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VEILED PAIN

A study in the Netherlands on the psycho-
logical, social and relational consequences
of female genital mutilation

Pharos is a Dutch Knowledge Centre that provides information, training and advice on the health of refugees and migrants. We aim to equip professionals and organisations that work in the field of health care for asylum seekers, refugees and migrants, with practically applicable knowledge and solutions.

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Royal Tropical Institute

PHAROS

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Foreword

Veiled pain is the result of an exploratory study which was conducted in the period from January 2008 to July 2009. The study focused on the psychological, social and relational consequences of female genital mutilation. The study is one of the many activities undertaken by Pharos during the last decade, made possible by the help of many health and community organisations to contribute to the fight against and prevention of FGM in the Netherlands. The aim of this report was to achieve an improvement in the way victims of FGM are provided with psychosocial and mental health care. Hence, the problems faced by these victims needed to be more clearly identified, including under what circumstances such problems come to the fore and what factors play a role in the development of psychosocial and sexual issues.

This research could not have taken place without the help of interviewers from the various ethnic communities living in The Netherlands. The commitment and involvement of Hawa Bashir, Sonia Khalil, Selam Tewolde, Mariam Ahmed Ali, Mabinty Kamara, Fetiya Adem and Shukri Said were important and very significant. Lianne de Vries and Dorota Sienkiewicz, who guided and supported our interviewers, contributed to the success of the study with their enthusiasm and perseverance. We are grateful to Eva Takoudia and Laurien Voorendt for their contribution to the quantitative analysis.

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Finally, we thank our respondents for their kindness in contributing to this research and their willingness in sharing with us their most intimate thoughts and experiences. We dedicate this book to them.

The Research Team: Erick Vloeberghs, Jeroen Knipscheer, Zahra Naleie, Anke van der Kwaak and Maria van den Muijsenbergh.

Summary

The study depicted in this report considers the psychological, social and relational consequences of female genital mutilation among a sample of 66 women, aged 18 to 60 years who have migrated from Somalia, Sudan, Eritrea, Ethiopia or Sierra Leone to live in the Netherlands. The women were included in the study by means of snowball sampling. The interviews were conducted by ethnically similar female interviewers who had been selected and trained by a team of researchers from Pharos, Foundation Centrum '45 and the Royal Tropical Institute. The interviewers gathered qualitative as well as quantitative data. During their first meeting with a respondent a semi-structured interview was conducted by means of a topic list on diverging themes such as: own experiences, influence of migration on the meaning of FGM, sexual behaviour and contact with caretakers. Short time later five questionnaires were administered including the Harvard Trauma Questionnaire (HTQ), the Hopkins Symptom Checklist (HSL-25), the COPE EASY and the Lowlands Acculturation Scale (LAS). A number of Focus Group Discussions were held with members of the target population. Coaching and monitoring of the interviewers was done in close cooperation with the Federation Somali Associations Netherlands (FSAN) and other community women organisations.

According to the datasets sixteen per cent of the respondents may suffer from PTSD while one-third reported symptoms related to depression or anxiety. The following factors appear to be of significance to the amount women who have been genitally mutilated suffer from psychopathological problems: the type of mutilation (infibulations goes along with more symptoms), the age on which it was done, clearness of the memory and the use of drugs were related to PTSD symptoms. While the type (infibulation), the use of drugs, not having work or following a course together with dysfunctional care seeking behaviour and coping style correlated with depression and anxiety.

The interviews show that talking about FGM is still difficult to a great number of women. Moreover psychological impediments as part of mental illness are

not always conceptualized or recognized. The idea that discussing the subject aggravates problems is still widespread – though there are differences among the communities in how open one is about it. Somali respondents seem to have more problems communicating about FGM. Since they reported far less psychological distress than all other women, underscoring might be possible. The major importance Somali women generally give to religion on the other hand may provide them with a more adaptive coping style.

Chronic pain appears to be related to memory. Pain triggers gruesome memories and vice versa: memorizing or speaking about FGM can make them feel the pain again. That agonizing memory does not need to be the mutilation itself but can be extended to an experience which is related to FGM (for instance, the first sexual intercourse during honeymoon or a delivery).

During childbirth or when suffering from medical or mental problems some respondents still feel reluctant to attend a caretaker. Difficulties with speaking Dutch and unwillingness to talk to non-family members about private matters (sexuality) are holding them back. Although the way the women are talked to and the knowledge of the caretaker are equally important in many cases. Being looked at in an invasive manner (medical gaze) provokes a lot of shame. But medical professionals who, in a careful way, show confidence in their actions and sensitive behaviour and respect toward the women, are able to smooth the tension and provide help.

Migration to The Netherlands has led to a major shift in how FGM is regarded. Very few respondents have a daughter being mutilated since they came to Holland. Only one women claim to be proud to be circumcised. The stream of information by the media as well as awareness campaigns and meetings among members of the communities has made the women more knowledgeable about the consequences of FGM. Learning to know that it was never written in the Koran, Hadith or Bible to genitally mutilate women, fuels the resistance of many of respondents. They claim that because FGM is culture, not religion, it can and must be abolished.

In a number of cases together with the knowledge of being circumcised came the suffering and the anger. Some women are troubled about their mother for having allowed their mutilation to take place, while others are angry with men for *'they are the only ones to profit from it'*. In at least one situation the divorce was a consequence of the inability of the infibulated women to comply with her husbands' sexual demands. In general however there seem to be acceptance of the changes due to migration and to the fact man and women should be allies in bed. Four of the respondents were clear in that their infibulation was not refraining them from having sexual pleasure.

In general the research shows that mental health problems were found but on a modest scale. This means there should not be a reason to psychologize or pathologize the consequences. On the other hand some serious problems were identified among a relatively small though significant number of respondents. Since the research was conducted in order to provide support to healthcare professionals, at the end of the report recommendations are given. Also in the final chapter the respondents are divided according to their coping styles to enable care providers to distinguish between the categories and thus provide the most adequate healthcare for women who suffer from FGM.

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1

Introduction

Women from countries where girls are circumcised find themselves with a difficult bridge to cross in the migrant setting. Things which were once taken for granted, the fact that circumcision was part of the culture and the mindset, is in stark contrast with the situation in the Netherlands where circumcision is punishable by law. How do women who have been circumcised experience this change? What does this mean for to them, how do they deal with it? Do these women suffer mental health problems and if so, when do these problems arise and how serious are these complaints? Do women talk about social or relational problems in relation to having been circumcised or do they suffer in silence and is their pain hidden beneath a veil: masked. What about their interaction with health care providers in the Netherlands? These questions require an answer in order to enable efficient psychosocial care or assistance. These questions were the underpinnings for this research study.

1.1 Reasons for carrying out this study

Social workers and researchers have suspected for some time now that FGM may be associated with psychosocial and psychiatric complaints. There have been quite a few studies on the somatic consequences of FGM, however there has not been much qualitative research into the psychological, social and relational consequences of FGM in the Netherlands. The dearth of studies in this area is due to the degree of difficulty involved in carrying out research of this nature. It involves private matters: genitalia, sexuality, and violence but also – for migrant women – the loss of and the treasuring of their own identity in an alien and sometimes hostile culture. This is because female circumcision is a topic that has taken on ethical and moral dimensions in the Netherlands. In addition, the researcher's access to the research sample may also be hampered by linguistic and cultural differences. Nevertheless more research into this topic is necessary. Female circumcision is a topic which may elicit strong emotions which may in turn give rise to stereotyping and prejudice. In the Netherlands

the procedure is legally prohibited and, in the West, the first response of those who are confronted with it is often one of revulsion. Respondents might be less willing to talk in this environment. All of this makes objective research into this controversial and very personal topic a tough assignment. The researchers have tried to deal with the complex and sensitive character of the subject matter by collaborating with individuals from the respondents' countries of origin. Right from the very start women from the respondents' communities have been actively involved in the research, including the design of the study, the operationalisation and analysis.

The significance of the research is two-fold: 1) it constitutes a useful and necessary contribution to the scientific body of knowledge about this topic; 2) it is essential that service providers gain further insights into the consequences of FGM in order to help them provide adequate care and develop effective prevention programmes. The aims and objectives of Pharos mean that the research also needs to have practical implications. The findings of the study must be used to facilitate information sessions for women who have been circumcised and for those who are offering health care services in the area of FGM.

1.2 Aims

The aim of this explorative research study is to provide further insights. On the one hand this involves insights into the nature and extent to which FGM may lead to psychological and social problems and problems in relations to sexual relationships, which women are affected and under what circumstances. On the other hand, this will involve insights into the way in which African women in the Netherlands, who have undergone circumcision, cope with it. These aims have resulted in the following research questions:

- 1 Does FGM lead to psychological, social and relationship problems and if so, what is the nature of these problems?
- 2 Which factors contribute to the development of problems in the areas mentioned above? More specifically women were asked about the influence of migration (life in the diaspora); marginalisation and exclusion; cultural norms; experiences with service providers in the Netherlands; the influence of religion; and the impact of information and education in relation to FGM.
- 3 What style of coping did women develop in relation to such issues?

1.3 Methodology

In order to further our insights, we wanted to find out what significance respondents themselves attached to the consequences of FGM, how they experienced living in the Netherlands, in relation to the fact that they had been cir-

cumcised, and how they dealt with any complaints. In other words, we wanted to put their views, experiences and behaviours centre stage. From a methodological perspective this led to a mixed methods approach. By using both quantitative and qualitative research techniques, by working together intensively with key individuals from the communities concerned and by additionally using interviewers from the ethnic groups themselves, we have tried to collect and interpret data in an accountable manner.

The quantitative component involved the use of four standard questionnaires, while the qualitative component comprised semi-structured interviews, Focus Group Discussions and other meetings, which were recorded and transcribed. The research sample involved sixty-six women ($n = 66$) originating from Somalia, Eritrea, Ethiopia, Sudan and Sierra Leone.

Our aim was to use the findings to generate well-founded conclusions about the long-term consequences of FGM and translate the insights thus acquired into useful knowledge for groups of practitioners who might be faced with the issue of FGM. The findings will be used to support women who have been circumcised and who have developed complaints of a psychological, psychiatric, social or relational nature as a result. Hence, the study is geared more towards a practical than a purely academic outcome. In our view, the fact that women from these communities played an important part in the study, plus the fact that the study combined both qualitative and quantitative methods, has resulted in some useful findings.

1.4 About this book

This book is set out as follows: the second chapter will present an overview of the existing literature on the subject and an outline of the theoretical framework. The third chapter will address the methodological aspects of the research and will outline its significance and the research instruments which were used.

The fourth chapter will present an overview of the findings and has been divided up into two parts. The qualitative findings are discussed first, followed by the quantitative findings. The section discussing the qualitative findings contains a considerable number of quotations concerning the psychological, social and relational consequences of FGM among women resident in the Netherlands. This provides further insights into how the study's respondents experienced the hinge moments, including the circumcision itself, the first sexual experience and childbirth. Respondents' (psycho) sexual experiences and encounters with family members and health care providers are also discussed. The section on the quantitative results centres around the question as to what extent respondents suffered anxiety, depression or Post Traumatic Stress Dis-

order (PTSD). Factors to do with migration, the significance of age, language skills, coping and religion are discussed in both the qualitative and the quantitative sections.

The fifth chapter is the discussion chapter: it will start with an overview of the findings followed by our interpretation of both datasets. This is followed by our methodological considerations in relation to the study. The sixth chapter presents our conclusions, based on the findings, as well as recommendations for further research.

2

Background information

This chapter will review the literature on FGM which has been published in both Dutch and English. After a general introduction into the subject matter, we will focus specifically on factors which are important for the research study under discussion here.

2.1 FGM in general

Female Genital Mutilation (FGM) is a procedure involving the external genital organs for which there is no medical necessity. FGM currently occurs in a large part of Africa (in particular within the triangle delineated by Guinea, Egypt and Kenya), and East Africa in particular. In Somalia as many as 98% of women aged between 15 and 49 appear to have been circumcised. In addition, FGM occurs in parts of Asia (Indonesia) and the Middle East (Kurdistan, Yemen) and recently also among groups of migrants in Australia, North America and Europe (WHO, 2009). There is a higher incidence among Muslims, but the custom itself is not Islamic, as victims of FGM may also be found among Coptic Christians (De Lucas, 2004). According to estimates by the World Health Organisation, at present some 100 to 140 million women and girls worldwide have undergone a circumcision. In Africa some 3 million girls are annually at risk of being circumcised – which comes down to some 6,000 to 8,000 girls per day.

Even though FGM has been a recent ‘foreign’ phenomenon in the Western world, it has a very long history, dating back some 5,000 years, as evidenced by signs of circumcision found on Egyptian mummies. In the Roman Empire, female slaves had rings put through their labia in order to prevent them from reproducing. It should be added that clitoridectomies were carried out in Europe until the first half of the twentieth century in cases of hysteria, epilepsy and masturbation (Whitehorn et al., 2002).

The circumcision is usually carried out before the girl has reached puberty, but may also be done at a later stage. Ages differ widely, with girls being circumcised soon after birth in Eritrea, whereas in West Africa women may be

circumcised just prior to marriage. It is becoming increasingly evident that girls living in the Netherlands are also circumcised (Van der Kwaak et al., 2003). There are some 25,000 women and girls in the Netherlands who are either at risk of being circumcised or who have already been circumcised. In total there are about 31,000 adult women from at-risk countries living in the Netherlands (CBS, 2009). Estimates vary, but it is thought that annually about fifty girls become the victims of circumcision.¹

Parents have their daughters circumcised to secure their daughters' future, because uncircumcised girls may not be able to find a partner in marriage. Being eligible to marry is very important as is collective pressure – because everyone has their daughters circumcised, everyone has to conform. Many women take the procedure for granted: it is part of life, as everyone has been circumcised. Girls may experience feeling proud once it has been done. Research has shown that, aside from this supposedly being a religious precept, those who adhere to the custom gave the following reasons for doing so.

- It will increase a woman's chances of getting married (Fokkema & Huisman, 2004).
- It will protect a girl's virginity and marital fidelity (Johnsdotter, 2003; Rahman & Toubia, 2000).
- It contributes to the marking of both female and male identity (Bartels, 1993; Van der Kwaak, 1992).
- It gives women a certain status within the community (Van der Kwaak et al., 2003).
- Infibulated women are beautiful and cultured (Lightfoot-Klein, 1989).

Within a community in which circumcision is the custom, *not* being circumcised may have significant (psycho)social consequences for a girl. She may be considered unclean or she may be suspected of being sexually promiscuous. An uncircumcised, 'open' woman will bring dishonour to the family, risks being expelled and has less chances of getting married.

Neither the Quran nor the Bible prescribe FGM as a religious requirement, but religion is nevertheless often quoted as the reason why girls are being circumcised. Somalians in particular often think that FGM is a religious requirement (Keizer, 2003). The strong belief that a woman needs to be circumcised in order to be a good Somalian Muslim woman, is handed down from one generation to the next and is deep-rooted (Nienhuis et al., 2008). Nevertheless FGM is not practised in a large number of Islamic countries, including Morocco, Algeria, Afghanistan and Saudi-Arabia. Hence FGM should be considered a cultural practice, and not a religious one.

¹ Information in Dutch about the origins and incidence of FGM around the world may be found on the Dutch site www.meisjesbesnijdenis.nl.

Female genitalia can be cut in a number of different ways. Variations occur depending on which part of the genitalia is mutilated and the extent to which this is done. The World Health Organisation distinguishes the following four types (WHO, 2009).

- *Type I*: Partial or total removal of the clitoris, and/or the clitoral hood. This type is known as *clitoridectomy*.
- *Type II*: Partial or total removal of the clitoris, and the labia minora, with or without excision of the labia majora. This is also known as *excision*.
- *Type III*: Narrowing of the vaginal orifice by cutting and closing the labia minora and/or the labia majora, with or without excision of the clitoris. This is also known as *infibulation*.
- *Type IV*: All other harmful procedures to the female genitalia for non-medical purposes, such as, pricking, piercing, incising, scraping and cauterization. Sometimes the word *sunna* is used to refer to this type.

A variety of terms is used to refer to the circumcision of young females. The terms *female genital mutilation* (FGM) or *female genital cutting* (FGC) are used in English speaking countries, while the term *mutilation génitale féminine* (MGF) is used in French speaking countries. The term *vrouwenbesnijdenis* (female circumcision) was formerly used in the Netherlands, however this has now been replaced by the term *vrouwelijke genitale verminking* (VGV) (Female Genital Mutilation). Because circumcision often occurs in young females, the term *meisjesbesnijdenis* (the circumcision of girls) is also used. We have intentionally made use of the latter term in the Dutch version of this book, because it indicates that what is involved is the circumcision of girls, who are children and hence under the age of consent.

2.2 Research into the consequences of FGM

In the early 1990s somatic health care in the Western world in particular became confronted with circumcised women and the medical consequences of female circumcision, for instance during childbirth. Much research into the somatic consequences of female circumcision has been carried out since then. This showed that more or less serious complications may occur depending on the type of circumcision, the (sterility of the) location, and the individual (a *daya*, butcher or doctor) who performs the circumcision (Reyners, 1989). Severe haemorrhaging, shock and serious infections may occur directly following the procedure. Complaints with urination, cysts, fistulas and infertility may develop later on (Morison et al., 2004). Research by the WHO Study Group on Female Genital Mutilation and Obstetric Outcome (2006) found that women in Africa who had been circumcised experienced more complications during childbirth: a larger incidence of Caesarean sections, haemorrhaging and a higher infant mortality rate. In addition, sexual problems were reported, in-

cluding complaints of dyspareunia and vaginism (Livermore et al., 2007; Whitehorn et al., 2002).

However criticism has been levelled at the quality of research studies into the way circumcised women experience their sexuality. A review by Obermeyer (2005) showed that women who have undergone a Type III circumcision, involving infibulation but possibly leaving the clitoris intact, had been under-represented in the study. She called in doubt the validity of research into FGM in relation to *sexual pleasure* (p. 455-457). Research by Catania et al. (2007) among 157 women shows that infibulated women were capable of reaching orgasm, but did not differentiate between excitement and lust, for instance. The findings of this study – where a third of the sample consisted of women who had not been circumcised, with another third consisting of women who had undergone a Type III circumcision and the final third of women who had undergone a repair procedure – ‘suggested that FGM/c does not necessarily have a negative impact on psychosexual life (fantasies, desire, pleasure, ability to experience orgasm)’. Dr El-Defrawi, an Egyptian psychiatrist, asked 250 obstetric patients² about their sexual behaviour and the way they experienced sexuality and the findings of that study were completely different: 80% of women had complaints of dyspareunia; half did not have enough vaginal fluid, did not feel like sex or did not enjoy it. Sixty percent said they did not achieve orgasm (El-Defrawi et al., 2001). All in all it is not clear what effect circumcision has on the woman’s sexual behaviour and sexual pleasure. Moreover, is this just some technical account about whether or not women are able to experience sexual stimulation; how important is it to experience orgasm? Or is the extent to which a woman feels like sex or experiences sexual problems influenced by the way she feels about her relationship and her sense of emotional closeness?

2.3 Circumcision of young females and migration

In a study conducted by Lockhat (1999) in Manchester (Great Britain) among Sudanese and Somalian women, three quarters of respondents indicated that they suffered recurrent intrusive memories and loss of impulse control. Research conducted among Somalian migrants in Canada presented a completely different picture, with 72% of women indicating that they felt happy during and after circumcision (Chalmers & Omer Hashi, 2000). A study into circumcision conducted in the Netherlands (n=12) showed that women mainly suffered from

² In some countries the terms ‘obstetric’ and ‘maternity’ are used almost interchangeably. In the Netherlands, pregnancy and childbirth are considered to be natural processes, to be dealt with by midwives. Hence obstetric wards are generally referred to as ‘maternity’ wards. The term ‘obstetric’ is then used to refer to those patients who experience obstetric problems, necessitating intervention by an obstetrician or gynaecologist, i.e. by a medical specialist.

the physiological consequences and less frequently from psychological consequences (Dekkers et al., 2006). A New Zealand study showed that girls who had been circumcised experienced this as something that was positive for the development of their identity. In addition they felt that the preoccupation with female circumcision was not justified; with other experiences possibly being just as significant, if not more so, as a source of psychological stress (Denholm, 2004).

It will be clear from the above that opinions differ considerably as regards the psychological, social and relational consequences of female circumcision. Are there any complaints, and if so, how severe are they and when do they occur? Do they occur to the same extent when someone is living in Africa as when that individual has migrated to a Western country? Is the incidence of complaints dependent on migration, or are other factors at play? The statements referred to above do not provide an unambiguous picture. There appears to be a lot of confusion as to women's experiences and the psychosocial consequences of this custom. For this reason it will be good to start by briefly examining the influence of migration, acculturation and language skills in relation to the reporting of mental health issues. This will be followed by a more specific examination of what is known about the impact of migration on women who have been circumcised.

2.4 Acculturation, mental health complaints and language skills

Migration brings with it changes which may affect well-being. Obviously at an individual level personality traits will impact on the extent to which a migrant is able to adapt to the new country. In addition to individual aspects, social, cultural and psychological processes also come into play in the acculturation process (Berry, 2008; Bhugra, 2004). Acculturation means letting go of elements from one's own culture and adopting elements from the host culture. This process will eventually result in either a greater or lesser degree of socio-cultural integration or exclusion and social isolation. The extent to which an individual is 'acculturated' can be measured, among other things, by the extent of social participation and access to social services (Knipscheer & Kleber, 2006). The change in living environment may be accompanied by feelings of loss; the person is often physically separated from family members, and there is the loss of the person's social network and the social status enjoyed in the country of origin. All these changes in the daily lives of migrants may lead to health complaints.

Even though the majority of migrants learn to deal with these issues, others may experience considerable psychological problems as a result. There are several studies indicating a possible link between acculturation and mental health complaints. As an example, a study in Great Britain showed a link between embarrassment, feelings of failure and diminished self-confidence as a result of migration (Walsh et al., 2008). Other research showed that acculturation could be linked to psychological problems (Madianos et al., 1998) and might even

cause depression (Nasroo, 1997; Vega et al., 2000). In contrast, Nesdale, Rooney and Smith (1997) held that acculturation might impact on self-confidence in both a positive and a negative sense. Various studies have shown a positive correlation between acculturation stress and the extent and severity of post-traumatic stress responses (Nicholson, 1997; Spasojevic et al., 2000; Silove et al., 2006). New traumatic events may occur within the context of migration and acculturation which may trigger secondary traumatisation and the subsequent development of mental health issues. Research among Bosnian migrants in the Netherlands concerning the extent of acculturation and the influence of post-traumatic responses on psychological well-being appeared to show correlations between mental health symptoms and the following two aspects in particular: cultural attachment and the acquisition of skills required in order to be able to function adequately in Dutch society. A combination of the maintenance of cultural traditions (through contact with members of their own community) and the ability to develop such skills (to allow participation in Dutch society) appeared to have predictive value for psychological well-being (Knipscheer & Kleber, 2006). Research by Kamperman, Komproe and De Jong (2003) among over a thousand Amsterdam residents of Turkish, Moroccan and Surinam origin, showed that, in addition to the socio-economic situation (SES), social integration, including language skills, also affected migrants' psychological well-being.

Generally speaking, migrants who are able to express themselves reasonably well in the language of the host country experience greater well-being than migrants who have not managed to master the language as yet. However this is not always the case. As an example, the more English language skills migrants in Great Britain acquired, the more they appeared to be expressing feelings of depression (Nasroo, 1997). Other research also showed that the better the migrants' knowledge of the language of the host society, the more they reported depressive complaints (Bhugra, 2003; Bhugra et al., 2009). It therefore remains unclear for the time being to what extent and in what way language skills – an important aspect of the acculturation process – impact on the reporting of depressive and possibly also other psychological complaints following migration. Acculturation may have an indirect impact on mental health through trauma response reactions, but may also influence these directly. However, the extent to which the person is able to cope may also impact on the degree of acculturation. For this reason it is not possible to develop any causal links, as this would require a longitudinal study.

2.5 Migration and the psychological, social and relational consequences of FGM

The past decade has seen the frequent publication of papers dealing with FGM in the context of migration. The advent of large groups of Somalian, Sudanese,

Ethiopian and other groups of African refugees in Europe and the USA also introduced the phenomenon of FGM. In the meantime varying aspects of FGM have been brought up for discussion, including the ethical discourse, the influence of the media on the women's own views, and political decision-making (Johnsdotter, 2007); the differences in legal approach within the European setting (Leye & Deblonde, 2004); the new spheres of power developing within migrant women's own relationships and their relationship with their mothers-in-law (Vissandjée et al., 2003); the effect of age at the time of migration as regards the person's views of FGM (Morison et al., 2004); and differences between the various African communities in relation to their changes in attitude regarding FGM (Johnsdotter et al., 2009).

Publications on the consequences of FGM as regards women's health in a migration context may be divided into the following two categories: the first deals with the medical consequences, while the second looks at the psychological, psychiatric, social and relational consequences. An awareness of the medical consequences quickly developed (Whitehorn et al., 2002). Service providers in the Western world were confronted with the consequences of FGM more frequently than previously; women would present to the family doctor, the outpatients' clinic or the Emergency Department for childbirth, with infections, cysts and other discomforts and medical complaints. In the mean time there have been reports on the experiences of circumcised women in a Swedish obstetric ward (Berggren et al., 2006), and on the experiences of circumcised women with perinatal care in Norway (Vangena et al., 2004) and with the care system in Switzerland (Thierfelder et al., 2005). The relative wealth of literature about the medical and obstetric consequences of FGM, often authored by midwives, gynaecologist, obstetric nurses or patient advocates is also noticeable. Sometimes these publications serve to initiate and provide a rationale for the establishment of a new approach, new intervention or medical procedure. Sometimes papers have been written in response to changes in proposed policy and the tasks to be undertaken by the various groups of practitioners in relation to the same.

Up until recently not much attention has been paid to the psychological, social and relational consequences of FGM (Whitehorn et al., 2002; Yount & Balk, 2004), even though the possibility of such research was proposed as early as the mid 1970s (Baashar, 1977). However anthropologists in particular long held that the circumcision was a painful rite of passage but that the negative consequences were more than compensated for by the positive experiences which followed the circumcision (i.e. the party, the presents and the social recognition).

The small number of publications which have appeared on the psychological and psychiatric aspects showed that circumcision may cause girls emotional trauma and may have a negative impact on mental health. As an example, it is said that girls are not usually prepared for the procedure and that it takes them

completely by surprise (Masclée & Meuwese, 2000). A comparative study among women who had been circumcised and women who had not been circumcised in Dakar, Senegal showed that women who had been circumcised were at a substantially higher risk of developing Post Traumatic Stress Disorder (Behrendt & Moritz, 2005). Other authors pointed out that in the long term circumcision may lead to trauma-related complaints, anxiety disorders, a distorted or negative self-image and feelings of incompleteness and distrust (Lax, 2000; Masclée & Meuwese, 2000; Menage, 1998; WHO, 1999).

Johansen (2002) found that women who underwent the ritual after migrating to a Western country were more likely to indicate pain than prior to migration. According to Johansen migration changed their experience of the circumcision from 'that of ritual to accidental pain'. In addition, it is well-known that pain and traumatising are mutually reinforcing. In relation to this, Asmundson et al. (2002) talked of mutual maintenance, meaning that chronic pain and traumatising maintain one another. Pain will trigger the thought (the image, the memory) of that which caused the pain, while thinking back to what happened at that time, whether consciously or subconsciously, may lead to a (re)experiencing of the pain suffered at that time. In addition, research by Whitehorn, Ayonrinde and Maingay (2002) showed that women who had been circumcised were more likely to suffer from chronic pain and mobility problems – where limited mobility may lead to social isolation, which means a woman or girl may become isolated from the community. Research by the Rutgershuis among 487 female visitors, including 39 from African countries such as Somalia, showed that more than half of the African women indicated serious complaints of pain at the time of their first sexual intercourse, 2.5 times the rate of that experienced by Dutch women (Loeber, 2008).

There are a number of experiences in the lives of women who have undergone circumcision which are experienced as very difficult or painful, and this includes the first experience of sexual intercourse. In countries such as Somalia and Sudan the husband will want to enlarge the vaginal orifice soon after marriage, often during the wedding night, in order to proceed with penetration. This is done by using the penis to enlarge the orifice, a little bit more, day by day. Either that, or the woman is defibulated: a razor/knife is used to cut open the labia which had been stitched together previously, and this is done with or without anaesthetic. Childbirth is another experience which may be associated with painful memories. Cases have been reported in both Scandinavian countries and the USA where childbirth involved a re-experiencing of the circumcision (Elwood, 2005; Johansen, 2002; Vangena et al, 2004). In some cases a painful experience may trigger memories of the source of the suffering, in this case the circumcision, and this may result in PTSD symptoms (see also Van der Kolk, 1994).

Lastly, pain – both psychological and physical – during intercourse may impact on the relationship between man and woman (Aydoğan & Cense, 2003;

Whitehorn et al., 2002). For this reason Obermeyer (2005) felt that pain was relevant for the psychological, social and relational well-being of these women and an important subject for further studies.

There is a dearth of targeted research into the psychological, social and relational consequences of FGM in a migration context. Various authors have indicated that there is a need for further insights into the psychological and psychiatric aspects which come into play with FGM, particularly in a migrant context (Behrendt & Moritz 2005; Daley, 2004; Gruenbaum, 2005; Obermeyer, 2005; Whitehorn et al., 2002; Unicef, 2005).

Meanwhile, a model has been developed which is specifically aimed at identifying factors which may influence the development of PTSD following genital mutilation. This model was developed by Dr. Haseena Lockhat based on her research into the consequences of FGM among Sudanese and Somalian migrants in England (Lockhat, 2004). According to this model, which was based on qualitative research, the type or circumcision and the associated physical complaints were the determining factors when it came to the development of a Post Traumatic Stress Disorder. The most severe form, Type III (infibulation), was associated with medical complications and an increased risk of developing PTSD. According to Lockhat, milder types of circumcision did not lead to PTSD. However, for trauma related complaints to develop, it is not just the type of circumcision which plays a role. According to her model three factors codetermine whether or not a woman will develop PTSD following female circumcision:

- 1 remembering the event and perceiving it as either something positive or something negative;
- 2 the presence or absence of social support; and
- 3 whether the operation was performed with or without anaesthetic.

A negative perception of the circumcision, a lack of social support and the absence of an anaesthetic are thought to increase the chance of PTSD. Lockhat's research also shows that it is important to gain more insight into the experiences these women have with the provision of care, since three quarters of respondents reported negative experiences with service providers. Upon further questioning, it turned out women were loathe to seek help because they often felt misunderstood (Lockhat, 2004).

The experience of women not feeling understood was also reflected in other studies carried out in Canada (Chalmers & Omer Hashi, 2000), Norway (Vangena et al., 2004) and Sweden (Berggren et al., 2006). The latter study involved pregnant migrant women in Sweden who were asked about their interactions with midwives. Because they felt they were 'being stared at and being looked down on', women stated that they preferred to stay at home, even if they knew they had health problems during pregnancy, in order to avoid alleged insults from the midwives' (Berggren et al., 2006, p. 54).

Keizer (2003) wrote something similar in her dissertation on the mental health consequences of FGM among key Somalian informants in the Netherlands. Keizer included twelve women, using standard questionnaires and conducting interviews. Her research examined, among other things, scores on the General Health Questionnaire and Beck's depression scale. Keizer reported that four out of twelve women were struggling with an emotional disorder and that two of the respondents might be suffering from depression. She argued that, when it came to presenting with complaints, psychological problems were rarely reported, due to cultural differences.

The fact that FGM is done in seclusion in a couple of at-risk countries, may also play a role, as may the fact that there is often a taboo on discussing such matters, especially with the non-initiated (Johnsdotter, 2007). For this reason, even daring to talk about what happened to them requires a considerable adaptation from these women. Breaking such a taboo is penalised in a number of African countries. In this context, the following question is important: does talking about FGM become more difficult due to migration or is the pressure removed and are women able to recount their experiences more readily?

2.6 FGM and stigma

In Europe and the Netherlands, people have only recently been confronted with the phenomenon of FGM. Whereas previously this was more of an exotic phenomenon, nowadays most people in the Netherlands are aware that there are women in their town or country who have been circumcised. Moreover, there is a good chance that this is happening 'here and now'. Politicians are keen to keep the phenomenon in the public eye so as to be able to ban the practice; every day the media are availing themselves of every opportunity to stress the repulsiveness of this practice. There is an element of horror to anecdotes and stories about FGM (Johnsdotter, 2007). Such a repulsive ritual simply asks for the branding of the evil; who would allow something like that to be done to his or her child? In answer to the question as to who is to blame, the finger is usually pointed directly at the mother. Women who have undergone a female circumcision are branded victims, with the implicit connotation that they are also capable of being the perpetrators.

The fact that it is not easy for women to refuse a centuries-old practice is not always recognised. Neither is the fact that this ritual used to give women status and identity, afforded opportunities and that it was carried out as a matter of course. A Somalian woman living in London told Norwegian anthropologist Aud Talle (2004): 'Being circumcised was once a sign of social solidarity and has now become a sign of difference.' What was once considered normal is now considered deviant. The experience of 'they are different to us' often provides a rationale for excluding the Other. If, in addition, the Other is suspected of having done something that is morally reprehensible and forbidden by law,

stigmatisation is only just around the corner. This type of ethical and moral discourse may heap feelings of guilt and shame on to a woman who has been circumcised. A lack of understanding for such sensitivities, or the repulsion reflected in the face of an interlocutor will make women feel they are not understood. Hence the question is how these women experience the focus on circumcision in the media and in interactions with service providers.

To summarise, to date research has not provided any conclusive answers to the following questions:

- Do women who have undergone circumcision report complaints at a
 - psychological
 - social and/or
 - relational level, and if so, what type of complaints?
- Are these complaints dependent on the type of circumcision?
- What is the significance of pain when women present with complaints? What sort of pain are we dealing with here: physical or emotional pain?
- How do circumcised women deal with their complaints (coping)?
- What influence does the partner have on how women experience the consequences of having been circumcised?
- How do they experience sexuality?
- What influence does migration have on how women experience the consequences of circumcision?
- How do women experience the provision of care?

The next chapter will outline the way in which the questions above have been operationalised in this study.

3

Research methodology

The research questions underpinning this study of the psychological, social and relational consequences of FGM were formulated in the previous chapter. This chapter will outline the design of this exploratory study and will describe how the research questions were operationalised, as well as the research instruments and methodology used to collect and analyse data.

3.1 Research design

This study involved a ‘methodologically pluralistic approach’ in accordance with a mixed methods design (Creswell & Plano Clark, 2007; Creswell, 2008), meaning that topics/themes were not only investigated in a quantitative manner (by categorising and measuring phenomena), but also in a qualitative manner, in particular in order to allow determination of the (cross cultural) validity of findings and interpretations and any resulting conclusions. In intercultural research it is necessary to supplement any data obtained by means of standard quantitative instruments with interviews which explore data in more detail (see Knipscheer & Kleber, 1999; Kurt et al., 2001; Mooren, 2001). Previous studies involving migrants (Drogendijk et al., 2003; Mooren & Kleber, 1996) showed that such a mixed methods approach resulted in rewarding findings which had a practical application. In recent years, expertise has thus been gained in the use of modified and/or culturally sensitive questionnaires in cross cultural situations (Shrestha et al. 1998; Terheggen et al., 2001). Qualitative research is appropriate if the aim is to describe and interpret people and events. Additionally this type of research offers the opportunity to ask questions in order to obtain the right information (Baarda et al., 2001). Hence qualitative research is inductive, showing a humanistic and holistic perspective. It offers informal and impressionistic research in contrast to the reductionism and the often seemingly sterile objectivity which characterises formal, standardised quantitative research (see also Ponterotto et al., 2001).

In this case, the mixed methods approach meant the use of questionnaires

that had been validated for the various communities, in order to enable the women (both interviewers and respondents) to better understand the questions. In addition we wanted to use questionnaires which were aligned with those used in regular psychotrauma research. Keizer's (2003) examination of the psychological aspects of FGM among key Somalian individuals in the Netherlands found that research methods were not or inadequately matched to the research sample, among other things, either due to language problems or due to the use of questionnaires which were inaccessible for the research sample. In order to achieve better matching in this study, it was important that the research sample was actively involved in the research process, both in terms of data collection, as in terms of the interpretation and processing of data. We wanted to consult (representatives of) the communities in question early on, the better to align the terminology, research method and research instruments.

3.2 Research sample

When deciding which communities to involve in the study we looked at the so-called StatLine data (statistical data collected by the Central Bureau for Statistics in the Netherlands; CBS, 2007) about women and girls resident in the Netherlands who originate from the so-called 'at-risk countries' – i.e. countries whose residents are known to practise FGM. Data as to whether women have been circumcised or not are not collected in the Netherlands (as is the case elsewhere), therefore exact numbers are not known. The only data we can be certain about are those concerning the number of women and girls from at-risk countries now residing in the Netherlands and the prevalence of FGM in the countries of origin. With respect to the number of women from at-risk countries resident in the Netherlands, the largest communities originate from Egypt, Eritrea, Ethiopia, Sierra Leone, Sudan and Somalia (Table 1).

In 2007 there were 25,670 women from those countries residing in the Netherlands. It also appears that the prevalence of FGM is very high in these countries, with between 85% (in Sierra Leone) and 98% (Somalia) of all girls and women having undergone circumcision (Unicef, 2005).

Once it had become clear which groups should ideally be involved in the research, contact was made with the communities in question. We succeeded in this through the hard work of Zahra Naleie of the FSAAN (Federation of Somalian Associations in the Netherlands) however in the case of the Egyptian community these efforts were not successful. We contacted four self-organisations as well as a mosque in Amsterdam which is attended by Egyptians. Time and time again the men – there were never any women present – assured us that 'they were not involved in FGM' and that this might have occurred previously,

Table 1 Number of women from African countries in NL and the prevalence of FGM (CBS 2007)

Country of origin	Prevalence (%)	Number of women	Young women (< 21 y)
Djibouti	95	102	49
Egypt	97	7300	3971
Eritrea	90	469	169
Ethiopia	90	4840	1803
Guinea	80	963	455
Guinea-Bissau	50	123	47
Mali	90	120	61
Sierra Leone	85	1814	760
Sudan	90	2453	1122
Somalia	98	8794	4077

but that this was now a thing of the past. After months of fruitless searching a decision was made not to involve Egyptian women in the research, even though they constitute the second largest group of women in the Netherlands who may have undergone circumcision. In the end, respondents were recruited from Somalia, Sudan, Eritrea, Ethiopia and Sierra Leone. A comparatively larger number of respondents (18 rather than 12) were sought from Somalia and Sudan, as it is in these countries that the most severe type of circumcision is practised (Type 111) and where the highest prevalence of psychosocial complaints and problems may possibly be found

The aim was to recruit 72 respondents overall because it was expected that this number would allow for both quantitative statements and for achieving the level of theoretical saturation, which is reached when approximately 30 interviews are carried out in a homogeneous research sample. In addition, it was important that respondents had undergone circumcision and were of child-bearing age (between 18 and 50 years of age). Because the aim was to investigate what if any differences there were in terms of behaviour and experiences, it was important to recruit respondents of diverse marital status. Our sample needed to contain young, unwed respondents, as well as married women with or without children, single women and divorced women.

Respondents were recruited using the so-called *snowball* method, which is a method of inclusion which is applied with marginal hard to reach populations in particular (Crescenzi et al., 2002; De Jong & Van Ommeren, 2002). Snowball sampling involves insiders in a particular group selecting individuals (based on certain characteristics) who are used as referents in order to contact others who meet the same criteria. In this case the interviewers approached women within their circle of friends and acquaintances, sometimes with the help of key people. They would then ask potential respondents whether they might know of other people whom they might be able to approach. Prior to

each interview, interviewers would have a personal conversation with respondents, outlining what the research study entailed and what to expect. In some cases, interviewers needed to visit respondents at home or talk to them on the phone several times before women were willing to participate. Once aim and method had been made clear and the respondent expressed their willingness to participate, a first appointment was made. During this time, the informed consent form could be signed and contact details of the support person were given – just in case the interview triggered any adverse experiences. Respondents received a small reimbursement for participating in the study.

Due to the nature of the snowball sampling procedure on the one hand, and the not always very structured administration by interviewers on the other hand, we are unable to provide an accurate number of respondents approached for possible participation in the study, meaning that response rates cannot be accurately established. We estimate that approximately 100 women from the relevant communities were asked to participate in the study. Based on an inventory carried out in conjunction with the various interviewers, we would estimate that roughly one in every two women approached did in fact participate. There turned out to be considerable variation between interviewers, e.g. one interviewer from Somalia stated that almost all of the women she approached did in fact participate, while other interviewers, originating from Ethiopia and Sierra Leone, had a lot of trouble finding respondents willing to participate in the interview.

3.3 Operationalisation

The following concepts were central to the research:

- 1 psychological consequences;
- 2 social consequences;
- 3 relational consequences;
- 4 coping.

Psychological consequences – In this study the term psychological consequences was used to refer to a range of symptoms and problems to do with the circumcision and the mental health status of the woman or girl which might (have) manifest(ed) themselves either at that point in time or in the long term. The WHO (1996) talks about psychological consequences such as depression, anxiety, frigidity or even psychosis. Aside from consequences such as these, we wanted to examine to what extent there were mental health complaints due to pain and acculturation stress.

Social consequences – When we speak of social consequences we refer to the consequences of FGM for the individual in relation to her environment. These may be subdivided into consequences:

- as seen from the person's own perspective, such as shame, alienation, distrust, feeling uprooted and isolation;
- as seen from the perspective of society, including social exclusion, ethnocentrism, discrimination and stigmatisation;
- in relation to seeking help and interacting with professionals (midwives, physicians, educators, teachers, etc.). This could include things such as: lack of awareness and embarrassment, shame, withdrawal or even refusal to go and see a doctor.

Relational consequences – These could include the following distinct matters:

- communication problems and disorders in relationships (intimate/sexual relationships; social relationships with family, acquaintances, colleagues, classmates, etc.);
- psychosexual consequences: disorders affecting sexual desire (including diminished sexual desire and aversion to sex), sexual arousal disorder, orgasmic disorder, pain disorder (dyspareunia and vaginism);
- feelings of confusion, uncertainty and feeling ashamed about one's own body. For example one respondent in a research study said: 'I felt I was an abnormal shape' (Toubia, 2005, p. 126) and a number of women indicated that they were continually concerned about their genitalia.

Coping – This refers to the ability to deal with difficult situations, such as an illness or limitation. Coping refers to the way in which people deal with their limitation, illness or condition at a behavioural, cognitive and emotional level. In this study coping also refers to coping with any limitations in the area of sex.

3.4 Research instruments

3.4.1 Qualitative research instruments

The qualitative data were collected by means of:

- Focus Group Discussions (FGD's) and interim meetings;
- semi-structured interviews using a Topic List.

Focus group discussions and interim meetings

Early 2008, following an appeal posted on the Pharos website and through liaising with the FSAN, fourteen people presented wanting to participate in an FGD. There was a men's group (consisting of five men), and a women's group (consisting of nine women). The resulting interviews were recorded and have been transcribed.

During these FGDs information was collected from the communities as to which themes were important in relation to this topic. Some of the questions

discussed included: does migration impact on the experiences of women who have been circumcised; can the topic be discussed and if so in what manner; does age at the time of migration play a role; what role do men play and can this question be asked; what other questions might be important? Findings from both groups were compared and distinctive themes were later translated into questions (Topic List Version 1). In addition, three meetings were held in the course of the research study which entailed interviewers and researchers talking about topics such as coping strategies, sexuality, as well as differences between types of circumcision and differences between the communities. These discussions were minuted.

Topic List

Developing the Topic List was a gradual process. The first version consisted of questions which had been mentioned as significant during the FGDS. In other words, these questions related to the themes referred to above. This included questions about the circumcision itself, about women's first sexual encounter, about whether respondents had been told what was going to happen, whether they were in contact with women who had not been circumcised, what their experiences were with service providers in the Netherlands, etc. The first version of the Topic List contained forty questions.

This first version of the Topic List was amended during the training sessions, in consultation with the interviewers, with changes involving both contents and timing. The interviewers pointed out the importance of the order in which the research instruments should be used. Doing the interviews first and then administering the questionnaires, would place the focus more on FGM as a traumatic event. In this way, the respondent would be aware that the questions would relate to the (consequences) of the circumcision and not some other painful experience. Timing was important too. The interviewers felt that the Topic List should be modified, in order to counteract the existing taboo in relation to discussing the topic. Neutral questions such as: 'When were you circumcised, was this discussed with you beforehand, or when did you come to the Netherlands?' were to be asked first during the interview. Other, more sensitive questions, for instance those relating to the women's (first) sexual experience or their interaction with service providers, were to be asked at a later stage. In addition, the way certain questions were phrased might cause women to clam up, and these were therefore amended. Finally, the interviewers pointed out to us that there are certain moments in the lives of circumcised women which are experienced as being very painful and sometimes even traumatic; the 'hinge moments'. A few questions pertaining to these important hinge moments were included in the Topic List: the first sexual experience (usually after marriage), the birth of their first child, and their (first) contact with health care providers in the Netherlands (medical examination). The Topic List used by the interviewers ended up comprising 58 questions.

3.4.2 Quantitative research instruments

The quantitative research component comprised a general socio-demographic questionnaire and four standardised questionnaires:

General socio-demographic questionnaire

This questionnaire contained questions on age, marital status, ethnicity, family composition, level of education and other demographic data, and also questions on what things had been like growing up, type of circumcision and age at that time, social status and length of time in the Netherlands. The questionnaires were amended following consultation with the interviewers so as to ensure that the concepts used were tailored to the research sample. This questionnaire contained a total of 26 questions, partly multiple choice questions.

Standardised questionnaires

The four standardised questionnaires were:

- 1 the Harvard Trauma Questionnaire (HTQ-30);
- 2 the Hopkins Symptom Checklist (HSCL-25);
- 3 the COPE-Easy; and
- 4 the Lowlands Acculturation Scale.

The Harvard Trauma Questionnaire (HTQ-30) – The Harvard Trauma Questionnaire (Mollica et al., 1992), is a transcultural screening instrument for PTSD. The HTQ was designed in order to detect Post Traumatic Stress symptoms in an ethnically homogeneous group of refugees. The original questionnaire consisted of four sections, only one of which was used in this study. The section that was used related to complaints which are sometimes mentioned by people after experiencing painful or fearful experiences. This part contained thirty items, one example of which was this item: ‘*Recurrent thoughts or memories of the most hurtful or terrifying events*’. The first sixteen items were directly based on the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-III) criteria for Post Traumatic Stress Disorder. The remaining fourteen items referred to symptoms relating to the traumas experienced, and were of a more culturally grounded nature. The HTQ makes use of a four-point scale for measuring the severity of symptoms experienced over the preceding week. The Dutch version of the Harvard Trauma Questionnaire was developed by Mook and adapted by Kleijn for use by Foundation Centrum⁴⁵ (Klein & Mook, 1999). We expected the Dutch version to be sufficiently reliable since the HTQ has been found to be culturally sensitive when used with a range of cultures in other countries (Smith Fawzi et al., 1997; Mollica et al. 1992). Mollica et al. (1992) arrived at a cut-off score of 2.5 in order to distinguish between individuals with PTSD (> 2.5) and individuals without PTSD (< 2.5), this score being based on validation research carried out with a clinical

sample of traumatised refugees from Indochina. The reliability of the HTQ-30 in the current sample was .96 (determined by means of Cronbach's α , which is excellent).

The Hopkins Symptom Checklist (HSLC-25) – The Hopkins Symptom Checklist is used to measure symptoms of anxiety and depression and was originally designed to identify psychiatric complaints in refugees. A shortened version of the Hopkins Symptom Checklist was used in the current study. This HSLC-25 contains 10 questions on anxiety and 15 questions on depression, and responses to each of the questions follow a four-point scale (1 = not at all; 4 = quite a bit). Examples of items on the anxiety scale include 'suddenly startled or scared' while items on the depression scale include 'low energy'. The HSLC-25 has proved useful as a screening instrument in various cross-cultural studies and patient studies (Hansson et al., 1994; Kleijn et al. 2001; McKelvey & Webb, 1997). The cut-off score for both anxiety and depression is 1.75, which means that respondents who score higher than this would meet the DSM-IV diagnostic criteria for depression. The cut-off score applies to either the mean score for either the anxiety or depression scale or the mean score for all 25 items. In research among refugee groups identification of depression was shown to have a sensitivity of 88% and a specificity of 73% (Kaaya et al., 2002). The most recent Dutch version of the HSLC-25 was revised by Kleijn et al. in 2000. The internal consistency of the HSLC-25 in the sample of the current study is very good, with a Cronbach's α of .96 (anxiety scale α = .93, depression scale α = .92).

COPE-Easy – The COPE-Easy allows researchers to gain insights as to which coping mechanisms and which coping styles have been used after subjects have been confronted with a traumatic experience. The full version of the COPE (Coping Orientations to Problems Experienced Inventory) questionnaire (Carver et al., 1989) contained 60 items, divided across 15 sub scales. To enable better use in clinical practice the COPE-Easy has been reduced down to 32 questions based on a reliability analysis and item-total correlations. It was found that items in the COPE-Easy could be grouped under three main theoretical dimensions as follows: 1) active problem-oriented coping, 2) support seeking coping and 3) avoidance behaviour. Examples of items associated with the three main dimensions would be: 'I made an extra effort to do something about it', 'I talked to someone about how I felt', and 'I looked for an activity which would distract me' respectively. Aside from these main dimensions the following subdimensions could be distinguished: accept the situation, seek comfort in faith, and humour. The last four questions of the COPE-Easy ask about the respondent's use of substances; however, this information does not constitute a subscale. This questionnaire again requires the respondent to respond using a four-point scale. The scores for the various dimensions need to be seen separately from each other, with a higher than average score for a par-

ticular dimension indicating a greater reliance on the associated coping style. Through its use of language and its transparency, the COPE-Easy is aimed for use with both native and migrant clients. The questionnaire has been proven to be more than adequately reliable in terms of its sub scales, especially as regards situation-specific application (as was the case in this study on circumcision). In addition, the COPE-Easy offers a nuanced profile of coping strategies (Kleijn et al., 2000). In this sample we found a good internal consistency with regard to the subscales of the COPE-Easy, with Cronbach's α varying from .67 for avoidance behaviour to .85 for humour, .86 for support seeking coping and acceptance to, .89 for religion and .91 for active problem-oriented coping.

Lowlands Acculturation Scale – Experiences with migration and acculturation were determined with the aid of the Lowlands Acculturation Scale (LAS) (Mooren et al., 2001). The LAS is a structured questionnaire which consists of 25 statements which have to be rated using a six-point Likert scale. The instrument comprises five sub scales. The Loss scale (7 items) contains items such as: 'I am homesick' and 'I miss the people still living in my country of birth'. Practical skills which are meaningful with regard to participation in Dutch society were inventoried using the Skills scale (5 items). This scale contains items such as: 'I have problems understanding and reading Dutch' and 'I depend on others to tell me how things are done here'. The *Traditions* scale (4 items) is oriented towards maintaining the person's own culture and customs. Examples of items would be 'I prefer listening to (Ethiopian) music' and 'I think it is important that our traditions are passed on to my (future) children'. Moral norms and values were inventoried using the *Norms and Values* scale (5 items). Examples are: 'I think Dutch law is too soft on criminals.' The last scale, which pertains to *Social integration* (4 items), refers to social interaction with Dutch people. This scale contains items such as: 'My experiences of interactions with Dutch people are good' and 'I have a lot of contact with Dutch people'. The total score has been calculated across the whole scale and refers to the respondent's general level of acculturation. The sum scores across the subscales refer to the respondent's level of acculturation in the psychological domain. The structural equivalence across ethnic groups allows use of the questionnaire in an ethnically diverse research population (Mooren et al., 2001). The current study included a 20-item version of the LAS. In order not to overload the respondent with more questions than strictly necessary, some questions deemed less relevant for this target group were removed. Another item (pertaining to views on sexuality in relation to the norms and values in the Netherlands) was intentionally added to the version used here. The internal consistency of the subscales in the current sample proved adequate, with Cronbach's α varying from .61 for *Traditions*, .62 for *Norms and Values*, .63 for *Skills* and *Loss* and .69 for *Social integration*).

3.5 Data collection

Recruiting interviewers from within the communities in question started on as the study commenced. This was because we wanted to actually employ women from the relevant communities as interviewers. Due to the complexity of the study, the many tasks and the fact that the interviews would need to be transcribed into Dutch, attempts were made to find women with an adequate level of education (minimal level of *MBO* i.e. Senior Secondary Professional Education), who were able to speak and write in Dutch and/or English, who had been circumcised themselves and who were originally from one of the five countries selected. In addition, interviewers needed to attend the training programme. After interviewing potential interviewers and after consultation with the *FSAN* advisor, seven women were recruited: two each from Somalia and Sudan and one each from the three remaining countries.

Interviewer training took place shortly after recruitment. The three-day training programme involved the following:

- discussion of the design, aims and implementation of the study;
- discussion and amendment of the Topic List, the first version of which had been established based on the focus group discussions with women and key individuals;
- discussion of the four standard questionnaires in relation to the research questions;
- practice using the questionnaires and recording equipment;
- discussion of how to deal with the existing taboo and practising interview techniques;
- practice using the Topic List and conducting semi-structured interviews.

De discussions during the training programme alerted the research team to the fact that this study might be taxing for respondents. For this reason, two physicians were contacted, who were willing to act as support persons – although in practice neither was ever approached by any of the interviewers. In addition, it was established that interviewers might need more support than originally thought. For this reason, assistants were involved for the duration of the data collection component of the study who would contact interviewers on a weekly, if not daily basis and who offered assistance if need be. The type of assistance given varied a lot. Interviewers asked for technical support (use of the digital recording equipment), for assistance with writing things out (in Dutch, in Microsoft Word) or for assistance in finding respondents. Eventually it was decided that researchers and interviewers would meet on a regular basis in order to discuss how things were going. As indicated before researchers and interviewers met three times during the data collection period.

In the period between August 2008 and April 2009, the seven interviewers

collected data in their own communities, with the aid of a manual. Each interviewer's experience with their first respondent was discussed with two of the researchers (pre-test). Two home visits usually sufficed to collect all data. During the first visit, the General Questionnaire was administered. The interview was conducted during the next visit, using the Topic List. Respondents were contacted by telephone in the week following the first visit. At that time the interviewer would ask the respondent how things were going for her and whether she might be able to make a second appointment. The four standard questionnaires were administered during the second home visit.

In spite of the manual, the tips and suggestions given and the supervision which was offered, a number of questionnaires were not completed in full. The interviewers stated that this was because some questions 'were similar to others' or because it was not clear what the purpose of a particular question was. Two respondents did not want to discuss their experiences any further after the first interview, and neither did they want to complete the questionnaires. The questionnaires were later handed in to Pharos, completed by hand.

3.6 Data analysis

3.6.1 Qualitative analysis

The focus group discussions took place prior to the collection of data from individual respondents. The transcribed data were used in particular to ensure that the Topic List was more suitable for use with the target group (in terms of wording) and what would be the best timing in terms of asking particular questions. The three meetings which took place in the course of the study were minuted. These discussions provided information as to contents, especially in relation to coping, sexuality and socio-cultural differences between respondent groups. In addition, these meetings were important in terms of ensuring the continuity of the study in terms of the common thread running through.

The interviews which were conducted with the aid of the Topic List were of between 1 and 2 hours' duration and were digitally recorded. In order to ensure anonymity, respondents were coded according to country of origin (using the first three or four letters of the name for their country) and allocated a number. For Sudanese and Somalian respondents numbers go from 1 to 18, while respondents from Sierra Leone and Eritrea were numbered from 1 to 12, and Ethiopian respondents from 1 to 6. In this way the code used to refer to the fourth Sudanese respondent who was willing to participate in the study was *Sud 4*, while the eighth respondent from Eritrea was coded *Eri 8*. This code was put on the questionnaires by the interviewers and also listed in the transcribed interviews.

Following each interview the interviewer would write it out – sometimes assisted by a research assistant. All interviews were typed out word-for-word. This was done to ensure that respondents' original statements were available for checking, thus diminishing the risk of interviewer interpretations playing a role in the representation of data. Following this, both oral and transcribed texts were mailed to one of the researchers. At a later stage, one or two of the oral interviews conducted by each of the interviewers in their own language were interpreted simultaneously and compared to the typed-out version. It was found that some relevant statements were not in the transcription of one of the typed versions of the interview. All other transcriptions were word-for-word and complete. The typed versions were checked by two researchers and by an independent reader.

In order to find an answer to the research questions and associated sub questions, the word-for-word typed out versions were coded. Some of the codes were based on the sub questions for the study and the theoretical framework for the Topic List. Other codes were based on whatever came up in the transcribed interviews. Without coding, it would not have been possible to look for structure and recurring common threads in the qualitative research material. The data was analysed using the ATLAS.ti research programme. This is a computer programme used for the coding of qualitative data (labelling) and for juxtaposing and comparing segments expressed by different respondents on a certain topic. Thus each piece of text is linked to one or more codes. Data which did not prove to be significant was left out and not coded. The programme also allowed the researchers to scan (a selection of) the data using certain search terms and to link up those text segments which had been labelled with the same code. Thus the first quantitative data analyses allowed us to check what information the qualitative data yielded at the level of either the respondent or the group (ethnic community, age group, type of circumcision, having been advised in advance or not, etc.).

3.6.2 Quantitative analysis

The quantitative data for the five questionnaires were imported into SPSS (Statistical Package for the Social Sciences). This programme was used to arrive at a first inventory of the respondents' sociodemographic data. For the IAS, three items (items 2, 4 and 6) needed to be rescored. The answers to some questions were missing for a number of respondents; these missing values were completed for each respondent by calculating means.

All variables were summarised using standard descriptive statistics such as frequencies, means and standard deviations. Measurements for skewness and leptokurtosis were used to establish the normal distribution of variables. To this aim, both *skewness* (extent of asymmetry of a distribution) and *kurtosis* (extent of

curvature in relation to normal distribution) were calculated. Both have to be smaller than 2 in order to meet the condition of normal distribution of a variable. Within the sample, only the variable for 'person who carried out the circumcision' was too peaked to be included in the multivariate regression comparisons. Additionally, the internal consistency, the degree of reliability, was determined by calculating Cronbach's alpha for the various subscales.

In order to determine which covariates to check in order to be able to provide a valid response to the central research questions, socio-demographic background information, traumatic responses and psychological problems (through scores for HTQ and HSCI), coping scores (scores for the COPE-sub scales) and acculturation scores (scores for the LAS sub scales) were subjected to a univariate analysis. Dichotomised variables were analysed by means of the χ^2 test or Fisher's exact test whenever the expected cell frequency was less than 5. If the distributions were approximately normal or not skewed, the mean scores for the continuous variables were analysed with the aid of parametric tests, such as Student's *t* tests for independent samples and single factor analyses of variance (ANOVA's). Continuous variables which were seriously skewed were analysed using the Mann-Whitney *U* test. In addition, Pearson's *r* (continuous variables), Spearman's rho (ordinal variables) and Eta (nominal variables) were subjected to a connective analysis, using measurements of correlation and association.

In addition to the analyses needed to answer the research questions, some additional analyses were carried out (further details as to the exact analyses will follow in the next chapter).

Multivariate direct logistic and direct multiple hierarchical regression analyses (Tabachnick & Fidell, 2001) were carried out in order to establish the relative meaning of predictors of subjective mental health (HTQ and HSCI total scores). This always entailed involving only those independent variables which showed a significant relationship with the independent variables at a univariate level. Thus each separate regression analysis comprised a specific set of covariates. *Odds ratios* were calculated for the logistic regression analyses in order to estimate the significance of the predictors.

Statistical annotations

The report on the quantitative findings is accompanied by the results of the statistical tests used (in the shape of letters or symbols). A short explanation would seem appropriate here. The text and associated tables contain not only the absolute numbers ($N = \text{number}$), percentages (%), means ($M = \text{mean}$), standard deviations ($SD = \text{a measurement for the distribution of the scores, the extent of deviation from the mean}$) and *range* (highest and lowest scores). This study deals with, among other things, differences between the various groups (for instance based on country of origin or type of circumcision). As an example we looked at whether one (sub) group showed higher or lower mean scores

for a particular scale. What is important in all cases is the p value, where ‘ p ’ stands for *probability*; the probability that findings are coincidental. A low p value – generally speaking we use the $p = 0.5$ as the criterion – indicates that the probability that any differences found are coincidental is negligible. In addition, the standardised *Beta*’s, 95% reliability intervals and the R^2 were provided for the multiple regression analyses. R indicates the correlation of the dependent variable with the total of all independent variables. The direction of the correlation can be deduced from the regression coefficient (*Beta*). *Beta* indicates the relative importance of the various independent variables. R^2 is the determination coefficient and indicates the percentage of explained variance in relation to the total variance: the higher the value of R^2 , the better the model ‘fits’.

4

Findings

This chapter will present both qualitative and quantitative research findings. But first we will present a brief overview of some of the socio-demographic characteristics of our respondents in Section 4.1.

4.1 Socio-demographic characteristics

The data below will provide an overview and first impressions of the individuals who made up our groups of respondents.

Table 2 **Descriptive Statistics of Sociodemographic Variables**

Demographic data	N	Percentage	% Validity
Country of origin	66	100	100
Somalia	18	27,3	27,3
Sierra Leone	12	18,2	18,2
Sudan	18	27,3	27,3
Eritrea	12	18,2	18,2
Ethiopia	6	9,1	9,1
Type of circumcision	65	98,5	100
Type I – clitoridectomy	21	31,8	32,3
Type II – excision	9	13,6	13,8
Type III – infibulation	35	53	53,8
Type IV – Other (including sunna)	0	0	0
<i>Missing values</i>	1	1,5	
Level of education	56	84,8	100
No education	4	6,1	7,1
Primary school	5	7,6	8,9

Secondary education	24	36,4	42,9
Higher education	23	34,8	41,4
<i>Missing values</i>	10	15,2	
Marital status	58	87,9	100
Single	23	34,8	39,7
Married	25	37,9	43,1
Divorced	7	10,6	12,1
Widow	3	4,5	5,2
<i>Missing values</i>	8	12,1	
Type of marriage	55	83,3	100
Arranged	10	15,2	18,2
Own choice	22	33,3	40
Not applicable (not married)	23	34,8	41,8
<i>Missing values</i>	11	16,7	
Family	58	87,9	100
No children	12	18,2	20,7
No children living at home	5	7,6	8,6
Children at home	41	62,1	70,7
<i>Missing values</i>	8	12,1	

Table 3 **Type of circumcision & country**

	Somalia	Sudan	Ethiopia	Eritrea	Sierra Leone	Total
Type I – clitoridectomy				10	11	21
Type II – excision	2	3	4			9
Type III – pharaonic, infibulation	16	15	2	2		35
Type IV – sunna, pricking etc.						
Not known					1	1
Total						66

4.2 Qualitative findings

This section will present the findings from the semi-structured interviews which were conducted with the aid of the Topic List and based on the insights gained from the focus discussion groups. The Topic List was used as a guide for asking questions as to how the women experienced certain events and how they now view the fact that they have been circumcised. The events in question often occur(red) within a (migration) context. For this reason, many of the matters which are to do with migration and other factors of influence have been mentioned in part under the relevant headings. Other matters to do with migration are pre-

sented in the next section. Following this, we focus on the women's coping strategies and the part religion may play in all this. This chapter will end by examining the respondents' experiences with service providers in the Netherlands.

4.2.1 Psychological consequences

Only five out of sixty-six respondents, including four from Somalia and one from Sierra Leone, indicated that they are proud or happy about the fact that they have been circumcised, in spite of the problems it has left them with. Two of these respondents said that being circumcised is part of their 'identity'. The remaining respondents indicated that being circumcised has mainly caused them trouble and problems. The most frequently mentioned consequences which have had a negative impact on mental health are outlined below.

Unpleasant memories and pain

A large number of respondents were frequently troubled by unpleasant memories. These tended to surface during or following situations in which the women felt confronted with the fact that they had been circumcised. For a number of women, pain during sexual intercourse was a direct trigger for an unpleasant memory. One Sudanese respondent literally said: 'When I think of sex, I immediately think about my *tahoor*³ (circumcision)'. In answer to the question whether she had any mental health complaints due to having been circumcised, one Somali respondent said:

Som 10: I will never forget the day I was circumcised (*habone*) for the rest of my life, I cannot compare it with anything else, how bad the pain was. Whenever I am confronted with the fact that I have been circumcised, I will dream about that day that night. I tend to read the Quran a lot in order to lessen the pain, but it will never completely go as long as you live.

Most women remember being circumcised, sometimes in detail. They mention razors, the way the woman who carried out the circumcision looked at them, the clothes she wore, their mother's attitude and the burning pain which kept on for a week afterwards. The most painful experiences post-circumcision involved the wedding night and childbirth. One infibulated Sudanese said she could never forget the first time she had sex: 'so much pain, so much pain'. When asked what her first time was like, one Ethiopian woman says: 'When I think about it, I feel sick and I feel like throwing up'. Another Sudanese respondent said that the pain during the circumcision was 'outright inhumane and the second time I was in unbearable pain was during childbirth and that is

³ This is just one of the many ways FGM is referred to in this particular country of origin. Every ethnic group or clan tends to have a different word for it. Some 200 dialects are spoken in Sudan alone.

supposed to be one of the most wonderful moments of your life’. Five respondents specifically mentioned the pain more than anything else, when they were asked about childbirth. But it was not just physical pain which triggered memories of the circumcision procedure and its consequences, other things triggered these as well. When asked what consequences she felt being circumcised had had for her, a respondent with six children replied:

Ethi 4: I get emotional when I hear that a woman is getting married or is about to have a child. All those painful memories resurface again.

One respondent from Sierra Leone remembered what had happened when she was circumcised because it left a scar. She was confronted with the memory, whenever she looked at her private parts. Events which were only indirectly related to their own circumcision would also trigger unpleasant memories in respondents. One respondent said she felt painfully confronted when she saw a niece being circumcised during a visit to the home-country. A slightly older respondent from Eritrea, who could not remember being circumcised because she was a seven-week old baby at the time, said she was often plagued by unpleasant memories, because she felt she had a ‘disability’, which is how she referred to the fact that she had been circumcised.

Eri 4: It was only when I became an adult that I became aware of my disability, I feel as if I am physically missing something.

Interviewer: Is that as a consequence of having been circumcised (*kishbo*)?

Eri 4: I often think about it, especially when I see something about female circumcision on TV. Or whenever the topic is mentioned, even when the words circumcision of young females are mentioned, everything will come back to me and the memory returns. I will feel really angry, sometimes I get nervous and start to shake.

Another respondent relayed how she went to visit a friend in another village during a visit to her home-country, and when she returned found that her mother-in-law had arranged for her daughter to be circumcised. Something that she had vehemently opposed had happened regardless. This threw a shadow over her relationship with her husband and daughter. The latter had not been able to forgive her mother to this day, causing the respondent great sadness. When asked how well respondents sleep and whether they were sometimes kept awake at night thinking about their circumcision, eleven of the respondents, in particularly those originating from the Sudan, Somalia and Sierra Leone, replied that memories of their circumcision occurred at night. When asked about her complaints, a woman from Sierra Leone replied that being circumcised ‘had ruined her life’ and that she still had nightmares about it. ‘It still troubles me. But there is nothing I can do about it. Luckily I am no longer in Africa’ (Sie 12). When asked what the consequences of being circumcised were for her, a young single respondent replied by saying:

Som 12: Yes, it can cause trauma and give you nightmares, an old woman with a knife, coming to circumcise you is something that is not easy to forget, and especially not when you suffer so much pain. I know women with serious problems, who respond in a very anxious manner when they talk about it and burst into tears, it's then that I see the impact being circumcised has had and I won't ask them about it any further.

Avoidance, tension and taboo

About a third of respondents avoided talking about past events for fear that this would trigger memories of the circumcision. Some of the respondents commented saying: 'the word alone causes me fear'. Talking about FGM caused all sorts of unpleasant sensations, affecting respondents from Sierra Leone, Somalia and Ethiopia in particular. According to the interviewer, two respondents were shaking with the tension and experienced goose bumps when responding to the question as to what being circumcised meant for them. Aside from the circumcision, they seemed to want to keep other unpleasant and painful events to themselves as well.

The traditional taboo in relation to discussing circumcision meant that respondents found it difficult to talk about. The respondents from Sierra Leone expressed this most explicitly. When asked whether they ever discussed FGM with people from outside the family, these women replied that talking about FGM (*bondo*) was not allowed in the home-country. Two of the women from Sierra Leone mentioned being told that they would be punished, with one saying that you would get 'a fat tummy', while the second said that 'the blade [of the knife] would turn against you'. A third respondent from this group phrased it as follows:

Sie 2: Even what I am doing now [talking to you] is audacious. If I was in Africa I would never dare to do this.

The fact that social pressure and the conventional taboo on discussing FGM could have serious consequences, will be clear from the following quote:

Sie 11: For some reason I have become an anxious person because of what they told me while I was being circumcised. They said you would be visited by a dead person while you are asleep and they made it seem so real that I believed it and the place was a strange, isolated place. Since that time I have been scared; it used to be so that I really could not be home alone by myself... that's all because of being circumcised. If a man makes a creepy joke, for instance, it can have such an effect on me that it spoils my whole day and that really pisses me off. That's why I have told my current boyfriend that he is not allowed to ever grab me from behind unexpectedly or come towards me sneakily. That can really frighten me and he is not allowed to play any scary jokes on me.

Respondents from all other communities sampled did not mention any penalties nor did they mention transgressing against a sanctioned taboo, but even so

they avoided talking both about what happened during the process of circumcision itself or anything that had happened as a result. ‘Talking causes harm’ according to one Somalian respondent. When asked why she did not go and see the doctor with her complaints, this respondent replied:

Som 10: My family doctor is a man and I don’t feel like showing him my private parts. That means having to explain everything all over again and that is something I absolutely don’t feel like, I don’t want to be reminded of the pain.

Interviewer: What does the pain do to you?

Som 10: I start to tremble all over and all the memories come flooding back. I cannot do anything for the next few days, and all I want to do is sleep.

A number of Somalian respondents found it very difficult to talk about FGM – even between themselves. While for respondents from Sierra Leone it was mainly the taboo at play, for Somalian women it was more something that was strictly private or just too painful to talk about. In two cases women indicated that they were avoiding the topic out of respect for others. Some Somalian women were very firm about the fact that they did not wish to discuss FGM with anybody other than their own husbands, sisters or mother. Just over half indicated that they found this difficult. When asked whether Dutch people ever tried to talk to her about FGM, one Somalian respondent replied:

Som 6: That happened to me once. I did not respond. I thought to myself: who are they that I would discuss my private business with them.

Interviewer: Why do you not want to talk about it?

Som 6: They are not familiar with my culture, they know almost nothing about female circumcision, so I am not going to get into a discussion with them, because it is my business after all, and the last thing I want is to be pitied. [Respondent appears agitated.]

Some respondents from Somalia and Sierra Leone were also adverse to answering questions about their sexuality. These women would say: ‘I don’t want to talk about that’ or they would not reply, but remain silent. However there was a difference of opinion within these groups of respondents as to whether you should talk about it and if so, with whom:

Som 15: It is a bit sad and unpleasant. But we should talk about it, even though it may not be a good topic to talk about.

Interviewer: But do people talk about it?

Som 15: That depends, some don’t. Yes, we do talk about it a little bit, during information sessions. But it was hard at first.

In spite of the fact that talking about (the consequences of) FGM can cause tension and aversion and the fact that some respondents from the communities in question found it psychologically taxing, there were respondents who did face

the challenge, no matter how difficult it was. There were significantly less women among the Eritrean and Sudanese respondents who indicated that they felt tense when talking or thinking about FGM. Some of these respondents said that the topic was now also being discussed in the home-country and that documentaries on FGM were being shown on TV and that the silence had been lifted. One Sudanese woman commented that she had two different groups of [female] friends: friends who were 'already aware' about what FGM entails and 'religious friends with whom I don't talk about this topic. They are also unaware that my daughter has not been circumcised' (Sud 2). There were also two Eritrean respondents who said they did not talk about it. When asked what reaction they had noticed when women from within their community found out that FGM was not done everywhere else, one of them said:

Eri 8: First of all, people don't discuss female circumcision in any depth. The type of circumcision I underwent and also the one [women in my] environment got was a lesser type and one that does not cause that many problems. That is why there is less interest in it, I suppose. But as to myself, I have been aware for a long time that girls do not get circumcised everywhere else.

Interviewer: Why do people not discuss it in any depth?

Eri 8: It's just taboo.

Fear

During the interviews, thirteen respondents mentioned anxiety or fear as a result of being circumcised. They indicated several points in time where they felt frightened, even paralysed. Firstly, many respondents said that being circumcised was painful and frightening. A considerable number of Sudanese and Somali respondents who underwent a circumcision of the third type indicated that it was a 'terrible and shocking' experience and that they would 'never forget that day'. However similar stories were heard from within the other communities. Two young women from Sierra Leone were 'in shock and startled that this happened to me' and were angry with their mothers to this day. Two others fainted because the pain was so bad. None of the Eritrean respondents can recall being circumcised, because they were only infants when it happened.

In addition these thirteen respondents indicated feeling very frightened prior to or during their wedding night and/or at the time of giving birth to their first child. When asked what it was like being with a man for the first time, one respondent said:

Eri 6: It was terrifying. I was so scared, because you are always told that sex is very painful the first time. I expected not being able to bear it. But it was much better than I had thought. It is not as painful as I had thought. I was just really scared in my mind. I thought it would be difficult. Especially with me being a circumcised woman. But after that I did not think it difficult or scary. I enjoyed it.

However, this was not always the case when a woman had been infibulated. Respondents from Sudan and Somalia said that it might have taken a week, sometimes longer before their partner had been able to penetrate them.

Sud 9: Yes, you feel really scared, especially on your wedding night. They have stitched you up completely, so how is it going to happen?

Interviewer: How did it feel when you had sex with your husband for the first time?

Sud 9: I was really scared. It took 30 days before he was able to penetrate me. Because I have been circumcised, penetration wasn't possible just like that.

Interviewer: Was it painful for you?

Sud 9: Yes, and especially because you feel scared. Your vagina feels like a wound.

However, some of the respondents who had been infibulated tended to respond with an understatement such as 'well that first night wasn't exactly satisfying'. In another case, a Somali woman who had been circumcised when she was nine said: 'I cannot remember very well, because I did not understand it all'.

At any rate, six respondents stated that they had been scared of the sexual deed, of sex itself, from their wedding night onwards. One Sudanese woman said that she did not feel like sex, after those first thirty days of pain, 'to the point where I would start to shake, because of my fear of sex and the pain it causes' (Sud 1). Another Sudanese woman went to see the doctor with her husband, after she had not felt like sex for a year. This doctor advised her to try a different position. He also gave her certain exercises 'which I have to do before sex, to take away my nerves'. These six respondents were still scared of having sex.

Sie 6: Take me as an example. To me it is terrible whenever I have sex with a man. It is as if he wants to rape me, because I don't enjoy it and it was only when I got here that I realised that women can also enjoy sex, just like men.

A number of respondents said that even though they had more of a dislike than a liking for sex, they had adapted over time. They no longer reported a fear of sex, but they did report other problems. As an example, two respondents stated that the pain associated with having sex stopped them from starting a family. The thought of this pain was the reason one 28-year old respondent avoided sexual contact. When asked what effect being circumcised had on her, this unwed Somali woman indicated that she was afraid to get married. 'I think that intercourse [having sex] will make the pain worse'. The section on Relational consequences (Section 4.2.3) will further examine the consequences of having been circumcised [as girls] for the women's sexuality and their relationships with their husbands.

A small number of respondents said that they adhered to the cultural (some would say religious) precept that the man is entitled to sex or the fact that a

(grand)daughter is required to be infibulated, because they were afraid of the way their partners or mothers-in-law might respond. Respondents who had been infibulated had sometimes had bad experiences with service providers in the Netherlands. This had led to them being afraid to go and see a service provider:

Sud 9: You feel ashamed, you don't understand why they are so startled. A lot of service providers came to see me when I was in labour. They would leave the room to talk to each other and then come back to have another look at me. It took me a long time to give birth and I told them to give me a Caesarean, but they said there was no reason to. There were about six or seven doctors in the delivery suite with me. I started to feel scared myself...

Fear and uncertainty when receiving care also play a role with women who have undergone a different type of circumcision. When asked what her first interaction with service providers in the Netherlands was like, one respondent replied:

Eri 4: Difficult. The first time I went to see the doctor was when I was six months pregnant. The doctor was really shocked at that time. He did not understand. At that time I could not understand any Dutch. He asked me a question, but I did not understand... I was afraid that my life or my child was at risk. I thought I might die. That something terrible was about to happen. Those doctors don't know anything about my situation, so how are they going to save me? How are they going to do that? All in all, it was a shock to me. Being in a foreign country with people who know nothing about your body. You are just a different person to them and you are nothing to yourself. Fear.

Listless, disempowered and worthless

The majority of respondents stated that migration had made them aware of the negative impact of circumcision, physically, mental health-wise and socially. A number of respondents from Somalia and to a lesser extent Sudan went on to say that they were 'a strong woman', while two of them stated that they had 'been through worse, including war'. They did not want to dwell too long on the fact that they had been circumcised. For most other respondents, however, migration to the Netherlands, which also resulted in FGM no longer being taken for granted, plus being confronted with women who had not been circumcised, had led to considerable doubt and confusion. When asked about the consequences of having been circumcised, one respondent said:

Ethi 9: It is different for everyone. Some have psychological problems, others have relationship problems. I sometimes feel depressed.

Interviewer: Do you think you have complaints which are not shared by women who have not been circumcised?

Ethi 9: I am sometimes troubled by unpleasant, recurrent memories of being circumcised (*girzet*). Women who haven't been circumcised don't have that.

When asked for their response when they found out that FGM was not a religious precept, many respondents indicated that they had felt cheated, 'because there was no need at all for the circumcision to be done'. Twenty-four women said they felt sad, surprised, disappointed or angry when they found out that FGM was not mentioned in the Quran, the Hadith or the Bible. Eight respondents wondered almost despairingly 'Why did they do this to me, why, why?' A number of respondents contacted their parents in order to get an answer to this question.

Interviewer: What was your response when you found out that circumcision is not a religious obligation?

Som 14: I was shocked. I was really sad, especially since my parents were the ones who did it. Of course I also had younger sisters who had not been circumcised by that time. I could not help them, because I rang my parents and told them how things were. But they continue to believe that the girls need to be circumcised. I still have one baby sister and I cannot help her. I feel powerless and without hope.

Now that they were living in the Netherlands, surrounded by women who had not been circumcised, some respondents felt damaged and inferior due to the fact that for them sex was associated with pain. Two Sudanese women and one woman from Sierra Leone indicated that they 'envied' women who had not been circumcised. Being confronted with the fact that there are women who have no problems enjoying sex was painful to four of the respondents, it made them feel 'different' and 'inferior', as if they were missing out on something. When asked how she felt now that she knew that not all women are circumcised, one respondent said:

Sud 4: It is very disappointing and painful and it causes a lot of trauma in you when you find out that not all women are circumcised. You realise that you are missing a part. That you are incomplete. You are missing a part of you that was given to you by God, like I said before. This has consequences for your mental health and your mindset. When I think of it myself, I feel really pissed off that I have been circumcised. I don't feel like a normal woman, especially during sex, I feel it is not the way nature intended. That has an effect on you, psychologically and you feel ashamed. Especially when you get to be a little bit older, you realise that it is damaging to you. Especially after you get married, you feel that there are a lot of things you are missing out on, things and feelings you were given by God. But you miss out on all that due to ignorance.

Feelings of powerlessness were also reported. When asked how they felt, three respondents said they were 'victims' and said they felt they were to be pitied. Other respondents from Somalia, Sierra Leone, Ethiopia and a small number of women from Sudan responded in a rather more apathetic, passive manner. One comment that was oft-repeated among these women was: 'whatever happened, happened and cannot be undone'. One Somalian respondent described her behaviour as follows: 'You have no choice. You have to play the game.' It

would appear that a number of respondents had of necessity accepted what had happened and were now trying to get on with their lives.

Som 3: At first I thought that female circumcision was linked to the Quran, but later on when I was in the Netherlands, I found out that was not the case. I was angry at first, but later on I realised that things are what they are and that I need to get on with my life. [Respondent comes across convincingly.]

Hence a number of respondents said they got on with their lives, in spite of their infections and complaints 'because the circumcision has been done and nobody can undo it'. Under more persistent questioning some of the respondents indicated that they had become apathetic due to the many years of suffering physical complaints in particular as a result of being circumcised. Periods were mentioned as a time of lingering infections and a lot of physical discomfort – affecting some of the infibulated women in particular. Two Somalian and one Sudanese respondent said they felt so exhausted and miserable when they had their periods that they isolated themselves and were temporarily unable to look after their families.

Som 1: Yes, one of the consequences of the circumcision is that we have a lot of health problems, take me for example – when I have my period, during childbirth or during intercourse. That is very hard to take emotionally. At such times I am incapacitated for the time being and unable to care for my family. I have to leave that to others, which is something I don't want, obviously. Another thing is that you don't know what it's like to really have a good time. [Respondent looks sad.]

Finally, five respondents indicated that it was not until they had arrived in the Netherlands that they had realised either that they had been circumcised or that they had undergone a type of circumcision which was much more drastic than they had previously thought. These women found out during information sessions or when talking to women in the same situation or, more recently than that, whilst talking to their mothers as a result of this study. Two of them said it had felt like a painful confrontation and made them feel inferior. When asked for her response to this 'new information' about her circumcision, one of the two – a slightly older respondent, mother of four, who had been resident in the Netherlands for twenty years – said that upon realising that there were four types of circumcision, she had been 'really shocked to learn that. I felt angry and sad at the same time'.

4.2.2 Social consequences

All but a few of the respondents said that they felt good about living in the Netherlands; they said they might feel a bit homesick from time to time, but safe and at home overall. Even so the use of the Topic List turned up some so-

cial problems which were directly linked to the fact that respondents had been circumcised. Problems were mentioned in relation to a range of different situations and not always linked to the country of origin. Anger was one of these.

Anger

Respondents mentioned a range of situations which made them angry or which continued to make them angry. First of all, as indicated previously, respondents mentioned the moment they found out that the circumcision had been unnecessary, that it was not a religious precept or that not every girl was circumcised. For four of the respondents this confrontation took place before they arrived in the Netherlands. The remaining respondents found out after arrival in the Netherlands. One Ethiopian woman asked the imam whether FGM was mentioned in the Quran and felt 'angry and above all disappointed' later on. A respondent from Sierra Leone 'turned to God. I asked for an explanation and I did not really get anything that made sense, just that the topic was taboo in our culture. So that did not help.' A Sudanese respondent angrily wondered: 'How can they misuse the Holy Book to such an extent?' A respondent from Eritrea 'felt as if I had been slapped in the face' when she realised that FGM was not something that was done everywhere. In addition, a number of respondents said they were angry with their parents (with their own mother, in two cases), however most respondents blamed the tradition itself. When asked how women around her had reacted when they had found out that FGM was not something that is done everywhere, one respondent said:

Eri 1: Women ask: why me, why us? We are all women. We all have the same organs, the same bodies, don't we? Then when you start asking more questions you find out why. And the response is anger. Angry with your traditions, your culture and mindset. Until I came to live here, I had no objection to the circumcision of young females. I was in favour. If I had lived in Eritrea and had a daughter, I would have had her circumcised. But whilst living here, I have learned so much that I keep asking myself: why, why just us, why not other people as well? I still get angry: Why did this happen to me? Did they do this on purpose and if so, why?? I now realise that something was taken from me. That I am disabled. That's not a good feeling. Even when the pain has gone, there is the awareness. And that makes you angry with yourself.

During the interview one Somalian respondent got terribly upset about the fact that her parents recently got her younger sister circumcised back in the home-country. Two respondents literally said they blamed it on 'their backward culture', however a majority of respondents expressed both anger and understanding for the fact that the circumcision was done out of ignorance, but with good intentions.

Eri 2: I feel bad and angry. But I think it is inexplicable how our culture and our parents came to this. Our parents did not intend to hurt their children. They think this is to keep us safe. So I am not blaming them in any way.

Anger was also reported when respondents compared themselves to women who had not been circumcised. When asked what she thought about that, one Ethiopian respondent said she thought it 'unfair' that she had been circumcised, but women in the Netherlands had not. She added: 'I feel assaulted'. When asked whether being circumcised or not makes any difference to sexual relationships, another respondent replied by saying:

Sie 12: When you have been circumcised you do not feel like sex as much, because you don't really enjoy it like a woman would who has not been circumcised. In my case I know that all this wretchedness is because I have been circumcised. That really has had a big impact on my life. All the stress... and I have a short fuse. Because I don't enjoy it, because I have been circumcised, but a woman who has not been circumcised doesn't have that problem.

In addition, respondents felt angry because of the discomfort and pain they suffered as a consequence of having been circumcised. They mentioned the many physical complaints they suffered, which caused them to feel disabled and, at times, unable to take good care of their families. For a number of other respondents, especially those from Sudan, Eritrea and Sierra Leone, it was the sexual limitations and the pain they suffered during intercourse in particular which caused them to feel angry. They said they felt angry with their partners, and in a few cases, with men in general. Remarkably, not one Somalian respondent expressed anger towards her husband or towards men in general. According to one unmarried Somalian woman, Somalian women usually 'try their best to please their husbands, in order to avoid arguments'. However, an infibulated respondent from another community said she had felt 'abused' by men for a very long time.

Eri 9: You sleep with a man and he is enjoying it while you are suffering. In my head I cannot accept that and this is why I feel angry. That has always been my problem.

It was also quite noteworthy that five Somalian respondents indicated feeling angry with the way FGM was reported in the media. All the more so because all other respondents were much more inclined to have praise for the fact that FGM was often in the spotlight, with gruesome images being shown – no matter how painful. One young Somalian woman was a little bit annoyed when she said that the media did not deal with this topic correctly, because they are 'showing us on tv like abused women whom people should feel sorry for. That's absolutely not correct!' When asked for her opinion on the way FGM was reported on in the media, another respondent from the same group said:

Som 7: It really started because of Hirsi Ali and a Somalian model, who both openly talked about their own experiences with being circumcised as a girl. I didn't like the fact that they were openly talking about it. Now everyone will think that every Somalian girl has been through the same. It would have been better if they had done it differently.

Interviewer: How?

Som 7: Maybe more an explanation of what the circumcision of young females entails and that it is something not religious. And not present it as something backward, something done by ignorant people. Because parents have their daughters circumcised because they love them and want to give them a good future.

Lastly about ten respondents said they felt angry with their partners for not taking into account the fact that they had been circumcised, or for not taking this into account sufficiently. In addition, two respondents were angry with their husbands for 'sticking with' cultural conventions and because they felt 'forced' to accept their (subordinate) position. Words such as repulsion and feeling furious were mentioned in this context. We will return to some of these matters in the next section, which will look at relational consequences.

Feelings of shame and guilt

Shame was frequently reported. Almost all respondents mentioned shame at one point or another during the interviews. One Ethiopian respondent commented: 'I feel ashamed because I have been circumcised'. Another respondent said: 'I used to feel proud because I had been circumcised, but now I feel ashamed. I don't even want anyone to know'. Two respondents indicated that, when asked, they felt ashamed to the point of simply denying that they had been circumcised. When asked whether the topic was ever brought up at school, one of these two respondents, a young Somalian woman who had indicated that she did not have any complaints earlier on in the interview, replied:

Som 3: At one time a teacher asked me, but at that time I denied it. I do feel ashamed.

Interviewer: Why do you feel ashamed?

Som 3: Because of all the negative publicity on TV. That has an influence on the opinions of people who have not been circumcised.

There was a big difference between the various communities as regards the way in which respondents talked about their shame. Generally speaking, Ethiopian and Somalian respondents replied briefly and succinctly, while respondents from Sudan in particular were much more explicit and sometimes talked extremely openly about why and when they felt ashamed. The respondents from Sierra Leone and Eritrea found themselves somewhere in the middle in this respect.

When asked whether they felt ashamed, many respondents admitted to feeling ashamed, with a number of different reasons provided. As an example, one Sudanese respondent said she felt too ashamed to go swimming with her Dutch girlfriends because she was afraid they might see her vagina, as the circumcision had left her with scarring. Two other women had obvious cysts close to the vagina which they felt embarrassed about. Yet another Sudanese respondent recorded feeling terribly embarrassed whenever she had visitors because:

Sud 4: Whenever I have to go for a pee, I have to run to the toilet because I cannot hold on. This has an enormous impact on me. Whenever I have visitors I have to run to the toilet. That is so embarrassing.

Most respondents felt ashamed whenever they were confronted with the fact that they were different. As an example, a respondent from Sierra Leone felt terribly ashamed when she was having sex with a former partner and he commented that 'it looks so different' to what he was used to. In addition, a considerable number of respondents felt ashamed when people from outside of the family asked whether they had been circumcised. Some got asked at school, others got asked when talking to the neighbours or to a colleague. When asked why women who have been circumcised find this so difficult to talk about, one respondent reacted by saying:

Eri 4: Because this is about feelings and more than that, it is about sex. It is really difficult. You cannot share that with other people. You feel terribly embarrassed. That is why circumcised women become isolated, mentally ill or mad. Either that or she stops talking, she keeps her mouth firmly shut. And nobody understands why. It sounds shallow, but it goes really deep. The difference is that a woman who has been circumcised will blame any pain she feels on the circumcision, even if it is nothing to do with it. That is all we know. And because we feel ashamed, we stay home with our problems.

Somalian and Ethiopian respondents were much less communicative. When asked whether any of her acquaintances might feel embarrassed at any stage, one Ethiopian respondent replied that every girl from the Oromo community in her country had been circumcised. For this reason the respondent could not imagine that there would be 'anyone my age who feels embarrassed'. A Somalian respondent said that some women might feel ashamed when they were with women who had not been circumcised.

Som 13: But I have not experienced that myself, nor even thought about it. But I have long accepted this fact [of having been circumcised], and the fact that this is part of my culture and that there is nothing much I can do. I think that women may experience physical consequences. I think Somalian women have accepted this and do not go on and on about the fact that they have been circumcised.

Feelings of isolation and loneliness

We saw earlier that many women felt ashamed when they were asked about their circumcision out of the blue and that a number of respondents would prefer not to talk about it with people who were not from their own communities. A small number of respondents said they were 'looked upon strangely' and that they felt 'embarrassed' as a result, or 'felt that people were laughing at them', reason for them preferring to avoid any contact.

Som 9: Women who have not been circumcised can make some very hurtful remarks about what they have seen about circumcision on TV, for example, And they think you have been circumcised in that way as well, they are not aware that there are so many different ways. I prefer not to talk to women who have not been circumcised, as they don't know what I have been through anyway.

A number of respondents felt excluded because they deviated from the norm in the Netherlands, which is that women are not circumcised. One respondent commented that the difference in opinion on FGM was so considerable, that this happened almost automatically in her opinion. When asked what consequence having been circumcised had had for her, she said:

Eri 2: When we were in Eritrea almost all of us had the same mindset, but here the gap is so big that we have a different mindset, a different way of thinking. So different that we cannot understand one another. Someone who has not been through a circumcision cannot understand how you feel. And that is how you become isolated.

When asked what consequences circumcision had had for them, three out of twelve respondents from Sierra Leone replied that 'you start to isolate yourself from people who have not been through it, and that this 'can turn into a social problem' (Sie 8). A number of respondents felt that, whenever they were talking to Dutch people about FGM, the latter felt sorry for them or pitied them. One of them recounted always making an effort to clarify things a bit more in those sorts of situations. Whenever this respondent was asked whether she had been circumcised and she admitted to it:

Eri 12: ...I get negative comments and sometimes a kind of pity. That happens a lot.

Interviewer: What do you think about that?

Eri 12: I know it [the circumcision] is not good. And they say it is not good and it is backward. And that is true. So in that case I try and tell them about our tradition and our culture, that we also have a very good tradition and culture.

So it would appear that some women felt that they had to justify themselves, that they were being asked to provide a reason for the fact that they had been circumcised. And this was keeping some respondents from entering into discussion on the topic. Among the Somali respondents in particular we found women who could not be bothered and who avoided contact with those who thought differently to themselves. They absolutely did not want 'pity'. These respondents indicated that they were selective as to whom they would discuss this with outside of their own little circle. When asked whether she talked to other women as to how they experienced their circumcision, one Somali woman said:

Som 15: Yes, I talk a lot with other people. My friends, for instance.

Interviewer: How about colleagues?

Som 15: No, I don't want everyone to see me as a pitiful girl. Some people respond in a very strange way, which is why I prefer not to talk to everyone about this.

It will be clear from the above that social isolation could occur in two different ways when it came to the topic of circumcision. On the one hand some women isolated themselves, did not want to talk about it, which was an active action and their own choice. On the other hand, some respondents felt excluded, as if they did not belong. This had to do with the way someone felt, something that happened to them, that they reacted to. Shame appeared to be somewhat associated with the existing taboo on talking about FGM, while feeling excluded was to do with the way FGM was discussed within the Dutch context, according to one respondent.

Eri 10: In an environment where the topic is taboo and cannot be discussed, or if you know that people are going to be negative about it, it will be very difficult to interact with people about it. This can happen with colleagues, with friends, when you are at work... It does not really matter what sort of work you do. But if you know there is a taboo on it or that people think about it in a negative way and you have been circumcised yourself, then you are not going to discuss it in as much depth as other women, who may not have been circumcised.

Loneliness was mentioned by four respondents. One of these, a respondent from Eritrea, mentioned the type of circumstances in which this feeling was likely to surface. When asked whether she interacted differently with women who had not been circumcised, she responded as follows:

Eri 12: Maybe women who have been circumcised are more guarded when it comes to dating and sex. Because someone who has not been circumcised cannot be as an equal to her friend who has been circumcised, so that makes interaction different.

Interviewer: And what consequences does that have?

Eri 12: I think loneliness is the most important consequence.

To one Sudanese woman and one woman from Sierra Leone the source of their loneliness and isolation was the fact that they were not able to please their husbands sufficiently. When asked to what extent psychological, social and relational consequences might be linked, the young respondent from Sierra Leone replied:

Sie 12: In every relationship you (the woman) need to look after your husband/partner well, especially in the area of sex, but if you are often not in the mood for it, this might be frustrating for him, and he might go to another woman. This will stress you out more and more, and in some cases you might isolate yourself from others. Of course you can socialise because of everything that happens in life. I can socialise, but still it is always a problem with my relationships.

Finally two Sudanese respondents found themselves shunned to some extent

by members of their own communities, because of their activities and work against FGM. ‘They consider me to be a backslider’, said one Sudanese respondent. She added: ‘Some people consider me to be very emancipated and they disapprove of that’. Sudanese respondents reported less feelings of exclusion in their interaction with Dutch people or isolation as a consequence of having been circumcised than respondents from other communities.

4.2.3 Relational consequences

This section will examine the impact circumcision had on women’s relationships with their partners, families and family back in the home-country. There will be a brief introduction, followed by a section on the women’s relationships with their partners, including the psycho-sexual aspects of these relationships. Following this, we will focus on the impact migration had on respondents’ views on FGM in relation to any daughters and sons they may have – more specifically whether they felt their daughters should be circumcised or whether their children should marry someone who had been circumcised. Lastly we will examine the women’s relationships with family members in the home-country.

Women’s relationships with their partners

A majority of respondents felt that FGM had an enormous impact on family life. A number of respondents had clear-cut problems when it came to relationships. One Somalian respondent was very apprehensive about getting married or being in a permanent relationship because of the pain, because of stories told by other women and her memories of being circumcised. One single woman with three children explained why she did not want to get married:

Som 12: Many women say that if we do not have intercourse with our men, big arguments arise. The man will then look elsewhere and the two will grow apart and this is how divorces may come about. To avoid that, we give them what they want, in spite of the fact that we don’t feel anything, let alone enjoy it. When I hear stories like that I feel scared of getting married and so I tell myself that it will be better to stay single.

Furthermore, for five respondents the fact that they had been circumcised had had such an impact on their family life that huge marital problems arose. In four cases, respondents, including three from Eritrea, indicated that being circumcised caused problems, but it was not clear from their statements whether the fact that they got divorced was a direct result of that. In one case it was clear that it was predominantly problems and stress around sex which had led to a divorce. This respondent felt that the circumcision was mainly motivated by sexual reasons: ‘The opening to the labia or the vagina needs to be tightened in order to pleasure men. The circumcision kills the woman’s sexual feelings.’ Even so this respondent realised that things could be done differently, that it depended on how the man treated the woman:

Eri 4: Some men are sensible and supportive and able to deal with the woman's problem in a sensible manner. And then there are those men who couldn't give a toss about the women. They are more interested in sex than in their female partner or wife.

Another respondent indicated that there were cases where women did not want to get pregnant again if childbirth was very difficult. 'She gets scared, hysterical. That causes problems in the relationship with her husband. He wants children, but she doesn't, because of the circumcision.'

When asked about their relationships with their partners, women's responses varied, depending on their country of origin. Broadly speaking, women from Sierra Leone indicated less pain during sexual intercourse than women from other countries of origin. In addition, Somalian and Ethiopian respondents were not very communicative, while respondents from Sudan and Eritrea sometimes provided detailed descriptions of how they experienced their relationships. But never immediately, as this remained a difficult topic to discuss, as will be clear from the discussion represented below:

Interviewer: Do you think that women who have been circumcised experience psychological consequences in relation to that?

Sud 13: Yes, of course. Some men respond very angrily when their wives are having sexual problems. This leads to arguments. And that makes the woman aggressive and causes her to feel lonely.

Interviewer: Does being circumcised have an impact on the relationship with the husband? [Respondent does not make a sound before asking the interviewer: 'This is anonymous, isn't it?' When her question is answered in the affirmative, she carries on.]

Sud 13: I will be open about this. A lot of circumcised women say that their relationships with their husbands are often tense because of sexual intercourse being difficult. The woman needs time, but the man doesn't understand that and gets angry.

Many women experienced their wedding night as their 'most painful' experience. The way in which the man responded and especially the fact of whether and how he penetrated could determine the way in which the spouses experienced the start of their married lives. In a number of cases respondents had talked about it beforehand and had encountered a man who took the time. However, in spite of this, the wedding night was something many of those of the respondents who had been infibulated were very apprehensive about and often still had bad memories of. One respondent spoke about her wedding night as follows:

Sud 8: It was as if he was pushing against a wall. That spot had been stitched shut all of my life, I thought: he will never fit in to that. I thought I would die, the first time I had sex. I was so tense and nervous until he came... My husband insisted on having sex with me, but because I have been circumcised, there is not even enough space for a match to go into. I begged him and

pleaded with him to be allowed to go to the doctor for him to make the opening wider by means of an operation. I went to see the doctor – I had made an appointment with him for the operation – in the end my husband came along too, and listened to the doctor's explanation. Once we were outside he said that was not going to happen, no operation.

When asked what the wedding night was like for them, five respondents (from Ethiopia, Sudan and Somalia) said that it took between four days and a month before penetration was possible. According to an Ethiopian respondent 'the first four weeks of marriage are the most difficult' for a woman. 'Instead of the woman enjoying married life, she will cry in pain, day and night. There is not a lot her husband can do about it. It is part of our culture.'

Fortunately there were respondents for whom the wedding night does not take on such a harrowing note. Ten respondents from Sudan, Somalia and Sierra Leone said how they were worried beforehand, but that their husbands took them into account. One woman said how she was frightened beforehand, but: 'When it happened, it was like the ice was broken between my husband and me.' When asked what the event was like for her, a Somalian respondent replied by saying:

Som 13: Of course I was frightened and I knew it was going to be painful. It did hurt, but not in a horrible, dramatic way. It also depends on your partner. If your partner is understanding and treats you with love, your experience is different.

Interviewer: Were you prepared?

Som 13: Yes, I was prepared for it. I was informed. I had heard the first time is painful for women.

The women's relationships with their partners were also determined by how much enjoyment both got out of their sexual encounters. Sex during marriage was not a matter of straightforward enjoyment for women who had been circumcised. Quite the contrary. Twenty-two women indicated that sex was painful. Overall, sixteen women said they did not really care for or feel like sex. One young woman from Sierra Leone who had undergone a clitoridectomy said: 'Whenever I have sex with a man, it's as if he is raping me, because I don't enjoy it.' A Sudanese woman suggested that 'she could hit her man, push him away or scratch him because it hurts so much.' Many of those respondents who have undergone a Type III circumcision indicated that they found sex 'very boring' and that they 'only do it because he wants it, but you don't feel much at all'. One respondent said she felt very unhappy because she did not enjoy sex at all, while 'I have to pretend I enjoy sex, because if I do, he enjoys it so much'. In spite of the fact that many of the infibulated respondents said that they had an aversion to sex, for others it was a matter of getting used to it. They passively tolerated the pain. 'What else are you supposed to do?' was a frequently heard response. When asked how she experienced her sexuality, yet another infibulated woman, a married Somalian respondent with two children, said that she did 'not notice anything in particular'. 'I think sexuality is something spiritual,

and of course it is also a physical exercise' as she added later on. So it would seem that this respondent was willing to 'practise [the exercise]'. Two other respondents from the same group said they found this difficult and admitted that they were not looking forward to night-time.

Sud 9: During the day there is no problem, but at night, when your husband wants to go to bed with you. You get really scared. When my husband wants to have sex with me, I get very tense and I try and focus on other things, until my husband has had enough.

Moreover, two of the respondents who had undergone a Type III circumcision indicated that they would 'come up with excuses' whenever their partners seemed to be showing signs of getting sexually excited. One Somalian respondent was reported as saying that as soon as her husband was showing signs of excitement she would fix him some nice food 'to compensate'.

As previously stated, sexual limitations and pain could sometimes lead to a respondent feeling temporarily unable to look after their families, and having to call in outside help. We have also seen that pain could trigger unpleasant memories. A respondent from Sierra Leone, who spoke about being plagued by nightmares about her circumcision, which she said had turned her into an 'aggressive woman' explained how things were between her and her husband:

Sie 12: Sometimes I have a really short fuse with my partner. I get fired up about nothing at all. It's like when someone is hurting (when something is bothering you) it can make you aggressive. That's what it's like with me. My relationship really suffers. I would be happy if this could stop.

Some respondents felt that their husbands wanted a passive woman. And a number of women felt that when all was said and done that was an important reason for carrying out the ritual. A woman from Sierra Leone was of the opinion that circumcision was important to men in Africa, because they wanted to marry 'more than one woman and because their wives won't cheat on them, because they don't feel anything anyway'. In a few cases respondents from Sudan mentioned the fact that men like marrying virgins. However, migrating to the Netherlands had caused things to change somewhat. Some respondents said that a number of the men were now no longer satisfied with the women taking a passive approach to sex and were wanting their wives to act with a little bit less reserve. The women's partners had been influenced by the media and by the internet – and in a number of cases also by having sex with women who had not been circumcised. A Sudanese respondent recounted how her husband would watch porn movies while having sex and would want her to try all sorts of positions. 'But I cannot possibly do what she is doing. I have been circumcised – she hasn't. So I will say to him: don't ask me to do the impossible'. A small number of respondents indicated that their husbands would have extramarital sex because they were not satisfied with the sex they were getting at home. When asked whether having been circumcised had had

an impact on women's relationships with their husbands, one respondent replied:

Eri 8: Yes. I hear a lot of men complaining about their wives. They say their wives are no good at sex and are not keen on it either. And that makes their relationship difficult. They are dissatisfied, the men start cheating on their wives and they may end up getting divorced.

Eight respondents reported feelings of despair, frustration and anger towards men in general, and their frequently self-centred behaviour in particular. In contrast, there were fifteen respondents, especially women from Ethiopia, Eritrea and Sierra Leone, who indicated that they did not have any problems with sex. They and their husbands had been able to find a way of being with each other that was sexually satisfying, taking time for each other. Two respondents felt that this was also a matter of being fortunate. When asked in what way her circumcision had had an impact on her family life, one respondent replied:

Sud 2: Having been circumcised [as a girl] has a huge number of consequences. It has an impact on your normal daily life. When you are having your period or if you are having sex again after a long time, you feel that pain again.

Interviewer: Has the circumcision had an impact on the way your husband treats you?

Sud 2: It doesn't have any impact for me. I'm lucky in that my husband understands and he is very much against female circumcision. He is aware of the consequences this has and he tries to make the best of it – put it that way.

Four respondents explicitly stated that love, sexual satisfaction and enjoyment were a matter of mindset. 'It is all in your head. It is always up to you to determine whether that is positive or negative', says one respondent. The same sort of sentiments in relation to sexual satisfaction were echoed during the focus discussion group meetings and in interim discussions with the interviewers. A respondent from Eritrea (with a Type 1 circumcision) recounted how her relationship had gradually blossomed:

Eri 9: In the past I used to have so many problems when we were making love because it hurt so terribly. The other thing is that he did not feel responsible for his behaviour, because he had no idea about my situation and my pain. But bit by bit I managed to win him over and he learned how and when to proceed. So now it is all good. We have our own way of doing things and we enjoy it... My husband knows how to proceed with me. I am very open with him. I can tell him how and what I feel and I can say Yes or No. He knows when he is allowed to carry on or when he has to stop. And he respects me and follows my signal. That is why I experience my own sexuality as good. If you do it with love and care, a circumcised woman can enjoy sex just like a normal person. That is why, like I said before, if a man is well informed, he can be a good and caring human being.

For this and one other respondent from Eritrea, and for the two previously mentioned respondents, both of whom had been infibulated, having good con-

tact, understanding, talking and trying things out together had been the key to eventually achieving a sexually satisfactory relationship.

Relationship with the children

During the interviews women were asked a few questions about their children. When asked whether they intended to have their daughters circumcised, all but one respondent resolutely said that they did not want that. 'I know what it is and what I have been through. I would never put my daughter through that', said a respondent from Sierra Leone. A respondent from Ethiopia replied: 'I don't think it is necessary' and a woman from Sudan said that she had fled her home-country because she did not want her daughter to be circumcised. A woman from Eritrea said that she did not want to 'ruin her daughter's life'. A few respondents from Somalia and Sudan indicated that they did not even discuss this with their partners because they were determined that their daughters were not going to be circumcised: 'It is not up for discussion' and 'even if my husband were to want that, I would say no'. For two of the respondents preventing their daughters from being circumcised was the reason they fled Sudan to take refuge in the Netherlands.

Only a small number of respondents had (a) daughter(s) who had been circumcised. However none of the respondents had had their daughters circumcised in the Netherlands. In every single case the circumcision had been carried out before the respondents had migrated to the Netherlands or while they had been visiting the home-country. One respondent had decided, in consultation with her husband, to have their two youngest daughters undergo a Type II excision rather than a pharaonic (Type III) circumcision. The respondent had agreed with her husband 'because he wanted to give their daughters a good opportunity to marry a Somali man'. In three cases daughters had been circumcised in the home-country against their mothers' wishes. When asked whether she had her daughters circumcised, one woman replied:

Sie 7: No. It wasn't me who had that done, but the people who were taking care of my daughters. It was done without my consent and I was really upset. My tribe removes up to half of the clitoris and that is what they did to my daughters as well.

Aside from the fact that almost all respondents had decided not to have their daughters circumcised, many women also said that they left it up to their daughters to choose their own partners. Most mothers said: 'It is up to her to decide'. However the Somali respondents in particular preferred their daughters to marry someone from the same sort of background and language, and more especially Muslim boys. Only one respondent said that she would also prefer her son to marry a girl who had been circumcised.

Som 13: For me it doesn't really matter who she [my daughter] takes home, as long as he has the same religion as her so as long as he is a Muslim. Religion is very important to me.

Interviewer: What would you think about your son marrying a girl who has been circumcised?

Som 13: I would like that.

This woman was the exception to the rule, because none of the other respondents agreed. They felt that their sons would be better off with a girl who had not been circumcised. When asked whether her sons would be allowed to marry women who have not been circumcised, one Somalian respondent said she would like that ‘because that means his wife could be herself, as Allah made her’. Another woman from the Somalian group admitted:

Som 1: I would not have consented to that when I was still in my home-country, but now I would like him to marry a woman who has not been circumcised, to avoid her from having to go through all that pain.

Several of the respondents commented that as a result of migrating to the Netherlands the situation within their families was quite different to what it used to be in the home-country. They know ‘that it is not allowed’ in the Netherlands and ‘that you end up in jail if you have your daughter circumcised’. Finally a large number of respondents thought that the days of FGM would soon be numbered or that it would no longer play a significant role. When asked whether her son would be allowed to marry a girl who had not been circumcised, a young 30-year old woman from Eritrea replied as follows:

Eri 6: I don’t even think he will be able to choose whether he wants to marry a girl who has been circumcised. By that time female circumcision will have become a thing of the past. Even if it still exists, I am confident that he will marry a girl he loves, whether she’s been circumcised or not. At the end of the day he was born here and this is where he will be growing up.

Relationship with the home-country

Women from all groups of respondents indicated that their views on FGM had changed following their arrival in the Netherlands. Because of migration, the state of affairs within their own nuclear families was now different compared to that involving their extended family in the home-country. In the Netherlands people are ‘penalised’ if they have their daughters circumcised, hence none of the respondents had daughters who had been circumcised in the Netherlands. It will have become clear from what was reported above that most respondents did not want to do this to their daughters – often to the dismay of family members in the home-country. As an example, one respondent recounted how her family from Eritrea were visiting the Netherlands and how her mother commented that:

Eri 12: ...girls are very animated or macho around boys. Then she said: Girls here need to be circumcised, that will calm them down a bit. Oh well, that is the mindset they have grown up with, they don’t know any better. It is not important to me. And my husband doesn’t care either.

The subject of FGM came into play in interactions with family members in the country of origin for about half of the respondents. One Ethiopian respondent thought it 'important, especially after migration' that family members in the home-country knew what people thought about it over here [in the Netherlands]. An Eritrean respondent recounted:

Eri 6: When I was in Eritrea back in 1998 my sister-in-law had had a girl, just a few months previously. My first question was: 'Did you have the little girl circumcised?' But luckily the answer was No. Because of information and campaigns they have become more aware and did not have a circumcision done.

The other half of respondents indicated that it was 'not important' to them what people in the home-country thought (Sierra Leone) or that they discussed other things when they talked to each other. When talking to family members overseas, they were more likely to talk about the war (Ethiopia and Eritrea). Almost all of the respondents from Sierra Leone indicated that they were not in touch with family members in their country at all. Only one of the Somalian respondents recounted having visited eight years prior to being interviewed. This may have been due to the safety concerns with regard to Somalia. However, replies by Somalian respondents showed that they were in touch with family members back home in different ways and that the family's opinion on the circumcision of young females was still relevant. They were talking about this being a 'deep-rooted' or 'significant' Somalian custom. Moreover, one Somalian respondent commented saying that she hoped 'that all people in Somalia wake up and do not adhere to this custom and don't do this to their daughters'.

It became clear from the interviews that a total of seven respondents had (or had been forced to have) one or more of their daughters circumcised in the home-country. In all but one case respondents were aged 45 and over at the time of the interview. In two cases the mother had been kept in the dark about the fact that their mothers-in-law (and their own husbands) were trying their utmost to have the respondents' daughters circumcised during a visit to the home-country. One Somalian respondent indicated feeling sad because her daughter underwent a circumcision in the home-country, when she was not there. It was done 'against her wishes'. Another respondent from the same group recalled: 'I was away on a trip when my mother had her [my daughter] circumcised. But I didn't want that'. In addition to this Somalian woman, two other Somalian respondents, as well as one respondent from three other groups indicated that they had a daughter who had been circumcised. All but one of the women regretted this. When asked why they had allowed this to be done, one of them said:

Eri 7: It is more than thirty years ago now. At the time I wasn't mature and aware enough to oppose it. Everything was done by my mother and mother-in-law. My daughter was given a Type I

circumcision. The decision was made by the grandparents; my husband and me were not consulted.

It was also clear from the interviews that the daughters underwent ‘a less severe’ type of circumcision than their mothers. It would appear that things had changed a bit in the home-country also.

Respondents reported sometimes heated discussions on FGM during their visits to the home-country. These did not always turn out to be successful – in spite of the information campaigns many women reported to be taking place. A couple of Sudanese respondents reported in great detail on what had occurred during such visits. One of them was a respondent who had gone to visit family a few years previously, together with her daughter who was 13 years old at the time. She said she felt ‘hounded’ by their questions.

Sud 2: Everyone kept asking me: ‘When are you going to have your daughter circumcised?’ To them, I am no longer interesting, because I am married with a child. But my daughter – she needs to be circumcised. You can tell that people are subject to a lot of pressure.

A number of respondents claimed that they had succeeded in rescuing a niece or younger sister from the threat of an impending circumcision. According to these women the situation had changed for the better. A respondent from Eritrea recounted how she had attempted, unsuccessfully at first, ‘to save’ her daughter. She had only succeeded by telling her sister-in-law: ‘Well, if you want me to get a divorce, fine! That was too much for her, so she stopped asking’. According to two other, Sudanese, respondents, mothers-in-law still had a crucial role to play when it came to their grandchildren being circumcised. Sometimes, these mothers-in-law demanded that their grandchildren were circumcised and that ‘is a big problem, because nobody can say No to her.’ A Sudanese respondent had the following experience:

Sud 4: I told my mother-in-law that I did not want to allow my daughters to be circumcised. She did not agree with me at all. She said my daughters were her daughters – and that she didn’t care what I thought about it. So I kept my mouth shut, because you have to listen to your mother-in-law, otherwise your marriage will be hell and you might even get divorced. She said I’d only be allowed to organise the party, buy my daughter clothes and gold, because she was going to be circumcised. I tried to postpone the circumcision as long as possible and in the meantime I went to see my family to discuss this with them. But my mother also felt that my daughters should be circumcised. So I met opposition from both sides... Fear because of young girls being circumcised was one of the main reasons we fled from Sudan. At first the father of my daughters agreed with his mother completely. I have had to jump through hoops to ensure my daughter was not circumcised. But my husband’s opinion changed once we got here. He attended a number of information sessions on female circumcision, and now he is strongly opposed to it.

4.2.4 Migration factors, coping and religion

This section will look at the significance of age and the impact this had on experiences with FGM. Following this, we will examine the impact of the media and information sessions. Finally, we will look at the way in which circumcised women dealt with their complaints and the role religion played in all this.

The significance of age

Age was relevant in two respects: firstly, the age at which women were circumcised and secondly the age at which respondents migrated. The latter had an impact on the way respondents felt about the fact that they had been circumcised once they were living in the Netherlands. The age respondents had been when they were circumcised was significant to the extent that they were either able to remember what had happened that day or not. Respondents from Eritrea had been circumcised as infants, while women from Sierra Leone had all been over 10 years of age. For this reason, a number of respondents from Eritrea indicated that they had not realised that they had been circumcised until they got a bit older. One respondent from Eritrea was informed about FGM when she joined the EPLF resistance movement twenty years ago, this having been 'discussed openly' at the time. Three other respondents from the same group also found out while they were still in the home-country. When asked what happened exactly, one of the women replied:

Eri 6: I saw a neighbouring girl, the same age as me, in pain, with a piece of cloth between her thighs. I asked my mother why. My mother said: 'She was circumcised for the second time, because the first circumcison (which they did when she was still a baby) hadn't been done correctly.' From that time on I was conscious of the fact that I myself had been circumcised.

With one exception, respondents from the other three communities had all been circumcised when they had been over 5 years of age. These respondents were usually able to remember their circumcison.

When asked at the interview to what extent age had an impact on their views on FGM, around twenty respondents provided a reply. Only two of these, both respondents from Somalia, said it made no difference, as to them FGM was nothing to do with age, but was everything to do with 'how you adhere to your culture and how much you know about Islam'. For a majority of respondents, however, the age at which someone migrated played a role in their views on FGM. Ten respondents felt that: 'Older people are usually for, but younger people are usually against' and 'Old people don't change'. Although two slightly older respondents were not so sure about this. One, a woman from Eritrea commented as follows: 'Look I am in my early fifties myself, but I am against female circumcison, so I suppose older people must be against it as well'. Even so most respondents indicated that younger people who had grown up in the

Netherlands, or who had arrived there at an early age ‘have a different perspective on FGM than the older generations’. When asked to explain in what way, one respondent replied:

Som 2: Younger people who arrived in the Netherlands at a young age are well aware that female circumcision is a cultural custom – and that it has nothing to do with religion. That is why they are more likely to be opposed to female circumcision than their parents.

For this respondent and for five other Somalian women and for two Sudanese respondents, the fact that there was no religious legitimisation was the main reason for their change in perspective. Other respondents were more likely to have changed their minds due to information sessions and ‘things you hear from people around you about the consequences of FGM’ which made people realise that a lot of problems and pain could have been avoided. Young Somalian men who had grown up in the Netherlands ‘don’t want a woman who has been circumcised. They want women to enjoy themselves during intercourse’ said one respondent. According to a couple of Eritrean respondents young people were able to ‘integrate more easily’ and ‘young people are usually against, no matter whether they are male or female’. One Sudanese woman with three daughters only changed her mind about circumcision when she got to be a bit older:

Sud 11: When I was younger, I had no opinion about female circumcision. I attended information sessions on the circumcision of young females and I was convinced by what was said during those information sessions. But at that time, I did not realise what consequences female circumcision had, because I was not married then.

Hence it would appear that age at the time of migration and length of stay in the Netherlands were important when it came to the respondents’ views on FGM. Finally, there were three respondents who indicated that age could also make a difference when it came to the type of circumcision carried out. According to one of these, a young Somalian respondent, ‘older women have usually undergone a pharaonic circumcision (infibulation) and have suffered more problems’ than younger women. As noted before, none of the respondents indicated that they had had (one of) their daughter(s) circumcised whilst in the Netherlands. In all cases where girls had been circumcised, this had been done in the home-country and often without the mother being aware or under duress from the mother’s own mother or mother-in-law.

The media spotlight

In general respondents were positive about the way in which FGM had been reported in the papers and on television. The topic has been reported on in the media regularly since 1990. With the exception of three respondents from Somalia and one from Sierra Leone, all respondents reported being happy with

the interest. 'I think it is good. As far as I am concerned, they should talk about it more often', according to one Ethiopian respondent. Respondents from Sudan felt that: 'It lowers the threshold, making it easier to talk about it' and: 'It is positive and necessary because this is still being done in Khartoum and in the villages'. Another Sudanese respondent stated:

Sud 7: I think it is good. Because when they talk a lot about female circumcision then that serves as a sort of information session for those who cannot read and write. I hope they will be talking about it more. Especially when it comes to the religious aspects. That used to be a very difficult topic, but not now, thankfully.

Media attention had strengthened women's conviction that they did not want to do that to their daughters and that FGM was an unnecessary tradition. In fact, the media attention legitimised the wishes and hopes of many respondents that things would change. One respondent recounted seeing a documentary on FGM ON TV:

Interviewer: What did you think about that?

Eri 11: Shocking. You cannot really watch it, dreadful. It is sad to see a girl suffering like that. And then to see what happens to a woman in childbirth, incredible. You feel helpless. It has had a huge impact on me. It is difficult to watch, but also informative. For those who have no idea or those who don't really believe that it is dangerous, this is a good way to make them aware. And for people who still think that female circumcision is a good thing, they will be able to see really well what their daughters will be going through. And hopefully that will make them change their minds.

Respondents from Sierra Leone were also positive about all the interest in the media. When asked what she thought about the way FGM was reported in the newspapers and on tv, one of these respondents replied: 'I think it is good and useful. That way you can teach people, the masses'. Another respondent from Sierra Leone said that she would not dare say this openly in Africa, but that she dared speak her mind [in the Netherlands], because: 'This is the free world and it is good what happens in the media'. Thus, a majority of respondents felt supported in their stance towards FGM, especially in relation to family members in the home-country. In addition, the focus in a number of their countries of origin was currently also on (the consequences of) FGM. One respondent who had visited Eritrea very recently claimed that 'there is an ongoing campaign and discussion on radio and television about female circumcision'.

Nevertheless, not all respondents voiced favourable sentiments, in particular about the way in which the media were reporting on FGM. Somalian respondents in particular disagreed. The 'shocking images', 'negative stories', 'hurtful comments' and the fact that the women were painted as 'to be pitied' did not go down very well with a total of six respondents. They felt that people in the Netherlands were being 'influenced incorrectly'. And according to a woman

from another group of respondents, this could impact on the women themselves.

Eri 3: I have heard service providers discuss female circumcision several times on TV. They say things like: 'It's terrible, it's incredible'. They must have said the same to the woman. How do you think she would have felt hearing that?

Interviewer: How?

Eri 3: She'd be scared, she'd think she's in great danger. No self-esteem, she'd be left feeling traumatised. She will want to be by herself and she will become isolated. She will only be thinking about what happened at the time. She may not want to go and see a doctor anymore

Information in the Netherlands

Most respondents said that they have been informed in the Netherlands. In a number of cases this was because one of their own community organisations provided information on the topic. This was especially true for respondents from Sudan and Eritrea. Generally speaking, Sudanese and Eritrean women were positive about these information sessions. In each instant, they had found these very helpful. When asked whether she was happy with her increased knowledge, one respondent replied by saying:

Sud 1: I am very happy indeed. I've learned a lot, I can now discuss the topic openly. I used to have a lot of pain, also after getting married. I did not know what caused that. Now I know it was caused by the fact that I've been circumcised.

Only a small number of Somalian respondents indicated that they had been informed, with a majority not wanting to talk about it at all. However, those three Somalian respondents who had received information were very pleased with it. One of them, a young Somalian woman with three children said it was 'nice' and she said she was 'glad that parents have now become aware about female circumcision'. Sometimes the topic might come up when talking to female friends or contemporaries. Another young Somalian respondent talked about a meeting of 'Somalian girls':

Som 3: We learned how to stand up for ourselves and how to say 'No' to circumcision. I thought it was an informative meeting. However I would have preferred having had that information before I was circumcised.

Interviewer: Were you ever informed previously?

Som 3: Yes, one meeting. I could have been informed previously, but I was not interested. They cannot undo the fact that I have been circumcised anyway.

When interviewed, only one out of six Ethiopian women indicated that they had been informed. There were also a number of respondents who indicated that the topic was talked about at the asylum seekers centre or in another location. One Sudanese woman with three children who had stayed at an asylum

seekers centre for six years, talked to Iraqi refugee women while she was there and found out that the latter had not been circumcised, even though they too were Muslim women. The respondent said that it 'felt as if my family had committed a crime by having me circumcised'. A woman from Sierra Leone had the same experience and felt 'bad' when she found out. Two respondents from Eritrea indicated that they learned more about FGM when they were learning Dutch as part of the process of becoming integrated into Dutch society. One of them said that 'everyone voices their opinion. At the same time, this breaks through the taboo' and also that she felt 'more liberated now'. Another respondent from Eritrea said that for her this had happened at her daughter's school:

Eri 5: They had organised an information session for all mothers, no matter where they were from, Dutch and others. It was presented by a doctor. It was about female circumcision, what it entails and what consequences it has. They also said that some women go on holiday to their countries of origin in order to have their daughters circumcised. I thought it was good and informative and excellent that they talked about it openly.

Coping and religion

Respondents were asked what they did in case of problems or complaints. Respondents from Sierra Leone, Eritrea and Sudan often answered this question firmly and succinctly, however most of the Somalian and Ethiopian respondents were not very forthcoming. A number of them indicated that they would prefer not to talk or even think about it 'because that does not help anyway'. One Somalian respondent put into words what in fact appeared to be the standard view among these women: 'I have to carry on with my life now and look ahead'. However when asked what she did when she was having a hard time, one respondent from this group, who was married with three children, replied that she would 'rather get into some form of physical exercise, that is more of a release. A lot of women watch tv or listen to music, but I find exercise more beneficial'. It was not just the Somalian respondents who liked to keep quiet about their problems and complaints. Other groups of respondents also included women who preferred to isolate themselves when they were feeling that way. 'I just go to my room and try to sleep. I keep quiet, that is true', said our youngest respondent, a woman from Sierra Leone who underwent a circumcision just four years prior to the interview.

A total number of seven Somalian respondents referred to religious activities as a means of achieving comfort and strength. By reading the Quran, 'and by prayer I try to alleviate the pain, because it is impossible to forget'. They also took comfort in the fact that FGM was not mentioned in the Quran. One respondent from this group said that she got involved 'in Islam' more 'to find comfort in it and answers as to how to cope'. Another respondent sought comfort in her faith 'when the site of the circumcision is bothering me':

Som 8: I am glad that there is no link with Islam. I am absolutely convinced that Allah has created people perfectly.

One respondent from the Somalian group went even further than that. When asked to what extent her faith helped her cope with her circumcision, this woman replied: 'A great deal, our religion is great. But you do not need religion to forget about this, you need people, distractions'.

Religion was also an important coping mechanism for women from other countries. Four respondents from Sierra Leone indicated that they would read the Bible whenever they were going through a bad patch. One respondent from this group said that she had forgiven her parents for having her circumcised. 'I would not have been able to do that without my faith.' Five of the Sudanese respondents and two of the Eritrean women sought comfort in prayer. 'Religion helps me carry on', said one Sudanese respondent. Whenever she thinks about her circumcision, one Eritrean woman tried to keep calm by praying.

Eri 4: And that usually works. If not, I would have started a war against my parents and my country. I would have considered it nothing short of murder.

While some respondents sought comfort in prayer, six other respondents tried to deal with their problems and complaints by listening to music. Respondents said 'I prefer to listen to songs from my home-country in that case'. For two respondents prayer and music went hand in hand. When asked what she would do when she was having trouble dealing with the problems resulting from her circumcision, one unmarried respondent with one child said:

Sie 6: I just try not to think about it, because I have a lot of problems, including problems with relationships. But if I do think about it, I try and find the way to God. I tend to listen more to gospel songs and I also start reading the Bible. My faith helps me a lot...

Lastly, two women admitted to bingeing on sweets when they were going through a bad spell. One respondent from Eritrea said: 'I drink a lot of coffee [when I feel like that], all the time'. When asked what she did when she felt 'confronted', one slightly older respondent from Ethiopia replied 'I start chewing qat, smoke a water pipe and go for a walk outside'. What was striking was that just one respondent mentioned qat as a form of coping in view of the fact that the use of qat is widespread in Eastern Africa and the fact that qat has been commonly imported into and used in the Netherlands.

Some respondents said they would talk when things were bothering them. In many cases, they would seek out friends, or talk to them on the phone. When asked what she would do at difficult times, one respondent who had been living in the Netherlands for more than thirty years replied:

Sud 2: Because I came to the Netherlands at a reasonably young age, and because I studied here, I have learned from Dutch people and through my training that I need to talk when something is bothering me. I talk about it to my husband, girlfriends, and colleagues at work. I treat myself to a sauna or a jacuzzi or I do some exercise.

Finally, two Somalian respondents said that they would take a salt bath whenever they were experiencing physical complaints, especially infections. We 'learned that from an older woman'. When asked whether she had been in contact with Dutch service providers, one of the two, a young unmarried woman replied:

Som 10: No, when I have an infection, I don't go and see the doctor, but I prepare a salt bath and I go and sit in that. I'll have a salt water bath for three days and by that time the infection will have gone.

4.2.5 Experiences with the Netherlands health care system

This section will examine in more detail what respondents said about their interactions with service providers. First, we will look at a couple of respondents who had experiences with mental health care. After that, we will see to what extent women appreciated or criticised the care they were offered. This will include any problems they said they encountered, including embarrassment and any feelings they might have had about having their genitalia stitched up again (or not) following childbirth, i.e. reinfibulation.

The fact that respondents were originally from at-risk countries also meant that they were usually refugees and had often experienced or witnessed gruesome events. Being women also meant that they might have been the victims of sexual violence. The respondents in the study also included women who had experienced trauma. Respondents were not specifically asked about other experiences of violence, however two of the women nevertheless indicated that they had been raped. One of them, an Eritrean respondent, recounted that whilst young and fleeing to Sudan, she had been raped by the guide who was taking them.

Eri 5: It was a bad and shocking experience.

Interviewer: What consequences did that have for you?

Eri 5: It caused a lot of problems. I fell pregnant after being raped. That was the worst thing that could have happened. I had to give up my baby later on.

This woman recounted how she had struggled with a range of physical and psychological problems, following this. Her vagina had probably been mutilated. When she fell pregnant again, after arriving in the Netherlands, and had to go to hospital to give birth, she felt very confronted by the fact that a great many people came to have a look at her. The respondent stated that she felt 'like she

was on display'. She experienced that particular birth, which had occurred twenty years prior to the interview, as traumatic. During the interview this respondent also said that she had watched a documentary on FGM in Somalia, and that she 'could not think of anything else all day but the image of that girl. And I sat in my chair all day, all tensed up'. But she later indicated that she had 'gradually put it all behind' her. 'Fortunately, I was able to work through it and I am happy with my three children and my partner now.' This case clearly shows that for her the circumcision and the rape were linked together, like an accumulation of trauma. Or to quote another respondent: 'So you're already in pain because you have been circumcised and then you're raped as well'.

Overall, three respondents indicated that they were seeing or had seen a psychiatrist or ambulatory mental health provider. Two women spoke to the treatment provider about problems they were experiencing as a result of having been circumcised. Both said that they 'felt better' after talking about it. One of them, a Sudanese respondent, talked to her psychiatrist about her circumcision within the context of sexual problems she was experiencing with her husband. She ended up talking about it, in spite of feeling embarrassed, 'because I felt exhausted because of all the misery'. Afterwards, the male psychiatrist, continued to talk to discuss the circumcision with her. 'He wanted to know whether the circumcision had had an impact on me, also after childbirth. Every time I talked to him about it, I felt better afterwards'. The other respondent who had had encounters with mental health services was a young woman who had been circumcised at age 16. When asked with whom she discussed this, she replied by saying:

Sie 12: I do talk to my friend about it sometimes. She is a Dutch woman. And I also talk to a counsellor with the RIAGG [ambulatory mental health services] to alleviate the pain. That helped a little bit. Sometimes I have nightmares about what happened that evening. It still affects me to this day, but there is nothing I can do about it. Fortunately I am not in Africa any more.

During the interview, the Eritrean respondent who had not yet discussed her circumcision with her psychiatrist wondered why she had not. She said she had been seeing the psychiatrist for four years but that she had nevertheless 'never discussed the circumcision with him... I suspect he knows I have been circumcised but he has not initiated any discussion about it'. During the interviewer's next visit, one week later, at which time the questionnaires needed to be completed, the respondent indicated that she had been feeling unwell the whole week. She had been quick to anger and had even sent her husband away to spend a few days with friends, to allow her time on her own. According to notes made by the interviewer 'her feelings have surfaced. Before this, she did not realise how much her circumcision had affected her. She only realises now'. When asked what advice she would give service providers in the Netherlands, the respondent replied:

Eri 9: My advice would be that whenever a woman from a country where young females were traditionally circumcised, visits a doctor and in particular any psychiatrist, they should give them a flyer or brochure with information about it. Without fail. That may start a conversation. That may give her the opportunity to start talking about it, to take the initiative. I would have done if I had been given the opportunity when I was seeing that psychiatrist.

Due to their refugee background, many of the respondents had their first encounters with Dutch service providers in a Reception Centre (*OpvangCentrum* or oc) and Asylum Seekers' Centre (*Asielzoekerscentrum* or azc). At the time of the interview, one of the respondents from Sierra Leone was still resident in a centre which also housed other asylum seekers. During the interviews, four respondents talked about their first encounters with nurses and doctors in such a setting. In all four cases, the first encounter was experienced as 'reassuring'. 'We had a good talk' said one respondent when recounting her first appointment with a doctor at the asylum seekers' centre, which included a 'full physical examination'. Another respondent, from Sierra Leone, who was still resident at the Reception Centre at that time, went to see the doctor with abdominal complaints and 'got talking. She [the doctor] said that if I wanted to know more, I should come back again, because she has a lot of information on female circumcision. I thought our first talk was nothing out of the ordinary'. The respondent who was mentioned above and who had not yet discussed her circumcision with her psychiatrist, had gone to see the doctor with a urinary tract infection, when she was still resident at the Asylum Seekers' Centre. During a conversation she had with the female doctor, the possibility of a de-infibulation was suggested to her. After a lot of to-ing and fro-ing, the respondent had consented. She did want 'it to be opened up a little bit'.

Eri 9: Because they cannot open it up all at once. It has to be done very gradually, bit by bit.

Interviewer: How did that conversation go?

Eri 9: She was friendly, nice. I was examined. She saw my private parts and asked me who had done that. I got a bit of a shock that she knew I had been circumcised... otherwise it was not a problem. She told me that she could open it up, if I wanted. And she did. I think she had experience with circumcised women.

All but three respondents had been resident in the Netherlands for more than five years. The overwhelming majority of respondents was no longer resident in a Reception Centre. Only three respondents said that they had never been in contact with a service provider. All other respondents had been to see the doctor, two of them had been to see a specialist (one a dermatologist and the other a urologist). Women most frequently presented with abdominal complaints and complaints to do with their periods. Three respondents mentioned recurrent urinary tract infections ('every three to five months'). One respondent said that she was incontinent as a result of complications during childbirth and that she had been under treatment for ten years. In addition, two

women had uterine myomas. One respondent said this was as a result of being circumcised.

Sud 8: Uncircumcised women can have myomas as well, but in my case the circumcision is the direct cause of the myomas developing. After I got married, my husband refused to allow me to have the vaginal opening widened and that made my problem worse.

When asked how they experienced care provided in the Netherlands, many respondents indicated that they often felt embarrassed or sad or guilty because of the way service providers behaved. The mere fact that the doctor saw their private parts during the physical examination and asked them questions was difficult for respondents. When asked why she did not discuss her circumcision with the doctor, one respondent from Sierra Leone responded by saying that she was 'pigheaded'. She said doctors or service providers 'sometimes ask whether I have been circumcised, but I don't respond to that'. For a number of respondents the look of surprise or shock on the face of the person carrying out the examination was enough to make respondents blush or make them feel as if they had done something wrong. When asked how the doctor found out that she had been circumcised, one respondent replied:

Sud 4: When I was examined for the first time, I noticed that the doctor thought it was very strange that I had been circumcised. He asked me what had happened and I told him that I had been circumcised. He then touched it with his hand and again asked me what it was. I replied that that was the area that had been stitched closed. He discovered that I have two openings to urinate through. I wanted to die of embarrassment.

Meanwhile a Sudanese respondent was recorded as saying that the doctor's reaction had caused her a lot of sadness 'because I felt people were looking at me as if I was a mouse'. Similarly the service providers look shocked and appeared to feel awkward. An Ethiopian respondent said she thought her first visit to the doctor was terrible, and that she felt 'abnormal'. A Somali respondent said: 'You can see the facial expressions of the nurse, the doctor, the midwife. You can see their faces, the range of emotions and how they are looking at my body. That hurts... Those people's eyes make you feel sick'. Feelings of shame could get to the point where women did not seek help for their problems. One respondent who did not dare to go swimming, for fear that her girl friends might see her vagina, still had not told her doctor: 'You feel too scared to say anything, it is really difficult, you wait for the doctor to spot it himself'. For many respondents, feelings of shame played a major role when it came to service providers in the Netherlands. When asked whether she currently went to see the doctor when she had any problems, one respondent said that she had eventually overcome her feelings of shame because her husband went to see the doctor with her.

Sud 10: But without him I would never have gone to see the doctor by myself. He encouraged me to be honest with the doctor, because he is the only one who can help me.

Respondents from Eritrea and Sierra Leone did not indicate feeling embarrassed when visiting a service provider as often as respondents from the other communities. This may be to do with the fact that a clitoridectomy is less obvious and also gives less complications than an infibulation or total excision. However those communities also included respondents who felt hurt and embarrassed, especially during childbirth. When asked what childbirth was like for her, a respondent who had undergone a Type II circumcision replied:

Eri 5: When I was admitted to hospital for the birth of my child, several nurses came to see me and looked at my private parts. One would come and go, another one would come and go again. I felt like I was on display. I didn't understand. I thought that there was something seriously wrong with me. I got worried, I didn't know what was happening to me. But then one of those nurses told me that they had never seen a circumcised woman before and that was why there was all the excitement. Everyone wanted to have a look at that part of my body. From that point on I have felt like a battered woman. I hate myself. I feel worthless and I feel ashamed. I don't want to talk to anyone. [Silence]

Interviewer: What impact has that had on you?

Eri 5: I felt so embarrassed, humiliated. I didn't want people to see me like that. I had a feeling that everybody was looking at me. And I felt different from everybody else. As if I didn't belong anywhere. It really was a very difficult time for me. And it was a long time before I felt a bit more human, or a bit more myself. But it never completely leaves you. It always stays with you.

Overall, a total of five respondents said they had felt similarly humiliated during childbirth in the Netherlands. Other respondents indicated that they had felt embarrassed beforehand, but that information provided before childbirth had meant that they had not experienced any problems.

A number of respondents were happy with the care provided and also with the interactions themselves. When a Sudanese respondent went to see the doctor prior to the birth of her second child, the doctor asked her whether she had been circumcised. 'And I said Yes. He asked me if I was aware of the campaign [against FGM], that it was risky, and so on. We had a nice talk.' Even though she was embarrassed about 'standing in front of him naked' everything else 'went well'. The conversation between an Ethiopian respondent and a female doctor also 'went quite well', according to the woman. When asked how they had experienced the care offered by doctors and nurses, respondents from Somalia provided a range of responses. Some women said they would prefer not to go and see a doctor; they indicated that they were able to take care of themselves to a reasonable degree or they 'absolutely did not want anyone other than their husbands to see their private parts'. However two women from this group were eventually able to conquer their feelings of embarrassment. When asked about

her experience with service providers, one respondent said that she found it difficult at first to tell a stranger what was bothering her:

Som 3: At first I thought it was very unpleasant standing in front of someone naked. So I came up with another problem at first and told the truth later on. I did not want him to see my private parts. But I was impressed that he knew so much about it and he treated me with respect.

A slightly older respondent from Somalia thought it ‘normal’ for her doctor to examine her. ‘It didn’t bother me, because a doctor has to be able to exercise his profession.’ Her statement was in some contrast with the response given by another respondent from the Somalian community, who was fifteen years her junior. When the younger woman was asked why she did not want to go and see the doctor, she replied as follows:

Som 8: I am a religious woman and I don’t want the doctor to look at my private parts. And I don’t want to explain anything either. I don’t feel like it... I try and get on with my life in spite of the infections. Through plain hard work.

Interviewer: Have you ever been in touch with service providers in the Netherlands?

Som 8: No, never, I never go and see the doctor when I have an infection. I don’t want to show him my private parts and having to tell him everything I have been through.

Interviewer: Would a female doctor be able to help you?

Som 8: I think so. With her I would not be scared and I would also be prepared to tell her my complaints. Because she would be a woman and she would understand me better, I think.

All in all, respondents in the study reported both positive and negative experiences with service providers. Respondents did think it was positive that of late, service providers ‘have been better informed about female circumcision’. Another respondent said ‘They are now aware of it in the Netherlands’. Interactions with doctors and nurses in the Reception Centres and later on, had been a positive experience for eight of the respondents; many of the service providers showed understanding, provided correct information and referred women on in case of problems.

To conclude the section on the qualitative findings, we will revisit the respondents’ childbearing experiences one last time, in particular those of women who had been infibulated. We will also look at whether or not the vagina was stitched close (re-infibulated) again after childbirth. Looking back on her experience one respondent said:

Sud 2: While I was giving birth he [the gynaecologist] widened up the opening of the vagina by giving a little cut to the side. It was painful, you forget that it is in fact a beautiful moment, that you are having a baby. After the baby was born, the opening they created is stitched up again and then, when you have to go for a pee, it hurts again. You cannot walk, you stay in bed until the wound has healed. Then they take out the stitches, it hurts again. And then of course having sex for the first time after birth. It is just like the first time again.

In four cases one or more children had been born in the country of origin and the vaginas of women who had undergone a Type III circumcision had automatically been stitched shut again 'like it had been before birth'. When asked why, one of the four said: 'Those are the traditions. This is how a woman has to be for her husband'. Respondents who had undergone a less serious type of circumcision, especially women from Sierra Leone and Eritrea, usually said that they had 'not been opened up' and that childbirth 'went well'. For ten respondents childbirth went 'normally' in the sense that if an episiotomy had to be done prior to birth, this was done 'to the side'. With many of the respondents who had been infibulated, but in three other cases as well, the child was born by Caesarean section. Overall, fifteen respondents said that one or more of their children had been born by Caesarean section.

Three respondents had their vaginas stitched up in the Netherlands after birth. 'I was big news in the hospital', said an infibulated woman from Sudan talking about the birth of her third child, the first one to be born in the Netherlands. 'I was stitched up all the way, up and down. After the birth, they asked me what I wanted them to do for me. I told them to stitch everything back the way it had been. And that is what they did.' In spite of the fact that this respondent was experiencing a lot of medical complaints and sexual problems at the time of the interview and even though the family doctor had recommended that she allow things to be opened up, she had elected to remain closed up. When asked how things went for them when they were giving birth, two other respondents said that they regretted that they had not been closed up again afterwards. One had this to say about it:

Sud 1: I mean when they cut to help the birth along and then they have to stitch it up after birth. But they don't do that, because that is not allowed in the Netherlands. That has impacted on me, mentally speaking...You feel a sort of emptiness inside, as if air is coming in because you have not been stitched shut.

However, two respondents indicated that in hindsight they were very happy that their vaginas had not been stitched back up again after childbirth. One of the two was a woman with seven children, six of whom had been born in the Netherlands. Her first child had been born in Africa. She had an episiotomy in four different places, and after that she was closed up again in an 'ugly' fashion, leading to a lot of scar tissue. After the birth of her second and third child, which took place in a tertiary teaching hospital in the Netherlands, this respondent had been closed up again each time. Each time this had happened against her wishes. When asked why she did not just ask to leave the area open, the woman replied:

Eri 4: Well you see, with [the birth of] my first three children in the Netherlands I couldn't understand any Dutch, not a word. Nor my husband either. I did not want anybody there, because I

thought I would die, I was that embarrassed. I was really shy, there was no interpreter, nothing. And I am not sure whether they asked me what I wanted or not. But when my fifth child was born, I was able to understand Dutch and talk it a little bit. That is why I was able to convey that I did not want to be closed up again. I had learned from my previous experiences to say No very clearly. And it worked. Then with my sixth and seventh child I had a home birth without any problems. My neighbours did not even hear anything. It was all like normal. [Respondent looks relieved, happy] But in hindsight it was my embarrassment and the fact that I did not have enough Dutch, those two played a major part. In that sort of situation you really need someone whom you can trust and who cares about you.

4.3 Quantitative findings

The following findings related to the self-reported complaints as established based on the standardised questionnaires. The demographic characteristics of the respondent group have been presented in section 4.1. In this part we will first present the results of the univariate analyses with sociodemographic variables and coping and acculturation scales in relation to post-traumatic stress, anxiety and depressive complaints. This will be followed by the results of the multivariate analyses with all relevant variables.

Missing values – A substantial number of respondents did not complete all questions – as a result the data of seventeen respondents were missing from the HTQ total score, while the data of twelve respondents were missing from the total score for the HsCL. The largest number of missing values related to the General Questions sections completed by Somalian respondents, the Lowlands Acculturation Scale completed by Sudanese respondents and the COPE-Easy completed by Ethiopian respondents. In some cases it was no longer possible to arrive at an informed guess as to what the missing values might have been, however, it was possible to arrive at a mean score for most of the omitted values with the aid of estimation procedures.

Pathology – One sixth of the subjects ($n = 11$, 17.5%) met the criteria for PTSD, whilst one third met the criteria for depression ($n = 22$, 34.9%) or anxiety ($n = 20$, 31.7%) disorders.

Type of circumcision – Women who had been infibulated ($n = 35$, 53.8%) reported more PTSD symptoms ($F(2.46) = 4.67$, $p < 0.05$) and more symptoms of anxiety/depression ($F(2.51) = 4.37$, $p < 0.05$) than those who had undergone a less severe type of circumcision ($n = 21$ and $n = 9$ respectively).

Country of origin – Subjects from Sudan reported more PTSD symptoms ($F(4.58) = 5.35$, $p < 0.05$) and more symptoms of anxiety/depression ($F(4.58) = 4.04$, $p < 0.05$) than those from the other countries, with the exception of Ethiopian subjects.

Marital status, type of marriage, level of education, family makeup and employment – No significant difference was found for marital status, type of marriage (arranged versus own choice), level of education and family makeup (with dependent children still living at home or not) with regard to symptoms of PTSD, anxiety and depression. Women who were unemployed ($n = 19, 33.9\%$) reported more anxiety/depression than those who had had some form of training, or who were in a job or on a benefit ($n = 37, 66.1\%$), $t(30.37) = -2.09, p < 0.05$.

Age – There was no significant correlation between age on the one hand and PTSD, anxiety and depression on the other hand. Where women had been older at the time of migration to the Netherlands, they reported more complaints ($r_{ptsd} = .38, N = 63, p < 0.01$; $R_{anx/depres} = .37, N = 63, p < 0.01$). Women who had been older at the time the circumcision was carried out reported more PTSD symptoms ($r_{ptsd} = .30, N = 60, p < 0.05$) but they did not report more anxiety and/or depression related symptoms.

Memory of the circumcision – Respondents who remembered the circumcision well ($n = 34, 55.7\%$) reported more traumatic symptoms ($F(2.56) = 14.48, p < 0.001$) and more symptoms of anxiety and/or depression ($F(2.56) = 6.10, p < 0.01$) than those who did not remember it vividly ($n = 13, 21.3\%$) or those who had no recollection at all of being circumcised ($n = 14, 23.0\%$).

Discussion before circumcision – For 25 (41.0%) of the subjects, the event had been carried out unexpectedly and without any preliminary explanation. Subjects with whom the circumcision had been discussed before it took place ($n = 36, 59.0\%$) reported more PTSD symptoms than those with whom it had not been discussed ($t(57) = -1.94, p < 0.06$) – No relation was found between prior explanation and anxiety and/or depression related complaints.

Information – Respondents who had received health information concerning the circumcision ($n = 28, 43.8\%$) reported more PTSD symptoms ($t(45.15) = 2.12, p < 0.05$) and more symptoms of anxiety/depression ($t(48.22) = 2.37, p < 0.05$) than those who had not been provided with any information about the imminent event ($n = 36, 56.2\%$).

Circumcision of daughters – We did not find any relation between symptoms reported by subjects and the fact of whether their own daughter had been circumcised or not ($n = 8, 13.6\%$).

Correlations with coping – A more avoidance oriented coping style was found to be associated with more PTSD symptoms and more symptoms of anxiety/depression ($r_{ptsd} = .42, N = 58, p < 0.001$; $r_{anx/depres} = .47, N = 60, p < 0.001$) – similarly, a higher incidence of substance abuse seemed to be associated with a higher incidence of psychological problems ($r_{ptsd} = .48, N = 52, p < 0.001$;

$r_{anx/depres} = .58$, $N = 54$, $p < 0.001$). A more support seeking coping style was found to be associated with more anxiety/depression related symptoms ($r_{anx/depres} = .32$, $N = 60$, $p < 0.05$). No relationship was found between any of the other coping dimensions and mental health.

Correlations with acculturation – Less practical skills in relation to acculturating to Dutch society were associated with a higher likelihood of PTSD symptoms and symptoms of anxiety/depression ($r_{ptsd} = .36$, $N = 56$, $p < 0.01$; $r_{anx/depres} = .27$, $N = 56$, $p < 0.05$ – especially for depression, not for anxiety). No relationship was found between any of the other acculturation dimensions and subjects' mental health.

Additional analyses – The univariate results showed that, even though Somalians had undergone infibulation at an older age (8 years), they reported significantly less psychological problems than women from the other countries. Therefore additional analyses were carried out for this group with regard to possible distinctive variables. These showed that Somalian women in particular scored higher for 'cognitive restructuring coping'.

Multivariate analyses – The results of the univariate analyses yielded information about the variables of type of circumcision, country of origin, age at the time of migration, age at the time of circumcision, employment status, receiving prior information about the circumcision, with women having the circumcision discussed with them, memory of the circumcision, avoidance coping style, substance abuse, supportive coping, and acculturation skills to correlate with the dependent variables (HTQ & HSCI Total Scores). The set of covariates for the multiple regression analyses with the HTQ-30 total score and the HSCI-25 total score therefore contained these variables. The following factors appeared to be of significance in a multivariate context with regard to psychopathological problems: the type of female genital mutilation (infibulation), country of origin (originating from Sudan), vividness of memory, and coping style (substance abuse) were specifically related to PTSD symptoms (Adjusted $R^2 = .67$; $F(4,38) = 22.04$, $p < .0001$). The type of circumcision (infibulation), the coping style (substance abuse and avoidance), the country of origin (originating from Sudan), and source of income (no income) were associated with anxiety/depression ($R^2 = .59$; $F(5,39) = 13.68$, $p < .0001$).

5

Discussion

This chapter will present the most important findings which will be discussed within the framework of the existing literature on this topic. Any methodological limitations of this study will also be discussed.

5.1 Overview and interpretation of the most significant findings

Gaining insights into the psychological, social and relational consequences of FGM in a migrant context was central to this research. Information about this set of problems was obtained with the aid of standardised questionnaires and topic interviews. It was expected, based on the existing literature, that African women in the Netherlands who had been circumcised would demonstrate symptoms related to anxiety, depression and post-traumatic stress (research question 1).

In addition, the researchers expected that reporting complaints would be associated with certain factors (research question 2). These involved: the type of circumcision, the country of origin, respondents' level of education, the memory of the circumcision and other related events, such as the impact of migration and having the necessary skills to adapt to a new environment (acculturation). The third question at the centre of this research involved the coping strategies used by these women in the Netherlands in relation to any complaints and problems they might experience due to the circumcision and, in relation to this, any experiences they reported in relation to their interaction with (mental) health service providers in the Netherlands.

5.1.1 Psychopathology as a result of being circumcised

A substantial group of women reported psychological problems due to having been circumcised or due to significant events associated with it, including the wedding night or giving birth to a child. Within the context of social interaction women reported feelings of embarrassment or shame, anger and exclusion as

a result of circumcision, while relational consequences mainly occurred during sexual intercourse (pain when making love) and relationships with men.

The quantitative analysis showed that almost one sixth (15.9%) of the women met the criteria for PTSD, with around a third reporting a pathological level of depression (34.9%) and anxiety (31.7%). The percentage of PTSD cases identified in this study coincided reasonably with that found in other research studies (Kleber & Brom, 1992; Knipscheer et al., 2009; Smith & North, 1993) but was less than that found in, for instance, a study conducted among Somalian refugees (31.5% PTSD, based on the HTQ; Roodenrijs et al., 1998). (Unfortunately there are no comparative figures available based on the HTQ in relation to Somalian women with specific traumas – or other African women.) In addition, around a third of circumcised women were found to suffer anxiety and depression. Again, these are relatively low percentages when viewed in the light of the available reference data, including a study conducted among 54 Somalian refugees which showed that 36% were suffering from anxiety disorders and 63% from depression, based on the HSCI (Roodenrijs et al., 1998). Other studies showed that out of 178 refugees from Afghanistan, Iran and Somalia, 10.6% had PTSD, while 39.4% had anxiety and depressive disorders. It should be said that women in particular are more likely to suffer from PTSD, and depression/anxiety (Gerritsen et al., 2006). Hence the findings for circumcised women are reasonably comparable to those of other studies involving traumatised refugees.

Women who underwent the most serious type of circumcision, i.e. infibulation, reported the most complaints. However, respondents who had undergone a milder type of circumcision also reported trauma-related complaints. In this respect our findings differed slightly from those of Lockhat's (2004) study. According to Lockhat's model, women who had undergone a mild type of circumcision did not have PTSD complaints (p.104).

A considerable number of women in our sample indicated that they did not have psychological complaints – in that the majority of respondents did not score above the threshold for psychopathology. There may be a number of conceivable reasons which may explain the relatively high percentage of respondents who denied having complaints. The most feasible reason would be a possible under-reporting of complaints. The qualitative analysis showed the following:

- 1 A number of respondents had only recently become aware that they had been circumcised. The way they saw it, any complaints they might have could not be associated with the fact that they had been circumcised. The fact that FGM was so much taken for granted meant that women were likely to blame any psychological complaints they had on other factors, because they never stopped to think that something that was experienced by all women in their environment might become a problem for them. In these cases, something that was experienced by

- ‘everybody’ – and hence normal – might not be seen or referred to as an individual complaint and would definitely not be associated with the circumcision.
- 2 For a considerable number of respondents there was a taboo on talking about FGM (social convention). Women indicated that they preferred not to say anything about it out of embarrassment, out of fear of being stigmatised, or because they felt that ‘talking causes problems’.
 - 3 In addition, it may be that the research instruments used were not suitable for arriving at a precise mapping of complaints among the target groups – for instance, in terms of low cultural validity of the measurement tools (see also under Methodological Considerations).
 - 4 In addition, we should not discount the possibility that most women did not view their problems as complaints but as a *fait accompli* which they had to learn to deal with (see Lockhat, 2004).

5.1.2 Distinguishing factors

Women were more likely to report post-traumatic health problems when they clearly remembered being circumcised, when they had been infibulated and when they made more frequent use of substances (drugs) as a coping strategy. Factors associated with women reporting anxiety and depression included avoidance coping styles, a higher incidence of substance use, infibulation and lack of schooling or employment. Complaints of anxiety and depression appeared to be more strongly associated with factors which were not directly associated with circumcision, more so than the trauma-related complaints. This was reflected in women lacking employment or schooling (poor social perspective) and using a dysfunctional type of support seeking behaviour – which may also have been due to the fact that they lacked language skills.

It was also apparent from the interviews that women showed varying degrees of openness, both as regards the extent to which they talked about the consequences of FGM and as regards the extent to which they did or did not discuss other topics. As an example, respondents from Sierra Leone did not appear to find discussing sexuality as threatening as respondents from Ethiopia or Somalia. However we should be careful not to generalise here, in view of the considerable individual differences to be found within each community. It was clear from the interviews, that differences were associated with place of origin (region, clan or ethnic community), and also in particular with age, type and manner of circumcision. In addition, all respondents differed in terms of the context in which they grew up, the reason they migrated and their lives in the Netherlands. From that perspective, the type of circumcision they underwent was a better predictor of problems than the country of origin and possibly their age at the time of being circumcised, their age at the time of migration and the length of time they had resided in the Netherlands.

Significance and influence of country of origin

We found few positive views on the ritual of circumcision among any of the respondent groups, with only a few respondents saying that they were happy or proud of the fact that they had been circumcised. Lockhat's (2004) model showed that a negative assessment of trauma may be predictive with regards to women developing PTSD. In this study, however, only one in six respondents demonstrated trauma-related complaints, in spite of the fact that respondents demonstrated a predominantly negative view of circumcision. Respondents from Sudan showed the highest scores on both questionnaires, while Somalian respondents had much lower scores, with the second lowest scores on the HTQ and the lowest scores on the HSLC. It was remarkable that Somalian women presented with a much lower incidence of complaints in view of the fact that most respondents from both Somalia and Sudan had been infibulated and had been circumcised at around the same age.

The differences in the extent to which women presented with complaints begs the question of whether Sudanese respondents' assessment of circumcision was more negative than that of Somalian respondents, as shown in Lockhat's model. Three findings from the current study provide the arguments needed to answer this question:

- 1 The quantitative analysis showed that cognitive reinterpretation as a coping mechanism was more frequently used by Somalian respondents than by those from other communities. Moreover, religious factors appeared to play a greater role for Somalian respondents than for those from other communities. It was clear from the interviews that Somalian respondents were more likely to use religious activities as a type of coping with problems than Sudanese respondents. In addition, the fact that FGM was not mentioned in the Quran was very important to a larger number of Somalian women than Sudanese women. Moreover, Somalian respondents were the only ones who mentioned that the *sunna* type of FGM was allowed according to the Holy Book. In contrast, all Sudanese respondents rejected the *sunna* option. All of this leads to the question as to what extent this new interpretation (*Idjtihad*) of what is written in the Holy Writ has led a number of Somalian respondents to a less negative assessment of circumcision than that found among Sudanese respondents.
- 2 More Sudanese than Somalian respondents had received information about FGM. Responses to the questionnaires showed that women who had been informed were more likely to present with complaints associated with anxiety, depression and trauma than women who had not been informed. It was also apparent from the interviews that Sudanese respondents were much more forthcoming when it came to talking about complaints resulting from having been circumcised. It is possible that Sudanese respondents were more aware of the consequences of the circumcision.
- 3 It was clear from the interviews that Sudanese respondents often responded in a frank manner to questions which were avoided by or not really answered by Somalian respondents. During focus group discussions and conversations

with the interviewers we often heard it said that Somalians tend to prefer to keep things 'in house' and that they are quite 'reticent'. It is also said that Somalians are too 'proud' to admit to any complaints, let alone mental health problems. Hence it is not inconceivable that Somali respondents did not speak their minds when the questionnaires were conducted and that they may have under-reported any problems.

In brief, it is possible that Somali respondents were less likely to arrive at a negative assessment of circumcision on religious grounds and that they were also less likely to have reported any complaints, when compared to Sudanese respondents.

Pain, memories and mutual maintenance

It became apparent that women who had clear memories of being circumcised were more likely to have trauma-related complaints, anxiety and depression. However, aside from the memory of the circumcision itself, subsequent events also gave rise to painful memories: in particular the first sexual encounter (*coitus*) and childbirth. Our findings confirmed the results of Johansen's (2002) study where respondents also described the aforesaid three events as being very painful physically speaking. In this context Johansen described a change in the significance of FGM for Somali immigrants as a result of migrating to Norway. Where this was previously seen as a ritual all women had to go through, it was now spoken of in terms of a 'painful moment'. The findings of the current study also confirmed those of Loeber's (2008) research into pain encountered during women's first sexual encounters. During her study at the *Rutgershuis* in Arnhem, the Netherlands, more than half of the African women in her study indicated that they experienced 'more than a little pain' during sexual intercourse. Many of the infibulated (and other) respondents in this study also indicated that they had experienced their first sexual encounter as painful.

It appeared that, when recalling the circumcision or associated events, experiences of pain and frustration had a major part to play in the incidence of problems. Women felt frustrated because of the feelings of shame and powerlessness they experienced in situations like that. There was a recurrence of pain, both physical and psychological, for a number of infibulated women in particular, whenever they had sex. This pain triggered memories of earlier painful experiences. The mutual maintenance model proposed by (Asmundson et al., 2002) appeared to apply, whereby physical pain keeps the memories alive and with them the consequences of previous traumatic experiences. Pain 'maintains' the women's sleeping problems, their avoidance of triggers, anxiety, loss of impulse control and other complaints. And also vice versa: thinking about what happened at the time (or talking about it) reawakens the pain. It was apparent from the interviews that this was the reason why quite a number of respondents did not want to talk or even think about FGM.

It is important to point out that these signals and psychological phenomena were not recognised as such by the respondents. This was partly due to the fact that they rarely associated things they considered to be normal with psychological problems and complaints. However, the fact that women had not been allowed to discuss any complaints resulting from circumcision for a long time (taboo) also played a role. Moreover, the lack of a conceptual framework for verbalising psychological and psychiatric problems in the countries of origin may also have played a part. People often assured us that Somali and Sudanese languages had no word for depression, while the concept of ‘flashback’ was also unknown. Interviewers did not always persist with questioning in order to not needlessly cause the other person ‘pain’, but possibly also because of the lack of a vocabulary needed to discuss psychological problems.

The influence of background variables such as age and level of education

We did not find an association between the age at which women had been circumcised and anxiety and depression-related complaints, however we did find an association between the former and trauma-related complaints. The older the women were at the time of circumcision, the more likely they were to report PTSD complaints. Women from Sierra Leone had a much better recall of the circumcision, because they had been circumcised when they were older, while women from Eritrea had been circumcised as infants, though both groups of women had undergone the same type of circumcision (clitoridectomy). Respondents from Eritrea reported the least PTSD-related complaints and were proportionally less likely to report complaints during the interviews. Respondents from Sierra Leone were more likely to report problems, especially of a psycho-sexual nature, and expressed horror when recounting what they had been through.

The absence of an association between age at time of circumcision and anxiety and depression may also be to do with the differences in the way the syndrome had come about and the course it had taken. In diagnosing PTSD the focus is on the trauma, an identifiable event in the past, in this case the circumcision. Where women recalled this event clearly, complaints of PTSD were reported. Other stressors impacted on the incidence and course of depression, including the loss of something familiar and the feeling of having been uprooted (*bereavement*), physical and mental exhaustion, the socio-economic situation and interpersonal relationships within the family. In other words, depression is linked to a complex of actual stressors, more so than PTSD, and depression often evolves after some time. In their state-of-the-science review on PTSD and depression, Nemeroff et al. (2006) wrote: ‘Depression may be conceptualized as an end-product of failed adaptation to chronic emotional stress’ (p. 10). It was clear from the qualitative data that in the case of some respondents the ongoing pain during sex or an aversion to sex, in combination with problems within the family and long-term tensions led to exhaustion and eventually to depressive complaints. Answers to the questionnaires indicated that

being unemployed (and not having money?) might be correlated to feelings of depression. Hence it is likely that factors other than age at the time of circumcision, particularly current stressors, were more influential when it came to the incidence of depression.

Researchers had expected to find a higher incidence of psychological problems among those women who had lower levels of education. This was, however, not confirmed by the findings of the current study. The absence of an association between mental health complaints and education, may be due to the fact that the majority of women in the sample had attended schooling at a secondary or tertiary level.

5.1.3 Relational consequences

No significant association was found between having children and the presence of psychological complaints. The researchers had expected women with children to have more problems. The expectation was that the painful experience of childbirth combined with the episiotomy and subsequent stitching up of the vagina among infibulated respondents might be experienced as problematic. One possible explanation for the fact that we did not find any significant association in this respect might be the fact that women experienced the consequences of this painful event, i.e. the birth of their child, as positive.

It was apparent from the interviews that the circumcision had a considerable impact on family life. The women's relationship with their partners seemed to be essential to their (sexual) well-being, especially in those cases where women had been infibulated. The pain associated with penetration, starting with the wedding night, meant that the partner played an important role in how the woman experienced her circumcision and the extent to which she was troubled by psychological and relational problems. Men who held on to the tradition out of self-interest (putting their own enjoyment first) and who took a self-centred approach, made it difficult for women to enjoy sex. However, when partners took their time with each other, sexual satisfaction was achievable. In this we agree with Catania et al. (2007) when they concluded that: 'Healthy mutilated women, who did not suffer from grave long-term complications and have a good and fulfilling relationship, may enjoy sex' (p.1675).

One last aspect worth mentioning here is the extent to which the women's partners were still influenced by their mothers (in the home-country) and were agreeable to having their own daughters circumcised. It was clear from the interviews that women's daughters were sometimes circumcised whilst visiting the country of origin, sometimes against the wishes and unbeknownst to their mothers. This corresponded with findings from a study by Vissandjée (2003). Her study showed that women from at-risk countries who settled in Canada in-

dicated that their mothers-in-law in the country of origin still had considerable influence when it came to whether their granddaughters were circumcised or not. Research conducted in the Netherlands by Dekkers, Hoffer and Wils (2006) among twelve mainly Somalian women indicated the important role a young girl's grandmother played in this decision.

5.1.4 Migration factors

Migrating to the Netherlands had triggered a lot of things for respondents. In general, they felt at home in the Netherlands, but they felt excluded whenever circumcision came to the fore in their interactions with people who were not from one of the at-risk countries. Where circumcision was previously taken for granted, this now appeared to have changed into a situation where people were opposed to this ritual. This change of view had been due to respondents finding out that circumcision is not a religious precept and had also been due to the fact that circumcision is prohibited in the Netherlands and due to the attention it had been given in de media. A study by Johnsdotter (2009) showed that the same was occurring among Eritrean and Ethiopian women in Sweden. They had gradually become aware that things could be different, that there was no need for this to be done. The study also showed that Somalian respondents, in contrast, were more likely to be of the view that FGM did not have a great many negative consequences. Our study also showed that there was a difference in the extent to which Sudanese and Somalian respondents reported problems. An increased awareness since arriving in the Netherlands of the consequences of FGM and the women's wish to prevent their daughters from misery and pain had resulted in the fact that FGM appeared to be coming to an end in the families of respondents. Hence any daughters born in the Netherlands had very rarely been mutilated. This corresponded with the findings of research carried out in Sweden. Berggren et al. (2006) indicated that almost all the women in her study used the strict legislation to support their decision to protect their daughters. Research carried out by Morison et al. (2004) in the UK also supported similar findings: Somalian women who had migrated to the UK at a young age were found to be significantly more likely to reject the practice of circumcising young females. Lastly, a recent study conducted by the TNO [Netherlands organisation for Applied Scientific Research] showed that figures in relation to the prevalence of FGM in the Netherlands were in fact much lower than had been assumed: four out of ten women from at-risk countries who visited a midwife's practice in 2008 were found to have been circumcised, rather than nine out of ten, as had been generally assumed (Korfker, 2009).

The specific role of language skills

Because of information sessions and the attention given to it in the media, some respondents now recognised what consequences FGM had. They had become more aware of any problems they might have as a result of having been

circumcised (awareness raising). The findings showed that respondents who did have complaints were not always able to find the right words and did therefore not always receive the support they expected. Especially the fact that they were not able to indicate what they wanted during childbirth and did not understand what was said to them was felt to be humiliating. Bad experiences with service providers in the Netherlands were partly blamed on the fact that they had not been able to speak or understand Dutch at that point in time. The quantitative findings indicated an association between the presence of mental health complaints and language skills, which constitutes one of the aspects of acculturation. Respondents who did not have the appropriate skills – in particular those who were not proficient in the Dutch language – were more likely to report complaints, especially anxiety and depression. This finding corresponded with the results of previous research into this aspect of acculturation and psychological well-being (Bhugra, 2003; Bhugra et al., 2009; Kamperman et al., 2003).

5.1.5 Experiences with service providers

Respondents indicated that they had had both positive and negative experiences with service providers. They had had good experiences with doctors and service providers in asylum seeker reception settings due to their knowledge, sensibility and resolute actions. Bad experiences were often associated with feelings of embarrassment or shame and exclusion. For those respondents who had been infibulated, shame and insecurity came into play whenever people were staring at their genitalia or when the eyes of bystanders showed uncertainty or repulsion. Aside from having trouble with the *medical gaze*, many circumcised women did not want to be seen as victims. Both of the above were felt to be humiliating; in addition they hampered the provision of care and negatively affected women's willingness to approach service providers in the case of any complaints. This corresponded with the findings of a Swedish study (Berggren et al., 2006) which showed that if service providers demonstrated the behaviours described above, pregnant women from at-risk countries 'preferred to stay at home, even if they knew they had health problems' (p. 54).

Having an understanding for tradition and respect for the person and their identity were key words which enabled a discussion. This is something that has been pointed out in previous publications as well. With regard to Somalians, it is a well-known fact that FGM has long been part of the experience of all Somali women and that it strikes at the heart of their cultural and gender identity (see also Van der Kwaak, 1992). After migration, the members of a community seek each other out and are known to adhere to their own traditions – sometimes even more so than when they were still in the home-country. For this reason Whitehorn et al. (2002) also agreed that it was crucial to show an understanding for the fact that 'seemingly abhorrent practices such as FGM might serve as an affirmation of cultural identity' (p. 165).

5.1.6 Coping

We expected the use of support-seeking coping to result in a decline in mental health complaints. However, one of the findings which struck us was that women who sought support did not present with less PTSD symptoms, but in fact presented with more complaints of anxiety or depression than women who did not seek support. It is possible that seeking support had a negative effect if the support received was not adequate. The manner in which support was offered may also have had an impact. If support was given by family or friends who showed an understanding and appreciation and who could be depended upon, this may have had a positive impact on the complaints. Being faced with critical comments, however, may have led to increased tension, which may have made problems worse (Lincoln, Chatters & Taylor, 2003). The interviews showed that a number of respondents had indicated that they did not receive a lot of support from people who were important to them, like their partners or mothers (in-law). A considerable number of respondents felt lonely and felt like a spectacle when seeking the help of service providers in the Netherlands, particularly when they were giving birth.

Support seeking coping also appeared to be associated with physical disabilities and anxiety-related pain (McCracken et al., 2007). This study confirmed that increased anxiety levels were associated with a perceived lack of support: some women stopped seeing their family doctors after a humiliating experience. In such cases unsatisfactory support-seeking coping turned into avoidance coping. In addition, avoidance as a way of coping may be specific to this intimate topic and may be in line with remaining silent about complaints and not discussing this taboo topic (Nienhuis et al., 2008).

In conclusion, we may state that, no matter how contradictory this may seem, both support seeking and avoidance coping styles seemed to be associated with higher levels of complaints of anxiety and depression.

The importance of coping: four types

Migration involves a change in a lot of areas and is accompanied by the problems and stressors with which migrants are faced. The circumstances of migration are determined by factors such as the person's socio-economic status, reasons for coming to the Netherlands, length of stay in the Netherlands and the person's own statements concerning their health. In a study which examined the way in which Turkish women dealt with their roles as migrants, Thomaes et al. (1997) distinguished four types of migrant women; the 'mothers', the 'advocates', the 'religious women' and the 'nameless'. Previously Kramer et al. (2003) had suggested a typology of the various categories of asylum seekers depending on how they adapted to their new environment. They distinguished between the 'puppet', the 'hibernator', the 'battler' and the 'explorer'. In both cases, the taxonomy helps the service provider to identify which type of help-seeking behaviour fits which category. It should be added

that there are no fixed patterns, as people change all the time, amending their roles and positions depending on the context. In our study, the type of circumcision women had undergone also played a role, in addition to the aforesaid factors. As we have shown above, the way a circumcised woman dealt with her complaints was also influenced by the way her partner responded to her sexual limitations and the way service providers responded when they first spotted the mutilated area. We also looked at the degree of influence a woman said she felt she had over her situation: did she dare to say No, did she stand up for herself?

The taxonomy below involves a categorisation of groups of women based on how they dealt with the fact that they had been circumcised and whether they sought help or avoided seeking help. The taxonomy also identifies the most urgent aspects and in part implies options for service providers as to what can or cannot be addressed.

Broadly speaking, we can distinguish four types of women:

- 1 the adaptives;
- 2 the religious;
- 3 the disempowered;
- 4 the traumatised.

The adaptives – The ‘adaptives’ were troubled by problems (of a physical and sexual nature) but they were able to cope with these. They talked about what bothered them and, if need be, went to see a service provider. Some had severed contact with their family in the home-country. They often took an independent position. Key was that this type of circumcised women enjoyed a good interaction with their male partners: with the latter taking the women[’s] [wishes] into account when they were having sex, (they didn’t rush things, they accepted the fact that the women did not always feel like having sex, etc.). Two respondents indicated that the situation at home gradually evolved. In the words of one respondent, there are ‘other ways of achieving satisfactory sexual contact’ even when the woman has been infibulated. This small group of women considered FGM as a *fait accompli* but often actively opposed circumcision within the Netherlands. It was this and also activities such as walking, reading a book and talking about it which gave them strength.

The religious – This group of women also suffered complaints, but what characterised them was the fact that they said they knew how to deal with these. Their discourse about FGM (their reason for denouncing the present code of behaviour) had its roots in the Quran or the Bible. Religion determined their identity and the way they coped. These women sought out like-minded women; in the case of Muslim women, the opinion of the *umma* (the religious community) was important. Sometimes their relationships with those who thought differently were not as good. They insisted that sexuality was a private

matter, which made it difficult to talk about. The religious found a lot of comfort and strength in prayer and in attending services. On the one hand, they accepted that which was expected of them as a religious woman and they were opposed to FGM based on the fact that it is a cultural custom, not based on either the Quran or the Bible, and that this made it a practice which was okay to change. As a group, the religious reported less fear and depression than non-religious women, and this may have been reflected in their adaptive coping. This coincided with the findings of earlier research (e.g. Brune et al., 2002; Khawaja et al., 2008).

The disempowered – The women in this group felt angry and defeated. However they bore their grief and did not see any way out. There was substance abuse, bingeing or watching too much television. They did not talk about what was done to them, they felt ashamed, alone and disempowered. They either avoided sexual contact or dissociated during sex. This often contributed to the poor relationships they had with their husbands. However, they did not wish to get divorced, nor did they wish to talk about things, they left things to their husbands. These women behaved in a manner which was inhibited emotionally and they had trouble letting go of their negative experiences. Sometimes they had serious psychological problems, but either felt inhibited or their husbands simply did not allow them to discuss these with a service provider. This category of women was characterised by hidden tension and a tendency to fatalism.

The traumatised – Of all subgroups, it was this group of women for whom things were hardest. This involved a small number of respondents who were experiencing physical, social and sexual problems. These women mostly had been infibulated and they suffered a lot of pain and sadness. They were either divorced or had a bad relationship with their husbands. They were often troubled by recurrent memories, sleep problems and chronic stress (at the thought of having sex, when reproached by their husbands, etc.). They felt misunderstood by their immediate environment and sometimes by service providers as well. Women in this group consciously isolated themselves in order to avoid confrontation. Shame, anger and reproach (also aimed at their mother or mother-in-law) played a major role, however these women did not know how to cope with these. One respondent indicated that she was seeing a psychiatrist, however she had never talked to him about the fact that she had been circumcised. The interview which was conducted as part of this study made it clear that her circumcision was an important underlying cause of her problems. Another respondent terminated the interview halfway through because she found it too difficult to carry on. According to the interviewer this was due to unpleasant memories resurfacing. As a group, the traumatised reported a higher incidence of anxiety and depression than other groups, which illustrated the difficult situation in which they found themselves.

5.2 Methodological considerations

Research has its ups and downs – and research involving immigrant target groups is no exception. Issues may involve data collection, the reliability of data and the generalisability of findings. There are several methodological issues which deserve attention in this study. These partly concern aspects involving the content and especially the question of whether the research design was such that a valid answer to the research questions could be obtained. Other limitations concern the technical aspects of the research.

5.2.1 Representativeness of sample

It may be that the sample was not optimally representative. The respondents were recruited from among those women who did not have a problem with talking about the fact that they had been circumcised and the consequences thereof: women, in other words, who may be said to have already broken through the taboo. It is possible that women who did not wish to discuss this topic had more problems or different types of problems. A number of the interviewers were key people within their communities. It may be that those who favoured the practice [circumcision] were not approached, or that they did not wish to be interviewed, fearing that this might get them into trouble. In addition, it is quite possible that some women refused to participate for fear of being recognised in the eventual report as someone who was in favour of this practice, which is illegal in the Netherlands. In short, our group of respondents probably contained a disproportionate number of those who were fighting to abolish FGM, and in that sense the respondents did not constitute a representative sample.

In addition there were some interfering factors. To what extent did the socio-economic situation (SES) of these migrant women have an impact on the way in which they perceived their own health in the Netherlands? The SES of these women has only been marginally considered in the study. In addition, this group of respondents had often experienced violence, including rape, during the war or whilst fleeing to the Netherlands. Other traumatic events or personal problems which were outside of the scope of the research (e.g. factors such as pretraumatic morbidity and personality traits) may have affected the way in which women experienced their circumcision. This came up for discussion during the interview in a few cases. In other words: there is no simple answer to the question of ‘whether psychological complaints were caused by being circumcised or by being raped’ and, in relation to this, to what extent we were dealing with sequential traumatisation (Keilson, 1979).

In addition, the method used to recruit respondents may have limited the generalisability of the findings. This was a cross-sectional study. The so-called snowball sampling method is often used to explore relatively hard-to-reach

groups such as migrants, especially where there is a taboo on the topics concerned. However samples selected using this method lack randomisation and cannot be compared to samples selected using representative sampling methods. Even so, this method is recommended for studies where population traits are not clear and a certain resistance to participation is to be expected (Kaplan, Korf & Sterk, 1987). In view of the frequently occurring reticence of ethnic minorities to participate in scientific research studies, this data collection method is recommended (see also Crescenzi et al., 2002; De Jong & Van Ommeren, 2002; Okazaki & Sue, 1995).

The sample appeared to be sufficiently representative; however it was difficult to assess this adequately. It was difficult to arrive at a sufficiently accurate assessment of either the target group populations or the response rates. This should not necessarily pose a risk to the validity of the findings (see also Van Loon et al., 2003). However, it would have been better if the respondents had been recruited at random. Unfortunately, the municipal administration system for the personal records of the residents of Dutch towns does not maintain data on ethnic background, except for the bigger ethnic groups. This seriously hampered any at random recruitment; at the time the study was conducted it was impossible to find out where women from at-risk countries resided in the Netherlands. Moreover, it would have been better if the study had involved a control group. As it was, we do not have any comparative data. Finally, this study could have included participatory observation, because we were trying to arrive at the emic view. Further insight into what actually happened at home, in the hospital, during information sessions or in the home-country might have increased the validity of the data. All in all, there is reason to observe some reticence in arriving at generalisable conclusions based on the findings of this study.

5.2.2 Reliability and validity of data

One of the main limitations of the current study lay in its reliance on self-reporting. As an example, respondents may have felt uneasy talking about what they had been through and about consulting certain types of service providers. In order to minimise the possibility of respondents providing ‘socially desirable’ responses, the interviewer would explain at the outset of the interview that it was all about the views and experiences of the respondent and that there were no good or bad answers. In addition, it was stressed that respondents would remain anonymous. Attempts were made to limit the possibility of socially desirable answers in the interviews themselves by avoiding closed questions and by keeping questions open at first. This was always based on information provided by the respondents themselves.

The reliability of the research was also enhanced by including a number of questions in the interviews which were aimed at identifying the same informa-

tion. It is conceivable that answers were also slightly affected by the interviewers' cultural backgrounds. On the one hand, it is possible that respondents tended to open up more and be more 'candid' towards interviewers from the same ethnic group, however it is also possible that respondents were more reticent because they were afraid of gossip (see Knipscheer & Kleber (2004a en b, 2006) for a similar discussion about the importance and effect of ethnic matching in the provision of health and social care).

In order to further enhance the reliability of the research, questionnaires were extensively discussed with interviewers during training. Research instruments were modified based on the resulting suggestions. The reliability of the data collected with the aid of both HTQ and HSCI was excellent. These questionnaires have now been used in many countries and have been demonstrated to have satisfactory psychometric qualities from a cross-cultural perspective (see for instance Hansson et al., 1994; Kleijn et al., 1998; McKelvey & Webb, 1997; Mollica et al., 1992; Smith Fawzi et al., 1997). Meanwhile, the reliability and validity of the Lowlands Acculturation Scale have also been demonstrated (see Mooren, 2001; Knipscheer et al., 2009). At the time of writing, there was no data available about the cross-cultural validity of the COPE-Easy questionnaire.

In spite of a possibly less than optimal methodological setting, the current research project was unique in character. The data collection and sampling methods and the active and intense participation by the target group could be called advanced while the *mixed methods* strategy could be called a strong point. Therefore, the study may be called successful in a number of respects, in spite of the aforesaid logistic, organisational and psychological factors which hampered the research. The contact persons and representatives of the women's organisations were downright enthusiastic. Their interest in and involvement with the research provided the researchers with additional motivation. In addition, in spite of the many complicating factors, a large number of respondents did cooperate. They openly talked about their personal experiences, their (psychological) well-being, their support seeking behaviours and their views on Dutch society and the provision of health and social care. In short, in spite of the complications, information obtained from focus discussion groups, structured questionnaires and topic interviews, provided sufficient underpinnings to be able to reliably answer the research questions.

6

Conclusions and recommendations

This chapter will present the main conclusions and recommendations. The research findings serve a dual purpose. Firstly, it is hoped that the findings may be used for the development of interventions aimed at assisting women who have undergone a form of genital mutilation. For this reason, relevant recommendations are obviously directed at the health professionals working with these women. Secondly, it is hoped that the research findings will constitute a valuable contribution to the body of knowledge about FGM.

6.1 Conclusions

1 Psychological symptoms are concomitant with FGM – but not by definition

Our respondents were found to show signs of psychological, social and relational consequences as a result of FGM. Symptoms of anxiety and depression were found among one third of the respondents, while one in six respondents suffered trauma-related symptoms. Respondents who had undergone a milder form of FGM also reported post-traumatic symptoms. For a substantial group of women, the fact that they had been circumcised coincided with an incidence of mental health symptoms, but not all circumcised women appeared to suffer these symptoms.

2 Serious symptoms might be attributed to a combination of factors

A combination of infibulation, vivid memory, migration at a later age, low levels of education and language skills and inadequate support from the partner were concomitant with serious symptoms. In particular women who had been infibulated, who had come to the Netherlands at a later age and who did not hold a job indicated feelings of depression and anxiety. Having a vivid recollection of their FGM also played a role. When experiencing symptoms, these women were not always able to find the right words to express themselves. They sometimes appeared to feel embarrassed and inhibited and failed to re-

ceive the support they were seeking and needed. The relationship with their partner played a crucial role in how they experienced sex. When their husband was considerate and mindful of their pain and limitations and demonstrated the patience to follow their wives' cues, satisfaction could be achieved. However, in those cases where the wives did not experience any support from their husbands, frequent and violent rows sometimes occurred. The inability of wives to meet the (sexual) demands of their husbands could sometimes lead to chronic stress and exhaustion, and had on occasion even resulted in divorce.

3 Pain triggered a lot of distress

Recurring pain and infections affected the occurrence of psychosocial and relational problems by triggering memories of either the FGM per se, or of situations adversely affected by this event (time of first sexual intercourse, childbirth). Chronic pain and bad memories mutually reinforced each other and led to a situation of *mutual maintenance*. In a number of cases, pain during love-making had an adverse effect on the relationship with the partner, and as a result, on occasion, this had also had an adverse effect on family life.

4 Taboo on talking about FGM a major influence

The impact being circumcised had on a woman's psychosocial well-being and whether or not she reported the fact that she had been circumcised when experiencing symptoms was highly influenced by the women's ability to talk about it. The social imperative (taboo) and the fact that FGM influenced the way a woman experienced sex (a private matter) made respondents more inclined to keep symptoms to themselves and to avoid (the effects of) FGM as a topic of conversation. These women were used to keeping silent, which was the socially acceptable thing to do within their community, even after migration to the Netherlands. Perhaps keeping silent offers more of a sense of security than talking about the issue. In other words, talking about it may cause insecurity and/or stress. Underreporting of symptoms appeared to be an important factor in explaining the relatively low number of women reporting serious psychopathologies. The taboo on talking about FGM and its effects may have played a role. That may mean that, while the figures appear relatively low, more depression, anxiety and trauma-related symptoms occur than are in fact reported.

5 Hinge moments are crucial to symptom development

In addition to the FGM, subsequent experiences also appeared to have a bearing on the development of symptoms. These could include the first sexual experience or childbirth. Women who had been infibulated in particular described these experiences as traumatising, especially when the women were sewn up again after the birth, as is common practice in their country of origin. The provision of culturally sensitive care and attention without bias are important during childbirth, in order to avoid humiliating experiences with healthcare workers which may subsequently lead to reduced therapy compliance.

6 Dysfunctional coping was linked to higher rates of symptom reporting

Our research showed a high incidence of avoidance and substance abuse, but also of excessive snacking and watching tv. This is a coping style which is dysfunctional in dealing with the symptoms. Avoidance was an important coping mechanism for our respondents. They tended to show a certain reluctance to discuss their FGM, because this opened up old wounds. Others actively avoided talking about the issue after having experienced feelings of being misunderstood or because they felt it was too personal.

7 The influence of acculturation skills was a crucial factor

In addition to the findings relating to our research questions, the conclusion is warranted that the social position and level of social integration of the groups were some of the deciding factors. The women's level of fluency in the Dutch language and the extent to which they felt comfortable in the Dutch (health) care system co-determined whether women did or did not talk about their symptoms and the social problems resulting from their own FGM or those experienced by their daughters. If the issue was discussed, the subject appeared to be broached in an indirect manner; this 'veiling' of the pain occurred to a greater or lesser extent across all communities. This demonstrated clearly that different integrated care models and interventions need to be used in order to reach these women.

8 Whether FGM was a religious requirement was of key importance

Despite having been infibulated, Somali respondents reported fewer mental health symptoms than all other respondents. This may be explained by under-reporting. On the other hand, what got our attention was the fact that many of them named the Quran as their most important coping mechanism and frame of reference. A number of Christian respondents from Sierra Leone and Eritrea also indicated that they felt supported by their religion and by their fellow believers. An additional statistical analysis showed that the 'religious' subgroup reported fewer feelings of anxiety and depression than any of the other subgroups. Both Muslim and Christian respondents felt morally and socially supported by the fact that FGM was not mentioned in their Holy Books and discussed the issue among themselves.

9 The role of media attention

Media attention and targeted information helped respondents recognise the effects of FGM. The attention in the media and debates among themselves and with third parties helped strengthen respondents in their rejection of FGM. In the Netherlands, none of the respondents' daughters had been subjected to FGM. The women's new-found knowledge was used to argue against FGM in discussions with relatives in the country of origin.

10 FGM appeared to be a dying practice in the respondents' families

Their migration to the Netherlands triggered a lot of things for our respondents. Their previous acceptance of FGM as the obvious course [of action] appeared to have changed into active resistance against this ritual. The realisation that FGM is not a religious requirement has influenced their change in attitude, as had the ban on FGM in the Netherlands. These changes as a result of their migration, the women's increased awareness of the effects of FGM and the desire to spare their daughters any suffering, have resulted in FGM apparently becoming an obsolete practice in the respondents' families.

6.2. Recommendations for service providers

The findings of this research yield a number of recommendations for [health] care workers:

- 1 Care must be taken not to label all circumcised women as 'psychiatric' or 'problem' cases, as it became obvious that certainly not all respondents suffered serious symptoms. In addition, the role of other migration-related and social factors must be expressly taken into consideration. In order to achieve this, extensive cooperation between practitioners in health care facilities and social services should be ensured
- 2 It is important that the new insights cited above be explicitly incorporated into the care of these women. This includes structural attention to their experiences and providing them with coping mechanisms to help them come to terms with their experiences. In addition, they should be helped to gain practical skills (including language competency) to help them hold their own in Dutch society.
- 3 Using therapy to equip these women with instrumental skills to help them cope in day to day life and promote social integration (for example, by enrolling in education/training programmes) in order to avoid social isolation, would also be a good starting point for improving mental health.
- 4 There is a need for better information regarding the kind of services the public (mental) health facilities can and cannot provide. Therapies must be tailored to the clients' social and cultural environment. However, therapists must take care not to focus exclusively on cultural and adjustment problems as an explanation for the symptoms presented, as this would involve ignoring underlying pathologies. At the same time, therapists must be open to the idea that the client's condition is not necessarily an indication of a psychological affliction resulting from their FGM, but rather the result of social, political and economic pressures.
- 5 It is the combination of acculturation issues and socio-demographic characteristics that in addition to the FGM itself proved an additional risk factor, warranting extra attention from service providers and policy-makers. Enhancing service providers' intercultural competencies and enabling a more flexible combination of material support (including assistance with financial and work-related issues) and assistance of a non-financial nature is recommended.

As for therapy, the role of acculturation can be explicitly incorporated into the treatment.

This research also provides a number of practical suggestions for healthcare professionals

- 1 It is important that healthcare professionals are well-informed about FGM. A healthcare professional dealing with FGM should be able to discern the various types, be knowledgeable about the related symptoms and the effects these may have, as well as be aware of the (cultural) background and the taboo surrounding the practice.
- 2 Having the right attitude will enable a meaningful dialogue. An understanding of the tradition and respect for the individual are crucial. In addition, the professional is expected to act with confidence and assurance, in particular when it comes to acute medical care and internal examinations.
- 3 In examination rooms, the number of people present should be limited to those who are indispensable. Preferably only women should be present when internal examinations take place. The number of non-experts should likewise be restricted. Students and interns should have had prior contact before assisting at an internal examination. Curiosity alone is not sufficient reason and can be highly confrontational for the patient (stigmatisation).
- 4 Traditionally, the reluctance to talk about the effects of having been circumcised is considerable. Discussing these issues can cause substantial distress, so a relationship of mutual trust is of the utmost importance. In order to achieve that trust, care workers must confer with their patient as to the next steps in their treatment.
- 5 If there is a language problem, it is advisable to contract an interpreter. Healthcare professionals should never assume that they can quickly arrive at the essence of the problem; this generally requires several patient encounters and sufficient time to arrive at the heart of the matter.
- 6 Specific attention to patients' pain experience is required. Pain can trigger memories of previous traumatic experiences and vice versa (mutual maintenance). Pain during sex can have an effect on the entire family. Therefore, it is important, whenever possible, to try to involve the patient's partner when discussing pain in relation to sexual problems – in close consultation with the patient.
- 7 Healthcare professionals should be alert to specific events, including:
 - Marriage. Thoughts of the patient's wedding night may trigger anxiety. The time following the wedding requires significant adjustments on the part of the bride. Pain and trauma as well as psychological symptoms may occur.
 - Childbirth. During labour or when a woman has allowed herself to be 'closed up' again afterwards, complications are liable to occur. Childbirth within the women's circle of relatives and friends is generally a key event, which may trigger both positive and negative associations.
 - Visits to the country of origin. A visit to the country of origin can be distress-

ing because of the patient's own recollections or the threat of another FGM in those cases where they are accompanied by a daughter.

- 8 Medical disciplines confronted with FGM, including professionals working in public (mental) health care, ought to be capable of discussing circumcised women's sexual behaviour. Sexuality is crucial to their sense of well-being and their functioning as a member of their family.
- 9 Be attentive to the fact that an increase in information on (the effects of) FGM can (temporarily) increase the level of symptoms. An increased awareness may cause painful feelings to 'surface'. Support your patient through this process and contact a mental health care worker if need be.
- 10 FGM is but one of a range of possible traumatising events. Therefore, do not focus exclusively on FGM and check whether there are other factors which may be causing the symptoms presented by the patient, such as sexual assault, a lack of meaningful occupation or the (financial) circumstances of the family. Feelings of depression may well result from those.
- 11 A number of respondents indicated that they resorted to snacking when feeling agitated and distressed; some reported consuming qat and possibly other substances. Obesity and substance abuse may be included as a topic for discussion when women from these at risk countries indicate that they are suffering from tension or stress-related symptoms.

6.3 Epilogue

Based on empirical findings, the present study has shown that female genital mutilation is associated with psychological problems among a substantial group of women. However, it has also shown that the general assumption that all genitally mutilated women suffer severe symptoms should be revisited. One might have the objective impression that being mutilated and having to flee your country is by definition traumatising, however our data have very clearly shown the range of diversity with the extent of trauma and memory as a crucial factor for whether women did in fact experience psychopathology. Also the way in which the women dealt with the consequences of genital mutilation (coping) and the fact that they were migrants (migration context) played an important role. Especially women who had been infibulated, had a vivid memory of the event, and were not really embedded in society in terms of work or training. These women tended to cope with their problems in an avoidant or palliative way (i.e. through substance abuse), and were at risk of serious psychological problems. They reported the most health problems but found it most difficult to ask for help from agencies or health providers. Matters such as religious beliefs and cognitive restructuring also played a role here. It may be that these factors strengthened the person's self-identity, something which is associated with less psychological distress, compared with other women who had come to realise that they were considered 'deviant'. When feeling alone with their prob-

lems in a judgmental society, this possibly led to bitterness and increasing levels of psychological distress.

The research and the added overview (see diagram) show the intertwining of the type of FGM, immigration factors, coping styles, attitude issues and socio-demographic characteristics, which were all equally associated with the health condition. But what about the causality? The current research does not offer an answer to this question. However, one may argue that being consciously involved with one's own cultural identity, whilst actively mastering practical skills to deal adequately with life in Dutch society, will increase one's self-confidence and improve one's well being. A balance has to be sought between holding on to supportive and identity-reinforcing cultural traditions, on the one hand, and learning practical and instrumental skills within the new country, on the other hand. Preventing social isolation whilst creating more control over one's daily life at the same time, seems to be a good starting point for better health.

It is clear that the health care provided to genitally mutilated women needs to be modified. In collaboration with the women's own communities, the aforementioned public (health) organisations and stakeholders, the researchers at Pharos intend to convert the findings of this research into practical guidelines and policies. Of particular importance are the question of how to deal with women who present with medical and psychological problems and what cues may be indicative of such problems. We will also examine how the knowledge of FGM among health care professionals can be further improved. This could include support in their intercultural communication skills in relation to these problems. Finally, our findings are consistent with the contextual approach regarding migrants' requests for help in relation to mental health issues (see Knipscheer & Kleber, 2005). Increased collaboration between mental health professionals, social workers, employers, teachers and other social services is desirable and therefore needs to be addressed.

In short, even though it appears as if FGM is now a dying practice in the families of the respondents, there remains much to be done in order to provide tailor-made care which might alleviate any psychosocial suffering emerging from underneath the veil.

Diagram **Overview of risk profiles**

Theme	Risk factors	Question	Answer
(1) Circumcision	Type	Type 1, 2, 3 of 4?	Type 2 but especially Type 3
	Memory of that point in time	How well can you remember being circumcised?	I can recall being circumcised very well
(2) SES and acculturation	Level of education	What is the highest level of education you have achieved?	Low education
	Age at migration	How old were you when you migrated to The Netherlands?	I migrated at a later age
	Information	Have you received information about FGM (awareness raising)	Yes
	Job	Do you have a job/currently studying or in training?	No, I'm not working neither paid nor voluntary
	Language skills	Can you express yourself well in Dutch?	No, my knowledge of Dutch is rather bad
(3) Coping style	Support seeking	Do you talk with others about your problems, and does it help you?	Sometimes I talk about it with others but it does not help me much.
	Avoidance	Do you often feel excluded (receptive) or do you (actively) keep yourself at a distance from others?	Yes, both; active as well as receptive
	Misuse of drugs	Do you often use drugs to feel better?	Yes, that happens quite a lot.
(4) Relational	Partner	In what way does your partner deal with the sexual constraints and pain?	He has little patience and acts in a selfish manner
	Stepmother and daughter	Does your partner follow his mother's wishes when it comes to subjecting his own daughter to the ritual?	His mother's wishes are more important to him.

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VEILED PAIN

Little is known about the psychological, social and relational consequences of female genital mutilation (FGM). Researchers from Pharos, Centrum45 and Royal Tropical Institute in collaboration with FSAN (Federation of Somali Associations Netherlands) mapped the experiences of women in the Netherlands who underwent FGM/c. Ethnic similar women interviewed in total sixty-six women from Somalia, Eritrea, Ethiopia, Sudan and Sierra Leone on the psychological, social and relational consequences of their circumcision. In *Veiled Pain* women talk about their anger and anxiety, feelings of exclusion and shame, and about how they cope with their pain, complaints and sorrows. Using standardized questionnaires it was found that one third of the women have feelings of anxiety or depression while one on six claims to have trauma-related symptoms due to the mutilation.

Migration to the Netherlands has a major influence on how they regard FGM/c. What once was obviously is now deviant and raises violent responses in our society. This has an impact on the perception of the consequences of the mutilation. The women spoke in veiled terms about the consequences of FGM/c on their experience of sexuality, and the impact it has on the relationship with their partner, family life and contact with others, including healthcare providers in the Netherlands. The insights from this mixed method study are particularly relevant for healthcare workers who meet with these women.