Pleasure and Orgasm in Women with Female Genital Mutilation/Cutting (FGM/C)

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ABSTRACT

Introduction. Female genital mutilation/cutting (FGM/C) violates human rights. FGM/C women's sexuality is not well known and often it is neglected by gynecologists, urologists, and sexologists. In mutilated/cut women, some fundamental structures for orgasm have not been excised.

Aim. The aim of this report is to describe and analyze the results of four investigations on sexual functioning in different groups of cut women.

Main Outcome Measure. Instruments: semistructured interviews and the Female Sexual Function Index (FSFI).

Methods. Sample: 137 adult women affected by different types of FGM/C; 58 young FGM/C ladies living in the West; 57 infibulated women; 15 infibulated women after the operation of defibulation.

Results. The group of 137 women, affected by different types of FGM/C, reported orgasm in almost 86%, always 69.23%; 58 mutilated young women reported orgasm in 91.43%, always 8.57%; after defibulation 14 out of 15 infibulated women reported orgasm; the group of 57 infibulated women investigated with the FSFI questionnaire showed significant differences between group of study and an equivalent group of control in desire, arousal, orgasm, and satisfaction with mean scores higher in the group of mutilated women. No significant differences were observed between the two groups in lubrication and pain.

Conclusion. Embryology, anatomy, and physiology of female erectile organs are neglected in specialist textbooks. In infibulated women, some erectile structures fundamental for orgasm have not been excised. Cultural influence can change the perception of pleasure, as well as social acceptance. Every woman has the right to have sexual health and to feel sexual pleasure for full psychophysical well-being of the person. In accordance with other research, the present study reports that FGM/C women can also have the possibility of reaching an orgasm. Therefore, FGM/C women with sexual dysfunctions can and must be cured; they have the right to have an appropriate sexual therapy. **Catania L, Abdulcadir O, Puppo V, Baldaro Verde J, Abdulcadir J, and Abdulcadir D. Pleasure and orgasm in women with female genital mutilation/cutting (FGM/C). J Sex Med 2007;4:1666–1678.**

Key Words. Female Genital Mutilation/Cutting; Infibulation; Deinfibulation; Sexuality; Female Circumcision; Clitoris

Introduction

Female genital mutilation/cutting (FGM/C) violates human rights and women's physical and psychological integrity. The World Health Organization (WHO) reports four types of FGM/C (Table 1) [1].

FGM/C women's sexuality is not well known and often it is neglected by gynecologists, urologists, and sexologists. Physicians caring for women with FGM/C have little understanding of the customs, culture, and tradition, and the roles they play in women's sexual experiences. Sexuality must be considered in the context of the environment in

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Table 1 The World Health Organization (WHO) classification of female genital mutilation/cutting (FGM/C)

	Definition
FGM/C	Ancient and dangerous traditional practices that involve partial or total removal of the external genitalia and/or injury to the female genital organs for nontherapeutic reasons. The WHO [1] reports four types of FGM/C:
Type I	Excision of the prepuce with or without excision of part or the entire clitoris
Type II	Excision of the prepuce and clitoris together with partial or total excision of the labia minora
Type III	Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening (infibulation)
Type IV	Unclassified: pricking, piercing, or incision of the clitoris and/or labia; stretching of the clitoris and/or labia; cauterization by burning of the clitoris and surrounding tissues; scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina; introduction of corrosive substances into the vagina to cause bleeding or herbs into the vagina with the aim of tightening or narrowing the vagina; any other procedure that falls under the definition of female genital mutilation given above

which a woman and her partner live [2]. On the other hand, many anthropologists and sociologists, and also psychologists, have dealt with this topic but sometimes they spread descriptions and conclusions often not based on a correct knowledge of the functioning of the female sexual organs: the embryology, the anatomy, and the physiology of the female erectile organs (trigger of orgasm) are not described in their specialist textbooks.

While some studies examining women's sexuality in FGM/C have been conducted in countries where this practice is indigenous (i.e., Sudan, Nigeria, Gambia, Egypt) [3–9], other studies have examined sexuality and FGM/C among immigrant communities residing in the West (Sweden, United States, Italy) [10–13].

In a systematic review of sources on FGM/C and women's sexuality published between 1997 and 2005, Obermeyer demonstrated that most of the existing studies suffer from conceptual and methodological shortcomings, and the available evidence does not support the hypotheses that FGM/C destroys sexual function or precludes enjoyment of sexual relations [14]. This review also shows that many of the available studies on negative sexual effects are characterized by poor design, inadequate analysis, and unclear reporting of results [14]. Other studies do not give information about the characteristics of the sample, the age of respondents, and the use of a scale of sexual satisfaction referring to how it was developed. Some terms used to investigate sexuality appear unlikely and unfamiliar for correct understanding by the women [14]. Finally 35 articles were selected and examined by Obermeyer [14]. These works show that, while one study reports that circumcised women are significantly more likely to suffer adverse consequences on sexual enjoyment [8], other studies, that measure sexual activity and pleasure, find no significant difference between circumcised and uncircumcised women [6,7,10,13,15].

Between 2000 and 2005, four investigations on sexuality of women with FGM/C were conducted in Florence at the Research Center for Preventing and Curing the Complications of FGM/C.

Aim

The aim of this report is to assess the results of four different investigations regarding the sexual functioning in different groups of mutilated/cut women (groups: A = 137 adult women with different types of FGM/C; B = 58 young women with different types of FGM/C; C = 15 women with type III after defibulation; D = 57 infibulated women), giving also anatomical descriptions and psychophysiological explanations of female sexual functioning.

Methods

Instruments: Semistructured Interview (Groups A, B, C); The Female Sexual Function Index (Group D)

First, a semistructured interview was developed with 61 questions and multiple answers on everything concerning sexuality (pleasure, sexual fantasy, how women perceived their own body and the body of an intact woman). Feelings related to the circumcision they felt at the time of the operation and of the interview were also investigated.

In the first model of the interview, the answers to the questions were open and the most frequent answers given by the women were selected to elaborate the multiple choice answers of the final version. Unpredicted answers given by some women (e.g., "I feel sexier because of my infibulation" or "I feel happy for my husband") were added to the final Italian version. Afterward, it was translated in English at the British Institute of Florence. A back translation was conducted by an

Italian interpreter. Several preliminary meetings with Somali men and women were also arranged to translate the more common words used to describe sexuality and all aspects regarding this topic. A Somali word often has different meanings and often the literal translation is not possible. For example, the corresponding Somali word used by women for defining orgasm means ejaculation (*bio bax*) or loss of erection (*kacsi bax*) as for men. The literal translation of *bio bax* is "water/sperm goes out" and of *kacsi bax* is "erection dies/finishes." It is interesting to note that *bio* in Somali means water and also sperm and *bax* means "to finish, to die, and to go out."

These Somali definitions were often used during the interview to make women understand the various questions. In the following table, some definitions are given (Table 2) [16].

Women were contacted and examined by a skilled female gynecologist known in the Somali community in Florence and assisted by a Somali gynecologist who is the head of the Research Centre for Preventing and Curing FGM/C. All investigated women were healthy and freely accepted to participate in the interview, to fill in the questionnaire and to have a gynecological examination; all participants were assured of confidentiality. The interviews were always conducted face to face. The settings were informal places, such as Internet points or social events, such as weddings or *shaash saar* (a very intimate female ceremony which happens 7 days after the wedding), and also at the Research Centre at the Department of Gynaecology and Obstetrics of Florence where women came to be seen for gynecological reasons, pregnancy, or for defibulation. It was impossible to have a technically random sample as women with FGM/C volunteered to be investigated. There were unfinished interviews that were not considered because 10–15% of women either refused to answer some questions or stopped the interview before completing it, leaving the research study.

Table 2 Somali words

English	Somali
Masturbation	*Seego*: male masturbation *Farees*: female masturbation *Far*: finger *Faree*: to touch something with fingers
Sexual intercourse	*Galmo*: penetration *Isu tag*: to get together (not only sexually) *Wasno*: to have sex (vulgar and insulting)
Orgasm	*Bio bax-Shahwa bax*: when sperm goes out (ejaculation: used by men and women but especially by men) *Kacsi bax*: when the erection finishes (used by men and women but especially by women)
Lubrication	*Qoyanaansho-Qoyan*: to be wet
Sexual desire	*Dareen kacsi*: sexual desire *Kacsasho*: sexual desire (when it already caused erection/arousal) *Qooq*: vulgar word to say "horny" (male) *Qooqday*: vulgar word to say "horny" (female)
Sexual satisfaction	*Isu tag fiican*: a satisfying sexual intercourse (also physically) *Qooq bax*: to express in a vulgar way the sexual satisfaction ("horny" has finished/has been satisfied)
Emotive satisfaction (during intercourse)	*Isu tag raaxo leh*: emotionally satisfying sexual intercourse
Pain	*Xanuun*
Physical intimacy—petting	*Buraash*: to brush *Taataab*
Enveloping caressing and hugging	*Salaax*: caress *Habsin/Bog saar*
Sexual fantasies	*Hami kacsi*
Penetration and also coitus	*Galmo*
Clitoris	*Kintir*
Vagina	*Siil*
Virgin/hymen	*Bikro*
Penis	*Gus*
To fall in love	*Jecel*: to be in love *Is jecleysii*: to desire passionately

Table 3 Distribution of female genital mutilation/cutting (FGM/C) types by country (group A—137 FGM/C women)

	Somalia (N = 122; 89.05%)	Nigeria (N = 12; 8.76%)	Sudan (N = 2; 1.46%)	Ethiopia (N = 1; 0.73%)
Type I* (N = 30; 21.90%)	20	10		
Type II (N = 19; 13.87%)	18			1
Type III (N = 84; 61.31%)	82		2	
Type IV (N = 4; 2.92%)	2	2		

*Clitoridectomy (N = 25; 18.25%), incision of the prepuce (N = 5; 3.65%).
Religion: Muslim (N = 122; 89%); Christian (N = 15; 10.21%).

Exclusion criteria were severe complications such as fistula, big cysts, and severe infections of the genital and urinary tract.

An Italian preliminary adaptation of the Female Sexual Function Index (FSFI) questionnaire was used. The FSFI is a brief, 19-item self-report measure validated on a clinically diagnosed sample of women with female sexual arousal disorder and it was used to assess key dimensions (desire, arousal, lubrication, orgasm, satisfaction, pain) of sexual functioning and sexual quality of life in the most recent 4 weeks [17]. Twenty-two out of 57 (almost 38%) women of group D (57 women with type III) studied with this instrument had some difficulties in filling in the FSFI and needed additional explanation so that, in some cases, the questionnaire turned into a sort of interview.

In conclusion, women answered the FSFI questionnaire ticking the different possibilities when they fit their experience. They answered and used their own words and expressions during the semi-structured interview.

Samples

Group A

The sample of this research included 137 immigrated adult women (35.8 ± 9.6 years old) affected by different types of FGM/C (Table 3) [12,13].

The women interviewed had different levels of education and the majority of this sample (N = 89; 64.9%) worked as assistants to elderly people or as housekeepers, despite their high level of education (they possessed a high school certificate or university degree). The rest were housewives.

At the time of the interview, all women were or had been sexually active and had various types of relationships (married and living with their husband or living alone because the partner was abroad, divorced, or widowed).

One hundred and two (74.4%) women of this group had lived in Italy or in North Europe (came on holiday to Italy) for almost 8 years.

Almost 50% of them electively came to the Research Centre to be cured for medical reasons, such as occasional vaginitis and urinary infections (these women had not suffered from it before), pregnancy, or contraception. Dysmenorrhea (N = 60; 43.79%) and vaginal/urinary infections (N = 26; 18.97%) affected the infibulated women of this group, but they reported suffering from these after leaving their countries. This might be due to other psychological or physical causes, or the result of women's new awareness of their suffering which they had considered "normal" when living in their own countries. "FGM/C-related complications are often 'normalized' among women who have undergone the practice" [18].

Thirty-five (25.6%) Somali women were interviewed in the United States (Virginia, Washington, DC, Maryland) where they had been living for almost 10 years. Four of them spoke neither Italian nor English and requested assistance from either their sisters or some of their close female friends in doing the interview.

Group B

The sample of this research included 58 young, unmarried, mutilated/cut women living in the West (average age 22 years) affected by different types of FGM/C and coming from countries where the practice of mutilation/cutting is used (Tables 4 and 5) [19].

The young women interviewed underwent FGM/C at a young age (during infancy or as a child). They had high levels of education and the majority of them (N = 40; almost 68%) possessed a

Table 4 Types of female genital mutilation/cutting (group B—58 young women)

	Type I*	Type II	Type III	Type IV	Total
N	11	1	45	1	58
%	18.9	1.76	77.58	1.76	100

*Incision of prepuce 17.24 (N = 10).
Clitoridectomy (N = 1).
Religion: Muslim (N = 52; almost 90%); Christian (N = 6; almost 10%).

Table 5 Nationality of group B (58 young women with female genital mutilation/cutting)

	Somalia	Nigeria	Sudan	Ethiopia	Total
N	38	7	8	5	58
%	65.71	11.43	14.29	8.57	100

Religion: Muslim (N = 52; almost 90%); Christian (N = 6; almost 10%).

high school certificate. The rest were still in school at the time of the interview.

All of them had boyfriends and were sexually active. They left their country at a very young age (as a child).

This research was conducted for a thesis for a degree in obstetrics [19].

Group C

The sample of this research included 15 infibulated (type III) women (average age 29 years) investigated after defibulation [20].

All women were Somali and were Muslim; their activity: eight housekeepers, three students, two freelances, one employee, and one unemployed. Among these, eight were living with their husbands and were sexually active. They have been living abroad for almost 10 years.

The defibulation was performed for mixed reasons often coexisting in the same patient (six for having first sexual intercourse, seven for improving sexual life affected by dyspareunia and/or for dysmenorrhea and urinary infections, and two pregnant women for giving birth in a natural way).

The sexually active women (N = 8) of the sample completed the semistructured interview before and after the operation.

Group D

The sample of this research included 57 infibulated women (G2), members of the Somali community in Florence (age 36.44 ± 9.01) and a similar control group of 57 unmutilated women (G1): three Somali and 54 Italian women (age 37.61 ± 10.63) [21].

Because of the difficulties in finding Somali women who had not undergone infibulation, a sample of Italian women was recruited. Before filling in the questionnaire, the women in this sample filled in a data sheet to provide information regarding age, job, etc. Also, in this case, the recruitment was at the Research Centre and in informal places and the women were examined by a female gynecologist.

All women were Somali and Muslim, residing in Florence from Somalia for the past 8 years; and were: employed (N = 34; 60%), housewives (N = 14; 25%), students (N = 6; 10%), or freelances (N = 3; 5%). All of them were engaged in a stable relationship and were sexually active in the most recent 4 weeks before filling in the questionnaire.

None of the women reported grave short-term complications after infibulation (except burning in urination for 5 days immediately after operation) or lifelong complications (except intense pain during first intercourse which resolved with time).

Results

The samples of these four investigations showed that women with FGM/C (all grades) can have orgasm.

Group A

The majority of the interviewed women (90.51%, N = 124), reported that sex gives them pleasure. Almost 86% (N = 118) of women with different types of FGM/C reported orgasm with penetrative vaginal sex (always in 69.23%; N = 95). Seventy-eight and forty-five percent (N = 107) of the same group reported orgasm also with manual masturbation by their partner (always in 64.66%; N = 88) (Figures 1 and 2).

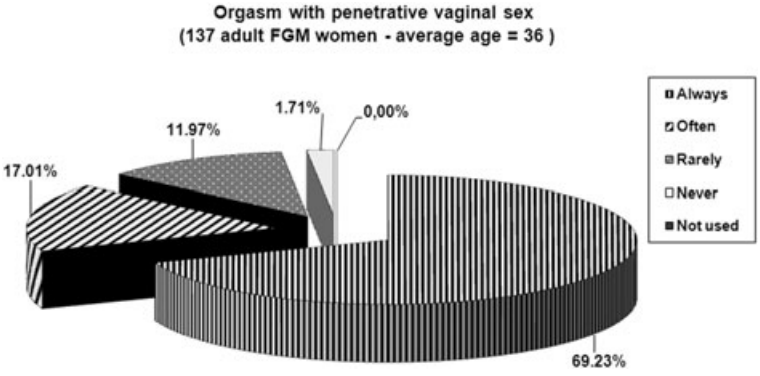

Figure 1 Orgasm with penetrative vaginal sex (group A—137 female genital mutilation/cutting women—average age: 36).

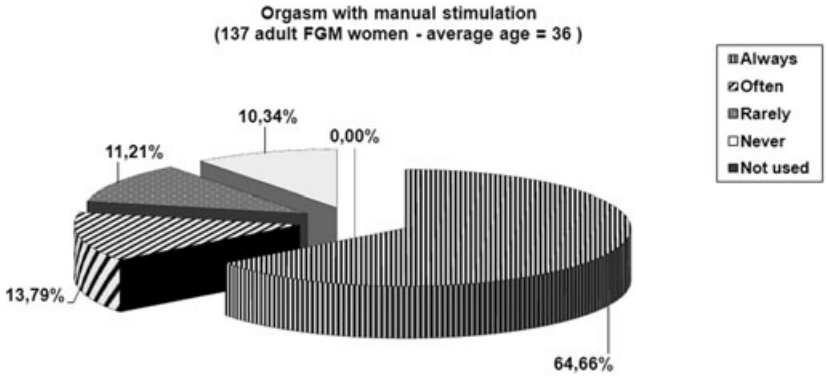

Figure 2 Orgasm with manual stimulation (group A—137 adult female genital mutilation/cutting women—average age: 36).

Group B

Of the 58 young women with different types of FGM/C, 91.43% (N = 53) reported orgasm with penetrative vaginal sex (always in 8.57%; N = 5). Almost 34% (N = 20) of the same group reported orgasm with manual masturbation by their partner (always in 5.71%; N = 3) (Figures 3 and 4).

Group C

Defibulation is the procedure used to reverse infibulation, to create a normal vaginal opening and to rebuild, medically speaking, a sort of "normal" anatomy of external mutilated genitals, respectful of their function also from the patients' eyes. It involves the incision of the scar tissue

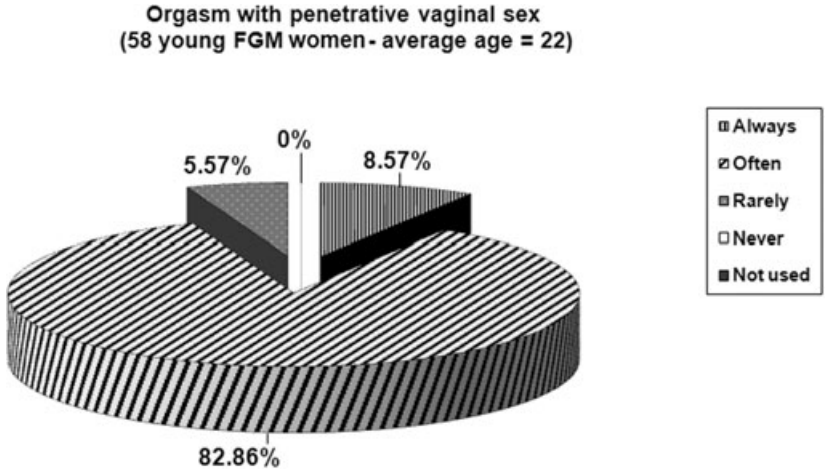

Figure 3 Orgasm with penetrative vaginal sex (group B—58 young female genital mutilation/cutting women—average age: 22).

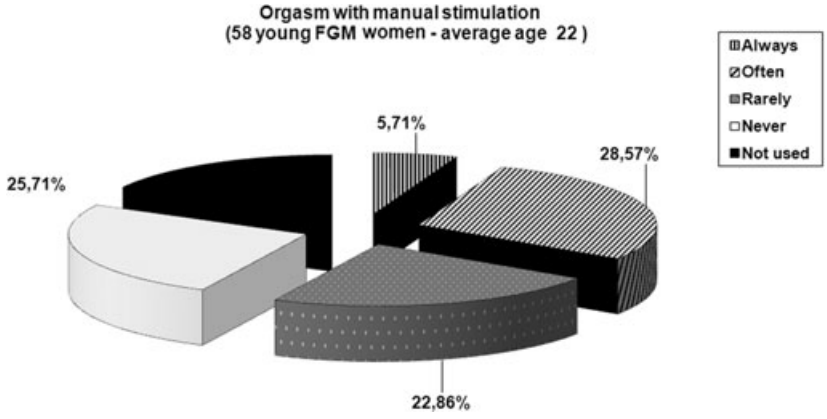

Figure 4 Orgasm with manual stimulation (group B—58 young female genital mutilation/cutting women—average age: 22).

to allow the widening of the narrowed vaginal opening and to visualize the urethral opening for a physiological urination. It may be partial (until exposition of the urinary meatus), or total. In this case, clitoral tissue and sometimes the whole intact clitoris are exposed.

Some months after the operation, the totality of the sample had intercourse, and 14 out of 15 could have orgasm with penetrative vaginal intercourse. The patients described the psychophysical effects of orgasm as involuntary pleasurable rhythmic contractions of the vagina, pulsations of internal genitals, and the feeling of warmth all over the face and the body. Women (N = 8) who had intercourse before the defibulation were satisfied with the reduction of dyspareunia. All women were satisfied with the improvement of the quality of life (reduction of dysmenorrhea, reduction of urinary and vaginal infections, and improvement in flow of urination and menstrual flux). This is in accordance with Nour et al. who state that defibulation is recommended for all infibulated women who suffer long-term complications [11].

Women of the three groups (A, B, C) claiming to achieve orgasm were asked to describe the effects that characterize the greatest moment of pleasure that they would define as orgasm. There was a variety of options answering these questions, and the interviewed women described the physical and psychological effects of the orgasm in the same way, giving detailed descriptions.

Table 6 presents the answers of group A [12].

Table 6 Description of orgasm (group A—137 female genital mutilation/cutting women)

	Frequency (%)
Description* of the physical events (137 women)	
Involuntary pleasurable rhythmic contractions of the vagina	65.69
Pulsations of the internal genitals	65.69
A feeling of warmth all over the face and body	62.77
Description* of the psychological events	
Uncontrollable words or sounds	53.28
Complete abandoning of the body	52.55
Complete loss of control	51.09
Feeling of exploding or melting	33.57

*It was possible to choose multiple options.

Group D

The group of 57 infibulated women tested with FSFI in comparison to the control group, obtained higher scores in some domains (desire, arousal, orgasm during sexual intercourse, and satisfaction). Significant differences were observed between G2 and G1 in desire, arousal, orgasm and satisfaction with mean scores higher in the group of mutilated women. No significant differences were observed between the two groups in lubrication and pain. Our study suggests that FGM/C also in this group of women has no negative impact on psychosexual life. Nevertheless, considering that the control group included 54 Western women and only three Somali, the G1 and the G2 were not fully comparable. Therefore, the results might be influenced by other factors, besides FGM/C, related to the differences in cultural background (Table 7) [21].

Discussion

Before discussing the results of these studies, we should relate that it was very difficult for the women of group D (57 infibulated women investigated with the FSFI) to distinguish the difference between desire and arousal [22–24]. Furthermore this questionnaire "does not measure sexual experience, knowledge, attitudes or interpersonal sexual functioning" [18]. That is why "the appropriateness of the FSFI as a useful measure is yet to be ascertained in unique populations such as presented in this study where there are deeper and yet complex layers within the socio-cultural context which remain unexplained by this tool" [18,22,24–

Table 7 Female Sexual Function Index statistical analysis (group D—57 infibulated women)

Domains	Mean G1 (±SD)	Mean G2 (±SD)	*t* (df = 112)	*P*
Desire	6.15 ± 1.81	8.49 ± 2.08	–6.37	<0.001
Arousal	15.12 ± 3.38	18.07 ± 3.22	–4.75	<0.001
Lubrication	17.24 ± 2.86	18.22 ± 3.83	–1.55	0.12 (ns)
Orgasm	11.91 ± 2.99	13.22 ± 3.72	–2.08	0.04
Satisfaction	12.10 ± 2.44	13.82 ± 2.39	–3.79	<0.001
Pain	12.80 ± 2.76	11.61 ± 5.07	1.55	0.12 (ns)

No significant differences were observed between the group of study (G2) and the group of control (G1) in lubrication and pain. Nevertheless, considering that the control group included 54 Western women and only three Somali ones, the G1 and the G2 were not fully comparable. Therefore, the results might be influenced by other factors, besides female genital mutilation/cutting, related to the differences in the cultural background.
G1 = group of control; **G2** = group of study (infibulated women).

26]. Hence "it is evident that FSFI needs to be further adapted and validated for use in non-Western culture" [18].

In contrast with the studies of some authors [8,9,27], and in accordance with others [4,5,10,11], our results suggest that FGM/C does not necessarily have a negative impact on psychosexual life (fantasies, desire, pleasure, ability to experience orgasm).

Johnsdotter and Essen in their ethnographic study with Somali immigrants show that these women never spoke about a disability in enjoying sex; on the contrary, most of them stated that they did not have sexual problems and enjoyed sexuality [10].

The discourse regarding the possibility of FGM/C women enjoying sex represents an enigma for Western people and often, the same physicians, sexologists, and psychologists are incredulous regarding these results [2]. "An increased understanding of cultural epistemology is needed to ensure quality care. The encounters that take place in obstetrical care situations can provide a space where gender and culture as prescribed norms can be questioned" [28], and "the failure of Western health care providers to fully understand the complex socio-cultural context of women's sexuality among societies which practice FGM/C" [18].

Human sexuality depends on a complex interaction of cognitive processes, relational dynamics, and neurophysiological and biochemical mechanisms [29]. It is influenced and modulated by many factors (biological, psychosexual, and social/contextual dependence) which act in a way that one factor can improve or inhibit the other and vice versa [30].

The samples of the present study did not suffer from very severe long-term complications; some types of circumcision left the whole clitoris intact which often was exposed during defibulation. In the most severe forms of infibulation, the deep erectile structures are thought to be intact, taking into consideration the female genital anatomy.

The erectile organs (trigger of the orgasm) in females and in males have the same embryologic origin [31–33]. The vulva is the homologue of the male penis and scrotum; the clitoris is equivalent to only a part of the male penis (corpus cavernosum and glans of male penis) [31,34,35]. The female erectile structure are the labia minora, the whole clitoris (glans, body, crura), the vestibular bulbs with the corpus spongiosum, and the corpus spongiosum of the female urethra; these structures are situated under the urogenital diaphragm and in front of the pubic symphysis in the anterior perineal region [32–38].

The corpus spongiosum surrounds the female urethra, as in the male, and becomes engorged (becomes erect) during arousal [32,33,35].

It is really important to remember that in infibulated women, some fundamental structures for the orgasm have not been excised. The women interviewed by Amhadu achieve orgasm by stimulating the vagina and consider the clitoris as something extra [39]. In reality they refer to the visible (external) part of the clitoris which is the "top of the iceberg" of the whole structure, strictly connected to the vagina. Nour et al. report intact clitoris buried beneath the scar in 40% of defibulated women [11].

Cultural influence can change the perception of pleasure, as well as social acceptance. "Age, marital status, number of wives/co-wives in the household, length of time in 'host/adopted' country, degree of acculturation, educational level, and adherence to one's cultural values as well as the degree and extent of FGC, among others, all may play a role in a woman's views on sexuality, body-image and beauty, sexual expression and response, as well as motivations to engage in sexual intercourse" [18]. "Women will develop different views about their bodies, sexuality, etc based on the social influences/network that are present in the environment in which they currently live" [18].

The cultural meaning of the FGM/C in the samples of the present study was often positively connoted: a girl who goes through this dangerous experience becomes heroic, honorable, and special. The women also reported fearful childhood memories (group A, N = 69; 50.36%) and displeasure for their condition (group A, N = 51; 37.20%) [12,13]. Nevertheless, the vast majority of our sample (group A) reported feelings of happiness the day after the mutilation and showed pride (group A, N = 57; 41.60%) for their present condition (Table 8) [12].

Table 8 Feelings concerning the circumcision at the time of the operation (group A—137 female genital mutilation/cutting women)

Condition*	N	Frequency (%)
Happy	62	45.25
Proud	60	43.79
Special	49	35.76
Afraid	50	36.50
Unhappy	29	21.16

*It was possible to choose multiple options.

The multiple answers bring out the coexistence of ambivalent feelings: it may be a result of not only cultural influences, but also of age, education, and degree of acculturation into the "host" society in the West.

At the Research Centre of Florence, only 15 out of 90 defibulated women accepted to be interviewed for research, because in the past years, women who asked to be defibulated were scared to expose their husbands to ridicule from their own family and community. In their culture, the defloration of the scar of the infibulation is an important demonstration of virility [40]. Hence, a man who allows his wife to be "opened" by a surgeon is severely criticized. However, recently, some young "virgins" with infibulation have decided to be defibulated despite being single, changing their feelings about being "opened" and their view of infibulation as "normal." During a preliminary meeting with them, we explained all the phases of the defibulation procedure and showed them that the operation does not damage the physical virginity, and that the hymen would remain intact [41]. We started to see "the difference in the effect of 'acculturation' on women's views about the normalcy of their genitalia," "currently residing in the West for varying amounts of time, and with varying degrees of acculturation into mainstream Western social and sexual norms" [18].

Morison et al. showed that "among young single male and female Somali, living in Britain from a younger age, was associated with abandonment of female circumcision and with changes in the underlying beliefs on sexuality, marriage, and religion that underpin it. Groups identified with more traditional views toward female circumcision include males, older generations, new arrivals and those who show few signs of social assimilation" [42].

Body image/genital image is culturally influenced: women in the present study considered the intact genitals awful: group A, 16.79% (23); group B, 12.82% (7); dirty: group A, 18.25% (25); group B did choose this option. They considered women with intact genitals not fully female: group A, 3.65% (5); group B, 17.95% (10); they thought that intact women have a highly developed sexuality: group A, 45.26% (62); group B, 30.77% (18); they were sure that uncircumcised women cannot be faithful: group, A 10.22% (14); group B, 2.56% (2). In this culture, women are afraid of their sexual impulses, while Western women welcomed it and the lack of it is considered a dysfunction. For Somali infibulated women, the sexual impulses are deplorable and shameful.

Only 5.84% of adults considered intact women as "normal" women while almost 36% (21) of young women concluded, in an ambivalent way, that intact women are lucky.

These results are in accordance with Gruenbaum. In her article she states: "Crucially, if FGC is believed to make one fully female and feminine, public health messages encouraging discontinuance would be improved by addressing fears that may arise about loss of femininity. Femininity ideals are reinforced by *aesthetic* values. Tissue removal often eliminates what are thought of as masculine parts, or in the case of infibulation achieves smoothness considered beautiful. Where infibulation is the established practice, the uninfibulated state can seem repulsive to women themselves and/or to their sex partners." and "Socially valued images of physical beauty and sensuality have not been well researched" [39]. "How do they differ among social groups and different ages? Are there concrete or symbolic aspects of female genital cutting practices that reinforce cultural conceptions of beauty in any given setting, and does the fear of being ugly or masculine interfere with proposals for modification or elimination of the practices? Aesthetic and cosmetic preferences are not trivial matters, as opinions about body hair, tissue flaps and smoothness, may be as salient to a sense of bodily beauty as tattooing one's lips, using lipstick, blacking eye lashes, and other such practices. Although it would be a challenge, could uninfibulated beauty be creatively marketed? Although this area of body normally is not visible, even to one's husband, it is considered sensual to be smooth, free of hair and well scented" [4].

"The roles of psychologic and interpersonal determinants need to be taken into account in this approach" [29]. The marital status plays an important role in a satisfying sexuality and almost the total of our groups of study had or had had a fulfilling relationship. That is in accordance with Ahmadu who states that "according to these women, female sexual pleasure depends on love and on the time the partner takes/allows to make love" [39].

Regarding the new generation, the same study reported different results. The research with 58 unmarried young women with FGM/C (group B) reported the presence of orgasm but with less frequency compared with the group of adults (group A). Fifty-eight young ladies were living in Italy but were circumcised/infibulated in their country during childhood. As children in their own country, they experienced positive feelings about

FGM/C, a sense of female completeness, they lived in a setting of social acceptance, felt family love and thought that FGM/C was "something that testified beauty and courage" [34,35,38]. Growing up in Western countries, their experience was transformed and given negative meanings: female mutilation, social stigma; they were depicted as victims of family violence and barbarity [38,40,41]. Their sense of beauty changed into ugliness. The social stigmatization and the negative messages from the media regarding their "permanently destroyed" sexuality provoke negative expectations on the possibility of experiencing sexual pleasure and provoke negative feelings about their own body image [38,40,41]. The social criticism and the negative cultural meaning regarding their painful experience cause distortion of their cultural values and they undergo a sort of "mental/psychological" infibulation which could result in iatrogenic sexual dysfunction [38,40,41].

An interesting prospective work on a sample of 453 mutilated/cut women, living in Europe, operated for clitoral rehabilitation between 1992 and 2005, showed that the operation provides promising cosmetic and functional results. However, it also showed that for 100% of these women, the most important reason for being operated on was to reobtain the female identity they connected to the presence of the clitoris, that is to say, the patients asked to have a visible clitoris restored without attaching importance to its functioning [43].

Johnsdotter and Essen reported that the Ethiopian immigrants in Sweden included in their study seem to have adopted a more Western view of circumcision as mutilation, and express their sense of having lost something because of the operation [10]. Ahmadu noted in her study that among women not achieving orgasm, there are women who had been educated in the West and who had heard criticism of the practice of mutilation [39]. These women became very angry about what had been done to them [39].

Therefore, FGM/C women living in the West who have sexual dysfunctions [30,44] also need pragmatic help: they can and must be cured with clitoral restoration [45], defibulation, an appropriate sexual therapy and a correct sexual education that also involves their partners. In addition, they need to feel respect for themselves and for their culture. Curing and caring for women with FGM/C led us to understand cut women's mentality, to gain trust and familiarity with their secrets, to enter their intimate world and their problems [40,41]. The possibility of facing the real facts with professional competence has resulted in some important considerations: women with FGM/C often are not aware that their physical problems are linked to the mutilation (especially infibulation), they do not know what type of FGM/C has been performed and whether or not they have had FGM/C [40,41]. They believe women's suffering is natural and normal [26, 40,41]. In addition they have difficulty in talking with their "Western" physician for feelings of shame or fear of being considered "unusual and mutilated object" [40,41]. Western physicians should demonstrate competence and knowledge [46–48]. They should cure complications, improve psychosexual health, and provide correct information and guidance, keeping women's personal dignity intact and avoiding the appearance of iatrogenic complications [40,41].

Conclusion

FGM/C violates human rights. In all parts of the world, people would like to see it eliminated through information, education, specific laws, and an adequate vocational training of the doctors and nurses who cure these women and of the community leaders who prevent these practices. On the other hand, for women with FGM/C, such practices very often have positive implications (gender, social, personal, and aesthetic) which are hard to change. Every woman (intact, disabled, and also with FGM/C) has the right to have sexual health and pleasure for the full psychophysical well-being of the person.

Furthermore, in FGM/C women, desire, arousal (mental and physical), and orgasm are phases of sexual response and often, a part of, or the whole clitoris has been found under the scar of the infibulation during the operation of defibulation [45].

Therefore, FGM/C women with sexual dysfunctions [47] can and must be cured: they have the right to have appropriate sexual therapy [49]. Our findings suggest that healthy mutilated women, who did not suffer from grave long-term complications and have a good and fulfilling relationship, may enjoy sex.

In FGM/C women, when their culture makes them live their mutilation as a positive condition, orgasm is experienced. When there is a cultural conflict, the frequency of the orgasm is reduced even if the anatomical and physiological conditions make it possible. Sexologists should pay

attention to sexual education when it is conditioned by the cultural influence as it can change the perception of pleasure and can inhibit orgasm. The present study should be replicated on a larger and random sample; but, for the moment, it gives us the possibility to compare ourselves with diversity and improve our knowledge. In addition, it can help sexologists to deepen their knowledge of FGM/C women's problem and overcome the prejudices about these women's sexuality often as a result of the lack of knowledge regarding anatomy, physiology, and mentality [40,41].

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