

Beyond the Blade: Men's Indirect yet Influential Role in Sustaining FGM/C in Nigeria

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Abstract

Female Genital Mutilation/Cutting (FGM/C) is widely recognized as a violation of human rights and a critical public health concern. However, its profound psychological and psychiatric implications remain insufficiently explored within dominant academic and policy discourse. Building on prior research examining men's roles in sustaining and contesting FGM/C in Nigeria, this commentary reframes the practice as a gendered mental health crisis embedded within systems of power, silence, and social conditioning. Drawing on trauma theory, social norms theory, and intersectional analysis, this paper argues that FGM/C operates not only as a physical act of harm but also as a mechanism of psychological conditioning, identity formation, and intergenerational trauma. It introduces the concept of *structural silence* to examine how men's indirect yet influential role sustains the practice without overt participation. The commentary further explores how harm is moralized as care, how trauma becomes normalized, and how cultural continuity persists across diasporic contexts. It concludes by calling for trauma-informed, culturally responsive, and gender-inclusive interventions that center mental health in efforts to eradicate FGM/C.

Keywords: Female Genital Mutilation (FGM/C), Mental health, Trauma, Nigeria, Gender norms, Masculinity, Intergenerational trauma

Introduction

Female Genital Mutilation/Cutting (FGM/C) remains a deeply entrenched practice affecting millions of women and girls globally, with Nigeria accounting for a significant proportion of cases [1,2]. In recent years, global efforts to eliminate FGM/C have intensified, including strengthened legal frameworks, increased advocacy through international organizations, and community-based interventions aimed at reducing prevalence [3]. Despite these developments, progress has been uneven, and the practice persists across both rural and urban settings, as well as within diasporic communities [1,3,4].

Existing scholarship has primarily focused on the cultural, social, and human rights dimensions of FGM/C. My prior work contributed to this discourse by examining the paradoxical positioning of men within patriarchal systems that sustain FGM/C [5].

While these analyses illuminate the structural and sociocultural conditions underpinning the practice, they insufficiently address its psychological and psychiatric dimensions. FGM/C

is not only a cultural act, but also a profoundly psychological event that shapes identity, embodiment, and intergenerational belief systems [6].

This commentary argues that FGM/C must be reframed as a gendered mental health crisis, sustained through mechanisms of trauma, internalization, and structural power. By shifting the analytical lens toward mental health, this paper deepens the conversation and identifies new pathways for research, clinical practice, and intervention. This commentary contributes to existing scholarship by explicitly centering mental health as a critical but underexamined dimension of FGM/C, offering a framework that bridges sociocultural analysis with psychiatric understanding.

Theoretical Framing: Power, Silence, and Psychological Control

A comprehensive understanding of FGM/C requires an integration of multiple theoretical frameworks. Intersectionality highlights how gender, culture, and power intersect to produce differentiated experiences of harm [7,8].

Social norms theory explains how practices are maintained through collective expectations and reinforced through social sanctioning [9,10].

Trauma theory [11,12] provides a lens for understanding how repeated or socially normalized harm becomes embedded within individual and collective psychological experiences. In addition, Foucauldian perspectives on power suggest that bodily regulation occurs not only through direct force but through internalized discipline and normalization [13].

Together, these frameworks reveal that FGM/C is not merely imposed upon bodies; it is a system that produces compliant subjects, regulates behavior, and sustains itself through both visible and invisible mechanisms of control [5].

Importantly, these frameworks must not be understood in isolation but as mutually reinforcing systems. Intersectionality reveals how gendered expectations are shaped not only by patriarchy but also by cultural identity, socioeconomic status, and generational positioning [8]. Within this intersection, FGM/C emerges as a practice that is both socially regulated and psychologically internalized [10]. Foucauldian perspectives further illuminate how power operates not solely through coercion but through normalization where individuals come to discipline their own bodies in accordance with societal expectations. This duality complicates intervention efforts, as resistance requires not only behavioral change but also the dismantling of deeply embedded cognitive and emotional frameworks.

A Moment of Silence: A Narrative Reflection

Consider a young girl, no older than five, led by familiar hands into a space she does not fully understand. There is no language offered to her that explains what is about to happen. Her body is restrained not by strangers, but by those she trusts. The act is swift, painful, and disorienting. In the aftermath, she is told that this was necessary, that it was for her good, and that she will understand when she is older.

What remains is not only a wound, but a question: *If this is care, what then is harm?*

This moment captures the psychological complexity of FGM/C. The violence is not framed as violence; rather, it is embedded within narratives of love, protection, and belonging. This duality complicates both the survivor's experience and the ability to name the act as harmful.

FGM/C as Psychological Trauma and Embodied Experience

FGM/C must be understood as both acute and chronic trauma [14]. The initial act constitutes a violation of bodily integrity under conditions of fear, pain, and coercion, often inflicted by

trusted caregivers [15]. The psychological impact of FGM/C can also be understood through the lens of betrayal trauma, in which harm is inflicted by trusted caregivers or authority figures. This form of trauma disrupts foundational assumptions about safety, attachment, and relational trust [11,12]. Survivors may struggle to reconcile the dual reality of being harmed by those who are also perceived as protectors, often leading to long-term emotional and relational challenges [6].

Furthermore, the normalization of FGM/C within community contexts creates collective trauma environments, where suffering is expected rather than recognized as harm. The absence of validation exacerbates psychological distress and limits opportunities for healing [6]. Over time, this contributes to the internalization of suffering as a normative aspect of womanhood, reinforcing the continuity of the practice across generations [16].

These psychological outcomes align with clinical presentations observed in trauma-related disorders, including post-traumatic stress disorder (PTSD), complex trauma, and somatic symptom disorders, as defined within psychiatric diagnostic frameworks [17,18], underscoring the need for psychiatric recognition and intervention. Cross-cultural research further emphasizes that trauma responses are shaped by sociocultural context, influencing both symptom expression and pathways to care [19].

Empirical studies have also demonstrated that survivors of FGM/C experience a range of psychiatric sequelae, including anxiety, depression, and chronic psychosocial distress, highlighting the enduring mental health burden associated with the practice [14,20,21].

Embodied Trauma

The body becomes a site of memory, with survivors experiencing chronic pain, somatic distress, and heightened physiological responses linked to trauma [12].

Sexuality and Psychological Disruption

FGM/C disrupts sexual identity and experience, often resulting in fear, shame, avoidance of intimacy, and diminished agency [6].

Identity Formation and Moral Conditioning

FGM/C is framed as a rite of passage, yet this transition is marked by harm. Girls are socialized to equate endurance with worth, embedding psychological acceptance of suffering [5].

Structural Silence as Gendered Power

A central paradox in FGM/C discourse is the role of men. While men dominate decision-making structures in Nigerian society, they are often absent from direct execution [22,23].

This commentary conceptualizes this as structural silence. Structural silence is an active form of governance in which power is exercised through non-intervention, delegation, and implicit endorsement. This creates a system of distributed responsibility, obscuring accountability while sustaining harmful norms [22].

Men's disengagement is not neutral; it is socially reinforced and psychologically conditioned, allowing them to benefit from outcomes while remaining distant from harm.

It is important to recognize, however, that men's roles within FGM/C-practicing communities are not uniform. Variation exists across social position (fathers versus brothers versus community elders), educational background, and geographic context (educated urban men versus rural traditionalists) [22,23]. The psychological costs of silent compliance among men who privately oppose but do not act, including moral conflict, cognitive dissonance, and suppressed dissent, also merit clinical and scholarly attention, as these internal states represent potential leverage points for intervention [24,25]. Acknowledging this variation does not diminish the concept of structural silence; rather, it refines it by identifying the conditions under which disengagement is reproduced or interrupted.

This commentary also acknowledges the anthropological critique that insider accounts of FGM/C, including those of women who describe the practice in terms of care, identity, and communal belonging, must be engaged rather than dismissed [26,27]. The cultural relativist position rightly challenges whether external frameworks adequately capture the experiential complexity of practices embedded in local cosmologies of womanhood and initiation. This paper does not dismiss these perspectives. Rather, it argues that acknowledging the subjective meaning of a practice does not preclude recognizing its documented psychological harms. A growing body of empirical research including survivor accounts gathered in diaspora and African contexts demonstrates that the same act can be simultaneously experienced as culturally meaningful and psychologically harmful, that these experiences are not mutually exclusive [6,28]. The challenge for intervention is to hold both realities: respecting the dignity and agency of communities while creating conditions in which harm can be named, processed, and ultimately prevented.

The Paradox of Protection and Harm

FGM/C is often enacted in the name of protection preserving purity, ensuring marriageability, and preventing social exclusion [29]. FGM/C persists not despite care, but often because of it.

This moralization of harm creates psychological tension, as survivors must reconcile pain with narratives of protection.

Intergenerational Trauma and the Reproduction of Norms

FGM/C operates within cycles of intergenerational trauma, where both practices and beliefs are transmitted across generations [30]. Without intervention, trauma becomes normalized, embedded within family systems, and perpetuated through internalized expectations. Emerging research on intergenerational trauma suggests that the transmission of trauma occurs not only through socialization, but also through psychological and biological pathways that shape emotional regulation, stress responses, and identity formation [31]. In this context, FGM/C is sustained not simply as tradition, but as an inherited system of meaning in which harm is normalized and reproduced across generations.

Masculinity, Emotional Distance, and Selective Disengagement

Masculinity within FGM/C-practicing contexts often involves emotional detachment and limited engagement with harm [24]. This reflects broader patterns within gendered systems of power, where hegemonic masculinity is associated with authority, control, and emotional restraint [24]. Within this framework, men's disengagement from FGM/C is not incidental, but structurally reinforced. This represents a system of selective disengagement, where men maintain authority while avoiding accountability, thereby reinforcing the persistence of FGM/C.

Efforts to address gender-based violence increasingly emphasize the importance of engaging men as active participants in social change, rather than passive observers [25]. However, in the context of FGM/C, such engagement remains limited. Without addressing these gendered dynamics of power and responsibility, interventions risk leaving intact the structural conditions that sustain the practice.

FGM/C Beyond Borders: Migration, Memory, and Continuity

FGM/C persists within diasporic communities, shaped by processes of cultural preservation, identity negotiation, and social adaptation [2,4]. Migration introduces new psychological tensions, including identity conflict, stigma, and increased secrecy due to legal restrictions [32]. Research has shown that women in diaspora contexts often navigate complex intersections of cultural belonging and health systems, which can influence both disclosure and access to care [32].

In Western contexts, healthcare providers also have an important role in supporting survivors and encouraging abandonment of the practice, which calls for culturally

competent care [32]. These dynamics illustrate how FGM/C is not confined to geographic boundaries but continues to evolve within transnational spaces, shaped by memory, identity, and institutional response.

Why Current Interventions Fail to Address Psychological Harm

Despite decades of global advocacy and intervention efforts aimed at eliminating FGM/C, many existing approaches remain insufficient in addressing the full scope of harm produced by the practice [3]. Legal frameworks, awareness campaigns, and community-based interventions have largely focused on reducing prevalence and preventing physical harm [3]. While these efforts are necessary, they often neglect the deeply embedded psychological and psychiatric dimensions of FGM/C. It is important to acknowledge that some programs, including those coordinated through the UNFPA-UNICEF Joint Programme on Elimination of FGM/C, do incorporate psychosocial components [3]. However, these components remain peripheral rather than central to intervention design, and the systematic integration of trauma-informed mental health care is rare across the broader programming landscape.

Current interventions tend to conceptualize FGM/C as a behavioral or cultural issue, rather than as a form of sustained psychological trauma [6]. This narrow framing limits the effectiveness of eradication strategies, as it fails to address the internalized beliefs, emotional conditioning, and identity formations that sustain the practice across generations. As a result, interventions may successfully reduce overt participation while leaving intact the underlying systems of meaning that normalize and justify harm.

Moreover, many programs adopt a protection-based framework that positions women and girls solely as victims, without adequately engaging with the broader relational and structural dynamics that shape their experiences. This includes the role of men, whose indirect influence through silence, expectation, and social reinforcement remains largely unaddressed in intervention design. Without disrupting these gendered dynamics of power and disengagement, efforts to eliminate FGM/C risk reproducing the very conditions that sustain it.

From a psychiatric perspective, the absence of trauma-informed approaches represents a significant gap [18]. Survivors of FGM/C often experience symptoms consistent with post-traumatic stress, anxiety, depression, and somatic distress, yet mental health support is rarely integrated into intervention frameworks [14]. This omission not only limits healing for survivors but also perpetuates cycles of unprocessed trauma that contribute to the intergenerational continuity of the practice.

To move forward, interventions must shift from a sole preventative model to one that is both preventative and reparative. This requires integrating mental health care, addressing internalized norms, and engaging entire communities, including men, in processes of critical reflection and transformation. Without this shift, the global response to FGM/C will remain incomplete.

Clinical and Policy Implications

Addressing FGM/C as a mental health crisis requires a fundamental shift in both clinical practice and policy frameworks. Clinically, there is a need to integrate trauma-informed care that recognizes the complex psychological and somatic impacts of FGM/C [18]. This includes culturally responsive therapeutic approaches that account for the intersection of trauma, identity, and community belonging. Family-centered interventions are also critical, as they address the relational dynamics through which FGM/C is both experienced and perpetuated.

From a policy perspective, mental health must be systematically integrated into FGM/C prevention and response strategies. Current frameworks often prioritize physical health outcomes and legal enforcement, while overlooking the psychological dimensions of harm [14]. Expanding these frameworks to include mental health services, survivor support systems, and community-based healing initiatives is essential.

Equally important is the inclusion of men in intervention strategies. As this commentary has argued, male disengagement functions as a form of structural power that sustains the practice. Engaging men in dialogue, education, and accountability processes is therefore critical to disrupting the social norms that underpin FGM/C [25]. Together, these clinical and policy shifts move beyond prevention toward a more comprehensive model that addresses both the immediate and long-term psychological consequences of FGM/C.

Conclusion

FGM/C must be understood not only as a cultural practice or human rights violation, but as a deeply embedded psychological and psychiatric phenomenon shaped by systems of power, silence, and social conditioning. This commentary has argued that the persistence of FGM/C cannot be fully addressed without centering its mental health dimensions, including trauma, identity formation, and intergenerational transmission of harm.

By reframing FGM/C as a gendered mental health crisis, this paper extends existing discourse and highlights the limitations of current intervention strategies that prioritize behavioral

change without addressing underlying psychological mechanisms. The concept of structural silence further reveals how power operates through absence, disengagement, and normalization, particularly in relation to men's roles within FGM/C-practicing contexts.

Addressing FGM/C therefore requires a multidimensional approach that integrates trauma-informed care, culturally responsive interventions, and gender-inclusive strategies. It also requires a fundamental shift in how harm is understood from isolated acts of violence to sustained systems of psychological conditioning.

Ultimately, ending FGM/C is not only a matter of changing practices, but of transforming the beliefs, narratives, and power structures that make those practices possible. Without this deeper transformation, efforts toward eradication will remain partial and unsustainable.

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