Archives of Sexual Behavior (2021) 50:1875–1885
https://doi.org/10.1007/s10508-020-01633-x

COMMENTARY

Protecting Children from Medically Unnecessary Genital Cutting Without Stigmatizing Women's Bodies: Implications for Sexual Pleasure and Pain

Brian D. Earp[1,2]

Received: 22 December 2019 / Revised: 4 January 2020 / Accepted: 8 January 2020 / Published online: 21 January 2020

The research studies on pain sensation and on medically unnecessary genital cutting have developed largely independently over the past few decades.[1] However, in recent years, both of them have shifted from a predominately physical focus (in the case of pain, looking for purely "organic" etiologies of aversive bodily sensations; in the case of genital cutting, attributing putative harms primarily to the physiological consequences of the cutting itself) to one that integrates biological, psychological, and wider social factors in understanding the phenomena in question—and their diverse effects on lived experience (Bossio & Pukall, 2018; Craig, 2018; Einstein, 2008; Jacobson et al., 2018; Karos, Williams, Meulders, & Vlaeyen, 2018). With respect to pain, such biopsychosocial models have happily become more dominant in the field (e.g., see Turk & Monarch, 2018), but have so far been applied only to certain domains. The Target Article by Connor, Brady, Chaisson, Sharif Mohamed, and Robinson (2019), which further develops and extends the purview of such models to sexual pain related to female genital cutting (FGC), makes for a valuable contribution.

In this commentary, I will start with some remarks about the fear avoidance model (FAM) of pain, which Connor et al. (2019) adapt and incorporate into the first quadrant of their integrative psychological pain response (IPPR) model. My goal will be to highlight the importance of threat interpretation in especially the latest versions of the FAM (Crombez, Eccleston, Van Damme, Vlaeyen, & Karoly, 2012; Vlaeyen, Crombez, & Linton, 2016), which may have important downstream consequences for the development of adaptive versus maladaptive (e.g. catastrophizing) cognitions surrounding pain, sexual or otherwise.

Having stressed the importance of threat interpretation, I then turn to the question of psychosocial and other contextual factors and ask how these may influence such interpretation(s) in the areas of genital cutting and sexual pain. In particular, I elaborate on one of the key psychosocial considerations raised by Connor et al. (2019), namely the potentially stigmatizing nature of much current activist, academic, and social-policy discourse surrounding non-Western forms of FGC (see Table 1) (Ahmadu, 2016; Bell, 2005; Ehrenreich & Barr, 2005; Johnsdotter, 2018b; Johnsdotter & Mestre i Mestre, 2017; Karlsen, Mogilnicka, Carver, & Pantazis, 2019; Lewis, 1995; Manderson, 2004; Obiora, 1996; Onsongo, 2017; Robertson & James, 2002; Shweder, 2000; Wade, 2009, 2011, 2012; Walley, 1997). I explore how this discourse may, at least along certain dimensions, inadvertently harm the very people it is intended to help, focusing on possible implications for sexual experience. As Scott (2019) argued, certain features of the social environment can influence the risk of developing chronic pain, and "invalidating or stigmatizing responses from others" have been associated with "worse

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

✉ Brian D. Earp
brian.earp@yale.edu

[1] Yale-Hastings Program in Ethics and Health Policy, Yale University, New Haven, CT 06511, USA

[2] The Hastings Center, Garrison, NY, USA

[1] According to the Brussels Collaboration on Bodily Integrity (2019), "an intervention to alter a bodily state is medically necessary when: (1) the bodily state poses a serious, time-sensitive threat to the person's well-being, typically due to a functional impairment in an associated somatic process, and (2) the intervention, as performed without delay, is the least harmful feasible means of changing the bodily state to one that alleviates the threat. 'Medically necessary' is therefore different from 'medically beneficial', a weaker standard, which requires only that the expected health-related benefits outweigh the expected health-related harms. The latter ratio is often contested as it depends on the specific weights assigned to the potential outcomes of the intervention, given, among other things, (a) the subjective value to the individual of the body parts that may be affected, (b) the individual's tolerance for different kinds or degrees of risk to which those body parts may be exposed, and (c) any preferences the individual may have for alternative (e.g. less invasive or risky) means of pursuing the intended health-related benefits (p. 18)."

Table 1 Non-Western "FGM" as compared to Western-style "cosmetic" female genital cutting. Adapted from Shahvisi and Earp (2019) and BCBI (2019)

Category	"Female Genital Mutilation" (FGM) as defined by the World Health Organization: namely, all medically unnecessary procedures involving partial or total removal of the external female genitalia, or other injury to the female genital organs—widely condemned as human rights violations and thought to be primarily non-consensual	Female Genital "Cosmetic" Surgeries (FGCS): typically medically unnecessary procedures involving partial or total removal of the external female genitalia, or other alterations to the female genital organs for perceived cosmesis—widely practiced in Western countries and generally considered acceptable if performed with the informed consent of the individual (cf. intersex cases, which are still primarily non-consensual)
Procedures + WHO typology	Type I: **Alterations of the clitoris or clitoral hood**, within which Type Ia is partial or total removal of the clitoral hood, and Type Ib is partial or total removal of the clitoral hood and the (external portion of the)[a] clitoris [i.e. glans and sometimes part of the body]	**Alterations of the clitoris or clitoral hood,** including clitoral reshaping, clitoral unhooding, and clitoroplasty (also common in "normalizing" intersex surgeries)
	Type II: **Alterations of the labia**, within which Type IIa is partial or total removal of the labia minora, Type IIb is partial or total removal of the labia minora and/or the (external)[a] clitoris, and Type IIc is the partial or total removal of the labia minora, labia majora, and (external)[a] clitoris	**Alterations of the labia**, including trimming of the labia minora and/or majora, also known as "labiaplasty"
	Type III: **Alterations of the vaginal opening** (with or without cutting of the clitoris), within which Type IIIa is the partial or total removal and appositioning of the labia minora, and Type IIIb is the partial or total removal and appositioning of the labia majora, both as ways of narrowing the vaginal opening[b]	**Alterations of the vaginal opening** (with or without cutting of the clitoris), typified by narrowing of the vaginal opening, variously known as "vaginal tightening," "vaginal rejuvenation," or "husband stitch"
	Type IV: **Miscellaneous,** including piercing, pricking, nicking, scraping, and cauterization	**Miscellaneous**, including piercing, tattooing, pubic liposuction, and vulval fat injections
Examples of relatively high-prevalence countries	Depending on procedure: Burkina Faso, Chad, Cote d'Ivoire, Djibouti, Egypt, Eritrea, Ethiopia, Gambia, Guinea, Guinea Bissau, Indonesia, Iraqi Kurdistan, Liberia, Malaysia, Mali, Mauritania, Senegal, Sierra Leone, Somalia, Sudan, and concomitant diaspora communities Source: UNFPA	Depending on the procedure: Brazil, Colombia, France, Germany, India, Japan, Mexico, Russia, South Korea, Spain, Turkey, USA Source: ISAPS
Actor	Traditional practitioner, midwife, nurse or paramedic, surgeon	Surgeon, tattoo artist, body piercer
Age at which typically performed	Depending on the procedure/community: typically around puberty, but ranging from infancy to adulthood	Typically in adulthood, but increasingly on adolescent girls or even younger minors; intersex surgeries (e.g. clitoroplasty) more common in infancy, but ranging through adolescence and adulthood
Presumed Western legal/moral status	Unlawful and morally impermissible	Lawful and morally permissible

[a]The qualification in parenthesis has been added. This is because the official WHO typology wrongly equates the external, visible portion of the clitoris with the entire clitoris, thereby diminishing the anatomical and sexual significance of the latter (Villani, 2019). Most of the clitoris, including the majority of its erectile tissues and structures necessary for orgasm, is underneath the superficial skin layer of the body—like an iceberg—and therefore cannot be removed without major surgery (which does not occur in any recognized form of FGM; see Abdulcadir et al., 2016). This may help to explain why, contrary to popular belief in Western societies, women and girls who have experienced WHO-defined FGM of various types may retain the ability to orgasm and can experience sexual pleasure (Ahmadu & Shweder, 2009; Catania et al., 2007). This does not, of course, entail that sexual function or quality is unaffected by such cutting, nor that the cutting does not introduce the risk of sexual harm. Rather, it is to dispel the common myth that FGM is sexually disabling per se—a myth that may itself cause harm to women and girls who have experienced ritual genital cutting and believe that they are (therefore) incapable of sexual enjoyment (Sharif Mohamed et al., 2020)

[b]In practice, the most severe instances of medically unnecessary narrowing of the vaginal opening regarded as infibulation (FGM) leave a smaller introitus and often cause greater functional difficulties than analogous procedures regarded as "vaginal rejuvenation" (FGCS). However, the WHO typology does not distinguish between more or less constrictive outcomes in its definition of Type III FGM, and both infibulation and "vaginal rejuvenation" fall on a spectrum. Thus, there is no anatomically decisive line between them, and in some cases, they may be practically indistinguishable, e.g. partial re-infibulation versus a so-called husband stitch (Edmonds, 2013; Foster, 2016)

pain outcomes" (p. e721). Mindful of this concern, I conclude with some suggestions for how ethical opposition to FGC can be grounded in a principled way that does not further stigmatize individuals who have already been affected by non-consensual, medically unnecessary genital cutting.

Fear Avoidance and Threat Interpretation

How can sexual pain in individuals who have experienced genital cutting best be understood? Connor et al. (2019) draw on a formulation of the FAM by Vlaeyen and Linton (2000; updated from Vlaeyen, Kole-Snijders, Boeren, & van Eek, 1995) to structure the first quadrant of their four-quadrant IPPR model. As they note, in this formulation, the experience of pain is influenced by one's initial negative feelings about the experience (such as depression or anxiety), which in turn elicits "negative cognitions, particularly viewing pain as catastrophic." Such catastrophizing may then lead to a cycle of fear and stress that is reinforced by certain maladaptive behaviours: hypervigilance about the affected body part or associated aversive sensations, avoidance of use of the body part, and so on.

In more recent versions of the FAM (see especially Vlaeyen et al., 2016), greater emphasis is placed on "threat interpretation" as a central feature of the model. In other words, the conscious or unconscious interpretation of pain as being a sign of threat to the body or self is proposed to drive all other processes, from catastrophizing onwards. Threat interpretation in this sense is also central to other emerging frameworks for understanding chronic pain such as the Imprecision Hypothesis (Moseley & Vlaeyen, 2015) or, for cancer-related pain, the Cancer Threat Interpretation Model (Heathcote & Eccleston, 2017; Heathcote et al., 2018).

As Heathcote (2019) has recently highlighted, there is a growing understanding in the pain literature that pain-related "somatic sensations are a product of the brain, a conscious signal emitted to provide protection. They do not reflect a direct read-out of the state of the body tissues" (p. 860). It follows from this, Heathcote argues, that subjectively experienced somatic sensations, including chronic or context-specific pain, can be "open to interpretation" and that our interpretation of the sensations can potentially "change the way in which we experience them, including their frequency, intensity, and quality" (*ibid.*).

If this view is correct, it will be vital to understand how individuals with a history of genital cutting interpret both non-sexual genital pain, and pain that is associated with sexual activity. Do they interpret these pains as indicative of ongoing threats to the body? Of irreversible tissue or nerve damage? Does the pain act as a reminder of the genital cutting event? The answers to these questions will obviously vary from individual to individual. As Einstein (2008) reported in a groundbreaking study, "[e]ven women who have had the same type of FGC recount unique memories of the event, as well as varied experiences of it after the initial cutting," with personal accounts reflecting everything from "pride, vanity, personal strength, and sexual pleasure" to "dyspareunia and the quenching of sexual desire" (p. 88).

Interpretations will also likely vary from culture to culture. At present, the FAM has not been well studied across a diversity of social contexts, having been largely developed within a Western framework. Asking how (changes in) both individual-level psychological factors and wider sociocultural factors may influence the likelihood of various interpretations of sexual pain—whether related to genital cutting or otherwise—will therefore be an important research question going forward (Hankivsky et al., 2017).

Potential Factors Affecting the Interpretation of Bodily Sensations

Some potential factors affecting the interpretation of bodily sensations in the case of genital cutting can be inferred from the existing literature. These factors should be considered for further investigation. At the individual level, such factors might include:

> [the affected person's] age or maturity at the time of cutting; their expectations about, attitudes toward, and appraisals of the cutting experience and the persons who authorized it or carried it out; their emotional sensitivity or resilience; the strength of their identification with the cultural group or sub-group in which they are being raised; their subsequent body image concerns, adult sexual preferences, [and] values concerning bodily integrity and sexual autonomy (Earp & Steinfeld, 2018, p. 11)

There are also individual differences in physical/biological factors related to genital cutting that may also affect threat interpretation. These could include "the means and extent of tissue removal and the type of tissue removed; the use or disuse of pain control, the existence and severity of any complications (beyond the intended effects of the cutting) and other specifics of the intervention itself" (Earp & Steinfeld, 2018, p. 11). As Connor et al. (2019) note with respect to FGC, there are several distinctive types across cultures, and these are performed in different ways under a variety of circumstances (see Table 1). It is unlikely that the risk of sexual pain, effects on sexual pleasure, and associated causal pathways are uniform over so much variance.

What about wider social considerations? How might these affect the interpretation of FGC or FGC-related sexual pain? As Johnsdotter (2013) explains, social and cultural factors are "integral to lived sexuality." As such, culturally learned

"sensation schemas" may affect how we "perceive bodily signals, whether we notice them at all, and what kind of meanings we ascribe to them" (p. 262). Consistent with this, and in keeping with the interpretational framework described above by Heathcote (2019), Hinton, Howes, and Kirmayer (2008) remarked that the meanings of sensory experiences are never a matter of physiology alone; rather, they are "always mediated by culture, in the sense of the ways of life, language, ritual practices, beliefs and aesthetics of a group, community, or society" (p. 143).

The Many Meanings of Genital Cutting

How this relates to FGC is complex. In addition to differences in type of FGC performed across cultures (Table 1), the root causes, symbolic meanings, social or religious connotations, and parental motivations for genital cutting of children or adolescents may also differ substantially (Earp & Steinfeld, 2018; see also Abdulcadir et al., 2012; Ahmadu, 2000, 2007; Dellenborg, 2007; Earp, 2016a; Earp & Steinfeld, 2017; Leonard, 2000a, 2000b; Manderson, 2004; Shell-Duncan & Hernlund, 2000; Shweder, 2000, 2013; Walley, 1997). Contrary to the often-simplistic Western stereotypes about African, Southeast Asian, and Middle Eastern forms of FGC, these causes, meanings, connotations, and parental motivations are not necessarily tied to patriarchal dominance of women by men (Abdulcadir et al., 2012; Baumeister & Twenge, 2002; Shell-Duncan, Moreau, Smith, & Shakya, 2018), nor to an urge to limit specifically female sexual desire or pleasure (Ahmadu, 2007; Ahmadu & Shweder, 2009; Earp, 2015b; Leonard, 2000a, 2000b; Wade, 2012). Instead, genital cutting practices affecting children of all sexes are undertaken for a wide variety of reasons across societies, with many, if not most, of these reasons construed as positive or affirming in the local social ontologies (Androus, 2013; Shweder, 2013; Svoboda, 2013; Vissandjée, Denetto, Migliardi, & Proctor, 2014). Recognizing this will be important for understanding the diversity of potential interpretations of FGC and any associated effects on sexual pain or pleasure.

Some of the most incisive research on this issue has been done by Johnsdotter (e.g., 2013, 2018a, 2018b, 2019). Noting that FGC is nearly always practiced in societies that also practice male genital cutting (MGC), but not vice versa, Johnsdotter (2018a) writes that in many cases FGC is likely to have been "introduced in imitation of the male ritual," with both practices often carried out in parallel ceremonies (see Abdulcadir et al., 2012; Caldwell, Orubuloye, & Caldwell, 1997; Manderson, 2004; Merli, 2010). Although Johnsdotter observes that the multifarious rationales for genital cutting of minors can vary with local context, "the genital modifications are often performed with similar motives irrespective of gender: to prepare the child for a life in religious community, to accentuate gender difference and to perfect gendered bodies, for beautification, for cleanliness, to improve the social status of the child through ritual, and so on" (Johnsdotter, 2018a, p. 32).

There are certainly contexts in which a desire to "tame" female (and in some cases, also male; see Darby, 2005; Italia, 2019; Shahvisi & Earp, 2019) sexual impulses is one part of the motivation for genital cutting (Johnsdotter, 2015). But as Leonard (2000a) has argued, when practiced as part of a cultural rite of passage, which is the typical situation, both male and female genital cutting are commonly seen as separating the initiate from the "asexual world of childhood" and incorporating them into the world of adulthood. In such contexts, "genital cutting is construed as having little to do with sex, per se. Rather, its function is to prepare young men and women to occupy [their adult roles] within the community" (p. 162).

From these descriptions, it can be seen that culturally supported interpretations of FGC, like those of MGC, are not always negative, at least in those communities where both forms of cutting are widely seen as normal and expected. In these communities, neither FGC nor MGC are typically regarded as mutilations, but, rather, as enhancements (see Earp, 2016a): that is, improvements to the embodied self that are perceived to carry aesthetic, cultural, and other kinds of value—not unlike so-called cosmetic genital cutting in Western societies (see Table 1). This, in turn, may have implications for how FGC-related genital sensations, whether positive or negative, are experienced, interpreted, or reinterpreted—for example, upon migration from one context to another (Connor et al., 2016; Earp, 2017a, 2017b; Hankivsky et al., 2017; Johnsdotter, 2018b; Johnsdotter & Essén, 2016; Wahlberg, Essén, & Johnsdotter, 2019).

Stigma, Pain, and Discourses on Sexuality

In a recent study documenting changing attitudes towards male and female genital cutting among Swedish Somalis following migration, Wahlberg et al. (2019) remarked that "the significance of bodily inscriptions [is] not static; rather, views of the body are constantly interpreted through the lenses offered by culture and context," including such factors as the prevailing discourses, social norms, and beliefs concerning childhood genital modifications (p. 631). In line with this perspective, Connor et al. (2019) noted that sexual experiences among women affected by FGC will likely "vary based on the messages they have received about the impact of FGC on their sexual function." For example, "exposure to Western-based media and advocacy messages related to female genital mutilation (FGM) can result in an expectation of poorer sexual function." This expectation can be explained in at least two ways. It could be that Western-based messaging prompts women to worry that they must be sexually damaged, when that is not how they would have interpreted

their experiences otherwise. Or, it could be that it enables the women to make sense of a disadvantage they had been facing along: for example, by giving them a conceptual/linguistic framework for processing negative aspects of their sexual experiences that were previously hard to discern or articulate (Sharif Mohamed, Wild, Earp, Johnson-Agbakwu, & Abdulcadir, 2020). Or it could be some combination of both.

In any event, it is common for women who experienced FGC in a setting where both male and female genital cutting are culturally normative to find, upon moving to a Western country, that their own altered genitalia, unlike that of their brothers, are no longer regarded as enhanced or improved (Johnsdotter, 2018b; Manderson, 2004). Instead, their vulvae are newly described as "mutilated," not only by activists seeking to end FGC, but in official documents, laws, and policies, and even in the medical literature. The unsubtle message conveyed by such language is that the genitals of women affected by non-Western forms of FGC—but not Western forms (see Table 1)—are disfigured, undesirable, even ugly, and sexually inadequate (Boddy, 2016; Foster, 2016; Johnsdotter, 2019; Kelly & Foster, 2012). Accordingly, many such women "experience distress about their genital appearance or function, believing that they cannot experience normal-range sexual pleasure, and attribute this real or perceived dysfunction to FGM/C only" (Sharif Mohamed et al., 2020).

Similarly, experiences of pain or discomfort during sexual activity may be presumed to have an entirely physical, causal explanation rooted exclusively in FGC or its somatic outcomes, in which case the pain may be maladaptively interpreted as inevitable, even in cases where effective treatment of the pain may be possible. Meanwhile, other potential contributing factors that are likely to be more malleable, such as a lack of adequate foreplay or difficulties in recognizing or effectively communicating one's sexual needs, may not receive as much attention. As Connor et al. (2019) noted, many studies have demonstrated that women who have experienced FGC of various types (including types affecting the external clitoris) can have positive sexual experiences (Abdulcadir et al., 2016; Ahmadu & Shweder, 2009; Catania et al., 2007; Johnsdotter, 2013). The authors note that this could be due to remaining clitoral tissue, sensation in other parts of the vulva or vagina, or even increases in sensitivity in other parts of the body such as the breasts. Connor et al. (2019) stress that "flexibility and adaptability of sexual behaviors, particularly in response to sexual pain, could prove to be advantageous" for some women and that "good communication between partners [is] an important component of sexual resiliency in response to sexual pain."

Unfortunately, healthcare providers who are not specially trained to help women affected by non-Western forms of FGC may unwittingly reinforce negative sexual expectations or other maladaptive responses (Palm, Essén, & Johnsdotter, 2019). Perhaps viewing such FGC as "barbaric" and essentially designed to subjugate women, these providers may reflexively attribute any adverse sexual feelings reported to them by their patients—including vulvar pain—to the FGC alone, without giving adequate consideration to the full range of potential causes (Hess, Weinland, & Saalinger, 2010; Johnsdotter, 2019; Palm et al., 2019; Schrijver, Leye, & Merckx, 2016; Sharif Mohamed et al., 2020; Vissandjée et al., 2014).

Yet such causes may be manifold. In one retrospective study, a large percentage of the surveyed women who had experienced FGC reported (other) past traumas, including forced marriage, rape, and war violence (Antonetti Ndiaye, Fall, & Beltran, 2015). These and other factors, individually or together, can have extremely negative implications for sexual experience or for how one interprets sexual encounters or sensations, making the independent contribution of FGC to reported outcomes in such cases more difficult to determine (Im, Swan, & Heaton, 2019; Kuwert et al., 2014; Obermeyer, 2005; Schrijver et al., 2016).

Of course, individuals who are experiencing psychosexual difficulties, whether or not their genitals have been cut, should be thoroughly and compassionately assessed in a culturally sensitive manner, and offered whatever supportive treatment is appropriate to their situation. And where FGC is a concern, as Connor et al. (2019) are right to advise, "providers can help women to understand that mutually satisfying sexual experiences with one's partner are possible." The women may find it helpful to learn, for example, "that even after Type III FGC, clitoral tissue remains" (see Table 1 for further discussion).

Side Effects of Stigmatization

There can be little doubt that dominant discourses surrounding non-Western forms of FGC are well-motivated, geared towards drawing attention to a set of practices that are sincerely believed to be profoundly harmful as well as unjust. Yet, as Johnsdotter (2019) has forcefully argued, while the ultimate goal is to protect girls presumed to be risk of FGC, current policies can have consequences that are, in fact, traumatic for the girls involved. Stigmatizing language and attitudes, including from healthcare providers, may contribute to this problem (Villani, 2019). Indeed, as pain researchers have begun to document in recent studies, under certain conditions, stigma, shame, guilt, and injustice (i.e. social emotions) can have adverse effects on the experience of pain itself (Karos et al., 2018; Scott, 2019).

What, then, can be done to address this problem of stigma? Sharif Mohamed et al. (2020) argued that "it is critical to acknowledge and discuss the potential sexual risks of [FGC], without stigmatizing girls and women who have had [FGC] by focusing so narrowly on their (altered) genitals, or by jumping to the conclusion that they must all have been

sexually disabled by the genital cutting as such." So although healthcare providers, campaigners, and other interested parties should certainly address and give weight to the feelings of those women who have been harmed by FGC, sexually or otherwise, it should not be simply assumed that women who have experienced FGC will be incapable of sexual satisfaction (Rahman, 2018). Not only is such an assumption empirically unsubstantiated, but it may lead to invidious stereotyping of affected women and girls, potentially magnifying the risk of sexual dysfunction through psychologically mediated pathways, including those relating to expectancy effects and feelings of shame about one's body and one's genitals in particular (Sharif Mohamed et al., 2020; see also Schrijver et al., 2016).

A related problem is the frequent lumping together of multiple distinct practices that have highly variable physical and psychological consequences and that are often done in different ways under different conditions by different groups for different reasons. For example, the World Health Organization (WHO) typology for "female genital mutilation" includes practices that range from pricking of the clitoral hood without removal of tissue, to trimming of the labia (considered a "cosmetic" practice in Western societies), to excision of part or all of the external portion of the clitoris, to infibulation, all of which the WHO simply defines as mutilations, regardless of (1) the level risk involved, (2) the severity of the actual cutting, (3) the extent of harm caused, (4) the maturity/consent of the affected individual, (5) the motivation(s) behind the cutting (unless medical in nature), or (6) the views of those women who do not regard their genitals as damaged or disfigured, but rather as culturally or aesthetically enhanced (WHO/UN, 2008).

This is problematic for a number of reasons. One of them is the seeming double standard it reflects vis-a-vis Western versus non-Western forms of FGC. As Table 1 shows, there is considerable overlap or a close anatomical parallel between each form of "FGM" as defined by the WHO, and Western-style female genital "cosmetic" surgery (FGCS). Neither set of procedures is medically necessary in most cases, yet only one of them is framed as categorically impermissible. How can this be explained? If one controls for clinical context, which varies across both sets and is often functionally comparable ("FGM" has been medicalized in many communities; see WHO/UN, 2008), the most plausible candidate for an explanation is that the typical age, and thus, the likely or presumptive consent status of the subject is in fact different between the two sets. What this suggests is that it is not the degree of invasiveness, specific tissues altered, or the precise medical or non-medical benefit-to-risk ratio of medically unnecessary FGC that is most central to determining its perceived ethical status. Instead, "it is the extent to which the affected individual desires the genital cutting and is capable of consenting to it" (Brussels Collaboration on Bodily Integrity, 2019, p. 20).

Rather than simply defining non-Western FGC as mutilating, then, an alternative approach would be to acknowledge the diversity of outcomes, meanings, and interpretations surrounding distinctive types of genital cutting across societies, both positive and negative, and allow affected individuals to decide for themselves whether they wish to be treated or seen as victims of "mutilation." By contrast, forcing victim status on an individual and defining their genitals as mutilated irrespective of (1)–(6) above is unlikely to foster the sort of "resilience" which Connor et al. (2019) argued may be important for responding adaptively to sexual pain.

Distinguishing Harmfulness and Wrongfulness

Why, then, is such a stigmatizing approach so widely taken? One possibility is that those who wish to prohibit medically unnecessary genital cutting of children may believe it is necessary to appeal to the extremes of sexual or other harms that can result from such cutting in order to explain why the practice is morally wrong. But relying on a harm-based approach to justify opposition to non-Western FGC as such—rather than, for example, only its more radical forms—can lead to empirically questionable, exaggerated, and over-generalized claims of harm that may then be assumed to apply to all women who have experienced such FGC. These claims and assumptions, in turn, may themselves cause harm insofar as they promote homogenizing, often race-based stereotypes about the affected women or their communities, or elicit body-shaming and sexual stigma (Sharif Mohamed et al., 2020).

So how should opposition to FGC be grounded? Recognizing the pitfalls of a harm-based approach, a number of activists, ethicists, physicians, legal scholars, feminists, and other stakeholders have sought to distinguish the moral concept of wrongfulness from that of harmfulness (on the distinction, see Duff, 2001). As I noted in a recent exchange, one way a person can be wronged is if they are harmed without adequate excuse or justification. But a person can also be harmed without being wronged: for example, if someone accidently and non-negligently bumps into them on a busy sidewalk, causing them to fall and scrape their knee. Finally, a person can be wronged without being harmed: for example, if someone "softly" sexually penetrates them while they are asleep (assuming no prior consent) in such a way that they could never find out, nor suffer any physical or emotional injury (Earp & Yuter, 2019).

One implication of this distinction is that medically unnecessary genital cutting could morally wrong a person regardless of

the level of harm caused, insofar as it is non-voluntary (that is, done without the informed consent of the affected individual) (Brussels Collaboration on Bodily Integrity, 2019; DeLaet, 2009, 2012; Dustin, 2010; Mason, 2001; Möller, in press; Munzer, 2018; Paalanen, 2017; Svoboda, 2013, 2017; Townsend, 2019). On this view, individuals have a fundamental moral and, in many settings, also a legal right against any interference with their sexual anatomy to which they do not consent, whether or not unambiguous harm (or ill intent) can be proven, unless (1) they are incapable of consenting and (2) there is an urgent medical need, such that the interference cannot reasonably be delayed without undermining the individual's future bodily autonomy (for example, by putting them at serious risk of death or disability) (Earp, 2019a).

A similar principle has been claimed to underlie, and explain, the intrinsic wrongfulness of sexual assault or rape. As Archard (2007) argued, the fundamental wrong of non-consensual sexual contact is not that it is always harmful (though it is often very harmful indeed); rather, such contact is wrongful because it illegitimately infringes upon the sexual integrity of the person who has not consented (see Earp, 2015c). In this, it denies that they are worthy of a certain kind of respect that is central to their embodied personhood, by eluding their right to decide who may engage with their most intimate anatomy under what conditions. Such behaviour is therefore inherently wrong "independent of any distress [the person] could experience" (Archard, 2007, p. 397).

Legal theorist Möller (in press) extends such reasoning to genital cutting. It is, of course, much worse from a moral perspective "to impose extremely grave physical harm on a girl, to irreparably damage or even destroy any possibility for enjoyable sex, to create various significant, further health risks, and to do all this as part of a structure that oppresses female sexuality" than it is to impose, for example, a "ritual nick with (arguably) no long-term damage, no further health risks, and no negative effects on sexual pleasure." But although these two cases differ significantly in terms of the likely degree of harm imposed on the child, they still share a common moral core: "namely the intrinsic wrong that lies in the fact that someone acts on a claimed entitlement to apply a sharp object to a child's genitals." In other words, the wrong of medically unnecessary, non-consensual genital cutting "flows *not* (in the first instance) from contingent empirical factors relating, for example, to harm or social structures, but from the child's right to have his or her [sexual] integrity respected and protected."

I agree with this view and have offered supporting arguments in a recent body of work, emphasizing that non-consenting persons of all sexes and genders have a moral right against any medically unnecessary interference with their sexual anatomy (Earp, 2013, 2015a, b, d, 2016b, c, d, 2017a, b, c, 2019a, b, c, d; Earp & Darby, 2015, 2017, 2019; Earp, Hendry, & Thomson, 2017; Earp & Shaw, 2017; Earp & Yuter, 2019; Myers & Earp, in press). By adopting such a rights-based approach, I suggest that campaigners against genital cutting could achieve two important ends. They could (1) promote and justify laws and policies aimed at protecting vulnerable children from such cutting, without having to resolve contestable empirical disputes about specific levels of harm, much less abstract philosophical disputes about what constitutes harm in a given context (see Earp & Darby, 2017, for extensive discussion); while (2) avoiding further stigmatization of those who have already experienced such cutting and may be looking for ways to heal. This could create room in the discourse for relatively more adaptive interpretations of medically unnecessary genital cutting and its potential effects on sexual pain or pleasure, without sacrificing a clear moral basis for opposing all such non-consensual genital cutting in future generations.

Compliance with Ethical Standards

Conflict of interest The author declares that he has no conflicts of interest to disclose.

References

Abdulcadir, J., Ahmadu, F., Essen, B., Gruenbaum, E., Johnsdotter, S., Johnson, M. C., … Shweder, R. A. (2012). Seven things to know about female genital surgeries in Africa. *Hastings Center Report*, *42*(6), 19–27. https://doi.org/10.1002/hast.81.

Abdulcadir, J., Botsikas, D., Bolmont, M., Bilancioni, A., Djema, D. A., Bianchi Demicheli, F., … Petignat, P. (2016). Sexual anatomy and function in women with and without genital mutilation: A cross-sectional study. *Journal of Sexual Medicine*, *13*(2), 226–237. https://doi.org/10.1016/j.jsxm.2015.12.023.

Ahmadu, F. (2000). Rites and wrongs: An insider/outsider reflects on power and excision. In B. Shell-Duncan & Y. Hernlund (Eds.), *Female "circumcision" in Africa: Culture, controversy, and change* (pp. 283–315). Boulder, CO: Lynne Rienner Publishers.

Ahmadu, F. (2007). Ain't I a woman too? Challenging myths of sexual dysfunction in circumcised women. In Y. Hernlund & B. Shell-Duncan (Eds.), *Transcultural bodies: Female genital cutting in global context* (pp. 278–310). New Brunswick, NJ: Rutgers University Press.

Ahmadu, F. (2016). Why the term female genital mutilation (FGM) is ethnocentric, racist and sexist–let's get rid of it! *Hysteria*. Retrieved from http://www.hystericalfeminisms.com/voices1/2016/10/16/why-the-term-female-genital-mutilation-fgm-is-ethnocentric-racist-and-sexist-lets-get-rid-of-it.

Ahmadu, F., & Shweder, R. A. (2009). Disputing the myth of the sexual dysfunction of circumcised women: An interview with Fuambai S. Ahmadu by Richard A. Shweder. *Anthropology Today, 25*(6), 14–17. https://doi.org/10.1111/j.1467-8322.2009.00699.x.

Androus, Z. T. (2013). Critiquing circumcision: In search of a new paradigm for conceptualizing genital modification. *Global Discourse, 3*(2), 266–280. https://doi.org/10.1080/23269995.2013.813282.

Antonetti Ndiaye, E., Fall, S., & Beltran, L. (2015). Intérêt de la prise en charge pluridisciplinaire des femmes excisées. *Journal de*

Gynécologie Obstétrique et Biologie de la Reproduction, 44(9), 862–869. https://doi.org/10.1016/j.jgyn.2015.01.008.
Archard, D. (2007). The wrong of rape. *Philosophical Quarterly, 57*(228), 374–393. https://doi.org/10.1111/j.1467-9213.2007.492.x.
Baumeister, R. F., & Twenge, J. M. (2002). Cultural suppression of female sexuality. *Review of General Psychology, 6*(2), 166–203. https://doi.org/10.1037/1089-2680.6.2.166.
Bell, K. (2005). Genital cutting and Western discourses on sexuality. *Medical Anthropology Quarterly, 19*(2), 125–148. https://doi.org/10.1525/maq.2005.19.2.125.
Boddy, J. (2016). The normal and the aberrant in female genital cutting: Shifting paradigms. *Journal of Ethnographic Theory, 6*(2), 41–69. https://doi.org/10.14318/hau6.2.008.
Bossio, J. A., & Pukall, C. F. (2018). Attitude toward one's circumcision status is more important than actual circumcision status for men's body image and sexual functioning. *Archives of Sexual Behavior, 47*(3), 771–781. https://doi.org/10.1007/s10508-017-1064-8.
Brussels Collaboration on Bodily Integrity. (2019). Medically unnecessary genital cutting and the rights of the child: Moving toward consensus. *American Journal of Bioethics, 19*(10), 17–28. https://doi.org/10.1080/15265161.2019.1643945.
Caldwell, J. C., Orubuloye, I. O., & Caldwell, P. (1997). Male and female circumcision in Africa from a regional to a specific Nigerian examination. *Social Science and Medicine, 44*(8), 1181–1193. https://doi.org/10.1016/S0277-9536(96)00253-5.
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. https://doi.org/10.1111/j.1743-6109.2007.00620.x.
Connor, J. J., Brady, S. S., Chaisson, N., Sharif Mohamed, F., & 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.
Connor, J. J., Hunt, S., Finsaas, M., Ciesinski, A., Ahmed, A., & Robinson, B. B. E. (2016). Sexual health care, sexual behaviors and functioning, and female genital cutting: Perspectives from Somali women living in the United States. *Journal of Sex Research, 53*(3), 346–359. https://doi.org/10.1080/00224499.2015.1008966.
Craig, K. D. (2018). Toward the social communication model of pain. In T. Vervoort, K. Karos, Z. Trost, & K. M. Prkachin (Eds.), *Social and interpersonal dynamics in pain* (pp. 23–41). Cham, Switzerland: Springer International Publishing.
Crombez, G., Eccleston, C., Van Damme, S., Vlaeyen, J. W. S., & Karoly, P. (2012). Fear-avoidance model of chronic pain: The next generation. *Clinical Journal of Pain, 28*(6), 475–483. https://doi.org/10.1097/AJP.0b013e3182385392.
Darby, R. (2005). *A surgical temptation: The demonization of the foreskin and the rise of circumcision in Britain*. Chicago: University of Chicago Press.
DeLaet, D. L. (2009). Framing male circumcision as a human rights issue? Contributions to the debate over the universality of human rights. *Journal of Human Rights, 8*(4), 405–426. https://doi.org/10.1080/14754830903324795.
DeLaet, D. L. (2012). Genital autonomy, children's rights, and competing rights claims in international human rights law. *International Journal of Children's Rights, 20*(4), 554–583. https://doi.org/10.1163/15718182-55680007.
Dellenborg, L. (2007). *Multiple meanings of female initiation* (Doctoral dissertation, Göteborg University). Retrieved from http://www.gu.se/english/research/publication/?publicationId=58638.
Duff, R. A. (2001). Harms and wrongs. *Buffalo Criminal Law Review, 5*(1), 13–45. https://doi.org/10.1525/nclr.2001.5.1.13.
Dustin, M. (2010). Female genital mutilation/cutting in the UK: Challenging the inconsistencies. *European Journal of Women's Studies, 17*(1), 7–23. https://doi.org/10.1177/1350506809350857.
Earp, B. D. (2013). The ethics of infant male circumcision. *Journal of Medical Ethics, 39*(7), 418–420. https://doi.org/10.1136/medethics-2013-101517.
Earp, B. D. (2015a). Do the benefits of male circumcision outweigh the risks? A critique of the proposed CDC guidelines. *Frontiers in Pediatrics, 3*(18), 1–6. https://doi.org/10.3389/fped.2015.00018.
Earp, B. D. (2015b). Female genital mutilation and male circumcision: Toward an autonomy-based ethical framework. *Medicolegal and Bioethics, 5*(1), 89–104. https://doi.org/10.2147/MB.S63709.
Earp, B. D. (2015c). 'Legitimate rape', moral coherence, and degrees of sexual harm. *Think, 14*(41), 9–20. https://doi.org/10.1017/S1477175615000172.
Earp, B. D. (2015d). Sex and circumcision. *American Journal of Bioethics, 15*(2), 43–45. https://doi.org/10.1080/15265161.2014.991000.
Earp, B. D. (2016a). Between moral relativism and moral hypocrisy: Reframing the debate on "FGM". *Kennedy Institute of Ethics Journal, 26*(2), 105–144. https://doi.org/10.1353/ken.2016.0009.
Earp, B. D. (2016b). In defence of genital autonomy for children. *Journal of Medical Ethics, 42*(3), 158–163. https://doi.org/10.1136/medethics-2015-103030.
Earp, B. D. (2016c). Infant circumcision and adult penile sensitivity: Implications for sexual experience. *Trends in Urology & Men's Health, 7*(4), 17–21. https://doi.org/10.1002/tre.531.
Earp, B. D. (2016d). Male circumcision: Who should decide? *Pediatrics*, *37*(5), e-letter. https://pediatrics.aappublications.org/content/137/5/e20160594/tab-e-letters#male-circumcision-who-should-decide.
Earp, B. D. (2017a). Gender, genital alteration, and beliefs about bodily harm. *Journal of Sexual Medicine, 14*(5, Supplement 4), e225. https://doi.org/10.1016/j.jsxm.2017.04.182.
Earp, B. D. (2017b). The right to bodily integrity and the concept of sexual harm. *Journal of Sexual Medicine, 14*(5, Supplement 4), e239. https://doi.org/10.1016/j.jsxm.2017.04.153.
Earp, B. D. (2017c). Does female genital mutilation have health benefits? The problem with medicalizing morality. *Practical Ethics*. Retrieved from http://blog.practicalethics.ox.ac.uk/2017/08/does-female-genital-mutilation-have-health-benefits-the-problem-with-medicalizing-morality/.
Earp, B. D. (2019a). The child's right to bodily integrity. In D. Edmonds (Ed.), *Ethics and the contemporary world* (pp. 217–235). Abingdon: Routledge.
Earp, B. D. (2019b). 'Unconstitutional' US anti-FGM law exposes hypocrisy in child protection. *The Conversation*. Retrieved from https://theconversation.com/unconstitutional-us-anti-fgm-law-exposes-hypocrisy-in-child-protection-109305.
Earp, B. D. (2019c). *Religious freedom, equal protection, and the child's (gender neutral) right to bodily integrity*. Presented at Secularism 2019: Reclaiming Religious Freedom, National Secular Society, London. Retrieved from https://youtu.be/GBH0g_Cl7Rk.
Earp, B. D. (2019d). Mutilation or enhancement? What is morally at stake in body alterations. *Practical Ethics*. Retrieved from http://blog.practicalethics.ox.ac.uk/2019/12/mutilation-or-enhancement-what-is-morally-at-stake-in-body-alterations/.
Earp, B. D., & Darby, R. (2015). Does science support infant circumcision? A skeptical reply to Brian Morris. *The Skeptic*, *25*(3), 23–30. https://www.researchgate.net/publication/269899744.
Earp, B. D., & Darby, R. (2017). Circumcision, sexual experience, and harm. *University of Pennsylvania Journal of International Law*, *37*(2-online), 1–57. https://www.researchgate.net/publication/315763686.

Earp, B. D., & Darby, R. (2019). Circumcision, autonomy and public health. *Public Health Ethics, 12*(1), 64–81. https://doi.org/10.1093/phe/phx024.

Earp, B. D., Hendry, J., & Thomson, M. (2017). Reason and paradox in medical and family law: Shaping children's bodies. *Medical Law Review, 25*(4), 604–627. https://doi.org/10.1093/medlaw/fwx027.

Earp, B. D., & Shaw, D. M. (2017). Cultural bias in American medicine: The case of infant male circumcision. *Journal of Pediatric Ethics*, *1*(1), 8–26. https://www.researchgate.net/publication/316527603.

Earp, B. D., & Steinfeld, R. (2017). Gender and genital cutting: A new paradigm. In T. G. Barbat (Ed.), *Gifted women, fragile men*. Retrieved from http://euromind.global/brian-d-earp-and-rebecca-steinfeld/?lang=en.

Earp, B. D., & Steinfeld, R. (2018). Genital autonomy and sexual well-being. *Current Sexual Health Reports, 10*(1), 7–17. https://doi.org/10.1007/s11930-018-0141-x.

Earp, B. D., & Yuter, J. (2019). Circumcision and morality: An exchange. *Letter*. Retrieved from https://letter.wiki//conversation/127.

Edmonds, A. (2013). Can medicine be aesthetic? Disentangling beauty and health in elective surgeries. *Medical Anthropology Quarterly, 27*(2), 233–252. https://doi.org/10.1111/maq.12025.

Ehrenreich, N., & Barr, M. (2005). Intersex surgery, female genital cutting, and the selective condemnation of cultural practices. *Harvard Civil Rights-Civil Liberties Law Review*, *40*(1), 71–140. https://pdfs.semanticscholar.org/a986/deba1d02e1035596bfde5befe171eaa95252.pdf.

Einstein, G. (2008). From body to brain: Considering the neurobiological effects of female genital cutting. *Perspectives in Biology and Medicine, 51*(1), 84–97. https://doi.org/10.1353/pbm.2008.0012.

Foster, E. A. (2016). Female circumcision vs. designer vaginas: Surgical genital practices and the discursive reproduction of state boundaries. In J. Dickinson (Ed.), *Body/state* (pp. 17–30). London: Routledge.

Hankivsky, O., Doyal, L., Einstein, G., Kelly, U., Shim, J., Weber, L., & Repta, R. (2017). The odd couple: Using biomedical and intersectional approaches to address health inequities. *Global Health Action, 10*(sup2), 1326686. https://doi.org/10.1080/16549716.2017.1326686.

Heathcote, L. C. (2019). From symptoms to sensations: Moving toward a normal psychology of somatic experiences in youth. *Journal of Pediatric Psychology, 44*(7), 859–861. https://doi.org/10.1093/jpepsy/jsz028.

Heathcote, L. C., & Eccleston, C. (2017). Pain and cancer survival: A cognitive-affective model of symptom appraisal and the uncertain threat of disease recurrence. *Pain, 158*(7), 1187–1191. https://doi.org/10.1097/j.pain.0000000000000872.

Heathcote, L. C., Goldberg, D. S., Eccleston, C., Spunt, S. L., Simons, L. E., Sharpe, L., & Earp, B. D. (2018). Advancing shared decision making for symptom monitoring in people living beyond cancer. *Lancet Oncology, 19*(10), e556–e563. https://doi.org/10.1016/S1470-2045(18)30499-6.

Hess, R. F., Weinland, J., & Saalinger, N. M. (2010). Knowledge of female genital cutting and experience with women who are circumcised: A survey of nurse-midwives in the United States. *Journal of Midwifery & Women's Health, 55*(1), 46–54. https://doi.org/10.1016/j.jmwh.2009.01.005.

Hinton, D. E., Howes, D., & Kirmayer, L. J. (2008). Toward a medical anthropology of sensations: Definitions and research agenda. *Transcultural Psychiatry, 45*(2), 142–162. https://doi.org/10.1177/1363461508089763.

Im, H., Swan, L. E. T., & Heaton, L. (2019). Polyvictimization and mental health consequences of female genital mutilation/circumcision (FGM/C) among Somali refugees in Kenya. *Women and Health*. https://doi.org/10.1080/03630242.2019.1689543.

Italia, I. (2019). A wrong against boys: An impossible conversation about circumcision. *Areo*. Retrieved from https://areomagazine.com/2019/09/24/a-wrong-against-boys-an-impossible-conversation-about-circumcision/.

Jacobson, D., Glazer, E., Mason, R., Duplessis, D., Blom, K., Mont, J. D., … Einstein, G. (2018). The lived experience of female genital cutting (FGC) in Somali-Canadian women's daily lives. *PLoS ONE*, *13*(11), e0206886. https://doi.org/10.1371/journal.pone.0206886.

Johnsdotter, S. (2013). Discourses on sexual pleasure after genital modifications: The fallacy of genital determinism (a response to J. Steven Svoboda). *Global Discourse, 3*(2), 256–265. https://doi.org/10.1080/23269995.2013.805530.

Johnsdotter, S. (2015). Genital cutting, female. In P. Whelehan & A. Bolin (Eds.), *The international encyclopedia of human sexuality* (pp. 427–500). Hoboken, NJ: Wiley. https://doi.org/10.1002/9781118896877.wbiehs180.

Johnsdotter, S. (2018a). Girls and boys as victims: Asymmetries and dynamics in European public discourses on genital modifications in children. In M. Fusaschi & G. Cavatorta (Eds.), *FGM/C: From medicine to critical anthropology* (pp. 31–50). Turin: Meti Edizioni.

Johnsdotter, S. (2018b). The impact of migration on attitudes to female genital cutting and experiences of sexual dysfunction among migrant women with FGC. *Current Sexual Health Reports, 2*(1), 1–7. https://doi.org/10.1007/s11930-018-0139-4.

Johnsdotter, S. (2019). The growing demand in Europe for reconstructive clitoral surgery after female gential cutting: A looping effect of the dominant discourse? *Droit et Cultures*, *79*(1), 93–118. https://www.researchgate.net/publication/333696275.

Johnsdotter, S., & Essén, B. (2016). Cultural change after migration: Circumcision of girls in Western migrant communities. *Best Practice & Research Clinical Obstetrics & Gynaecology, 32,* 15–25. https://doi.org/10.1016/j.bpobgyn.2015.10.012.

Johnsdotter, S., & Mestre i Mestre, R. M. (2017). 'Female genital mutilation' in Europe: Public discourse versus empirical evidence. *International Journal of Law, Crime and Justice, 51*(1), 14–23. https://doi.org/10.1016/j.ijlcj.2017.04.005.

Karlsen, S., Mogilnicka, M., Carver, N., & Pantazis, C. (2019). Female genital mutilation: Empirical evidence supports concerns about statistics and safeguarding. *British Medical Journal*, *364*, l915. https://doi.org/10.1136/bmj.l915.

Karos, K., Williams, A. C., Meulders, A., & Vlaeyen, J. W. S. (2018). Pain as a threat to the social self: A motivational account. *Pain, 159*(9), 1690–1695. https://doi.org/10.1097/j.pain.0000000000001257.

Kelly, B., & Foster, C. (2012). Should female genital cosmetic surgery and genital piercing be regarded ethically and legally as female genital mutilation? *BJOG: An International Journal of Obstetrics & Gynaecology, 119*(4), 389–392. https://doi.org/10.1111/j.1471-0528.2011.03260.x.

Kuwert, P., Glaesmer, H., Eichhorn, S., Grundke, E., Pietrzak, R. H., Freyberger, H. J., & Klauer, T. (2014). Long-term effects of conflict-related sexual violence compared with non-sexual war trauma in female World War II survivors: A matched pairs study. *Archives of Sexual Behavior, 43*(6), 1059–1064. https://doi.org/10.1007/s10508-014-0272-8.

Leonard, L. (2000a). Interpreting female genital cutting: Moving beyond the impasse. *Annual Review of Sex Research, 11*(1), 158–190. https://doi.org/10.1080/10532528.2000.10559787.

Leonard, L. (2000b). "We did it for pleasure only": Hearing alternative tales of female circumcision. *Qualitative Inquiry, 6*(2), 212–228. https://doi.org/10.1177/107780040000600203.

Lewis, H. (1995). Between Irua and "female genital mutilation": Feminist human rights discourse and the cultural divide. *Harvard*

Human Righst Journal, *8*(1), 1–55. https://pdfs.semanticscholar.org/cde0/b1cc1a7fdc3777ecabb0b4e62170a5776823.pdf.

Manderson, L. (2004). Local rites and body politics: Tensions between cultural diversity and human rights. *International Feminist Journal of Politics, 6*(2), 285–307. https://doi.org/10.1080/1461674042000211272.

Mason, C. (2001). Exorcising excision: Medico-legal issues arising from male and female genital surgery in Australia. *Journal of Law and Medicine*, *9*(1), 58–67. http://europepmc.org/article/med/12116672.

Merli, C. (2010). Male and female genital cutting among Southern Thailand's Muslims: Rituals, biomedical practice and local discourses. *Culture, Health & Sexuality, 12*(7), 725–738. https://doi.org/10.1080/13691051003683109.

Möller, K. (in press). Male and female genital cutting: Between the best interests of the child and genital mutilation. *Oxford Journal of Legal Studies*.

Moseley, G. L., & Vlaeyen, J. W. S. (2015). Beyond nociception: The imprecision hypothesis of chronic pain. *Pain, 156*(1), 35–38. https://doi.org/10.1016/j.pain.0000000000000014.

Munzer, S. R. (2018). Examining nontherapeutic circumcision. *Health Matrix*, *28*(1), 1–77. https://scholarlycommons.law.case.edu/healthmatrix/vol28/iss1/5/.

Myers, A., & Earp, B. D. (in press). What is the best age to circumcise? A medical and ethical analysis. *Bioethics*.

Obermeyer, C. M. (2005). The consequences of female circumcision for health and sexuality: An update on the evidence. *Culture, Health & Sexuality, 7*(5), 443–461. https://doi.org/10.1080/14789940500181495.

Obiora, L. A. (1996). Bridges and barricades: Rethinking polemics and intransigence in the campaign against female circumcision. *Case Western Reserve Law Review*, *47*, 275–378. https://scholarlycommons.law.case.edu/caselrev/vol47/iss2/4/.

Onsongo, N. (2017). Female genital cutting (FGC): Who defines whose culture as unethical? *International Journal of Feminist Approaches to Bioethics, 10*(2), 105–123. https://doi.org/10.3138/ijfab.10.2.105.

Paalanen, T. (2017). Sexual rights of young people: Dilemmas concerning sexual autonomy. *Journal of Sexual Medicine, 14*(5), e239. https://doi.org/10.1016/j.jsxm.2017.04.151.

Palm, C., Essén, B., & Johnsdotter, S. (2019). Sexual health counselling targeting girls and young women with female genital cutting in Sweden: Mind–body dualism affecting social and health care professionals' perspectives. *Sexual and Reproductive Health Matters, 27*(1), 1–11. https://doi.org/10.1080/26410397.2019.1615364.

Rahman, S. (2018). Female sexual dysfunction among Muslim women: Increasing awareness to improve overall evaluation and treatment. *Sexual Medicine Reviews, 6*(4), 535–547. https://doi.org/10.1016/j.sxmr.2018.02.006.

Robertson, C. C., & James, S. M. (2002). *Genital cutting and transnational sisterhood: Disputing US polemics*. Chicago: University of Illinois Press.

Schrijver, L. D., Leye, E., & Merckx, M. (2016). A multidisciplinary approach to clitoral reconstruction after female genital mutilation: The crucial role of counselling. *European Journal of Contraception & Reproductive Health Care, 21*(4), 269–275. https://doi.org/10.3109/13625187.2016.1172063.

Scott, W. (2019). The psychosocial context of chronic pain in people living with HIV. *Pain Reports, 4*(2), e721. https://doi.org/10.1097/PR9.0000000000000721.

Shahvisi, A., & Earp, B. D. (2019). The law and ethics of female genital cutting. In S. Creighton & L.-M. Liao (Eds.), *Female genital cosmetic surgery: Solution to what problem?* (pp. 58–71). Cambridge: Cambridge University Press.

Sharif Mohamed, F., Wild, V., Earp, B. D., Johnson-Agbakwu, C., & Abdulcadir, J. (2020). Clitoral reconstruction after female genital mutilation/cutting: A review of surgical techniques and ethical debate. *Journal of Sexual Medicine*. https://doi.org/10.1016/j.jsxm.2019.12.004.

Shell-Duncan, B., & Hernlund, Y. (2000). *Female "circumcision" in Africa: Culture, controversy, and change*. Boulder, CO: Lynne Rienner Publishers.

Shell-Duncan, B., Moreau, A., Smith, S., & Shakya, H. (2018). *Women's business? A social network study of the influence of men on decision-making regarding female genital mutilation/cutting in Senegal*. Lecture presented at the International Expert Meeting on Female Genital Mutilation/Cutting, Montreal. Retrieved from https://www.alignplatform.org/sites/default/files/2018-06/Women%27s%20business-%20Montreal-Full5.26.2018.pdf.

Shweder, R. A. (2000). What about "female genital mutilation"? And why understanding culture matters in the first place. *Daedalus*, *129*(4), 209–232. http://www.jstor.org/stable/20027671.

Shweder, R. A. (2013). The goose and the gander: The genital wars. *Global Discourse, 3*(2), 348–366. https://doi.org/10.1080/23269995.2013.811923.

Svoboda, J. S. (2013). Promoting genital autonomy by exploring commonalities between male, female, intersex, and cosmetic female genital cutting. *Global Discourse, 3*(2), 237–255. https://doi.org/10.1080/23269995.2013.804757.

Svoboda, J. S. (2017). Nontherapeutic circumcision of minors as an ethically problematic form of iatrogenic injury. *AMA Journal of Ethics, 19*(8), 815–824. https://doi.org/10.1001/journalofethics.2017.19.8.msoc2-1708.

Townsend, K. G. (2019). The child's right to genital integrity. *Philosophy & Social Criticism*. https://doi.org/10.1177/0191453719854212.

Turk, D. C., & Monarch, E. S. (2018). Biopsychosocial perspective on chronic pain. In D. C. Turk & R. J. Gatchel (Eds.), *Psychological approaches to pain management: A practitioner's handbook* (3rd ed., pp. 3–24). New York: The Guilford Press.

Villani, M. (2019). Reconstructing sexuality after excision: The medical tools. *Medical Anthropology*. https://doi.org/10.1080/01459740.2019.1665670.

Vissandjée, B., Denetto, S., Migliardi, P., & Proctor, J. (2014). Female genital cutting (FGC) and the ethics of care: Community engagement and cultural sensitivity at the interface of migration experiences. *BMC International Health and Human Rights, 14*(13), 1–10. https://doi.org/10.1186/1472-698X-14-13.

Vlaeyen, J. W. S., Crombez, G., & Linton, S. J. (2016). The fear-avoidance model of pain. *Pain, 157*(8), 1588–1589. https://doi.org/10.1097/j.pain.0000000000000574.

Vlaeyen, J. W. S., Kole-Snijders, A. M. J., Boeren, R. G. B., & van Eek, H. (1995). Fear of movement/(re)injury in chronic low back pain and its relation to behavioral performance. *Pain, 62*(3), 363–372. https://doi.org/10.1016/0304-3959(94)00279-N.

Vlaeyen, J. W. S., & Linton, S. J. (2000). Fear-avoidance and its consequences in chronic musculoskeletal pain: A state of the art. *Pain, 85*(3), 317–332. https://doi.org/10.1016/S0304-3959(99)00242-0.

Wade, L. (2009). Defining gendered oppression in U.S. newspapers: The strategic value of "female genital mutilation". *Gender & Society, 23*(3), 293–314. https://doi.org/10.1177/0891243209334938.

Wade, L. (2011). Journalism, advocacy and the social construction of consensus. *Media, Culture and Society, 33*(8), 1166–1184. https://doi.org/10.1177/0163443711418273.

Wade, L. (2012). Learning from "female genital mutilation": Lessons from 30 years of academic discourse. *Ethnicities, 12*(1), 26–49. https://doi.org/10.1177/1468796811419603.

Wahlberg, A., Essén, B., & Johnsdotter, S. (2019). From sameness to difference: Swedish Somalis' post-migration perceptions of the circumcision of girls and boys. *Culture, Health & Sexuality, 21*(6), 619–635. https://doi.org/10.1080/13691058.2018.1502472.

Walley, C. J. (1997). Searching for "voices": Feminism, anthropology, and the global debate over female genital operations. *Cultural Anthropology, 12*(3), 405–438. https://www.jstor.org/stable/656558.

WHO/UN. (2008). *Eliminating female genital mutilation: An interagency statement*. Retrieved from https://www.who.int/reproductivehealth/publications/fgm/9789241596442/en/.