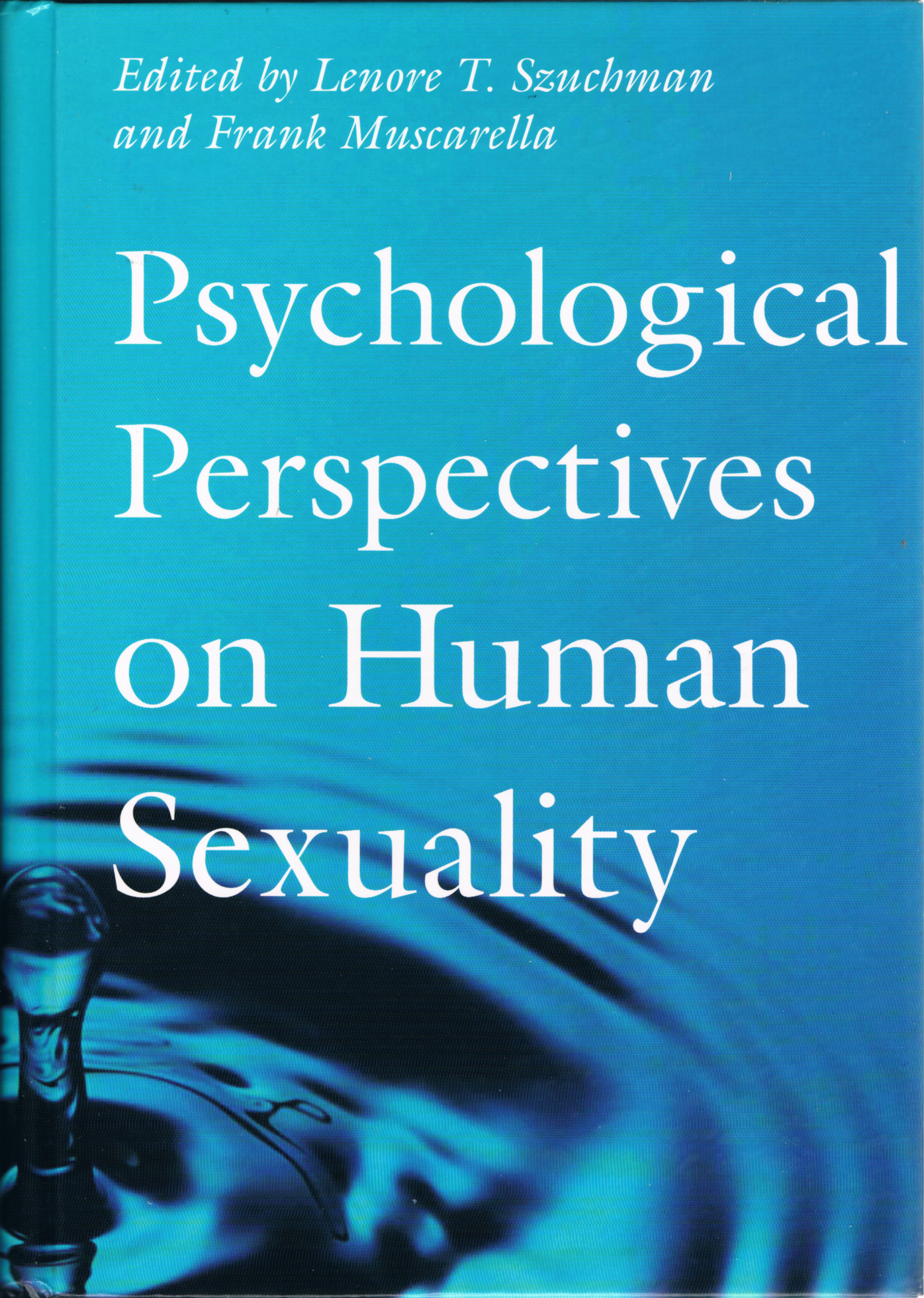


*Edited by Lenore T. Szuchman
and Frank Muscarella*

Psychological Perspectives on Human Sexuality

A blue-toned photograph of a person's face and hands, with a glass object in the foreground. The image is out of focus, showing a person's face and hands in a close-up, intimate pose. The lighting is soft, and the overall mood is sensual and contemplative. The glass object in the foreground is partially visible, adding to the artistic composition.

Credits:

Page 60: *Can't Help Lovin' Dat Man*, words and music by Jerome Kern and Oscar Hammerstein II.
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*To the members of the Department of
Psychology at Barry University*

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Library of Congress Cataloging-in-Publication Data:

Psychological perspectives of human sexuality / edited by Lenore T.

Szuchman and Frank Muscarella.

p. cm.

Includes index.

ISBN 0-471-24405-8 (cl. : alk. paper)

1. Sex. 2. Sex (Psychology) I. Szuchman, Lenore T., 1948-

II. Muscarella, Frank, 1958-

HQ21.P77 1999

306.7—dc21

99-30531

Printed in the United States of America.

10 9 8 7 6 5 4 3 2 1

CHAPTER 12

Genital Surgery on Children below the Age of Consent

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FEMALE GENITAL MUTILATION

AWATIF IS readying herself for admission to University Hospital, where she is about to give birth to her third child. Her two older children were born in a remote town in Somalia. Within recent years, the family has fled to the United States, where her husband is presently pursuing graduate studies.

Several of Awatif's compatriots, in similar situations, help her pack the small satchel that she will take with her. Selva, who has already given birth in a U.S. hospital, elicits an outburst of uproarious laughter from the others when she impishly advises Awatif, "Don't forget to tell them all about your car accident!"

To the uninitiated outsider, such an outburst of merriment is meaningless. To these women, however, Selva's admonition plays upon a familiar, well-worn inside joke and touches a shared anxiety, one that all of them have experienced. The laughter in response to Selva's mocking advice is fueled by the absurdity of the remark and by the fear it elicits in them.

Awatif's pudendum is perfectly smooth. It is devoid of all features save for a five-inch medial scar that runs from the mons veneris down to a severely reduced vaginal aperture. Her condition is the result of ritual genital mutilation.

*"Female Genital Mutilation" was written by Hanny Lightfoot-Klein, "Intersex Genital Mutilation" was written by Cheryl Chase, and "Male Genital Mutilation" was written by Tim Hammond and Ronald Goldman.

She was subjected to this in early childhood, much as all of the other women in her culture were.

Awatif has not been in a car accident or any other such accident. However, if the examining doctor, nurse, or midwife has had no previous exposure to or understanding of her special condition, as is all too often the case, it is practically a certainty that she will be asked "What happened to you? Were you in a car accident?" Such a question may be cause for mirth when the patient is among her peers. However, in a medical setting, it elicits a justifiable anxiety that the health practitioner will not know how to deal with the unique problems that are part and parcel of her physical condition, or understand and respect the demands of propriety that her culture imposes on its women (Lightfoot-Klein, 1991b).

SCOPE OF THE PROBLEM

There have been an estimated 200,000 immigrants into the United States in the past decade from countries where female genital mutilation (FGM) is customary. The women among these immigrants constitute a practically invisible, silent entity as far as U.S. medical services are concerned (Garb, 1990). The primary reason for the lack of recognition is the profoundly subordinate status of women in the cultures that institutionalize FGM. To obtain medical treatment, women from such cultures must first obtain the permission of their husbands or other custodial male relatives. Furthermore, the women can then be examined or treated only in their presence. In many of the cultures from which these women originate, a woman is considered to have been dishonored if a man other than her husband touches her body. A husband may divorce his wife on the spot under a religious legality that makes divorce ludicrously easy for men, while stringently curtailing the rights of women (Saadawi, 1982).

FGM is ubiquitous at all levels of society in at least 28 countries in Africa (U.S. Department of State, 1997). It is also practiced sporadically on the Arab Peninsula and occasionally in some regions of Asia. In Africa alone, along an uninterrupted belt across the center of the continent and along the length of the Nile, an estimated 115 million to 130 million women have been genitally mutilated (U.S. Department of State, 1997).

ORIGINS OF THE PRACTICE

Female sexual mutilation is an ancient blood ritual that is known through the writings of Herodotus to have been culturally embedded in Africa at least 2,500 years ago. The practice may have multiple origins, but they are obscure. Available historical resources and anthropological findings can furnish only educated guesses on how the practice actually arose (Lightfoot-Klein, 1989a).

In the original adoption of any practice, whatever its nature, there is always some culturally relevant reason. With the progression of time and evolution of

culture, different reasons may be substituted and the original reasons completely forgotten and lost (Montague, 1946). Thus, genital ablation practices may have their origins in a group's effort to control the forces of nature or to placate ancestral spirits to ensure or limit fertility. Quite possibly, they may have taken the place of human sacrifices: a valued part is offered up to ensure the well-being of the whole (Lightfoot-Klein, 1989a). A similar notion clearly appears to have been operative in the beginnings of male foreskin ablation among Jews, as chronicled in the Old Testament. Over time, these religiously based, deity-appeasing reasons may have been replaced by the group's more sociologically based desire to control women's sexuality, thus ensuring the virginity of a girl being prepared for womanhood and marriage (Davis, 1975).

THE PROCEDURES

In communities that perform genital ablations as an integral element of the rites of passage, one is not simply born a woman. One becomes a respected person and an integrated female only after implementing the socially designated course to dignity and status, which culminates in a partial removal of the genitals (Lionnet, 1992). Regional practices differ. Among some peoples, partial or total ablation of the clitoris is customary. Among others, the procedure includes excision of the inner labia. The most drastic excisions occur in the Horn of Africa as well as in western areas of sub-Saharan Africa, Northern and Central Sudan, Egypt, Djibouti, Somalia, Sierra Leone, Mali, parts of Kenya, and Ethiopia (U.S. State Department, 1997).

In these regions, FGM includes total ablation of the clitoris and excision of the inner labia. Additionally, the outer labia are "shelled out." The remaining skin is sewn together over the wound, down to the perineum, so as to form a chastity belt made of the girl's own flesh. Only a tiny opening, the circumference of a straw or match stick, is left. This may or may not be minimally adequate for passing urine and menstrual fluid (Lightfoot-Klein, 1989a). This widely practiced extensive procedure is called infibulation or Pharaonic circumcision, and it is a source of pride in the Sudan, where the bulk of my research was carried out. The Sudanese take great pride in "scraping the girls clean" (Lightfoot-Klein, 1989a). This sense of pride allows people in Sudan to speak freely even to a Western woman about the practices; however, in other parts of Africa, for example, Kenya, Ethiopia, and Sierra Leone, it is taboo to speak of them to any outsider, and a vow of silence is an integral part of the ritual (M. Barrie, 1997, personal communication; M. Ramsey, 1994, personal communication).

In Somalia and parts of Ethiopia, introcision, an even more drastic and damaging procedure, is added. In this procedure, most of the vaginal musculature is deeply incised or scraped away. Ostensibly, this is done to make childbirth easier. However, not only does childbirth become more difficult, but this additional mutilation makes sexual intercourse as painful and undesirable for a

woman as possible. In these cultures, an excised and perfectly smooth pudendum is valued as beautiful and sexually desirable, whereas an intact organ is variously regarded as repulsive, filthy, foul smelling, dangerous to the life of an emerging newborn, and hazardous to the health and potency of the husband (Assaad, 1980; Dareer, 1982). In Sudan, for example, it is believed that if the clitoris is not cut, it will grow to the size of a goose's neck and dangle between the legs, in competition with the husband's penis. This notion elicits great anxiety and revulsion among men.

Whereas clitoridectomy and excision are practiced by Africans of various religious and cultural orientations, infibulation is performed almost exclusively by Islamic peoples. It appears to be a regional rather than a religious practice, however, as it predates Islam by at least 1,200 years and is not customary among an estimated 80% of the world's Moslems (Lightfoot-Klein, 1989a). It is altogether possible, however, that this estimate is not accurate. Because so many Islamic women's lives are shrouded in secrecy, few if any facts concerning the condition of their genitals have escaped from behind the veil. Thus, the amount of information available to the West remains sparse and of uncertain reliability.

Most sexual mutilation rituals are still carried out among the village populace without the benefits of anesthesia or antibiotics and with rudimentary, unsterile instruments such as razors, scissors, and kitchen knives (Lightfoot-Klein, 1989b). Practitioners are more often than not medically untrained older women, often with failing eyesight, and the ceremony is generally performed on the earthen floors of huts, under inadequate lighting conditions, on struggling children forcibly held down. The mutilations may be carried out in the cities by midwives with some medical training, or by nurses or local doctors, using local anesthetic. However, by Western standards, the circumstances would not pass as sterile conditions, and the operation is still life-threatening (Lightfoot-Klein, 1989a).

As might be expected, immediate complications include hemorrhage, shock due to excruciating and prolonged pain, infection, septicemia, tetanus, gangrene, and retention of urine due to occlusion. Fistulas may be created in the struggling child by accidental damage to the urethra and anus, causing lifelong incontinence (Koso-Thomas, 1987; Lightfoot-Klein, 1993a; Verzin, 1975). Although no exact statistics exist on how many fatalities result from the rituals, medical estimates run high. In Sudan, where the bulk of my research was carried out and where the procedures are generally extreme and highly damaging, medical estimates of fatalities ran variously from 10% to 30%. This information was obtained through personal interviews with more than 30 gynecologists, pediatricians, residents, and interns between 1979 and 1984.

When a girl has been infibulated so that only a tiny opening remains proximal to her perineum, it is prevented from closing up totally by the insertion of a straw. Thereafter, she is able to urinate only by laboriously squeezing out her urine drop by painful drop (Beck-Karrer, 1996; Lightfoot-Klein, 1991b).

THE LIFELONG CONSEQUENCES OF FGM

The physical consequences of these drastic mutilations are far-reaching and lifelong. Because the rituals permeate entire regions and are carried out, for the most part, on small girls, no basis for comparison with intact women exists. Therefore, the cause-and-effect relationship between the procedures and their consequences later on in life is not understood by the populace (Lightfoot-Klein, 1989c). Disabling infections are common. As progressively more and more urinary debris accumulates behind the blockage, infections occur and may ultimately spread through the entire reproductive and renal systems. Further, gynecological and genitourinary complications may develop, for example, keloid and calculus formation, abscesses and cysts, dyspareunia and hemocolpos (Dareer, 1982; Koso-Thomas, 1987; Lightfoot-Klein, 1989a; Verzin, 1975).

The problem created by a tight infibulation is compounded yet further when the girl matures sexually and begins to menstruate (Beck-Karrer, 1996; Lightfoot-Klein, 1989a, 1991b, 1994b). It is virtually impossible for a tightly infibulated virgin to express her menstrual blood. Much of it may eventually clot behind the infibulation and simply remain there. A normal 4- to 5-day menstrual period stretches into as many as 10 to 15 days. A girl is often so disabled by pain and toxicity that she is unable to attend school or hold a job (Lightfoot-Klein, 1989a, 1991b, 1994b).

When a girl marries, her infibulation has to be torn open by her bridegroom. Generally, he accomplishes this by creating a rip which he then gradually enlarges with repeated attempts to penetrate her vagina, over an excruciatingly painful period of days, weeks, or even months, until the tear is large enough to allow intercourse. Whereas it is considered shameful for a man not to be able to penetrate his wife with his penis, in the opinion of Sudanese doctors, most men are actually not able to do this, no matter what they would have one believe. According to the doctors, the "wall of flesh" created by the fibrous and hardened mat of scar tissue that constitutes an infibulation cannot be broken down by mere human flesh. The truth of the matter is that most men resort to "the little knife" themselves, or, if this does not work, they secretly pay a midwife not only for her services but for her silence. Several of the doctors I spoke to related incidents in which they broke several scalpels in an effort to deinfibulate an anesthetized patient.

When the woman gives birth, the fibrous, inelastic scar tissue of her infibulation prevents her from dilating more than 4 cm of the 10 cm required to pass a fetal head. It must therefore be cut in an anterior direction and tightly resutured once more after she has given birth. The agonizing process of her husband's reopening her vagina is repeated after each birth. I personally witnessed more than 100 births in hospital delivery rooms and on the earthen floor of village huts. Not a single birth was possible without three-inch incisions lateral to one or both sides of the infibulation scar.

Persistently recurring infections are an integral part of this process due to the overwhelmingly septic conditions under which it takes place. Hemorrhage

is common (Lightfoot-Klein, 1989a). Predictably, the lives of excised and infibulated women are characterized by recurring episodes of extreme anxiety, phobia, and depression in the face of anticipated and inescapable pain (Lightfoot-Klein, 1989b). These may be expected to occur at the time of the anticipated mutilation, at the onset of menstruation, at marriage, and with the birth of each child (personal interviews with Sudanese psychiatrists; see Lightfoot-Klein, 1989a).

RATIONALE AND MISCONCEPTIONS

It is difficult to understand why these profoundly damaging practices continue to exist. However, the women who are sexually mutilated have grown up in cultures where female circumcision is a matter of course. They regard it as altogether normal and are persuaded that it is absolutely necessary for their health, well-being, and social acceptability. Within the cultural framework of these societies, a girl who has not been circumcised is regarded as foul, unmarriageable, and deserving only of pity (Lightfoot-Klein, 1989b). With the exception of the Western-educated, the men and women I interviewed expressed shock and genuine concern when I revealed that my own sex organs were altogether intact. They feared for my welfare in my thereby unmarriageable, unprotected state, and they manifested genuine anxiety on my behalf for all the evil that would most assuredly befall me.

Adherents to FGM firmly believe that this practice carries with it an impressive array of what are in actuality totally nonexistent health benefits (Koso-Thomas, 1987). Genital mutilation is believed to promote cleanliness, provide immunity against all manner of disease, enhance fertility, make conception and childbearing easier, prevent acutely dreaded malodorous vaginal discharge, and prevent vaginal parasites and the contamination of mother's milk. Infibulation is further believed to prevent uterine prolapse. When genitally mutilated women do fall ill, it is assumed that this is brought on by supernatural causes. It is often argued that genital ablation and infibulation maintain good health in a woman. Moreover, circumcision is credited with having healing powers. It is claimed to have cured women suffering from melancholia, nymphomania, hysteria, insanity, and epilepsy, as well as kleptomania and proneness to truancy (Koso-Thomas, 1987). This phenomenon has its parallel in the United States. The greater part of the U.S. population has been similarly persuaded of the salubrious advantages of ablation of the foreskin of its male progeny. The myth that it provides health benefits and protection against a spate of dreadful diseases continues to be believed and acted on, in spite of mounting scientific evidence to the contrary (see Hammond & Goldman, "Male Genital Mutilation," in this chapter).

Beginning in the early nineteenth century, clitoridectomies and hysterectomies were performed on thousands of adolescent girls in the United States and England for similarly bogus health reasons and as a presumed cure for masturbation. The last case recorded in the United States occurred in 1955 (Feibleman, 1997).

"Surgical corrections of nature's mistakes" in the form of clitoral surgery to infants born with enlarged clitorises or ambiguous genitalia, performed largely to alleviate the anxiety of parents and to make the genitals "look more normal," is a cultural practice still holding sway in the United States (see Chase, "Intersex Genital Mutilation," in this chapter).

An intact vulva is regarded in sub-Saharan Arab Islamic Africa as the mark of a slave or prostitute. In a culture where a family's honor is measured largely by the sexual deportment of its women, a tightly infibulated introitus is testimony to a girl's unviolated chastity and thereby, all importantly, the unsullied honor of her family (Saadawi, 1980): "To keep the young girl pure and the married woman faithful, genital operations are maintained among Africa's most valued traditions" (Ogunmodede, 1979 p. 30).

In an extensive study of 3,210 women and 1,545 men in Sudan, Dareer (1982) found that 82.6% of women and 87.7% of men interviewed were in favor of continuing Pharaonic circumcision. Lightfoot-Klein's (1989b) in-depth interviews with more than 400 respondents resulted in similar findings (1989a). The most common reason given for supporting the mutilations was "It is custom." Furthermore, the likelihood exists that the number of people actually favoring continuation of the practice is much higher than that. Under Sudanese law, Pharaonic circumcision has been a punishable offense since 1956, although clitoridectomy remains legal. In spite of the law, Pharaonic circumcision continues more or less unabated. Youseff (1973) observed, "The laws against infibulation have not been obeyed because the custom is still an integral, positive-functioning component of the familial complex, and so, indirectly of the entire socio-cultural system" (p. 335). Within the cultures practicing these rites, they are regarded as an indispensable purification.

The presumed purifying functions of cutting off a girl's genitals are multiple. Women's intact sex organs are believed to be the source of irresistible temptation to unbridled promiscuous sexuality. Their removal is considered necessary to attenuate the girl's sexual sensitivity and reduce her sex drive (Giorgis, 1981; Lightfoot-Klein, 1989b). Whereas genital sensitivity appears, in fact, to be considerably reduced in some, although by no means all, genitally mutilated women, there is evidence that the sex drive is not so affected. According to the observations of Burton (1954), the nineteenth-century explorer who studied this phenomenon firsthand, the sex drive tended to become intensified rather than reduced in genitally mutilated women. He conjectured that this was so because sexual satisfaction was made more difficult by the mutilation. Both of these attributes are considered dangerous in a "decent" woman who is worthy of carrying on a family's lineage. The problem is believed to be solved by removing the offending parts, in other words, her genitals. Infibulation in particular is believed (quite falsely) to serve as a deterrent to rape, while effectively guarding the girl against her own errant sexual impulses. An intact infibulation assures the bridegroom that the purity, chastity, and honor of his bride and, consequently, the honor of both his family and hers

are unsoiled. It is common knowledge among people in the cities, however, that if a girl is not a virgin, she need only have herself reinfibulated before marriage to appear to be one. In Sudan and other infibulating cultures, the rather curious notion of "renewable virginity" exists. Thus, if a girl is raped, has had a premarital or adulterous affair, or remarries after having been widowed or divorced, she is reinfibulated and becomes a "virgin" once more.

Uncircumcised girls are often subjected to great peer pressure, so that many eventually press their families for their own circumcisions. They are ridiculed by those who have already undergone the rite for "still having that disgusting thing dangling between [their] legs," and they are taunted for "smelling bad" (Lightfoot-Klein, 1989a, p. 72).

PSYCHOLOGICAL EFFECTS

The rites of FGM themselves are couched in mystery, so that the girl does not have a clear idea beforehand of what is about to happen to her. Although she has a vague notion that her flesh will be cut and that there will be pain and bleeding, these matters are glossed over, and her attention is more or less successfully diverted from these anxiety-producing aspects of the event. The social benefits she is about to reap are impressed upon her and joyfully celebrated. The day of circumcision is represented as the most important day in her life, the culmination of her preparation for respected womanhood. A festive atmosphere prevails; she is the center of all attention and receives many coveted gifts.

A change of heart or an escape is not possible. She is generally not yet of an age when she can run away. Increasingly, most genital mutilations are performed on small children because they are easier to manage (Lightfoot-Klein, 1989a). It is not until the circumciser actually cuts into her flesh that the little girl realizes the enormity of what is happening to her.

In view of the extensive trauma involved, one would expect to see some profound personality changes commonly occurring in young girls who have undergone genital mutilation. For example, a lively and outgoing child might become timid and withdrawn. Verzin (1975) reports that he discussed this on many occasions with various local doctors and that they tended to report that they had not observed such a change. Not a single doctor among the many that I spoke with was able to recall even one girl being brought to him for becoming timid and withdrawn. Such behavioral manifestations are accepted not only as perfectly normal in a girl, but even desirable. One doctor, whose family I lived with for some months, told me that the only difference he noticed after his own daughters had been Pharaonically mutilated was that they were "less hyperactive" than before, and that this was, in any event, as it should be.

Other observers, however, categorically state that there is considerable evidence that a child becomes withdrawn in the first year or two following her mutilation. This tends to give place to an observable pride when girls are a few years older and before the complications associated with menstruation set in.

Obviously, their self-esteem has been enhanced by having proven themselves worthy to become responsible, marriageable women and by having earned their family's approval and gratitude for upholding family honor.

By way of further explanation, Sudanese psychiatrists cite the cohesive and warmly supportive influence of the extended family as a powerful force for creating emotional stability and adaptability in girls and which also helps them to come to terms with their trauma. My personal observations tend to verify that the emotional life of children in Sudan, as well as in some other parts of Africa, is characteristically rich and joyful. They tend to develop in an atmosphere of enviable love and emotional security relative to the experience of the average child in the Western world. This emotional security helps them overcome the seemingly insurmountable trauma of the genital mutilation. It also tends to further the likelihood of a strong marital bonding for both sexes in later life, which, in turn, enables women to overcome the equally horrendous traumas of deinfibulation and childbirth (Lightfoot-Klein, 1989a). Although I did witness some evidence of depression, acute phobia, anxiety, despair, and other emotional disturbance among girls and women on a day-to-day basis in the areas I studied, it was generally not highly visible. Many towns and villages have their madman or madwoman, but major psychiatric breakdown as a consequence of FGM is not often seen. This observation was validated by all the health professionals consulted for this study. However, it must be understood that depression resulting in impotence in men is considered in these cultures to be a health problem of major concern. On the other hand, women's anxiety, depression, despair, or phobic manifestations, no matter how acute, are simply not within the definition of serious emotional disturbance in these cultures. In fact, some anxiety, fear, and distress may be encouraged to keep women in their subordinate role.

On one occasion, I stayed with some teachers at a girls' secondary school in a small town. When night fell, I announced my intention to sleep in the garden of the school courtyard. My announcement was greeted with exclamations of horror from the young teachers. They fluttered about me nervously, like hens whose adopted duckling charges are hastening toward the water.

"Oh, you must not do that!" they implored. "It is terribly dangerous."

"But how can it possibly be dangerous, here in the garden?" I asked.

"Robbers will rob you!" they exclaimed.

"How can there be robbers when there is a high wall around us, the gates are locked tightly, and there is a watchman outside the gate? Do not be afraid. No one will rob me."

"Oh you must not do it!" they pleaded. "The wild dogs will eat you!"

"The dogs are all outside the gate, and cannot come in. Do not worry. The dogs will not eat me."

"But there are evil spirits that come in the night, and they will harm you."

"There are no evil spirits, and even if there were, closed doors would not stop them. No, all the spirits are good, and Allah will watch over me."

"But, the watchman will see you!"

"Well then, the watchman is a kindly old man, and if he sees me, he will watch over me. You will see. Nothing bad will happen."

They stood there, wringing their hands, helpless and frightened. "But we are afraid," they finally said.

"Why are you so afraid?" I asked.

"Because they teach us to be afraid. From the beginning, when we are little, little girls, they teach us to be afraid."

"Afraid of what?"

"Afraid of everything. We sleep wrapped up in our blankets, with the covers over our heads, with all the windows bolted and shuttered, and the doors locked. We huddle together, and still we are afraid. We are always afraid."

And they did indeed all sleep wrapped round and round tightly like mummies, in their hot airless chamber. I came into their room in the morning, after one of them had unlocked, unhooked, unlatched, and unbolted the door. The little room was airless and sweltering with the heat of many bodies, and I could hardly bear to enter it. One by one, they crawled out of their cocoons, and each embraced me, as though I was freshly risen from the dead. They were so happy and relieved that indeed I had come to no harm.

"Allah is merciful. Praised be Allah!" they exclaimed over and over again. "But were you not afraid?" they marveled. "Were you really not afraid?"

Later, we spoke together of their greatest fear, the one that is always with them, the one that has been with them from early childhood on, the one that never leaves them. It is the most terrible, potent fear of all. It governs their waking hours and pervades their dreams. It is their fear of being raped (Lightfoot-Klein 1989a, pp. 215–216).

THE POLEMICS OF AFRICANISM

It generally comes as a shock to Westerners to find that even educated women, as well as men, may be among the ancient blood ritual's staunchest advocates. They justify the mutilations as an integral part of their tradition and unity as a people. They defend it against what they perceive to be yet another imperialist attempt to destroy their identity as Africans. Sad to chronicle, there have been a plethora of such attempts throughout colonial history, beginning with the well-meaning, albeit misguided, efforts of Christian missionaries and culminating in laws imposed by oppressive colonial rulers (Obiora, 1997):

If it is deemed necessary to introduce laws to combat a custom as sensitive as female circumcision, a genuine attempt must be made to grasp the full socio-psychological implications of these laws in order to avoid their undesirable results or unintended consequences. (Babiker Badri, cited in Obiora, 1997, p. 289)

The embittered defense of the practices by many African intellectuals is virtually impossible for Westerners to understand. Westerners, perceiving the practices from outside the culture, can only regard them as barbaric anachronisms. In the view of Lerner (1986), the mutilations become somewhat more

comprehensible once it is understood that uncircumcised women, particularly in sub-Saharan Arab Islamic societies, have historically been slaves, prostitutes, and other non-male-protected women of low caste, whose sad lot in life has always rendered them and, even more tragically, their children easy prey to rapists, marauders, and slavers.

Genital mutilation, by contrast, has for centuries been a way to ensure for wives and daughters the protection of a male-dominated compound. It is for these powerfully persuasive reasons that the honest efforts of Western governments to simply do away with "the barbaric practice" fail. This occurs with both African immigrants to Western countries and in the attempts of Western feminists to educate Africans to leave their daughters genitally intact. Ironically, the outraged opposition to such Western interference with millennia-old blood rituals comes most often not from men, but from women. Moreover, with very few exceptions, the efforts of Western feminists to bring about change in Africa have all too often been clumsy, crassly insensitive, ignorant of African culture, and self-serving:

I have visited villages where, at a time when the village women are asking for better health facilities, lower infant mortality rates, pipe-borne water and access to agricultural credit, they are presented with questionnaires . . . on female circumcision. There is no denying that certain statistical relationships can be established between such variables, however that is not a priority from the point of view of those who make the research subjects. (Achola Pala, cited in Obiora, 1997, p. 297)

On the brighter side, a growing number of Western women and men, working alongside activist, educated Africans, have sought out long-term, firsthand experience with different African cultures at the grassroots level. When such individuals have been willing to listen rather than insist on dictating their own belief systems, they have gleaned an understanding of how to begin to unravel the conundrum of FGM. They are acutely aware that statistical analyses based on highly questionable data, as well as academic writings with no hands-on experience (that do little more than rehash what has been written by others about the issues involved), have little if anything to contribute to a solution.

AND WHAT ABOUT THE AFRICAN WOMAN ON OUR OWN SHORES?

"If we care about the genitals of these women, we need also to care about their feelings" (Lane & Rubenstein, cited in Obiora, 1997, p. 327). And what of the African woman in today's ever increasing migration into the countries of Europe and the Americas? When a genitally mutilated woman is living in her own country, where every woman has been enculturated as she has, she is prone to accept her suffering as being simply "a woman's lot." In Western countries, what has been done to her in her native country in the name of social acceptability is abhorred as the ultimate form of abuse. All too often, it becomes quite

clear to her that neither her presence nor her problems are welcome, and she is likely to be overwhelmed by feelings of confusion and alienation (Lightfoot-Klein, 1994). If her awareness grows, she may understand for the first time that there is a connection between the mutilation she has been subjected to in childhood and the recurrent episodes of pain and disability that she yet suffers as a consequence. Added to her physical pain, she is now likely to experience the emotional suffering that comes with the realization that she has been robbed of an irreplaceable part of her body, the possession of which is taken completely for granted by women native to her new environment (Lightfoot-Klein, 1994).

Quite possibly, the result may be a profound shift in the way she perceives herself and the society that has created her affliction. Because she has so little power, this new awareness will only serve to heighten her confusion and emotional suffering. But will it prevent her from creating yet another generation of mutilated daughters, either by finding a practicing circumciser somewhere in the African community of her adoptive country, or by sending her daughters home "to the grannies" to be mutilated when their time comes? How can we help such women? How can we, first of all, ease their suffering and thereby open a door that may persuade them not to deal with their daughters as they themselves have been dealt with?

There are no comfortable solutions. No matter in which direction the genitally mutilated woman turns, she finds herself trapped. If she opposes genital mutilation on a personal level and refuses to subject her own daughters to the rituals, her family will almost certainly cast her out. If she finds the courage to break her vow of silence and speak out against it publicly, not only she but her entire family will become pariahs and will be subjected to insults, ostracism, threats, and even violence.

Even if she is no longer convinced that the ritual is either necessary, beneficial, or even "perfectly normal," she may find herself unable to defy the social compulsions or, for that matter, her own driving and ill-understood repetition compulsion, the acknowledged by-product of violence perpetrated on small children. It is not surprising that not many such women, even those who live in the relative anonymity of the Western world, have the courage to speak out and actively work against the practices. Those who do are certainly to be admired and are deserving of our most compassionate support. If lifestyle options other than marriage become open to the woman, and consequently to her daughters through education, such options may well form the beginnings of some meaningful change. Consistent, appropriate medical care, backed by an understanding of the woman's complicated culture and its stringent demands, would seem to be a logical first step in helping her to break free from the past and its oppression.

Furthermore, it is essential that we educate our own medical and psychological caretakers to enable them to deal knowledgeably and sensitively with such patients. We need to caution doctors not to put them on display as medical curiosities, but rather to help them reach an understanding of how their childhood

mutilation is afflicting their bodies currently, and how their medical problems may be managed most effectively. Because they have generally been raised in a loving environment by a caring extended family, circumcised women are likely to cling to the notion that the mutilation was performed as an act of love and for their own benefit. They will declare with pride and conviction that the circumcision was done for them, not to them. It is important that prospective psychotherapists remember this, in order to not represent or refer to these loving caretakers, the carriers-on of a tradition of which they themselves have been victims, as sadists or bloodthirsty monsters.

At a broader level, sensitively planned and respectful reeducation is needed to begin the arduous process of dissolution of this deeply ingrained, age-old custom. It must be based on careful assessments, nurtured rapport, and insight into the mentality of each individual African woman and her family. Care must be taken as well to encourage the women, and when possible their families, to continue the more positive customs that are also a part of their heritage. It is to be hoped that through these efforts, genital mutilation will begin to lose its stranglehold on the populace. However, we cannot expect this to be an easy task.

INTERSEX GENITAL MUTILATION

Genital ambiguity is "corrected" not because it is threatening to the infant's life but because it is threatening to the infant's culture.

—Suzanne Kessler (1990, p. 25)

CULTURAL PRACTICE OR RECONSTRUCTIVE SURGERY?

"New Law Bans Genital Cutting in United States," reads the headline on the front page of the *New York Times* (Dugger, 1996). The law seems clear enough: "Whoever knowingly circumcises, excises, or infibulates the whole or any part of the labia majora or labia minora or clitoris of another person who has not attained the age of 18 years shall be fined under this title or imprisoned not more than 5 years, or both." Yet this law was not intended and has not been interpreted to protect the approximately five children per day in the United States who are subjected to excision of part or all of their clitoris and inner labia simply because doctors believe their clitoris is too big (Coventry, 1998; Dreger, 1998a). There is even a medical standard for how big is too big: over 0.9 cm, about 3/8 of an inch (Kessler, 1998).

Sexual anatomies, and genitals in particular, come in many sizes and shapes. Doctors label children whose sexual anatomies differ significantly from the cultural ideal as "intersexuals" or "hermaphrodites." Medical practice today holds that possession of a large clitoris, or a small penis, or a penis that has the urethra located anywhere other than at the tip is a "psychosocial emergency" (Meyers-Seifer & Charest, 1992). The child would not be accepted by the mother, would

be teased by peers, and would not be able to develop into an emotionally healthy adult (American Academy of Pediatrics, 1996). The medical solution to this "psychosocial problem" is surgery—before the child reaches 3 months of age, or even before the newborn is discharged from the hospital (Parker, 1998). Although parental emotional distress and rejection of the child and peer harassment are cited as the primary justifications for cosmetic genital surgery, there has never been an investigation of nonsurgical means, such as professional counseling or peer support, to address these issues.

The federal Law to Ban Female Genital Mutilation (1996) notwithstanding, girls with large clitorises are "normalized" by excising parts of the clitoris and burying the remainder deep within the genital region (Oesterling, Gearhart, & Jeffs, 1987). And boys with small penises? Current medical practice holds that intersex children "can be raised successfully as members of either sex if the process begins before 2½ years" (American Academy of Pediatrics, 1996, p. 590). Because surgeons cannot create a large penis from a small one, the policy is to remove the testes and raise these children as girls. But first they "carve a large phallus down into a clitoris, creat[ing] a vagina using a piece of [the child's] colon," marveled one science writer, who spoke only to physicians and parents, not to any of the identified patients who were the nominal beneficiaries of this miracle technology (Hendricks, 1993, p. 10). "You can make a hole, but you can't build a pole," quipped one surgeon to Hendricks (p. 15). Efforts to create or extend a penile urethra in boys whose urethra exits other than at the tip of the penis, a condition called hypospadias, frequently lead to multiple surgeries, each compounding the harm (Stecker, Horton, Devine, & McCraw, 1981). Heart-rending stories of the physical and emotional carnage are related by victims of these surgeries in "Growing Up in the Surgical Maelstrom" (Devore, 1999) and, with black humor, in "Take Charge: A Guide to Home Catheterization" (Nicholson, 1999).

"Reconstructive" surgeries for intersex infant genitals first came into widespread practice in the 1950s. Indeed, one enthusiastic surgeon even cited the tradition of clitorrectomy in Africa as evidence that the practice is not harmful (Gross, Randolph, & Crigler, 1966). Intersexuality is treated as shameful, and physicians discourage open discussion by their patients. Indeed, they recommend lying to parents and to adult intersex patients (Natarajan, 1996). Thus, until recently, most victims of these interventions suffered alone in shame and silence (Dreger, 1998b; Kemp, Groveman, Anonymous, Tako, & Irwin, 1996).

By 1993, the accomplishments of a progression of social justice movements—civil rights, feminist, gay and lesbian, bisexual and transgender—helped make it possible for intersexuals to speak out. Initially, according to newspaper reports (e.g., Angier, 1996; Mulgrew, 1997), physicians scoffed at assertions that intersexuality was not shameful and that medically unnecessary genital surgeries were mutilating and should be halted. One surgeon from Johns Hopkins, the institution primarily responsible for developing the current medical model, dismissed intersex patient-advocates as "zealots." Others cited the

technological imperative: doctors "don't really have a choice" whether or not to perform surgery (Szasz, cited in Mulgrew, 1997).

By 1997, the intersex movement had gathered enough strength for advocates to visit Congress and ask that the Law to Ban Female Genital Mutilation be enforced to protect children not only against practices imported from other cultures but also against this uniquely American medicalized form of mutilation. Their work won coverage in the *New York Times* (Angier, 1997) and on NBC's *Dateline* (Shapiro, 1997). In 1998, *Urology Times* reported a small but growing "new tidal wave of opinion" from physicians and sex researchers supporting the activists (Scheck, 1998). Unfortunately, the struggle of intersex activists against American medicalized genital mutilation has yet to attract significant support or even notice from feminists and journalists who express outrage over traditional African surgeries (Chase, 1998).

WHAT ARE THE LONG-TERM OUTCOMES OF THESE SURGERIES?

All parties agree that there has been a shocking lack of follow-up after surgery, and few objective data are available: "Long term results of operations that eliminate erectile tissue [i.e., surgery routinely performed on intersex children] are yet to be systematically evaluated" (Newman, Randolph, & Parson, 1992, p. 192). "Past decisions about gender identity and sex reassignment when genitalia are greatly abnormal have by necessity occurred in a relative vacuum because of inadequate scientific data" (Reiner 1997a, p. 224). "There is a dearth of systematic knowledge about the psychosocial functioning of hypospadias patients at various ages. . . . Besides, to what extent patients' perception of their penile appearance is related to their psychosocial functioning has never been investigated" (Mureau, Slijper, Slob, & Verhulst, 1997).

In 1996, demonstrators picketed the annual meeting of the American Academy of Pediatrics (AAP), protesting the group's continuing support of cosmetic genital surgery on infants and refusal to open a dialogue with patient-advocate groups. The AAP reacted by dispatching a spokesperson with a press release reasserting confidence in its policy of addressing the "emotional, cognitive, and body image" concerns of intersexuals with genital surgery between 6 weeks and 15 months of age. Meanwhile, inside the meeting, surgeon David Thomas spoke to assembled pediatric specialists, acknowledging that "the people who are picketing the AAP at the moment do have a point," and that psychological issues surrounding intersexuality and cosmetic genital surgery "are poorly researched and understood" ("Is Early Vaginal," 1997). Johns Hopkins pediatric urological surgeon Robert Jeffs, reacting to the demonstration, conceded to a journalist that he had no way of knowing what happens to patients after he performs surgery on them: "Whether they are silent and happy or silent and unhappy, I don't know" (Barry, 1996, p. 7).

What is clear is that genital surgery can cause such physical harm as scarring, chronic pain, chronic irritation, and reduction of sexual sensation, as well

as psychological harm. Indeed, apart from the harm specific to genital surgery, surgery is never without risk. Even surgeons from Johns Hopkins, an institution that continues to perform and to promote the surgery, told journalist McCroy (1998) that "there is no medical necessity to reduce the size of a clitoris" (p. 18) and, in a published reply to a critical letter, acknowledged that the surgery "does not guarantee normal adult sexual function" (Chase, 1996, p. 1140).

Perhaps more important than physical harm is the psychological harm that has been reported by former patients. Schober (1998) reported that a sex therapist, H. Martin Malin, discussing patients who had been subjected to early genital surgeries, noted they had been told that vaginoplasties or clitorectomies had been performed because of the serious psychological consequences they would have suffered otherwise. In spite of the surgeries, or perhaps because of them, the patients still reported long-standing psychological distress.

FOR WHOSE BENEFIT ARE THESE SURGERIES PERFORMED?

There is a growing realization that surgeries are performed on intersex infants to alleviate the emotional distress of the parents and other adults (e.g., Oesterling et al., 1987). Surgery must be performed during the first few weeks of life, says surgeon John Gearhart; "Otherwise, every time the mom, dad, or auntie changes the diaper, everybody gets upset. You cannot have a child who causes the auntie, when she pulls down the diaper, to say, 'My God!'" (Hendricks, 1993, p. 12).

Suzanne Kessler (1990), in her ethnography of the physicians who perform these surgeries, concluded, "Genital ambiguity is 'corrected' not because it is threatening to the infant's life but because it is threatening to the infant's culture" (p. 25). However, as Schober (1998) argues, although surgeons believe they can maximize a child's acceptance by the family, they do so without knowing the psychological cost to the infant patients in their adulthood.

BUT DON'T YOU WANT TO BE NORMAL?

Genital surgery is irreversible: once removed, a clitoris, penis, or testicle can never be restored. Scarring produced by surgery can never be undone. There are many documented cases of people who have lived apparently emotionally healthy and productive lives with their atypical anatomy intact. Some of these actually refused surgery when it was offered (Fausto-Sterling, 1993; Young, 1937). Like large clitorises, small penises are capable of providing sexual arousal, genital pleasure, and orgasm. The men investigated by Reilly and Woodhouse (1989) were able to live satisfying lives as men with no impairment of sexual function; they had small penises that would be judged "inadequate" according to current medical protocols. Surgeons argue that genital surgeries must be performed on intersex children to save them from feeling different from other children or being marginalized by society. But

many children grow up with physical differences that may cause them to be marginalized, yet we do not advocate using plastic surgery to eliminate all physical differences. For instance, children of racial minorities are often marginalized, teased, and even subject to violence. Yet few would condone using nonconsensual plastic surgery during infancy to eliminate racial characteristics.

Prejudice against people with unusual genitals is culturally determined. Some cultures have high regard for people with intersex genitals (Herdt, 1994; Roscoe, 1987). Even awareness of this cultural relativity does not seem to dampen the enthusiasm of some clinicians for surgery. For instance, pediatric endocrinologist Marie New recognizes that during the European Middle Ages and Renaissance, "hermaphrodites were integrated quite forthrightly into the social fabric" (New & Kitzinger, 1993, p. 10), but she does not question today's medical policy of early cosmetic surgery.

Kessler (1997) provides evidence that adults, asked to imagine having been born with atypical genitals, would not have wanted their parents to permit cosmetic genital surgery on them. Shouldn't this raise doubts about the ethical nature of the surgeries? Perhaps adults allow surgery on infants because they find it difficult to imagine a child as a future sexual being; in contrast, when asked to consider genital surgery on themselves, they are aware of and value their sexual functioning over cosmetics. The growing body of first-person narratives by intersex people and accounts uncovered by historians provide a wealth of examples of people who bitterly regretted having been subjected to "normalizing" genital surgery (including some whose surgery did not occur until adolescence) and of people who were happy to have escaped surgery (Chase, 1997a, 1997b; Dreger, 1998b, 1999).

Finally, cosmetic genital surgery does not provide "normal"-looking genitals. Reporting on the cases of a dozen girls aged 11 to 15 who had undergone clitoroplasty and vaginoplasty, Scheck (1997) cited pediatric urologist David Thomas, who concluded that the results were "indifferent and, frankly, disappointing." Over time, reconstructions showed visibly different appearance from the original cosmetic result, with the clitorises withered and obviously nonfunctional. All required some additional vaginal surgery (Sheck, 1997). Even surgeries performed by leading experts had poor outcomes: "Even after surgery, [boys and men] perceive differences in penile appearance . . . because hypospadias surgery never produces a perfectly normal penile appearance" (Mureau et al., 1997, p. 373).

Surgeons insist that cosmetic genital surgeries performed on intersex infants are not "mutilations" because their intent is to help, not to harm, the infant. But "mutilation" is a value judgment. Surely, in determining whether or not a particular form of genital cutting is a mutilation, professionals should give the greatest weight to the experience of the person whose genitals are cut, rather than to the person doing the cutting. Parents in sub-Saharan Africa who have traditional cutting performed on their daughters believe that they are doing what is best for their child.

WE CONTROL YOUR SEX AND GENDER

The current medical model insists that doctors can make any child into any sex that they wish. But there is clear evidence that this is little more than wishful thinking. For instance, surgeons insist that genetic females with a condition called congenital adrenal hyperplasia (CAH) who are born with enlarged clitorises or even with male genitals are clearly, universally, and inevitably female. In these cases, asserts John Hopkins surgeon John Gearhart, "There is not controversy there . . . the child is going to be a female" (cited in McCroy, 1998, p. 18). But before medical interventions began in the late 1950s, many such individuals lived their entire lives as men (Young, 1937). Today, a significant number of CAH individuals also choose, in their teens or as adults, to live as men even after having undergone drastic "modern" interventions such as removal of the penis (Meyer-Bahlburg et al., 1996; Money, Devore, & Norman, 1986; Zucker et al., 1996).

The most dramatic refutation of the "We control your sex and gender" thesis is the case of "John/Joan" (Diamond & Sigmundson, 1997b). "John" was born in the 1960s, one of a pair of identical male twins with typical sex anatomy and genitals. John's penis was accidentally destroyed during circumcision when he was 8 months old. A team of physicians and sexologists at Johns Hopkins determined that the best course was to raise him as a female. His testes were removed, cosmetic surgery was performed on his genitals, and his parents were instructed to raise him as a girl and to conceal his true history from him. For decades, medical literature cited this case as a glowing success story and as proof that physicians were justified in assigning intersex children a sex according to surgical convenience above any other consideration.

However, it turns out that "John/Joan" was not a success story, but an unmitigated disaster. The follow-up in Diamond and Sigmundson (1997b), reported in more detail in Colapinto (1997), reveals that John never felt female, that he resisted physicians' attempts to further feminize his body through hormones and additional cosmetic genital surgery, and that today he lives as a man, is married to a woman, and is the adoptive father of her children. The medical model tolerates no ambiguity about a child's sex. Thus, the medical team actively resisted "Joan's" attempts to avoid additional feminizing procedures, such as estrogen and vaginoplasty.

WHERE DO WE GO FROM HERE?

What the intersex activist movement and its professional allies are recommending is not terribly radical. Before the late 1950s, intersex children were raised either as girls or as boys and made their way in the world as best they could, usually without any professional help. Sometimes, they changed sex, without any professional help. Today, knowledge of genetics, embryology, and endocrinology could allow medical experts to make a better guess about which sex would be most comfortable as a label for an intersexed child (Diamond & Sigmundson, 1997a; Reiner, 1997b). But just because professionals give

a child a label, it does not follow that doctors must perform surgery to make the child's genital appearance more closely approximate what is implied by the label.

Furthermore, with some specialized training, mental health professions would be well equipped to address the emotional distress of the parents and of the child as he or she grows up. The nascent intersex patient advocacy movement is struggling to create the infrastructure to provide peer support for both parents and intersexuals. In fact, some intersex adults themselves are now beginning to choose psychotherapy as a profession, with the intention of offering the type of help they wish they and their families could have had. Support groups have sprung into existence all over the world; many are listed at the Web site of the Intersex Society of North America (<http://www.isna.org>).

The controversy has drawn the attention of scholars from outside the medical profession, including medical historians, bioethicists, social psychologists, sociologists, sex researchers, and anthropologists. Their investigations have revealed the extent to which the traditional medical practice lacks scientific basis and suffers from a virtual absence of long-term follow-up. At the end of 1998, a special issue of the *Journal of Clinical Ethics* brought together much of this work for the first time in one volume. Every contributor (including a pediatric endocrinologist, a pediatric psychiatrist, and a pediatric urologist) calls for drastic changes in medical practice (Dreger, 1998c). An indication of how polarized the issue has become is that Alice Dreger, the editor of the special issue, reports that none of the physicians advocating infant surgery whom she invited to contribute to the issue were willing to do so. Thus, the surgical literature continues to present surgery as uncontroversial, the ethics literature unanimously condemns the practice, and the two communities do not speak to each other.

Medical practices that were once professionally respectable but have now been eliminated because of social condemnation include forced sterilization for eugenic purposes; hysterectomy and oophorectomy for psychological disorders in women (practiced at least until the end of World War II); lobotomy, electroshock, and aversion therapy for treatment of homosexuality (practiced at least through the 1960s); clitoral excision or cauterization for elimination of masturbation (practiced at least through the 1950s); radiation experiments on institutionalized handicapped children; and syphilis experiments on impoverished African American men. "Genital reconstruction" of intersex infants should finally be added to this list.

The federal Law to Ban Female Genital Mutilation (1996) permits excisions when "necessary to the health of the person on whom it is performed." But the law also says that in determining whether surgery is necessary, "no account shall be taken . . . of any belief . . . that the operation is required as a matter of custom or ritual." At what point is standard medical practice simply "a matter of custom"?

MALE GENITAL MUTILATION

Although no documents record the number of girls and boys who fall victim to genital cutting customs, one can reasonably estimate that approximately 100 million females (Toubia, 1994) and more than 650 million males (Vital Abstracts of the U.S., 1994) are alive in the world today who were subjected as children to various forms of involuntary genital mutilation. Each year around the world, an estimated 2 million girls and 13 million boys (Denniston & Milos, 1997) are subjected to "circumcision" customs, occurring in a wide variety of either developing or developed nations. The severity and rationalizations for altering children's healthy genitals differ between genders, as well as from circumciser to circumciser and from culture to culture. The customs may be carried out on the dirt floor of a village hut or in an urban hospital. The highly respected circumcisers may be local barbers, influential tribal or religious leaders, or medical professionals. Parents who offer their children to the circumciser may be sheep-herding Nomads, middle-class laborers, or college-educated professionals. In all cases, social, religious, or historical imperatives demand the removal of a misunderstood, often feared or despised, portion of the genitals, a removal that the adults sincerely believe to be in the child's "best interests."

Although the vast majority of male circumcisions in the world occur under the same rudimentary and unsanitary conditions as female circumcision, the U.S. custom of male genital alteration is a medical routine. In a world where 80% of males are genitally intact (Wallerstein, 1985), the United States is the last developed nation to continue subjecting the majority of its male newborns to circumcision for nontherapeutic and nonreligious reasons. Consequently, the United States has long been a battleground for progressive and reactionary forces in the campaign to protect male children from genital cutting. Annually, over 1.25 million infants are subjected to unanesthetized genital surgery in the United States. The American national average rate of circumcision fluctuates at around 60% (U.S. National Center for Health Statistics, personal communication, 1996), down from a high of about 85% around 1970. Rates vary by region, from 80% in the Midwest, where social conformity is highly valued, to 34% in the West, where the constraints of tradition and family pressure are weaker. The persistence of male circumcision (like female circumcision) may be due to an undervaluing of the benefits of intact genitals and a minimization of the adverse consequences of genital alteration.

MALE GENITAL ANATOMY AND FUNCTION

During sexual arousal, the flaccid penis becomes erect and increases in length about 50%. As it elongates, the sleeve of preputial tissue unfolds, providing the skin necessary for full expansion of the penile shaft (Figure 12.1). This double fold consists of an outer layer of epidermal tissue and an equal layer of inner mucosal tissue (Figure 12.2). The two layers of preputial tissue account for 50%

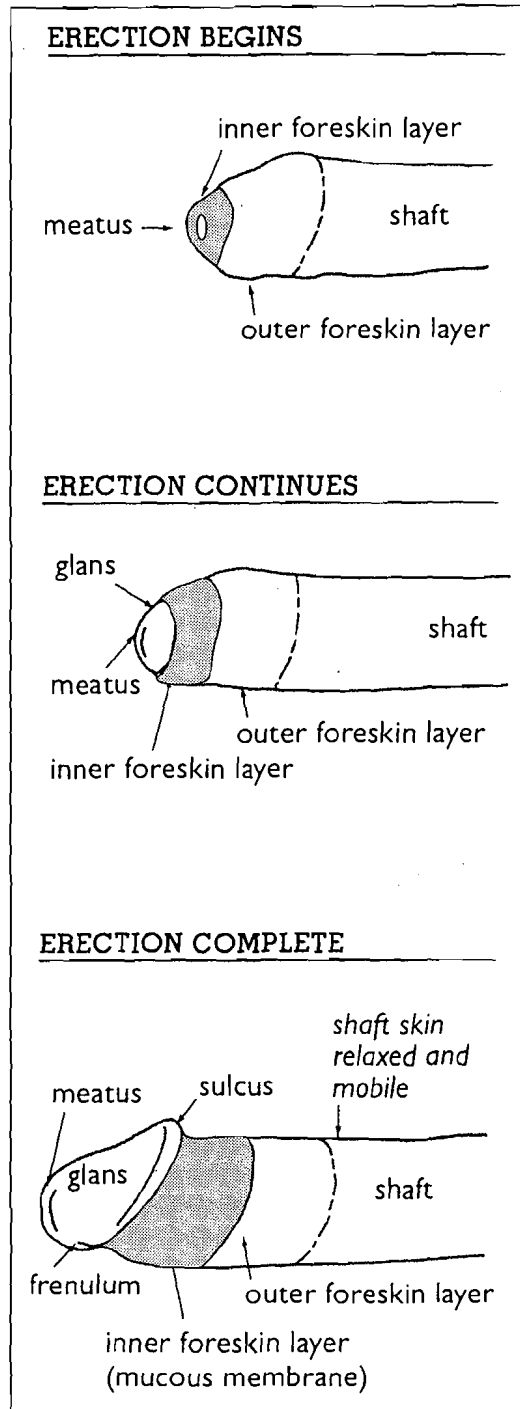


Figure 12.1 Erection Process of the Intact Penis. Reprinted with permission from *Circumcision Exposed: Rethinking a Medical and Cultural Tradition* by Billy Ray Boyd. © 1998. Published by The Crossing Press, P.O. Box 1048, Freedom, CA 95019.

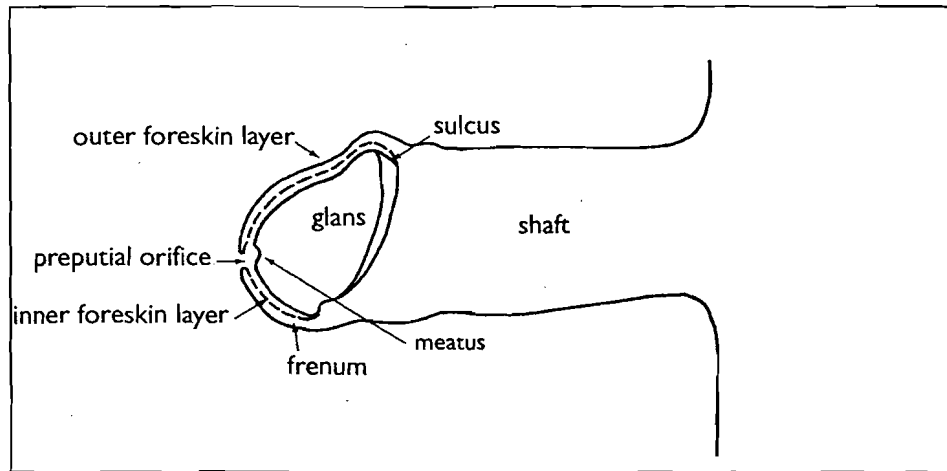


Figure 12.2 Inner and Outer Foreskin Layers. Reprinted with permission from *Circumcision Exposed: Rethinking a Medical and Cultural Tradition* by Billy Ray Boyd. © 1998. Published by The Crossing Press, P.O. Box 1048, Freedom, CA 95019.

or more of the penile shaft skin (Taylor, Lockwood, & Taylor, 1996). Recent case reports demonstrate that the inner and outer linings of the average adult prepuce form a total tissue surface area of 64 to 90 cm² (10–14 sq. in.) (Werker, Terng, & Kon, 1998). The prepuce provides a platform for several nerves and is “an important component of the overall sensory mechanism of the human penis” (Taylor et al., 1996, p. 291). The prepuce is specialized tissue, richly supplied with blood vessels, highly innervated, and uniquely endowed with stretch receptors. The inner surface of the prepuce displays a transversely arranged zone of mucosal ridged bands that merge with the densely nerve-laden frenulum on the underside of the glans penis. This ridged band zone is richly endowed with Meissner’s corpuscles, similar to nerve endings in the fingertips and lips. When the prepuce is retracted, the ridged band zone is everted on the penile shaft and available for external stimulation (Taylor et al., 1996).

Because the prepuce is a moveable sheath, two of its other functions are readily identifiable. In its static position (usually covering the glans), it maintains the glans as an internal organ, protecting it in much the same way that the female prepuce (clitoral hood) protects the clitoris. In both male and female, the prepuce keeps these internal organs moist, sensitive, and out of contact with a harsh external environment (dirt, drying effects of air, and abrasiveness of clothing). Without the protective foreskin, the normally mucosal surface of the glans penis dries out and forms several layers of dead protective tissue (keratinization) (Bigelow, 1995).

The gliding function of the foreskin both causes and responds to sexual stimulation. Stretching the foreskin forward over the glans or backward toward the body activates preputial nerve endings, enhancing sexual excitability and contributing to the male ejaculatory reflex (Milos & Macris, 1994). Both

the glans and the foreskin itself benefit from the stimulation of the foreskin as it glides back and forth over the corona of the glans. In the intact male, masturbation involves the manipulation of this gliding foreskin. Circumcised men must use compensatory techniques.

Lubrication is another significant function of the foreskin. When an intact male engages in heterosexual intercourse, the moist, nonkeratinized mucosal surfaces of the glans penis and inner foreskin layer move back and forth across the mucosal surfaces of the labia and vagina, providing nontraumatic sexual stimulation to both partners (Milos & Macris, 1994). A recent scientific review also indicates that the inner mucosal lining of the male prepuce, like other human mucosa, demonstrates immunological functions, thereby reducing an intact male's risk of contracting sexually transmitted diseases (Cold & Taylor, 1999; Fleiss, Hodges, & Van Howe, 1998). Thus, the foreskin is an important, purposeful aspect of male sexuality, without which "the fundamental biological sex act becomes, for the circumcised male, simply satisfaction of an urge and not the refined sensory experience that it was meant to be" (Falliers, 1970, p. 2194).

MEDICALIZATION OF A RITUAL

A recent biocultural analysis describes childhood circumcision as "low-grade neurological castration" (Immerman & Mackey, 1998, p. 372), resulting in traumatic neurological reorganization and/or atrophy of brain circuitry and sexual desensitization from glans keratinization. Perhaps this is a primitive effort to limit male sexual excitability and to produce a male who is more amenable to group authority figures. The authors propose positron emission tomography (PET) and/or magnetic resonance imaging (MRI) to detect differences in the somatosensory cortex when it receives stimuli from the genitalia of circumcised men compared with similar cortical areas of genitally intact men. Experience suggests, however, that circumcision "does not reduce sexual drive, but leads to compensatory behaviors including sexual compulsivity, altered sexual practices, and other personal/societal consequences" (Hammond, 1999, p. 5). The control of children's sexuality through circumcision is consistent with the motivations of religious authorities in the past (Aldeeb Abu-Sahlieh, 1994; Boyd, 1998) and with those of nineteenth-century physicians (Comfort, 1967; Wallerstein, 1980).

No action has entrenched the practice of male genital mutilation more than its legitimization through the medical profession. Circumcision evolved from a religious ritual or puberty rite into routine surgery for "health" reasons in the English-speaking countries during the nineteenth-century, when the etiology of most diseases was unknown (Milos & Macris, 1992). Victorian antisexual attitudes were largely responsible for a theory that masturbation caused a wide array of mental and physical ills. In a naïve attempt to prevent or cure masturbation, various forms of control were imposed on children of both sexes (Paige, 1978). These included religious lectures, diets of bland foods,

physical apparatuses (chastity belts, straitjackets, genital cages, and spiked penile rings), carbolic acid on the clitoris, and surgical interventions. For boys, sewing the foreskin almost completely shut (infibulation) or circumcision was effective at reducing or eliminating the mobility of this erogenous tissue (Comfort, 1967). None of these was effective, however, at eliminating masturbation.

In the United States, despite the various reasons put forth to perpetuate this genital alteration (which most of the world has never considered), the American medical community has consistently failed to prove conclusively that circumcision carries any significant advantage over the intact state for the vast majority of men. This failing was recognized in 1971, when the American Academy of Pediatrics (AAP) convened a task force on circumcision to study the issue. It concluded that there are no valid medical indications for circumcision in the neonatal period. The task force thoroughly refuted claims that circumcision reduced or eliminated risks of penile cancer, cervical cancer, and sexually transmitted diseases. It clarified that the alleged problem of phimosis (nonretractile foreskin) was, in fact, a normal manifestation of infant and early childhood anatomy that resolves as the penis develops. It asserted the benefits of good hygiene over surgical intervention. Finally, it recognized that the parental decision-making process was rarely based on medical factors but rather was strongly influenced by emotion and custom. This, perhaps more than any other reason, is why newborn circumcision continued unabated in the United States even after the AAP's decisive statement, which was reiterated in 1975 (AAP Committee on Fetus and Newborn).

By the mid-1980s, articles had appeared in law journals questioning the legality of imposing medically unnecessary circumcision on healthy infants. In California at that time, a lawsuit was brought to the state Appellate Court questioning parents' assumed rights to consent to medically unnecessary surgery on their children (Bonner & Kinane, 1989). Although unsuccessful, the case may have threatened the medical community. Shortly thereafter, new medical "evidence" emerged to justify circumcision: reduced risk of urinary tract infections (UTIs) as well as speculation that the foreskin increases a man's risk of contracting HIV/AIDS.

In 1989, this "evidence" prompted the AAP to convene a new circumcision task force to revisit the issue. Although recognizing that the UTI studies were "retrospective in design and may have methodological flaws" and "the study population may have been influenced by selection bias" (AAP Report of the Task Force on Circumcision, 1989, p. 389), the task force concluded that infant circumcision "has potential medical benefits and advantages, as well as [inherent] disadvantages and risks" (p. 390). The fact that "potential" does not equal "proven" was lost on the U.S. media, which reported that this otherwise neutral statement constituted a "reversal" of the AAP's opposition to infant circumcision.

Since 1989, new research demonstrates that an increased risk of UTI is not associated with the presence or absence of a foreskin but with congenital anomalies of the male urinary tract (Mueller, Steinhardt, & Haseer, 1997) and that there is no proof that lack of circumcision is a risk factor for increased UTI

(Thompson, 1990). Studies of HIV infectivity reveal that the alleged importance of circumcision is inconclusive, often due to selection bias (DeVincenzi & Mertens, 1994; Van Howe, 1999). The preponderance of evidence indicates that the risks of penile cancer, cervical cancer, and sexually transmitted diseases (STDs), including HIV/AIDS, are not the result of being intact or circumcised, but of sexual behaviors (Poland, 1990). Circumcision does not confer protection from AIDS or any other STD. Good hygiene, limiting one's sexual partners, and use of condoms are a more reliable means of STD riskreduction than is sexual surgery.

For every problem that circumcision was once alleged to prevent or treat, there are now effective alternative methods of nonsurgical prophylaxis and treatment that respect the patient's genital integrity (Doctors Opposing Circumcision, 1997). In other medically advanced English-speaking nations with a prior history of male circumcision, medical associations have adopted positions less ambiguous than that of the American Academy of Pediatrics:

Australia (infant circumcision rate less than 10%):

The Australian Medical Association will continue to discourage circumcision of baby boys in line with the Australian College of Paediatrics. ("Circumcision Deterred," 1997, p. 5)

The possibility that routine circumcision may contravene human rights has been raised because circumcision is performed on a minor and is without proven medical benefit. (Australian College of Paediatrics, 1996, p. 1)

Neonatal male circumcision has no medical indication. It is a traumatic procedure performed without anesthesia to remove a normal functional and protective prepuce. We are opposed to male children being subjected to a procedure, which had they been old enough to consider the advantages and disadvantages, may well have opted to reject the operation and retain their prepuce. (Australian Association of Paediatric Surgeons, 1996, p. 1)

Britain (infant circumcision rate less than 1%):

Where conditions can effectively be treated conservatively, it is accepted good practice to do so. . . . Therefore, to circumcise . . . where medical research has shown other techniques to be at least as effective and less invasive would be unethical and inappropriate. (British Medical Association, 1996, p. 1)

Canada (infant circumcision rate less than 25%):

Circumcision of newborns should not be routinely performed. (Canadian Paediatric Society, 1996, p. 769)

In 1999, the AAP released a new circumcision policy, stating that any potential medical benefits were not significant enough to recommend that circumcision be routinely performed and that it is not essential to a child's well-being.

By making an unequivocal call for pain medication, it recognized that the extreme pain and trauma of circumcision cannot be ignored. The AAP Task Force on Circumcision acknowledged reports that "penile sensation and sexual satisfaction are decreased for circumcised males" (AAP Task Force on Circumcision, Policy Statement, 1999, p. 687).

It left open the possibility, however, for physicians to cut the genitals of any boy without medical need if a parent requests it for cultural reasons. This policy conflicts with two related AAP policies. Its Committee on Bioethics stated that pediatric health care providers "have legal and ethical duties to their child patients to render competent medical care based on what the patient needs, not what someone else expresses" (AAP Committee on Bioethics, 1995, p. 315). The AAP also advised its members against participation in any form of genital cutting for girls for cultural reasons (AAP Committee on Bioethics, 1998), including removal of the clitoral hood, which many physicians admit is less severe than amputating a boy's foreskin.

PSYCHOSOCIAL MOTIVATIONS TO CIRCUMCISE

Our science is affected by our cultural values, and circumcision reflects a cultural value rooted in neither science nor medicine. Despite the possible immediate harmful effects of male circumcision and potential adverse long-term effects, it is difficult for us to change because the practice is deeply embedded in American culture. Circumcision of infants may be a reenactment of the trauma of one's own circumcision. A survey of randomly selected primary care physicians showed that circumcision was more often supported by doctors who were older, male, and circumcised (Stein, Marx, Taggart, & Bass, 1982). Defending circumcision requires minimizing or denying the harm and perhaps overstating medical claims about its alleged protective effects. Religious beliefs may also be used to defend circumcision.

Parents are solicited by hospital personnel to make a decision about circumcision. This may imply to them that it is a beneficial practice. Those parents who agree to circumcision of their newborn son are typically not aware of counter-information and may not understand what circumcision does (Terris & Oalman, 1960). Doctors say they circumcise because parents request it, but parents choose it because doctors do it (Briggs, 1985). Communication between physician and parents about circumcision is often insufficient for informed consent, largely because of emotional discomfort with the subject. The discussion may instead include incorrect tacit assumptions by doctor and parent about what the other really wants or means (Briggs, 1985). These assumptions lean toward the decision to circumcise. The parents' lack of expertise leads them to defer to the doctor's knowledge. Although doctors do not require that parents choose circumcision, and parents believe they are freely making their own choice, doctors do exercise control over the parents' decision by controlling information and sometimes making a recommendation (Briggs, 1985; Patel, 1966).

A national study of 400 pediatricians and obstetricians indicated that two-thirds of doctors took a neutral position on circumcision when advising parents (Herrera, Cochran, Herrera, & Wallace, 1983), but this may not provide accurate and complete information to those who are asked to make the decision (Goldman, 1997). Even when doctors advise against circumcision, their continued willingness to perform it at parental request suggests to parents that circumcision may not be harmful.

The importance of conformity in the circumcision decision is illustrated by a survey of parents of 124 newborn males born at a Denver hospital. The results showed that for parents making the circumcision decision, social concerns outweighed medical concerns. Parents' reasons for circumcising were based mainly on an interest that the baby look like his father, brothers, and friends. Only 23% of the uncircumcised fathers had circumcised sons. In contrast, 90% of the circumcised fathers had circumcised sons. The authors concluded that the circumcision decision has a strong base in social and cultural beliefs (Brown & Brown, 1987).

In a study at a Baltimore hospital, social conformity was a major consideration among parents making the circumcision decision. A group of parents was given special information on circumcision, which concluded that circumcision is not medically necessary. A control group in the study was not given any special information on circumcision. The circumcision rates of the two groups were not statistically different. The researchers concluded that parents found social reasons alone sufficient to choose circumcision (Herrera et al., 1983). However, there is no empirical evidence to support the assumption that a boy would want to be circumcised if his father or peers are circumcised (Goldman, 1999).

The following factors call into question the validity of the decision to circumcise for social or "matching" reasons:

- The circumcision status of the father is not necessarily known or important to a male child.
- A circumcised boy who "matches" others may nevertheless have negative feelings about being circumcised (Goldman, 1997).
- It is not possible to predict prior to circumcision how a boy will feel about it later.
- As a growing minority in the United States, most uncircumcised men are happy to be intact.
- An intact man who is unhappy about it can choose to be circumcised, but this is rarely done. The estimated rate of adult circumcision in the United States is 3 in 1,000 (Wallerstein, 1980).
- An intact man who is unhappy about his status may feel differently after learning more about circumcision and the important functions of the foreskin (Goldman, 1997).
- The social factor is much less of an issue for boys born today because of the overall trend away from circumcision.

CONSEQUENCES OF CIRCUMCISION

Parents' Responses

The typical hospital circumcision is done out of view of the parents in a separate room. However, a few are observed by parents, and many Jewish ritual circumcisions are done in the homes of the parents. There are no studies of how these parents respond to observing their son's circumcision. Personal accounts vary and may include strong emotions such as grief, horror, and shock. Some parents regret their son's circumcision and report that they wish they had known more about circumcision before they consented to it (Goldman, 1997; Goodman, 1999; O'Mara, 1993; Pollack, 1995).

Effects on the Infant

In neonatal circumcision, most surgical complications are immediately apparent, such as hemorrhage, infection, skin loss in excess of that intended, urinary retention, iatrogenic hypospadias or epispadias, penile amputation, and death. From these and other consequences, one investigator concluded, "[Male circumcision] is not harmless and cannot be recommended without unequivocal proof of benefit" (Thompson, 1990, p. 195).

The question of pain is often raised in debates about circumcision. Some doctors believe that the newborn nervous system is not sufficiently developed to register or transmit pain impulses (Katz, 1977; Tilney & Rosett, 1931). However, this belief has been called "the major myth" of physicians regarding infant pain (Schechter, 1989). Anatomical, neurochemical, physiological, and behavioral studies confirm that newborn responses to pain are "similar to but greater than those in adult subjects" (Anand & Hickey, 1987, p. 1326). In one study, infants circumcised without anesthesia (reflecting common practice) experienced not only severe pain but also increased risk of choking and difficulty breathing (Lander, Brady-Freyer, Metcalfe, Nazerali, & Muttit, 1997). Increases in heart rate of 55 beats per minute have been recorded during circumcision, about a 50% increase over the baseline (Benini, Johnson, Faucher, & Aranda, 1993). After circumcision, the level of blood cortisol (stress hormone) increased by a factor of three to four times the level prior to circumcisions (Gunnar, Malone, Vancer, & Fisch, 1985). As a surgical procedure, circumcision has been described as "among the most painful performed in neonatal medicine" (Ryan & Finer, 1994, p. 232). Investigators reported, "This level of pain would not be tolerated by older patients" (Williamson & Williamson, 1983, p. 40). Using a pacifier during circumcision reduced crying but did not affect hormonal pain response (Gunnar, Fisch, & Malone, 1984). An infant also may go into a state of shock to escape the overwhelming pain (Goldman, 1998). Therefore, although crying may be absent, other body signals demonstrate that severe pain is always present during circumcision.

There is disagreement among physicians about using anesthesia during circumcisions. Prior to the mid-1980s, anesthesia was not used because infant pain was denied by the medical community. That belief has changed among

many physicians, but an anesthetic (local injection, the best option tested) still is not typically administered due to a lack of familiarity with its use as well as the belief that it introduces additional risk (Ryan & Finer, 1994). Although there is indication that the risk is minimal, most physicians who perform circumcisions do not use anesthetics even after they are taught how. When an anesthetic is used, it relieves only some but not all of the pain, and its effect wanes before the postoperative pain does (Stang, Gunnar, Snellman, Condon, & Kesterbaum, 1988).

Circumcision results in behavioral changes in infants that have been shown to interfere with parent-infant bonding and feeding (Anand & Hickey, 1987). Researchers conclude that circumcision has "behavioral and psychological consequences" (Richards, Bernal, & Brackbill, 1976, p. 310). The AAP Task Force on Circumcision (1989) notes increased irritability, varying sleep patterns, and changes in infant-maternal interaction after circumcisions. Canadian investigators report that during vaccinations at age 4 to 6 months, circumcised boys had increased behavioral pain response and cried for significantly longer periods than did uncircumcised boys. The authors believe that "circumcision may induce long-lasting changes in infant pain behavior" (Taddio, Katz, Ilersich, & Koren, 1997, p. 602). One study suggests that circumcision may permanently alter the structure and function of developing neural pathways (Walco, Cassidy, & Schechter, 1994).

Studies investigating circumcision pain have referred to circumcision as traumatic (Lander et al., 1997; Taddio et al., 1997). From the perspective of the infant, all the elements in the *DSM-IV* description of traumatic events can be applied to the experience of circumcision: the procedure involves being forcibly restrained, having part of the penis cut off, and experiencing extreme pain. Based on the nature of the experience and considering the extreme physiological and behavioral responses of the infant, circumcision traumatizes the infant.

Later Effects on the Child

The negative impact of circumcision on the mother-child relationship is perhaps as evident from some mothers' distressed responses as it is from the infants' behavioral changes. The disrupted mother-infant bond has far-reaching developmental implications (Arend, Gove, & Sroufe, 1979; Donovan & Leavitt, 1985; Kestenbaum, Farber, & Sroufe, 1989; Reite & Capitanio, 1985; Vandell, 1980) and may be one of the most important adverse impacts of circumcision.

Surgical complications can become more evident as the child develops. These include prominent scarring, meatal stenosis (when the meatus—urinary opening—shrinks or closes due to ulceration of an unprotected glans, sometimes necessitating a surgical reopening of the meatus), and painful skin bridges (a tethering of the mucosal tissues of the corona and shaft, formed during the healing process when tissue of the glans fuses with the remaining inner foreskin tissue on the shaft behind the sulcus) (Sathaye, Goswami, & Sharma, 1991).

Effects on the Man

Surgical complications from infant circumcision may become more prominent and troublesome in adulthood (Snyder, 1989). Unlike adult circumcision (Money & Davidson, 1983), the adverse outcomes on men's well-being from infant circumcision have never been monitored or investigated by the medical community. The only systematic approach to documenting these consequences is an ongoing survey of more than 500 circumcised men conducted by the National Organization to Halt the Abuse and Routine Mutilation of Males (NOHARMM). Titled *Awakenings: A Preliminary Poll of Circumcised Males*, the published findings of the survey (Hammond, 1999) revealed that circumcised respondents suffered a wide range of consequences from this surgery they did not choose.

Various religious backgrounds were represented by respondents. The majority were from Christian families (77%), for whom circumcision is not a religious mandate. Respondents from religious minorities with a tradition of circumcision reported less physical harm than did Christian respondents, but higher degrees of emotional and psychological distress over their circumcision. (Jewish males accounted for more than 4% of the respondents, although they account for only 2% of the U.S. male population).

There was significant variability in how the effects of circumcision manifest themselves due to the following factors: (1) type of circumcision method; (2) expertise of the circumciser (often, hospital circumcisions are delegated to less experienced medical students and residents); (3) zealousness of the circumciser (which can determine how much or how little skin is removed); (4) nonuse of anesthesia; (5) how the injury heals (scars can be erogenous, painfully hypersensitive, or numb to sensation); (6) age at circumcision (the younger the age at which children experience pain, either by abuse or surgery, the deeper and more serious is its traumatic impression) (Green, 1983; Levy, 1945); and (7) presence or absence of cultural indoctrination (convincing a child that his circumcision is a mark of normalcy, superiority, or holiness may ameliorate trauma and resentment by offering social enfranchisement, but may also be shattered later by contradictory knowledge and awareness).

The physical and sexual harm reported by respondents included (1) progressive sensory deficit in the glans (61%); (2) excess stimulation required to reach orgasm, leading to sexual dysfunctions and orgasmic difficulties (40%); (3) prominent scarring (33%); (4) insufficient shaft skin to cover the erect penis (27%); (5) erectile bowing/curvature from uneven skin loss (16%); (6) pain and bleeding upon erection (17%); (7) painful skin bridges (12%); and (8) physical anomalies that included beveling deformities of the glans and meatal stenosis (20%).

Many respondents reported that they had to resort to prolonged and excessive thrusting to stimulate the residual nerve endings in the penis to trigger orgasm. This, and the unnatural dryness of the circumcised penis, often made coitus painful for them and their partners (O'Hara, 1999).

Reported psychological damage included feelings of (1) sexual mutilation (60%); (2) unnaturalness, abnormality, or lack of wholeness (57%); (3) resentment/depression (59%); (4) rage (52%); (5) physical violation (46%); (6) low self-esteem and inferiority to intact men (50%); and (7) betrayal over what was done to them (30%). In circumcising cultures such as the United States, these forms of psychological disturbances are not yet recognized. Therefore, few mental health professions are trained to treat them as such.

We must acknowledge that this survey group is a self-selected population of men who are well-educated about male anatomy and the effects of circumcision. However, three separate men's body image surveys demonstrate that dissatisfaction with this involuntary genital alteration is not uncommon among circumcised men. In 1989, an Australian *Forum* survey discovered that "Quite a lot of circumcised men (20%) were dissatisfied with the way they had been cut" (Badger, 1989, p. 14), and "18% of the circumcised men would rather not have been" (p. 15). In 1992, a survey of almost 200 American men by the magazine *Journeymen* (Boynton, 1993) found that 20% of circumcised respondents expressed dissatisfaction with their circumcised condition, and only 3% of uncircumcised respondents registered dissatisfaction with being intact. Conversely, the survey found that 78% of intact male respondents were happy with their genital status compared to a 38% satisfaction rate among the circumcised. Another U.S. survey in 1996 (*Men's Forum*) revealed that 50% of respondents circumcised as infants were unhappy about it, versus 3% of intact respondents who were unhappy that they had not been circumcised at birth.

In general, however, men have no acceptable means of expressing negative feelings about circumcision. Illustrative of this, the *Awakenings* survey found that 54% of respondents had not sought help for their perceived harm for the following reasons: (1) felt no recourse was available (43%); (2) embarrassment (19%); (3) feared ridicule (17%); and (4) mistrusted doctors (11%).

Many of the survey respondents (53%) were undergoing uncircumcision procedures (foreskin restoration). These nonsurgical methods involve a gradual process of skin expansion that applies gentle tension on the penile shaft skin. The resulting new growth of skin approximates the look, feel, and function of a prepuce, with a corresponding increase in self-esteem and sexual enhancement (Bigelow, 1995).

Respondents credited a fair amount of their knowledge and awareness about the foreskin and circumcision to two sources. One was the National Organization of Restoring Men (NORM). This (now international) self-help group was begun in 1990 to offer circumcised men moral and technical support in regaining their physical integrity through nonsurgical foreskin restoration. The other source, *The Joy of Uncircumcising!* by Jim Bigelow (1995), details the histories of circumcision and uncircumcision as well as the various methods of restoration.

Infant circumcision appears to be the only surgery that later prompts the patient to deliberately invest time, money, and effort to "undo" the effects of the

physician's scalpel. Like the long-term effects on men of infant circumcision, the outcomes of restoration have yet to be studied by the medical community.

Awakenings respondents demonstrated that two important factors affect circumcision satisfaction levels: knowledge of foreskin functions and awareness of how circumcision impacts penile functioning. A higher degree of this knowledge and awareness corresponds to a lower level of circumcision satisfaction. The less accurate information a man has about the foreskin and circumcision, the more positively he views the circumcised condition. Respondents reported that, prior to obtaining this knowledge and developing their awareness, they denied that circumcision had damaged their bodies or their sexuality. Any challenge to their previous concept of the correctness of circumcision had been met with defensiveness or anger.

SUMMARY

The foreskin, together with the glans, is an integral part of the pleasure dynamics of movement, sensation, and lubrication that occur during masturbation, foreplay, and sexual intercourse. Pro-circumcision empiricists pursue a search for scientific evidence that supports prophylactic benefits of surgery. Their findings remain narrow and ambiguous. A disturbing silence exists in the medical community, however, regarding the normalcy of the intact foreskin, loss and grief associated with circumcision, and circumcision's impact on a man's overall psychosexual development.

Increasing numbers of circumcised men are restoring themselves and, like their African female counterparts, are breaking historical silence to challenge these childhood assaults (Boyd, 1998; Dillon & Hammond, 1995). Although important distinctions remain between the practices of male and female circumcision, they share more similarities than differences. The functional anatomy of the female genitals is identical to that of males (Toubia, 1994). The social motivations of both customs parallel each other (Lightfoot-Klein, 1989a). The paucity of scientific evidence on the sexual and psychological effects of these practices is due in part to the historical silence of the majority of victims, for whom the psychological effects are likely to be subtle and buried beneath layers of denial, mixed with resignation and acceptance of social norms (Goldman, 1997; Toubia, 1994). In many respects, the shared core issue is not severity, but sovereignty (Van Howe, Svoboda, Dwyer, & Price, 1999).

The health hazards and psychological risks to children from male genital cutting are a sociocultural, health, and human rights problem. Eradication efforts must be empathic, not alienating. They must recognize all forms of cultural manipulation and mutilation of males, whether physical or psychological, as a form of genital and sexual abuse that subjects the child to the whims of an adult. It must not be equated too closely, however, with child abuse. Genital mutilation is undertaken with "good intentions" based on "normalizing" a child, whereas child abuse isolates a child. Discussion must begin on where to

draw the line between the parental desire to cute male genitals and society's obligation to protect children from harm. Such discussions are already underway in many cultures where circumcision is endemic.

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