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A Listening Guide Analysis of Bisi's Story of Living with Female Genital Mutilation

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A Listening Guide Analysis of Bisi's Story of Living with Female Genital Mutilation

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Abstract

Female genital mutilation (FGM) is recognized worldwide as a fundamental violation of the human rights of girls and women. It reflects a deep-rooted inequality between men and women and constitutes an extreme form of discrimination against women. Studies have examined the short and long-term impacts of FGM, including the impact on the sexual functioning of women. The aim of this article was to gain an in-depth insight into one woman's experiences of living with FGM. The analysis presented in this article is grounded in the voice-centered relational or "listening guide" (LG) method of in-depth narrative data analysis developed by Gilligan and colleagues (2003), and feminist theory which places gender and power at the center of its explanatory framework. The LG is an analytical framework that allows for the systematic consideration of the many different voices embedded in a person's story. The identification of different voices revealed contradictions in Bisi's voices, which could imply on-going emotional and psychological distress resulting from undergoing FGM. Bisi's narrative is a testimony of how a harmful cultural practice like FGM can promulgate unequal power relations that relegate women to inferior and subordinate positions in intimate relationships. Bisi struggled with maintaining intimate relationships because of the impact of FGM on her enjoyment of sex; thus, she experienced rejections and a consequent breakdown of intimate relationships. For Bisi, it could be that the practice of FGM, which is perceived to enable her to achieve complete womanhood, denied her of those culturally normative ideals of womanhood, which are relationship and family. This insight requires further consideration in research studies that could eventually contribute to public campaigns geared towards combating the practice of FGM. Also, analysis shows that her experiences of rejection may have influenced her physical and mental health difficulties. Such a finding could inform professional intervention and may inspire researchers to examine in more depth the negative health outcomes for survivors of FGM. Findings further highlight the need for more proactive efforts targeted at supporting the well-being of girls and women who have undergone this practice.

Keywords: Female genital mutilation, Feminist theory, Intimate relationships, Listening guide, Narrative data analysis, Nigerian women, Women's health

Introduction

According to the World Health Organization (WHO), female genital mutilation (FGM) "is recognized as a fundamental violation of the human rights of girls and women and reflects a deep-rooted inequality between men and women" (WHO, 2022, p. 1). FGM, which is also known as

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"female genital cutting' or infrequently as 'female circumcision' is carried out on girls between the ages of 0 and 15 years old and encompasses all procedures involving partial or total removal of the external female genitalia or injury to the female genital organs for non-medical reasons" (WHO, 2022, p.1). Because it is mostly performed on girls, FGM reflects an extreme form of discrimination against the girl child, thus violating the 1989 Convention on the Rights of the Child. Although there have been legislative provisions in different countries targeted at combatting this practice, it is believed that FGM is still practiced in many regions of the world including Africa, Middle East, and Asia (Forward UK, 2022). With the current immigration patterns observed across regions of the world, FGM has become a worldwide concern (UNICEF, 2016). In the UK, for example, Forward UK (2022) estimates that 60,000 girls under the age of 15 remain at risk of FGM, while 137,000 women and girls are living with the consequences of FGM. To further contextualize this problem, figures from the National Health Service (NHS, 2021) show that in the period of April 2020 to March 2021, there were 5,395 individual women and girls who had undergone FGM procedures. Also, recent data shows that from October 2021 to December 2021, 1,450 women and girls were identified to have undergone FGM (NHS, 2022). The enforcement of the Prohibition of Female Circumcision Act of 1985 made FGM a specific offense in the UK. This Act was later replaced by the Female Genital Mutilation Act of 2003, which includes a penalty of up to 14 years in prison and/or a fine. It also makes it illegal to take girls who are British nationals or permanent residents of the UK abroad for FGM, whether it is lawful in that country or not. Furthermore, the Act makes it illegal to aid, abet, counsel, or procure the carrying out of FGM abroad, and includes FGM Protection Orders and an FGM mandatory reporting duty (Female Genital Mutilation Act, 2003). Despite these provisions, only one successful conviction has been achieved in the UK. The conviction is that of a 37-year-old Ugandan mother from east London whom the Central Criminal Court of England and Wales found guilty of mutilating her three-year-old daughter on February 1st, 2019. On March 8th, 2019, she was sentenced to 11 years in prison.

The poor prosecution rate of FGM in the UK may suggest that the legal intervention to combat the practice is limiting. Berer (2019) argues for a shift from punitive measures to interventions that involve community engagement and collaboration in challenging the norms that promote this practice. Other strategies have involved research and campaigns focusing on highlighting the short and long-term consequences of FGM. Studies show that the short-term complications of FGM could include bleeding, infection, damage to surrounding tissues, problem with healing, and death (e.g., Berg & Underland, 2014; WHO, 2022). Research into the long-term implications of FGM have reported on women's experiences of post-traumatic stress disorder (PTSD), depression or anxiety, and other outcomes related to maternal obstetric health, such as "prolonged labour, obstetric tears/lacerations, caesarean section, episiotomy, instrumental delivery, obstetric/postpartum haemorrhage and difficult labour" (Berg et al., 2014; Berg & Underland, 2013, pp. 4-7; Reisel & Creighton, 2015). A few studies have reported possible impaired sexual functioning in women who had undergone FGM (e.g., Nzinga et al., 2021; Recchia & McGarry, 2017; Reisel & Creighton, 2015; Yassin et al., 2018). Drawing on feminist theory, this current study builds on these findings to show how impaired sexual functioning impacted one woman's ability to maintain intimate relationships.

Feminist theory for understanding violence against women places gender and power at the center of its explanatory framework. It illuminates how certain beliefs and norms about the status and roles of women in a society can lead to male privilege, dominance, and female subordination (Dobash & Dobash, 1979). Hartmann (1979) conceptualizes systems of male power over women as patriarchy. Similarly, Eisenstein (1979) is of the view that patriarchy consists of a sexual

hierarchy which is embedded in the gendered roles of women in the society. Feminists have long argued that gendered roles and expectations are used to sustain patriarchal ideologies that influence gender inequalities, in turn reproducing underlying gendered power relations (Watson, 2012). Based on the perceived benefits of FGM, which include curbing women's sexual appetites, adding to the sexual pleasure of husbands, preserving chastity, ensuring marriageability, and improving fertility (Adeniran et al., 2015; Ashimi & Amole, 2015), the practice of FGM is grounded in gendered roles and expectations which deliberately give control to men whilst disempowering women in sexual and reproductive areas of their lives. Also, because it is women who perform and maintain this act, such women could be seen as colluders, whose own social positioning is elevated through performing the practice. This demonstrates how ideas about gender can inform women's experiences of violence at a personal level (Brownmiller, 1975; Dobash & Dobash, 1979; Yllö & Bograd, 1988). The narrative of the subject of our study, Bisi (a pseudonym), is presented here as an example of how a human rights or women's rights violation like the practice of FGM can disempower women and may work to sustain unequal power relations between men and women in intimate relationships. Although limited to one woman's story, the analysis presented in this article serves as a call for more studies examining social and relationship consequences of FGM. It also supports the case for intervention strategies that dismantle the perceived benefits of FGM.

Method

The case study presented here comes from a larger study that explored if and how cultural beliefs, norms, and practices might contribute to violence against Nigerian women living in England. This research was approved by the Research Ethics Committee of the first author's institution. The larger study prioritized the telling of stories through conducting in-depth narrative interviews (Clandinin & Caine, 2008) with twelve women of Nigerian origin living in England. The women were aged between the ages of 27 to 46 and had all experienced sexual violence. Women were interviewed in English, and all interviews were conducted between May 2017 and August 2017. Informed consent was renegotiated before the interviews, and a consent form was signed by the individual women and researcher before the interviews commenced. Interviews were audio-recorded and lasted between 30-60 minutes, with each woman receiving either £10 cash or £10 gift voucher as a "thank you" for sharing their story. The ethics of safeguarding women who participated in this study was very important. Safeguarding strategies included allowing women to dictate the pace of their interview, offering regular breaks to women during the interview, reaffirming the woman's strength at the end of the interview, and ensuring they were debriefed. Women were also given a debrief sheet containing information and contact details of three relevant and accessible sources of help in case they required further support.

This current work utilized a case study approach to examine Bisi's experiences of living with FGM. Yin (2009) defines a case study as "a strategy used to explore a phenomenon in-depth and within its real-life context" (p. 19). It is also widely used when the amount of information or detail collected is large (Gomm et al., 2000). Although there were criticisms levied against case study research with regards to generalization, and whilst it is important to note that the findings of this study cannot be generalized to other women who have undergone FGM, we agree with Flyvbjerg's (2006) assertion that "the case study provides multiple wealth of details needed to study real-life situations" (p. 392). Indeed, its uniqueness in securing contextual knowledge and holistic perspectives makes it relevant for studying women's experiences of violence at a personal level. In addition, it offers important support for feminist research and analytical approaches like the Listening Guide (LG) which permit women's stories to be heard in their own terms (Brown &

Gilligan, 1992, 1993). Thus, it contributes to addressing the concern of women's voices not being adequately represented or heard in research studies (Gilligan et al., 2003). Furthermore, Bisi's voice serves as a testimony of a human/women's rights violation. Testimonies capturing the experiences of human/women's rights violations through narratives have been known to help in bringing such violations to the limelight and in pushing for the recognition of such experiences as abuse (Whitlock, 2007). It also serves as evidence to support the work of campaigners and women's rights actors by helping them to channel their advocacy efforts for social and cultural change more effectively (Goodmark, 2005), which can play an important role in policy and intervention initiatives.

The Listening Guide (LG): An Analytical Framework

The LG focuses on voice "as a channel of connection, a pathway that brings the inner psychic world and feelings and thoughts into the open air of relationship where it can be heard by oneself and by other people" (Brown & Gilligan, 1993, p. 14). Gilligan and associates (2003) argue that "Within the psychic life, women's voices are said to be polyphonic and complex, therefore, the LG provides a way of systematically attending to the many voices embedded in a person's expressed experience" (p. 30). Gilligan and Eddy (2017) also argue that this framework enables the researcher to go deeper to examine what is spoken, unspoken, and contradictory in the woman's narrative.

The audio recorded narrative interview was listened to three times: first, for familiarization with the data; second, for verbatim transcription of data; and, third, to fill in gaps missed by the first transcription. Brown and Gilligan (1992, 1993) propose four readings of the transcripts which they call "listenings." Each listening focuses on a different aspect of the woman's voice. In this study, the focus of the four listenings were: overall geography or plot of the story, concepts of self ("I Poems"), contrapuntal voices, and power relations. The four approaches to listening are described below.

The LG Phases

In this first phase, I (first author) read Bisi's transcript several times to establish an understanding of what had happened, to follow the plot and the unfolding of events. I listened for the "who, what, when, where, and why" of the experiences (Brown & Gilligan, 1992, p. 27). I attended to the use of recurring words, metaphors, themes, and contradictions within the text. In the second phase, I read the transcript to listen for the voice of "I" which speaks about self, following and underlining every first-person pronoun and words that provide context. In this phase, I noticed that Bisi also used "me," "my," and "you" to refer to herself. Thus, as Woodcock (2016) notes: "by attending to the different ways women speak of 'self', the 'I Poem' subsequently constructed may not completely resemble or align with the 'I Poem' suggested by Gilligan and Colleagues" (Woodcock, 2016, p. 7). After identifying the voice of self, I then cut and pasted all the voices of selfhood traced from the narrative and listed them in the order of appearance, with each pronoun starting a new line in order to construct what Woodcock calls an "I Poem." The third listening, known as "listening for contrapuntal voices" (Gilligan & Eddy, 2017, p. 79), focused on relationships and social networks that Bisi was affiliated with. This allowed me to listen to multiple facets of the story being told and to unpack several layers of expressed experience (Forrest et al., 2016). This listening included listening for the voice of self-silencing as a result of "debilitating cultural norms" (Brown & Gilligan, 1993, p. 17), the voice of psychological distress characterized by uncertainty, and the voice of resilience, indicative of help-seeking, coping

strategies, and support. In the fourth phase, I read the transcripts to listen for power relations and where dominant ideologies and structural factors constitute the voice of silence and oppression. I attended to the dialogical organization of discourse within narratives. For example, I compared the ways in which Bisi positioned the self ("I") in relation to others ("they") and considered how that indicated power relations (Harré & Van Langenhove, 1999). A limitation of the LG is that the systematic analysis and structuring of data based on the four listenings can lead to the fragmentation of the narrative. To address this concern, the transcript was first analyzed using the four listenings, then re-read before combining the different voices. This ensured that the product of analysis aligned with the plot of the story and the dynamic way the story was told. The following presents an LG analysis of Bisi's narrative of living with FGM.

Bisi's Narrative

Bisi is a 43-year-old single mother of four children. She had been living in the UK for nine years at the time of this study. She lives with three of her children while her oldest child lives with a friend in Nigeria. At the time of this study, she was seeking asylum in the UK. She tells a story of love and rejection, which is her reality of living with FGM. The main events of Bisi's narrative center around love, rejection, gendered power relations, impacts of FGM, and resilience. Bisi first constructs her narrative around her first relationship, which involves falling in love and family life in Nigeria. This part of her narrative was brief as she shifted her narration to her struggles with the impact of FGM in her marriage. She spoke of her desire to remain in the marriage, but she was forced to leave when her husband married another woman. The powerlessness and distress resulting from the situation led to her decision to relocate to the UK. Following her relocation, Bisi constructs her narrative around a second relationship but not necessarily one of love. Again, Bisi tells of her struggles in the relationship as a result of the impacts of FGM. The relationship finally ended after she had two children. The last part of Bisi's narrative depicts a continuation of her relationship struggles when she tells of a third rejection. The analysis is presented in accordance with her narrative landscape under the following headings: first, second, and third relationship. Analysis shows that, although dissatisfied, Bisi continues to live within the boundaries of the expectations of womanhood prescribed by a culture which centers around heterosexual relationships. Whilst this seems to be at odds with her lived experiences of FGM, Bisi continues to uphold this cultural ideal of womanhood with the cost of emotional and psychological distress. Readers should note that Bisi told this story in English, which is not her first language; therefore, the direct quotes presented here have been edited for clarity.

First relationship

The first part of Bisi's narrative came immediately following this opening question, "Is there anything about what happened to you that you would like to share?". She stated:

> I was born a Christian and the person I married... that I fell in love with, in Nigeria, was Muslim. The family didn't support the marriage from the beginning, but we loved each other. He was happy to carry on, and I was happy to carry on because the two of us loved each other.

Bisi then briefly talks about the problems they encountered from both families because of their inter-faith marriage, and then ends by stating: "That one is a long story, I just wanted to briefly mention it to you." Bisi then continues by describing how the relationship broke down:

> So if the person that loves you, everything just changed; he said he didn't want to continue in this marriage any more. Later, he decided to marry another person and left me and the kids. We had three children at that time, and we lost one. He didn't tell me that I should go but he kept saying... "I don't like you; I don't like you, and if you like then stay there." He just maltreated me more because I was circumcised, that is FGM. I didn't enjoy sex, and he used that against me by telling me that I was not even good in bed. You know, at the beginning he loved me, but he now used that against me. I had to ... I couldn't go back to my family because they didn't want me, and he didn't want me either. What would I do? Life is just something else for me. I loved this man, but this thing is getting too much. I couldn't cope anymore, so that is why I decided to come here.

The above extract provides some insight into how the practice of FGM influenced the rejection Bisi experienced in this relationship. An "I Poem" constructed from the above extract highlights a number of voices as shown below.

I	Me	You
I married **I** fell in love **I** was happy to carry on **I** was circumcised **I** didn't enjoy sex **I** loved this man **I** couldn't cope anymore **I** decided to come here	Left **me** and the kids He just maltreated **me** He used that against **me** They don't want **me** He doesn't want **me** Life was just something else for **me**	The person that loved **you**

The voice of self in the first stanza describes a woman who is honest and in tune with herself: "I was circumcised, I didn't enjoy sex." This voice, which does not dissociate self from FGM, in some ways could be seen to precede self-silencing and capitulation. It may also tell of a woman who has accepted the power that men will continually hold over her because of FGM. The second stanza presents her voice of rejection and the powerlessness she feels as a result of living with FGM and her husband's response to it.

Overall, the account above points to two closely related voices. The first is love and the second is rejection. Bisi used the word "love" in different ways when describing this first relationship: "Two of us loved each other… the person that loves you… he loved me… but I loved this man…" Here, her voice of love and commitment is clearly heard. The use of "love" in the context of the first relationship helps us to understand Bisi's commitment to her first relationship. Closely aligned with love is the voice of rejection, as she states: "He didn't tell me that I should go but when... I don't like you; I don't like you…". As she continues to describe the rejection, Bisi used the metaphor, "life is just something else for me" to express uncertainty and despair, an indication of her voice of psychological distress. It is possible that the uncertainty and despair in her voice also stems from the intersection of living with FGM and the structural disadvantage associated with living as an asylum seeker in the UK. Bisi also speaks of a self that is burdened by the impacts of FGM, confused and yet indecisive, as she states: "I loved this man, but this thing is getting too much…." The conflict in this extract can be heard through the dialogue between two voices: the voice that is still in love and the voice that resists victimization and rejection: "I loved

this man, but…". Through careful listening, one can also see how the voice that is still in love was interrupted and silenced by the voice that resists victimization and rejection by the introduction of "but" (Gilligan & Eddy, 2017). This conflict also represents her voice of psychological distress.

Second Relationship

Without prompts, Bisi continued her narration by stating:

> I didn't prepare to come and stay, just to come and … because I had come before for a visit and gone back. I landed in [name of city], so the person I stayed with there said he couldn't accommodate me anymore. One day I just went to the train station, so I met this man in the train station. You know when you have given up totally and you don't have anybody to talk to? This man came and asked, "what happened?" So, since I didn't have anywhere to go back to, I followed him to his house, but I didn't even think about it properly because that was not my mission. I still loved this man [first relationship]. He said I should not worry, and along the line we started living together. And first thing about me, if I meet a man, I will let them know my problem because it affects me. I know that they've already done it to me when I was a baby, so there is nothing I can do.

An I Poem constructed for the above account is presented below:

I	My, Me	You
I met this man **I** followed him **I** still love this man **I** let them know Nothing **I** can do.	**My** problem It affects **me** They already did it to **me**.	When **you** have given up totally **You** don't have anybody.

Although the I Poem in the first stanza seems to indicate the powerlessness Bisi feels as a woman living with the impacts of FGM, a closer reading, however, draws attention to the voice of a woman who is committed to an authentic relationship. This voice is heard when she states: "… I still love this man," indicating a voice of love and commitment cut short and silenced by FGM. The second stanza presents a voice of self that is victimized and impacted by the consequences of FGM. Although she is very much committed to finding an authentic relationship, Bisi cannot help the feeling of being inadequate and uncertain about her future. This seems to be organized around her acceptance of an inferior and subordinate position in intimate relationships, as she states: "… they've already done it to me… nothing I can do." This uncertainty is overtaken by the voice of pain in stanza three as she slips into the second person pronoun to disconnect herself from the pain, which is an indication of psychological distress. This voice conveys how she feels at present in dealing with the consequences of living with FGM with regards to intimate relationships.

Bisi continues her narration by describing how their family grew and hinting at the impact of FGM upon the relationship:

> I had my first daughter with him in 2010. This man still stayed by me, although sometimes he would just say "how come you don't even ask for sex?" You know I would pretend to enjoy it because I must tell you the truth, I didn't enjoy it. Even though when they were doing it, it was like they were hurting me. I was not enjoying it. And you know the men, if they know you are not enjoying it, they will not enjoy it as well. So, he would ask, and I

> would say, "I told you about my problem from the beginning," and he would say, "don't worry." I would be watching blue films [pornographic films]. I had the second baby with him in 2011. He would try and try, and he would say "don't worry," but then, he would say, "what kind of body do you have?" He started his own problem with me. Along the line, he just left me for another woman, and he said I should find my own way.

This account draws attention to the negative impact of FGM on Bisi's enjoyment of sex in this second relationship. Here, Bisi tells of her struggles with the long-term sexual health implications of FGM. Although some older studies (e.g., Okonofua et al., 2002; Nwajei & Otiono, 2003) report no significant negative effect of FGM with regards to sexual enjoyment, others (e.g., Nzinga et al., 2021; Recchia & McGarry, 2017; Reisel & Creighton, 2015; Yassin et al., 2018) report that FGM adversely affects women's sexual enjoyment. In a similar vein, Bisi's narrative brings to light an area that has received very little attention in studies: the perceived belief that FGM can promote the sexual pleasure of the man (Adeniran et al., 2015; Ashimi & Amole, 2015). Bisi dismisses this myth, suggesting that FGM also negatively impacts men's enjoyment of sex, similar to findings from other studies (e.g., Berggren et al., 2006; Fahmy et al., 2010). Bisi states: "…and you know the men if they know you are not enjoying it, they will not enjoy it as well." This reversal in the perceived sexual pleasure of the man with regards to FGM also contributed to the rejection Bisi experienced in her first relationship, and in this second relationship, "… he just left me for another woman." Bisi continues:

> You know what my problem is? Where I come from, they are still practicing it even today. Where I come from, if a family has girls, they must perform it. They believe that if they don't do it, it will affect the girl in the future. It is the belief that if they don't do it, then the children will have problems.

Bisi uses the phrase "what my problem is" to represent FGM as a micro-level expression of an ideology that disempowers women, and perhaps, also highlights a wider issue of domination and subordination inherent in patriarchal societies where FGM is practiced. Bisi's narrative presents a concrete example of how this form of control promotes unequal power relations in intimate relationships. As shown by the analysis presented in the preceding sections, Bisi continually occupied an inferior position within her relationships because of FGM. The above extract describes how the dominant ideology around the practice of FGM perpetuates the silencing of women's voices. It also highlights the relationship between gender, culture and power. Further, it perhaps strengthens the idea that when a practice is culturally and socially accepted, it becomes powerful. Bisi used the word "they" to indicate the unequal power relation that exists between women and the culturally/socially accepted practice of FGM. The social and cultural acceptance of the practice of FGM in some parts of the world enforces conformity to the practice such that non-adherence exposes women to stigma and possible social ostracism (Oyefara, 2014). Thus, women continue to participate in the perpetration of FGM, which illustrates the extent to which gendered roles and expectations can leave women in a powerless position, such that they may become accepting of "systems of male domination and female subordination" (Hunnicutt, 2009, p. 553).

In addition, the interaction of gender and power reflected through social actors seems to propagate the continuity of the practice. The statement, "It is the belief that if they don't do it then the children will have problems," points to a domain of power in which unwritten rules or norms of everyday life reinforce existing power relations (Smith, 2013). First, this domain of power reinforces stereotypical gendered roles by focusing on the culturally perceived benefits of FGM,

which include curbing women's sexual appetites before marriage to preserve chastity, sexually pleasing the husband, and ensuring marriageability (Adeniran et al., 2015; Ashimi & Amole, 2015; Oyefara, 2014). Another important aspect of the extract, "It is the belief that if they don't do it then the children will have problems," is that it provides the platform for examining the rules and ideas around ensuring the marriageability of young women in cultures that practice FGM (Oyefara, 2014). One way of examining this is to consider what is culturally considered as beautiful and feminine in cultures that practice FGM. Although socially accepted forms of physical beauty and sensuality have not been well researched in different cultures (Ahmadu, 2000), within some cultures, it is believed that the clitoris or the female genital is dirty and may lead to promiscuity (Abdel-Azim, 2012). Others have reported that FGM is seen by some cultures as the removal of the masculine part of the woman, similar to opinions about the removal of body/pubic hair to achieve smoothness considered beautiful (Catania et al., 2007). Gruenbaum (2005) also notes that the smoothness derived from type 3 FGM, which involves the narrowing of the vaginal orifice and creating a covering seal (WHO, 2022), is considered in some cultures to be feminine and sensual. Invariably, the fear of being culturally and socially seen as ugly or masculine or as a target for ridicule continues to promote an acceptance of FGM even amongst women in those communities (Abdel-Azim, 2012; Catania et al., 2007).

Third Relationship

During the interview, Bisi was carrying a baby, and she speaks of putting in a new asylum claim on the grounds of being a "parent of a British citizen":

> I had two girls with the first partner I met here in 2009 when I came here. This one (baby) is another man's. The father of this one is British, but along the line, he told me that he didn't need a wife. Anyway, he came and made a passport for the boy, a British passport for him. That is what I used for the new fresh claim I made now. He didn't support me financially but sometimes he called; he would say, "you know we are just boyfriend and girlfriend…"

Although Bisi's intention was to provide information about her new asylum claim, her voice of rejection could be heard in the above extract. This third voice of rejection re-emphasized Bisi's relationship struggles as a result of FGM and resounded when Bisi stated: "… he told me that he didn't need a wife… we are just boyfriend and girlfriend." Since Bisi's voice of rejection echoes across her three relationships, it is possible that there is a link between FGM and her relationship struggles. Also, the voice of rejection uncovers Bisi's need for an authentic relationship and her desire for a culturally accepted relationship. Perhaps, Bisi aligned her own identity with this perceived need for a relationship and family, resulting in the compulsion to reclaim her identity through relationships. Although, at this point in her life, she is beginning to demonstrate resilience, this seems to not be transformative in her struggles with identity. Her struggles are gendered and are related to the normative ideals of womanhood within Nigerian culture, which relates to relationship and family. It is striking that the same practice of FGM which is believed to enable women to achieve full womanhood can also deny them of that same identity.

As she concludes her narration, Bisi further develops an overall picture of the impacts of living with FGM. It is possible that the rejections she experienced contributed to the physical and mental health problems she developed. However, her voice of resilience is heard towards the end of the extract as she identifies her children as her source of resilience. She states:

> …if I wanted to give up, I would have. I developed a lot of sickness which I didn't even know of. Doctors said that I am depressed. I have heart problems. My heart will just be racing, so I am on medication. So, the situation made me develop a lot of…now I have high blood pressure, and I am on tablets as well. Even next Wednesday I have to go back to the doctors; they want to set up 24-hour monitoring. You know, it is just getting too much for me. It is just too much. Because of these kids I am going to keep going ahead because I don't want these children to go through what I went through. Nobody can look after your kids like you, so because of them, I am just trying to be strong for them. And I know by God's grace everything will be ok. That is what I think.

This strong voice of resilience shows Bisi's commitment to her children, which in turn enhanced her capacity to cope with her situation. Indeed, this voice was heard through her determination to be available to protect her children and to help in building a future for them. Finally, in responding to how she felt sharing her story, Bisi states: "I think it helped. Sometimes all these problems used to affect me. Even when I leave here [support group] it still affects me, but I have tried to avoid that, and I have prayed against it. So, I just cut out that thought." Bisi uses the metaphor "I just cut out that thought" to refer to another coping strategy for dealing with the impact of living with FGM. Kelly (1990) argues that "we forget experiences in order to cope with an event that we do not understand, cannot name, or that places acute stress on our emotional resources" (p. 124). This coping strategy adopted by Bisi brings to light the emotionally damaging nature of FGM and informs us of her voice of psychological distress.

Conclusions

The analysis presented in this article is grounded in feminist theory in order to understand violence against women, and it is also based on the listening guide (LG) analysis of one woman's story of living with FGM. The LG as an analytical framework offered useful insight into how Bisi experienced heterosexual relationships. It allowed the centering of Bisi's voices to go deeper in examining the distinctive ways she speaks of herself and others, and how she speaks of her experiences of FGM within different relationships. The identification of different voices revealed contradictions, which implies on-going emotional and psychological distress. Also, analysis shows that her experiences of rejection might have influenced the physical and mental health difficulties that she developed, an insight that could inform professional intervention and management. Although studies (e.g., Berg & Underland, 2014; Berg et al., 2014; Reisel & Creighton, 2015) have pointed out the mental and physical health impacts of FGM, this finding impresses on research studies to further examine the nuances that underline mental and physical health conditions for women who have undergone FGM.

Bisi's account is a clear testimony of how a harmful cultural practice like FGM can expose unequal power relations that relegate women to inferior and subordinate positions in intimate relationships. Although Bisi's first relationship started with love, this was quickly cut short by her experience of rejection, which was observed across the three relationships. She struggled with maintaining intimate relationships because of the impact of FGM on her enjoyment of sex. This speaks contrary to one of the perceived benefits of FGM, the sexual enjoyment of the husband (Adeniran et al., 2015; Ashimi & Amole, 2015; Oyefara, 2014). Furthermore, analysis points to the view that FGM also negatively impacts the sexual enjoyment of the male in a heterosexual relationship, an area which requires further attention in research studies. As a result, Bisi

experienced rejection and consequent breakdowns of her intimate relationships. Therefore, for Bisi, it can be surmised that the practice of FGM, which is perceived to enable her to achieve complete womanhood, denied her of the culturally normative ideals of womanhood, which are relationship and family. This is an insight that requires further attention in research studies and could contribute to campaign strategies geared towards combating the practice of FGM. Despite her relationship struggles and her continual expression of despair and uncertainty about her future, her voice of self tells of a woman who has not given up on her desire for an authentic relationship.

The narrative presented here brings to the public sphere the personal struggles faced by one woman who had undergone FGM. Whilst FGM is recognized as abuse and a violation of women's rights in England, this personal narrative points to the need for more proactive efforts targeted at supporting the well-being of girls and women who have undergone this practice. Although in England the National FGM Support Clinics (NFGMSCs) work to support women with complications resulting from FGM (National Health Service [NHS], 2022), it is also imperative to consider funding more locally run FGM support organizations, because for some women, such organizations may be a more accessible choice.

References

Abdel-Azim, S. (2012). Psychosocial and sexual aspects of female circumcision. *African Journal of Urology*, *19*(1), 141-143. https://www.ajol.info/index.php/aju/article/download/95973/85321

Adeniran, A., Fawole, A., Balogun, O., Ijaiya, M., Adesina, K. & Adeniran, P. (2015). Female genital mutilation/cutting: Knowledge, practice and experiences of secondary schoolteachers in North Central Nigeria. *South African Journal Of Obstetrics & Gynaecology*, *21*(2), 39-43. https://www.ajol.info/index.php/sajog/article/view/129871.

Ahmadu, F. (2000). Rites and Wrongs: An Insider/Outsider Reflects on Power and Excision. In: B. Shell-Duncan & Y. Hernlund. eds. (2000). *Female "Circumcision" in Africa*. Boulder, CO: Lynne Rienner, 283–312.

Ashimi, A., Amole, T. & Ugwa, E. (2015). Reported Sexual Violence among Women and Children Seen at the Gynecological Emergency Unit of a Rural Tertiary Health Facility, Northwest Nigeria. *Annals Of Medical & Health Sciences Research*, *5*(1), 26-29. https://www.ajol.info/index.php/amhsr/article/view/112496.

Berer, M. (2019). Prosecution of female genital mutilation in the United Kingdom: Injustice at the intersection of good public health intentions and the criminal law. *Medical Law International*, *19*(4), 258–281. https://doi.org/10.1177/0968533220914070.

Berg, R.C., & Underland V. (2013). The Obstetric Consequences of Female Genital Mutilation/Cutting: A Systematic Review and Meta-Analysis. *Obstetrics and Gynecology International*, 1-16. https://dx.doi.org/10.1155/2013/496564.

Berg, R.C., & Underland V. (2014). *Immediate Health Consequences of Female Genital Mutilation/Cutting (FGM/C)*. Knowledge Centre for the Health Services at The Norwegian Institute of Public Health (NIPH), Oslo, Norway; PMID: 29320014.

Berg, R.C., Underland, V., Odgaard-Jensen J., Fretheim, A. & Vist, G.E. (2014). Effects of female genital cutting on physical health outcomes: a systematic review and meta-analysis. *BMJ Open*, *4*(11), 1-12. https://bmjopen.bmj.com/content/4/11/e006316.short.

Berggren, V., Bergström, S. & Edberg, A. (2006). Being different and vulnerable: experiences of immigrant African women who have been circumcised and sought maternity care in

Sweden. *Journal of Transcultural Nursing*, *17*(1), 50–57. https://doi.org/10.1177/1043659605281981.

Brown, L.M. & Gilligan, C. (1992). *Meeting at the Crossroads: Women's Psychology and Girls' Development*. Cambridge, MA: Harvard University Press.

Brown, L.M. & Gilligan, C. (1993). Meeting at the Crossroads: Women's Psychology and Girls' Development. *Feminism & Psychology*, *3*(1), 11-35. https://doi.org/10.4159/harvard.9780674731837.

Brownmiller, S. (1975). *Against Our Will: Men, Women and Rape*. London: Seeker & Warburg.

Catania, L., Abdulcadir, O., Puppo, V., Verde, J. B., Abdulcadir, J., & Abdulcadir, D. (2007). Pleasure and orgasm in women with Female Genital Mutilation/Cutting (FGM/C). *Journal of Sexual Medicine*, *4*(6), 1666-1678. https://doi.org/10.1111/j.1743-6109.2007.00620.x.

Clandinin, D., & Caine, V. (2008). Narrative Inquiry. In L. M. Given (Ed), 2008. *The Sage Encyclopedia of Qualitative Research Methods*. Thousand Oaks, CA: Sage, 542-545.

Dobash, R. E., & Dobash, R. P. (1979). *Violence against wives: A case against the patriarchy*. London: Open Books.

Eisenstein, Z. R. (1979). *Capitalist patriarchy and the case for socialist feminism*. New York: Monthly Review Press.

Fahmy, A., El-Mouelhy, M.T., & Ragab, A.R. (2010). Female genital mutilation/cutting and issues of sexuality in Egypt. *Reprod Health Matters*, *18*(36), 181-190. https://doi.org/10.1016/S0968-8080(10)36535-9.

Female Genital Mutilation Act 2003 [United Kingdom of Great Britain and Northern Ireland], 30 September 2003. https://www.refworld.org/docid/47d159962.html

Forward UK. (2022). *Female genital mutilation: In numbers.* https://www.forwarduk.org.uk/violence-against-women-and-girls/female-genital-mutilation/

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry*, *12*(2), 219–245. https://doi.org/10.1177/1077800405284363.

Forrest, J., Nikodemos, L., & Gilligan, C. (2016). The experience of receiving scholarship aid and its effect on future giving: a listening guide analysis. *Qualitative Research In Psychology*, *13*(1), 47-66. https://doi.org/10.1080/14780887.2015.1106628.

Gilligan, C., Spencer, R., Weinberg, M. K., & Bertsch, T. (2003). On the listening guide: A voice-centred relational method. In: P. M. Camic, J. E. Rhoades and L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design*. Washington, DC: American Psychological Association, 157-172.

Gilligan, C., & Eddy, J. (2017). Listening as a path to psychological discovery: an introduction to the Listening Guide. *Perspectives On Medical Education*, *6*(2), 76-81. https://link.springer.com/article/10.1007/s40037-017-0335-3.

Goodmark, L.S. (2005). Telling Stories, Saving Lives: The Battered Mothers' Testimony Project, Women's Narratives, and Court Reform. *Arizona State Law Journal*, 709-757. https://digitalcommons.law.umaryland.edu/cgi/viewcontent.cgi?article=2457&context=fac_pubs

Gomm, R., Hammersley, M., & Foster, P., eds. (2000). *Case study method: Key issues, Key Texts*. London: Sage.

Gruenbaum, E. (2005). Socio-Cultural Dynamics of Female Genital Cuttings: Research Findings, Gaps and Directions. *Culture, Health & Sexuality*, *7*(5), 429–441. https://doi.org/10.1080/13691050500262953

Harré, R., & van Langenhove, L. (1999). *Positioning Theory: Moral Contexts of Intentional Action*. Oxford: Blackwell.

Hartmann, H. (1979). Capitalism, Patriarchy and Job Segregation by Sex. In: Z. Eisenstein, ed., 1979. *Capitalist Patriarchy and the Case for Socialist Feminism*. New York: Monthly Review Press.

Hunnicutt, G. (2009). Varieties of patriarchy and violence against women: resurrecting "patriarchy" as a theoretical tool. *Violence Against Women*, *15*(5), 553-573. https://doi.org/10.1177/1077801208331246.

Kelly, L. (1990). *Abuse in the making: the connections between pornography and sexual violence.* Bristol: CWASU.

National Health Service [NHS] (2021). Female Genital Mutilation - April 2020 to March 2021, Official statistics. https://www.gov.uk/government/statistics/female-genital-mutilation-april-2020-to-march-2021

National Health Service [NHS] (2022). National FGM Support Clinics -Female genital mutilation (FGM). https://www.nhs.uk/conditions/female-genital-mutilation-fgm/national-fgm-support-clinics/

National Health Service [NHS] (2022). Female Genital Mutilation – October 2021 to December 2021, Official statistics. https://digital.nhs.uk/data-and-information/publications/statistical/female-genital-mutilation/oct-2021-dec-2021

Nwajei, S.D., & Otiono, A.I. (2003). Female genital mutilation: implications for female sexuality. *Women's Studies International Forum*, *26*(6), 575–580. https://doi.org/10.1016/j.wsif.2003.09.011.

Nzinga, A., Castanheira, S.D., Hermann, J., Feipel, V., Kipula, A.J., & Bertuit, R.J. (2021). Consequences of Female Genital Mutilation on Women's Sexual Health – Systematic Review and Meta-Analysis. *The Journal of Sexual Medicine*, *18*(4), 750-760. https://doi.org/10.1016/j.jsxm.2021.01.173.

Okonofua, F. E., Larsen, U., Oronsaye, F., Snow, R. C., & Slanger, T. E. (2002). The association between female genital cutting and correlates of sexual and gynaecological morbidity in Edo State, Nigeria. *British Journal of Obstetrics and Gynaecology, 109*(10), 1089-1096. https://doi.org/10.1111/j.1471-0528.2002.01550.x.

Oyefara, J. L. (2014). Ritual Female Genital Mutilation: A Psychosocial Analysis of a Flourishing Rather than a Dying Tradition in Oworonshoki Community, Lagos, Nigeria. *Ife PsychologIA, 22*(2), 72-83. https://journals.co.za/doi/abs/10.10520/EJC163459.

Recchia, N., & McGarry, J. (2017). "Don't judge me": narratives of living with FGM. *International Journal of Human Rights in Healthcare*, *10*(1), 4-13. https://doi.org/10.1108/IJHRH-10-2016-0016.

Reisel, D., & Creighton, S.M. (2015). Long term health consequences of Female Genital Mutilation (FGM). *Maturitas*, *80*(1), 48-51. https://doi.org/10.1016/j.maturitas.2014.10.009.

Smith, K. (2013). Narratives of resistance: Listening to women seeking asylum in the UK. In: S. Wray & R. Rae, eds. *Personal and public lives and relationships in a changing social world.* Cambridge: Cambridge Scholar Publishing, 18-39.

United Nations Children's Fund [UNICEF] (2016). Female Genital Mutilation/Cutting: A global concern. https://data.unicef.org/resources/female-genital-mutilationcutting-global-concern/

Watson, C. (2012). *Gendered Social Institutions, Young Women and Girls. Overview of Key Analytical Perspectives and Policy Thrusts for Further Reflection*. London: ODI.

Whitlock, G. (2007). The Power of Testimony. *Law & Literature*, *19*(1), 139-152. https://doi.org/10.1525/lal.2007.19.1.139.

Woodcock, C. (2016). The Listening Guide: A How-To Approach on Ways to Promote Educational Democracy. *International Journal of Qualitative Methods*, *15*(1), 1-10. https://doi.org/10.1177/1609406916677594.

World Health Organization [WHO] (2022). Female genital mutilation. https://www.who.int/news-room/fact-sheets/detail/female-genital-mutilation

Yassin, K., Idris, H. A., & Ali, A. A. (2018). Characteristics of female sexual dysfunctions and obstetric complications related to female genital mutilation in Omdurman maternity hospital, Sudan. *Reproductive Health*, *15*(7), 1-5. https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-017-0442-y

Yin, R. Y. (2009). *Case Study Research: Design and Methods*. 4th ed. Thousand Oaks, CA: Sage.

Yllö, K.A., & Bograd, M., eds. (1988). *Feminist perspectives on wife abuse*. Newbury Park: Sage.