCS, there were no group differences in the women's reported relationship satisfaction [3]. The

authors concluded that women are not likely to be seeking FGCS as a means of improving relationship satisfaction. Nonetheless, women may still be having specific worries about a partner's view of her genitals, even if the overall relationship was unproblematic.

Perceived Negative Evaluations by Others

In one of the few studies comparing women seeking FGCS to a control group [3], the influence of media ideals and women's internalisation of those ideals differed quite significantly between groups. Those seeking FGCS were more likely to have seen more media images and expressed a stronger desire to resemble those images. In particular, internet images and exposure to advertisements for FGCS were identified as predictors of wish for FGCS [3]. This replicated findings in other studies [11,30].

Negative evaluation by others or negative comments about female genitals made by others can also impact on female genital self-image. In one study, a third of the women who sought FGCS had experienced negative comments by partners, family members or friends [31]. Bullying behaviour is known to contribute to self-consciousness, poor psychological functioning and increased desire for cosmetic procedures in teenagers [32]. It is therefore especially important that during the consultation, the clinician assesses whether there have been harmful comments by others, and whether these comments were actual, perceived or anticipated.

Body Dysmorphia and Perceptual Distortions

Body dysmorphic disorder (BDD) is a diagnosis in the Fifth Edition of the *Diagnostic and Statistical Manual of Mental Disorders* [33] and characterised by one or more perceived defects or flaws in physical appearance. The perceived flaw may be not observed or observed only minimally by others. Nevertheless, to the person affected, it evokes clinically significant distress or impairment which is associated with compensatory behaviours such as mirror checking, reassurance seeking and/or comparing her appearance to that of others. BDD typically begins in adolescence and can have a chronic course punctuated by remissions and relapses [34]. People with BDD make maladaptive interpretations of their appearance, leading to increased anxiety, depression and unhelpful behaviours [35].

BDD is more prevalent among cosmetic surgery users. Only 2% of the general population meet formal criteria for BDD [34] compared to 18–20% of women requesting labiaplasty, according to some studies [20,23]. This is in line with the 14–24.5% prevalence in people pursuing aesthetic surgery [35]. Although there could be short-term improvement in BDD symptoms, cosmetic surgery does not lead to long-term improvement of BDD symptoms [34,35]. While only a proportion of women seeking FGCS would meet formal diagnostic criteria for BDD, we strongly recommend that BDD is part of a comprehensive psychological assessment before surgery. Guidelines for the psychological assessment of BDD among women seeking FGCS are outlined in a subsequent section.

Gaps in Research on Psychological Factors

The literature is scant when it comes to evaluating the psychological characteristics of women seeking FGCS. Even less is known about the psychological, relational and sexual outcomes of FGCS. More importantly, among the existing studies, this literature suffers from significant methodological limitations. These are outlined in Table 13.1, in which strategies for future research are also suggested.

Role of the Medical Expert

This topic is addressed in detail in Chapter 12 (this volume). Suffice to say that physicians at the point of entry into the medical system play a crucial role in beginning the process of critical psychoeducation for women seeking FGCS [37] influenced by factors such as appearance concerns, physical discomfort, media influence, genital shame and perceived partner expectation [38]. Most women requesting labiaplasty have normative labial dimensions [39]. Visible labia minora are as common as recessed labia minora [40]. The viewing of manipulated vulval images can negatively influence a woman's perception of what she considers normal and desirable [14,41], while viewing of images of natural vulvas can improve genital self-image [42]. We strongly recommend that health care providers keep a variety of educational resources in their office setting including, for example, picture books like *Petals* [43], educational websites like the Labia Library [44] and Great Wall of Vagina [45] and videos such as Labiaplasty [46] (see also Resources in the appendix). Surgery should never be offered on the initial consultation and never to teenage girls whose genital development is as yet incomplete [37,39]. Adolescents should be supported in their exploration of identity and self-concept rather than being operated on [20].

Table 13.1 Methodological limitations in research on psychological factors associated with FGCS

Existing limitation	Proposed alternative for future research
Sample sizes tend to be very small.	Studies need to be powered to detect significant differences. Effect sizes, response rates and attrition rates at follow-ups should be reported in all studies.
Studies do not include a comparison group of women with similar demographic profiles.	Demographically matched groups of women not seeking FGCS need to be included.
Retrospective design	Outcomes should be measured before and after surgery and at a future follow-up time point.
Participants are recruited from specialty and/or private clinics that offer FGCS, which may bias outcomes given that women have typically paid expenses out-of-pocket for such procedures, and cognitive dissonance theory, which posits that people seek to have harmony between behaviour (spending money on cosmetic procedures) and beliefs (seeking FGCS is a good thing), is at play.	Recruitment should be broader, from public hospitals and health centres. There is a critical need for future research to take account of cognitive dissonance factors in women's self-reported FGCS outcomes.
Lack of long-term follow-up of women who have received FGCS – there is preliminary evidence that even when there are self-reported improvements after surgery (at least in the domain of sexual satisfaction), these tend to disappear by 9-month follow-up [27].	Women should be assessed in the long-term follow-up.
Regret long after the surgery is not typically measured, yet may impact outcomes.	Together with measuring cognitive dissonance [36], efforts should be made to measure regret.

Role of the Psychological Expert

The probing for pre-existing psychological factors such as poor self-esteem, eating problems and tendencies to anxiety require the skills of a psychological clinician. In our experience, this kind of integrated care is far from typical in the cosmetic surgery industry. Nevertheless, we strongly recommend that every woman seeking FGCS undergoes a comprehensive psychosocial and psychosexual assessment by a qualified mental health expert. The components of this assessment, as outlined in Table 13.2, should include (1) motivations for FGCS; (2) assessment of psychiatric symptoms and diagnoses, including BDD; (3) assessment of body image, self-esteem and genital self-image; (4) sexual and relationship factors, including current sexual response and expectations of change with surgery; and (5) exposure to and influence of media ideals, and associated perceptions of others' evaluations.

Assessing for Body Dysmorphic Disorder

We recommend that the provider carry out a thorough assessment of BDD using the criteria laid out by the DSM-5 [33]. A diagnosis of BDD is a predictor of

poorer psychosocial outcomes after cosmetic surgery [47], and effort should therefore be made to screen for BDD in advance. This entails a careful, respectful and Socratic-style questioning of preoccupations with the appearance of the genitals. In some cases, we would recommend the use of a validated assessment of BDD, such as the Body Dysmorphic Disorder Questionnaire [48] which can be used as a screening tool, or the Body Dysmorphic Disorder modification of the Yale-Brown Obsessive-Compulsive Scale [49] as a much more detailed assessment of BDD.

Furthermore, as symptoms of BDD may overlap with symptoms of a social anxiety disorder [33], the latter should also be part of the assessment. Essentially, it is important to decipher whether the woman's fear of being negatively evaluated by a partner or by others is due to her appearance or to a more general fear of being embarrassed.

Psychological Treatment Strategies

Depending on the range and severity of distorted body-related thoughts experienced by the woman seeking FGCS, and by the range and intensity of the

Table 13.2 Outline of a psychosocial and sexual assessment for women seeking FGCS

Motivation for FGCS	Assess for motivations related to perceived physical flaw in genital appearance, concerns about appearing abnormal, physical discomfort and pain. Given that women may be highly motivated to receive FGCS and aware of barriers or difficulties toward that end, women may minimise psychological motivations and emphasise functional ones.
Assessment of psychiatric symptoms and diagnoses, including BDD	A history of anxiety and depression are significant risk factors for poor psychosocial outcomes after cosmetic surgery and must be assessed. This includes history as well as current symptoms of an anxiety disorder and major depressive disorder, as well as subthreshold clinical syndromes. Given that women with BDD are more likely to seek cosmetic surgeries of all types, it is important that the clinician assess for the symptoms of BDD and determine the extent to which perceived distortions of the genitals are contributing to the desire for FGCS.
Assessment of body image, self-esteem, and genital self-image	Assess general attitudes to female genitalia and the individual's perceptions of her own genitals. Ask about her perception of normal and consider showing photos of a range of vulvas during this assessment to gauge reactions on the perception of what is normal. Assess self-esteem by asking questions about the woman's life more generally and her feelings about key aspects of her life.
Sexual and relationship factors, including current sexual response and expectations of change with surgery	Ask about all domains of sexual function: desire, arousal, lubrication, orgasm, sexual satisfaction and sexual pain. Validated measures can also be used. Inquire about the woman's expectations about the impact of FGCS on sexual functioning. If in a relationship, ask about partner's own sexual function, and her perceptions of the partner's view of her sexual functioning. Ask about pressure placed on her by a partner to seek FGCS, and whether this pressure is actual or perceived. If possible, try to assess the partner separately to inquire about the woman's reasons for FGCS. This might also include asking about partner's perceptions of the look of the woman's genitals and what has been expressed.
Exposure to and influence of media ideals, and associated perceptions of others' evaluations	Inquire about exposure to pornography and the woman's attitudes, beliefs and emotions when viewing such images, and how those images might have influenced her wish for FGCS. Assess for negative evaluation by others or negative comments about female genitals made by others. Bullying behaviour is known to contribute to self-consciousness and poor psychological functioning, so that a desire for cosmetic procedures in teenagers should be assessed.

associated emotions, an individualised psychological treatment plan may be required. Ideally, this would be offered as an alternative to FGCS. There is, however, as yet no evidence that psychological interventions can reduce the prevalence of FGCS. In our own experience working within a multidisciplinary team in a large metropolitan centre, however, targeted psychological therapy can prevent or delay surgery in the majority of cases. Even if the woman has already decided on surgery, should there be clear indications for psychological interventions, they could take place post-surgery at some point.

Based on the generic empirical literature for body image concerns and distortions, we recommend individually tailored applications of psycho-therapeutic techniques drawn on: (1) behaviour therapy, (2) cognitive behavioural therapy, (3) mindfulness-based therapy and (4) sex therapy.

Behaviour Therapy

Behaviour therapy focuses on identifying problematic behaviours including avoidance. This type of work focuses on helping people to take a step at a time to distract from, delay, or inhibit performing unhelpful behaviours and on taking up more adaptive new behaviours. A component of behaviour therapy is exposure. This involves the progressive and systematic exposure to what is feared or avoided, in this case an area of the body, that elicits anxiety and shame. By building exposure to the feared object or situation, anxiety will progressively decrease. This is often part of a program known as systematic desensitisation [50]. For example, in the case of a woman with genital image concerns, she may be guided to first construct a hierarchy of fear or aversion. The hierarchy may include items such as looking at an image of a vulva in a book using, e.g., available resources [43–46], looking at a vulva in a video online, looking at her own vulva, inspecting her labia more closely with a hand-held mirror, asking a partner to look closely at her vulva and so on. These items are rank ordered on the hierarchy and the woman is exposed to the easiest item and progresses to the more challenging ones. After several weeks of consistent practice, she may be able to progress to the most distressing item (e.g., asking a partner to look closely at her vulva) with significantly less, or hopefully minimal, distress.

Another configuration of mirror exposure technique may involve the woman fixing her gaze on her reflection in the mirror, and describing her body from head to toe, and then from toe to head, using neutral

descriptive language and avoiding judgement or value-laden words as if ‘describing it to a blind person’ [51]. Three sessions administered to women with significant body-related concerns were sufficient to significantly reduce body checking, body image avoidance, body dissatisfaction, depression and low self-esteem. Since this intervention combined exposure therapy (sustained looking at the feared object) together with mindful describing without judgement, the authors were not able to decipher which aspect of the treatment contributed to the positive outcomes. It seems that either modality, or their combination, would be suitable for women with concerns about vulvar image. More information about mindfulness-based approaches appears in the text that follows.

Cognitive Behaviour Therapy

Cognitive behavioural therapy (CBT) has been widely used in the treatment of body image distortions since the early 1980s. CBT rests on the premise that problematic thoughts which elicit negative emotions and behaviours have been learned and can be unlearned. Cognitive aspects included having participants challenge their own (typically distorted) perceptions of their body and replacing those with more accurate, balanced and compassionate thoughts. This approach entails teaching clients to observe how such negative thoughts make them feel (e.g., disgust, shame, fear, embarrassment) and act (e.g., avoid looking, looking obsessively, comparing to media images, etc.). By addressing the underlying unhelpful thoughts, clients can have a different emotional experience and behavioural outcome. CBT approaches to body image distortions have long been supported by the evidence [52] and, when compared to other stand-alone psychological treatments, have been shown to be highly effective [53]. Moreover, the benefits of CBT on body image persist even after therapy has ceased [54].

A Cochrane Review of the evidence finds CBT to be highly effective in the treatment of BDD [54]. However, we could not locate any specific study that directly evaluated CBT for the treatment of genital image concerns in women seeking FGCS. Nonetheless, given that this population of women experience cognitive, emotional and behavioural difficulties associated with their view of their vulvas [55] and the existing evidence for the efficacy of CBT for body image distortions more generally, a cognitive behavioural approach seems promising for women with genital image concerns.

Mindfulness-Based Approaches

Some of the behavioural exposure-based treatments for women with body image distortion involved having women describe out loud what they saw when they examined their body in a mirror. They were told, “Let your thoughts and emotions flow and do nothing to counter them” [56]. Such an approach decreased body dissatisfaction and emotional discomfort when women viewed their bodies. Although this approach was described as exposure therapy, and thus classified as a behaviour therapy intervention, the instruction of observing emotions and sensations without action falls in line with the broad array of mindfulness-based skills.

Mindfulness-based interventions evolved out of the work developed by Jon Kabat-Zinn and co-workers at University of Massachusetts Medical School from the late 1970s and tested originally in patients suffering from chronic and debilitating pains [57]. Mindfulness approaches involve moment-by-moment self-direction of attention to a particular target, such as the breath, body, sounds or thoughts. Sensations are observed compassionately and non-judgementally. An internet-based program of compassion training for undergraduate women with body image dissatisfaction included a compassionate body scan, an affectionate breathing exercise and a loving-kindness meditation focused on the body [58]. There were significant reductions in self-criticism and body image distress with the online treatment, but no changes in self-compassion itself. In the context of women experiencing genital self-image distortions, women may practise attending to physical and/or visual sensations of the vulva, and noticing those sensations moment-by-moment while letting go of the tendency to negatively label the area or the sensations.

Acceptance and commitment therapy (ACT) is considered a type of mindfulness-based intervention which rests heavily on the identification and clarification of the client’s values. An unpublished doctoral dissertation by Anna Katherine Smith explored ACT as a treatment for women’s genital and body dissatisfaction [59]. Smith developed a group intervention based on the principles of ACT that targeted genital self-image, sexual self-esteem, sexual openness and general body image. There were six 90-minute weekly sessions led by two experienced ACT facilitators and participants were college students with genital image concerns. The results of this excellent and comprehensive program are not yet available.

Sex Therapy

Approaches borrowed from sex therapy may be useful for the subgroup of women seeking FGCS who are particularly distressed about their sexual functioning, and/or believe that their partners are distressed about their sexuality and that FGCS will improve sexual satisfaction. Among the various sex therapy techniques utilised and studied over the past decades, sensate focus would be a suitable technique among this population. Sensate focus is a structured behavioural exercise developed by Masters and Johnson [60] and originally designed to address the widespread experience of anxiety that they observed in the men and women seeking sex therapy.

There are three stages to sensate focus: Stage 1 focuses on sequential touching of one partner and then the other, excluding the breasts and genitals, during which the giver of the touch was guided by his own curiosity, not by what he believed his partner liked. The recipient of the touch provided verbal feedback to the toucher about the qualities of the touch. After approximately 15 minutes, roles were reversed and the toucher now became the touchee. There was a focus on sensual, rather than erotic, pleasure, and overt sexual activity was often prohibited during the period of sensate focus practice. Stage 2 now included breast and genital touch and the goal remained to learn about the partner’s body, rather than the overt creation of pleasure. Stage 3 involved mutual touching with the progressive reintroduction of intercourse. The therapist sought to monitor the couple’s responses to prescribed homework activities, and would emphasise positive reinforcers while removing negative ones.

The outcomes of sensate focus have been studied systematically and Masters and Johnson found success rates in the range of 72–98% following sensate focus when it was practised daily, and only a 5% relapse rate after 5 years (1960). To this day, sensate focus remains a very popular technique [61] used for couples where there may be anxiety associated with sexual activity, perceptions of negative outcomes during a sexual encounter, significant distractions during sex or intense negative emotions associated with the encounter.

For women who are distressed about the look and feel of their genitals, sensate focus may offer them an opportunity to remain in the present moment while a partner touches the entire body, including the genitals. It may help the women to tune into positive

sensual feelings while her eyes are closed, and it may enforce the role of relaxation while receiving touch, which gives way to subsequent sexual arousal. Though sensate focus has never been evaluated for addressing sexual or body image concerns among women seeking FGCS, our own clinical experience demonstrates its enormous utility. Future studies should seek to evaluate sensate focus in this population.

Although techniques drawn on behaviour therapy, CBT, mindfulness-based approaches and sex therapy can be useful in the treatment of women with genital image distress, the literature is scant on the evaluation of such approaches. We advocate strongly for researchers to evaluate their use of these strategies among women seeking FGCS.

Case Study 13.1 Leanne's Story

Leanne, a 24-year-old healthy young woman, was referred to her gynaecologist from her primary care provider after reporting increasing levels of anxiety and depression related to unhappiness with the size and shape of her labia. The gynaecologist carried out a clinical assessment and physical examination and concluded that Leanne was completely normal and that no labiaplasty would be offered. Leanne became extremely distressed. She agreed to be referred to a psychologist. The psychologist carried out a more extensive psychological and psychosexual assessment.

Leanne revealed that her reason for attending the appointment was to get the psychologist's approval for her to have surgery. She sought labiaplasty to reduce the asymmetry of her labia minora and to reduce the amount of protrusion. Leanne explained that for most of her life she had experienced discomfort from her labia "rubbing against one another" and that this had led to a need to "go to the bathroom five or six times per day to adjust myself". She noticed more discomfort during times of exercise and other outdoor activities, which she engages in avidly. On a scale of 0 to 10, Leanne rated the degree of her labial distress as 7 and said that her concerns had limited her physical activities such as running. She denied any vulval pain, and mainly expressed only discomfort.

When asked about her perception of normal vulval appearance, she revealed having consulted online media depicting women's genitals in the past year or so. The sources of those media tended to be pornography, which she reported that her boyfriend of the past 18 months had been viewing regularly. On occasions when they viewed pornography together, Leanne would fixate on

the small size of the actresses' labia and repeatedly ask her boyfriend if he preferred the vulvas of the actresses to her own. She would usually dismiss his reassurances.

Leanne's responses to a validated inventory suggested that she met criteria for BDD. On further probing, it was evident that she also felt dissatisfaction and discomfort about her body more generally. However, she felt that labiaplasty would improve her sexual function and mood, and the quality of her relationship. She worried about the impact of not having surgery, including her current partner leaving her.

In terms of mood, Leanne reported current symptoms of generalised as well as social anxiety and periodic episodes of depression throughout her teenage years. She reported one uncued panic attack several years ago. She described a moderate level of current stress that is likely attributable to balancing the demands of her university education, participation on a varsity athletic team, and involvement in her community as a volunteer. She reported trying to distract herself when she thought about her labia but found that it did not help. She appeared to understand the risks associated with labiaplasty. She has discussed this with a close friend of hers, who apparently encouraged Leanne to seek surgery.

Given Leanne's intrusive thoughts, and anxiety surrounding the fate of her current relationship, Leanne was encouraged to delay considering FGCS and instead focus her efforts on self-acceptance and address some of the biased and inaccurate beliefs she held about her body. The psychologist told her to consider putting surgery on hold, at least temporarily, and that if she still wished to pursue it in 3 months' time after completing a course of psychological therapy, the psychologist would explore this with her at that time. Leanne was diagnosed with Social Anxiety Disorder and BDD, and together with the psychologist, embarked on a 10-week program focusing on cognitive behavioural therapy as well as some components of mindfulness meditation. They agreed to meet weekly for an hour-long session.

In the initial stages of treatment, Leanne was taught to notice negative thoughts about her vulva when they happened. She tracked her mood, activity, and any precipitating events or thoughts prior to those irrational ones. With time, she discovered that she was more likely to have negative thoughts about her vulva when watching pornography, when changing in the locker room after sports, and in general when she was anxious or stressed about school. She

was also taught to monitor her body sensations in response to those thoughts, and she found great relief in learning to practice progressive muscle relaxation. She learned that negative thoughts about her vulva triggered a series of physical reactions in her body, such as increased muscle tension, chest breathing, and light-headedness. She also learned, through CBT, that this constellation of body sensations led her to be even more vigilant about her body.

The psychologist also integrated into the treatment mindfulness meditation skills. Specifically, Leanne learned to view negative thoughts as passing mental events in the more spacious mind and that these events were neither factual nor needed to be followed up. She practised meditation to online instructions at least 15 minutes per day, and after approximately a month, she became more able to experience without reaction negative and judging thoughts as passing events. Over the course of our 2 months, Leanne's perceptions about her partner began to loosen, and she no longer believed that he would leave her.

By the end of 10 weeks, Leanne experienced a significant reduction in her anxiety associated with negative thoughts about her body. She was more able to de-escalate unhelpful thoughts when she noticed that they were beginning to arouse distressing emotions in her.

Conclusion

Women seeking FGCS may experience an array of psychological symptoms including anxiety, depression, poor body image and low self-esteem. Health care providers should be equipped to assess whether psychological symptoms are present, and evaluate the extent to which these are impacting the woman's desire for surgery. Whenever possible, we strongly advocate for the inclusion of a psychological assessment by an experienced practitioner, to adequately evaluate the psychological factors and work collaboratively with the physician. Where BDD may be contributing significantly to the body distortion and distress, we strongly recommend against pursuing FGCS and encourage the patient to acquire some psychological strategies to address the BDD first. There is a need for additional research on the long-term psychological outcomes of women seeking FGCS, whether they received surgery or not. Given the evidence of the benefits of psychological skills borrowed from behaviour therapy, cognitive behaviour therapy, mindfulness-based interventions, and sex therapy, we recommend that these approaches be

utilised when working with women's genital image concerns, whether or not the women are currently seeking FGCS.

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