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The Effect of Sexual Assertiveness Training on Women's Genital Self-image: A Randomized Clinical Trial

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ABSTRACT

Background & aim: The genital self-image refers to women's attitudes, beliefs, and feelings about their genitalia and genital system that are involved in sexual intercourse. Sexual assertiveness is individuals' ability to meet their sexual needs. Considering the dearth of study on women's genital self-image, this study aimed to evaluate the effectiveness of a sexual assertiveness training program on women's genital self-image.

Methods: This parallel randomized clinical trial was performed on 60 married women referred to Imam Reza Health Center in Mashhad during September and October 2016. A sample size of 30 subjects was assigned to intervention and control groups. The training classes including two 90 minutes sessions were held once a week for 2 consecutive weeks. The tools for data collection consisted of Hulbert sexual assertiveness and women's genital self-image questionnaires. A pretest was completed in two groups at the beginning of the study and a post-test was done for both groups one week after training the intervention group. To analyze data student t-test, paired t-test, Mann-Whitney, Wilcoxon, Chi-square and one-way analysis of variance were used.

Results: The score of genital self-image was the same in two groups before carrying out the intervention ($z= -1.762$, $p= 0.780$). However, following the implementation of training program the two groups showed significant differences and the score of genital self-image was higher in intervention group ($z = - 4.077$, $p < 0.001$).

Conclusion: Sexual assertiveness training can improve women's genital self-image. So it is recommended to tailor training programs to enhance women's genital self-image, particularly, in women with sexual dysfunction in order to improve their sexual health.

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Introduction

The genital self-image refers to women's attitudes, beliefs, and feelings about their genitalia and genital system that are involved in sexual intercourse (1, 2). These attitudes are generally based on a complex combination of factors including the sexual practice, behavior, and experience that women have during their sexual life. A positive body image may facilitate the mental experience of sexual desire and practice, while a negative body image may impede sexual experience and practice (1). The women's body image is mostly exquisite, rather than holistic. Accordingly, body organs may be evaluated individually and unequally. Studies of body image assessment dissatisfaction confirm that somebody organs are more vulnerable to negative self-assessment than other organs. For instance, fewer women (from 500 women's in a study) express dissatisfaction with their own face (11-20%) than those who complain of the middle trunk (50-57%) or lower trunk (47-50%) (2). The individual mental image and

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feelings about sexual behavior, organs, and gender can affect sexual functions (3).

Assertiveness is the ability to express feelings, beliefs, and thoughts and defend self-rights in a rational way, including the following three dimensions: 1) ability to express feelings, 2) ability to express openly pleasant and unpleasant thoughts and beliefs and make a clear and decisive decision even if it deprives them of advantages or is difficult to be emotionally performed, and 3) ability to sustain the self-right assertiveness and prevent others from harassing or abusing a personal weakness (4). Sexual assertiveness is a psychosocial-asocial feeling that is defined by one's personal interpretation of how to express feelings in sexual relations (5). In many societies, women have difficulty in their sexual assertiveness and have low self-esteem, and thus it is difficult for them to express their needs or maintain their independence in sex (6). Lack of attention to the importance of sexual problems in marital relationships largely damages the couples' relationship (7). In Iran, most of women suffer from inattention to their sexual demands, and 50-60% of divorces and 40% of betrayals and secret relationships are also due to this reason (8-10). Problems about sexual issues, such as the lack of sexual desire and sexual dysfunction, are hidden and unexpressed probably because of fear and anxiety, shame and embarrassment, or feeling of inadequacy and guilt. In particular, women do not express symptoms of such problems due to modesty, and thus the hidden sexual problems will be manifested in other symptoms, such as physical diseases, depression, and dissatisfaction with the marriage (11). According to research by Schick et al. (2010) on 217 female students, a higher dissatisfaction with the appearance of genitalia is along with more self-awareness of this organ during the sexual intercourse, and it thus results in lower sexual self-esteem, less sexual satisfaction, and lower motivation to avoid high-risk sexual behavior. These findings emphasize the destructive impact of negative perceptions of genitalia on the sexual health of young women (12). In another study on male and female students, Reinholtz et al. (1995) indicated that women had a more negative attitude towards their genitals than men and felt more concerned about their sexual partner's reaction to their genitals; there was a significant positive relationship between the perception of genitals and sexual activity (13). Similarly, results of research by Morrison et al. (2005) on female students in Canada indicated that a good understanding of genitals had a positive relationship with sexual self-esteem, but a reverse relationship with self-awareness of body image and sexual anxiety (14). Women, who do not have good feelings about the efficiency and appearance of their genitals, may feel more ashamed of sexual intercourse with their partners, and this can lead to less arousal and more pain during the sexual intercourse. Results of qualitative studies have also indicated that many women with dyspareunia had feelings of guilt, shame, embarrassment, failure, and loss. In addition, these women considered themselves abnormal and incomplete, had a negative attitude that led to its generalization to all their genital organs, and considered this organ a dead and useless part of the body (1).

Sexual problems often have roots in educational deprivation and false beliefs about sexual desire and intercourse (15). The lack of proper information about women's sexual rights and finally its adverse consequences on marital relationships indicates the importance and urgency of this issue (16). Sexual assertiveness training includes attitudes and behaviors associated with the initiation of sexual relationships, as well as behaviors related to sex refusal. Only a few studies have looked at sexual assertiveness (17, 18). Studies on the impact of sexual assertiveness on self-assertion, self-esteem, and interpersonal relationship satisfaction revealed substantially higher than interpersonal relationship satisfaction scores (18). According to Amini et al. (2015), sexual education using a cognitive-behavioral approach influenced both positive and negative aspects of couples' self-image (19). Despite the importance of the findings of this study, no substantial variations in sexual assertiveness training have

been observed in some studies. The mean scores of participants in the workshop on sexual assertiveness training and the control group did not vary in an intervention study on female students with the aim of sexual assertiveness training.

Sabbaghan found that the training package did not affect genital self-image and sexual function (19). A group of researchers criticized the sexual assertiveness training for women, and some of them believed that sexual assertiveness training for women decreased the sexual desire in men (20).

There are only a few ideas about how sexual assertiveness impacts marital life and how it interacts with other marital issues (17). Women now have a better understanding of their rights in sexual matters; however, there is still a lack of awareness and expertise in this field.

Even though information on sexual issues is not scarce, there are issues on low sexual knowledge in relation to women, the taboo aspect of talking about sexual desires, and women's complaints in society (21). In addition to the genital self-image and women's perception of their genitalia (22), 89% of women expressed dissatisfaction with the appearance of their genitalia and considered it abnormal (12, 23, 24). Besides, there is scarce documentation about the impact of sexual assertiveness education on the genital self-image. Therefore, the present study sought to determine the impact of sexual assertiveness education on the genital self-image in women who were referred to health centers of Mashhad city in Iran.

Materials and Methods

In this study 60 married women referred to Mashhad Imam Reza Health Center in 2016, participated. This study is a randomized clinical trial assignment parallel study with a control group. The study was registered at the Iranian Clinical Trial Registration Center (IRCT2016062628650N1) and was approved by the Research Council of Mashhad University of Medical Sciences. The sample size formula was used to assign 24 subjects per category (= 0.05, Z1-2 =1.96, d = 0.6, = 0.1) using a reliability coefficient of 95% (= 0.05), a test power of 90%, and the formula for the comparison of means (= 0.05, Z1-2=1.96, d = 0.6, = 0.1). The number of subjects was projected to be 30 women per group based on a 20% drop in each group. The intervention group consisted of 32 subjects, two of whom were removed from the sample. A total of 31 subjects were included in the control sample, and one subject was omitted from the study (Fig. 1). Being married, first marriage of the spouses, not staying away from the husband or husband's bigamy, non-pregnancy, no menopause, not using hormone therapy, passing at least one year of marriage, having sexual intercourse in the previous month, not the first year after childbirth, substance non-use of the couple, not having medical or psychological disorders impairing sexual function, no experience of a traumatic occurrence in the previous 6 months, and not being treated for sexual dysfunction were the inclusion requirements. Daily education about sexual relationships by a counselor or health staff, reluctance to continue with the research, pregnancy during the research, no sexual relationship during the study, having a traumatic experience for couples during the study, and engaging in a course or class and receiving sexual education differently during the review, missing more than one training session, and failing to show up for the post-test were all the exclusion criteria in this study.

The sampling was then carried out. First, the researcher (who was not blinded) used random sampling at the health center to monitor the flow of knowledge between the experimental and control groups. The two groups were randomly assigned to the first or second half of the week, with the first and the last three days of the week chosen for the control and experimental groups, respectively (random allocation of the study subjects based on the Weekdays) (27). Women referred to the center for health services were given a rundown of the research project and instructions on how to answer the questions when they were recruited for both the control and experimental groups.

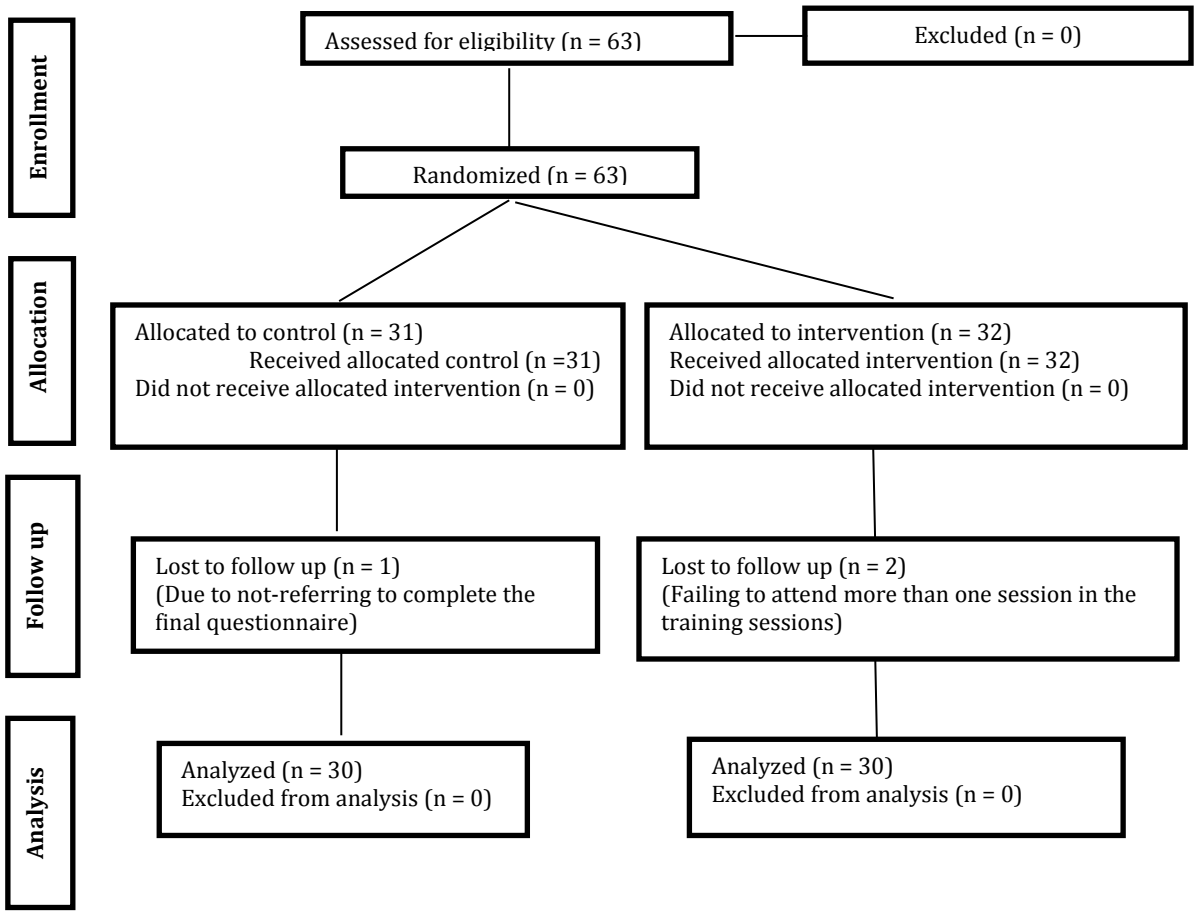

Figure 1. Consort statement

The participants were ensured that the details would be kept private and then they signed a written consent form to participate in the study. The participant-recruiting checklist was completed through an interview and consideration of the participation criteria. The Hulbert sexual assertiveness questionnaire (28) and the women's genital self-image questionnaire (29) were completed by participants (29). Due to a lack of classroom space and to improve instruction, the experimental group was split into two equal subgroups and attended the daily teaching session. The training sessions were held once a week for 2 weeks in a row. Previously, 3-h sex education was shown to have the same, if not slightly higher, impression on a girl's sexual sufficiency compare to 6-h instruction (30). The lessons were delivered via lecture and PowerPoint presentations throughout two 90-minute sessions. The intent of the training, lesson plans, and learning goals were all explained in the first teaching class. The next set of questions focused on women's understanding of general sexual and emotional problems, their sexual rights, and their effect on couple satisfaction. In the first session an explanation about the necessity of marriage, family peace and comfort, family stability and factors affecting it, family stability from the perspective of the Holy Qur'an and the traditions of the infallible, definition of a healthy sexual relationship and its requirements, sexual relations` benefits for couples, sexual relations

from the perspective of the Holy Qur'an and infallible practices, sexual function characteristics and sexual reaction cycles in men and women, how to meet sexual needs of men and women, couples' rights and consequences of neglecting it, especially women, and divorce and its sexual reasons has been explained. In the second session concepts of sexual assertiveness, couple sexual rights, Islamic views on women's sexual rights, differences between partners, the effect of women's sexual assertiveness on marital life, and application of sexual assertiveness were presented. The training package was prepared under the guidance of spiritual and religion professor, using relevant articles and tools, as well as the opinions of subject experts. After the second session the contents of the second session was given to experiment group as a booklet to review at home. One week after the completion of training both group were asked to and complete the Hulbert sexual assertiveness and genital self-image questionnaire. Finally, any concern or problem raised by either party was addressed in accordance with the study subject.

The Hulbert index of sexual assertiveness (HISA) questionnaire include 25 questions, with the options chosen using a 5-item Likert scale. The scoring ranges from "Always (0)" to "Never (4)" for each multiple-choice question. Questions 3-5, 7, 12, 15-18, 22, and 23 are scored in reverse (Always = four, Never = zero). The test has a scale of 0-100 points, with a higher score suggesting greater sexual assertiveness. Hulbert David Farley tested the sexual assertiveness questionnaire in a report (28). Bay determined the standardized content validity of the questionnaire in Iran, with an internal accuracy of 0.91 (31). Cronbach's alpha coefficients of $\alpha = 0.86$ and $\alpha = 0.92$ (25) were obtained in the implementation of HISA by David Farley Hulbert and Shafiee (2006), respectively. The reliability of this scale was computed by $\alpha = 0.84$ in the current study.

The genital self-image questionnaire was designed by Bremen et al. (2003) to measure women's feelings and thoughts about their genitalia. The questionnaire contains 30 questions with two sub-scales. The first sub-scale with 18 questions is about women's awareness of genitalia at a 4-point Likert scale ranging from 0 (always) to 3 (never). The second sub-scale includes 12 questions under which a number of traits about the genitalia are as "It is not true for me" (0) and "It is true for me" (1). The obtained score of this questionnaire is from 0 to 66 and higher scores reflect higher genital self-image (44). In Iran, the validity and reliability of this questionnaire were confirmed by Jafarnejad et al. (2014) (29). Marvi et al. (2017) also re-determined the validity by the content validity and finally, the reliability was confirmed by a Cronbach's alpha coefficient of 0.77 (33).

The outcome measure of this study was women's genital self-image and confounding variables that would not be deleted or have very little effects on the study results. As a result, they were taken into account and tracked in the data collection tool, which includes the quantitative like wife's and husband's age, marriage length, infertility length, the number of abortions and dead infants, the number of children, the number of deliveries, and qualitative variables such as place of residence and accommodation, residing with people other than the spouse and children in the same place, and infertility background. The type of deliveries, the type of contraception used, viewing pornographic films and photographs, different methods of sexual intercourse, the dominant sexual intercourse process, the amount of intercourse per week, and so on were all factors considered here.

SPSS (Statistical Package for Social Sciences, Version 11.5, SPSS Inc. Chicago, IL, USA) was used to analyze the results. The characteristics of the subjects were evaluated using descriptive statistical methods, such as a frequency chart, mean, and standard deviation. The Chi-square, Mann-Whitney, and Wilcoxon tests were used for qualitative and non-parametric variables, while quantitative variables were compared using the independent t-test and paired t-test. Finally, the effects of confounding variables

were regulated using one-way analysis of variance (ANOVA). Statistical significance was described as a p-value less than 0.05.

On Sunday, August 28, 2016, the sampling began after the analysis was approved by the disciplinary committee of Mashhad University under the code IR.MUMS.REC.1395.284. The study goals were explained to the participants and written approval was given after the Ethics Committee reviewed the proposal.

Results

The mean (± SD) ages of the intervention and control groups were (30.65) (7.75) and 30.40 (8.20), respectively.

Table 1. Frequency distribution of demographic characteristics of the study subjects

Variable	Intervention Group N (%)	Control Group N (%)	X^2	p-value
Educational Level				
Primary reading and writing	10(33.35)	11(36.70)		
Secondary	14(46.65)	14(46.60)	2.14	0.571*
Higher education	6(20.00	5(16.70)		
Spouse Educational Level				
Primary reading and writing	13(43.30	18(60.00)		
Secondary	11(36.70)	9(30.00)	2.10	0.536*
Higher education	6(20.00)	3(10.00)		
Household income levels				
Lower-than-enough	13(43.40)	12(40.00)		
Enough	16(53.35)	17(56.60	Fisher's exact =0.70	>0.990
More than enough	1(3.25)	1(3.40)		
Have a separate bedroom				
Yes	20(66.70)	16(53.40)	1.11	0.431*
No	10(33.30)	14(46.60)		
Occupation				
Housewife	24(80.00)	22(73.30)	2.53	0.614*
Employed	6(20.00)	8(26.70)		
Husband's occupation				
Unemployed	2(6.80)	3(10.00)		
Employee	5(16.65)	3(10.00)	Exact x^2=2.36	0.852*
Self-employed	23(76.64)	24(80.00)		

Which were not significantly different between the two groups ($p > 0.05$). There were no major variations in other demographic features of the two groups of participants (Table 1). To test for confounding variables, one-way ANOVA findings revealed no major differences between the two groups ($p > 0.05$; Table 2).

The mean score of genital self-image was 30.50 (37.82) in women. Results of the Mann-Whitney test indicated that there was no statistical difference in the genital self-image score between the intervention (26.85 ± 69.50) and control (27.15 ± 6.15) groups at the significance level of 5% ($p = 0.780$) before the intervention.

After the intervention, there was a statistical difference in genital self-image scores of intervention (35.93 ± 4.67) and control (31.07 ± 3.60) groups (($p < 0.001$). Wilcoxon's test results indicated that there was a significant difference in the intervention group before and after intervention in terms of genital self-image score ($p < 0.001$), but no statistically significant difference was seen in the control group ($p = 0.500$) (Table 3).

Table 2. Frequency distribution of the qualitative characteristics of participants in the two groups

Some Confounding variables	Sum of Squares	Mean Square	F	df	p-value
Educational Level					
Between Groups	80.30	26.80		3	
Within Groups	1858.60	33.20	0.80	56	0.491
Total	1938.90			59	
Spouse Educational Level					
Between Groups	106.40	35.50		3	
Within Groups	1832.50	32.75	1.08	56	0.364
Total	1938.90			59	
Household income levels					
Between Groups	24.40	12.20		2	
Within Groups	1914.50	33.60	0.40	57	0.690
Total	1938.90			59	
Have a separate bedroom					
Between Groups	27.25	57.20		1	
Within Groups	1911.70	32.10	0.80	58	0.365
Total	1938.90			59	
Occupation					
Between Groups	70.20	23.40		3	
Within Groups	1868.70	33.40		56	0.551
Total	1938.90		0.70	59	
Husband's occupation					
Between Groups	217.40	54.35		4	0.157
Within Groups	1721.50	31.30	1.73	55	
Total	1938.90			59	

Table 3. Before and after the analysis, the mean and standard deviation of genital self-image in intervention and control groups

Variable	Group		Mann-Whitney p-value
	Intervention	Control	
	Mean ± SD	Mean ± SD	
Genital Self-image before the study	26.85 (69.50)	27.15 (6.15)	z = -1.762 p = 0.780
Genital Self-image after the study	35.93(4.67)	31.07 (3.60)	z = - 4.077 p < 0.001
Wilcoxon p-value	z = - 3.173 p < 0.001	z = -0.674 p = 0.500	

Table 4. Before and after the analysis, the mean and standard deviation of sexual assertiveness in the intervention and control groups

Variable	Group		Independent T-Test p-value
	Intervention	Control	
	Mean ± SD	Mean ± SD	
Sexual Assertiveness before the study	55.15 (15.75)	52.25 (17.65)	t= - 0.70 p = 0.50 df =58
Sexual Assertiveness after the study	64.10 (11.95)	49.50 (16.75)	t= - 3.90 p< 0.001 df =58
Paired T-Test	t= -4.80 p < 0.001 df =29	t=2.55 p = 0.17 df =29	

According to the results, the sexual assertiveness score increased significantly in the experimental group compared to the control group. The findings of the study showed that sexual assertiveness training increased the participants' sexual assertiveness (Table 4).

Discussion

This study aimed to see how sexual assertiveness training affected women's genital self-image. According to the findings, obtaining sexual assertiveness skills is a positive effective contributing factor to women's genital self-image. Another research looked into the impact of sexual assertiveness education on self-expression, self-esteem, and interpersonal relationship satisfaction. They discovered that learning sexual assertiveness skills is an important component of women's self-expression and self-esteem (17). Results of research by Morrison et al. (2005) on female students in Canada also indicated that a good understanding of genitalia had a positive relationship with sexual self-esteem and a reverse relationship with self-awareness of body image and sexual anxiety (34). In a cross-sectional study with 421 women to verify the relation between sexual function and genital self-image in practicing physical activity women in gyms, Lordelo found that practicing physical activity women with adequate sexual function had more positive genital self-image (35). In another study, it was discovered that sexual assertiveness training mediated the relationship between women's sexual function and their perceived facilitative partner responses. A woman's belief that her partner is motivated to find strategies for adapting their sexuality to the pain may lead to a more harmonious and safe environment in which she can address her sexual needs. This communication could help people feel attraction and arousal, which are two aspects of sexual function (36). Bavi et al. (2014) also stated that sexual education affected the sexual self-image (37). Marvi et al. studied the impact of sexual education on the genital self-image in infertile women and concluded that sexual education had a favorable effect on the genital self-image in infertile women (33).

Furthermore, our findings revealed that sexual assertiveness education improved women's genital self-image and increased their sexual assertiveness. This finding is in line with that of a report on the impact of education on saying no to fair and unfair sexual demands without feeling guilty, recognizing and demanding sexual intercourse based on their own sexual pleasure, and identifying and requesting sexual intercourse based on their own sexual satisfaction, sexual campaigns, the use of subjective sexual terms, and so on. According to the findings of this report, sexual assertiveness education will lead women to have more sexual interactions with sexual partners. Furthermore, since sexual relations play such an important role in marital life, sexual assertiveness education classes may play an important role in marital and sexual satisfaction (38). According to our findings, sexual assertiveness teaching is a mechanism in which people learn the requisite knowledge and skills for sexual assertiveness while also forming their own attitudes, beliefs, and values, which has a positive impact on their genital self-image. The cognitive domain (i.e., facts and knowledge), the emotional domain (i.e., thoughts, beliefs, and attitudes), and the behavioral domain (i.e., actions and behaviors) are all linked to sexual assertiveness training (i.e., communication skills and decision-making). Knowing what sexual conduct is acceptable or not is the first step in sexual assertiveness training. Furthermore, it is a complicated ability that is primarily acquired through adequate preparation and can be further improved through more intensive practice (38- 39). However, several societal and cultural expectations regarding genitalia, as well as personal and social sexual experience, all have a strong effect on women's genital self-image. Sexual activity can be predicted by a person's genital self-image (40). However, only a few studies have looked at and investigated the consequences of teaching sexual assertiveness (41). The results of the current study are in line with previous research. For

example, the success of sexual assertiveness training in reducing verbal victimization can be explained by the fact that sexual assertiveness approaches can enhance people's awareness, attitudes, self-esteem, self-efficacy, and assertiveness (42). Furthermore, assertiveness training is appropriate as a recovery approach for people who have problems with interpersonal situations. Assertiveness preparation has been shown to improve adolescent social contact. An assertive person may establish close relationships with others and be free of others' mistreatment. An individual who lacks decisiveness, on the other hand, assumes that they would be unable to cope with the misuse of others (43).

As previously mentioned, sexual assertiveness plays a role in the participants' genital self-image of this study. Developing a sexual assertiveness program and its impact on women's genital self-image, on the other hand, is important to consider the specific cultural and religious aspects, as well as the laws, norms, and values that regulate society and the family. One crucial point to consider is that women have a variety of options for controlling and anticipating their sexual circumstances. The use of sexual assertiveness training in this region, amid cultural taboos and obstacles in relation to sexual matters, was one of the strengths of this study, as was the spread of sexual education topics. Related studies are one of the variables that can aid researchers in comparing their findings. However, one of the disadvantages of this new research is the lack of adequate context for this comparison. Another disadvantage of the study was the stigma of talking about sexual issues, which prevents study subjects from normal behavior due to tradition, guilt, and decency standards. Another limitation was that the study did not recognize body dysmorphic disorder criteria based on DSM-5 in this study.

Conclusion

According to the findings, sexual assertiveness training improved married women's genital self-image. As a result, the use of sexual assertiveness instruction is suggested as a subset of sex education that has a positive impact on women's genital self-image. These findings may be used by healthcare executives and policymakers to create prerequisites for sexual assertiveness training in healthcare facilities in an effort to enhance women's sexual assertiveness and genital self-image.

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Conflicts of interest

Authors declared no conflicts of interest.

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