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Female Genital Cutting in the United States: Implications for Mental Health Professionals

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The increasingly multicultural composition of the United States can pose numerous challenges for mental health professionals. Although clinicians may have worked with culturally diverse female populations that have experienced various types of sexual violence, there has been a limited discussion of female genital cutting (FGC) and its consequences in the psychological literature. In this article, the prevalence of FGC in the United States; the literature regarding the physical, psychological, and social consequences of this practice; and the practice's implications for mental health services are reviewed and discussed. Finally, the authors provide recommendations for clinical practice, education and training, research, and advocacy.

Keywords: female genital cutting, female genital mutilation, female circumcision, immigrant women

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> There is no way you should be born in America and still be worried about female genital mutilation. America is the land of the free. In this country girls are protected. But FGM [female genital mutilation] is not something that is happening in a far away place, it is happening here to American girls. They may come from immigrant communities, that doesn't make it acceptable.
>
> —Jaha Dukureh, Executive Director, Safe Hands for Girls, *American survivor of female genital mutilation calls on US to take action*, The Guardian, 5/12/2014 (Topping, 2014)

This article provides mental health professionals with an overview of female genital cutting (FGC), a group of controversial practices that involve the partial or total removal of external genitalia or other modifications to these sex organs for cultural, religious or other nonmedical reasons (United Nations Children's Fund [UNICEF], 2013; World Health Organization [WHO], 2014). These ancient customs are rooted in parts of Africa, Asia, and the Middle East and have spread through the migration of people from these high prevalence areas to Western countries, including Australia, Canada, France, Sweden, the United Kingdom, and the United States (Baron & Denmark, 2006; Utz-Billing & Kentenich, 2008; Whitehorne, Ayonrinde, & Maingay, 2002). The article focuses on the negative psychological and physical sequelae of FGC, even though there are women and girls who view the practice positively and report no negative consequences. The authors also provide recommendations for practice, education and training, research, as well as advocacy. FGC is also referred to as female genital mutilation (FGM) and female circumcision (FC). The term FGC will be used throughout this article.

This article is informed by the authors' experiences as psychologists who have worked with individuals affected by FGC in various settings in the New York metropolitan area, including a public and a not-for-profit hospital, as well as independent practice.

Overview of FGC

Before reviewing the FGC literature, it is helpful to have some salient background information, including the various rationales given for FGC; the worldwide and United States prevalence rates; the four categories of FGC; and key variables related to FGC (e.g., age, tools).

Justifications for FGC

The common reasons given for this practice can be grouped into five categories: (a) psychosexual (e.g., lessening a woman's sexual desire; maintaining virginity before marriage and fidelity during marriage; increasing male sexual pleasure); (b) sociological (e.g., initiation into womanhood; cultural identification/affiliation); (c) hygienic and aesthetic (e.g., external genitalia seen as dirty and aesthetically unpleasing); (d) myths (e.g., enhancing fertility, reducing infant mortality); and (e) religious (e.g., required by faith)

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(Baron & Denmark, 2006; United States Department of Health and Human Services [USDHHS], Administration for Children & Families, 2011; WHO, 2014). These rationales vary by culture and country.

Prevalence Rates

The prevalence rates of FGC around the world have been difficult to document because of the secrecy surrounding the rituals and other obstacles to collecting reliable data. Thus far, most of the FGC estimates come from countries where the practice is common and prevalence rates are high. A recent UNICEF study (2016), based on data from 30 countries in Africa, Asia, and the Middle East, reported that at least 200 million girls and women have experienced some form of FGC. The inclusion of data from Indonesia, where almost half of the female population has undergone some form of FGC, and the population growth in affected countries explain the increase over the previous estimate of 133 million girls and women (Belluck & Cochrane, 2016; UNICEF, 2014). Although the affected population has risen, there has been an overall decline in the prevalence of FGC. A closer examination reveals that almost half of the 200 million girls and women live in Indonesia, Egypt, and Ethiopia; 44 million girls are under the age of 15; and prevalence rates in Somalia, Guinea, Djibouti, and Egypt are above 90% (UNICEF, 2016). In the United States, the latest estimates of women and girls who are at risk or have been cut range from 506,795 to 513,000, which are more than twice the 2000 figure of 228,000 (Goldberg et al., 2016; Mather & Feldman-Jacobs, 2015).

Various Forms of FGC

The WHO (2014) organized the various types of FGC into four categories:

- Type I: “Sunna” or “Clitoridectomy” involves the excision of the clitoral hood or prepuce only, or the removal of the clitoris with the prepuce. This is the mildest type of procedure.
- Type II: “Excision” includes the removal of the labia minora; the partial or total removal of the clitoris and the labia minora; and the partial or total removal of the clitoris, the labia minora, and the labia majora.
- Type III: “Pharonic” or “infibulation” is the severest form of FGC, as it involves removing the labia minora and/or the labia majora, with or without excising the clitoris, and sealing or narrowing the vaginal opening with stitches or glue. A very small opening is left for urination and menstruation.

  Two procedures linked to Type III FGC are defibulation and reinfibulation. Defibulation (i.e., surgical opening of the labia) is performed to enable penetration during sexual intercourse and for childbirth and in certain cultures followed by reinfibulation (i.e., surgical narrowing of the labia). In some communities, there is a cycle of repeated defibulation and reinfibulation.
- Type IV: This category includes all other harmful, nonmedical procedures that do not remove tissue from the genitalia, such as cauterizing, labial stretching, pricking, and scraping (Nour, 2004; Whitehorne et al., 2002).

Much of the current literature is based on the experiences of girls and women who have undergone Type III FGC, arguably the procedure with the severest consequences (Nour, 2004; Utz-Billing & Kentenich, 2008; WHO, 2014). This type of cutting, however, represents about 15% of all affected individuals worldwide (White, 2001). It is worth noting that in several African countries infibulation constitutes 80% to 90% of all FGC procedures (White, 2001).

Age

Typically, FGC is performed on girls between the ages of 4 and 12; however, depending on local customs and traditions, newborns, toddlers, adolescents, and adults are cut in some regions (Nour, 2015; UNICEF, 2013; Utz-Billing & Kentenich, 2008; WHO, 2014). The average age at which girls undergo FGC appears to be decreasing in some countries, including Côte d′Ivoire, Egypt, Kenya, and Mali (Plan International [PI], 2005; Sanctuary for Families [SSF], 2013; Yoder, Abderrahim, & Zhuzhuni, 2004). Some researchers posit that the targeting of infants and young girls for FGC allows family members and traditional excisors to hide their activities more easily from the authorities, especially in countries with laws against the practice. In addition, younger girls are less able to resist than older ones (PI, 2005).

Practitioners

Traditional practitioners are usually older, well-respected women who perform FGC in the majority of countries where the ritual occurs. These circumcisers have status within the community and are well compensated for their services (Jones, Ehiri, & Anyanwu, 2004; Kallon & Dundes, 2010; UNICEF, 2013). Traditional circumcisers often have little to no medical knowledge or training, resulting in girls and women being cut without anesthetics, antibiotics, or antiseptics. Some rely on a variety of herb mixtures to treat the cut area (Baron & Denmark, 2006; Nour, 2004; Whitehorne et al., 2002).

In recent years, trained health care professionals (e.g., physicians, midwives) have begun to take a more prominent role in performing FGC than in the past, partially because of the push to make the practice safer, often referred to as the “medicalization” of FGC. With the greater participation of medical professionals, cutting increasingly occurs in doctors’ offices, hospitals, and clinics. There is no evidence, however, that medicalization reduces obstetric or other long-term complications associated with FGC (WHO, 2008). This trend has been noted in Indonesia (Belluck & Cochrane, 2016) and in several African countries (Bjälkander et al., 2012; Sanctuary for Families [SSF], 2013; UNICEF, 2013). In the U.S., medicalization is not an option, as many medical associations, including the American Medical Association (AMA), the American Academy of Pediatrics (AAP) and the American College of Obstetricians and Gynecologists (ACOG), have published policy statements against FGC since the 1990s (Nour, 2015).

Instruments

Razor blades, scissors, knives, sharp stones, and shards of glass are a few examples of the instruments used to perform FGC (Baron & Denmark, 2006; Morris, 2006; UNICEF, 2013; Whitehorne et

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al., 2002). These tools are often unsterilized and may transmit disease (e.g., HIV).

Location

Usually, FGC is conducted in private homes or in secret locations (Baron & Denmark, 2006; Bjälkander, Leigh, Harman, Berstrőm, & Almroth, 2012; Kallon & Dundes, 2010; UNICEF, 2013). Depending on local customs and decision-making practices, girls or women are cut individually or in groups (Ahmadu, 2000; Bjälkander et al., 2012; Kallon & Dundes, 2010).

A Review of the FGC Literature

To date, much of the FGC literature comes from medical professionals (e.g., doctors, nurses) and anthropologists who work or have worked in countries where these rituals are practiced historically, as well as from human rights organizations and activists. Research in these countries has investigated a range of issues, including the historical and cultural background of FGC, as well as its prevalence (Tag-Eldin et al., 2008); physical aftereffects such as infections, infertility, complications in pregnancy, and death (Abor, 2006; Morison et al., 2001); and mental health consequences (Abor, 2006; Lax, 2000; Nour, 2004; Utz-Billing & Kentenich, 2008; Whitehorne et al., 2002; Williams, Acosta, & McPherson, 1999; WHO, 2014), including posttraumatic stress disorder (Chibber, El-Saleh, & El Harmi, 2011; Kizilhan, 2011; Vloeberghs, Knipscheer, van der Kwaak, Naleie, & van den Muijsenbergh, 2011) and affective disorders (e.g., anxiety, depression) (Behrendt & Moritz, 2005; Elnashar & Abdelhady, 2007). A smaller body of literature reports positive outcomes such as enhanced sexual desire, improved sexual satisfaction, and increased sexual activity (Ahmadu & Shweder, 2009; Catania et al., 2007; Esho, Enzlin, Van Wolputte, & Temmerman, 2010). Even though the WHO (2014) and some researchers have acknowledged that psychological impact often results from FGC, most of the literature focuses on the physical effects, with relatively few articles investigating the psychological ones (Mulongo, Martin, & McAndrew, 2014).

In addition, many authors have written about the various demographic variables (e.g., education level, ethnic membership, geographic location) that differentiate the women and girls who have undergone FGC from those who have not (Tag-Eldin et al., 2008). These factors vary by cultural group, geography, and a family's level of adherence to the norms of these demographic variables. Researchers have examined the impact of governmental efforts to eradicate these rituals by enacting laws or decrees against FGC and of international organizations classifying FGC as a violation of the health and human rights of women and girls (Leye et al., 2008; Monahan, 2007).

More recently, investigators in the United States and other Western countries that have experienced an influx of immigrants from regions where FGC is commonplace have been adding to the literature. These articles have dealt with topics including the knowledge, attitudes, and experience of health care providers; attitudes toward FGC among immigrant family members; medical and sexual problems (Elgaali, Strevens, & Mårdh, 2005); legal, preventive, and educational efforts to eliminate this practice (Jaeger, Caflisch, & Hohlfeld, 2009); and acculturation (Gele, Kumar, Hjelde, & Sundby, 2012; Upvall, Mohammed, & Dodge, 2009). Some articles proposed clinical and cultural guidelines for working with affected individuals (Horowitz & Jackson, 1997; Nour, 2004) and with African immigrant communities in medical settings (Horowitz & Jackson, 1997). These guidelines focus on cultural sensitivity and education (Williams et al., 1999).

FGC in the United States

The most recent prevalence estimates range from 506,795 to 513,000 females in the U.S. who are at risk or have been cut, with up to a third of these being girls under the age of 18 (Goldberg et al., 2016; Mather & Feldman-Jacobs, 2015). It is worth noting that data from Indonesian immigrants were not included in these approximations. These figures are more than double the 2000 estimate of 227,887 and three times more than the 1990 estimate of 168,000 (WHO, 2000). The precipitous rise in women and girls who are affected by FGC reflects a growth in immigration to the United States from countries with high FGC prevalence rates. More specifically, 55% of U.S. women and girls at risk come from Somalia, Egypt, and Ethiopia where the prevalence rates for females ages 15–49 are 98%, 91%, and 74%, respectively (Mather & Feldman-Jacobs, 2015). Sixty percent of these women and girls live in eight states: California, Maryland, Minnesota, New Jersey, New York, Texas, Virginia, and Washington (Mather & Feldman-Jacobs, 2015).

As with earlier immigrant groups in the United States, people from FGC practicing countries have brought aspects of their cultures with them, such as social and cultural institutions; family expectations and obligations; gender roles; and cutting (Burstyn, 1995; Sussman, 2011). The controversial tradition of FGC sets these immigrants apart from the mainstream culture and may complicate their efforts to adjust to life in the United States and cause intergenerational conflict in some families. For instance, parents may consider it important for their daughters to be cut, regardless of the girls' wishes, as a way to maintain their identity with the family and its cultural community of origin. Others may want the girls in their family to undergo FGC as a way to protect them from aspects of American culture (Burstyn, 1995; Sussman, 2011).

The fact that FGC is illegal in the United States and considered a human rights violation and a type of gender-based torture (Barstow, 1999; Cook, Dickens, & Fathalla, 2002; Monahan, 2007; WHO, 2014) may negatively influence how members of the mainstream culture and these immigrant groups view each other. These immigrants face specific difficulties, especially when it comes to dealings with medical and mental health care providers. Women and girls who have undergone cutting or are at risk for being cut may have to deal with health care providers who have little to no knowledge, training, or experience treating them. Furthermore, these professionals may bring their unexamined opinions and attitudes about this tradition to their interactions with and treatment of their patients.

FGC and United States Laws

On the legal front, the practice of FGC raises child protection issues (Jaeger et al., 2009; Webb & Hartley, 1994), with some scholars referring to it as a human rights violation (Barstow, 1999;

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Cook et al., 2002; Monahan, 2007; WHO, 2014). Based on these concerns, a set of international, federal, and state laws have been enacted to restrict or eradicate FGC. In the United States, two federal laws specifically address FGC. In 1996, Congress outlawed the act of performing FGC on girls under 18 years of age when it passed the Illegal Immigration Reform and Immigrant Responsibility Act (Center for Reproductive Rights, 2004). Furthermore, the act excluded cultural grounds as a way to justify the practice of FGC. To circumvent this law, parents and/or guardians sent girls abroad to undergo FGC, usually during the summer months. This practice came to be known as "vacation cutting." In 2013, Congress passed the Transport for Female Genital Mutilation Act, closing this loophole (SFF, 2013).

With the 1996 decision to grant asylum to a young woman who left Togo fleeing FGC and a forced marriage, FGC was acknowledged as a form of gender-based persecution and a basis on which women and girls could seek asylum in the United States (Equality Now, 2015). In recent years, there have been reports of increasing numbers of girls and women seeking political asylum due to actual or feared FGC (Kea & Roberts-Holmes, 2013; Lee, 2008; SFF, 2013).

Since 1994, 24 of the 50 states in the United States have criminalized FGC. The states with statutes against FGC are Arizona, California, Colorado, Delaware, Florida, Georgia, Illinois, Kansas, Louisiana, Maryland, Minnesota, Missouri, Nevada, New Jersey, New York, North Dakota, Oklahoma, Oregon, Rhode Island, South Dakota, Tennessee, Texas, West Virginia, and Wisconsin. Aspects of these state laws differ from the federal ones, but their definition of FGC is consistent with the federal statutes. There is a great deal of variability among the state laws; for instance, some states outlaw the practice on any female regardless of age, while others address the need for culturally sensitive education and outreach to affected communities. At least 12 states have made it a felony for a parent or guardian to allow a female minor to undergo FGC, irrespective of whether the parent or guardian arranges or performs the cutting. Only seven state statutes address vacation cutting by making it a felony to knowingly remove or allow a female minor to be removed from the state to undergo FGC (Equality Now, 2015; SFF, 2013). It is important for clinicians and organizations (e.g., clinics, schools) to know their state laws and professional responsibilities as mandated reporters.

States without FGC laws use their general child abuse or assault statutes to prosecute FGC cases as do states with FGC laws, especially when they have higher sentencing guidelines than the state FGC laws (SFF, 2013). Every state has child abuse and neglect laws that broadly cover FGC, but few mention it as a form of abuse. The Child Abuse Prevention and Treatment Act (1974, 2010) establishes the minimum standards for state laws regarding child abuse and neglect as

> any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm. (USDHHS, Administration for Children & Families, 2011)

As with other forms of abuse and violence against minors, state mandated reporters (e.g., mental health professionals, physicians, teachers) have the responsibility to notify child protective agencies of suspected cases of FGC. Because it is a cultural practice, mandated reporters often are unsure whether FGC constitutes abuse and whether they have a legal obligation to report suspected cases of cutting. Furthermore, family members and children at risk for cutting may be reluctant to talk with others or to contact the authorities for fear of getting other relatives, including their parents and grandparents, arrested, prosecuted, and possibly deported.

Even though these state and federal laws are intended to restrict or eliminate FGC, the criminalization of these practices can force them underground with negative consequences, including the increased use of inexperienced excisors. These laws may also inhibit research and health care seeking behavior for complications related to FGC (Morris, 2006; Sussman, 2011). Thus, many argue for the importance of culturally sensitive education and outreach programs within affected communities as well as community-led programs (WHO, 2014).

Recommendations

With the increasing numbers of female immigrants to the United States from regions in the world where FGC is practiced, psychologists working in urban settings are likely to encounter immigrants or children born to immigrants who have been exposed to the practice (SFF, 2013). Given this reality, it is our professional and ethical responsibility to be informed about this cultural practice, and to possess the awareness, knowledge, and skills to intervene. It is crucial that psychologists practice within the "Guidelines for Psychological Practice for Girls and Women" (American Psychological Association [APA], 2007) and recognize the importance of not pathologizing the experiences of all girls and women who have undergone FGC. The following recommendations focus broadly on the ways in which psychologists in the United States can address the needs of women and girls who have experienced FGC and report negative sequelae. It is important to understand that often, such experiences extend beyond the individual to her sexual partners, family, and community. As such, the recommendations we present encompass practice, education and training, research, and advocacy spheres.

Clinical Practice

Just as it can be in their countries of origin, FGC is a very private and sensitive matter for many immigrant females and their families in the United States. A number of women and girls who have had the procedure have reported distressing interactions with Western health and social service providers (Kallon & Dundes, 2010; Nour, 2004). Often mental health professionals are unfamiliar with the special needs and concerns of this population, because of limited knowledge and training, and a lack of cultural competency skills.

To promote sensitive and culturally informed care for this population, we recommend that practitioners:

- Develop a solid knowledge base of the physical, psychological, and social implications/consequences of FGC.
- Use nonjudgmental, neutral language or invite the client to share her preference for the term that she feels best describes her experience.
- Monitor countertransferential responses closely so that any personal and/or judgmental responses regarding the practice of FGC do not cloud service provision.

- Seek opportunities for sharing practice methods and theories within the field of psychology that can address the special needs of this population, recognizing there may be methods of treatment that incorporate culturally syntonic techniques into practice (APA, 2010).
- Cultivate a strong network of multidisciplinary resources for referrals and support, for example professionals who can assist with management of obstetric and gynecological care, psychosexual issues, and even legal issues specific to FGC.
- Recognize potential developmental considerations. For example, an adult woman cut during infancy may have different mental and physical needs, and as a result face different challenges, than an adolescent cut while on vacation in her home country.
- Use well-trained and trusted interpreters who have an understanding of the culture, are sensitive to these issues, and can ensure confidentiality (O'Hara & Akinsulure-Smith, 2011).
- Engage the patient's partner whenever possible, as the experience of FGC can impact sexual intimacy and the health of the relationship.

Education and Training

To improve and enhance training opportunities in FGC for graduate students and encourage training for and retention of professionals who work with populations impacted by FGC, we recommend educational and training opportunities that:

- Provide information about relevant state and federal laws pertaining to FGC.
- Address current developments in the FGC literature.
- Highlight the importance of effective collaboration between psychologists and interdisciplinary resource agencies, community leaders, paraprofessionals, and cultural brokers to address the needs of this population.
- Develop and disseminate culturally and linguistically appropriate informational materials for women and girls from communities with high prevalence rates of FGC in both traditional and nontraditional settings (e.g., home-based, community-based). For example, clinicians who work with members of these communities could have informational materials about the practice, written in a clear manner in several languages, on hand for psychoeducation (e.g., *Female genital mutilation: A fact sheet*; Amnesty International, 2005).

Research

To advance the knowledge base regarding the emotional and behavioral health of women and girls who report adverse consequences of FGC, we recommend that researchers:

- Use qualitative, quantitative, and mixed methods in a complementary fashion to improve validity and cultural significance and to fully understand mental health and psychosocial problems faced by women and girls in the United States, as well as the key factors influencing the continuation of the practice.
- Assess the knowledge, attitudes, and practices of health care professionals regarding FGC and those who have been cut, their families, and their communities. This research is essential because it can aid in the development of culturally informed interventions to enhance effective service provision (Kaplan-Marcusán et al., 2010; Leye et al., 2008). Thus far, no such explorations have been conducted among service providers in the United States.
- Examine the developmental consequences of FGC. To date, most of the current FGC literature focuses on the experiences of adult women (Akinsulure-Smith, 2014; Gele, Johansen, & Sundby, 2012; Kallon & Dundes, 2010). Even though the practice typically occurs in childhood, there is no research investigating the short- and long-term physical and psychological consequences of FGC on girls who undergo the procedures (Suardi, Mishkin, & Henderson, 2010).
- Explore the attitudes of men toward FGC (Bjälkander et al., 2012; Kallon & Dundes, 2010) and its impact on sexual and marital satisfaction. A primary argument for FGC has been to ensure virginity and marital fidelity, and to enhance male sexual pleasure (Mulongo et al., 2014; Upvall et al., 2009); however, men have been largely absent from the conversation.
- Examine the different types of FGC, and move beyond the focus of the most extreme form of FGC—Type III.
- Explore the severity of the psychological impact of FGC and differences within and across various affected communities.

Advocacy

To improve collaboration between and among individuals, organizations, and systems that provide care to women and girls who have experienced FGC negatively, we recommend that where possible psychologists:

- Assist in asylum claims by conducting psychological evaluations for women and girls seeking asylum. Because FGC is seen as a human rights violation and a form of torture (Barstow, 1999; WHO, 2014), it is possible to gain asylum in the United States based on FGC (Kea & Roberts-Holmes, 2013; Lee, 2008). In an effort to protect themselves and/or their daughters, an increasing number of women and girls have come to the United States fleeing this procedure. In this context, psychologists may be asked to assess the "credible fear" of such individuals during the asylum process.
- Support the development of a range of services for women and girls seeking asylum on the grounds of FGC (e.g., medical, mental health, job placement, housing).
- Seek opportunities for collaborations between research and practice in order to enhance the data on effective treatment with this population and strengthen the effectiveness of clinical services being offered.
- Facilitate opportunities for collaboration and bidirectional training between psychologists and community leaders/paraprofessionals/cultural brokers.

Conclusion

As women and girls from countries with high rates of FGC immigrate to the United States, it is imperative that mental health professionals are well prepared to provide knowledgeable and culturally informed therapeutic services to those who are at risk of or report negative sequelae due to FGC. Given the influx of immigrant females from countries with high prevalence rates of FGC and the limited information available regarding FGC in the United States, psychologists need to be well informed about the

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physical and psychological consequences of this practice and the role the profession can play in education and training, research, and advocacy. A thorough understanding of these factors is fundamental to promoting appropriate care for those who have had FGC and for developing effective interventions to prevent new FGC cases in the United States where the practice is illegal.

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