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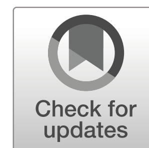

Sex, Grief, and Psychic Trauma: Considering History and Politics in the Psychosexual Treatment of Women with FGC

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Abstract

Purpose of Review This paper stems from a presentation given at the "Second International Expert Meeting on Female Genital Mutilation/Cutting (FGM/C): Sharing data and experiences, improving collaboration," which took place at Centre Hospitalier Universitaire Ste. Justine, Montreal, Canada, in May 2018. It aims to shed light on the psychosexual health of women with female genital cutting (FGC), drawing from both scientific research and clinical work. This paper also addresses the inherent challenges to healthcare delivery for "cut" women and seeks to illuminate the social and historical realities that form the backdrop to the clinical encounter.

Recent Findings While there is a vast body of literature on the psychological determinants of sexual health, studies on "cut" women's sexual health have yet to delve into its psychological correlates. In addition, healthcare delivery for women with FGC poses a number of challenges, which impinge upon patient experience and health-seeking behavior.

Summary Ethical considerations in care delivery for women with FGC must delve into the hegemonic nature of the patient-practitioner interactions and politics of Otherness. Interdisciplinary research and praxis on FGC will prevent biological reductionism and the pathologization of these women. It will afford more integrated, comprehensive, and ethical care for women with FGC.

Keywords Female genital cutting (FGC) · Psychosexual health · Ethics of care · Trauma · Patient care

Introduction

This paper stems from a presentation given at the "Second International Expert Meeting on Female Genital Mutilation/Cutting: Sharing data and experiences, improving collaboration," which took place in 2018. The topic for the session, "Psychosexual health," allows for a plethora of entry points to address the sexual and reproductive health of women with female genital cutting (FGC). As researchers-practitioners, our clinical work informs our research and drives our epistemologies. My presentation was hence weaved through the words and stories of each and every circumcised woman I have worked with.

As a clinical psychologist, I offer group psychotherapy for women with FGC. In line with the patients' culture and historiographies, the therapeutic framework was conceptualized as a healing circle. Indeed, FGC is practiced in collectivist societies which place great emphasis on oral tradition, making it more "culturally consonant" to structure the treatment as a talking circle. Additionally, in many FGC-practicing countries, young girls are "cut" *together*, and so healing can take place *together*. Psychotherapy becomes a collective healing experience, which echoes women's childhood experience of the practice.

Fantasy: Body and Desire

We live in a world that is inexorably complex. Globalization and geopolitics have brought about more hybridity but also greater polarization [1–3]. Undergirded by myths and the collective unconscious, pervasive fantasies and projections are

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fueled by recent individual and societal trauma [4], as well as historical trauma, such as the Hottentot Venus, and the dehumanization of Black women's bodies during slavery. In such a context, what does it mean to be a racialized Other, particularly in these troubled times we live in?

1. Fantasies around women with FGC

   There have been myriad staunch fantasies around African women's bodies, through the colonial era and through slavery, in medicine, which as a discipline has a history and culture of its own. Lest we forget that Dr. Marion Sims' statue in Central Park was only dismantled in 2018[1] [5•, 6]. From not being recognized as sentient beings, to being portrayed as hypersexual, to being viewed as sexually maimed by FGC, how African women's bodies and more particularly "cut" women's bodies are perceived socially and by health care professionals is something that "cut" women are acutely sensitive to. Women often report being keenly attuned to negative perceptions, to what may be construed as judgment, condescension, or blatantly caustic remarks [7]. For example, when asked about their experience with the Canadian healthcare system, a Somali woman recounted:

> "When I go the doctor, first of all I don't like to go to the doctor, but when I go, I prefer a lady doctor- *I look at her and see how she looks at me*. So that's how I decide if I talk".[2]

This quote exemplifies how the medical gaze can drive or be an impediment to disclosure in a healthcare setting, thereby impacting doctor-patient interactions and quality of care [8•, 9]. The fact that the perception of the practitioner's gaze is a subjective experience is somewhat of a peripheral issue; it is ancillary to both our clinical ethos and Levinasian responsibility [10], which impel us to sensitivity and humanity during our clinical encounters, as we come face to face with the Other, notably regarding a woman with FGC's "intimate face."

2. Fantasies of women with FGC

   Women who have experienced FGC also hold fantasies, which are modulated by cultural and contemporary discourses on FGC, as well as migratory experiences.

(a) Fantasies around "uncut" women

   FGC is purported to decrease a woman's libido and capacity for pleasure[3] [11]. Consequently, "cut" women sometimes perceive "uncut" women as having a greater capacity to feel pleasure. This can generate feelings of discomfort with regard to their own body, but also curiosity and feelings of alienation towards other women, particularly in a migratory context. It is paramount to acknowledge this as we treat patients, as these fantasies affect the patient-practitioner relationship. Patients often wonder, will my "uncut" doctor understand me? If I feel shame or anger about my FGC experience, how do I speak my wound and my pain? Is it safe to talk about my sexual concerns with someone who does not share an experiential knowledge of FGC? This is particularly compelling because it is now well established that sociocultural differences between patient and practitioner lead to poorer health outcomes when these differences are not reconciled in the clinical encounter [12–14].

(b) Fantasies around sexual satisfaction

   Sexual satisfaction is unquestionably a subjective experience. When a woman asserts that FGC has decreased her sexual desire and pleasure, unless she underwent the ritual after she started having sexual relations, this is the internalization of someone else's discourse, because by definition, she cannot know. Mobilizing a comparison between a "before and after," FGC is beyond the bounds of possibility [15, 16]. That is not to say that FGC has no bearing on sexual pleasure, but rather that we need to be prudent in our assertions and fully cognizant of their consequences on women's embodied experiences, including their sexual experiences and how they can be modulated by our discourse. The following excerpt originates from an Ethiopian woman's narrative, as she was recounting her birthing experience:

> "It was difficult, you know. I was really doing my best. But the nurses were surprised to see me like that. And I'll never forget, they call each other and they were looking at me and talking about me… Finally one of

[1] Regarded as the founding father of modern gynecology, Dr. Marion Sims performed experimental gynecological surgeries on enslaved Black women he "purchased" specifically for his experimentations, performing as many as 30 surgeries on one woman alone. In addition to the brutal legal assault of foregoing any form of consent and egregious encroachment to human dignity, he performed all his experimentations without anesthesia [4]. Dr. Sims is also the inventor of the modern speculum, also devised from prototypes he tested on enslaved Black women.

[2] This quote and all others that appear in this paper are drawn from interviews conducted with women with FGC. All subjects gave free and informed consent and this research was approved by the Université du Québec à Montréal Psychology Department Ethics Committee.

[3] From a structuralist perspective, FGC has served to regulate social interactions and maintain social cohesion. By being a marker of marriageability, through its presumed ability to safeguard virginity and faithfulness, FGC has coded gender interactions, cultivated values of sexual modesty, and forged community ties and a feeling of shared group identity [11].

> the nurses said 'why are you like that?'. I said 'I don't know. What's wrong?'. She said it's because of circumcision that it's difficult to give birth. But I thought all women are like that. I told her 'you're not like that?'. She said 'No! Even for your daughter, don't do that!'. She told me it's mutilation and something is missing. Now I regret it! I regret it so much! (cries…). It ruins everything! And it affects your libido, your sex life"

This woman reported a satisfactory sex life before her obstetrical experience in Canada. Her distressing encounter with the healthcare system at a most vulnerable time undeniably altered her body image and sexual satisfaction. The patient specified that the abovementioned comments were made during contractions, while her husband and close female friend were outside the medical room. While the professionals may have thought it best to share their views privately and confidentially, this approach deprived the patient of family support while addressing a sensitive topic and further reinforced the patient's feelings of shame, alienation, and anxiety.

The patient had undergone FGC and all the while was able to experience sexual pleasure; that is before her harrowing experience at delivery. Although it is a reality that clashes with contemporary discourses around FGC, it is possible for women with FGC to feel sexual pleasure. A removal of the external part of clitoris does not equate an absence of pleasure. This clinical vignette illustrates that there is a distinction to be drawn between *cutting off* the genitalia and a woman *cutting* herself *off* from pleasure, which is paramount so that the body does not become a metaphor for absence. Part of my work as a clinician consists in loosening this association and dispelling this misconception, so that the patient can reconnect her body to pleasure in her pursuit of healing. This clinical vignette also highlights the need for sensitivity, discernment, and reassurance when addressing FGC so that our prevention or education efforts do not cause further angst or distress.

Psychic Wound: Trauma and Grief, Fear, and Shame

While there is an abundant literature underscoring the biomedical consequences of FGC, research data on its psychological impact remains scant. The following section, far from being exhaustive, delineates what I posit to be central issues regarding FGC and mental health, first addressing the "trauma controversy" as well as general mental health. This section also delves into the emotional repercussions to FGC, the mind-body connection, and the concomitant intricacies of clinical care.

1. FGC and trauma

   Does FGC cause trauma? Yes. Does it *always* lead to psychic trauma? Simply stated, it does not[4] [17••, 18, 19]. There is however, a type of trauma that we seldom consider in relation to FGC. It is the trauma that arises years later through migration, protracted displacement, when a woman is informed of the negative biomedical and sexual consequences of FGC. Diasporic women with FGC migrate from a land where the practice grants legitimacy, status, and respect, to a country where it is regarded as an egregious violation of human rights and where sanctions against FGC are more stringent. The myriad information on its deleterious effects compels women to revisit their experience. From an etiological perspective, this new perception of FGC can trigger distress and at times the reification of trauma. This is in line with the Freudian concept of *Nachträglichkeit*, or "afterwardness," whereby trauma does not stem from the original event but from a later context that triggers a change in understanding of the initial event [20–22]. Hence, the pervasive moral outrage and the insistence on the dire effects of FGC—albeit somewhat effective as a prevention strategy—are replete with ramifications for "cut" women due to their trauma-inducing effect. The previous quote on the birthing experience of an Ethiopian woman also illustrates how a patient can psychically integrate her FGC event, but may experience severe distress after being told that FGC is "mutilation" and warned about the dangers of the practice. This is also in line with recent research results pointing to the impact of the ubiquitous negative discourse on FGC on affected women's body image, sexual self-esteem, and sexual health, following migration [23••]. While prevention is paramount, wording is key, particularly as words have various meanings and signifiers in different languages, and most often than not, the consultation is not conducted in the patient's mother tongue but in the language and culture of biomedicine.

2. Grief, fear, and shame

   When we grieve, the body feels pain. Depressive symptoms can enter the body when one feels victimized or psychically wounded. As Kleinman has aptly described in his sociosomatic theories, somatic distress can be rooted in social suffering [24] and pain can speak to dire social contexts

[4] From a historical, sociological, and epistemological perspective, the belief that FGC invariably leads to trauma is partly based on Western beliefs and attitudes about the practice. It posits certain assumptions that create a bias in psychiatric morbidity research on FGC [17••], one which some scholars deem "scientific imperialism" [18, 19]. The semantics of suffering, distress, and trauma seemingly become entangled, leading to a tendency to pathologize "cut" women.

and painful events. In addition, emotional pain and angst trigger a shift in attentional processes that make us more attuned to physical sensations. They become more salient and more vivid. For women with FGC, this can manifest itself in terms of general somatization, as well as urogynecological pain and psychosexual concerns. During her keynote address at the 2nd International FGM/C Expert Meeting conference, Dr. Nawal Nour addressed the phenomenon of "Pan Positive" FGC patients, for whom "everything hurts." Well indeed, when one shows symptoms of depression or is emotionally wounded, pain can manifest itself in the body. Such a phenomenon is an integral part of medical semiotics [25], one which opens a window on the patient's emotional pain. It must be mentioned though that physical pain often has an organic etiology, as is often the case in FGC and this pain can be treated medically. For instance, recent studies indicate that painful clitoral neuroma in women with FGC can be successfully treated by neuroma surgical excision [26].

For a number of women with FGC, grieving also involves mourning the "intact" body. This is a lengthy psychological process, and while reconstructive surgeries may be beneficial [27, 28], the outcome of the surgery to reconstruct the "intact body" has not yet been studied. To date, little is known about the long-term effects of reconstructive surgeries [28]. Hence, work needs to be done to better determine the impact of such surgeries and to generate a more holistic patient-centered approach [29, 30]. In addition, surgical interventions do not avert the psychological work of mourning the "pre-FGC" body. Hence, it is important to draw a distinction between *reparation* and *restitution* and how each resonates with feelings of completeness.

In the context of seeking healthcare, "cut" women often experience a lingering fear: fear of judgment, fear of physical pain [7, 8•]. Yet, one emotion that typically requires longer to openly emerge is the underlying shame: shame of the fear; shame of the stigma; shame around feelings of sexual inadequacy. While both fear and shame are uncomfortable, shame differs in that it is wounding. It occurs when a part of who we are or what we have experienced is unbearable to ourselves and difficult to expose to others. In a clinical setting, time is required for women to speak openly about their sexual experience, notably because of the shame. As a result, it is quite frequent that their narrative and the extent of their disclosure evolves over time.

FGM Medical Inquiry: Asking the Difficult Questions

As clinicians, encountering Otherness compels us to rethink our practice and ascertain that we are providing patients an auspicious setting for treatment and healing. The clinical encounter with FGC patients can be challenging, notably as one tries to balance respect for cultural modesty and gathering medical information. Yet, at times, avoiding certain questions for fear of cultural insensitivity colludes and reinforces family and societal taboos and precludes us from being a *witness* to our patient's reality.

Contrary to popular belief, women with FGC typically wish to address sexual health [8•]. The following quotes from a Djiboutian woman illustrate this wish for more sexual and reproductive health information:

> Djiboutian woman: "It's like, like the education part! I want to know more. I want to know the side effects in order to improve my activity you know, sexual activities. Because, I want to improve my life. I want to have a lady doctor to tell her how I feel and what I need, this and that, you know. I wish I can have a solution. I wish I can be like before. I wish I make my husband happy and myself happy. But to talk about it and everything it's not easy you know.
> SK: and would you have liked them [doctors] to bring up the subject?
> Djiboutian woman: if they are ready to help me, sure! Why not? I'm sure they see it, but, ugh! I'm sure they see it, it's not normal. I know. But they never mentioned anything. They never ask me how I feel, they never ask me how my sex life is, they never mention anything, anything at all! (…) Even if the doctor is from another country, but really like, committed to her profession, and listens, asks, take time, I will be more than happy to discuss about it and find a solution to go through tests and everything".

On the topic of physical sensations, women with FGC are sometimes intrigued as to whether what they feel is normal or a result of FGC. Exploration of the patient's urogenital sensations not only allows for symptoms investigation and management but also serves as a good starting point to approach sexual health and provide guidance and information.

In light of the feelings of shame mentioned above, certain aspects of the clinical consultation merit further consideration. At the cultural level, generalizations or stereotypes about the patient's country of origin can be perceived as antagonistic. The patient may already be grappling with fear of judgment around the contours of her body and the comments about her cultural identity risk further widening the gap between the patient and the professional. This is particularly paramount in light of the patient's vulnerability in seeking healthcare and is further compounded by the traumatogenic fantasies and projections around Black women's bodies.

At an esthetic level, patients may also experience feelings of shame. Through the migratory process, women with FGC

are amenable to developing a dichotomous view of the vulvar area, as if there were "normal/uncut" genitalia and "abnormal/cut" vulvas. It may hence be helpful to shift the focus from such a dichotomous and alienating perspective to a more inclusive and accurate one, by reminding women of the universal, wide variety in shapes and appearance of the female body.

At the institutional level, feelings of shame can make women with FGC uncomfortable in having residents and colleagues called upon for medical education purposes. There is both the personal discomfort of being examined and gazed upon, compounded by the historical transgenerational trauma of exposing the Black female body to exotic scrutiny. It is hence recommended that clinicians explain the relevance of calling colleagues in for consultation or for education purposes and reassure the patient that giving consent is not a prerequisite to receiving professional care.

Conclusion

This paper aimed to problematize the myriad fantasies about women with FGC notably around their sexuality and mental health. To date, the pervasiveness of these beliefs is antinomic to the dearth of studies on these subjects. Moreover, the recent studies that shed light on the sexual and mental health of "cut" women tend to circumscribe their focus to one of these two subjects: either sexual health or mental health. Yet, a dichotomous conceptualization of sexual and psychological health interrogates our epistemologies. Indeed, studies exploring the relationship between FGC and sexual health without an integrative perspective run the risk of biological reductionism, and studies on mental health with a strict adherence to a biomedical model of research and diagnosis may pathologize women with FGC. Both research methods and clinical work with "cut" women impel professionals to reflect critically on their ethos, praxis, and posture.

How can we assuage women's lingering fear of medical institutions, bridge the gap in health disparities, and spearhead a significant optimization of care for "cut" women? Perhaps part of the solution rather lies in decolonizing methodologies, and policies and praxis, which collaboratively engage women with FGC.

Compliance with Ethical Standards

Conflict of Interest The author declares that she has no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

The two interview excerpts included in this paper stem from a research study, which was approved by the Université du Québec à Montréal Psychology Department Ethics Committee. Women were handed an information sheet stipulating the aim of the research project and the main themes of the study. Written consent was sought prior to any data gathering. The project was performed in accordance with ethical standards.

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