

Cultural protection against traumatic stress: traditional support of children exposed to the ritual of female genital cutting

Jon-Håkon Schultz
Inger-Lise Lien

Norwegian Centre for Violence
and Traumatic Stress Studies,
Oslo, Norway

Abstract: This study explores the factors addressed in folk psychology in The Gambia for protecting the girl-child from the potential traumatic stress of female genital cutting (FGC). The type and quality of the psychological care was analyzed and compared with research on traumatic stress and principles for crisis and trauma intervention. Thirty-three qualitative indepth interviews were conducted with mothers who had supervised their daughters' FGC, women who had been circumcised, and professional circumcisers. The findings indicate that the girls have largely managed to handle the potentially traumatic event of FGC. The event is placed in a meaningful system of understanding, and the stress is dealt with in a traditional way that to a great extent follows empirically-based and evidence-based principles of crisis intervention. However, the approach tends to be culturally encoded, based on the local cultural belief system. This puts circumcised individuals in a potentially vulnerable position if they are living outside the homeland's supportive cultural context, with consequences for psychological and culturally competent FGC health care in exile.

Keywords: female genital cutting, traumatic stress, trauma-informed care, cultural psychology

Introduction

The origins of female genital cutting (FGC) are uncertain, but there seems to be an association between FGC and slavery that dates the tradition back more than 2,000 years to ancient Egypt.¹ Today it is estimated that more than three million girls in Africa are at risk of being circumcised each year, and that the total number of circumcised females worldwide is close to 140 million.² Opposition to FGC was articulated throughout the 20th century by missionaries and colonial administrators. Since the 1970s it has featured as a discourse in women's health, empowerment of women, and later as a subject in international human rights. Despite the long and widespread tradition, little attention has traditionally been paid to the practice by researchers. FGC was for a long time considered too intimate, culturally marginal, and eccentric to be a part of serious anthropological analysis.³ The literature is scattered in research fields such as anthropology, demography, epidemiology, history, public health, law, social work, psychology, and political science.⁴ Recent decades have seen growing interest within the fields of anthropology,⁵ medicine,^{6,7} and psychology.⁸ This heightened academic interest can be explained by the increasing immigration from African countries where FGC is practiced, which brings the ritual closer to Western society.³

FGC has no known health benefits; on the contrary, it interferes with the natural functioning of the body and causes several immediate and long-term health consequences.

Correspondence: Jon-Håkon Schultz
Norwegian Centre for Violence and
Traumatic Stress Studies, PO Box 181,
Nydalen, Oslo 0409, Norway
Tel +47 9348 3440
Email j.h.schultz@nkvts.unirand.no

First and foremost, it is very painful.^{2,6} In a systematic review of quantitative studies, Berg et al⁸ note that the psychological consequences of FGC are an under-researched and neglected issue. They were unable to draw conclusions regarding causality, and the evidence base is insufficient to draw conclusions about the psychological effects. However, the results from the studies in their review substantiate the proposition that a woman whose genital tissue has been partly removed is more likely to experience more pain as well as psychological disturbances, have a psychiatric diagnosis, and/or suffer from anxiety, somatization, phobia, and low self-esteem. A study of the psychological impacts on 23 circumcised Senegalese women showed a significantly higher prevalence of post-traumatic stress disorder (PTSD) (30.4%) and other psychiatric illnesses (47.9%) than in an uncircumcised control group.⁹ Similarly, a study of 92 circumcised Kurdish girls in Northern Iraq revealed a significantly higher prevalence of PTSD (44.3%), depression disorder (45.6%), and somatic disturbance (36.7%) than in a control group.¹⁰ In a sample of 66 circumcised women living in exile, the prevalence of PTSD was 16%, and 30% reported anxiety and depression.¹¹ These studies are generally aligned with or show a somewhat higher prevalence of PTSD than the large body of research literature which shows about 30% of people exposed to traumatic events develop PTSD or strong PTSD symptoms.^{12,13}

Despite the lack of studies with a rigorous quantitative design to control for the type of circumcision and whether it was performed with local anesthesia, there is now a considerable body of qualitative and quantitative studies describing various types of FGC procedures as painful and as potentially traumatic events.^{9,11,14} According to diagnostic criteria, a potentially traumatic event consists of life threat, fear, horror, or helplessness, and might lead to a PTSD diagnosis.¹⁵ In the research literature, there has been little focus on how the girl-child is psychologically cared for and supported during and after circumcision. A healthy way of dealing with the event would be paramount to achieving the cultural goals of continuing to practice the ritual and having the girls grow up with an integrated identity as cut, proud, and honorable women. Conversely, if a large group of women suffer openly from the procedure, this would threaten the continuation of the practice. Understanding the type and quality of the psychological care given is important for understanding and tailoring culturally informed psychological care for circumcised women, adolescents, and children in Western health care systems.

This study explores and analyzes the psychological care provided for girls undergoing the ritual of FGC, and describes

the common belief system underlying the provision of care in The Gambia. The psychological care given through the ritual of FGC is analyzed and compared against research on psychological care.

Materials and methods

Participants

Purposive sampling was used to increase the range of data on circumcision experience and experience of having one's own daughter circumcised. Potential informants were approached individually through Gambian networks after key persons within the networks had been provided with information about the research project. The selection criteria for the 15 women and five mothers (aged 32–60 years) were the completion of any type of FGC, and that the mothers had had their girls cut before arriving in Norway. Participants reported a range of circumcision types, with a majority having type 3 circumcisions that seal or narrow the vaginal opening, also called “infibulation”. FGC is defined by the World Health Organization as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for nonmedical reasons. The different types of procedures are classified into four main categories: clitoridectomy; excision; infibulation; and type 4, which includes all other procedures for nonmedical purposes, for example, pricking, piercing, incising, scraping, and cauterization.²

Three of the informants had had the procedure performed with local anesthesia or pain medication, but the majority did not. The ethnic backgrounds were from The Gambia, with two from neighboring countries and three from Somalia. Informants with their origin outside The Gambia were used to contrast and provide nuances in the descriptions of the ritual in order for the researchers to understand the specifics of the rituals performed in The Gambia. All were living in Norway at the time of the interview. The 13 circumcisers were recruited and interviewed in The Gambia; eight had recently joined a local program for preventing FGC and had stopped their practice, whereas five were still active practitioners. The circumcisers had been practicing from 3 to 50 years, most of them between 10 and 25 years. The study was also informed by research trips to The Gambia, Ethiopia, and Kenya, where medical doctors, nurses, religious leaders, elders, and anti-circumcision activists were interviewed. The authors have also attended workshops and conferences in these countries initiated by local governmental organizations campaigning against FGC.

Procedure

Several preliminary meetings with Gambian women in Norway were arranged to translate and clarify common words used in describing the procedures and rituals of FGC. Interviews in Norway were conducted in English or Norwegian, with the five mothers all using their first language. The mothers were recruited and interviewed by members of their cultural community whom we had trained in how to use the interview guide. All interviews involved semistructured and frequently open-ended questions. To capture specific childhood experiences, respondents were asked to give their own narratives about the ritual. The majority of the participants in Norway were interviewed twice. In total, we used three different translators, who also served as cultural advisors during discussions throughout the research process. One of the cultural advisors was also present in The Gambia during interviews with the circumcisers. Most interviews were audiotaped and transcribed verbatim.

The interviews with the circumcisers were conducted in a multidisciplinary way, involving four different researchers with professional backgrounds in medicine, anthropology, psychology, or education. Each of the researchers conducted two interviews individually or in pairs; in the remaining interviews, all four researchers were present. In these interviews one researcher led the interview, while the others were observers and asked clarifying questions at the end. The group of researchers and the cultural advisor attended several group discussions where the content of the interviews was discussed. This methodological approach enabled a preliminary analysis drawing on a rich range of disciplines, including medicine, anthropology, psychology, and education. The analysis was further inspired by grounded theory. In each case, the data were generated and clustered according to the following categories: folk psychology, care and protection, and dealing with potential traumatic stress. Core concepts were constructed by grouping across the individual cases. The further theoretical framework builds on the theory of psychological traumatic stress and medical anthropology.

Results

Preparing for and carrying out the ritual

In the cultural context where our data were collected, it is the mother's responsibility to prepare and make sure the ritual is carried out. Mothers are supported and supervised by their own mothers and older women. When the daughter

is of the right age, a circumciser is selected on the basis of reputation, availability, and cost. If the process of approaching a circumciser is dragged out, other local women intervene, asking when the ritual will take place. The daughter's classmates will also impatiently ask questions. Mother, grandmother, and the circumciser have an initial meeting where they agree on the type of circumcision, although this is usually not a subject for extended debate or negotiation since most of the professional circumcisers are already well known, as are the types of circumcision they perform. They further agree on when and where the procedure will take place and what sort of preparation they should carry out. One central point in the preparation is to seek advice from the local marabout, a man of spiritual and religious standing. He will help to prepare "jujus", small pieces of leather sewn together with an enclosed paper with passages from the Holy Koran. Several jujus with religious power should then be carried by the mother, the child, and the circumciser. The various preparations are religious or practical in nature. In The Gambia, the true content of the ritual is kept secret from the child, who is taken to the scene covered in a hood. For weeks now, the girl has been told that the whole family is about to have a big celebration and she will get lots of presents and many of her friends will be there. The secrecy makes it exciting and the young girls are eager to participate in the celebration. The hood is protecting the girls against evil spirits and is removed on arrival. There the girl finds herself together with other girls of the same age. The cutting ritual is organized into four spheres. In urban housing each sphere is often defined by different rooms. The child is first taken to a room where mothers and family members are together with the girls, singing and dancing. Drums and loud singing are used to suppress the screams from the room where the girls are cut. One by one each girl, usually accompanied by a relative, is taken to be undressed in the second sphere in the adjacent room. She is then cleansed with holy water, and brought into the third sphere, where she is blindfolded to protect her from seeing the cutting and seeing the professional circumciser who enters the room. The girl is held down by assistants, called comforters. The circumciser performs the cutting and then leaves the room while the comforters remove the blindfold and apply herbs to stop the bleeding. Gambian mothers are not allowed to participate in the cutting procedure and they are not allowed to enter this room that constitutes the third sphere. There is a line ("caddo") separating spheres two and three, which forbids the mother from crossing into the third sphere. The mother is permitted to see and comfort her daughter only when the girl is brought to the healing room in

the fourth sphere, where she must lie to heal for 2 weeks on a mattress alongside the other cut girls. Aja from The Gambia was cut when she was 7 years old. She explains:

I was excited but a little unsure. Initially we had fun, we were dancing to the drums. Then my cousin came. She took my hand and led me into another room. I was asked to take my clothes off, and I did. Then I was blindfolded and led to yet another room. Somebody asked me to lie down on a mattress, and they held my legs. I did not know what was about to happen. My legs were spread. Then suddenly pain – the most terrible pain between my legs. I was shocked. I hated my cousin from that very day, really hated her. She had tricked me.

Aja lay on the mattress for about 2 weeks. Urinating is extremely painful for the first days while the urine passes through the open wound. At first, the girls urinate while lying on the floor. Later in the week they are helped to the toilet. Family members arrive with gifts and praise the girls for their courage. Seven days later the cut is inspected, followed by a further inspection after 14 days. Throughout the healing period, Aja received formal instruction on how to become a woman and how to behave as a woman.

When you lie there you are given lessons. They inform you that men will trick you. You learn about menstruation, sex education, and how to behave with men. And they say this is all a secret, you cannot tell this to others. “What happens in the room stays in the room.” They say they will take you back and do it again if you talk about it. It belongs to the room.

Fatou was cut when she was 4 or 5 years old. She remembers people holding her, the cutting, the smells in the room, and the cold floor tiles. “I don’t remember if I passed out and I don’t remember any faces – a lot of it is blocked out.” But she remembers being comforted by her mother afterwards and she remembers the gifts. After 2 weeks of healing, Fatou, the four other girls, and their mothers walked through town in a parade, as the people cheered and waved to them.

We had nice new clothes on, our hair was braided with gold strings and people were singing. When we came home more people were greeting us and more gifts were waiting. But the strange thing is that I don’t remember any feelings. I don’t remember if I was happy or sad. I was just there. I think I blocked it out.

Both Fatou and Aja received variations of formal instruction during the healing period. A few in this study had been cut at

an older age, in the context of the coming-of-age ritual, which involved a more extensive ritual and more formalized instruction. Large groups of girls aged 11 or 12 years stayed in a “jujuyo”, a circumcision hut, out in the bush for up to 2 months. During this period they received formal instruction in traditional knowledge, ie, songs, dances, religion, cultural norms, how to behave as a woman, menstruation, pregnancy, respect for elders, and food taboos. They report good social experiences and the development of close relationships among the girls. The formal instruction was given by a designated teacher called a “Kantallalo” and was provided in the form of songs, dances, recitation, repetitions, questions and answers. It was common for the girls to establish a relationship with their Kantallalo, and they could ask questions after the formal education ended. At the end of the period the girls had to take an oath of secrecy: they swore not to speak about the details of the ritual (“what happened in the room stays in the room”).

The most important task for the mother and her supporters is to make sure that the ritual takes place, to help her daughter to understand the importance of the procedure, and how to behave, so she will later be ready for marriage. Immediately after the procedure, it is the mother’s duty to calm her daughter down, and to make sure she follows the healing procedures so the cutting can be approved. In the retrospective interviews, the women report either that they remember their mother had played an active role in making the ritual happen, or that they do not recollect their mother’s role, or they remember she was not involved in the cutting and that she had had a hard time during the procedure. The few Somali informants in this study who were connected with their mothers through the cutting, remember that this negatively affected their child-mother relationship in the initial weeks, and then the relationship normalized.

The mothers who were interviewed all spoke of the difficult process of having their own daughters cut. They tell of uncertainty and doubts about the ritual, based on their own painful memories of the same procedure. Two of the mothers reported sleep disturbances, nightmares, and the return of strong images from their own cutting. The remaining three mothers reported moderate to strong discomfort in connection with parts of the process. All the mothers felt comfortable about not being present during the actual procedure in order to protect themselves. They found emotional support in talking with other mothers who also had the same reactions. One mother expressed her uncertainties: “I was in doubt. But talking to other mothers I realized that the advantages of cutting by far overcame my desire and need to protect my daughter against the initial pain.” When they could finally have the official celebration for their daughters, this was also a

celebration for the mothers, who had completed their maternal obligation. Also, the mothers received gifts, words of praise, and acknowledgment from family, friends, and neighbors.

Circumcisers and their professional care

To become a circumciser in The Gambia one first serves an apprenticeship for 2–5 years, starting as a comforter where one assists by holding the girl, and later cleaning the wound and staunching the bleeding. The profession usually runs in the family, and one is appointed at the age of 16 years or older, after having been cut and married. Most of our sample of Gambian circumcisers work or have worked only part-time, and have additional occupations, such as being a midwife and carrying out vaginal openings prior to marriage and births. The part-time cutters report more than 100 cuttings a year; and one of the full-time practitioners reported more than 1,000 cuttings a year. The recruitment process can be as follows:

I was 35 years old when they informed me that I should start the training. Wife number one saw that I was interested and said I could start. I showed interest because it was a tradition in the family. I wanted to learn and help support my family. I was very proud when I started as a comforter.

Circumcisers describe a range of individual preferences and smaller rituals within their performance of the cutting ritual. It is common to invoke Allah and the good spirits. Prayers and jujus are used; several practitioners report using holy water to clean their instruments. The water becomes holy when small pieces of paper with writing from the Koran, prepared by the marabout, are dissolved in the water. The belief is that Allah and the good spirits will guide the circumcisers through the cutting and protect the girl from evil spirits. The selection of days is also important; Fridays and Sundays are viewed as “Allah’s days, they enhance the closeness to Allah and his protection”. Further, it is “better to cut in the morning or during the winter when the air is cooler because this prevents the blood from running freely from the wound”. The circumcisers are very passionate when telling about their special herbal blends that help the wound to heal and chase away evil spirits that might cause problems. These recipes are handed down through generations, and the blend of herbs and their healing effect contribute to each practitioner’s personal reputation.

Reasons for cutting and changes in the education process

It was never necessary to explain to mothers why they should circumcise their daughters. As one practitioner with more than 30 years experience said:

Everyone did what they were supposed to do. No one ever refused ... we got them all. It is a tradition, you know, and we have always done it.

When asked what would happen to those who don’t carry it out, the unambiguous answer was that there is no option. It was further argued that Allah wants them to carry it out in order to make them clean and honorable women, it prevents sexual desire, and the cutting constitutes who they are as a group. It is also commonly argued that the ritual serves as a way of building character, and that handling the pain is a part of being a proud and courageous woman. As one circumciser explained:

It is a very quick and easy procedure. They scream, you know, because it is painful. Some try to be brave and not scream. To become a woman you need to have courage, you have to be brave. That’s what it is all about, being a woman. And yes, pain is a part of it.

The circumcisers report several recent changes in the ritual for two major reasons, ie, public campaigns and health issues. Because there have been campaigns to end FGC in the region and there is “information going around that it is a bad practice”, people tend to minimize the ritual and the ensuing celebrations:

The most important thing is to get it done – therefore we scale down the celebrating to make less fuss about it. The celebration is not the most important part, the cutting is ... to get the girl clean.

Other reasons mentioned were that the celebrations are a costly practice, and, since there is a tendency to cut younger girls, they will not profit from the lengthy training that was originally involved. Another change is that it is no longer common to have big groups of girls circumcised together; now it is more private and individualized. This also means that the instruction is now more privatized, as opposed to the traditional formalized and community-based education which today has generally become institutionalized within the regular Gambian school curriculum.

The younger practitioners report that there are health concerns involved in cutting older girls:

Now we cut them as early as possible because the older they are the more they get afraid and they can have more problems. The older children react more strongly and they bleed more. A child’s body has a special healing capability; they heal very fast. I prefer them to be from one month to one year, maximum three years old.

For the older girls the shock might be too much for them. They react strongly and can behave strangely. Therefore we have to take them earlier. Some cry, some get angry at their mothers. And some just get up without showing any feelings at all.

A commonly held view among practicing circumcisers is that it was the old practice that was harmful. Now important changes have been introduced: clean razor blades are used, they cut younger girls and less is removed, and sometimes local anesthesia and painkillers are administered. When asked about problems in not being able to staunch the bleeding or the possibility of death after performing the cutting, they acknowledged the possible dangers of bleeding to death. But most of the circumcisers we interviewed did not see any direct link between the cutting procedure and possible death. Hemorrhaging and possible death were caused by evil spirits, and had no direct causal connection with the cutting itself.

Circumcisers in The Gambia often use drums, loud singing, and blindfolds to protect the girls from hearing screams and seeing the cutter. They explain that the girls should never know who cut them, otherwise they might point out that person and frighten uncut girls. It is stressed that uncut girls should know as little as possible about the circumcision prior to the ritual. Such knowledge would only upset the child and make her run away and increase the risk of “difficult” situations during the cutting. “They are protected because they have no idea what’s going to happen.”

Reactions

When the women in this study were asked whether they could remember their circumcision, they all had clear recollections of it; some were even puzzled by the question. One woman said: “(...) it is all recorded down to every detail as if it was a film. My problem is not remembering, but trying to forget.” She experienced periods of frequent nightmares and seeing images of her own cutting, which caused concentration problems and energy loss and could make it hard for her to function normally. The majority recalled that immediately after the cutting procedure they had “strong reactions that lasted for weeks”. The negative reactions described were varying degrees of pain, anxiety, being scared, numbing, disbelief, betrayal, and anger at the mother. The effects on mother-daughter relationships seemed mostly short-term. But after exposure to arguments against FGC, usually in exile, several of the women said they experienced substantial emotional challenges in their relationships with their mothers. These were expressed as frustration, sadness, and anger, as well as a loss of trust in letting the grandmother be around her

grandchildren, due to a fear of her organizing a cutting ritual. More than one third of our informants reported occasional PTSD symptoms as adults; such trauma-related symptoms became more pronounced, more frequent, and stronger in exile. It was only in exile that most of the women became aware that FGC is viewed as a health threat, physically and psychologically, and as a violation of the rights of the child. After being exposed to other views of FGC, they established a connection between their own symptoms and FGC.

There were also reports of positive reactions. Some respondents clearly remember all the gifts and the festivities of the homecoming ceremony, and how women were praising them. Several informants said that, at the time, they viewed this as a very proud moment in their lives. They were proud that they had managed to complete the ritual, and were curious about what now lay ahead of them in their new position.

Discussion

Five principles of trauma intervention

The structure of the ritual frames and defines the provision of care. The traditional FGC ritual can be divided into three phases, ie, cutting, seclusion and instruction, and finally the returning home ceremony.¹⁶ Comparison between the preventive measures included in the ritual and results of research on effective crisis intervention show several similarities. There are consensus reports and international guidelines of evidence-based and empirically-based research that define intervention and prevention efforts following disasters, mass violence, domestic violence, and sexual abuse.^{17–23} The intervention and prevention principles are overall the same, even though the practical unfolding of care would differ depending on the type of crisis, level of exposure, and individual factors. We find it relevant in this study to apply the general principles in the comparison with the care built into the FGC ritual due to the generalized manner of the principles. Hobfoll et al completed a comprehensive review of intervention research for those exposed to disasters and mass violence, and reviewed related fields of research.²³ Five empirically supported principles were identified; these have become widely accepted and are used to inform intervention and prevention efforts for the early to mid-term stages, ranging up to 3 months after the critical event.

The first principle is to promote a sense of security. When people are forced to respond to an event that threatens their lives, their integrity, or their loved ones, many report initial negative post-trauma reactions. Disaster-affected populations have high prevalence rates of mental health

problems, including acute stress disorders, PTSD, depression, incident-specific fears, phobias, somatization, traumatic grief, and sleep disturbances.²⁴ These post-trauma reactions tend to persist under conditions of ongoing threat or danger, and have been shown in studies of a range of cultures.²⁵ When security is introduced and maintained, reactions tend to show a gradual decline over time.²³ The circumcision rituals in our study involve a formalization of providing feelings of a sense of security and safety immediately after the potentially traumatic event by having the child reconnect with her mother. For children and adolescents, connection with parents is the primary goal in disaster-related interventions.²⁶ First separating the mother from her daughter and the scene of the painful cutting, and then bringing her into the healing room for comfort, seems to be a way of protecting the important mother-daughter relationship, allowing the mother to retain the vital position of being able to help and support her daughter. If the girl should feel betrayed and lose trust in her mother, the mother still has the chance to try to rebuild that trust and confidence. Throughout the ensuing healing period, all the mothers remained close by, making frequent visits that helped to rebuild and reinforce the child's sense of security. At least one mother was present at all times in the healing room, to make sure the girls were behaving appropriately, to provide assistance for toilet visits, and to ensure the girls did not share negative chat, spreading rumors or scaring each other. The mothers also provided food and small presents.

The second principle involves the promotion of calming. The research review indicates that individual initial responses of experiencing some anxiety, heightened arousal, and numbing responses are normal, and even healthy. The problem appears if these reactions remain at a heightened level and interfere with daily life, sleeping, eating, and decision-making. Most individuals will return to more manageable emotional levels within days or a few weeks. Persistent or extremely high emotional levels may lead to panic attacks, dissociation, and later PTSD. Hyperarousal can have a major effect on risk perception, so that the surroundings are perceived as potentially harmful beyond reality. In response to elevated levels of fear, processes of avoidance behavior may appear. Thus it is advisable to include calming as a key element in care intervention.²³ In the circumcision cases in our study, calming is effected in the seclusion and instruction part of the ritual, starting with the reconnection with the mother. The mother becomes a role model, calm and proud, and helps to regulate and shape the daughter's emotions by her own example. The mother explains that it is alright to be afraid and scared, and it is normal to feel pain: this is how

it is supposed to be. In this way, she works to normalize the reactions. This involves another key intervention principle, ie, to enhance calming by helping the affected individuals to see their reactions as normal, accepted, and expected. As such, the mother's explanation is limited and would not qualify under the intervention principle referred to as "psychoeducation," which can have a calming effect by explaining the nature of how and why the body reacts to traumatic stress. All the same, the explanations given by mothers and the instructors do seem to be of a normalizing character.

The third principle, promoting a sense of self-efficacy and collective efficacy, is about re-establishing a sense of control over positive outcomes in one's own life. Bandura describes self-efficacy as the individual's belief that their actions are likely to lead to generally positive outcomes.²⁷ In our study, the women present in the healing room instruct and teach the girls how to behave in order to achieve proper healing and how to relieve pain when urinating. The children also face a motivational challenge, having to lie still for up to 2 weeks. The mothers explained how they had to keep motivating the girls to stay patient, so that they can heal properly and pass an inspection of the cut. Our respondents report a consequent line of praise that in various ways gave feedback on how courageous they had been in managing to bear their pain and carry out the necessary procedures. During this process, the girls are helped to break down the challenge into smaller, more manageable units of time, and they get praised for this. Strategies like this help the girls to gradually regain self-efficacy, a sense of control, and predictability in their lives.

Antonovsky describes collective efficacy as the sense of belonging to a group that is likely to experience positive outcomes.²⁸ The group focus is stressed throughout the healing period by conversations with the girls and the Kantallalo, the designated teacher. The formalized instruction involves a clear presentation of why the procedure is important and had to be completed. All our respondents had received this type of instruction, and all reported that after participating in the ritual they had no doubts about the importance of the procedure.

The fourth principle, promoting connectedness, relates to the large body of research on the central importance of social support and sustained attachments to loved ones and social groups in dealing with stress and trauma.^{23,29} Being socially active improves the possibilities of engaging in a range of supportive activities like practical problem-solving, sharing of traumatic experiences, normalization of reactions and experiences, and sharing of coping strategies. Of the five

principles mentioned here, promoting connectedness is probably the most empirically validated, but there has been little empirical research on how to translate this into practical interventions.²³ Nevertheless, connectedness stands out as probably one of the strongest protective factors in traditional rituals, including circumcision.

The healing period is the beginning of the seclusion and instruction phase, which in the ritual theory of transitional rituals is defined as the liminal phase.³⁰ This is a transitional phase for healing and learning, as well as getting the cut approved before the girl can enter her new position as a “clean” girl ready to become a woman. In The Gambia, this liminal phase traditionally lasts for up to 2 months. Liminality as practiced in tribal rituals often includes elements of homogeneity, equality, anonymity, absence of property, humiliation, total obedience, maximization of the religious (as opposed to the secular), and acceptance of pain and suffering.³¹ Our informants report establishing bonds and close relationships with the other girls who become fellow companions, sharing the same experience and faith. This phase is constituted by something out of the ordinary. It has what Turner would call an “anti-structure,” and provides the opportunity to establish “communitas”, ie, a feeling experienced here and now of spontaneous fellowship among persons reaching towards a perfect state of unison.³¹ The older women in our study referred to social involvement, strong feelings of communitas, and the establishment of close and long-lasting relationships with the other girls. By contrast, such descriptions were not heard from those who had been cut at an early age or who had shorter more privatized rituals. The strength of the formalized rituals’ potential for care lies in the various stages of connectedness.

The fifth principle, promoting hope, is the final key principle proven to be of central importance for mass trauma interventions. Those who can remain optimistic are likely to have more favorable outcomes after experiencing mass trauma, because they retain a reasonable degree of hope for their future.³² Instilling hope is crucial, because trauma is often accompanied by feelings of a truncated future, a shattered worldview, and catastrophe.²³ Antonovsky describes a state of hope as the “sense of coherence” when one’s external and internal environments appear predictable and one feels there is a high probability that things will work out.^{28,33}

One of the circumcisers formulated the meaning of pain: “To become a woman you need to have courage, you have to be brave. That’s what it is all about, being a woman. And yes, pain is a part of it.” The importance of the procedure was communicated and repeated to the girls throughout the ritual:

This is what will turn you into a proud and honorable woman, so that you can get married, have children and ultimately live a good life. That is the meaning of the ritual and it is the meaning of the pain. And those who have endured it have every reason to hope for a good life, and benefit from a positive self and collective efficacy that all circumcised women will have a successful life. You will also realize that you now belong to a special group, the group of circumcised adolescents and women: you are one of them.

The traditional ritual structure has incorporated an intentional closure of the possible traumatic memory by making the girls swear an oath of secrecy:

What happened in the room stays in the room. You could talk about the traumatic memories during the seclusion and instruction phase, but not afterwards. Instead, you were encouraged to treat the memories as something belonging to the past, something “belonging to the room”.

Role of the mother

In the seclusion and instruction phase, the mother seems to be the main provider of mental health care. She is helped by the structure of the ritual to organize and provide care at various stages, assisted by the other mothers, who together share the responsibility for caring and looking after all the girls in the healing room. She is instructed and advised by the circumcisers on what to do in order to promote the healing process, medically and spiritually. The mother is further advised by her own mother and by the other grandmothers. The grandmothers have experience; they take responsibility for the planning, organizing, and follow-up of the ritual and they are close at hand to support their own daughter in her duties. Finally the mother, often together with her own mother, may consult the marabout for spiritual advice.

During preparations for the ritual, mothers might feel uncertain. “I was in doubt. But talking to other mothers I realized that the advantages of cutting by far overcame my desire and need to protect my daughter from the initial pain.” The ritual provides the mother with meaning and sufficient comfort to go ahead with the procedure. To a large extent, this structuralized empowerment of the mother provides her with the core principles of the five essential elements of trauma intervention. Again there is a focus on collective efficacy, and the returning home ceremony is as much a celebration of the mothers and their accomplishments.

In recent work on improving pediatric care, there has been a particular focus on the prevention and treatment of pediatric medical traumatic stress (PMTS).³⁴ PMTS is defined as a set

of psychological responses of children and their families to pain, injury, serious illness, medical procedures, and invasive or frightening treatment experiences. It is reasonable to put FGC, as described in this paper, in the category of an invasive or frightening treatment and a potentially traumatic event for a child, and perhaps for her mother. Recent decades have seen a gradual change from a clinician-oriented and disease-oriented focus towards patient-centered care, where the patient and the family are actively informed and involved in the treatment process, and several studies have shown that such an approach is associated with better clinical outcomes.³⁵ The Institute of Medicine has recommended that US health care delivery systems become patient-centered, and has outlined an empirically valid treatment model.³⁶ Comparing the FGC health care delivery described here with the research-based treatment model, we find that they are only partly similar. The way mothers are informed, empowered, and included in the treatment is up to the full standard of the research-based model. The significant difference lies in the lack of information and direct communication with the child prior to the procedure. There are many variants of FGC rituals, however, and the traditional way the ritual has been performed in Somalia would appear to be more in line with standards of informing and motivating a patient before a procedure (for descriptions, see Schultz and Lien).¹⁴

This study adds to the body of qualitative and quantitative studies describing various types of FGC procedures as painful and as potentially traumatic events that can lead to symptoms of PTSD or a full diagnosis thereof. The World Health Organization has reported an increase in medicalization of the FGC procedure. More than 18% of FGCs are currently being performed by health care providers with access to health care knowledge and medication.² When defining types of FGC procedures as potentially traumatic events, this is based on the sudden and lasting pain and the child's lack of understanding and control during the critical event. If appropriate administration of pain medications and explanations were provided for the child, the potential for FGC to be a traumatic event would probably be reduced.

Changing culture, beliefs, and reactions

Why did more than one third of the informants develop pronounced, frequent, and strong psychological symptoms connected to their circumcision after leaving their home cultural context? If we approach this from the angle of medical and psychiatric anthropology, it could relate to the classical and controversial question of how cultural conceptions of sickness influence the prevalence, symptoms, and

course of a particular disorder. The work of Arthur Kleinman has shed light on the cultural construction of the illness experience as an individual and socially adaptive response, distinguishing between disease as the malfunction of biological and psychological processes and illness, which refers to the psychosocial experience and meaning of the perceived disease.³⁷ Commonly, a disease will have a typical course and characteristics independent of the setting, whereas an illness is more or less unique. Kleinman goes on to explain that the illness then becomes the shaping of the disease into behavior and experience; thus, illness must be understood within a specific context of norms, symbolic meanings, and social interaction. In our study, the mothers and older circumcisers all said that there had been no symptoms related to the cutting procedures. Any complications that occurred were seen as related to other factors, like evil spirits. Younger practitioners were influenced by the cause-and-effect thinking of antircircumcision campaigns, but justified the current cutting procedure because they had altered some of the "old procedures". In other words, here we could also see no causality connected to the cutting itself and later symptoms, and no recognition of any illness or linking such symptoms to the cutting. Without actually having an illness, there is no significance attached to the disorder and no symptoms to identify or report. This line of reasoning might indicate that, due to the lack of cultural recognition that illness could be linked to FGC, the symptoms did not become shaped into an illness until the woman was living in a different cultural setting, in exile.

Another line of reasoning is that the psychological care given was largely effective, but the previous care did not prove sustainable when the original belief system underwent change in exile. There are indications that, when moving from a society practicing FGC to a society with laws against the tradition, a significant number of individuals will tend to become skeptical, change their attitude, and finally reject or end the practice. This attitudinal change is partly explained by being exposed to and gradually being influenced by a new set of values.^{14,38-40} Johnsdotter shows how the culture upholding FGC in Somalia is context-specific, and how each and every one of these aspects is challenged in exile.⁴¹

To further understand aspects of the attitudinal change, Schultz and Lien explored the type and quality of children's acquired knowledge of the ritual.¹⁴ We found that the limited instruction and explanations the children received were based primarily on tautological explanations at the level of metaphorical learning, producing a closed system of knowledge that was taken for granted. The learning process

was carefully monitored and regulated, and was brought to a halt before critical reflexive thinking could set in. Such knowledge tends to be deeply internalized, embodied, and morally embraced. The informants possessed a limited cognitive frame of understanding that lasted until they left their home country and went into exile. The structure of this knowledge is what has to be changed, altered, or replaced in order to give way to new knowledge and new values. A further study by Lien and Schultz shows that replacing deeply internalized, embodied, and morally embraced knowledge of FGC can be a long, hard, and painful process.⁴² We found that the new information could be met with resistance, disbelief, and ridicule. Those women who internalized the new knowledge and mentally “hit bottom” experienced an epistemological pain. As one informant explained: “I used to be a proud woman, but when I got information about FGM, I lost my pride and came to see myself as a victim of a harmful tradition. I fell into a deep depression and cried. Then I started to work against the tradition, and was proud again.”⁴²

Converting to a new system of belief and knowledge will force a shift in attitude, from seeing oneself as a clean and honorable woman, perhaps without a clitoris and infibulated, to seeing oneself as a mutilated woman and/or abused child, robbed of her sexuality and injured for life. Knowledge from the new exile context can be painful to internalize because it will contradict the idea of an honorable and proud woman based on FGC and perhaps lead to a feeling of shame instead of pride. The mother goes from having helped her daughter to a successful life in their home country to violating her daughter’s human rights, and even risking prosecution and possibly jail in the exile context.

In a study of FGC among Somali women in Norway, Johansen concentrated her analyses on the subjective experience of the associated pain, and found that the experience of pain related to the procedure is deeply inscribed mentally, emotionally, and physically.^{43,44} Johansen argues that acute pain, as well as intolerable pain, is not necessarily affected by the cultural models that justify it, rather it is so overwhelming that it is an “anticultural experience”, ie, a counterpoint to culture. Women in her study did not easily talk about their pain. Some identified three painful events related to infibulation, when the procedure was done, the opening procedure at marriage, and the need for further opening while giving birth. Johansen argues that the anthropological literature on FGC seems to have ignored the importance of the pain experience. “Pain” was, in Johansen’s study, the major argument that the bearers of the traditions held against continuation of the practice.

In our study, we can identify the descriptions of immediate pain as an “anticultural” experience, as found in Johansen’s study. But the pain does not remain anticultural. As the physical pain resides and the meaning-making process continues, the experience becomes culturally encoded. Later, when the culturally encoded meaning is challenged and possibly lost in exile, the protective factors embedded in the cultural meaning-making seem to weaken, once again revealing the pain and the FGC experience as an anticultural experience without the cultural protection. What is challenged is the woman’s very identity, due to the upheaval and renewal of her belief system. When the meaning disappears from the old belief system, the woman discovers that she has been lied to. Not only that, the person who lied the most was the one who also helped the most, ie, her own mother.

Conclusion

We have shown how crisis intervention principles empirically based on research are already built into the ritual of female circumcision in The Gambia. After the cutting, which might meet the criteria for a potentially traumatic event, the girls are provided with a sense of security over the next few weeks, in that they are calmed down and encouraged through the healing period. They are supported in building an understanding of the importance of the procedure, and manage to establish emotional equilibrium after the event. Self-efficacy is empowered; indeed, connectedness and collective efficacy, the feeling of belonging to a group, emerge as strong factors. The ritual is completed with a homecoming ceremony where the girls are cheered and praised. The girls are proud of their accomplishment and also curious and hopeful about their new status, position, and future identity as proud and honorable women in society.

Intervention principles were incorporated into the ancient ritual structure long before the principles became empirically sound in the fields of psychology and psychiatry. The ancient ritual structure provides the participants with care in an organized form. The marabouts, circumcisers, and grandmothers are all considered specialists in their fields; together they systematically empower, educate, and assist the mother so she can support her child. The mother is the main provider of mental health care, and gives her daughter guidance to sustain the effort needed for recovery. This deliberate empowerment of the mother and her active participation in the healing process is particularly in line with recent principles of client-centered and family-centered care. Having said this, it is necessary to point out that the principles of care are not necessarily built into the ritual to protect the girl-child. The care might equally be put in place as a necessary means to

ensure the mother enforces the cutting as well as protecting the culture and the ritual itself to make sure it is carried out across generations and centuries.

Our findings indicate that, to a large extent, the girls have learned to deal with the potentially traumatic event of circumcision. The event is placed in a meaningful system of understanding, and potential traumatic stress is dealt with on the basis of crisis intervention principles recognized in recent research. This seems to have contributed to fostering the girls' resilience.

On the other hand, more than one third of the informants reported trauma-related symptoms that they, mainly in exile, linked to their circumcision; moreover, these symptoms became more pronounced, more frequent, and stronger after the women were living in exile. From a medical anthropology viewpoint, it can be argued that the illness must be understood within a specific context of norms, symbolic meanings, and social interaction. Without a cultural recognition of any medical or psychological consequences of the FGC procedure, there is no significance attached to the disorder and no symptoms to identify or report. We can further argue that even if the traumatic event has been dealt with on the emotional level, the culturally encoded intervention remains deeply rooted in the traditional cultural belief system. That belief system consists of ideas and knowledge about FGC on a metaphorical level, deeply internalized, embodied, and morally embraced, all constituting a framework of meaning. Then, when the woman is exposed to another belief system that disapproves of and even criminalizes the practice, her culturally encoded therapeutic intervention is severely challenged. This puts circumcised females of all ages in a potentially vulnerable position when they live in exile, far from the supportive cultural context of their homeland.

Most informants in the study had had a medium-length ritual of 2–3 weeks, which is considerably shorter than the traditional ritual in Gambia, that used to last for up to 2 months. Today girls in The Gambia are cut earlier, and with less ritual and less formalized education. This finding from our interviews is supported by several studies that indicate how FGC has changed, with the procedure being conducted on younger girls and with less ritual fanfare than before.^{38,45,46} When the ritual is shortened and changed, the built-in protective factors are weakened and the ritual gets stripped of many of its therapeutic functions. Thus, the medicalization of the ritual with the use of pain medication might reduce the potential of the procedure to be a traumatic event.

Due to the scarcity of research on the psychological consequences of FGC, it is a challenge to provide circumcised

females in exile with psychologically and culturally competent care. In order to individualize psychological care, practitioners in the health care system should be encouraged to explore and familiarize themselves with the previous kinds of care provided during the ritual. Knowing and understanding the underlying protective factors and coping strategies previously proven to be effective in other cultures can help practitioners within the health system to assist in the rebuilding or empowering of coping strategies.

Limitations

The primary data sources of this study and indepth interviews of circumcisers, mothers, and cut women provide a rich set of data to address the research questions. The selection of informants also provided limitations to the study. Our retrospective qualitative interviews could not in a precise way differentiate between the psychological reactions that the women had experienced as children and adolescents. Nor could they precisely describe the FGC experience which happened decades ago. It is likely that descriptions of being afraid, being in pain, and other reactions and feelings would have been told differently if newly cut children were interviewed. Such a description, from a child's perspective, is lacking in the FGC literature. We refrained from interviewing children due to legislation and ethical challenges. Moreover, it proved difficult to recruit mothers in exile, because of Norwegian legislation against FGC, so we could not achieve the desired variation in the sample of mothers who had had their daughters circumcised. Nor did we have adequate variety in the sample of women who had undergone all the various types of FGC, with and without pain medication, and FGC performed in a medical setting with professional medical care. We also lacked a variety of women in exile who did not suffer from mental health problems related to FGC.

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Disclosure

The authors declare no conflicts of interest in this work.

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