

# Female genital mutilation: cultural and psychological implications

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**ABSTRACT** *Female genital mutilation (FGM) is widely practised in several regions of the world. It is often associated with physical, psychological, sexual and social sequelae. Migration of persons from cultures that actively practice FGM to the UK and other Western countries increases the chances that clinicians will be faced with patients who have undergone this procedure. Clinical presentations often occur against a background of differences in culture and social identity, which may pose a challenge to any form of intervention. Perceptions of normalcy, human rights violation and gender roles may also differ. This paper discusses historical, cultural, gender and identity issues associated with FGM and its psychological and sexual implications.*

## Introduction

Female Genital Mutilation (FGM), also known as female circumcision, has a history spanning over 5000 years across different cultures (Elchalal *et al.*, 1997). Previously practised in parts of Europe and America, it remains a traditional practice in some African, Middle Eastern, Asian, South American and Pacific countries. As these populations migrate to Western countries, it is increasingly likely that healthcare professionals will be faced with patients with physical, psychological or sexual sequelae of this procedure.

The World Health Organization defines FGM as any procedure that involves partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or non-therapeutic reasons (WHO, 1997). This involves surgical removal of parts of the clitoris, labia minora and labia majora. The clitoris is an extremely sensitive organ and plays a central role in female sexual stimulation; its removal therefore impairs normal female sexual response.

The World Health Organization (WHO, 1997) estimates that over 130 million girls and women have undergone some form of circumcision, and that there are up to 6000 new cases every day. In a number of African countries national rates range from 5% to 98%. In Somalia, for instance, over 90% of women undergo an

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extensive form of circumcision and 1% of women giving birth die because of complications resulting from circumcision (WHO, 1993). The main causes of high short-term mortality and morbidity are haemorrhage and infection (Barstow, 1999).

Other long-term medical complications include infertility, urinary retention and infection, haematocolpos, and the formation of fistulae (Barstow, 1999; Morris, 1999), as well as an increased risk of contracting HIV (Brady, 1999).

The focus on these physical complications distracts from the often neglected psychological morbidity associated with the practice of FGM. This may range from disorders such as post-traumatic stress disorder, anxiety and depression, to psychosexual problems (Elchalal *et al.*, 1997).

Understanding the different types of female circumcision and their medical, obstetric and psychological complications is important for medical practitioners. However, enmeshed in these presentations are historical and cultural beliefs and practices which need to be addressed sensitively in order to effect appropriate interventions.

### **A historical perspective**

Although the origin of FGM is uncertain, there is evidence from Egyptian mummies that female circumcision was routine practice 5000 years ago (Elchalal *et al.*, 1997). In ancient Rome slaves had metal rings passed through the labia minora to prevent procreation and women in medieval England wore chastity belts. These practices are not specifically associated with any particular religious faith, as they have been observed in Muslims, Jews, Christians and animists alike (Morris, 1999), and actually predate these religions.

Although FGM is commonly perceived in present day Western countries to be a 'foreign' phenomenon, clitoridectomy (the surgical removal of the clitoris) was a recognized practice in 19<sup>th</sup> century Britain in the management of epilepsy, sterility and masturbation (Kandela, 1999). The Obstetrical Society (1866) challenged proponents of the value and ethics of this procedure in the *Lancet*. Indeed, some of the 'clinical' justification demonstrated attitudes towards women similar to those in many other parts of the world today. The ensuing debate argued that "we have scarcely more right to remove a woman's clitoris than we have to deprive a man of his penis" (Moore, 1866). However, a protagonist (Bantock, 1866) suggested the clitoris had a rudimentary role, with clear functional and anatomical differences between it and the penis. Another advocate of clitoridectomy emphasized the virtues of the procedure as a cure for the 'vice' of masturbation asserting that, "surgery comes to the rescue and cures what morals should have prevented" (Brown, 1866). Although such radical methods were aimed at male control over female chastity, there is no documented evidence that male masturbation was 'dealt' with so aggressively. The Obstetrical Society (1866) finally concluded of clitoridectomy: "if it be useless it is a lamentable mistake, and if it be unnecessary it is a cruel outrage". Similar views were held by a number of US clinicians. In 1889 Dr Joseph Jones, a medical professor, suggested that 'hopeless insanity' was a consequence of masturbation, resulting in hereditary insanity for offspring (Jones, 1889). A few

years later, Dr A. J. Bloch (1894), a US surgeon wrote ‘Sexual perversion in the female’, referring to female masturbation as a “moral leprosy” cured by “liberating the clitoris from its adhesions”. In the twentieth and twenty-first centuries there has been an international drive by organisations such as the WHO and Amnesty International emphasizing the human rights violation of girls and women through this procedure. Various national governments have also set up legislative frameworks to abolish and criminalize FGM.

### **Female circumcision: tradition or abuse?**

Many explanations have been put forward to explain the practice of FGM, varying with individual culture. These include maintaining marital fidelity, controlling the female sex drive, preventing lesbianism, ensuring paternity, calming the female personality, and to prevent the clitoris growing long like the penis (Eke & Nkanginieme, 1999). Other reasons cited are to improve hygiene, aesthetics and community belonging and to enhance fertility—these explanations are arguably partly driven by ‘sexist’ views of women as subservient to men and second-class citizens of society.

In some societies a woman’s honour is dependent on her being circumcised (Rising Daughters Aware, 1999). For instance, in a village where all the women have been circumcised, not to be circumcised is to become a social pariah, and lose all chance of having a husband. It is therefore understandable that pressure would be brought to bear by relatives and the community on women to undergo such procedures. In societies where a woman’s position is low on the social echelon, an important rite of passage is an opportunity to be honoured, even celebrated, and is therefore likely to be an event that is romanticized and clung on to (Rising Daughters Aware, 1999). The complexity of this cultural interplay was noted in a study that found over 60% of 282 female student nurses in Egypt favoured circumcising their own daughters and considered it beneficial (Dandash *et al.*, 2001).

### **The practice of female circumcision**

Traditional FGM is often carried out on girls between the ages of two and 12 (Barstow, 1999). However, in some cultures it is carried out in adolescence, just before marriage, or at childbirth. The ‘operator’ is usually an older woman in the community, either a relative or a traditional birth attendant. In some situations FGM is carried out without anaesthesia, antiseptics, analgesics or antibiotics (Barstow, 1999). Surgical instruments may not be available, and the ‘surgery’ is carried out using whatever is available, for example sharp rocks, razor blades, broken glass, or even the operator’s teeth (Barstow, 1999). The wound may be treated by applying local herbs, ash, or even mixtures containing cow dung. The different types of FGM conducted are shown in Table I.

FGM by qualified medical personnel may be carried out in sterile surgical conditions with local or general anaesthesia. In fact, a survey of the views of a group

TABLE I. Types of female genital mutilation

*Classification*

Type I Excision of the prepuce with or without excision of part or all of the 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

*Source:* WHO (1997).

of male Egyptian medical students found 22% had no objections to carrying out female circumcisions as doctors (Refaat *et al.*, 2001).

### **FGM and gender issues**

In traditional societies where FGM is practised a woman may be perceived to be unworthy of marriage if she has not undergone circumcision (Omer-Hashi *et al.*, 1995). This is because circumcision is thought to guarantee female chastity. It is interesting that no such constraints are put on men, but men have traditionally preferred chaste women in order to ensure their paternity (Daly & Wilson, 1978 cited in Bhugra, 1998). Lax (2000) says that psychoanalytical findings indicate that the motive for FGM is based on men's unconscious fear of women's sexuality and the need to suppress it. This suggestion is understandable in that, while FGM suppresses female sexuality by diminishing the capacity to enjoy a sex life, increased pleasure from tightening of the vagina has been described by some males (Ng, 2000). In many societies women assume the role of the submissive wife, child-bearer and mother. However, in recent years this stereotype has been challenged in many societies the world over, as women have become increasingly socially independent of men. Mackie (1996) compares FGM to foot binding in China, and asserts that both practices originated in an attempt to ensure exclusive sexual access for the male. He suggests that FGM may be eradicated in a similar way to foot binding by forming associations of parents who pledge not to let their daughters undergo FGM, or let their sons marry women who have undergone FGM. This may be complicated by the fact that a significant proportion of FGM is perpetuated by women, some of whom are willing to assume a submissive role. Joseph (1996) suggests that FGM is perpetuated by the 'split-off internal and cultural sadist, women who have dissociated from their own relationship to pain and project it onto the bodies of

their children'. This simplistic view suggests that women who have undergone FGM feel that their own children should undergo what they endured (Williams & Sobieszczyk, 1997), hence perpetuating cycles of pain. However, this ignores the importance of circumcision in the cultural rites of passage from childhood to adulthood, in which the status of women is raised significantly (Rising Daughters Aware, 1999). It is therefore clear that if FGM is to be eradicated there must be fundamental changes in both the attitudes of men and women and in attitudes about women and female sexuality across cultures. The independence and individual sexuality of women should be attributes that are celebrated and not suppressed.

### **FGM and immigrant cultural identity**

While FGM has been illegal in Britain since 1985, it is still practised secretly or ignorantly in some immigrant communities. In some situations girls are sent abroad to circumvent legal restrictions on the procedure (Black & Debelle, 1995). Indeed, medical practitioners carrying out these procedures in the UK have been struck off the medical register (Black & Debelle, 1995). Refugee populations who traditionally practise FGM have shared the problems of the refugee experience often associated with psychological stress (Spouse, 1998), trauma of conflict, persecution, loss and separation, as well as the confusion, turmoil and uncertainties of arriving in foreign country. The refugee may arrive in a society built on a value system quite different from his or her own (Rising Daughters Aware, 1999). Refugee groups may find their racial and ethnic identity challenged by the migration and acculturation process. It is therefore unsurprising that such people form close-knit communities in which traditional values and practices are held to be important for preserving their cultures. These immigrants may therefore strive to preserve this aspect of their cultural identity (Morris, 1999) as they would their diet or religious practice. It is vital for healthcare professionals to be sensitive to the identity issues that these immigrants experience, and to understand how seemingly abhorrent practices such as FGM may serve as an affirmation of cultural identity.

### **The psychological burden of FGM**

FGM is also associated with various degrees of psychological morbidity. Lax (2000) described psychological consequences following FGM such as "loss of trust, prevailing lack of bodily well-being, post-traumatic shock and depression". Interestingly, the psychological morbidity following the procedure in countries where FGM is culturally acceptable or prevalent is thought to be minimal (Black & Debelle, 1995). In fact, these authors argue that not to be circumcised in certain communities has a greater psychological impact than the trauma caused by circumcision itself. This is because, as discussed above, not being circumcised in certain communities is to become a social pariah.

A female member of the community traditionally carries out the FGM procedure. She may be closely related (mother or grandmother) or a total stranger (Ortiz, 1998). Some individuals describe a sense of betrayal by

someone emotionally close. Some proponents of the procedure argue that, through the experience of pain, the girls realize a sense of kinship with each other, and a sense of achievement of reaching adulthood (Rising Daughters Aware, 1999). However, witnesses of FGM dispute the suggestion that a mystical state is reached through the pain of the procedure, and suggest that extreme pain, dangerous blood loss and potentially fatal infection are the characteristics that mark it (Charlotte Metcalf, personal communication). While there are limited data on the rates of individual disorders, psychological effects of FGM, such as depression, anxiety and post-traumatic stress disorder (PTSD) have been described. Black and DeBelle (1995) suggest this is less likely to be a problem among those living societies where FGM is routine, as experiences are normalized. Studies of PTSD in refugee children fleeing persecution and conflict demonstrate that the prevalence of PTSD is proportional to the level of traumatic exposure (Almqvist & Brandell-Forsberg, 1997). One can postulate that the prevalence of PTSD is likely to be higher in girls who undergo the more extensive procedures, or whose procedure was associated with serious complications. PTSD is associated with flashbacks triggered by reminders of the traumatic event and may be accentuated by experiences such as sexual intercourse, gynaecological examination and childbirth in vulnerable persons.

As a consequence of FGM many women are affected by chronic pain syndrome and mobility impairment (Lightfoot-Klein, 1993). The chronic pain may be linked directly to the trauma of the procedure, or be a result of the complications that ensue, such as infection or menstrual difficulties. As with other causes of chronic pain there is an increased risk of depressed mood, with reduced social functioning, worthlessness, guilt, and even suicidal ideation. Limited mobility also increases social isolation and role loss in society. Sadly some women fail to present to medical services because to do so they must first seek permission from their husbands or other male members of their family (Lightfoot-Klein, 1993). In addition, the husband may insist on being present during consultations, potentially restricting discussion of emotional difficulties.

### *Sexual dysfunction*

FGM potentially causes a whole host of sexual problems. Dyspareunia, orgasmic delay and anorgasmia are not uncommon (Brighthouse, 1992). However, this may not be perceived as a problem if the girl underwent the procedure before becoming sexually active, or if her peers too are anorgasmic. Orgasmic difficulties are more likely to be reported in groups that undergo the procedure after a period of adolescent sexual activity or before childbirth. El-Defrawi *et al.* (2001), however, observed significant rates of sexual difficulties in 80% of a circumcised population, namely, lack of desire (45%), reduced pleasure (49%) and orgasmic failure (60.5%).

Immigrant females in cultures with different or 'more liberal' attitudes towards sexuality may face challenges or altered expectations as a result of the new sexual culture, media or new peers. The circumcised female aware of differences in the appearance of her genitalia may feel deeply embarrassed during clinical examination

or coitus. Furthermore, such women aware of a lack of sexual enjoyment may respond with feelings of anger, guilt, shame or inadequacy.

FGM has been associated with infertility in some cases (Eke & Nkanginieme, 1999). This can be attributed to complications arising from the introduction of infection such as pelvic inflammatory disease, from formation of keloid scars, or even from inadequate penetration during sexual intercourse. The psychosocial consequences of infertility in communities where childbirth and child rearing play a major role for women should not be underestimated. In some societies the failure to produce children is blamed on women, and may even be attributed to a curse (Charlotte Metcalf: personal communication). This can result in the woman being rejected by her husband and even by her extended family, resulting in further social isolation.

While there has been much focus on the sexual and psychological problems that FGM causes for women, the emotional and physical needs of their partners and the impact on their relationship are often neglected. Emotional or physical pain during intercourse diminishes the enjoyment of both the woman and her partner and the woman is reduced to a masturbatory object during sex (Longmans *et al.*, 1998). This certainly has implications for intimacy in the relationship.

In some countries specialist centres have been developed that offer surgical reconstruction of the female genitalia (discussed in Momoh *et al.*, 2001). These procedures potentially reverse or reduce the risk of physical and obstetric complications, and consequently may reduce psychological difficulties. Great sensitivity is needed when providing this sort of care, however. As many myths surround FGM, these must be explored in a culturally sensitive manner. In addition, the gynaecologist carrying out the procedure must be aware that routine examination and instrumentation of the vagina may trigger flashbacks, and that the idea of a further surgical procedure, albeit repair, may be a source of distress as well.

### **Implications for healthcare professionals**

While it is essential to approach FGM in a culturally sensitive way, there is a danger that some health professionals might avoid interventions for fear of being perceived as racist. Eke and Nkanginieme (1999) argue that shying away from the issue for the sake of political correctness is morally unacceptable, as the fear of being culturally out of one's depth may cause neglect of the medical and psychological needs of circumcised women.

In this paper we have seen that FGM is an ancient cultural practice that still affects many women around the world today. While the original aim was to ensure women adopted a submissive position towards men in society, societal shifts, human rights awareness and changes in sexual roles make it unnecessary in modern society. Its continued perpetuation is dependent on the interplay of culture, lack of awareness and acceptance in some societies. With an increasingly 'multicultural' society and an increasing migrant population it is likely that healthcare professionals, especially those in inner city areas, will come across women who have undergone FGM. Because of the nature of the procedure this contact is most likely to occur in

primary care, paediatrics, obstetrics and gynaecology, and psychological or psychosexual services. An increased awareness of the practice is essential among all health and social science professionals, as well as an integral part of training curricula. While the healthcare professional is likely to find the practice of FGM abhorrent, it is essential that the topic be approached with cultural sensitivity as without this there is unlikely to be trust, and thus little chance of a successful outcome to the clinical encounter (Gibeau, 1998). Specialist services developed to manage women who have undergone FGM and their attendant obstetric and gynaecological problems (Momoh *et al.*, 2001) can also provide a gateway to psychological counselling and mental health services. However, one cautions against the risk of pathologizing well adjusted persons who have no complaints. A lack of awareness of how differently and subtly psychiatric problems may manifest in different cultural groups may influence referral pathways, as some women are unlikely to present to health services. There may also be traditional support resources within their own community. Linguistic, religious and gender differences may also influence how sensitive information is disclosed.

Health professionals must be aware of these issues in their interventions, without being judgmental. The role of close liaison between primary care, paediatric, obstetric and gynaecological and psychological services on the one hand, and these immigrant communities on the other, can not be over-emphasized in changing attitudes and health education about the practice of FGM. The challenge of changing these attitudes also needs sustained campaigning by international, non-governmental, human rights and national organizations on the deleterious effects of female circumcision.

However, in the meantime we have a duty of care to girls and women who have undergone such procedures, as well as to prevent further perpetuation to their daughters. This can only be achieved if healthcare professionals demonstrate adequate awareness of the origins, traditions and psychosocial implications of genital mutilation with cultural sensitivity.

## **Acknowledgement**

The authors thank Charlotte Metcalf for providing some personal reflections about FGM from her experiences of filmmaking in Somalia and Ethiopia.

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