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Pleasure, womanhood and the desire for reconstructive surgery after female genital cutting in Belgium

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ABSTRACT

Growing numbers of women are showing interest in clitoral reconstructive surgery after 'Female Genital Mutilation'. The safety and success of reconstructive surgery, however, has not clearly been established and due to lack of evidence the World Health Organization does not recommend it. Based on anthropological research among patients who requested surgery at the Brussels specialist clinic between 2017 and 2020, this paper looks at two cases of women who actually enjoy sex and experience pleasure but request the procedure to become 'whole again' after stigmatising experiences with health-care professionals, sexual partners or gossip among African migrant communities. An ethnographic approach was used including indepth interviews and participant observation during reception appointments, gynecological consultations, sexology and psychotherapy sessions. Despite limited evidence on the safety of the surgical intervention, surgery is often perceived as the ultimate remedy for the 'missing' clitoris. Such beliefs are nourished by predominant discourses of cut women as 'sexually mutilated'. Following Butler, this article elicits how discursive practices on the physiological sex of a woman can shape her gender identity as a complete or incomplete person. We also examine what it was that changed the patients' mind about the surgery in the process of re-building their confidence through sexology therapy and psychotherapy.

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"I think that I am not normal, not like other women. I have pleasure during sex and enjoy it very much but there is something missing. In the gaze of others there is always something missing."

At the FGM reference centre in Brussels (CeMaViE), as well as in other centres across Europe, the desire to 'feel like a woman' or be 'like other women' brings many migrants who have undergone female genital cutting[1] to request clitoral reconstructive surgery (Jordal, Griffin, and Sigurjonsson 2018; Villani 2015; Villani and Andro 2010). The surgical procedure, which was first developed by the French urologist Pierre Foldès in the 1990s, is

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meant to provide some relief to women suffering from the negative consequences of FGC, particularly sexual problems, but also psychological issues. The surgery is growing in popularity among migrant women and is available free of charge on the public healthcare services of various countries across the EU (End FGM EU 2021). Since Foldès' original surgical technique, surgeons have developed variations, which are described, sometimes in conjunction with other therapeutic procedures and multi-disciplinary care, in scientific publications.[2] Yet, no official guidelines or recommendations exist on clitoral reconstructive surgery and the WHO does not recommend it based on insufficient evidence (Abdulcadir, Rodriguez, and Say 2015).

Previous research has looked at women's motivations for requesting the reconstructive surgery (Griffin and Jordal 2019; Jordal, Griffin, and Sigurjonsson 2018; Villani 2015). Foldès, Cuzin, and Andro (2012) described requests as being linked to a recovery of identity, improved pleasure, and pain reduction. Sociological research addresses notions of wanting to feel 'normal', complete, and to put an injustice right again (Griffin and Jordal 2019; Villani 2015; Villani and Andro 2010).

Yet, the notion of womanhood associated with reconstructive surgery is ambiguous. What is meant when patients report that they want the surgery to 'feel like a woman'? From an anthropological perspective, the idea that 'womanhood' can be reconstructed through a surgical intervention repairs a 'female genital cutting' is intriguing, as FGC has long been associated with coming of age and initiation into 'womanhood' (Ahmadu 2000; Hernlund 2000; Johnson 2000; Ngugi Wa, 1965; Shell-Duncan et al. 2011; Shell-Duncan and Hernlund 2000; Thomas 2003). In the anthropological literature, FGC is understood as a marker of gender identity (Ahmadu 2000; Boddy 1989; Gruenbaum 2001; Johnson 2000; Merli 2010); it renders a woman honourable and respected within her identity group and grants her full status. For those who uphold FGC, womanhood is linked to belonging and to social status (Ahmadu 2000; Dellenborg 2004; Johnson 2000; O'Neill 2018; Thomas 2003). Interestingly, those who want to undergo clitoral reconstructive surgery in Belgium, and other European countries, also want to 'belong'. There is a strong desire to appear like other 'women' in their social environment, very different to the context of ritual initiation described in the earlier anthropological literature (Griffin and Jordal 2019).

In this article we are interested in the ways in which female identity can be 'reconstructed' through surgical genital modification or through therapy. We describe two cases of women in Belgium who wanted clitoral reconstructive surgery but changed their mind about the operation after having undergone therapy. Both cases have in common that they experienced intense sexual pleasure and orgasm despite having undergone FGC but requested reconstructive surgery, nonetheless. From a clinical perspective this is alarming as evidence to date shows that 23% of women have pleasure and orgasm pre-operatively experience a loss in the ability to orgasm after the surgical intervention (Foldès, Cuzin, and Andro 2012).[3] The women seeking surgery at the Brussels clinic were therefore also potentially at risk of losing their ability to experience orgasms or pleasure if operated. Public health experts, gynaecologists and the WHO have expressed a need for an in-depth understanding of the factors that discourage those who do experience clitoral pleasure from rushing into the operation (Abdulcadir, Rodriguez, and Say 2015, Abdulcadir et al. 2017; Sharif Mohamed et al. 2020).

In this paper we therefore explore notions around pleasure and its potential enhancement or loss through the operation and what this may mean for women and the discursive context in which pleasure becomes an important aspect of female identity (Griffin and Jordal 2019).

We are interested in institutionalised processes of re-building gender identity through sexology therapy and psychotherapy. In *Gender Trouble* Judith Butler (1990: 10) asks, 'If gender is constructed, could it be constructed differently, or does its constructedness imply some form of social determinism, foreclosing the possibility of agency and transformation?' Following Butler, our analysis shows that corporal sex is not pre-discursive but shaped by regulatory norms, social conventions and public discourses. Women's desire for clitoral reconstruction can be a response to discourses on the female sex and womanhood in the European context where women with FGC are often perceived as lacking part of their womanhood, regardless of whether they have any health problems linked to their condition. Reconstructive surgery as a technology carries the hope of transforming one's life and gender identity and regaining control in response to stigmatising experiences linked to the appearance of their genitals. We show that surgery is not always necessary for this transformation to take place.

Ethnographic research at an outpatient clinic: motivations and context

In Belgium there are two accredited centres specialised in receiving women who have undergone FGC. In Brussels, the reference centre was established in 2014 by Dr Martin Caillet, the gynaecologist who performs reconstructive surgery. The therapeutic team includes a sexologist, a psychologist and a midwife with expertise in caring for women that have undergone FGC. When patients first book an appointment to enquire about clitoral reconstructive surgery, they are seen by the midwife who takes down the patient history, makes the women feel at ease, and does a first examination. The surgeon then examines the patient to see if an operation is feasible. The examination of the clitoris is non-invasive and takes 60 seconds, consisting of a palpitation of the scar to locate the clitoris.[4] When the patient is dressed again the gynaecologist, explains the surgical procedure, potential complications and how long the recovery period is likely to take. The Belgian health service authorities (INAMI) stipulate that for the procedure to be reimbursed, the patient has to have at least five appointments before surgery. In CeMaViE the patients have to see the midwife, the sexologist, the psychologist and the gynaecologist. The team discusses all surgery requests in the monthly staff meetings and decides together whether and when the patient is ready for surgery.

The first author, Sarah O'Neill, was asked by the midwife, Fabienne Richard and the gynaecological surgeon of the clinic, Martin Caillet, to undertake anthropological research among patients in order to gain a better insight into what motivates women to request the surgery, treatment pathways and what helps women get better. Many women are very happy after the operation. For those who were content, regaining an externally visible clitoris was key to their personal satisfaction and improved psychological well-being, which is commonly described as follows: 'I finally walk with my head up high', 'I am proud of myself', 'I finally feel like a woman', 'I feel like an injustice has been put right', 'I feel like I've won the lottery' (also see Caillet et al. 2018). For some, the outcome of the operation is disappointing, often because they expected a significant increase in pleasure.[5] Reasons for dissatisfaction with reconstructive surgery have been insufficiently addressed in the scientific literature to date. Numerous experts have expressed concerns about the psychological outcome, psychiatric morbidity, and potential harmful consequences of the surgery (Abdulcadir, Rodriguez, and Say 2015; Creighton, Bewley, and Liao 2012). Women who have gone

through FGC are at risk of post-traumatic stress disorder (PTSD) and the experience of new pain at the site of excision, such as after reconstructive surgery, can elicit memories of the cutting and other PTSD related symptoms (Abdulcadir et al. 2017). Beltran et al. (2015) recommend that reconstructive surgery is performed with caution: women who have undergone FGC are often subject to other forms of violence (i.e. forced marriage) which may impact on sexuality in important ways beyond the sexual functioning and response of the clitoris. Abdulcadir and colleagues (2015) suggest that a better understanding of how both surgery and sexual therapy including anatomy lessons might improve sexuality and body image is needed. In response to lack of evidence on the safety of the procedure, the WHO has highlighted the need to explore alternative, multi-disciplinary approaches such as psychotherapy, sexology therapy. Based on these reflections, the team was therefore keen to explore how women's lives can be improved without surgery, as they agree that it should be the last resort.

Methods

Participant observation, informal conversations and in-depth interviews were carried out in the clinic context. In this article, qualitative data from two patients who decided not to go for the operation is discussed. Between 2017 and 2019, fifty-three patients requesting surgery were followed during 146 consultations observed.[6] These particular cases were thus purposively selected for further analysis due to emerging theory and thematic analysis during the ongoing data collection (Bernard 2006).[7]

With the patients' consent, Sarah sat in during consultations at various points in time, observing and conversing with the patient. Conversations with the patients presented in this article took place in French and English. In-depth interviews were undertaken with patients at suitable times before and/or after the operation or when the patient had made a final decision not to go for the operation. Participant observations took place during (i) reception consultations with the midwife; (ii) consultations with the surgeon-gynaecologist (although gynaecological examinations also took place during the reception appointments); (iii) sexology-therapy sessions; (iv) psychotherapy sessions between October 2017 and October 2019. With some patients, regular contact was maintained via WhatsApp (calling, sending greetings over a time period of between a few months to a few years). However, the two patients presented here did not keep in regular contact beyond meetings at the clinic.

Positionality of the ethnographer

Having done extensive research in various African countries and having lived in rural Fouta Toro in northern Senegal, Sarah has reached a conversational level of fluency in the Pulaar language. Furthermore, she has extensively worked on FGC in Senegal, Guinea and diaspora. Being able to converse with some patients in their mother tongue and being very familiar with their cultural references has made patients particularly of Haalpulaar origin from Mauritania, Senegal and Guinea open up in conversations. During gynaecological consultations Sarah often chats to patients to make them relax, holds their babies if necessary or plays with the children, if the patient needs to focus on the consultation. In-depth knowledge of the cultural background of patients has also helped, at times, during sexology or

psychotherapy consultations, to contextualise practices and beliefs linked to sexuality and culturally endorsed customs linked to marriage and other perceived obligations. Although as a researcher Sarah is not in a therapeutic relationship with patients, at times patients relate to her as part of the team, as someone able to help out and ask for her personal opinion. When this happens, Sarah states that she is not part of the consultation team but a neutral researcher with no vested interest in any of the medical or therapeutic forms of intervention. Yet, Scheper-Hughes (1995: 419) argues in the *Primacy of the Ethical* that the act of witnessing positions the anthropologist 'inside human events as a responsive, reflexive, and morally committed being, one who will 'take sides' and makes judgements'. Despite the anthropological code of conduct that stipulates nonengagement with either ethics or politics as required in a culturally relativist stance, the ethnographer agrees with Scheper-Hughes that when sincerely and closely engaging with individuals and being drawn into their personal lives and decisions, it is impossible and potentially even unethical to remain a passive and un-involved 'fearless spectator' of social life. Furthermore, in the ethnographer's view, in the process of immersion and building empathy, taking sides with the informant and wishing them the well is part of the process, particularly when working on FGC, sexual violence and medical interventions linked to these phenomena, even if such social interactions no longer appear culturally or morally relativist (Scheper-Hughes 1995).

Ethics review

This study was approved by the local hospital ethics committee O.M. 007 of CHU Saint Pierre hospital on October 16th, 2017—reference number: B076201733644. All study participants provided written informed consent to participate in this research and were asked each time if they agreed to the researcher sitting in during the consultations. Strict confidentiality and anonymity of the respondents was ensured. The names and personal identifiers of the patients in this article have been changed.

Results

In the following sections, the two cases of women who decided against the operation are presented in the voice of the ethnographer and first author. Pseudonyms are used and personal identifiers have been changed to protect patients' anonymity.

Penda—'for me it was the "gaze" of others'—genital modification to avoid stigma

I meet Penda on the day of her first consultation. She is a 42-year-old Malinke woman from Guinea, very well dressed in Western-style clothes. She comes across as very confident and highly educated. It turns out that she is the daughter of a diplomat. I walk in while she is talking to a medical student who introduces me to her. I greet Penda warmly. Many patients come in with complaints linked to pain and discomfort during sex, but Penda experiences pleasure, generally enjoys sex and says that it is an important part of her life. With existing research on potential loss of pleasure in mind, I ask her if she is aware that she might lose this pleasure through the operation and whether she

is not afraid that her sensitivity may be reduced and that she may lose the ability to have orgasms. She replies that she wants to put back what was wrongfully taken away and that she has already made up her mind and that we cannot change her decision anymore.

Two months later Penda has her first sexology appointment. She says that her current partner, who she is in the process of separating from, does not know how to sexually satisfy her. Sometimes it feels like something is missing.

> 'Everytime you meet a man you need to prepare him and explain "listen, I was excised…"'

> Cendrine, the sexologist responds: 'But you know every woman is different. When babies are in their mother's womb, they already look different, every vulva is different just like people's faces. Some people have big noses or small noses and big eyes. And when a man is going to sleep with a woman he always has to search for the clitoris because among some it's easy to find. Among others it's hidden away in the folds of the vulva. Excised or not, all vulvas are different'.

> 'But wouldn't you talk about it?'

> 'Well, when you have trust and you get to know the person. But your sexuality works well, you are a bomb who knows more about her body than some non-excised women', the sexologist encourages her in response to the self-confidence with which she talks about her own sexual needs and the enjoyment she conveys.

The sexologist draws a vulva and asks Penda to point out where the vagina opening is and where the clitoris scar located. When Penda has done this, Cendrine draws the vestibular bulbs of the clitoris in the background, which are invisible when looking at the vulva. She explains that even though Penda's external clitoris has been cut, 95% of the clitoris is still there and that this is the body that swells when it is stimulated and gives pleasure. Penda listens attentively.

A few weeks later in her first psychotherapy consultation Penda tells us that she came to Belgium in 2000 and then lived in the UK for a few years but eventually returned to Belgium in 2010. She now works for a public welfare centre in Antwerp. In Guinea she studied history at University. Although among her ethnic group FGC is often practiced in a ritual initiation context, her father was strongly opposed to the practice and did not want her to be cut. It thus happened in a non-ritual context:

> 'I was 10 years old. I remember my Mum asked me to come for a walk and then it happened, they took me to an old lady and I was cut. It was such a shock! I was so angry! And my father was too! I have this rebellious side to my character. People used to say, "if you stay like that you'll have problems throughout your life" and it's true. I've been rebellious all my life'.

Excision has been described as a practice that is personally meaningful in a ritual context as coming of age and the making of womanhood (Ahmadu 2007, 2000; Johnson 2000). However, Penda's father rejected the practice and thus she was cut secretly without his consent. The meaningful aspects of public initiation and coming of age were therefore absent and she perceived it as an act of injustice. She describes her feelings of anger and rejection of the cultural value of FGC and re-affirms her reluctance to comply with custom by saying that she has always been rebellious. In Guinea, as in other West African societies, obedience of elders and compliance with custom is highly valued. Those who defy their

authority are generally perceived as rebellious, impolite or said to lack respect for what is locally celebrated as tradition. In public discourses where FGC is associated with a gender ideal of womanhood, compliance with the practice is valued and socially rewarded. Women who conform to this gender ideal are celebrated for their social decorum and respectability by being called 'good woman' (*debbo moyyo* in Pulaar and *muso nyuma* in Malinke). Those who disagree with such notions of womanhood and publicly defy the practice are perceived as socially deviant and somehow deficient in their female personhood—not in line with reified notions of tradition. Despite the rejection of FGC and the connotations of womanhood associated with it, Penda, like other women yearn for completion embodied in a different form of womanhood, conforming to the European gender-norm:

> Francoise[8] the psychologist asks:
>
> —'Why did you come to see Dr Caillet?'
>
> —'I think that I am not normal. I have pleasure during sex and enjoy it very much but there is something missing. In the gaze (le regard) of others there is always something missing'.
>
> —'What do you expect from the procedure?'
>
> Penda responds: 'I want to be normal like other women'.

As described in previous studies (Jordal, Griffin, and Sigurjonsson 2018; Villani and Andro 2010), her desire for the procedure is linked to notions of normality in the European context (Griffin and Jordal 2019) where public discourses generally depict the practice as a form of 'mutilation' that harms women leading to psychological and sexual problems. Although Penda does not personally have any sexual problems because of her excision, her sense of not feeling normal is linked to 'the gaze' of other individuals in her social environment. She is concerned about what others think of her as a woman who has undergone the practice. Yet, Penda is beginning to question whether the procedure is right for her. She continues:

> —'But they [the doctor and the midwife] did make me think because they said that I might lose the pleasure I'm experiencing'.

The psychologist continues to ask Penda if there is anything in particular she expects to achieve through the procedure. Penda responds hesitantly:

> 'I'm not so sure about it now. When I went to see the sexologist, she showed me lots of different kinds of clitorises and that made me think. And I have to admit that I went to have sex with a guy afterwards and he said, "luckily you have been excised because otherwise we'd have to call the fire-brigade". He thinks that I experience lots of pleasure'.

Penda repeatedly elicits an image of herself as highly sexual. She clearly distances herself from the image of the sexually mutilated victim and instead depicts herself as sexually 'on fire'. In a recorded in-depth interview four months later Penda tells me that her change of mind about the reconstructive surgery was linked to what the sexologist had said.

> 'She showed me in detail that women's sex organs are all different. No two women have the same vagina. You know for me it was more "the gaze" (le regard) of others not the sensation. Although there are women whose clitoris is hidden away and hardly visible and among others it is well exposed. So, she showed me these drawings and said to me "have you ever looked at

> yourself in the mirror?" This is something that I had never done before, so last time, after the meeting with her I did not hesitate, I had a look. I shaved away all my pubic hair and I had a look and I thought to myself "she is not wrong, it's not dramatic". The main thing is that I have sensations. If I had no sensations, ok, but I have a lot of feeling down there. And if these were no longer there then love would no longer exist for me. You make love to have pleasure, but if the pleasure is no longer there because they tried to put back what was taken away, what I wanted to be restored then… I think that there is no point. And I have my boyfriend and when I make love to him it's wonderful. So, I no longer see the need to do the operation. There is no point in doing the operation if I risk losing my sensations. Because I have a lot of feelings'.

This passage shows that various aspects were important in her decision making. First of all, potential loss of sensation through the operation and the realisation that this is a risk she is not willing to take. Secondly, an awareness that all vulvas are different and that the appearance of her vulva is not different to 'other women'—which in the European context often means uncut European women (Villani 2020). The following section from the recorded interview shows how her acceptance of her vulva as it is, is linked to an affirmation of her sexuality by her partner.

> 'I had sex with my new boyfriend and he said, "this is great" and I said "really? You know I was going to have surgery" and he told me "you don't need to, you really don't! It's ok, you don't have to worry about that". He loved it. "Are you sure?" I said. "Yes", he replied. "You're not pretending?", I asked. "No, no I'm serious", he replied. I didn't think of myself as an excised person when I made love to him. And whether he likes it or not, I like it! That's the most important thing. I wasn't going to do the operation for someone else, but for myself, just to feel ok when I open my legs. Because every time I open my legs at the hospital, the next time I come, the doctor is with somebody else to show them what my sex looks like. But in bed with my boyfriend it's ok. When I was having my second child there were 4, 5 people looking at me. They were not doing anything, only one. I was so frustrated. And I thought, God, you are not helping, what are you looking at?'

Although Penda remembers being cut in Guinea, she encountered no other health issues associated with her FGC status. She says that it was 'the gaze' of others in the European context that made her perceive herself to be different and put her in a position of having to explain what happened to her. Being exposed to situations in which she felt that she was perceived as abnormal, and evoking pity, made her feel very unconformable. Her request arises out of the desire to appear physically 'normal', like other women in the European context. Awareness of being different to other European women occurred during childbirth at the hospital, when she felt stared at and singled out due to her 'abnormal' female genitalia. She experienced felt stigma (Goffman 1963). Stigma is a process whereby a person is disqualified from full social acceptance within a community or society because of a particular attribute they possess (Goffman 1963). According to Goffman's classification such attributes can be a visible physical de-formation (i.e. scars or missing limbs); personal traits or lifestyles that deviate from what is perceived as the social norm (i.e. drug addiction, homosexuality, criminal background); or so-called 'tribal stigmas' linked to ethnicity, nationality or religion (Goffman 1963). The stigmatizing attribute is often accompanied by stereotypes that characterize its possessor in negative ways. Various other patients who were subject to FGC have told us during consultations that men often lose interest in them once they find out that they have been cut, which is a painful experience for women.

Link and Phelan (2001) suggest that stigma becomes entrenched through a sequential process. The first stage is the distinction and labelling of a trait of human difference, which is followed by attaching a negative stereotype to the label. What follows is

discrimination—separating 'them' from 'us'. In the case of FGC, the label is 'mutilated' or 'unable to have pleasure'. Labelled persons experience loss of status and are considered inferior within a given social context. In these kinds of cases, the request for reconstructive surgery is a form of protection whereby women want to prevent loss of status due to their deviation from the social norm as a result of the stigmatising attribute. By requesting reconstructive surgery she aims to avoid the loss of status and inferiority associated with the 'FGM label'.

For Penda, the awareness of the fact that all vulvas are anatomically different was a decisive factor against the operation as was her understanding that the appearance of her vulva may be just as unique before as after the operation, and that her potential lovers most likely would not notice the difference between an 'intact vulva' and a reconstructed clitoris. Ahmadu (2007) describes the sexual encounters of cut women with European men in the Gambia. In her ethnography, the Gambian women's sex partners could not tell the difference between women who had undergone the practice and those who had not. Dopico (2007) and Johnsdotter (2013) also show in their work that it cannot be assumed that a woman is unable to experience pleasure because she has undergone FGC. Johnsdotter (2013) argues that culture based sexual scripts are more important determinants for the ways in which women express their enjoyment of sexual pleasure than whether or not cutting of the genitals has taken place. Embodied cultural norms around sexuality, modesty and etiquette have a significant impact on how women speak about sexuality and womanhood and also how they perceived of their FGC.

In Penda's example her male lover has an affirmative role reassuring her of her sexual 'normality' despite her excision in a cultural context where cut women victimised and seen as sexually handicapped (Andro et al. 2009). The next example shows how women's sense of womanhood and self-esteem regarding their sex can be affected negatively and later on positively by experiences with lovers. We argue that not only women's sexuality is culturally embedded but also their sense of being a woman and self-value in response to sexual experiences with different lovers in a given cultural context.

Nafi—'he completely demolished me'—rebuilding a life out of the ruins of a broken relationship

Nafi is a 47-year-old Senegalese woman. She has two children aged 6 and 8. My first meeting with Nafi was during a sexology session in March 2018.

Cendrine, the sexologist, asks her what she expects from the CeMaViE centre. Nafi responds:

> —'I need help to continue with my life and all the things that don't work. And try and improve them. I'm feeling lost in my life. I feel lost with sex and with men'.

Cendrine asks her if she has a partner. Nafi explains that she is in the process of divorcing her husband after 15 years of marriage. It was a love marriage with a Belgian man but in the end, there was no more love and a lack of respect for each other. They started to grow distant in everyday life and in bed and eventually he spent more time away, staying out late for work and with clients.

> 'In the end he went to Indonesia and when he returned, I could see lipstick all over his clothes and I searched and found messages and lots of stuff. When I first confronted him with it, he denied it, but there was nothing to deny. It was obvious. When I asked him what it was that made him search for sex outside our relationship, he said that it was my lack of a clitoris'.

Nafi says that she had a lot of pleasure in bed throughout their years of marriage and that her partner knew that she was experiencing pleasure. During a consultation with Fabienne, the midwife, Nafi showed her genital piercing and explained what gives her pleasure and how she masturbates. The sexologist asks her if she is aware that she could lose the pleasure she is experiencing through the operation and that surely this would be very disappointing to her. Her response to this is:

> 'Yes, that's what the Doctor told me. But I don't want any man to ever say that to me again. He recently called to stop the divorce and that he wanted to come home and for our relationship to continue. But the things he said to me hurt me deep down. He completely destroyed me'.

Nafi's interest in reconstructive surgery was triggered by a breakup after 15 years of marriage. Her husband's statement that the cause of the breakup was her lack of a clitoris was extremely painful and psychologically damaging as she had perceived her sex life as fulfilled and pleasurable until then. Profoundly hurt by his comments, she projects a repair of this psychological damage onto the operation despite never having experienced any sexual or health complications as a result of her FGC. The surgical restoration of her external clitoris is her perceived solution to the pain that her husband has caused her. As in the previous case, negative discourses about 'not having a clitoris' have impacted on her self-esteem to the extent that a surgical modification is perceived to be the solution.

Cendrine, the sexologist, tells her that what he said hurt so much because it touched on her identity and her womanhood. Her husband destroyed her image of her identity and a physical operation would not be able to reconstruct that. She refers her on to the psychologist, saying that a physical reconstruction would not reconstruct her heart and her identity which has been destroyed by her husband.

The sexologist puts forward the idea that notions of identity and womanhood are socially constructed and shaped by experiences with other individuals within a given social environment. Nafi feels vulnerable due to the fact that her sex is different to 'other women' and that this is the reason for her rejection by her husband and the relationship breakdown. Cendrine, the sexologist links this negative sense of self to her sexual identity (womanhood), reiterating that this negative affect towards one's identity cannot be repaired through a physical intervention or body modification. Nafi does not see it that way yet.

I see Nafi a few weeks later in the waiting area while she is waiting for a psychotherapy appointment. We talk a bit. She tells me that she is set on the operation, that she needs it. She hopes that they are going to let her have the operation, she doesn't really want to go through all this therapy, she is convinced that the operation will make her feel better about herself. I reply that at the end of the day it is her decision and conjecture that the team is not going to refuse something that she really wants, but their recommendations may be different. Unfortunately, I'm called away on another matter and cannot sit in on the consultation. The psychologist tells me later that in the following psychotherapy sessions, they worked on body image, learning not to feel embarrassed by one's body, as well as building self-esteem.

The next appointment I follow is with Fabienne, the midwife in July. Fabienne reads the notes and tells Nafi that the team has concerns regarding the operation because she experiences

pleasure and that they are worried that her desire for the operation is a reaction to the break-up with her husband. Nafi says that the pleasure she feels is not in the area of the [external] clitoris. I ask her how her divorce is going, and she says that it is still in progress. The husband wants to come back, but for her it's over, she doesn't want him anymore, it's finished. It's better to be alone than in bad company. No, for her it's over with men she is not interested in them anymore, she prefers women! She has found a girlfriend, whom she met at work. A little while after they met, she sat down with her and told her that she had been excised and that this is a practice they do in Senegal. When they made love, the girlfriend said that it's not true that she doesn't experience any pleasure and that she doesn't need this operation. When Dr Caillet and Fabienne continue to express doubts about the operation Nafi says:

> 'I want to live my life, I want to continue with my life, I want to do this for myself, not for him (husband), it's for myself'.

Nafi's request for the surgery is not based on a physiological complaint, lack of sexual sensitivity or desire but on the need to change 'for herself'. Initially triggered by a crisis based on the break-up with her husband, she believes that the physical modification would align her body with social norms and thus alleviate her pain and bring happiness. In her analysis of the social function of notions of happiness and social norms, Ahmed (2010) looks at how claims to happiness make certain forms of personhood valuable. She argues that social norms are adhered to in the faith that particular forms of living or practices will secure one's contentment. This is particularly interesting when thinking about women's aspirations when desiring reconstructive surgery.

In September I sit in during a sexology session. Cendrine asks her if she has spoken to her girlfriend about the operation, and Nafi affirms that the girlfriend said that she had slept with excised and un-excised women but that she felt that Nafi was no different to un-excised women in bed. Yet, Nafi is scared of losing her:

> 'I'm afraid that perhaps one day she won't feel comfortable with me anymore. Perhaps she just says that she's happy but maybe she's not saying how she really feels, perhaps I'm not enough for her and she's lying to make me feel better about myself'.

> Cendrine replies saying that such an operation should only be done for oneself and no one else. Otherwise a partner might say 'I want your nipple higher or your stomach flatter'. There is a limit to what we should do to our bodies to please others. Nafi agrees thoughtfully. The sexologist then draws a picture of the vulva again and explains that there are so many different kinds of vulvas in the world and that a reconstructed clitoris would not be like her original clitoris anyway and her vulva is unique regardless of whether she has the operation or not. Eventually Nafi says in response to a woman she saw before the consultation and whom she assumes to have gone through the operation:

> —'There was a woman in the waiting room who had difficulties walking, olala, that looks tough'.

> Cendrine responds: 'Yes but we told you that, didn't we. We said that it hurts and that it would be tough'.

> —'But like that? Wow. Frankly I don't want to do the operation anymore after seeing that woman. I don't want to go through that'.

> Cendrine explains that the woman in the waiting area was operated on recently and that the pain does get better after a couple of weeks. But it is important that she is aware of what she wants and what her needs are and no one else can know this instead of her.

> —'You were hurt by your husband, you are a warrior!! I call you ladies warriors!' she says with the difficulties of many women who come to the clinic in mind and their resilience in the process of re-building their lives.
>
> —Nafi says: 'When I walk out of here, I feel great! It's in the evening when I'm back home and I want to make love that it all comes back. But I have to learn to find courage within myself'.
>
> —'Sometimes I have couples here who come together because they want to change their sex life. But the clitoris itself may not make a lot of difference. It's like someone who doesn't have a toe, as if you couldn't dance with someone who has a toe missing. It's better to dance with someone with one toe but who is in it with his heart than with someone who sits down and says "I can't dance."'

We all laugh heartily until tears come to our eyes. This is the last time we see Nafi.

Nafi lost all confidence in herself as a result of her husband's stigmatising comments. Felt stigma is important because it does not just influence how a person may feel about themselves in terms of their sense of self-worth and identity, but also how they engage with and relate to others. Despite being aware of the risk of loss of pleasure, Nafi continues to believe that reconstructive surgery would resolve this sense of deficiency for a long time. Eventually being accepted as sexually 'no different' to uncut women by her new lover restores her confidence in herself as well as the realization this the operation is very painful.

Reconstructing what? Sex, gender and identity

Prior to Butler's analysis on the social constructions of sex and gender, it was commonly assumed that gender is culturally constructed, whereas sex is the biological predisposition that distinguishes women from men (1993). From this vantage point, it was assumed that the anatomical differences that exist between women and men are infallible. Gender on the other hand was (and often still is) thought to be based on social conventions that influence how men and women are seen, and what kinds of behaviours are thought of as feminine or masculine. Social gender constructions were thought to have little to do with corporeal sex. In contrast, Butler is interested in how the materiality of the body is linked to the performativity of gender. She argues that sexual difference is never a function merely of material differences which are not in some way both marked and formed by discursive practices (Butler 1993: 1). The matter of bodies is 'indissociable from the regulatory norms that govern their materialisation and the signification of those material effects' (Butler 1993: 1). Although Butler refers mainly to the heteronormative ways in which sex and gender are constructed and differentiated through social conventions, regulatory norms and discursive practices, the cases presented above show perfectly how perceptions of gender and womanhood are linked to the physiological appearance of the genitalia. In northern European discourses, a 'complete' woman's genitalia has and external clitoris. Such discursive practices construct a woman who has undergone FGC as incomplete, mutilated and sexually less competent than uncut women (Johnsdotter 2013; Lunde et al. 2020; Villani 2015). These discourses then shape how healthcare professionals and sexual partners view cut women, and how women who have undergone FGC perceive themselves. For excised women residing in Europe, reconstructive surgery is a technology that restores their femininity and promises happiness (Ahmed 2010) in that it symbolically aligns the body with a social ideal of womanhood in a Western context.

Scholarship on sexuality and gender has shown how cosmetic and plastic surgery is increasingly used to modify the female body according to local ideals of femininity (Brooks 2017; Jarrin 2015; Kulick 1997; Leem 2017). Kulick for instance describes how *travesti* in Brazil inject litres of silicone, originally produced for industrial purposes and not for cosmetic surgery, to enhance the shape of their buttocks and hips according to locally perceived ideals of a feminine figure (Kulick 1997). Ideals of beauty, youthfulness and sexuality are often shaped by media images and popular culture. Recent ethnographies show how such images are highly racialised. In her ethnography on the booming Gangnam style plastic surgery in South Korea Leem describes how computerised face scans suggest changes to clients that would enhance their features to resemble those of Caucasians and of local celebrities who embody such ideals of beauty (Leem 2017). Notions of 'self-improvement' associated with cosmetic surgery are also described in terms of race and social hierarchy in Brazil by Jarrin, who argues that 'beauty can be understood as a technology of biopower in Brazil, insofar as it produces, segregates, and ranks populations within the national public sphere—providing some bodies more value than others according to a scale of racialized characteristics' (Jarrin 2015: 536). As for cosmetic surgery and traditional FGC, the request for clitoral reconstructive surgery 'improves', repairs and re-sexualizes the body of 'mutilated women' so as to conform to the ideal of sexually active, orgasmic, youthful femininity.

Rebuilding self-esteem

These cases are illustrative of the many women whose request for reconstructive surgery is triggered by particular events that occurred which led to a sense of feeling different as a result of their FGC status, leading to low-self-esteem and fears around relationship security. The belief that their FGC status is the cause of their social malaise makes them want to reverse this process through the operation. Both cases hoped that a 'reconstructed clitoris' would prevent further stigma in encounters with men or health professionals, enhance intimacy in a sexual partnership, and ensure relationship security. Thus, the psychological reconstitution of the 'missing' organ can help heal their suffering—and this does not always happen through a surgical intervention. The clitoris is seen as a guarantor for long-term relationships and to securing a partner's fidelity for life.

The psychological effects of social evolutionism and mutilating discourses

What is it that leads to this sense of feeling 'abnormal', inferior and less sexually competent compared to unexcised women? We have argued that in places where FGC is a social norm, the practice is often associated with womanhood and gaining status and maturity within a given community (Ahmadu 2007, 2000; Leonard 2000). In contrast to this, Western discourses on the sexual 'mutilations' of black women commonly depict the 'cultures' of those who perform such practices as 'barbaric', 'inhumane', 'backward' and 'in need of' development.

Boddy's (2007) and Thomas (2003) analyses of discourses on FGC in Sudan and Kenya during the colonial period at beginning of the 20th century and in the 1940s shows how notions of FGC as barbaric and unchristian justified colonial policies, and even the training of missionaries and midwives to 'civilize' child-birthing practices. Such policies and civilizing missions had political repercussions and led to rebellions (Boddy 2007; Thomas 2003), which is why the WHO dropped

recommendations to ban the practice until it was brought up again by American feminist Fran Hosken in the 1970s (Abu-Salieh 2001; Hosken 1993; O'Neill et al. 2020).

European responses to African customs that are labelled as 'barbaric' and 'backward' take us all the way back to the social evolutionist claims that justified colonialism in Africa 150 years ago. Yet in Europe, such social evolutionist connotations are woven into public discourses in the media, the educational system as well as in hospitals and even in people's homes through two-dimensional media. The cases presented in this paper show how excised women living in the European diaspora respond to such humiliating and negative discourses of excised women as 'handicapped', 'sexually mutilated' and unable to experience pleasure. Even those who experienced pleasure and had fulfilled sex lives begin to believe that they have been 'mutilated'—as if their womanhood had been cut away from them along with their external clitoris. It makes them feel tainted and blemished (Goffman 1963), to the extent that even women who are sexually fulfilled feel like they need surgical intervention to become 'normal' again.

Conclusion

Womanhood and the ways in which the female sex is perceived is subject to social change and cultural context. We have argued that in the European context gender norms propagated through media images, pre-dominant discourses on womanhood and sexuality strongly shape women's perceptions of their bodies, their genitals and their expectations regarding sexual pleasure and performance. Social evolutionist and racialised discourses on 'mutilated' African women's genitals evidently affect women's views of themselves and of their bodies and leads them to a sense of inferiority and insufficiency. We do not intend to argue that women who have undergone FGC should never undergo surgery, as some women do benefit from and flourish after reconstructive surgery. However, caution is needed as some women evidently suffer more from stigma-related experiences linked to their FGC status rather than from a physical condition resulting from FGC.

Notes

1. Female Genital Cutting (FGC), also referred to as Female Genital Mutilation (FGM) by the World Health Organization (WHO 2020) and activists, is commonly performed on girls between infancy and adolescence in at least 30 countries in Africa, the Middle East and Asia. In this paper FGC is the preferred term for its neutrality. The term FGM is used when referring to the WHO definition or when the term was used by institutions or research participants themselves. The WHO (2020) estimates that 200 million women worldwide have undergone some form of FGC. The given reasons for the practice, as well as the procedure, varies. The WHO classifies FGM into 4 types. The one's most relevant to this article are type 1 (partial or total removal of clitoral glans and/or clitoral hood) or type 2 (partial or total removal clitoral glans and labia minora, with or without excision of the labia majora) which are both commonly practiced in Burkina Faso, Guinea, Senegal etc. Due to migration and population movement, the occurrence of women with FGC has become more frequent in high-income countries i.e. in European countries and north America.
2. See Caillet et al. (2018), Diouf et al. (2017), O'Dey (2019), Ouédraogo et al. (2016), and Thabet and Thabet (2003).
3. Between 1998 and 2009 Foldès performed this surgery on 2938 women and has now operated on more than 6000. Foldès and colleagues (2012) report that women's expectations from sur-

gery were the recovery of identity (feeling whole and recovering personal autonomy by rejecting the physical mutilation imposed on them by their family group) for 2933 (>99%) of the 2938 women, an improved sex life for 2378 (81%) women, and pain reduction for 847 (29%) women. They report that one year after the operation 51% of women experienced orgasms. However, among women who had experienced regular orgasms preoperatively, almost one in four reported a reduction in intensity after surgery (Foldès, Cuzin, and Andro 2012).

4. If the cut is too deep this is a counterindication for surgery due to the risk of retraction.
5. Such cases will be addressed in more detail in a forthcoming publication.
6. Each one of the cases was met 4 times as described in the ethnography.
7. Due to word limitations, we are not able to elaborate on the cases of other women here but have selected these two which are thematically representative for all cases of women who request reconstructive surgery despite experiencing pleasure.
8. In clinical practice the therapists are mostly referred to by their first names by patients or as Madame (i.e. Madame Francoise) whereas the gynaecologist is referred to as Dr Caillet.

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Ethical Approval

The names and identifying information of patients have been changed to safeguard their confidentiality. The study was approved by the ethics committee of CHU St Pierre hospital O.M. 007 on October 16th, 2017 - reference number: B076201733644.

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