A case study perspective on psychological outcomes after female genital mutilation

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Abstract

Female genital mutilation is still performed throughout Africa and in a few countries of Asia and the Middle East, affecting over 100 million females worldwide. It includes procedures that intentionally injure female external genital organs for non-medical reasons, and can have deleterious consequences for the physical, psychological and sexual lives of its victims. This paper presents three case studies illustrating the psychological and sexual consequences of female genital mutilation. Data were gathered about child and family history, employment, medical and psychiatric history, and the genital mutilation experienced. Self-report measures of self-esteem, mental health status and sexual life were also administered. The results obtained highlight the need for European professionals to develop greater knowledge about female genital mutilation and its serious consequences, especially as regards sexuality. This is particularly important given the large numbers of immigrant women now residing within EU countries.

Key words: genital mutilation, females, clinical case study, assessment, psychopathology.

Theoretical and research basis

Female genital mutilation, often referred to as female circumcision, female genital cutting, or ritual female genital surgery, is still performed throughout Africa, as well as in a few countries of Asia and the Middle East (World Health Organization, 2000). It affects over 100 million females worldwide and involves the partial or total removal of external genitalia or other injury to the female genital organs, whether for cultural or other non-medical reasons (World Health Organization, 1998). It is recognized internationally as a violation of the human rights of girls and women, and is regarded as a form of child abuse (Black & Debelle, 1995). Dealing with its consequences has become a public health concern in most Western countries because of increasing international migration from areas where the practice is widespread (Elchalal, Ben-Ami, Gillis, & Brzezinski, 1997; Gallard, 1995; Kjaergaard, 1994; Retzlaff, 1999). Indeed, the migratory flow from African countries towards Europe in recent years has posed complex problems for professionals involved in providing services to women and children (Kaplan-Marcusan et al., 2009; Leye, Powell, Nienhuis, Claeys, & Temmerman, 2006). As a result, there have been calls for legal guarantees and clear policy statements in order to combat these practices and to protect girls from this kind of victimization (Black & Debelle, 1995; Retzlaff, 1999). However, most European professionals actually have limited knowledge about female genital mutilation and its social and cultural background (Kaplan-Marcusan et al., 2009).

Types of mutilation and how they are justified

Female genital mutilation covers a broad spectrum of practices and is often classified into three main forms: a) circumcision or *sunna*, referring to the removal of the clitoral prepuce, with or without scission of part or all of the clitoris (Type I); b) excision or cliterectomy, where the prepuce, clitoris and all or part of the labia minora

are removed (Type II); and c) infibulation or Pharaonic circumcision, the most severe form and often repeated after each childbirth, involving the excision of part or all of the external genitalia and then, through infibulations, stitching the vulva closed, leaving only a small opening for urination and menstruation (Type III). The World Health Organization (1996) also suggests a fourth form (Type IV) which includes unclassified procedures such as cauterization of the clitoris, cutting of the vagina, and the introduction of corrosive substances or herbs into the vagina for the purpose of tightening or narrowing it.

The arguments in support of female genital mutilation have traditionally been based on cultural, religious and social beliefs within families and communities, although religion actually offers little support and justification for the practice (Silverman, 2004). As such, the reason why the practice of female genital mutilation is performed and perpetuated has more to do with social convention, tradition and cultural ideals of femininity (World Health Organization, 2000). Nevertheless, research has shown that in cultures which defend the practice, a majority of the most highly educated classes, such as university students, continue to believe that it is a religious dictate (77.4% of males and 50% of the females), this being especially the case among Muslim students (Herieka & Dhar, 2003). Despite this, female genital mutilation is now illegal in most countries, including the majority of countries in which it was traditionally practised (Cook, Dickens, & Fathalla, 2002; Webb & Hartley, 1994).

Physical, psychological and sexual consequences

The long- and short-term medical consequences and physical health risks associated with female genital mutilation have been well documented (for a review see Reyners, 2004 or Sha, Susan, & Furcroy, 2009) and involve, among others, haemorrhages, infections from unsterile cutting instruments, ulceration of the genital region, urinary

problems, menstrual disorders, sexual dysfunction, infertility, and later pregnancy and birth complications. Many girls also die as a result of the mutilation or its repercussions, although few official records are kept and deaths due to the practice are rarely reported to the authorities (World Health Organization, 1996).

In contrast to the considerable research that has been conducted into the physical impact of genital mutilation, the psychological and sexual consequences have largely been neglected in the empirical literature (Erian & Goh, 1995; Reyners, 2004; Sha et al., 2009), although among the few studies that have addressed these issues, the majority highlight the potentially negative outcomes related to the procedure (Benjet, 2010; Mahran, 1981). For instance, the pilot study by Behrendt and Moritz (2005) found a higher prevalence of post-traumatic stress disorder and other psychiatric syndromes in circumcised women from Senegal, as compared to uncircumcised women, and confirmed the severe psychological consequences of female genital mutilation. Similar results related to post-traumatic symptoms were obtained in mutilated women from Ghana (Abor, 2006). Another study, however, found no differences in mental health between Bedouin women who had undergone female genital mutilation and those who had not (Applebaum et al., 2008).

In light of these findings, greater attention needs to be paid to the psychological status of genitally-mutilated females in Western countries so that healthcare professionals can help these women to cope with the potentially negative consequences of this victimization suffered in childhood. In this context, and given the lack of research into the negative sexual and psychological effects of female genital mutilation (Cook et al., 2002) the present case study, based on diagnostic assessment, aimed to describe the impact of female genital mutilation (focusing on the psychological and sexual areas) in adult immigrant women living in a European country.

Case presentation

The three cases were contacted via a public-sector healthcare professional and invited to participate in a study about the sexual life and emotional status of adult women who had been subjected to genital mutilation during childhood. None of them had attended the health centre for problems related to genital mutilation. The three women were all born in Nouakchott (Mauritania) and belonged to the Muslim religion.

Origin and family

Case 1: S.T. is a 39-year-old Black woman who had grown up with her parents and six siblings. Like her two sisters she was genitally mutilated at a very young age, in her case this being type I genital mutilation. She got married when she was 14 and had her first child at age 15. She has four children, one boy and three girls, and none of the latter have been genitally mutilated. In 1994 she came to Spain with her husband and children in search of a better life.

Case 2: K.B. is a 35-year-old Black woman. She has four brothers and a sister, who like her was mutilated at a very young age. In K.B.'s case the genital mutilation was type III. She married and had her first child when she was 14, and she now has three daughters, none of whom have been mutilated. She came to Spain with her husband and children in 2005 in the hope of finding a better way of life.

Case 3: M.D. is a 45-year-old Black woman. She has two brothers and two sisters, both of whom, like her, were genitally mutilated at a young age. In her case the genital mutilation was type I. She married when she was 14 and had her first child at age 15. She now has three children, two boys and a girl. Her daughter has not been subjected to mutilation. She came to Spain with her husband and her children in 2003 in search of a better life.

Education and employment

None of the three women had attended school during childhood, and during the interview they reported being unable to read and having great difficulties with writing. They all came from rural families and, therefore, their work experience in Africa was limited to the harvest season for local crops (such as corn or peanuts). It was not until they arrived in Spain that they abandoned such rural tasks, with S.T., for example, working as a cleaner in factories or offices, or in the restaurant trade. K.B. and M.D. explained that since emigrating they had devoted their time entirely to domestic tasks and child care. All three women acknowledged that the genital mutilation suffered had interfered with their working lives, causing them pain and preventing them from working long days.

Medical and psychiatric history

As regards their medical history the only problems mentioned were hypertension (S.T.) and asthma (K.B.). None of them had ever seen a psychologist and neither were they aware of what such a professional might do for them. As such, their psychiatric history was unknown.

Assessment

The three women were invited to take part in a group session followed by a semi-structured interview about their experience as women who had been genitally mutilated in childhood. The sessions were led by two psychologists and were conducted in Spanish, since the three women had an acceptable level of comprehension in this language. The data collected included socio-demographic information (e.g. age, family, education, employment, medical and psychiatric history) and detailed coverage of the genital mutilation they had suffered in childhood, the questions asked being based on previous studies of female genital mutilation (e.g. Herieka & Dhar, 2003). Given the findings of previous research in this area they were also asked about, in the following

order, their level of self-esteem (Rosenberg, 1965), the presence of general symptoms of psychopathology *(*Derogatis, 1993), and their sexual activity, sexual satisfaction, the existence and severity of sexual dysfunction, and other sexual aspects of interest (Sánchez et al., 2004). The questions about their sexual and married life were deliberately left until the end, by which time the women felt more comfortable with the interviewer and had already spoken about less sensitive issues. They were not specifically asked about post-traumatic symptomatology, despite this being a relevant variable in previous studies (Abor, 2006; Behrendt & Moritz, 2005), because none of them showed signs of this disorder.

Case conceptualization

Genital mutilation

Description: The three women had all suffered genital mutilation when they were very young. They did not remember exactly when they were mutilated, but it was before the end of childhood, as occurs in many African countries (Applebaum et al., 2008). S.T. said that some girls in her village were genitally mutilated when they were only a few weeks or months old. None of the women remembered who had mutilated them, since it is not a topic of discussion among families. However, K.B. and M.D. said that it was most likely to have been done by a female elder with experience of the procedure, as had occurred in other cases they knew about. Nobody had ever explained to them why they had undergone genital mutilation or what the justification for it was. In fact, all three stated that the practice was so common in their immediate context that nobody ever asked why it was being done to girls. For them it was a tradition, and all the women in their families had been subjected to it. They went on to explain that the main argument used to justify the practice in their context is that it prevents infidelity and promiscuity in women, in other words, it is a way of controlling female sexuality (Cook

et al., 2002; Jirovsky, 2010; Webb & Hartley, 1994). Since women who have been genitally mutilated feel pain rather than pleasure during sexual intercourse, they will not, so the argument goes, look for it with anyone other than their husband, thereby attenuating their sexual desire (Benjet, 2010). A further argument they had heard was that the practice meant that girls remained clean, pure and virgin until they got married (Silverman, 2004; Webb & Hartley, 1994).

Self-reported physical and sexual consequences related to genital mutilation: None of the women recalled the pain caused by the mutilation itself, although bleeding and haemorrhage had been common in their development. K.B. said, *"That initial pain is not like the pain that will accompany us for the rest of our lives"*. They all reported extreme fear and anxiety before their marriage in relation to the idea of having sex, which was experienced by them as a painful obligation rather than a pleasurable or voluntary act. As regards the consequences related to the mutilation they reported pain and discomfort during sexual intercourse, which led them to avoid sexual relationships and intimacy and had a negative impact on their marital relationship (McCaffrey, 1995). Problems during childbirth were also common: S.T. and M.D. reported long and painful labours, while K.B. required caesarean sections for all three of her children (Retzlaff, 1999; Sha et al., 2009).

Personal opinion about genital mutilation: They were all against the practice and did not want their daughters to suffer it. They said that it was elders within their communities who preserved the tradition and beliefs regarding female genital mutilation, adding that men did not play an active role in the intervention. They also stated that when men in their communities had daughters and saw how women suffered and the repercussions it had on their subsequent married life, they tended to change their views and express their disagreement with the continued practice of genital mutilation

(Wheelwright, 1989). However, they said they had never spoken about this with their husbands, making it clear that the only time the topic came up was in the context of the consequences of genital mutilation for sexual relationships.

All three women felt that immigration encourages an opinion against genital mutilation. However, they said they risked being pressured by family and society whenever they visited their homeland, and therefore they usually sought to obtain a certificate from the Spanish authorities prohibiting the practice while in their country of origin. This gives them a greater sense of security when in their own country as they feel they have more power to prevent their daughters from being genitally mutilated within their home communities. They added that having issued a certificate the police monitor each case, including checking that girls are still intact when they return to Europe. Although the women acknowledged that these police measures help them to feel safer, they said that the tradition would only be eradicated by raising awareness in the countries of origin, especially through education of younger generations (Odu, 2008). Furthermore, both K.B. and S.T. thought that it will take several generations before the practice is eradicated, although they did recognize that the status of women in their country had changed considerably in recent years, a factor which would help to end the practice. All three women firmly believed that adapting to one's host country helps in this regard and serves as a form of protection.

Clinical formulation

Psychological consequences: In relation to mental health the three women reported a high level of self-esteem (Rosenberg, 1965) and low scores on psychological symptoms when compared to Spanish populations. The highest scores among the three cases were on somatization, a subscale related to distress arising from perceptions of bodily dysfunction (Derogatis, 1993).

Sexual functioning: In terms of the areas of interest assessed by Sánchez et al. (2004), the three women manifested sexual problems with their sexual partners, mainly in relation to vaginal dryness during sexual activity and, to a lesser extent, problems with vaginal penetration and sexual anxiety. However, they also said they did not have any problems with achieving orgasm. M.D. explained that since living in Europe she had received help with her sexual relationships through the provision of lubricants by healthcare services. The women said that they themselves did not initiate sexual relationships, and they reported moderate levels of sexual satisfaction and sexual communication with their partners. They avoided intimacy, and the frequency of their sexual relationships was very low (1-2 times per month).

Implications of the case findings

The objective of the present study was to describe the mental health status and sexual life of genitally-mutilated women who had emigrated to a European country. Given that large numbers of women from countries in which female genital mutilation is practised end up residing in Europe each year, there is an urgent need for Western professionals to have access to research-based information on this topic, thereby enabling them to understand better the implications of this practice for women's lives and their relationships with their partners and families (Retzlaff, 1999).

Many professionals are overburdened and do not know how to help these women, especially in the psychosocial context, and as a result their interventions tend to be based on their own experiences, opinions and personal priorities (McCaffrey, 1995). Given the lack of research that has been conducted with genitally-mutilated women residing in Europe it is difficult to make an adequate assessment of the real problems they face as adults living in a society which rejects the legitimacy of this practice, or to

know their own opinions in this regard. The present study has therefore sought to offer a description of these women in the Western context.

The three women agreed to participate in a study on this topic for two reasons: firstly, in order to share their real experience with professionals, so that the latter could then speak about genital mutilation and its consequences in a knowledgeable way and based on the lives of real people; and secondly, so as to express their own views about this ancestral practice and become involved in the fight to eradicate it. In agreement with previous findings (e.g. Herieka & Dhar, 2003) they stated that it was the women in their culture who perpetuated this childhood victimization, it being mothers and grandmothers who mostly made the decision to subject their daughters to genital mutilation. This is difficult to explain if one considers that it is women who suffer directly the consequences of genital mutilation. As a result, some authors have argued that these women may have become dissociated from their own pain and project it onto the bodies of their daughters (Joseph, 1996). In addition, many women in these countries continue to depend on female circumcision as a means of living, making them reluctant to act as advocates for women's health (Wheelwright, 1989). However, recent studies carried out with university students show that a large percentage of females have negative attitudes towards female genital mutilation (Odu, 2008). Furthermore, research has also indicated that a higher level of education is associated with a lower probability of having suffered genital mutilation (Ehigiegba, Selo-Ojeme, & Omorogbe, 1998; Snow et al., 2002).

All three of the women studied here were against genital mutilation and none of their daughters had been subjected to this form of victimization. Indeed, they turned to governmental organizations in order to protect themselves and their daughters against this ancestral tradition when visiting their home country. In this regard, they stated that

European legal and police measures protected them and made them feel safer in the face of social pressure when returning home with their non-mutilated daughters. In contrast to these views, many Western professionals are against such measures being imposed by European governments, arguing that the problem cannot be eradicated through public sanction and media exposure, but only in the context of the families themselves, whether in the host country or the country of origin (Cook et al., 2002; Oduro et al., 2006; Silverman, 2004; Webb & Hartley, 1994).

The women studied here all reported feeling satisfied and showed high levels of self-esteem. The psychological assessment did not reveal any significant problems, a finding that is consistent with some previous studies in this context (Applebaum et al., 2004). Although the women's test responses were compared to the norms for a Spanish population, since they resided in Spain and the tests were administered in Spanish, cross-ethnic studies have demonstrated in different cultures the construct validity of the questions asked in the present study (Hoe & Brekke, 2009). The three women now live in a country that is against the practice of genital mutilation, one in which they are in the minority for having suffered it, but this does not appear to have produced psychological problems; this finding differs from the conclusions of some previous reports (Behrendt & Moritz, 2005). Neither does it seem plausible to argue that the negative psychological effects of this practice on these women were mitigated by a strong conviction that its performance purified and ennobled them, as has been suggested by some authors (Lightfoot-Klein, 1989). One possible explanation for the present findings is that these women, who openly expressed their opposition to genital mutilation and dared to participate in a study in order to defend their views in this regard, may be more resilient and less prone to the development of psychological problems (Masten, Best, & Garmezy, 1990). It is also possible that the three women

have problems which are not covered by the questions asked in this study, and this should be borne in mind as a potential limitation. At all events, it should be noted that even if genital mutilation were not associated with psychological problems, it would still be a severe form of child victimization and a violation of women's rights (Cook et al., 2002).

The most relevant symptoms presented by the three cases were of a somatic nature, this being consistent with previous studies that have found a high probability of somatization syndromes in *immigrant* populations in Europe (Aragona et al., 2005; Ritsner, Ponizovsky, Kurs, & Modai, 2000). Having said that, it is likely that much of the pain experienced by these women is linked to the mutilation they suffered, rather than specifically to an anxiety state. However, the information obtained in the present study is insufficient to clarify this aspect.

All three women reported sexual and gynaecological problems, mainly in terms of heightened anxiety in the context of sexual relations, accompanied by avoidance of intimacy and problems with penetration. These findings are consistent with previous results (Mahran, 1981; McCaffrey, 1995). However, and despite what Western observers may imagine about the sexuality of these women, they reported being able to experience orgasm in spite of their genital mutilation, a finding that has been previously reported (Lightfoot-Klein, 1989). At all events, it is surprising that female genital mutilation has traditionally been seen as a way of feminizing a woman's otherwise androgynous genitalia (Silverman, 2004; Webb & Hartley, 1994). As was the case of the three women studied here, the difficulties that genitally-mutilated women experience in the sexual area lead to many problems and conflicts with their partners, despite the traditional view that the practice actually favours a woman's marriage (Cook et al., 2002; Wheelwright, 1989; World Health Organization, 1998).

Although some authors have argued that female genital mutilation is supported and encouraged by men (Black & Debelle, 1995), other studies have found that the majority of male undergraduates surveyed would prefer to marry a non-circumcised female (Herieka & Dhar, 2003). Thus, despite the fact that female genital mutilation has been seen as a feminist issue, there is a need for men to be included and involved in educational programmes, since, in many cases, they are not in favour of this form of victimization, the consequences of which they suffer in their marriages (Herieka & Dhar, 2003).

Recommendations to clinicians and students

The results of the present study, in line with previous research, show that women who have suffered female genital mutilation present a number of serious problems, especially in the sexual and gynaecological areas. Health professionals from Western countries need to be aware of these problems, since international migration and the presence in Europe of women from cultures where the practice is common mean that it is no longer a reality confined to certain African and other countries (Black & Debelle, 1995; Kjaergaard, 1994; Reyners, 2004).

However, the Western view of these women often does not correspond to the reality which they themselves report when interviewed directly, and there is therefore a need for further studies such as this in order to ensure that these women's voices are heard. As can be seen, these women may have high self-esteem and feel good about themselves. Indeed, they need not have psychological problems, for many of them seem to be resilient in the face of their experiences (Masten et al., 1990). It should also be noted that not all of them accept mutilation as a tradition which should be continued, and neither do they wish to see it persist for generations. According to these women, and in contrast to the view held by many European professionals (Black & Debelle,

1995), men do not appear to play an active role in this ancestral ritual, and neither are they always in favour of it. Although the women interviewed said that the status of women in their culture helped foster the continued practice of genital mutilation, they also stated that men suffer the consequences of it in their role as husbands and fathers; in their view, this led men to reconsider the appropriateness of the practice, and even to oppose it (Herieka & Dhar, 2003).

Despite international efforts to eliminate the practice of female genital mutilation, the number of girls undergoing the procedure is not declining as rapidly as hoped. Therefore, Western professionals need to educate themselves and develop a clear and objective view of the problem, as only thus will they be able to help the women who have suffered this type of childhood victimization to heal and break the generational pattern (Adams, 2004).

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References

Abor, P. A. (2006). Female genital mutilation: Psychological and reproductive health consequences. The case of Kayoro traditional area in Ghana. *Gender & Behaviour, 4* (1), 659-684.

Applebaum, J., Cohen, H., Matar, M., Abu Rabia, Y., & Kaplan, Z. (2008). Symptoms of posttraumatic stress disorder after ritual female genital surgery among Bedouin in Israel: Myth or reality? *Primary Care Companion to the Journal of Clinical Psychiatry, 10* (6), 453-456.

Aragona, M., Tarsitani, L., Colosimo, F., Martinelli, B., Raad, H., Maisano, B. & Geraci, S. (2005). Somatization in primary care: A comparative survey of immigrants from various ethnic groups in Rome, Italy. International Journal of Psychiatry in Medicine, 35 (3), 241-248.

Behrendt, A., & Moritz, S. (2005). Posttraumatic stress disorder and memory problems after female genital mutilation. *American Journal of Psychiatry, 162* (5), 1000-1002.

Benjet, C. (2010). Childhood adversities of populations living in low-income countries: prevalence, characteristics, and mental health consequences. *Current Opinion in Psychiatry, 23*, 356-362.

Black, J. A., & Debelle, G. D. (1995). Female genital mutilation in Britain. *British Medical Journal, 310*, 1590-1592.

Cook, R. J., Dickens, B. M., & Fathalla, M. F. (2002). Female genital cutting (mutilation/circumcision): ethical and legal dimensions. *International Journal of Gynecology and Obstetrics, 79*, 281–287.

Derogatis, L. R. (1993). *Brief Symptom Inventory: Administration, scoring and procedures manual* (4ª ed.). Minneapolis, MN: NCS, Pearson, Inc.

Derogatis, L. (1994). SCL-90-R. Symptom Checklist-90-R. Administration, Scoring and Procedures Manual. Minneapolis: National Computer System.

Ehigiegba, A., Selo-Ojeme, D., & Omorogbe, F. (1998). Female circumcision and determinants in southern Nigeria. *East African Medical Journal 75*, 374-376.

Elchalal, U., Ben-Ami, B., Gillis, R., & Brzezinski, A. (1997). Ritualistic female genital mutilation: Current status and future outlook. *Obstetrical & Gynecological Survey, 52* (10), 643-651.

Erian, M. M., & Goh, J. T. (1995). Female circumcision. *The Australian & New Zealand Journal of Obstetrics & Gynaecology, 35* (1), 83-85.

Gallard, C. (1995). Female genital mutilation in France. *British Medical Journal, 310*, 1592-1593.

Herieka, E., & Dhar, J. (2003). Female genital mutilation in the Sudan: survey of the attitude of Khartoum university students towards this practice. *Sexually Transmitted Infections, 79*, 220-223.

Hoe, M., & Brekke, J. (2009). Testing the cross-ethnic construct validity of the Brief Symptom Inventory. *Research on Social Work Practice, 19* (1), 93-103.

Jirovsky, E. (2010). Views of women and men in Bobo-Dioulasso, Burkina Faso, on three forms of female genital modification. *Reproductive Health Matters, 18* (35), 84-93.

Joseph, C. (1996). Compassionate accountability: An embodied consideration of female genital mutilation. *The Journal of Psychohistory, 24* (1), 2-17.

Kaplan-Marcusan, A., Torán-Montserrat, P., Moreno-Navarro, J., Castany-Fàbregas, M. J., & Muñoz-Ortiz, L. (2009). Perception of primary health professionals about female genital mutilation: from healthcare to intercultural competence. *BMC Health Services Research, 9*, 1-8.

Kjaergaard, G. (1994). Tema: omskaering. Når kulturen skader sundheden. [Theme: circumcision. When culture harms health]. *Sygeplejersken, 94* (18), 8-11.

Leye, E., Powell, R. A., Nienhuis, G., Claeys, P., & Temmerman, M. (2006). Health care in Europe for women with genital mutilation. *Health Care for Women International, 27*, 362-378.

Lightfoot-Klein, H. (1989). Rites of purification and their effects: Some psychological aspects of female genital circumcision and infibulation (Pharaonic circumcision) in an Afro-Arab Islamic society (Sudan). *Journal of Psychology & Human Sexuality, 2* (2), 79-91.

Mahran, M. (1981). Medical dangers of female circumcision. *IPPF Medical Bulletin, 15* (*2*), 1-3.

Martín Albo, J., Núñez, J.L., Navarro, J.G., & Grijalvo, F. (2007). The Rosenberg Self-Esteem Scale: Translation and validation in University students. *The Spanish Journal of Psychology,* 10 (2), 458-467.

Masten, A.S., Best, K.M., & Garmezy, N. (1990). Resilience and development: Contributions from the study of children who overcome adversity, *Development and Psychopathology, 2*, 425-444.

Mccaffrey, M. (1995). Female genital mutilation: consequences for reproductive and sexual health. *Sexual and Marital Therapy: Journal of the Association of Sexual and Marital Therapists, 10* (2), 189-200.

Odu, B. K. (2008). The attitude of undergraduate females toward genital mutilation in a Nigerian University. *Research Journal of Medical Sciences, 2* (6), 295-299.

Oduro, A. R., Ansah, P., Hodgson, A., Afful, T. M., Baiden, F., Adongo, P., & Koram, K. A. (2006). Trends in the prevalence of female genital mutilation and its effect on

delivery outcomes in the Kassena-Nankana District of Northern Ghana. *Ghana Medical Journal, 40* (3), 87–92.

Pereda, N., Forns, M., & Peró, M. (2007). Dimensional structure of the Brief Symptom Inventory with College students. *Psicothema, 19* (4), 634-639.

Retzlaff, C. (1999). Female genital mutilation: not just over there. *Journal of the International Association of Physicians in AIDS Care, 5* (5), 28-37.

Reyners, M. (2004). Health consequences of female genital mutilation. *Reviews in Gynaecological Practice, 4*, 242-251.

Ritsner, M., Ponizovsky, A., Kurs, R., & Modai, I. (2000). Somatization in an immigrant population in Israel: A community survey of prevalence, risk factors, and help-seeking behavior. *American Journal of Psychiatry, 157,* 385-392.

Rosenberg, M. (1965). *Society and the adolescent self-image*. Princeton, N.J.: Princeton University Press.

Sánchez, F., Pérez, M., Borrás, J.J., Gómez, O., Aznar, J., & Caballero, A. (2004). Diseño y validación del Cuestionario de Función Sexual de la Mujer (FSM). *Atención Primaria, 34* (6), 286-292.

Sha, G., Susan, L., & Furcroy, J. (2009). Female circumcision: history, medical and psychological complications, and initiatives to eradicate this practice. *The Canadian Journal Of Urology, 16* (2), 4576-4579.

Silverman, E. K. (2004). Anthropology and circumcision. *Annual Review of Anthropology, 33*, 419-445.

Snow, R. C., Slanger, T. E., Okonofua, F. E., Oronsaye, F., & Wacker, J. (2002). Female genital cutting in southern urban and peri-urban Nigeria: self-reported validity, social determinants and secular decline. *Tropical Medicine and International Health, 7*, 91-100.

Webb, E., & Hartley, B. (1994). Female genital mutilation: a dilemma in child protection. *Archives of Disease in Childhood, 70*, 441-444.

Wheelwright, J. (1989). Female circumcision comes under the knife. *New African, 265*, 26.

World Health Organization (1996). *Female genital mutilation. Report of a technical working group*. Family and Reproductive Health. Geneva: World Health Organization.

World Health Organization (1998). *Female genital mutilation. An overview*. Geneva: World Health Organization.

World Health Organization (2000). Female genital mutilation. Fact Sheet No. 241. http://www.who.int/int-fs/en/fact241.html