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Reconstructing Sexuality after Excision: The Medical Tools

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ABSTRACT

Clitoral reconstructive surgery is not sufficient to restore women's sexual pleasure after excision. If the surgical technique aims at reconstructing the cut clitoris after type 2 female genital mutilation, the surgery alone cannot reconstruct other dimensions invoked by women in their requests for the procedure. In France, where clitoral reconstructive surgery since 2004 has been entirely covered by national insurance, a multidisciplinary approach precedes the surgery. Ethnographic fieldwork in one public hospital contributes a wider comprehension of the entire process of clitoral reconstruction, as well as the tools elaborated by the medical team. In particular, analysis of the assessments of the psychologist and sex therapist compiled in the medical folders shows how the multidisciplinary medical team developed specific tools. These tools are oriented at reconstructing the patient's sexual sensibility, at breaking through psychological blocks such as self-esteem and body image, and/or at addressing abusive intimate relationships.

KEYWORDS

Clitoris; counseling; female genital cutting; reconstruction; sexuality; surgery

Since 2004, a surgical technique has been introduced in France as a healthcare procedure for women who have undergone female genital mutilation/cutting (FGM/C). This surgery, completely reimbursed by national insurance, aims at reconstructing the exterior part of the cut clitoris, restoring the organ, and repositioning it in its original site (Foldès 2004). This technique is indicated particularly for women reporting type 2 of FGM/C (WHO 2008), although studies are still needed to clarify the benefits and side effects (Abdulcadir, Rodriguez and Say 2015). As a result of France's relationships with its former colonies, there is specific migration from francophone West Africa, regions where type 2, also called excision,[1] is widespread. Although the prevalence of excision varies according to geographical origin and ethnic belonging (Yoder, Abderrahim and Zhuzhuni 2014), type 2 is the most common form of FGM/C in France. Here, a new target population has started to ask for clitoral reconstruction: young women born in France from sub-Saharan immigrant parents. Most of these women were cut[2] in childhood during short trips to or holidays in the countries of parents' origins; few have been cut in France, as this was highly repressed by the French Court for twenty years between 1980 and 2000, and has long been criminalized (Villani 2020).

The surgery is today available in many French public hospitals, and widely in Europe (Jordal and Griffin 2017), as part of a broader multidisciplinary healthcare (Leye 2018). A multidisciplinary team often includes a gynecologist (who is also the surgeon), a midwife, a psychologist and a sex therapist. Once entered in the protocol, women see each specialist in an individual consultation along what I called the "reparation journey" (Villani 2009). Once they start the protocol, women step into a pathway of reconstruction, involving multiple consultations mainly within the hospital. At the end of this pathway, the medical team discusses, in a staff meeting, the patient's profile and her request for surgery. Finally, the specialists decide together on the appropriate treatment. In this article I briefly explain the general functioning of the multidisciplinary protocol (for detail, see Villani 2009). I pay particular attention to the

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psychological and sexual counseling, both of which are compulsory and precede the surgery.[3] Based on an analysis of the psychological and sexual assessments contained in the medical folders, I describe the cognitive environment in which women's narratives are produced, induced by the psychologist and the sex therapist. During the consultation, women invoke many dimensions (Villani 2017), and the medical team aims at responding and orientating women's demands into effective reparative and restorative approaches. In this article, I analyze the translation of women's demands into a medical procedure.

Sexual pleasure, excision and advances in medicine

The literature concerning pleasure and desire among women with FGM/C is mainly based on a biomedical understanding of sexuality (Johnsdotter 2020; Johnson-Agbakwu and Warren 2017) and embedded in Western representations and definitions of sexuality and sexual health (Ahmadu 2000; Giami 2002; Johnsdotter 2013). Sexuality as apprehended by social sciences and sexuality studies (Irvine 2014), however, is the result of a process of learning and socialization (Gagnon and Simon 2005). Quantitative studies of sexual function among women with FGM/C report sprawling results: when groups of cut and uncut women are compared, differences are small (Catania et al. 2007; Ismail et al. 2017; Rosen et al. 2000). The limitation of quantitative studies and the necessity to improve questionnaires concerning the Female Sexual Function Index (FSFI) have been highlighted (Abdulcadir et al. 2016; Berg and Denison 2012; Catania et al. 2007; Johnson-Agbakwu and Warren 2017; Obermeyer 2005).

Change due to migration displaces a number of things – not only people, but also cultural references, norms and values. Qualitative studies, albeit few in number, show that sexual norms change in the context of migration, producing a shift from normality to abnormality (Bell 2005; Connor et al. 2016; Villani 2015). Another study using mixed methods reports that the change of context and cultural references may have negative effects in the form of "chronic psychosocial and sexual problems" (Vloeberghs et al. 2012:692). The intergenerational transmission of values and traditions from the first to the second generation of migrants also raises the question of moral behavior concerning women's sexuality (Koukoui, Hassan and Guzder 2017; Villani and Bodenmann 2017). Other studies show the difficulty and ambiguity by which women with FGM/C in Western countries signify and understand medical gestures such as defibulation (Johansen 2017).

If African activist women struggle with FGM/C in their own countries (Gruenbaum 2005; Hernlund and Shell-Duncan 2007), the interventions of international organizations have reproduced a Western vision of the practice (Ahmadu 2000). Prevention campaigns and media discourses have contributed to constructing women with FGM/C as "victims of barbarism," stigmatizing their culture of origin or their ethnicity (Alhassan et al. 2016). Western discourses on mutilation have produced a cognitive and cultural environment in which FGM/C is seen as an experience of loss of identity, defective femininity, or sexual deformity (Catania et al. 2007; Johnsdotter et al. 2009; Villani 2017). The WHO still defines both types (I and II) as "the partial or total removal of the clitoris," while referring to the glans of the clitoris. Although clitoral anatomy has been updated, the external visible part of the clitoris is portrayed – even in official documents and public discourses[4] – as proof of the organ's functionality. The diachronic definition crystallizes the unsolved tensions between scientific and ideological positioning when it comes to bodily integrity (Manderson 2004). Moreover, in the West the clitoris has become a symbol of women's sexual liberation (Fusaschi and Cavatorta 2018; Gosselin 2000), while excision is seen as a symbol of the sexual domination of women (Ahmadu 2000; Fainzang 1985). This environment influences also male partners who have started to adhere to the representation of FGM/C as an expression of defective femininity and dysfunctional sexuality (Gele, Johansen and Sundby 2012; Johnsdotter et al. 2009; Johnson-Agbakwu et al. 2014; Wahlberg et al. 2017).

In this context, clitoral reconstructive surgery has proliferated in different European countries, and – although the benefits and side effects are unclear (Abdulcadir et al. 2015) – women with FGM/C in Europe undergoing clitoral reconstructive surgery mostly report that their sexual life is enhanced and improved (Foldès, Cuzin and Andro 2012). The principal motives for surgery for clitoral reconstruction are social aspirations (Villani 2017) and hope for a "better life" (Jordal, Griffin

and Sigurjonsson 2018). On one hand, the will to repair the stigma of FGM/C needs to be read in relation to the construction of discourses stigmatizing FGM/C; on the other hand, the personal and sexual experiences of women with FGM/C living in European countries must be taken into account. The research on which this article is based originated with the aim of understanding how the logic of women patients and the medical establishment coexist in the context of reconstruction after excision.

Clitoral reconstruction, because it touches varied dimensions (well-being and pain, sexuality and identity), demands diverse tools: physical reconstruction and physiological rehabilitation of the clitoris; re-education on the way to touch; the adaptation to new sensations and feelings; learning a new theoretical framework to enable women to live their sexuality differently. The process of clitoral reconstruction is intended in terms of the rehabilitation of pleasure, but also of adjustments of sexual desires. While the process of organ rehabilitation is the subject of many medical articles, few have analyzed psychological and sexual healthcare and the medical tools elaborated in order to respond women's demands.

Methods

The analysis is based on ethnographic fieldwork conducted during doctoral research, in one public hospital in France offering a multidisciplinary approach to healthcare. In addition to participant observation at staff meetings for two years, data from medical files were collected. In particular, I examine 108 expert assessments included in the medical files of women who made the request for the surgery between November 2005 and March 2008. All these files were archived. In order to analyze the medical process of classification, evaluation and finally interpretation of women's request, I focus in particular on the assessments of the sex therapist (61 reports) and the psychologist (47 reports).

Reports are often handwritten and reflect the specialist's point of view concerning women's requests. In analyzing the reports, I highlight on the one hand the medical reasoning, and on the other, how excision is supposed to be treated in the context of psychological and sexual rehabilitation. I used textual and thematic analysis methods (Packer and Addison 1989; Prasad 2005), focusing in particular on the choice of words to describe and classify women's requests. I have selected some cases in order to illustrate aspects of medical activity and interpretation (medical doubts, questions, ambivalences, hesitancy).

I consider the medical report as a product of the medical knowledge (Kitsuse and Cicourel 1963), tracing the medical power of naming and framing (Dodier 1994), in that they establish a medical decision about healthcare and treatments. In this sense, I conducted a meta-analysis of the medical files as a product of medical knowledge (Illic 1976; Latour 1993) and of discourses surrounding FGM/C.

From women's requests to medical treatments

The motivation for surgery is central to entering the protocol. The medical team interrogates women's motivations for the surgery and classifies them into four categories: physio-pathological, sexual, identity and symbolic. The physio-pathological motivation is based on the patient's complaint about a felt symptom (burning, itching), discomfort or pain in the area of the excision (the scar). Most of the time, a disorder is diagnosed: dyspareunia (pain during sexual intercourse), dysmenorrhea (pain during menstruation), pelvic infections, keloid scars, or dysuria (micturition disorders).[5] Many of these immediate and long term consequences are reported in the scientific literature (Berg and Denison 2012), but the physiological motivation represents the smaller number of requests of clitoral reconstructive surgery (Villani 2017). The sexual motivation is based mostly on the desire of the patient to improve her sexual life, by the wish to "feel more," "have pleasure during intercourse," "be more excited," and increased libido, which women judged as too low. The identity related demand is motivated by a distorted body image and discomfort linked to the appearance of the body, the genitals (seen as abnormal, deviant, different) and their projection of gender

(femininity). The psychologist in particular points to women's desire to conform their physical appearance and the esthetics of their genitals to what is considered to be "normal."

The symbolic motivation mainly expresses feelings of betrayal or having been subjected to a form of violence and desire for a reparation for what has been done. In the medical files, feelings such as anger and hatred are registered. The psychologist and the sex-therapist write down women's formulations such as the sentiment of "having been betrayed" or "having been subjected to violence" or the impression of "having had something stolen that belongs to her." Both the psychologist and sex therapist report that clitoral reconstructive surgery represents, in some women's requests, a way of being rewarded, paid back and finally repaired. The identity and the symbolic motivations are the most commonly cited reasons for surgical revision reported in the psychologist and sex therapist assessments.

After having been registered in the medical files, women's requests are evaluated in a first stage, then assigned to specific treatments in a second stage. Those treatments are complementary and framed in therapy before the surgery. Temporality is adjusted according to the woman's maturity (Villani 2009); the protocol is not rigid in terms of time. Some requests may appear "unclear," "ambiguous," or even "paradoxical;" the psychologist might judge that women's expectations are "too high" or "unrealistic," and state that the woman "needs more time to reflect." Other requests are considered "clear," "thoughtful," and "mature," and the medical team states that the patient is "ready" for surgery. The medical team discusses collectively and assesses the adequacy of the treatment. Subsequently, because the words with which women formulate their requests may influence the team, the decisional process is not definitive, but is structured along an expanded timeframe during which women are invited – more or less explicitly – to adjust their initial intentions and expectations.

From a medical perspective, time plays an important role in the re-formulation of demand. Some women have no memories of their excision, especially if it was done in early childhood. Some affirm that the "discovery" of having been cut comes later, during adolescence or early adulthood, or at the time of first sexual intercourse or first gynecological examination. Moreover, the discovery of the excision represents the moment in which women start to feel embarrassed or ashamed of their bodies, their genitals and their family. Their shame or sense of culpability confirm the sociocultural construction in France of excision as a "bad practice" (Ahmadu 2000). Time from discovery to request for clitoral reconstruction could extend from a few months to several years: it corresponds to the time in which excision is reformulated by women as a problem. The analysis of medical files shows the plasticity of women's narratives, which develop and change along the path. The whole process deals with the back and forth movement of framing and reframing narratives of excision and reasons for reconstruction.

Ambivalent desires, unclear motivations, and unsuccessful demands

In this section, I analyze demands that considered as insufficiently discernible or unclear. I will use as illustration five cases in which specific elements are identified by the medical team as obstacles to clitoral reconstruction – elements constituting barriers to the efficacy of surgery. The medical team identify specific conditions before surgery for reconstruction to be successful. To aid such success, the psychologist and the sex therapist offer some tools to the patients.

The first condition is that the woman presents a clear intention to the medical team. If the intention is seen as vague and unclear, the desire for change is perceived as ambiguous. Kadi, for example, was classified as "ambivalent." She was 25 years old. and had moved to France three years earlier from the Ivory Coast, where she grew up. She belonged to the Djoula ethnic group. When she submitted her request, she was awaiting the regularization of her residence permit, and so was temporarily excluded from public health services. The psychological report underlines the ambivalence of her request, reflecting the ambiguity of her civil status:

> The patient seems closed at first sight. Difficulty in developing reasons for the request and expectations for the surgery. She mostly put forward the sexual problem, her sexual dissatisfaction, her desire 'to go until the end'

> and access pleasure. The patient has a low investment in her relationship with her companion, whom she describes as a rigid man, 'not modern,' steeped in tradition and opposed to clitoral reconstruction because it is 'natural' to be excised. The patient defines herself as detached from the tradition, but her speech reflects an integration of beliefs justifying excision ('if I had a clitoris I may go here and there',[6] 'the fact of being excised allows me to control my sexuality'…). Ambivalent request. Allow time (Psychologist).

Aisha's demand was classified as paradoxical. Aisha was 44, born in Nigeria from the Ijaw ethnic group. She arrived in France at the age of 20 to pursue her university studies, and, after graduating in social sciences, teaches English. She is childfree and in a relationship with a married French man. She was excised in very early childhood and has no memory about the event:

> She is not so much traumatized by her excised status (the abnormality of which only appeared after migration to France), and, at the same time, she seems quite free as a woman, considering her culture of origin. She is very free sexually, has a very 'active' sexuality, but has relations with men which are visibly very unsatisfactory, she is caught in a cultural scheme which is quite 'submissive' (she is with a married man who she can see only rarely) – she seems to have little interest in her own pleasure (Sex-therapist).

Patient decided to do the reconstructive surgery, but relatively paradoxical motivations: on one hand she wants to find out what it's like to have a clitoris, but on the other hand, she affirms that she was cut only 'a little bit' (minimizing the mutilation); she wants to be a woman like the others BUT has never been embarrassed or shaken since the discovery of her excision. She is shocked by media reports on excision, but she does not identify herself with the mutilating and violent aspects of mutilation, nor does she see herself as a victim. For her, in Nigeria, FGM is almost symbolic, as the gesture is reduced to the smallest cut 'to please the grandparents' (Psychologist).

Both Kadi and Aisha's sexual demands were refused. If Kadi appeared too comprehensive and her arguments are judged as contradictory, Aisha appeared too far from the image of "victim" (Bader 2019) that is commonly portrayed of women with excision. Aisha's speech is perceived as "minimizing the mutilation" because she doesn't emphasize the traumatizing aspects of being cut. The way in which she copes with her excision troubles the medical presupposition of what it means to live with excision. Finally, the specialists interpret Kadi's ambivalence as a sign of immaturity, instead of lying on a continuum with the ambiguity of her immigrant status (she has been in France for three years but is still undocumented), and regard Aisha's paradoxical standpoint as suspicious (she is cut but she is not traumatized).

Another type of element that leads the medical team to postpone or refuse the reconstructive surgery is what is identified a "block." Yacine's case is an example. She is 22 years old, born in Paris of Malian parents, and is pursuing her studies at the university. She was excised at the age of six in France, but does not remember this. She has suffered from a prolonged and severe form of dysuria from her childhood through to her adolescence.

> Charming but quite 'inhibited': never had romantic relationships, because quite negative self-image (does not see how a boy could be interested in her). Attempted to caress her sex, but quickly stopped because of feeling shame/embarrassment. Apparently quite 'repressive' education. Great desire for personal fulfilment and 'normalization' ('no boyfriend at 22 is serious … '), but able to understand that it is primarily herself that she must 'work' on in the long term (Sex therapist).

From the sex therapist's point of view, Yacine should engage in body exploration and work on a process of freeing herself from her "repressive" upbringing. Major blocks pointed out in her file are feelings of shame and embarrassment regarding sex and touching her own body. In the interest of addressing these, the sex therapist suggests non-oriented caresses.

Awa illustrates another type of block interfering with the process of reconstruction. Awa is 20 years old and was born in Paris of Senegalese parents. She discovered having being cut very recently, from her gynecologist. Until that day she perceived herself as "normal," but since then she started to feel "troubled in her body." This feeling led her to test herself in different sexual

experiences (different partners, bisexuality) and contexts (partner-swapping). As she declared, she wanted to see if "everybody sees her as different."

> Anxiety about showing her body. Impression of abnormality. Sexual intercourse in general not too difficult. In particular, she had a very 'initiating' partner who allowed her to perceive herself as a desirable and desired woman. He introduced her to masturbation (very taboo until then) and sex with desire/pleasure/orgasm (Sex therapist).

> Motivation above all symbolic. Surgical reconstruction is part of a global journey of reparation, of reappropriation of life by the patient. No exaggerated expectations, but an essential step in her personal journey (Psychologist).

Both the sex therapist and the psychologist find that Awa's experiences are "very similar to uncut girls of her age." She is encouraged in these sexual experiences, which help her to work on her self-confidence. Both Yacine and Awa are classified as making identity related requests; both of them state that they feel uncomfortable in their own bodies and with their femininity. The sex therapist suggests to Yacine some body exploration and awareness of new sensations, and Awa is invited to explore her sexuality. The medical team concludes that surgery will not solve the quest for "normality." Shame and anxiety are feelings affecting women's self-esteem, which are here considered as priority blocks that need to be resolved before surgery is considered.

A third element noticed by the medical team as a potential factor preventing the success of surgical reconstruction is the gender roles within the couple and the nature of the intimate relationship. Sakina is a 26-year-old woman, born in Paris of Malian parents. Since early childhood, her polygamous father had exposed her to multiple types of violence. When she was five, he forced his first wife (Sakina's mother) to go back to Mali and then married a second wife: Sakina suffered from abandonment. From that moment, Sakina experienced many forms of child abuse: she was obliged to work in the house and was beaten; she was forced to marry a cousin; when she refused, she was banished from the family and suffered from social isolation. She has two children who she brings up alone, and one of these is being monitored by child welfare. She lives on social benefits in a very precarious condition and suffers from depression. Her partner, born in France of Senegalese parents, is absent and described by Sakina as "blunt, brusque, absent."

> Currently: sexual intercourse is almost always painful; little spontaneous desire/a little desire but more 'answering his desire.' Very recently rather positive evolution: excitement (brief) during readings, films; pleasure (a bit short too) in certain positions (she on top of him). No self-eroticism (masturbation) but experience of erotic dreams (astonished…). Problem of dialogue with the partner = cannot express her needs. Partner 'little caressing' → she is lacking (tenderness, small touches) but she cannot manage to tell him (Sex therapist).

The absence of autoeroticism is diagnosed as a sign of dysfunction of the couple. The partner is described by the sex therapist as engaging in "little caressing'" and as not listening. For the sex therapist, the couple does not have "good functioning" and is the major problem. In a staff meeting the sex therapist insists on explaining that sexual pleasure comes from reciprocity and all the activities are shared by the partners: dialog, agreement, sensual caresses, kisses, reveries, foreplay. Sakina was denied these forms of engagement from an early age, and excision is only one point in a constellation of violent experiences that Sakina has suffered over her life course.

Clear claims and mature requests: Successful demands

In this section, I analyze demands identified as "mature" and "clear," which enable women prompt surgery. I will report five cases, each illustrating a different type of speech leading to surgery. Mayeni is the first example. She is 38 years old, born in the Ivory Coast among the Guere ethnic group. She arrived in France when she was 12 and was almost unschooled when she was married at the age of 15 to a man from Ivory Coast, 20 years older than her. She has four children and defines her arranged

marriage as happy. She works as a caregiver. Mayeni's discourses around sexuality and sexual rights are very modern, and very much appreciated by the medical team:

> The patient expresses a clearly thought out request for reconstruction, which is more symbolic than physical. A desire to feel like others, no excessive expectations at the level of physical sensations, but evokes the importance of the aesthetic aspect for her = in her last romantic relationships source of embarrassment and shame (rejection more or less expressed by her partner) ⇒ clear, mature request (Psychologist).

The medical team particularly appreciated the moderation of Mayeni's request as thoughtful, discrete, without unrealistic expectations from the surgery. Mayeni is considered a reasonable patient and fit for the surgery. Like other migrant women, Mayeni builds her narrative around the desire to be "like others," that is, like uncut women living in France, but also having access to pleasure like "everybody else." The medical team agrees with the psychologist's classification of Mayeni's request as symbolic, because in this case it is not the expected result (major changes after surgery) but the intention (trying to conform, wanting to be like others) that is valorized.

Women of the second generation who present for clitoral reconstruction are often younger. Their narratives also vary and are often expressed through feelings of hate and rage. Rougi is the first example. She is a 23-year-old woman, born in Paris of Senegalese parents belonging to the Toucouleur ethnic group. She is childfree and in a relationship with a French man. She has a university degree and works as an agent in a private insurance company. Her request was justified in particular by her hatred toward her parents' culture.

> Young woman, intelligent and clear. She: 'I feel hate' against my aunts, against my grandmother, against African men. Never wanted to return to Senegal since she was 13 years old. Motivation for surgery: 'to be complete', to be repaired from what was taken from her, and 'to turn the page': 'It could help me to forgive, to come back to Senegal to see my grandmother … I cannot live with this hate' (Sex therapist).

Rokhaya was also born in Paris of Senegalese parents, belonging to the Soninke ethnic group. She is a single woman aged 30, without children, with a university degree, working as director of a recreational center for children.

> Great anger against her father (had power in her community, unlike her mother who was not there to protect her). Anger about women's inequalities. She was in opposition since her adolescence and left parent's home for living alone. Strong identity demand ('*to be complete,*' '*to decide by myself on my life*'). Strong personality, very mature, very lucid, very rich development on verbal level (Sex therapist).

For women of the second generation, feelings of hatred and anger directed at mothers, grandmothers, parents, even African men in general, are registered in the medical file. Their arguments are less about sexual pleasure and more about gender identity. Women born in France often highlight the idea of equality in terms such as "I want to be like all other women," in terms of completeness and integrity, also expressed by statements such as "I want to be complete." Clitoral reconstruction becomes the way to reconstruct the subject they would have liked to be, had they not been cut. These women imagine that they could have been different, and see the excision as the moment when their life course was interrupted. According to the sex therapist, their anger and hatred are "emancipatory feelings," providing them with a catalyst for change. They are portrayed as "fighters" with strong wills, manifesting their rebellion against family's members representing the tradition. They are considered women who have the resources for change. The violence they suffered becomes the strong motivation that justifies their request for surgery. Recognizing themselves as victims, and their capacity for resilience, are emphasized in the reports.

The desire for reaching completeness is also expressed by denouncing the trauma of being deprived of bodily integrity. Dior's request particularly highlighted her will to find body comfort and to protect herself from vulnerable situations. Dior was 19, born in Paris of Malian parents of the Soninke ethnic group. She was in an abusive relationship with a man from Martinique, and she reports having been accused of feigning pleasure during intercourse. Her partner accused her of lack of sexual desire. She feels insecure and ashamed about her body, and agrees to sexual intercourse

only in the dark in order to avoid "that he sees my body." Her request is motivated by her need to redress her sense of emptiness:

> The discovery of her excision was simultaneous with a television shock report. Total cessation of sexual intercourse for several reasons: shame of her body, sensation of having suddenly switched into abnormality, afraid of questions which remain unanswered, in fact of her total absence of memories, afraid of the judgment of her parents by her boyfriend. Conduct of avoidance of sexual relations BUT not towards her body: began to look at her sex for the first time, 'there is nothing, it is all empty' [Psychologist].

Zuma is 32, born in Guinea Conakry in the Sousou ethnic group. She arrived in France when she was nine, just after her excision, which took place in a hospital. She was completely schooled in France and after a second degree, she started to work in the administrative sector. She married twice and has a child from her second marriage.

> Everything was going well for her sexually until the moment he 'brutalized' her, saying that she was excised and therefore could only simulate the pleasure, from that moment there was deterioration of the couple and finally separation. (Sex therapist).

The medical team interprets the difficulties of living with a stigma (the excision) as a form of "handicap" preventing women from engaging in many activities (sexual intercourse, showing the naked body), leading to them feeling ashamed over their genitals. Many women relate having been accused by their male partners of being "bad sexual partners." These accusations affect sexual well-being and lead to feelings of shame and discomfort; the sex therapist considers these experiences highly traumatizing.

Finally, Samya's case illustrates how the medical team appreciates moderate, reasonable and deliberate speech about sexual pleasure. Samya is 25, born in Paris of Malian parents. She is a single mother and raises her two year old son alone; her Senegalese partner is in prison.

> More psychological motivation: to know that she has recovered what has been removed from her, even if there is no change in sensations. Before seeing the sex therapist, motivation to 'be normal,' like others but a big change since her interview with sex-therapist: apparently regained confidence in herself because she relativizes the unbridled sexuality and full enjoyment of uncircumcised women (Psychologist).

All cases, summarized in Table 1, helped to illustrate the medical process of collecting and registering women's requests, categorizing them into main types (physiological, sexual or identity related), and determining appropriate treatment.

Conclusions

If female genital mutilation/cutting (FGM/C) has been constructed as a barbaric practice damaging to women's health and sexuality, the rawness of images used in early prevention campaigns and other discourses against FGM/c contributed to the portrayal of women with excision as victims of a barbaric culture who had forever lost their femininity and capacity for sexual pleasure (Manderson 2004). These representations, in images and discourses, of female violated and brutalized bodies, affect women's perceptions of being cut, living in France. Women state that they "start" to perceive themselves as "different" or "abnormal" after the "discovery" of their excision. The discovery is usually revealed to them by a male partner or a gynecologist, or as a result of FGM/C targeted interventions in sexual education courses at school.

The aggressive Western campaigns conducted in Europe and in sub-Saharan countries produced a cultural background of stigmatization against women with excision, which was felt strongly by women who grew up in France. The feeling of alienation that they developed against their origins, their families and toward their own bodies is mostly expressed in terms of "abnormality" or by "feeling troubled." These feelings impair women with excision in France and render them vulnerable to intimate partner violence: most have experienced some form of violence from their male partners (regardless of sub-Saharan or European origin).

Table 1. Women's demands and medical treatments.

Case	Successful arguments	Counter-arguments	Medical evaluation	Medical decision	Assigned treatment and tools
Kadi 25 years old, arrived in France at 22 years (1st generation)	"I want to have pleasure"	"but, if I had a clitoris I would be dissolute"	Ambivalent demand	Rejected	None
Aicha, 44 years old, arrived in France at 24 years (1st generation)	"I want to see what having a clitoris is"	"but, I am not traumatized, excision was just a little cut"	Paradoxical demand	Rejected	None
Yacine, 22 years old, born in Paris (2nd generation)	"I want to be normal"	"but I understand that I have to first work on myself"	Breaking through repressive education's block	Not ready for surgery, extra-time allocated	Psycho-sexual therapy, body exploration, non- targeted caresses
Awa, 20 years old, born in Paris (2nd generation)	"I am afraid that everybody sees me as different"	but her sexual experience is *"very similar to uncut girls of her age"*	Breaking through psychological block concerning body image	Don't need surgical reconstruction	Psycho-sexual therapy, encouraged sexual experiences
Sakina, 26 years old, born in Paris (2nd generation)	"I want to enhance my intimate relationship"	But her partner very "blunt, brusque, absent" and she lacks listening	Poor intimate relationship	Not ready for surgery, very fragile psychological profile	Psychological therapy, learn to express her needs
Mayeni, 38 years old, arrived in France at 12 years (1st generation)	"I want to be like others"	None	No excessive expectations	Clear, mature request	Operated
Rougi, 23 years old, born in Paris (2nd generation)	"I feel hate, surgery would help me to turn the page"	None	Young woman, intelligent and clear	Motivation oriented on need to completeness and family's forgiveness Surgery will help	Operated
Rokhaya, 30 years old, born in Paris (2nd generation)	"I want to be complete, I want to decide by myself on my life"	None	Strong personality, very mature, very lucid, very rich development on verbal level	Strong identity related demand. Surgery will help	Operated
Dior, 19 years old, born in Paris (2nd generation)	"There is nothing, it is all empty, feel very uncomfortable in my body"	None	Conduct of avoidance of sexual relations BUT not toward her body	Surgery will help to reconstruct sense of emptiness	Operated
Zuma, 32 years old, arrived in France at 9 years (1st generation)	Afraid to be accused of being a "bad sexual partner"	None	Accusations are highly traumatizing and affect her sexual well-being	Surgery will help to protect her from accusations	Operated
Samya, 25 years old, born in Paris (2nd generation)	Want to be like others, but still experience well-being in sexuality	None	Psychological motivations: need to feel "recovered"	Surgery will help in regain self confidence	

The issue of reparation resides in the multiple and polyvalent dimensions of clitoral reconstruction. Surgical reconstruction is only one of these dimensions (Villani 2017), but surgical reconstruction is not considered sufficient alone by the surgical team. Clitoral reconstructive surgery can restore the materiality of the body and the functionality of the clitoris, but other tools are suggested to women along their path of reconstruction. Some are invited to perceive themselves differently, working on aspects of self-esteem and enhanced body image. Others are oriented through body exploration to recognize pleasant sensations and feelings by caressing and touching. Both the sex therapist and the psychologist aim to identify the many specific "blocks" that could prevent successful surgical reconstruction. They are identified as cultural and rooted in myths and beliefs

transmitted by tradition, by stigmatizing discourses around FGM/C, and by the overvalorization of the sexuality of uncut white women (Bourdin 2013). Blocks could be relational as a result of abusive intimate relationships, where women see themselves as accused by male partners of feigning pleasure or being "bad sexual partners."

Cultural and relational blocks are discovered through the medical activity of evaluation and interpretation of women's motivations and expectations, particularly explored by the psychologist and the sex therapist. The classification of women's motivations for surgery into four types orientate both medical treatments and tools. There is no single motivation that takes precedence in the decision to operate. Rather, how women's intentions and expectations are expressed plays a major role, and the medical team evaluates women's demands in terms of ambivalence or maturity, clarity or vagueness.

The sex therapy and psychological approaches come together when investigating the patient's family history, body image and intimate relationships. The sex therapist focuses on physical sensations, sexual experiences and fantasies, sometimes proposing tools to develop erotic imagery (where considered poor), or encouraging body exploration or sexual experiences, or dialog and reciprocity in the couple. Gender roles within the couple are also taken into account and may be seen as major symptoms of missing pleasure. The psychologist points out feelings linked to memories (if accessible) and toward family's members. Excessive expectations of reconstruction are also explored, leading to the need for additional time for women prior to surgery.

Finally, the symbolic demand is multifaceted (physical, sexual, identity related), but is mainly characterized by women's desire for delivery both from traditional trajectories and gender models transmitted by previous generations of family members and from stigmatized images and victimizing representations of being woman with excision in France.

Notes

1. In this article, I use the term FGM/C for discussing the literature, and the specific term "excision" for discussing the findings, as it is the only term used both by women and clinicians in France.
2. Refer to the national quantitative research study "Excision and Handicap" conducted in France between 2007 and 2009, reported in Andro et al. 2009.
3. Additional psychological and sex-therapy counseling may be offered in the post-operative stage per the woman's demand.
4. See the web page of the European Network. The picture of razor and needle and thread is still used, see the video – https://www.endfgm.eu/female-genital-mutilation/what-is-fgm/.
5. This refers to abnormalities in the process of voiding urine, including bladder control, frequency of urination, the volume and composition of urine.
6. *Aller à gauche et à droite* literally means "going around without discernment" and refers to dissipated sexual behavior or promiscuity.

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