Escaping Social Rejection, Gaining Total Capital: The Complex Psychological Experience of Female Genital Mutilation/Cutting (FGM/C) Among The Izzi in Southeast Nigeria

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Research

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Abstract

Background: While the deleterious effects of FGM/C on physical health are well documented, the psychological experience of this harmful practice is a neglected area of research, which limit global mental health actions. As FGM/C was a traditional practice in some areas of Nigeria, the study aimed to understand the psychological lived experience of FGM/C in a sociocultural context.

Methods: This qualitative study was completed in urban and rural Izzi communities in Southeast Nigeria where FGM/C was widely practiced. Ethnographic interviews were completed with 38 females using the McGill Illness Narrative Interview (MINI) to explore the psychological lived experience of FGM/C before, during and after the procedure. The MINI was successfully adapted to explore the meaning and experience of FGM/C. We completed content analysis and used the concepts of total capital and habitus by Bourdieu to interpret the data.

Results: During the period of adolescence, Izzi girls who had not yet undergone FGM/C reported being subjected to intense stigma, humiliation and rejection by their cut peers. This chronic psychological suffering led many girls to accept or request to be cut, in order to end their psychological torture. Virtually all women reported symptoms of severe distress before, during and after the procedure. Some expressed the emotion of relief from knowing their psychological torture would end and that they would gain social acceptance and total capital from being cut. Newly cut girls also expressed that they looked forward to harassing and stigmatizing uncut girls, therein engaging in a complex habitus that underscores their severe trauma as well as their newly acquired enhanced social status.

Conclusion: As FGM/C is profoundly embedded in the local culture, prevention strategies need to involve the whole community to develop preventive pathways in a participatory way that empowers girls and women while preventing the deleterious psychological effects of FGM/C and corresponding stigmatizing behaviour towards the uncut. Results suggest the need to provide psychological support for girls and women of practicing Izzi communities of Southeast Nigeria.

Lay abstract

While the deleterious effects of FGM/C on physical health are well documented, we have little knowledge on the psychological experience of this harmful practice. This study aimed to understand the psychological lived experience of FGM/C in Izzi communities in Southeast Nigeria where FGM/C was widely practiced. In depth ethnographic interviews were completed with 38 females to explore the psychological lived experience of FGM/C before, during and after the procedure.

Our results found that during adolescence, Izzi girls who had not yet undergone FGM/C reported being subjected to intense stigma, humiliation and rejection by their cut peers. This chronic psychological suffering led many girls to accept or request to be cut, in order to end their psychological torture. Virtually all women reported experiencing severe distress before, during and after the procedure. Some expressed relief from knowing their psychological torture would end and that they would gain social acceptance and

a rise in status from being cut. Newly cut girls also expressed that they looked forward to harassing and stigmatizing uncut girls, therein engaging in a complex behaviour that underscores their severe trauma as well as their newly acquired enhanced social status. Our results suggest that prevention strategies need to involve the whole community to develop preventive pathways in a participatory way that empowers girls and women while preventing the deleterious psychological effects of FGM/C and corresponding stigmatizing behaviour towards the uncut. Results suggest the need to provide psychological support for girls and women of practicing Izzi communities of Southeast Nigeria.

Introduction

Female genital mutilation/cutting (FGM/C), referred to in many practicing groups as circumcision, comprises all procedures that involve partial or total removal of the female external genitalia and/or injury to the female genital organs for cultural or any other non-therapeutic reasons (1,2). While the physical health consequences of FGM/C are well documented, studies on the psychological experience and consequences of FGM/C are very limited both in number and in scope (1,3–6). According to the World Health Organization, only 15% of the literature on FGM/C reports partial information and/or understanding of the psychological dimensions of this practice (1). According to the latest reviews (3,7), FGM/C is likely to produce psychological disturbances such as anxiety, somatisation, phobia, low self-esteem, and a higher likelihood of psychiatric disorder such as PTSD in those who undergo the procedure. However, the design of these studies did not provide enough evidence to draw conclusions on the lived experience and corresponding psychological consequences of FGM/C in a sociocultural context. The psychological experience and psychopathology surrounding FGM/C is thus a neglected area in the FGM/C literature which limits guidance for global mental health policy and programming that aims to eradicate, prevent and provide psychological counselling relating to FGM/C in practicing as well as host countries with immigrants and refugees from practicing countries. There is thus an urgent need to better understand the complexity of the psychological experience of FGM/C in social and cultural context.

Background of the study. Nigeria has the highest absolute number of cases of FGM/C in the world, harbouring a quarter of the world's estimated 115 to 130 million girls and women (8). With the signing of the Violence Against Persons (Prohibition) Act of 2015 into law in Nigeria, FGM/C is now a criminal offence in Nigeria, as all forms of violence against persons are prohibited (9).

Although there are wide regional variations of prevalence in Nigeria, a survey completed in West African countries obtained a total national prevalence of 22.1% for Nigeria (10). The Southeast and Southwest of Nigeria have the highest prevalence of the country, with rates of 49.2% and 46.4% respectively (10). Ethnographic studies done in these regions reveal a strong cultural support for the persistence of the practice, with reasons presented such as chastity, fidelity and tradition being adduced to justify the practice (11–13). The Izzi sub-tribe of the Igbo ethnic group, located in Ebonyi State in Southeast Nigeria, was selected for this study because all types of FGM/C are performed in this state, with 46% being types I and II, 19% type III with infibulations and 33% of indeterminate type (14). The chosen urban site for the study was Amike Aba Community, in Abakaliki, the state capital and major urban settlement of Ebonyi

State. The chosen rural site was the Mgbalukwu Community in Izzi Local Government Area. Among the Izzi, FGM/C is locally called circumcision and is described as a compulsory rite of initiation and the only avenue through which an Izzi woman could be allowed matrimonial rights, to participate in community affairs, enter full womanhood and bear children considered to be normal (14). This practice occurs during adolescence or early adulthood among the Izzi, unlike in other ethnic groups were FGM/C is carried out in infancy or early childhood (10). Carrying out the study in a community where FGM/C is done during adolescence provided the opportunity to obtain information on the psychological experiences of being cut as well as the period before and after the procedure. These characteristics led to the selection of the study sites. The research question that guided this study was, "what was the lived psychological experiences surrounding FGM/C in women across the life cycle in the Izzi rural and urban communities of Southeast Nigeria". This article is the second in a series of studies in which qualitative methods are used to determine the psychological experiences of FGM/C through the life cycle (5).

Methods

Sample & sampling. The sample for this study comprised 38 girls and women who had undergone the FGM/C procedure with 20 living in urban settings and 18 in rural communities of Ebonyi state, Southeast Nigeria. Using the snowball sampling technique participants were initially identified by community members and invited to participate in an interview (15). The snowball sampling offered the practical advantage of reaching the target population in a timely and informal manner that fostered credibility of the data required to understand the complexity of the FGM/C experience.

McGill Illness Narrative Interview (MINI).We aimed to explore the women's embodied and emotional experience of FGM/C in the Izzi cultural context. Based on the premise that FGM/C generates a bodily injury that involves a treatment and healing period, the McGill Illness Narrative Interview Schedule (MINI) was chosen as it is conceptualized to explore the complexity of the psychological and embodied experience of health problems in a cultural context (16). The initial English generic version of the MINI was adapted by the last author (DG) to explore the experience of FGM/C and was thereafter translated into the Izzi dialect by one of interviewers with a bachelor degree and fluent in the Izzi dialect of Igbo and an expert in the Izzi dialect and English Language did the back translation (see Appendix 1. for the English version of the MINI adapted for FGM/C). The entire team of researchers then met to finalise the instrument, which was then pretested in the Izzi speaking communities and adjusted for clarity. The four main sections of the MINI (16) were adapted to explore the FGM/C experience. The first section seeks to elicit a narrative of the sequence of events leading to the psychological and embodied experience of FGM/C in the cultural context. The second section aims to ask the interviewee to identify and compare one's FGM/C experience with prototypical experiences of FGM/C involving family members, community members and the media. The third section explores the lay explanatory models the interviewee uses to explain why they underwent FGM/C as well as local labels used to refer to the experience. The fourth section explores pathways to care following FGM/C, potential issues with treatment, and life changes brought about by the FGM/C.

Interview Process. Each interview lasted an average of one to two hours and they were conducted in quiet, conducive places within the community, usually under a tree, in the town hall or in a clearing in the bush. We ensured that the interviews took place out of earshot of others, such that while others could see from a distance, they definitely could not hear the conversation taking place to ensure confidentiality. Each participant received 500 Nigerian Naira (3US Dollars) to cover the cost of refreshments.

The third author of this paper (NE) completed 14 of the 39 interviews, while the remaining 25 were carried out by 5 research assistants who were university graduates who could speak and understand the Izzi dialect. Three of the interviewers were female and two were male. While the team was concerned about the possibility that part of the FGM experience would not be disclosed to a male interviewer, they rapidly were reassured after comparing the transcriptions of the interviews done by female interviewers. In addition, the male interviewers had previous experience in conducting field research in the area under study. One of the co-authors (NE), acting as the fieldwork leader for the study, also indicated that it was best to have a mix of male and females to carry out the interviews as the cutting process was carried out by males and females alike and that both men and women were activity involved in the cutting process.

Data Analysis. The interviews conducted with the adapted MINI were tape-recorded and transcribed in Izzi dialect. NE also listened to the tapes and cross-checked with the Izzi transcription to ensure that it corresponded with the audio recording and also ensured that key ideas and quotes were well captured. All the other team members read through the transcriptions and raised queries, which were resolved after discussion. The Izzi transcriptions were thereafter translated into English and transcribed a second time. Following the transcription of the interviews, the principal investigator (OO) and two co-investigators (TB and JA) held a three-day data analysis workshop in Ibadan (Southwest Nigeria) to read through the transcribed interviews, identify ambiguous sentences, phrases and words, and seek clarification from the research team in Abakaliki where the interviews were conducted. Another qualitative analysis workshop led by the senior author (DG) took place with the research leaders of the team (OO, TB, and JA). Transcripts of the interviews translated in English were used during the workshop and 5 main themes were obtained at this initial contextualization of the data. Thematic content analysis was conducted using inductive coding to identify emerging themes. Following this analysis workshop, 14 additional interviews (7 urban and 7 rural) were completed to ensure data saturation (Green & Thorogood, 2014), for a total of 39 final interviews. The remaining interviews were transcribed and coded and we then produced summaries for each large categories of thematic codes. Our conceptual framework was used to interpret the summaries of the codes in the objective of answering the research question.

Theoretical Framework. In this study, we build from Bourdieu's (17,18) concepts of habitus and total capital to guide our interpretation of the coded transcripts of the narrative relating to the psychological lived experiences of FGM/C. We choose to use the above-mentioned concepts as a lens to understanding the complexity of the overall experience of FGM/C asking if and how the psychological dimension of the experience is governed by corresponding gains or loss of power before, during and after being cut. Bourdieu states that in any social space individuals find themselves in power relations with others and that access to power is determined by total capital which includes economic, social, cultural and

symbolic forms of capitals (19–21). Of relevance to the interpretation of our results, social capital refers to networks of social connections that can be called upon for help and support; cultural capital can occur in different forms with one being the embodied state corresponding to “long-lasting dispositions of the mind and body” (18) expressed in a person’s means of communication and self-presentation, acquired from their own cultural background (22). Finally, he defines symbolic capital as the prestige and respect a person has acquired based on specific accomplishments and/or status that are valued in specific social spaces. Finally, Bourdieu (17) defines habitus as a mental disposition, inculcated by the familial and social environment, that constitutes a way of being and using the body that feels natural for the person and close ones. Considering that FGM/C is not a private practice but a cultural rite of passage to womanhood violently inscribed onto the body, we also examined, for the purpose of examining the changing potential of this practice, if and to what extent, the practice of FGM/C constituted a habitus. In the logic of the feasibility of developing culturally appropriate strategies to eradicate FGM/C, the question of FGM/C being or not a habitus, is key to guide our reflections on the relevancy of future actions.

Results

Participants of this study produced narratives relating to their psychological lived experience of FGM/C which they structured around five temporal phases including: 1) the ‘akpapyi’ period characterized by socio-emotional suffering; 2) the emotional elevation phase following the decision to be cut; 3) the cutting procedure where girls experiences ‘flight or fight’ response and extreme pain; 4) the post-cutting period characterized by mixed emotions including elevation, trauma and betrayal and; 5) the long term period where they spoke of the psychological consequences of FGM/C.

1. The ‘akpapyi’ period. The emotional experience relating to the ‘akpapyi’ period is key to understanding why young women accept, or even request in some cases, to undergo the FGM/C procedure. It is a pejorative term used to describe the ‘uncircumcised’ female. Virtually all participants described experiencing intense negative psychological feelings during this period of their lives ranging from anger, sadness, shame and embarrassment. In some instances, these emotions were accompanied by social withdrawal with the community exhibiting extreme forms of stigma toward uncut women and girls. Furthermore, this community did not allow the akpapyi to gather with the ‘circumcised’ and if they approached such gatherings, they were asked to leave. Women across the life cycle in urban and rural areas recounted feelings of shame and anger recalling being mocked and humiliated during their ‘akpapyi’ period.

Before I went for circumcision, I used to be ashamed of the insults received from people. As they mocked me, it annoyed me. Why it annoys me is because they mock me saying I’m an uncircumcised (akpapyi) that I should look at my size. (45 years, urban)

The stigma against the akpapyi is sustained by a community discourse stating that the uncut behave badly, have increased libido (which is perceived negatively), are promiscuous and are likely to have

adverse experiences when they give birth. This stigmatization also extends to their children as they are often portrayed as being considered less than human.

If I married without circumcision and eventually gave birth to a child or children, the child or children cannot be taken as a human being and are described as fools. (47 years, rural)

I heard that a pregnant woman…. in the process of her delivery, met some women to help her to deliver, when they opened her wrapper and saw her private part (she was uncut), they abandoned her to go and invite others to come and see the horrible thing they are seeing (45 years, rural)

Participant recalled that while they were an 'akpapyi' they responded with strong feelings of sadness, crying, feeling unaccepted and social withdrawal, depressive symptoms which included dropping out of school for some of the girls. Subsequently, many of the girls and women felt resignation toward the inevitability of undergoing FGM/C while putting aside their initial fear or apprehension of the procedure. Escaping the experience of extreme stigma during the 'akpapyi' period gave rise to a strong justification for undergoing FGM/C. Many describe the determination to do the FGM/C as a bid to avoid mocking and insults, remove the shame, humiliation and isolation, and be able and comfortable to participate in society.

I have already volunteered myself for the cutting because of the insult of being called "akpapyi" and if you did not circumcise, it was not good then. (48 years: urban)

When we are bathing together, my mates will be laughing at me and I was ashamed and I told my mother that I will be going for FGC. (34 years: rural)

Being among their peers and being allowed to participate in social activities was particularly important for the younger girls. They described the need to be 'among' or 'belong' as a reason for deciding to go for the FGM/C.

2. The decision to be cut: emotional elevation. Some of the girls and women recounted experiencing emotional elevation once the decision to be cut was made and as they were approaching the date of their cutting. The sense of happy anticipation was clearly evident as the girls and women approached the 'circumcision' day and as plans were made for the event.

I was very happy. I was even the first person to wake up and reminded my mother: "hope you said I will be circumcised today" (25 years, urban)

The anticipation of happiness was associated with escaping the akpapyi experience and what the girls and women described as great joy appears in many instances to be due to a sense of liberation and relief as seen in several of the narratives of our participants.

I was happy when they told me that I was going to undergo circumcision because I have been embarrassed enough. (19 years, urban)

The way it was to me is that I'm unhappy because any time I go out, my mates will be mocking me. One day, I told my mother how my mates had been molesting me about being uncircumcised and I asked her to let me be circumcised. She accepted and after a while she asked me to prepare that she will take me to the place I will be circumcised, and I was happy. (30 years, rural)

My age mates insulted me so much by calling me names like "akpapyi" any time I am in their midst and I used to feel so bad, so when I had the chance to have it performed on me, I was so happy and ran to the woman's house to have it done. My family members were not even at home when I ran to the woman's house with my friends to have it done! (20 years, rural)

Narratives also revealed that this feeling of happiness was also associated with the clear rise in social status provided by the cutting which was seen as a rite of passage to womanhood and respectability.

What I saw then that made me feel happy was that since the circumcision can make me complete as tradition prescribed, I said let me do it just as my mates are doing it. Just as you know that there is a difference between a girl and a woman, and the beginning of womanhood starts with this circumcision. That is why I was glad to do it as this will lead me into womanhood. (46 years: rural)

3. During the FGM/C procedure: 'fight or flight' response. As they stood in queue waiting for their own turn to be cut, many expressed intense fear from hearing the shouts of those who had just gone through the procedure.

Before the circumcision, I was afraid and shivering because I heard the cry of the first person, and I started shaking because I did not know how mine will be. (28 years, rural)

Whether waiting in line or during the actual cutting of their genitals many interviewees described experiencing an acute physiological response of 'fight or flight' in reaction to the extreme stress and fear imposed by the imminent danger and pain they experienced. They explained experiencing fear and immense anxiety, palpitations, and trying to run away from the terror of being cut. They knew this procedure could cause serious complications such as pain, bleeding or ultimately death. Their narratives report that in response to the fear exhibited by the girls, the cutters commonly used aggression to obtain their compliance.

When I saw others cry and bleed during their circumcision, I was terrified. And when it was my turn, and I was held hands and legs down, I was terribly frightened. (20 years, rural)

Reports of crying and shouting during the procedure were common in the narratives and the reactions of the cutters to this reaction varied with either leaving those to be cut for a while or getting strong men to hold them down and in some cases, sitting on the young girls during the procedure to keep them still.

It was paining me and due to the pains and cry, the woman that was giving the cut now started feeling for me and said they should leave me and continue with others. After theirs, she will now finish my own. (26 years, urban)

If you are the type of person that does not know how to sit or may cry, someone will sit on your chest, a strong man and he will hold your two hands so that you will not be shaking your bottom. (60 years, urban)

The first people that were circumcised laid down but I was so much afraid that I was held by people in a sitting and leaning position and they held my two legs. (34 years, rural)

Many girls also reported that they were told that crying and shouting means weakness.

What actually happened was that during the cutting, if you eventually cry and people were asked to hold you, it means that you are not strong and will be ashamed of yourself just like during my own circumcision; so because of that, people don't tell the story about it. (47 years, rural)

Possibly due to flashbacks from the cutting event, evidence of distress was for example recorded in a 28 year old rural dweller as she took deep breaths and paused when describing the event which in her own words 'tore her body apart'.

4. Emotional states after the cutting. Our participants expressed a variety of different emotions and feelings after the cutting was completed. These varied from having mixed feelings, betrayal, anger, fear of dying from the extreme pain or blood loss, but also feeling of happiness from escaping stigma and gaining a higher status that conveyed respect and their reintegration into the community.

I became happy because I hate being called 'akpapyi', it put an end to insults. (34 years, rural)

I was so glad to have done it because that brings about the end of the insults I used to receive, with a welcome into the community. (45 years, urban).

I can't really say but the only thing I know is that after the circumcision, I was so happy that each time I see my friends I will tell them that I have done the circumcision. Because I am no longer akpapyi, and my friends will not be abusing me again.

During the procedure it was painful and after the procedure I was happy because I can go to any place, no more embarrassment and partake in events with my age mates. (55yers, rural).

Some of the things that brought on joy and happiness were also the change that came with FGM/C that made them thereafter eligible for marriage or it meant they would be receiving special attention from family and friends such as having a special meal cooked for them. Many also expressed being happy because of their desire to participate in mocking the other 'akpapyis', a severe stigmatizing situation from which they had just recently escaped from.

Ah! It sweets my mind (made me very happy), because I know that I will follow and make mockery of the others. (45 years, rural).

Others described a period of mixed feelings in the immediate aftermath of FGM/C. One described it as neither happy nor sad and others as mixed feelings.

I was not happy again, but with time I ignored the pains. I can't say that am sad but I was not happy because of the pains. (26 years, urban)

My feeling then was mixed up. (58 years, rural)

Moreover, some were afraid of dying because of the extreme pain or important blood loss they experienced. Others may have had organic mental health manifestations due to excessive blood loss, with what appears like clouding of consciousness and fainting.

After the cutting, it bled so heavily that I nearly died and for two days I did not get myself. The bleeding was so heavy that all my energy was lost and I nearly fainted, until the end of that day I did not get myself. (48 years, urban).

(Hmmm) yes, I was filled with regrets and lamenting that is this how my life will end just because of circumcision. I was afraid because then I used to have constant dizziness thinking that I have lost all my blood that I will soon die. (30 years, urban).

It was so painful and I experienced much bleeding, I never knew I will live to survive that day. I felt bad about it especially when I got home; after the procedure I still couldn't get myself and thinking if I could survive it or not. (45 years, urban).

Feelings of betrayal by a loved one was expressed by a few who had been lied to about the procedure. Others expressed anger and regret about doing the FGM/C because of the weakness, pain and blood loss they had experienced.

Hei! My body was so weak that I regretted doing it and I was so angry for doing it. (48 years, urban).

5. Long Term Psychological Consequences of FGM/C. The narratives reveal two distinct psychological long-term responses to undergoing FGM/C. Some expressed emotional elevation from not experiencing any complications following the physical healing period and others experienced clear emotional turmoil suggesting symptoms of PTSD.

Emotional Elevation in the Absence of Complications. A feeling of happiness was described by some because they had survived the procedure and the FGM/C procedure was over and done, suggesting a sense of relief.

After the circumcision, I was so happy because I know that am not going to undergo the circumcision again. (26 yeas, urban).

I have heard because when they were announcing things they said some people died due to excessive bleeding while some were rushed to the hospital but I am happy because all these things did not occur in

my own situation. (25 years, urban).

Other women experienced long term emotional turmoil after undergoing FGM/C with experiences of flashbacks, symptoms of anxiety and depression, a situation suggestive of Post Traumatic Stress Disorder (PTSD).

What I remember is that, it is usually any moment I...it is usually any moment I see razor now, any moment I see...razor or scissors, I will remember....and it is what made me now, I don't use razor to cut nails because, if I see razor 'aphufuru ekwo nta (razor that is unwrapped now, I will remember when I was circumcised, how it did to my body. That whenever I see razor or scissors, I will remember that circumcision I cut that time. And it is usually when a person has accident, he has wound, that he is sewn something or that....they put scissor to his body or razor, my heart will run to...when they circumcised me, that...that thing was what touched my body (something that has affected me or deeply touched me), it boiled me in the body. (22 years, rural).

Anger, grief and regret were expressed by a 48 years old woman, whose wound had sealed and who subsequently have difficulty in childbirth.

After the circumcision was done, the place sealed back, I really suffered as I told you that my body was torn before I was able to deliver my baby as there was no hospital then. Whenever I remember that day I was circumcised, I do get angry and grief and I don't know whether it is because of the circumcision I did that I don't use to find it easy when I am pregnant and during child delivery. If I had known I wouldn't have even thought of it let alone doing it. Even now I cannot take my children for that. It is a regretful act. (48 years, urban)

Discussion

The results of this study provides insight into the complexity of the psychological experience of FGM/C among Izzi women within their socio-cultural context (23–25). Considering FGM/C is linked to specific ethnic groups in Nigeria and that a national survey indicates that 1/3 of girls and women are in favour of this practice (26), we will discuss the two psychological processes involved in the willingness of undergoing FGM/C among the Izzi girls while they are aware of the extreme physical pain involved in the practice. In an African cultural context where identity is more collective than individual and social ties are based on inter-dependency rather than on independence (27,28), we will argue that positive emotions mentioned in the narratives of our participants are linked to knowing that being cut will both stop the stigma they are being subjected to while providing them with gains in what Bourdieu calls total capital. We will thus discuss below the relations between FGM/C, loss and gains of various forms of capital and how this translates into the complex psychological experience of FGM and corresponding implications for culturally appropriate prevention of FGM/C. We will also address the question of habitus by arguing that while the practice of FGM/C is ritualized it is not an habitus. Rather, it is the behaviour of harassing and stigmatizing other non-cut girls that occurs in the aftermath of the FGM/C that constitute a habitus.

Accepting FGM/C to end psychological torture. The present study reveals that Izzi girls were strongly ostracized and bullied if they were known to be uncut. This very strong stigma and persistence at inflicting shame associated with the Akpapyi status is also described in other cultural groups practicing FGM/C (26,29,30). For example, in the Masai of East Africa, uncut women with children would not be called a mother, until they were cut (4,31). The humiliation does not necessarily end with the mutilation. In fact, the narratives of the participants of our study also shows stigmatization against women who experience complications following the FGM/C procedure. The reason for this behaviour is not entirely clear, however it may serve as a strategy to reinforce the practice by blaming those who do not succeed in completing the procedure without problems. Our results also suggest that the extreme ostracizing and harassment imposed on uncut Izzi girls equates to their social death, leading to great distress, as expressed by their feelings of anger, sadness, shame, embarrassment, social withdrawal and depressive symptoms. They therefore come to resign themselves to be mutilated because they prefer to suffer an acute and major physical pain from a potentially life-threatening procedure than to continue experiencing the unbearable chronic psychological torture afflicting them. Our results thus suggest that, in the cases where Izzi girls express “happiness” for being cut, this feeling of happiness streams from the relief of knowing their chronic psychological torture will end followed by a gain in total capital including their social, symbolic, cultural and economic capitals.

Being cut as a gain in various forms of capitals. The findings of this study reveal that the quality of our participant’s peer social network, what Bourdieu calls their social capital, is highly dependent on the fact of being cut or uncut. This needs to be understood in a context where FGM/C is being practiced by a collectivist society, where social relations are weaved in a web of interdependent relations (23, 28, 32, 33) wherein rites of passage, such as FGM/C (26) contribute to the construction of one’s identity. In a context where people from collectivist groups tend to pay less attention to internal processes and more to external processes to determine their social behavior, it becomes virtually unconceivable to go against such a strong sociocultural norms as FGM/C (34). Those who attempt to go against these norms suffer deleterious consequences, as the group may ultimately exclude dissenting individuals (18,35) which is what the participants mentioned was being done to them until they accepted to undergo FGM/C.

Conversely in conforming to the expectations of FGM/C, girls know they will get rewarded with gifts, food and social recognition. Thus FGM/C not only marks the end of the akpapi period of severe stigma but also provides the girls and women with a strong reintegration into their peer group, providing them with an identification that is crucial to the construction of their collectivist self (35). The narratives reveal their need to belong is a powerful, fundamental, and extremely pervasive driving force (36) behind their acceptance of FGM/C. It is therefore not surprising that social acceptance is the reason most frequently mentioned by women and girls to justify the perpetuation of the FGM/C practice in Nigeria, a phenomenon also observed in other African countries (24,26,37).

Girls are also aware they will gain in symbolic capital as soon as they get cut, with immediately gains in prestige, dignity and recognition by becoming officially a women fit to marry. This entry into womanhood confers respect with their new status being celebrated with gifts and food received during the ritualized

festivities of the post-FGM/C period, bringing a feeling of happiness mentioned by the participants of our study. The results also suggest that this gain in symbolic capital is intimately linked to the central cultural value attributed to women's reproductive role and the maternal body. In fact, African woman commonly value themselves through their "motherhood identity", with this social position giving them voice and power (38).

Our results also suggest that FGM/C attributes gains in cultural capital, by creating a maternal body that is thereafter believed to correspond to the culturally valued body of a complete woman, considered to be in control of her sexuality, capable of reproduction and giving birth to "normal" children. As FGM/C is believed to lead to a decreased libido, women also anticipate this will delay sexual intercourse after childbirth, thus ensuring child spacing, which would in turn allows better maternal care for children, thus improving their health. FGM/C thus contributes to cultural capital by giving a culturally valued body of a good mother and a good wife.

Finally, participants mentioned receiving immediate material rewards after being cut, such as gifts and special meals, which also suggest that being cut, will provide gains in economic capital. But more importantly, by becoming eligible for marriage provides cut girls with financial security otherwise hard to obtain. This phenomenon was observed in many other African communities, since a majority of women have neither access to education nor socio-economic conditions to be financially autonomous. Thus "marriageability" through being cut is considered synonymous of survival (23,33), especially in a context of widespread poverty. Thus, our results suggest that as long as the subsistence of women will be circumscribed within the context of gender inequities and economic dependence on men, and that women will not have access to the empowerment required to be financially independent, girls and women are likely to conform to the cultural norm for fear of jeopardizing their livelihoods (34).

There is however a relatively recent trend among African men towards wanting FGM/C to end (26) with an increasing number of them, particularly younger and more educated men, being aware of the risks of FGM/C, that would rather marry a non-mutilated woman (25). Yet one third of Nigerian girls and women report not being aware of what men may think of FGM/C (26). This may be explained by the fact that FGM/C is virtually never discussed between men and women (26).

Happy of passing from victim to persecutor. Above all, a striking finding of this study is the expressed desire and happiness of many newly cut girls to mock and persecute uncircumcised ones. Our results suggest that two related phenomenon, one sociological and the other psychological can explain this. By witnessing the perpetuator's behaviour over a long period of time, Izzi girls unconsciously internalize the fact that the persecuting behaviour is normal and expected from cut girls, a phenomenon Bourdieu calls an habitus; a behaviour that is experienced as natural, normal and expected way of behaving by the ones adopting it and by others of the same group (17). Thus by persecuting uncut girls, newly cut ones adopt an habitus that is also an expression and affirmation of their newly acquired status and corresponding gain in total capital. But from a psychological perspective, one would think that after being victims of psychological torture and the physical aggression of FGM/C, girls would advocate to protect their uncut

peers. In fact, studies have shown, that this type of behaviour of victim becoming aggressor can occur in cases of chronic aggressions exceeding the person's tolerance, a phenomenon known as the « identification with the aggressor » where a victim experiencing overwhelming fear and anxiety, often during a life-threatening experience, becomes executioner, thereby substituting a passive role to an active one, in which the aggressive revenge provides some form of relief (39,40). Moreover, adolescents who have undergone trauma often re-enact or replicate past traumas in their daily lives (41), which may explain why newly cut girls often display aggressive stigma toward uncut girls.

Paradoxically, this thirst for vengeance is not expressed towards the aggressor: victims are aggressive towards "a substitute" (40), seeking to belong to the group that formerly oppressed them (42,43). This reaction would in fact derive from a complex cognitive strategy allowing the victim to cope with the trauma, "to achieve some feeling of strength in an otherwise humiliating situation" (44). This dehumanized reaction, in which "emotions become detached from the events and dissociation serves as a means of survival" (42), would be stronger when victims have been traumatized over a prolonged period of time (44,45). In summary, taking revenge on their uncut peers allows them to make sense of being cut, reduce their cognitive dissonance, as well as find some form of relief from the psychological torture and trauma they experienced while expressing their new status and corresponding social power.

Psychological Consequences of FGM/C. The narratives of our participants thus reflect the incommensurable intensity of the psychological and physical aggression and humiliation Izzi girls are subjected both during the Akpapyi phase, as well as before, during and after the FGM/C procedure. These deleterious psychological consequences are, among other things, expressed by the newly adopted behavior of perpetuator and by the fact that many Izzi girls and women have reported suffering from psychological symptoms such as flashbacks, anxiety and depressive mood even years after the events, which can be related to a post-traumatic stress disorder. Our study also provided insight regarding the underlying psychosocial processes which contribute to the high rates of anxiety, depression and PTSD documented in adolescents who have undergone FGM/C (6,7,46–48).

Public health implications. The psychological results of this study suggest that knowing about the negative implications of FGM is not enough to prevent girls from voluntarily undergoing FGM/C. Efforts in achieving the eradication of FGM/C should account for the complexity of its underlying psychological, cultural and social intricacies. First, any activity aimed at preventing FGM/C must include mechanisms to eliminate the stigmatization and harassment towards unmutilated girls in the Akpapyi phase. This implies raising awareness – to all members of the community, including cut girls, about the deleterious physical and psychological implications of FGM, including during the uncut period. This also implies finding innovative and culturally appropriate strategies to replace the habitus in which cut girls harass and reject their uncut peers. Other beliefs such as "all men prefer having a cut wife" need an innovative intervention to debunk involving boys and men and key leaders in these communities.

Second, activities aimed at the elimination of FGM/C must offer culturally tailored strategies allowing the provision of new avenues for girls to increase their total capital. For example, finding alternative rites of

passage into womanhood could provide girls with symbolic and cultural capital. Other markers of passage into adulthood which could evolve from these communities through discussion and suggestion include reaching a certain level of education [5] which could also contribute to enhancing their economic and symbolic capitals. Finding local strategies such as micro-financing and entrepreneurship for reducing the economic dependency of women for subsistence would also help to enhance their economic capital.

Alternative strategies to favour girls' cultural capital should also be discussed and proposed, such as ways of redefining what a normal and valued body is. Additionally, in order to support good mothering and prolonged childcare by spacing out pregnancies, mothers should be encouraged to exclusively breastfeed for the first six months of the life of their child in order to delay the return of fertility [30], and should be provided with efficient and accessible contraception.

Third, our results suggest, in line with other studies (26), that developing and implementing prevention strategies should involve all members of the community including men and women, young and old as well as cut and uncut women and girls to better reflect the community dimension of FGM/C. Communities must be empowered to find their own solutions.

Strategies combining education and social mobilization have been shown successful at significantly decreasing the FGM/C prevalence. Among these, Diop & Askew [31] have evaluated a community education program implemented in Senegal, which included not only empowering women, but also involving the whole community towards eliminating FGM/C "through a broad range of educational and health-promoting activities". The program included components such as education on human rights regarding health and bodily integrity for adults and children, on problem-solving skills contributing to reinforce human rights protection, on the harmful effects of FGM/C on women's health, including reproductive health. Last but not least, the rejection and social stigma girls experience before undergoing FGM/C is to be taken seriously, because it gives rise to major deleterious psychological impact. Therefore, prevention of FGM/C program must provide psychological support and counselling for uncut girls if and when they are exposed to harassment and stigma. Furthermore, cut girls and women need to receive the appropriate care, either from the healthcare system or from community agencies, to reduce the psychological consequences of FGM/C, in accordance with the "World Health Organization guidelines on the management of health complications from FGM/C" (49).

Limitations Of The Study

Although the present findings provide socio-culturally contextualized and novel insights into girls' and women's experience surrounding FGM/C across the life cycle, it has some limitations. Firstly, it was focused on the Izzi ethnic group, which could possibly demonstrate unique behaviours, unshared by other communities. More research is needed in order to find out if this phenomenon of psychological torture is spread among other communities. This study was also limited by the fact that only cut girls and women were interviewed. It would have been more complete to also interview mothers, to find out if they too are pressured to have their daughters cut, as was found in other contexts (37) and younger and older men to

understand how they perceived FGM/C in relation to the notion of marriageability of girls. Finally, more research in different contexts is needed to better apprehend the complex phenomenon surrounding psychological torture around FGM/C.

Conclusion

The process of undergoing FGM/C involves tremendous suffering and corresponding short and long term deleterious psychological consequences in spite of the emotion of relief expressed by participants when they knew they would escape from social rejection associated with being uncut. This study informs public health program planners and policy makers to address loss and gain in total capital, as well as planning the involvement of whole communities in the process of developing strategies from within to eradicate FGM/C. Eliminating FGM/C is a human rights imperative to protect girls' and women's physical, mental and social wellbeing, their bodily integrity and their life, but this needs to be done by taking into account the psychological, social and cultural contexts in which this harmful tradition is being practiced.

Abbreviations

FGM/C: female genital mutilation/cutting

UNICEF: United Nations Children's Fund

WHO: World Health Organization

Declarations

Ethical Approval and Consent to participate The Research and Ethics Committee (REC) of the Ebonyi State University Teaching Hospital (REC approval number: 13/10/2011-31/01/2012) and the World Health Organization's (WHO) Ethical Committee gave approval for this study. Informed consent forms were read by all participants or read to those who could not read and each participant either signed or thumb printed the forms.

Consent for publication.

Not applicable.

Availability of supporting data.

Given the qualitative and personal nature of the data, the data is not available for others outside the research team.

Competing interests.

No competing interest exist for the authors of this paper.

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Authors' contributions.

Olayinka Omigbodun worked with the co-investigators in the conceptualisation of the study including the research methodology, supervised the research activities, participated in all stages of the analysis and wrote the first draft of this manuscript. Nkechi Emma-Echiegu Tolulope Bella-Awusah, Jibril Abdulmalik and Akinyinka Omigbodun also worked to conceive the research protocol, participated in all stages of the analysis and contributed to writing of the manuscript. Danielle Groleau and Marie-Hélène Doucet co-wrote the introduction, method, discussion and conclusion sections. Danielle Groleau edited all sections, supervised the methodological aspects of the study, trained the research team to qualitative methods and the use of the MINI. She also adapted the English version of MINI to address the psychological experience of FGM and completed the theoretical interpretation of the data.

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References

1. World Health Organization. A systematic review of the health complications of female genital mutilation including sequelae in childbirth. 2000.
2. WHO. Eliminating female genital mutilation: an interagency statement-OHCHR, UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCR, UNICEF, UNIFEM. World Health Organization; 2008.
3. Berg RC, Denison EM-L, Fretheim A. Psychological, social and sexual consequences of female genital mutilation/cutting (FGM/C): a systematic review of quantitative studies. Norwegian Knowledge Centre for the Health Services; 2010.
4. Mulongo P, McAndrew S, Hollins Martin C. Crossing borders: Discussing the evidence relating to the mental health needs of women exposed to female genital mutilation. Int J Ment Health Nurs. 2014;23(4):296–305.
5. Omigbodun O, Bella-Awusah T, Groleau D, Abdulmalik J, Emma-Echiegu N, Adedokun B, et al. Perceptions of the psychological experiences surrounding female genital mutilation/cutting (FGM/C) among the Izzi in Southeast Nigeria. Transcult Psychiatry. 2020;57(1):212–27.

6. Behrendt A, Moritz S. Posttraumatic stress disorder and memory problems after female genital mutilation. Am J Psychiatry. 2005;162(5):1000–2.
7. Mulongo P, Martin CH, McAndrew S. The psychological impact of Female Genital Mutilation/Cutting (FGM/C) on girls/women's mental health: a narrative literature review. Journal Of Reproductive Infant Psychology. 2014;32(5):469–85.
8. UNICEF. Situation Analysis of Children and Women in Nigeria, 2011 Update. 2011.
9. Federal Republic of Nigeria. Nigeria: Violence Against Persons (Prohibition) Act, 2015 (VAPP) [Internet]. Refworld. [cited 2021 Apr 2]. Available from: https://www.refworld.org/docid/556d5eb14.html.
10. Sipsma HL, Chen PG, Ofori-Atta A, Ilozumba UO, Karfo K, Bradley EH. Female genital cutting: current practices and beliefs in western Africa. Bull World Health Organ. 2012;90:120–7.
11. Dattijo LM, Nyango DD, Osagie OE. Awareness, perception and practice of female genital mutilation among expectant mothers in Jos University Teaching Hospital Jos, north-central Nigeria. Nigerian Journal of Medicine. 2010;19(3).
12. Dare FO, Oboro VO, Fadiora SO, Orji EO, Sule-Odu AO, Olabode TO. Female genital mutilation: an analysis of 522 cases in South-Western Nigeria. J Obstet Gynaecol. 2004;24(3):281–3.
13. Ugboma HA, Akani CI, Babatunde S. Prevalence and medicalization of female genital mutilation. Nigerian journal of medicine: journal of the National Association of Resident Doctors of Nigeria. 2004;13(3):250–3.
14. Echiegu AOU. Yesterday & Tomorrow in Ezaa and Izii's Today. I. Loyola Books Centre; 1998.
15. Green J, Thorogood N. Qualitative methods for health research. sage; 2018.
16. Groleau D, Young A, Kirmayer LJ. The McGill Illness Narrative Interview (MINI): an interview schedule to elicit meanings and modes of reasoning related to illness experience. Transcult Psychiatry. 2006;43(4):671–91.
17. Bourdieu P. Distinction: A social critique of the judgement of taste. Harvard university press; 1984.
18. Bourdieu P. The forms of capital. Handbook of theory and research for the sociology of education. JG Richardson New York Greenwood. 1986;241(258):19.
19. Bourdieu P. Social space and symbolic power. Sociological Theory. 1989;7(1):14–25.
20. Groleau D, Sigouin C, D'souza NA. Power to negotiate spatial barriers to breastfeeding in a western context: When motherhood meets poverty. Health Place. 2013;24:250–9.
21. Groleau D, Rodriguez C. Breastfeeding and Poverty: negotiating cultural change and symbolic capital of motherhood in Quebec, Canada. Oxford: Blackwell Publishing; 2009. pp. 89–98.
22. Bourdieu P, Passeron J-C. Reproduction in education, society and culture. Vol. 4: Sage; 1990.
23. Obiora LA. The little foxes that spoil the vine: revisiting the feminist critique of female circumcision. Can J Women L. 1997;9:46.
24. Yoder PS, Mahy M. Female genital cutting in Guinea: qualitative and quantitative research strategies. Measure DHS+, ORC Macro;; 2001.

25. Gosselin C. Feminism, anthropology and the politics of excision in Mali: Global and local debates in a postcolonial world. Anthropologica. 2000;43–60.
26. UNICEF. Gupta GR. Female genital mutilation/cutting: a statistical overview and exploration of the dynamics of change. Reproductive Health Matters. 2013;184–90.
27. Kpanake L. Cultural concepts of the person and mental health in Africa. Transcult Psychiatry. 2018;55(2):198–218.
28. Triandis HC. Individualism-collectivism and personality. Journal of personality. 2001;69(6):907–24.
29. Yoder PS, Camara PO, Soumaoro B. Female genital cutting and coming of age in Guinea. Female genital cutting and coming of age in Guinea; 1999.
30. Shell-Duncan B. The medicalization of female "circumcision": harm reduction or promotion of a dangerous practice? Soc Sci Med. 2001;52(7):1013–28.
31. Boyle EH. 1962-. Female genital cutting: cultural conflict in the global community [Internet]. Baltimore: Johns Hopkins University Press; 2002 [cited 2021 Apr 1]. Available from: http://site.ebrary.com/id/10021645.
32. Jackson M. Life within limits: Well-being in a world of want. Duke University Press; 2011.
33. Abusharaf RM. Virtuous cuts: female genital circumcision in an African ontology. Differences: a journal of feminist cultural studies. 2001;12(1):112–40.
34. Abusharaf RM. Rethinking feminist discourses on female genital mutilation: the case of the Sudan. Canadian Woman Studies. 1995;15(2).
35. Triandis HC. The self and social behavior in differing cultural contexts. Psychological review. 1989;96(3):506.
36. Baumeister RF, Leary MR. The need to belong: desire for interpersonal attachments as a fundamental human motivation. Psychological bulletin. 1995;117(3):497.
37. Vissandjée B, Kantiébo M, Levine A, N'Dejuru R. The cultural context of gender, identity: female genital, excision and infibulation. Health Care Women Int. 2003;24(2):115–24.
38. Oyewumi O. Introduction: Feminism, sisterhood, and other foreign relations. African women and feminism: Reflecting on the politics of sisterhood. 2003;1–24.
39. Ferenczi S. Confusion of tongues between adults and the child: The language of tenderness and of passion. Contemporary psychoanalysis. 1988;24(2):196–206.
40. Freud A. The ego and the mechanisms of defence. Routledge; 2018.
41. Hamblen J, Barnett E. PTSD in children and adolescents. National Center for PTSD, in www ncptsd org. 2014.
42. Mészáros J. Building blocks toward contemporary trauma theory: Ferenczi's paradigm shift. The American journal of psychoanalysis. 2010;70(4):328–40.
43. Sironi F. Comment devient-on un bourreau. In: Les mécanismes de destruction de l'autre Conférence prononcée au Collège de France le 31 Janvier 2001. 2001.

44. Melsky RE. Identification with the aggressor: How crime victims often cope with trauma. FBI L Enforcement Bull. 2004;73:16.
45. Chagnon J-Y. Identification à l'agresseur et identification projective à l'adolescence. Topique.2011; (2):127–40.
46. Im H, Swan LE, Heaton L. Polyvictimization and mental health consequences of female genital mutilation/circumcision (FGM/C) among Somali refugees in Kenya. Women Health. 2020;60(6):636–51.
47. Piroozi B, Alinia C, Safari H, Kazemi-Karyani A, Moradi G, Farhadifar F, et al. Effect of female genital mutilation on mental health: a case–control study. The European Journal of Contraception Reproductive Health Care. 2020;25(1):33–6.
48. Abdalla SM, Galea S. Is female genital mutilation/cutting associated with adverse mental health consequences? A systematic review of the evidence. BMJ global health. 2019;4(4):e001553.
49. World Health Organization. WHO guidelines on the management of health complications from female genital mutilation. World Health Organization; 2016.

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