



# Conceptualizing Sexual Pain in Women with Female Genital Mutilation/Cutting

Jasmine Abdulcadir<sup>1</sup> · Lucrezia Catania<sup>2</sup>

Received: 11 November 2019 / Revised: 21 March 2020 / Accepted: 23 March 2020 / Published online: 11 April 2020  
© Springer Science+Business Media, LLC, part of Springer Nature 2020

In their Target Article, Connor, Brady, Chaisson, Sharif Mohamed, and Robinson (2019) present an integrative pain response model to conceptualize sexual pain in migrant and immigrant women who have experienced female genital mutilation/cutting (FGM/C). They propose it as a guide for clinical assessment, treatment of sexual pain, and future research with women with FGM/C. This interesting model is based on pre-existing pain response models to other types of pain (e.g., back pain, vulvodynia, headache) (Hasenbring, Verbunt, 2010; Sturgeon & Zautra, 2016; Vlaeyen & Linton, 2000). It distinguishes the four following types of sexual pain response, each of them with specific cognitive, affective, and behavioral processes that can worsen or cope with the experience of pain:

- (1) Fear avoidance, where pain is viewed by the woman as catastrophic, leading to anxiety, hyper-vigilance around the partner, no communication about the pain, and fear and avoidance of sex and intimacy. According to Connor et al., a similar response can undermine the quality of relationship and sexual experience and contribute to chronic pain (maladaptive response).
- (2) Distress and (3) eustress endurance, where the experience of pain is minimized or ignored with oneself and others, focusing on other things (e.g., family, relationship, work). In distress endurance, the thoughts about pain are suppressed. In eustress endurance, pain is acknowledged but minimized and approached positively. Connor et al. hypothesize that women who

engage in both eustress and distress endurance behaviors will experience pain and eventual injuries, creating painful body memories, anxiety, and possibly undermining the quality of relationship and sexual experience (maladaptive response). Connor et al. consider eustress endurance response as a form of adaptive response when acculturation is low.

- (4) Resilience, where cognitive and coping processes and positive social interactions and communications (including with a partner) facilitate acceptance of chronic pain and lead to psychophysical adjustments. Painful sexual activities are stopped, but less painful forms of sexual contacts and activities are maintained. Exploring alternatives to penile–vaginal intercourse is beneficial for the woman and the couple (adaptive response). However, such flexibility might be limited in some cultures where vaginal penetration is seen as the only acceptable form of sex.

Connor et al. (2019) underline that other factors such as acculturation, history of sexual trauma, relationship dynamics, and other biopsychosocial causes for sexual pain different than FGM/C should be assessed while using this model. They also suggest possible interventions that can facilitate resilience. These include: (1) finding or creating positive meanings, (2) treating anxiety and depression, (3) enhancing social support, particularly communicating needs to one's partner, (4) finding and exploring sexual activities and adaptive strategies that are culturally appropriate and without pain, and (5) couple therapy, cognitive behavioral therapy or acceptance commitment therapy (a form of mindfulness-based therapy, theorizing that greater well-being can be attained by overcoming negative thoughts and feelings).

Connor et al. (2019) finally call for more quantitative and qualitative research: (1) to understand how each type of sexual pain response applies to populations living in both high- and low-income countries, (2) to identify further resilience mechanisms, and (3) to assess psychotherapy. The suggested

This Commentary refers to the article available at <https://doi.org/10.1007/s10508-019-1422-9>.

✉ Jasmine Abdulcadir  
jasmine.abdulcadir@hcuge.ch

<sup>1</sup> Department of Paediatrics, Gynaecology and Obstetrics, Geneva University Hospitals, 30 Bld de la Cluse, 1211 Geneva, Switzerland

<sup>2</sup> Florence, Italy

research outcomes to be evaluated are the decrease in sexual pain intensity and the increase in positive mood, relationship satisfaction, and sexual satisfaction.

There is still a lack of research and literature on promoting sexual health and understanding and treating sexual pain among women with FGM/C and their partners in high prevalence, migration, and immigration countries (Abdulcadir, Rodriguez, & Say, 2015a). The existing evidence has mainly focused on the etiologies and surgical treatments of sexual pain after FGM/C (Berg, Denison, & Fretheim, 2010; Berg, Taraldsen, Said, Sorbye, & Vangen, 2017a, 2017b) and not on the responses to such pain. Women and girls with FGM/C present some specific biological, psychological, and socio-cultural factors that cause and can maintain sexual pain.

Biological factors include: (1) the type of cutting, its severity, and complications, (2) past obstetric perineal traumas (Belihu, Small, & Davey, 2016; Wuest et al., 2009), (3) recurrent genitourinary infections that can lead to pelvic inflammatory disease (Berg, Underland, Odgaard-Jensen, Fretheim, & Vist, 2014), (4) recurrent vulvar fissures and abscesses (Abdulcadir et al., 2016a), (5) post-traumatic granulomas and neuromas of the clitoris (Abdulcadir, Pusztaszeri, Vilarino, Dubuisson, & Vlastos, 2012), (6) painful incarceration of the clitoris (Abdulcadir, Manin, & Huber, 2019), (7) vulvoclitral cysts (Abdulcadir et al., 2012; Rouzi, 2010), and (8) keloids and adhesions or bridles (Abdulcadir et al., 2016a).

Psychological factors include depression, anxiety, or post-traumatic stress disorder (PTSD) related to FGM/C and personal coping strategies of the past experience of cutting (Berg et al., 2010; Vloeberghs, van der Kwaak, Knipscheer, & van den Muijsenbergh, 2012). FGM/C is often physically and psychologically traumatic even though a considerable number of women are capable of coping and may regard the ritual as “normal” and not distressing. The interpretation, memories, and experience of the FGM/C are diverse and can affect sexual pain and sexual response (Vloeberghs et al., 2012). In addition, some painful genital experiences can recall the trauma of FGM/C (Abdulcadir, Bianchi Demicheli, Willame, Recordon, & Petignat, 2017). Many migrant and immigrant women with FGM/C have also lived other past traumatic events that can contribute to the onset or maintenance of sexual pain (e.g., sexual violence, reinfibulation after rape to preserve marriageability) (Abdulcadir, Marras, Catania, Abdulcadir, & Petignat, 2018; Antonetti Ndiaye, Fall, & Beltran, 2015).

Relational and sociocultural factors involve: (1) education, (2) information on FGM/C, on female genital anatomy, physiology, and sexuality, (3) beliefs; norms, (4) religion, and (5) migration and acculturation. In some ethnic groups where FGM/C is traditional, forced and arranged marriages can also be a common practice (Antonetti Ndiaye et al., 2015).

Younger migrant women with FGM/C, growing up in the West, exposed to negative or stigmatizing messages about their genital cutting, have been reported to be at increased risk of sexual dysfunction, genital or body image dissatisfaction, and negative expectations about their future sexuality (Johnsdotter, 2018). It was also found that the first painful sexual intercourses can differently contribute to future chronic sexual pain among women with FGM/C type III who are not yet defibulated, depending on where and how such pain is experienced and perceived (Catania et al., 2007). In the study by Catania et al., older infibulated women who had started sexual intercourses in a high FGM/C prevalence country, a long time before migration, described and considered sexual pain at first intercourses as the “norm.”

These women experienced little, or no, effect on sexual pleasure and satisfaction once sexual pain was gone (e.g., after their infibulations were surgically re-opened, which often occurred at the time of first parturition). In contrast, sexual pain at first intercourses was often described as abnormal, terrifying, and traumatizing among younger infibulated women who had migrated to the West at a young age and had had their sexual debut in a country where such pain was not the norm (Catania et al., 2007).

Research on sexual response after FGM/C using the Female Sexual Function Index also showed that in spite of high sexual pain scores, sexual pleasure and satisfaction scores can remain normal (Abdulcadir et al., 2016; Catania et al., 2007). Connor et al.’s (2019) integrative psychological pain response model will be useful to understand better the mechanisms behind such findings. The model can be employed: (1) to assess, document, and investigate the response to sexual pain in women with FGM/C in a common, scientific, and standardized language; (2) to prevent maladaptive responses that might worsen chronic sexual pain; (3) to promote alternative responses that might improve sexual health and decrease pain; (4) to explain to women and men their cognitive, affective, and behavioral responses; (5) to study therapeutic surgical and non-surgical interventions for sexual pain after FGM/C.

This model could be applicable to several clinical conditions causing sexual pain other than FGM/C, such as endometriosis, vulvodynia, genitopelvic pain penetration disorder, and painful scar tissue caused by other vulvovaginal or perineal traumas or surgeries. In the case of FGM/C, the specific biopsychosocial factors discussed above should be assessed and managed together with all the possible co-existing factors responsible for sexual pain that might be different than the genital cutting itself. Health professionals should be careful not to focus only on the FGM/C, forgetting all other diagnosis and possible managements of sexual pain. Health professionals should also avoid exclusive focus on non-surgical management (e.g., counseling, psychosexual therapy), when the cause of the pain is treatable surgically. FGM/C often differs

from a form of localized or generalized vulvodynia as sexual pain has often a visible and surgically treatable cause such as a cyst, an adhesion, a neuroma, or the cutaneous barrier of infibulation.

The Target Article by Connor et al. (2019) focuses on the possible use of the model for assessment and management of sexual pain. In addition, this same model could be probably used to study, assess, and manage those factors that facilitate acceptance or cause refusal of treatments for such pain. Many women with FGM/C type III (infibulation) can suffer from genitourinary problems and severe sexual pain but still refuse defibulation (Abdulcadir et al., 2018). Defibulation is the opening of infibulation, a technically easy and effective treatment reducing or completely resolving sexual pain as well as other symptoms. Women's refusal can be due to sociocultural reasons or fears regarding the defibulated genitals and future marriageability (Abdulcadir et al., 2018). When the woman refuses the treatment for sexual pain, she can engage in a fear avoidance, an endurance response, or a resilience response. In this particular case, a resilience response consisting of finding strategies to avoid penetration and defibulation might be interpreted as a maladaptive response too. Refusing defibulation can negatively affect a woman's sexual, obstetric, genitourinary, and relationship health.

Surgical interventions to reduce or treat sexual pain include defibulation, removal of cysts, adhesions and bridles, post-traumatic neuromas, and clitoral reconstruction (Berg et al., 2017a). Connor et al. did not mention clitoral reconstruction. This surgery is indeed not universally accepted as effective and safe yet (World Health Organization (WHO), 2016). However, clitoral reconstruction is increasingly requested and performed, in part, to treat sexual pain. Current guidelines and expert opinions (Abdulcadir, Rodriguez, & Say, 2015b; WHO, 2016) insist on the importance of psychosexual therapy or psychotherapy before and after surgery, and future research on this topic is needed. Connor et al.'s (2019) model could certainly be used to study and describe in a standardized way sexual pain response before and after clitoral surgery.

Non-surgical treatments for sexual pain include pelvic floor therapy, psychosexual therapy, and all the possible resilience interventions mentioned by Connor et al. (2019). Non-surgical treatments have not yet been studied in the population of women with FGM/C and their partners. Moreover, they are not always available, refunded, offered, or adapted to the population of women with FGM/C.

Among the resilience strategies mentioned by the Connor et al., it is supposed that women might obtain advice from friends and relatives about sexual pain reduction methods and communicate with their friends and husband. This might vary

considerably in different ethnic and cultural groups and age groups. Unmarried sexually active women or lesbian women might have more difficulties in obtaining such advice where sex is socially acceptable only in a heterosexual married couple. Subjects like defibulation are extremely private and not disclosed within some groups. Especially where the opening of infibulation is still considered a sign of men's virility, a pre-marital surgical opening could be shameful and so, not easily disclosed and advised (Abdulcadir et al., 2018).

Intra-couple communication about sexual practices, preferences, adaptive strategies, and sexual pain can also vary considerably according to the ethnic group considered. FGM/C is often discussed as a unique condition, but there is a huge diversity in types and consequences, age at which, and setting in which, the cutting was performed, beliefs, cultures, religions, countries, traditions, practices, misconceptions, myths and attitudes toward sex, communication about sex, and sexual pain. Future research on sexual pain should acknowledge such diversity. Discussing anal and oral sex as alternatives to vaginal penetrative sex for instance could be seen as a sin among some communities (Catania et al., 2007). The same goes with masturbation (Abdulcadir et al., 2016b). Future research using Connor et al.'s (2019) model could explore the strategies that can facilitate the self-exploration of the genitals, communication, and peer education among women and their partners. Women's inter-generational peer education about sex is also a resource to be explored. In some communities, however, communication about sex is restricted to the moment of marriage only.

In conclusion, Connor et al.'s (2019) model will be a useful resource to study, understand, and manage sexual pain among women who have experienced FGM/C. The model could be enriched by considering the response of the woman's partner to the sexual pain. The partner's different responses can positively or negatively influence the woman's sexual pain and function. In our clinical experience with mostly heterosexual women with FGM/C, men can engage in very different behaviors and responses to the sexual pain of the partner, which range from successful adaptive resilience strategies including advocacy and support of surgical defibulation in case of FGM/C type III, mutual masturbation or to more maladaptive responses that can worsen pain, distress, suffering, and loss of physical and emotional intimacy in both members of the couple.

Connor et al.'s (2019) integrative model will certainly improve and encourage the understanding and management of sexual pain response. As such, it will aid our understanding and management of sexual function in women with FGM/C, which is one tile in a bigger mosaic of women's sexual health.

## References

- Abdulcadir, J., Bianchi Demicheli, F., Willame, A., Recordon, N., & Petignat, P. (2017). Post-traumatic stress disorder relapse following clitoral reconstruction after female genital mutilation: A case report. *Obstetrics and Gynecology*, *129*(2), 371–376.
- Abdulcadir, J., Botsikas, D., Bolmont, M., Bilancioni, A., Djema, D. A., Bianchi Demicheli, F., et al. (2016a). Sexual anatomy and function in women with and without genital mutilation: A cross-sectional study. *Journal of Sexual Medicine*, *13*(2), 226–237.
- Abdulcadir, J., Catania, L., Hindin, M. J., Say, L., Petignat, P., & Abdulcadir, O. (2016b). Female genital mutilation: A visual reference and learning tool for health care professionals. *Obstetrics and Gynecology*, *128*(5), 958–963.
- Abdulcadir, J., Manin, E., & Huber, D. (2019). Clitoral pain and dyspareunia after female genital mutilation/cutting: A case report. *International Journal of Clinical Medicine*, *10*(7), 379–385.
- Abdulcadir, J., Marras, S., Catania, L., Abdulcadir, O., & Petignat, P. (2018). Defibulation: A visual reference and learning tool. *Journal of Sexual Medicine*, *15*(4), 601–611.
- Abdulcadir, J., Pusztaszeri, M., Vilarino, R., Dubuisson, J. B., & Vlastos, A. T. (2012). Clitoral neuroma after female genital mutilation/cutting: A rare but possible event. *Journal of Sexual Medicine*, *9*(4), 1220–1225.
- Abdulcadir, J., Rodriguez, M., & Say, L. (2015a). Research gaps in the care of women with female genital mutilation: An analysis. *BJOG: International Journal of Obstetrics and Gynaecology*, *122*(3), 294–303.
- Abdulcadir, J., Rodriguez, M. I., & Say, L. (2015b). A systematic review of the evidence on clitoral reconstruction after female genital mutilation/cutting. *International Journal of Gynaecology and Obstetrics*, *129*(2), 93–97.
- Antonetti Ndiaye, E., Fall, S., & Beltran, L. (2015). Benefits of multidisciplinary care for excised women. *Journal de Gynecologie, Obstetrique et Biologie de la Reproduction*. <https://doi.org/10.1016/j.jgyn.2015.01.008>.
- Belihu, F. B., Small, R., & Davey, M. A. (2016). Episiotomy and severe perineal trauma among Eastern African immigrant women giving birth in public maternity care: A population based study in Victoria, Australia. *Women and Birth: Journal of the Australian College of Midwives*, *30*(4), 282–290.
- Berg, R. C., Denison, E., & Fretheim, A. (2010). Psychological, social and sexual consequences of female genital mutilation/cutting (FGM/C): A systematic review of quantitative studies. In *Rapport fra Kunnskapscenteret - Systematisk oversikt nr. (p. 13)*. Oslo: Norwegian Knowledge Centre for the Health Services.
- Berg, R. C., Taraldsen, S., Said, M. A., Sorbye, I. K., & Vangen, S. (2017a). The effectiveness of surgical interventions for women with FGM/C: A systematic review. *BJOG: International Journal of Obstetrics and Gynaecology*, *125*(3), 278–287.
- Berg, R. C., Taraldsen, S., Said, M. A., Sorbye, I. K., & Vangen, S. (2017b). Reasons for and experiences with surgical interventions for female genital mutilation/cutting (FGM/C): A systematic review. *Journal of Sexual Medicine*, *14*(8), 977–990.
- Berg, R., Underland, V., Odgaard-Jensen, J., Fretheim, A., & Vist, G. (2014). Effects of female genital cutting on physical health outcomes: A systematic review and meta-analysis. *British Medical Journal Open*, *21*(4), 11e006316.
- Catania, L., Abdulcadir, O., Puppo, V., Verde, J. B., Abdulcadir, J., & Abdulcadir, D. (2007). Pleasure and orgasm in women with female genital mutilation/cutting (FGM/C). *Journal of Sexual Medicine*, *4*(6), 1666–1678.
- Connor, J. J., Brady, S. S., Chaisson, N., Mohamed, F. S., & Robinson, B. B. E. (2019). Understanding women's responses to sexual pain after female genital cutting: An integrative psychological pain response model. *Archives of Sexual Behavior*. <https://doi.org/10.1007/s10508-019-1422-9>.
- Hasenbring, M. I., & Verbunt, J. A. (2010). Fear-avoidance and endurance-related responses to pain: New models of behavior and their consequences for clinical practice. *Clinical Journal of Pain*, *26*(9), 747–753.
- Johnsdotter, S. (2018). The impact of migration on attitudes to female genital cutting and experiences of sexual dysfunction among migrant women with FGC. *Current Sexual Health Reports*, *10*(1), 18–24.
- Rouzi, A. A. (2010). Epidermal clitoral inclusion cysts: Not a rare complication of female genital mutilation. *Human Reproduction*, *25*(7), 1672–1674.
- Sturgeon, J. A., & Zautra, A. J. (2016). Social pain and physical pain: Shared paths to resilience. *Pain Management*, *6*(1), 63–74.
- Vlaeyen, J. W., & Linton, S. J. (2000). Fear-avoidance and its consequences in chronic musculoskeletal pain: A state of the art. *Pain*, *85*(3), 317–332.
- Vloeberghs, E., van der Kwaak, A., Knipscheer, J., & van den Muijsenbergh, M. (2012). Coping and chronic psychosocial consequences of female genital mutilation in the Netherlands. *Ethnicity & Health*, *17*(6), 677–695.
- World Health Organization (WHO). (2016). *WHO guidelines on management of health complications from female genital mutilation*. Geneva: Author.
- Wuest, S., Raio, L., Wyssmueller, D., Mueller, M. D., Stadlmayr, W., Surbek, D. V., & Kuhn, A. (2009). Effects of female genital mutilation on birth outcomes in Switzerland. *BJOG: International Journal of Obstetrics and Gynaecology*, *116*(9), 1204–1209.

**Publisher's Note** Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.