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Psychosexual Complications of Female Genital Mutilation for Couples: A Comparative Study

Osman Mahmoudi^{1*}, Elham Hosseini²

1. Dept. of Family Counseling, Shaheed Chamran University, Ahvaz, Iran.
2. Payame Nour University Center of Javanrood, Kermanshah, Iran

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***Corresponding Author:**
Shaheed Chamran University, Ahvaz,
Iran. Tel: +98 9187301650

Email:
mahmoudi.osman@gmail.com

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Abstract

Introduction: Female genital mutilation (FGM) comprises of various procedures that damage female genitalia for non-therapeutic intentions, and it offers multidimensional and interdependent effects. Objectives: The aim of this study was to determine whether FGM versus non-FGM couples in Kermanshah in Iran vary in relationship characteristics, such as relationship satisfaction, sexual satisfaction, and mental health.

Methods: To achieve this goal of research, a sample of 414 couples (206 FGM couples and 208 normal couples) of Uramanat area in Kermanshah Province, were selected by non-randomized sampling. Enrich Marital Inventory, 25-SCL Mental Health Inventory and the Arizona Sexual Experience Scale were used for data collection. Data were analyzed between the two groups by utilizing independent t-test. The significance level was $P < 0.05$.

Results: The findings indicated that there was a significant difference between FGM couples and normal couples. Besides, the results revealed that the two groups of participants had significant differences in mental health, marital satisfaction, and sexual function. Overall, FGM couples compared with normal couples had lower levels of mental health, marital satisfaction, and sexual function.

Conclusion: FGM is associated with frequent psychosexual difficulties in Uramanat couples; notably orgasm difficulties, sense of incomplete sexual-needs fulfillment, and neurotic symptoms. Awareness of the psychosexual effects of this operation could help women cope with psychological and psychosexual problems, and could prevent the performing of this inhuman action on others.

Introduction

Intertwined cultural and religious traditions globally perpetuate the practice of FGM. Despite a strong international campaign against this practice, most of Africa, the Middle East, and Southeast Asian cultures continue to use this practice (1). According to the World Health Organization (WHO) (2), each year more than three million girls are circumcised. In addition, WHO estimates there are from 100 to 140 million girl and women victims of FGM (2). FGM dates back more than 5,000 years and currently is practiced in over 30 countries (3). In most parts of Kurdistan, this practice is performed by traditional circumcisers, who usually hold key positions in the community in attending childbirths or other important ceremonial events (1). However, this procedure is increasingly being carried out by medically trained personnel (4).

Much of the empirical exploration of FGM has focused on medical or individual level effects. Less is known about the psychological and relational effects of this practice, although this is important to consider. At a very basic level, FGM offers immediate medical complications such as injury to other nearby genital

tissue and maturation, as well as urine retention, hemorrhage, severe pain, shock, tetanus, or sepsis (bacterial infection), open sores in the genital region, infections, and even death (2). Additionally, Braddy (1999) reports the occurrence of chronic problems such as infertility, recurrent bladder and urinary tract infections, and cysts. Some of these chronic problems require the need for multiple surgeries (5). Other chronic problems include: anemia; incontinence; menstruation problems; and dyspareunia (5). Since FGM is often practiced in less-developed areas, problems often occur due to the lack of proper surgical methods and resources. These include increased risk of HIV and blood-borne diseases (6), as well as serving difficulties in future pregnancies and delivery, often resulting in miscarriages and other fatalities (7). While much is known about individual medical and physical effects of FGM, less is known about the psychological effects. More importantly, less is known about the impact of these psychological effects on women and their marital and couple relationships. With regard to psychological effects of FGM, a handful of studies have identified a high frequency of FGM women and their husbands with

psychiatric and psychosomatic illnesses (8). These women also report frequent nightmares, chronic irritability, and feelings of incompleteness, fear, inferiority, and suppression (6 & 12), as well as general frustration (8). In addition to psychological effects, there are known psychosexual effects. Other researchers have found that circumcised women have a number of symptoms that lessen sexual satisfaction, such as vaginal dryness during intercourse, as well as a significant decrease in sexual desire, fewer orgasms, as well as difficulty in achieving an orgasm (8 & 9). These two studies provide elementary support that FGM reduces sexual satisfaction in couples. The current study added to these studies looking at FGM and sexual satisfaction by examining the level of satisfaction in Kurdish couples in Kermanshah.

With the medical, psychological, and psychosexual effects discussed above, it is appropriate to assume that these individual effects impact the couple relationship. For example, when a woman believes that a part of her is missing and that it is irreversible, her self-esteem is decreased and her self-worth is diminished (10). Additionally, the pain associated with intercourse, as well as the decreased sexual desire (8) often lead to couples reluctantly engaging in their "duty" of sexual activity together, even though it may be a traumatizing experience psychologically or physically (11 & 12). While we might assume that FGM decreases sexual satisfaction and marital satisfaction, this assumption has yet to be explored in the context of culture. Marital satisfaction and sexual function of couples is likely to be negatively impacted by the physical and psychological effects of FGM, but there is also a mediational cultural effect that has yet to be analyzed.

The objective of this study was to investigate how common relationship characteristics of gender role attitudes and sexual function may predict the differing levels of marital satisfaction among couples who live in Uramanat region of Kermanshah. This study focuses on one specific aim: whether FGM versus non-FGM couples in Uramanat region of Kermanshah vary on relationship characteristics such as relationship satisfaction, sexual satisfaction, intimacy, spousal support, and mental health.

Materials and methods

This study used a quantitative, survey methodology to test the research hypothesis. The study used couples of Uramanat region of Kermanshah Province, as well as FGM versus non-FGM sample groups, with the level of analysis being couples with the aim of investigating whether there are relational differences among circumcised and uncircumcised married females and their husbands.

This study utilized self-administered paper-pencil surveys on a convenience sample. The surveys took approximately 20–30 min to complete. The role of culture was given particular attention in the construction of standardized instruments and research methodologies in general.

Participants were recruited from counseling sessions that were presented in the seventh month in Hamraz counseling center. There were 414 married women with

their husbands. These consisted of two hundred and six couple victims of FGM and 208 non-genital mutilated females with their husbands; couples who came for counseling to the Hamraz counseling center of Javanrood during the year 2015, and who were selected by non-randomized sampling, with mean age of couples being 35.21. To be included in the study, participants had to be married and live in one of the four cities of Javanrood, Salas, Paveh, and Ravansar. The most frequent category of age both in couple victims of FGM and normal couples was 20–30 years, the most common level of education in normal couples was high school for wives and it was high school for husbands in couple victims of FGM. The educational level of women without FGM was higher than for those who had undergone FGM but there was not a significant difference. Women without FGM were also more frequently working outside of the house than women with FGM. Eighty-three point seven per cent of wives in the FGM group and 72.41 per cent of wives in the normal group were housewives. Also, in the group of couple victims of FGM, 68.93 per cent of participants were living in urban areas and 31.07 per cent of them were living in rural areas, and in the group of normal couples, 75.48 per cent of participants were living in urban areas and 24.52 per cent of them were living in rural areas.

In this study, three questionnaires were used for data gathering:

ENRICH questionnaire (13): The questionnaire was designed by Olson et al. (2004) in order to evaluate potential problem-making issues or to identify enriching and nurturing relationship issues. The questionnaire was also used to identify couples who wanted to enrich their relationships and who needed advice. For this scale, Cronbach's alpha was 0.74 and the questionnaires showed acceptable reliability and validity (14).

25-SCL: The 25-SCL was initially introduced in the literature review (see Section 4.5). The 25-SCL is a self-report questionnaire designed for use as a psychiatric case-finding instrument, as a measure of global symptom severity, and as a descriptive measure of psychopathology. It is intended to measure symptom intensity on nine different subscales (15). Findings related to exploratory factor analysis with principal components and varimax rotations confirm factor structure for 25-SCL that can justify 82.16 per cent of the variance. Also analyses shows there was a negative significant relationship ($P < 0.05$) between sub variables of 25-SCL, psychological and social well-being, divergent validity of 25-SCL. Furthermore, there was a positive significant relationship between subscales of 25-SCL. Also, it produces high Cronbach's alpha (0.71–0.95) and split-half coefficient (0.65–0.96) for subscales and the whole scale score (16).

Arizona Sexual Experience Scale: Sexual function was measured by using an early version of the Arizona Sexual Experience Scale; a gender-specific, five-item, self-report measure. Subjects rate, on a 5-point Likert

scale, their current level of sexual drive, psychological arousal, physiologic arousal (erection or vaginal lubrication), ease of orgasm, and orgasm satisfaction.

Low scores depict sexual response to be “as strong, easy, or satisfying as ever,” while high scores depict the absence of response, e.g., “no sex drive,” “never aroused,” or “never reach orgasm.” Higher scores, therefore, indicate greater sexual dysfunction (17). The Persian version of ASEX has shown good psychometric properties, Cronbach’s alpha of the questionnaire was 0.89 and questionnaires showed acceptable reliability and validity (18).

Statistical Package for the Social Sciences was used to analyze data. Initially, descriptive statistics were used to examine the data. The study was cross-sectional: two groups of participants were compared including three variables; marital satisfaction, sexual functioning, and general health. Data were analyzed between the two groups by *t*-independent group test for two groups. A significance level of $P < 0.05$ was determined

Results

Descriptive findings included: mean; standard deviation; and minimum and maximum frequency rating scores related to age of normal couples and of couples circumcised. The most frequent category of age both in couple’s who were victims of FGM and normal couples, was 20–30, the most common level of education in normal couples was high school for wives and high school for husbands in couple’s who were victims of FGM. The educational level of women without FGM was higher than education level of those who had undergone FGM, but this was not significant. Women without FGM were also more frequently working outside of the house than women with FGM. Eighty-three point seven per cent of wives in the FGM group and 72.41 per cent of wives in the normal group were housewives. Also, in the group of couple’s who were victims of FGM, 68.93 per cent of participants were living in urban areas and 31.07 per cent of them were living in rural areas, and in the group of normal couples, 75.48 per cent of participants were living in urban areas and 24.52 per cent of them were living in rural areas.

Results in Table 1 show that there is a significant difference between normal couples and couples who were victims of FGM in the variable of mental health, and average mental health scores of couples who were victims of FGM ($X = 30/4$) was higher than the average of normal couples ($X = 23/91$). It should be noted that the lower scores on the Mental Health Inventory 25-SCL indicate high level of mental health. Also, a significant difference between the non-circumcised women ($X = 22/76$) in comparison with circumcised women ($X = 30/90$) is observed in the variable of mental health ($t = 3/42$ and $P \leq 0/001$). In addition to this, average mental health scores of husbands of non-circumcised women were different from the average mental health scores of husbands of circumcised women ($t = 2/4$ and $P \leq /02$).

Also, scores on the subscales of 25-SCL showed couples who were victims of FGM and normal couples significantly different ($P \leq 0.05$) from each other in all subscales except in the physical stimulation subscale, and couples who were victims of FGM had significantly higher scores than normal couples in 25-SCL subscales ($t = 2/04$ and $P \leq /02$). As already mentioned, higher scores in the 25-SCL Mental Health Inventory indicate that couples who are victims of FGM have lower levels of mental health than normal couples. These findings indicate the prevalence of fear, paranoid thoughts, psychotic thoughts, depression, anxiety, obsessive-compulsive tendencies, and feelings of inferiority and inadequacy among couples who are victims of FGM.

Table 2 shows that there is a significant difference between normal couples ($X = 161/27$) and couples who are victims of FGM ($X = 138/62$) in the variable of marital satisfaction ($t = 8/35$ and $P \leq 0/0001$).

Also, a significant difference between non-circumcised women ($X = 157/92$) in comparison with circumcised women ($X = 122/56$) is observed in the variable of marital satisfaction ($t = 9/47$ and $P \leq /0001$). In addition to this, average marital satisfaction scores of husbands of non-circumcised women ($X = 164/62$) are different from those of husbands of circumcised women ($X = 154/68$).

Table 1. Shows the *t*-test to compare the mean scores of mental health in couple victims of FGM and normal couples

| Groups | Couple victims of FGM | Normal couples | Couple victims of FGM (wives) | Normal couples (wives) | Couple victims of FGM (husbands) | Normal couples (husbands) |
|---------|-----------------------|----------------|-------------------------------|------------------------|----------------------------------|---------------------------|
| N | 206 | 208 | 92 | 87 | 114 | 121 |
| Mean±SD | 30.4±14.62 | 23.91±18.32 | 30.90±15.39 | 22.76±17 | 30±14.15 | 24.74±18.99 |
| d.f | 205 | 207 | 91 | 86 | 113 | 120 |
| T | 3.97 | 3.42 | 3.01 | 3.34 | 2.4 | 3.002 |
| Pvalue | 0.0001 | 0.001 | 0.001 | 0.0001 | 0.02 | 0.001 |

Table 2. Shows the *t*-test to compare the mean scores of marital satisfaction couple victims of FGM and normal couples

| Groups | Couple victims of FGM | Normal couples | Couple victims of FGM (wives) | Normal couples (wives) | Couple victims of FGM (husbands) | Normal couples (husband) |
|---------|-----------------------|----------------|-------------------------------|------------------------|----------------------------------|--------------------------|
| N | 206 | 208 | 92 | 87 | 114 | 121 |
| Mean±SD | 138.62±27.44 | 161.27±27.77 | 122.56±22.60 | 157.92±27.01 | 154.68±32.34 | 164.62±27.76 |
| d.f | 205 | 207 | 91 | 86 | 113 | 120 |
| T | 8.35 | | | 9.47 | | 2.52 |
| Pvalue | 0.0001 | | | 0.0001 | | 0.001 |

In the comparison of subscales, there was a significant difference among the items of following subscales: personal issues ($t= 8.50$ and $P\leq 0.0001$), marital relationship ($t=11.73$ and $P\leq 0.0001$), solving problems ($t= 9.38$ and $P\leq 0.0001$), financial management ($t=6.42$ and $P\leq 0.0001$), leisure ($t = 2/53$ and $P \leq 0/002$), sexual relationship ($t = 20.62$ and $P\leq 0.0001$) and total of two groups of participants ($t= 8.35$ and $P\leq 0.0001$), and FGM couples had lower score in all subscales, except marriage of children, relatives and children, and regional tendency, compared with the non-FGM group.

The results in Table 3 show that the mean scores of sexual function in couples who are victims of FGM ($X = 18/60$) were significantly different from those of normal couples ($X= 14.04$) ($t= 4.97$ and $P\leq 0.0001$). Also, mean scores for sexual function in non-circumcised women ($X = 19/05$) were different from those of circumcised women ($X= 18.15$) ($t=7.63$ and $P\leq 0.0001$). In addition

to this, average mean score for sexual function of husbands of non-circumcised women ($X=13.99$) was different from average sexual function scores of husbands of circumcised women ($X= 14.12$) ($t= 5.02$ and $P\leq 0.0001$).

Regarding the results of Table 4 below, there was a significant difference between the items of psychological arousal, physiologic arousal, ease of orgasm, orgasm satisfaction, and total of two groups of participants. The comparison of average of scores between two groups indicated that FGM couples had higher score in all subscales, except sex drive, than those in the non-FGM group. It is necessary to point out, higher scores in the Arizona Sexual Experiences Scale indicate that couples who are victims of FGM, compared with normal couples, have lower levels of sexual function

Table 3. Shows the t-test to compare the mean scores of sexual function of couple victims of FGM and normal couples

| Groups | Couple victims of FGM | Normal couples | Couple victims of FGM (wives) | Normal couples (wives) | Couple victims of FGM (husbands) | Normal couples (husband) |
|---------|-----------------------|----------------|-------------------------------|------------------------|----------------------------------|--------------------------|
| N | 206 | 208 | 92 | 87 | 114 | 121 |
| Mean±SD | 18.60±6.15 | 14.04±5.99 | 19.05±6.31 | 18.15±5.4 | 14.12±6.11 | 13.99±5.08 |
| D.f | 205 | 207 | 91 | 86 | 113 | 120 |
| T | 4.97 | | 7.63 | | 5.02 | |
| P-Value | 0.0001 | | 0.0001 | | 0.0001 | |

Table 4. Comparison of mean sexual function in couple victims of FGM and normal couples in the Arizona Sexual Experiences Scale

| Arizona Sexual Experience Scale Item | Couples | Mean±SD | T | P |
|--------------------------------------|---------------|--------------|-------|--------|
| Sex drive | Victim of FGM | 3.75 ± 1.49 | 1.03 | 0.22 |
| | Normal | 3.40 ± 1.51 | | |
| Psychological arousal | Victim of FGM | 3.89 ± 1.47 | 2.128 | 0.005 |
| | Normal | 3.15 ± 1.29 | | |
| Physiological arousal | Victim of FGM | 3.97 ± 1.40 | 7.74 | 0.0001 |
| | Normal | 2.95 ± 1.29 | | |
| Ease of orgasm | Victim of FGM | 3.711 ± 1.48 | 0.84 | 0.0001 |
| | Normal | 3.33±1.41 | | |
| Orgasm satisfaction | Victim of FGM | 3.86±1.45 | 7.506 | 0.0001 |
| | Normal | 2.75±1.58 | | |
| Total | Victim of FGM | 18.60±6.15 | 4.97 | 0.0001 |
| | Normal | 14.04±5.99 | | |

d.f= 412, $P\leq 0.05$

Discussion

Most research on the health and sexuality consequences of FGM has been limited to circumcised women, and prior to this study, no research was done on the effects of FGM in couples. With attention on psychosexual problems related to FGM and on increasing numbers of women who were circumcised in childhood and who have now reached the age of marriage or of being married, the sexual function, mental health and marital satisfaction of these women and their husbands is going to become an increasingly important issue. Unfortunately only ones in this review are those conducted on Kurdish populations—on Uraman women in Iran (19). Also There is no previous research on health and psychosexual effects of FGM in couples. For reasons discussed above, this study was conducted on a couples population in Kermanshah Province, Uramanat region in Iran, and it enabled us to give a

wider picture of the sexual function, mental health, and marital satisfaction in women affected by this practice and their husbands.

Our study makes several contributions to what is known about the association between the relationship of mental health, marital satisfaction, and sexual function among couples who are victims of FGM. We found that FGM is strongly associated with marital dissatisfaction, sexual dysfunction, and psychiatric symptoms for both wife and husband victims of FGM. First, normal couples reported better health and fewer behavioral problems than couple victims of FGM, and we found significant differences among couples who were victims of FGM which have not been previously documented. As we expected, in the field of fear, paranoid thoughts, psychotic thoughts, depression, anxiety, obsessive-compulsive tendencies, and feelings of inferiority, couples who were victims of FGM were in worse mental

condition than normal couples. The results of our research were consistent with those of (19, 20 & 21). They showed that genital mutilation has harmful effects over females' physical and mental health and it leads to shocks in girls and it also decreases the female's potential to reach an orgasm. Also, according to UNICEF data, this action violates females' basic rights and it really hurts their health. These findings indicate that the prevalence of fear, paranoid thoughts, psychotic thoughts, depression, anxiety, obsessive-compulsive tendencies, and feelings of inferiority and inadequacy among couples who are victims of FGM is higher than that in normal couples (22).

Second, we found that marital satisfaction of couples who were victims of FGM was lower and worse condition than that of normal couples, specifically in the fields of personal issues, marital relationship, solving problems, and sexual relationship. These results were consistent with results of other studies (19, 23, 24 & 25). One of the items of marital satisfaction was sexual satisfaction, and it was at the lowest level in genitally mutilated females, and the results of this research were also similar to those of DeMaria, who explained that there was a positive relationship between high satisfaction in life and high satisfaction in sexual life (23 & 24). Also, the results of this research are similar to those of Alariqi (2007) that she found 24% of Yemeni females were circumcised or genitally mutilated, and dissatisfaction of sexual relationships in them was higher than in females who did not have mutilation (23). Finally, we found that sexual function of couples who were victims of FGM was lower, specifically in psychological arousal, physiologic arousal, ease of orgasm, and orgasm satisfaction, compared with normal couples. These results are consistent with those of a study in Egypt that suggested circumcision has a negative impact on a woman's psychosexual life, raising common problems and sexual dysfunction (10 & 26).

The results obtained from this study suggest that those women with FGM and their husbands more than likely also experience low mental health, marital dissatisfaction and sexual dysfunction in societies with power disparities hidden in social and cultural expectations, and this may also affect relational expectations. A qualitative study would be useful in

confirming and delving into this finding, as the results of this study suggest that women are predominantly placed in disadvantaged positions through the socialization of traditional gender roles. Even though the findings of this study did significantly support all of the researcher's hypotheses, the analysis used to arrive at the results was useful in pointing out the differences and means between groups, to demonstrate that the practice of FGM yields significant difference in marital satisfaction and mental health, as claimed by its victims (27).

This study examined several contributions, i.e., the gaps in FGM literature and lack of empirical studies on the impact of FGM on couples. However, it is important to note some of its limitations. First, it was a cross-sectional study. A cross-sectional study is convenient and time efficient. However, it has an inherent limitation in that conclusions will be based on one-time observations. Therefore, a longitudinal study examining the same couples across different life cycles, towns, and countries would prove beneficial. The longitudinal study will provide information about individual change; separate aging effects; and, subjects will serve as their control. This will lead to more accurate and reliable findings.

Conclusion

Psychosexual dysfunctions that result from FGM certainly have implications for the marriages and relationships of these couples (21), as suffering from a psychosexual disorder would complicate the process of psycho-sexually satisfying a partner. Evidently, FGM is associated with many long-term psychological, marital, and social problems for the women who undergo the procedure and for their partners. It is important then for health centers, hospitals, mosques, and women's organizations to spread the message about the health impairments associated with FGM in order to protect women and couples in the future (19 & 28). This is especially important for counselors working with victims of FGM. It has even been suggested that counselors seek to be a part of promoting public engagements about ending the practice. By doing this, counselors could help women and couples protect their health and their marriage within society.

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