6-1-2013

Female Genital Mutilation and Marital Satisfaction among Kenyan Females

Caroline Bosibori Nyairo
Loma Linda University

LOMA LINDA UNIVERSITY
School of Behavioral Health
in conjunction with the
Faculty of Graduate Studies

Female Genital Mutilation and Marital Satisfaction among Kenyan Females

by

Caroline Bosibori Nyairo

A Dissertation submitted in partial satisfaction of
the requirements for the degree of
Doctor of Philosophy in Family Studies

June 2013

Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

_____, Chairperson
Brian Distelberg, Associate Professor of Counseling and Family Sciences

_____
Curtis Fox, Professor of Counseling and Family Sciences

_____
Carmen Knudson-Martin, Professor of Counseling and Family Sciences

_____
Tabitha Muchee, Senior Lecturer, Family and Consumer Science, University of East Africa, Baraton, Nairobi Extension Center

ACKNOWLEDGEMENTS

I would like to thank the chair of my dissertation committee, Dr. Brian Distelberg for his support and continuous guidance through the process of completing my dissertation. Additionally, I would like to thank Dr. Curtis Fox, Dr. Knudson-Martin, and Dr. Tabitha Muchee for their dedication and sincere involvement in my dissertation as committee members. I thank all my professors who have mentored me in some way through this process and throughout the years. Also, I thank all my classmates who made long nights of hard work bearable through laughter, a meal, or a prayer. A special thank you to Sherria Taylor, and Shereen McFarlane for their help and support through statistics courses and beyond. Sherria, you will always be my Soul Sister! See you at the top!

Next, I would like to thank my husband Waswa who spent countless hours helping me in numerous ways; either entering data, formatting, or simply helping me keep my sanity. Babe, your support and patience are priceless. Sometimes words cannot express enough gratitude for what you have done and continue to do. I also thank you, my son, Samuel and daughter, Taraji, for continuously surrounding me with love, encouragement, support and for believing in me through this entire doctoral journey. To my son Samuel, thank you for offering to assist me with my homework because I assisted you with yours. To our new addition, Taraji, you bring joy to all of us and we know you will do greater things.

I also thank my grandmother Elizabeth Nyanchama Nyairo for her consistent wisdom that exceeds intellect, and love that surpasses understanding. To my grandfather

Jonhson Nyairo Omwena, your love and enthusiasm for knowledge and education has been inspirational in my journey. To my sister Selpha, you remain my role model in many ways, thanks for your love and support.

Last, but not least, to my Father, Friend and Creator of all good things, thank you for your provision, undeserved patience, and faithfulness that have sustained me through everything. I continue to marvel at your goodness and mercy!

DEDICATION

I would like to dedicate this work to my children, Samuel and Taraji. Set no limits for yourselves. Greater things than this you shall do!

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ABBREVIATIONS

FGM	Female Genital Mutilation
FGC	Female Genital Cutting
FC	Female Circumcision

ABSTRACT OF THE DISSERTATION

Female Genital Mutilation and Marital Satisfaction among Kenyan Females

by

Caroline B. Nyairo

Doctor of Philosophy, Graduate Program in Family Studies
Loma Linda University, June 2013
Dr. Brian Distelberg, Chairperson

The pernicious practice identified as Female Genital Mutilation (FGM) comprises of various procedures that damage female genitalia for non-therapeutic intentions and is widely considered a human rights violation. Globally, tangled cultural and religious traditions are responsible for perpetuating Female Genital Mutilation. Women continue to be victims of this practice irrespective of their socio-economic status, and irrespective of an ardent worldwide campaign against it. The current empirical investigation into the consequences of FGM is multi-faceted and reveals negative impacts on women physically, psychologically, and psychosexually. This study presents an investigation addressing one significant aim in the current research. The aim of this study is to determine whether FGM versus non-FGM married females in Kenya and Kenyan immigrants in the United States of America vary on relationship characteristics such as relationship satisfaction, sexual satisfaction, intimacy, spousal support, and gender role attitudes.

One hundred and thirty six married females between the ages of 18 and 79 completed five different surveys. Among these married women, some women had undergone FGM while some had not. Factorial analysis of variance (MANOVA) was

used to test study hypotheses. The emerging data illustrated that even though non-significant, there are differences in marital satisfaction between Kenyan locals and Kenyan immigrants in the United States. Based on these findings, implications are suggested for future research in this area for further understanding the impact of female genital mutilation on marriages both in Kenya and the USA.

CHAPTER ONE

INTRODUCTION

Purpose Statement

This study seeks to investigate the effects of Female Genital Mutilation (FGM) on marital satisfaction and other relationship level characteristics. Specifically, this study compares FGM versus non-FGM groups of married females living in Kenya and the United States (U.S.) to determine the effects of FGM on relationship satisfaction, intimacy, sexual satisfaction, spousal support, and gender roles. The outcome of this empirical investigation contributes globally by providing information on the negative impact of this practice on couples. Consequently this knowledge would help accelerate the eradication of this practice. Secondly, this study is critical to family therapists and family life educators because it enlightens these professionals on the practice and impact of FGM.

Background

Prevalence

Intertwined cultural and religious traditions globally perpetuate the practice of FGM. Despite an ardent global campaign against this practice (Elwood, 2005; WHO, 2008), many African, Middle Eastern, and South-Eastern Asian cultures continue to use this practice. According to World Health Organization (WHO, 2008), each year, more than 3,000,000 girls experience genital mutilation world-wide. Additionally, the World Health Organization (WHO) estimates that between 100-140 million girls and women are victims of FGM (WHO, 2008). FGM impacts women medically, psychologically, and

psychosexual which often can culminate in damaging a woman's esteem and worth, resulting in marital and relational problems in families (Baron & Denmark, 2006; Bikoo, 2007). While some empirical investigations have explored the effects of FGM (WHO, 1997; 2008), most of these studies have taken an individual approach to studying the psychological, emotional, and medical consequences. While these individually focused studies are useful, systemic thinkers such as Fisher (2006) posit that relational research methodologies should be incorporated, as they might yield a richer picture of the couple/family dynamics. Though women will tend to uniquely experience FGM through the context of a particular traditional society, this study hypothesizes that certain effects cut across countries and cultures.

FGM is also known as female circumcision or Female Genital Cutting (FGC). In either case, FGM and FGC are terms that incorporate various procedures that involve injury to female genitalia, including partial or complete removal of external female genitalia for cultural and other non-therapeutic intentions. FGM dates back more than 5000 years (Elchalal, Ben-Ami, Gillis & Brzenzinski, 1997) and currently is practiced in over 30 countries. In most parts of Africa, this practice is performed by traditional circumcisers, who usually hold key positions in the community in attending childbirths or other important ceremonial events (Shell-Duncan & Hernlund, 2000). The traditional circumciser may also be closely related to the victim (i.e. mother or grandmother) or a total stranger (Ortiz, 1998). However, this procedure is increasingly being carried out by medically trained personnel (Magied et al., 2003).

Types of FGM

While one might consider FGM as one targeted procedure, there are in actuality multiple variations of this practice. The variations of this practice are important to this particular study as research shows that a severe form of FGM such as infibulation leads to more medical complications (Refaat, Dandash, El Defrawi, & Eyada; WHO 2008; Litorp 2008), and consequently more relational problems such as limited arousal, a low sexual libido, fear of painful intercourse, decreased satisfaction etc. (Alsibiani & Rouzi (2008). The WHO (2008) has categorized and defined four distinct types of FGM:

Type I: Clitoridectomy - partial or total removal of the clitoris and rarely, the prepuce (the fold of skin surrounding the clitoris) as well.

Type II: Excision - partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

Type III: Infibulation - narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the inner, and sometimes outer, labia, with or without removal of the clitoris.

Type IV: This consists of other types of scraping of the vagina, piercing, pricking of the clitoris or vulva.

Reasons for FGM

There are many arguments used to perpetuate FGM. These reasons range from religious to socio-cultural motivations. For many cultures, historical traditions and religious legacies have served to sustain the practice whereas in other cultures FGM is a

politically motivated issue (Wangila, 2007). Consequently, the reasons for undertaking female circumcision vary greatly depending on factors like geographical location, cultural heritage, demographic description, and social-economic status. Understanding these cultural constructs is important in understanding how an individual experiences FGM. Below are some of the reasons for undertaking FGM;

a) Religious and Spiritual

Some of the dominant drivers of FGM are the religious and spiritual beliefs within a culture. FGM is performed on women in Muslim, and Christian, Coptic groups (Von der Sacken & Uwer, 2007), as well as indigenous religious groups in other regions of Africa. Some Muslim pro-FGM individuals argue that the clitoral hood is the anatomical equivalent of the foreskin on the penis, therefore removing it will enhance a woman's sexual experience with her partner (Muslim Women's League, 1999).

Those that suggest that there is no basis in religion for FGM argue that neither the Koran nor the Bible prescribe to this practice (Bikoo, 2007; Baron & Denmark, 2006). While the Koran mentions FGM (and it is also commented upon by Muhammad), it is not mandated. Rather, circumcision is required for men and is considered "permissible" for women (Aldeeb Abu Salieh, 1994).

The Bible does not directly address the issue of FGM. However, there are a number of verses that have been interpreted to provide guiding principles against the practice. The first such reference is found in Genesis 1: 31, "And God saw all that He had made, and it was very good" (NIV)—what God saw as "very good" when He passed judgment on His creation, therefore, this surpasses the negative messages that many uncircumcised women receive about their genitals (Wangila, 2007).

b) Socio-cultural

While religious and spiritual beliefs are common drivers for the perpetuation of FGM, other socio-cultural messages and traditions are additionally strong motivations. The strength of these powerful cultural messages is evident by the elevated social status of circumcisers in communities that perpetuate FGM (Bikoo, 2007). These socio-cultural drivers are manifested in messages of either hygiene or sexual morality.

c) Hygiene and Esthetic

In some societies, there is the notion that girls are “clean” and "beautiful" after removal of body parts considered "male," “ugly” or "unclean." These societies perceive external female genitalia as unclean and ugly and are hence removed to promote hygiene and enhance feminine esthetic appeal (Momoh, 1999). In these societies, women are expected to discard a piece of flesh (clitoris) perceived as physical deformity, in an effort to achieve the feminine ideal of beauty and cleanliness (Momoh, 1999). Some believe that contact between a woman’s clitoris and her baby during childbirth will kill the child or result in hydrocephaly, or that a man will die if he comes in contact with a woman’s clitoris (Momoh, 1999). Additionally these cultures believe that once the clitoris, which is considered a “male-like organ”, is removed, a girl becomes more docile, obedient, and feminine; conversely if not removed, the clitoris will grow and hang between the legs (Barstow, 1999).

d) Psychosexual

Psychosexual motivations for performing FGM are to prevent masturbation and lesbianism, suppress libido in females, uphold chastity and virginity before marriage, increased sexual pleasure for males, and prevent infidelity and divorce (Adinma & Agbai,

1999; Dandash et al., 2001; Dare, 2004; Elgaali et al., 2005; Litorp, 2008; Magied & Shareef, 2003). Generally, FGM practicing communities believe that undergoing female genital mutilation "guarantees" premarital virginity and post-marital monogamy (Baron & Denmark, 2006).

Given that the practice of FGM is perpetuated by these long standing socio-cultural beliefs, it is necessary for a study of FGM to account for an individual's culture of origin as well as their alignment with these cultural beliefs. For this study, the methodology will limit the cultural influence to Kenya and the US. By focusing solely on Kenyan married females and US-Kenyan immigrant females, the methodology of the study will focus directly on the differences in cultural influence on the impacts of FGM on the couple relationship.

Impacts of FGM

FGM offers multidimensional and interdependent effects. Currently much of the empirical exploration of FGM has focused on the medical or individual level effects. While important to consider, less is known about the relational effects of this practice.

At a very basic level, FGM offers immediate medical complications such as injury to other nearby genital tissue and micturition, as well as urine retention, hemorrhage, severe pain, shock, tetanus, or sepsis (bacterial infection), open sores in the genital region, infections and even death (WHO, 2008). Additionally Braddy (1999) reports the occurrence of chronic problems such as; infertility, recurrent bladder and urinary tract infections, and cysts. Some of these chronic problems require the need for multiple surgeries (Brady, 1999). Other chronic problems include: anemia, incontinence,

menstruation problems, and dyspareunia (Brady, 1999).

Since FGM is often practiced in less developed areas, problems often occur due to the lack of proper surgical methods and resources. These include increased risk of HIV and blood borne diseases (Ounga, Okinyi, Onyuro & Correa, 2009) as well as serve difficulties in future pregnancies and delivery often resulting in miscarriages and other fatalities (Utz-Billing & Kentenich, 2008). While much is known about the individual medical and physical effects of FGM, less in known about the psychological effects. More importantly, less is known about the impact of these individual effects on women and their marital and couple relationships.

In regards to psychological effects of FGM, a handful of studies have identified a high frequency of FGM women with psychiatric and psychosomatic illnesses (Magied & Ahmed, 2002). These women also report frequent nightmares, chronic irritability, and feelings of incompleteness, fear, inferiority, and suppression (Behrendt & Moritz, 2005; El-Defrawi et al., 2001), as well as general frustrations (Magied & Ahmed, 2002). In addition to psychological effects, there are known psychosexual effects. El-Defrawi, Mohammed, Dandash & Eyada (2001) as well as others (Magied & Ahmed, 2002; Mukoro, 2004) have found that circumcised women had a number of symptoms that lessen sexual satisfaction such as vaginal dryness during intercourse, as well as a significant decrease in sexual desire, fewer orgasms, as well as difficulty in achieving an orgasm. These two studies provide elementary support that FGM reduces sexual satisfaction in couples. The current study added to these studies by looking at the cultural influence on FGM and sexual satisfaction by examining the level of satisfaction in Kenyan and US immigrant married females.

FGM and Marital Satisfaction

With the medical, psychological and psychosexual effects discussed above it is appropriate to assume that these individual effects impact the couple relationship. For example, when a woman believes that a part of her is missing and that it is irreversible, her self-esteem is decreased and her self-worth is diminished (El-Defrawi et al., 2001). Additionally the pain associated with intercourse, as well as the decreased sexual desire (Magied & Ahmed, 2002) often leads to women reluctantly engaging in their "wifely duty" of sexual activity with their husbands, even though it may be a traumatizing experience psychologically or physically (Bikoo, 2007; Baron & Denmark, 2006). While we might assume that FGM decreases sexual satisfaction and marital satisfaction, this assumption has yet to be explored in the context of culture. Marital satisfaction is likely to be negatively impacted by the physical and psychological effects of FGM, but there is also a mediational cultural effect that has yet to be analyzed.

Objectives

FGM is a multi-faceted practice with many detrimental effects. Among a plethora of reasons for its perpetuation, it is claimed to cement a satisfactory and robust couple relationship (Baron & Denmark, 2006; Dandash et al., 2001; Magied & Shareef, 2003). Therefore, FGM requires an empirical scrutiny to ascertain its impact on the marital satisfaction of a couple, especially in industrial developing countries.

The objective of this study is to investigate how common relationship characteristics of gender role attitudes and spousal support, may predict the differing levels of marital satisfaction among married females who live in Kenya and immigrant

Kenyan females who live in the US. This study focuses on one specific aim: whether FGM versus non-FGM females in Kenya and Kenyan immigrants in the US vary on relationship characteristics such as relationship satisfaction, sexual satisfaction, intimacy, spousal support and gender role attitudes. This specific aim was evaluated with an MANOVA analysis where the relationship characteristics are tested as the DV, and the two factorial variables of FGM versus non-FGM and Kenyan versus US-Immigrant Kenyan individuals serve as the anticipated predictors of variance in all the DVs. Five research hypothesis drove the analysis:

1) Relationship satisfaction varies by whether individuals have FGM (versus non-FGM) and whether they currently reside in the US (versus Kenya).
2) Sexual Satisfaction varies by whether individuals have FGM (versus non-FGM) and whether they currently reside in the US (versus Kenya).
3) Intimacy varies by whether the individuals have FGM (versus non-FGM) and whether they currently reside in the US (versus Kenya).
4) Spousal support varies by whether individuals have FGM (versus non-FGM) and whether they currently reside in the US (versus Kenya).
5) Gender role attitudes vary by whether individuals have FGM (versus non-FGM) and whether they currently reside in the US (versus Kenya).

Rationale

A review of available published empirical investigations on Female Genital Mutilation (FGM) reveals the literature to be relatively dominated by empirical studies on the prevalence, psychological, and medical consequences of FGM. Currently there are

no empirical studies investigating how FGM impacts couple relationships. While one might assume that women individually experience FGM within the context of their current society, and this experience directly impacts their relationships with their spouses, the actual processes behind the relationship between culture and relational effects is still unknown empirically. This study contributes to the field of family science and relational research by identifying how relationships of Kenyan couples are differentially impacted by living in Kenya versus the US post FGM.

CHAPTER TWO

CONCEPTUAL FRAMEWORK

Conceptualizing Female Genital Mutilation through a Feminist Lens

Feminist theory seeks to illuminate societal processes such as oppression, diversity, culture, and power differentials (Chappell, 2000; Goldner, 1985; Hare-Mustin, 1978; Mahoney & Knudson-Martin, 2009). There is not a single "feminist theory" but rather inextricably interwoven theories consisting of a broad range of perspectives. Osmond and Thorne (1993) state that feminist theory is, in addition to a political movement, a social vision with "knowledge that will help to confront and end the subordination of women and related patterns of subordination based on social class, race, ethnicity, age and sexual orientation" (p. 590). Similarly, Linda Gordon (2007) sees feminism as "an analysis of women's subordination for the purpose of figuring out how to change it" (p. 107). In this definition, Gordon identifies areas which require thorough understanding and scrutiny.

The first is the experiences of women and girls. Feminist theory seeks to make women's experiences visible, consequently illuminating gaps, myths, and misconceptions in knowledge that assert to be "inclusive but in fact [are] based on the experiences of Euro-American, class-privileged, heterosexual men" (p. 593). Feminist theory, therefore, seeks to acknowledge the negative and difficult experiences women have undergone and continue to experience.

The second area of focus is the oppression women face under existing social arrangements. Hare-Mustin (1978) proposed that the socialization of traditional gender roles tends to predominantly place women in a disadvantaged position. Light is being

shed on power disparities and inequalities hidden in social and cultural expectations of gender taken for granted in daily interactions (Knudson-Martin & Mahoney, 2009). This leads to another indispensable theme worthy of scrutiny that emerges from feminist theories. This third theme focuses on gender and gender associations as central to social life. It does not only look at the oppression of women nor simply on illuminating women's experiences, but it focuses on benefiting both genders by addressing and focusing on their interactions with a vision of equality (Knudson-Martin & Mahoney, 1998).

Influence of Gendered Power and Culture on FGM

Culture, gender, and power are some of the social processes linked to the perpetuation of female genital mutilation. Therefore it is crucial to identify and recognize how these societal processes contribute to relationship functioning and ultimately the eradication of this practice. It is also important to recognize that there are accepted social patterns in places that traditionally have placed women at a disadvantaged position in most societies that carry out FGM.

Through the exploration of the concepts of gendered role attitudes power and collectivist culture, this study employs a feminist ideology to establish how concepts such as patriarchy and subjugation to culture influence the practice of FGM and consequently, the impact of this practice on women and its effects on marital satisfaction.

FGM and Gendered Power

Akin to other socio-cultural preferences, FGM is practiced under the implicit or

explicit blessings of the patriarchal authority structures that ubiquitously prevail over most societies (Candib, 1999). Throughout history and across diverse cultures, the structural context of FGM and other types of harmful rituals e.g., abortion of female fetuses, female infanticide, foot-binding, etc., have been accepted and acknowledged privately or publicly both by laymen and political patriarchal powers. Kenyan culture being predominantly of a patriarchal society, men continue to hold dominant positions in the political arena, whereas women are mostly relegated to the private-domestic sphere in which their activities are limited to childcare, and household chores (Frederiksen, 2000). Women are therefore consigned to subordinate positions and males to influential positions of power and decision-making at large (Omwami, 2011).

The perpetuation of FGM is closely linked to a woman's survival within her community and family in a multi-generational context of male dominance (Njue, Rombo & Ngige, 2007). Considering that some of the reasons put forth for the perpetuation of FGM are marriageability, male pleasure and loyalty to her husband, it is of paramount importance that the eradication of FGM be considered within a broader context that integrates patriarchy. A simple cursory glance reveals men to be at the helm of the hierarchical power structure in most societies that practice FGM. Consequently, it is imperative to integrate this substantive influence in efforts both to understand it and to eradicate it.

Collectivist Culture

Kluckhohn (1954) states that "culture is to society what memory is to individuals". He says that culture consists of transmitting those experiences that worked

to future generations. These experiences may consist of norms, traditions, rituals, and unstated assumptions. They are transmitted through the use of time, place and language.

Trandis (1995) states that collectivism consists of four global scopes. In the first scope, the group and the self are reliant upon each other and share resources among group members. The second scope places the group's goals above individual ones. In the third scope, social behavior is guided by a sense of obligation, duty and responsibility in the execution of cultural principles from in an obligatory manner. The last scope puts emphasis on relationship, even at the disadvantage of individual group members. This chapter will use the above definitions in discussing how collectivist culture influences FGM.

FGM and Collectivist Culture

Njue, Rombo, and Ngige (2007) note that cultural belief and collective problem-solving contribute significantly to the wherewithal of Kenyan families. This means that resources for emotional, financial, and spiritual well-being are obtained through sustained harmony between cultural belief and collectivism. Additionally, the literature suggests that the African self-concept is defined by feelings toward riches, properties, family, and position in the community (Njue, et al, 2007). Consequently, it is through the comparison of oneself with the outer world that the individual is best understood, because changes in the outer world delineate the solidity of the self. Thus, the African self-concept is said to comprise of unfailingly seeking peace and harmony with others, instead of mastery of self and things. This will view will likely influence how people think of

marital satisfaction. As a result, family, kin, cultural beliefs, traditions and status in community become the most significant features of one's life.

We could therefore deduce that the perpetuation of such harmful practices such as FGM are the result of such collectivist ideologies where community systems of socialization and organization are centered on tradition and rituals —a subjugation to culture and tradition which unfortunately oppresses and harms women (Njue, et al., 2007). In these collectivist FGM practicing cultures women are discouraged to speak up or be noticeable, and above all not question the rules and roles in place within a traditional gender and cultural structure (Trandis, 2001, 1995). Consequently, women in these cultures are taught to value harmony, avoid arguments and use indirect styles of dealing with conflict, [struggle and pain] (Hoested, 2001). So, even if they may disagree or hate the practice of FGM, they are unlikely to speak out. As the Japanese proverb says "The nail that sticks out gets hammered down." Women in patriarchal and collectivist cultures are treated as second class, taught to be subordinates to men (Lober, 1994); with their personal views being of less value than those of men which further reinforces inequality of the genders, leading to oppression in women.

Impact of Gendered Power and Collectivist Culture on Couples

Current focus in feminist theory consists of emphasizing and understanding gendered power in relationships, women's experiences, and commitment to change. Consequently, detrimental properties that traditional family roles can have on the wellbeing of both men and women, along with economic exploitation and social inequalities have been revealed (Mahoney, & Knudson-Martin 2009).

Cultural feminists (Sampson, 1988; Schrauger & Schoeneman, 1979) also suggest that the socialization and experience of women replicate a collective rather than an individuated self-concept, which in this case, also contribute to the perpetuation of FGM. In these cultures, women have been socialized to suffer in silence in order to "keep the peace" in their marriages and relationships. This may be one of the foremost feminist concerns of which Bø (2008) speaks while discussing the heavier burden women carry in caring for the relationship. With the carrying of this burden, along with power issues ingrained in couple relationships, women's personal health and wellbeing are jeopardized, leaving the woman feeling overwhelmed, stressed, and isolated in the relationship (Bø, 2008; Knudson-Martin & Mahoney, 1998).

More precisely, one can deduce that because women have been socialized to be subordinates to men, the practice of FGM is part of historically gendered pattern organized around male power to fulfill his needs (marriageability, loyalty, pleasure among many reasons for FGM). Consequently, women may acquiesce to this practice not because they want to or it benefits them, but for their survival. In these societies with stereotypic gender patterns, couple relationships may suffer due to the roles and rules that mostly benefit men, creating inequality in the genders and oppression in women.

On the other hand researchers note that in some collectivist cultures, the gender equality ideal is becoming important to younger men and women (e.g., Moghadam, Knudson-Martin, & Mahoney, 2009; Quek & Knudson-Martin, 2006). But, as elsewhere the actualization of this ideal construct is often elusive due to the traditional gender structures that promote gendered power (Mahoney & Knudson-Martin, 2009).

Eradication of FGM

Early feminist theory has propelled researchers and scientists to incorporate gender, power, and culture in understanding and eradicating harmful practices such as FGM, which is pivotal.

African feminists recognize men's role in oppression, however, they realize that "throwing stones," will compromise their security and solidarity (Wangila, 2007). They, therefore, want men as friends, and consequently may negate attacking them while promoting methods that will promulgate change with them. Other African feminist perspectives reveal women not only as sufferers but also as perpetrators of oppression against themselves, through practices such as FGM and others that compromise their welfare as a result of subjugation to culture and traditional beliefs (Wangila, 2007).

Therefore, programs and approaches that engage and enlist men who customarily wield power in FGM practicing communities, will exploit the skewed gender power structure to promote strategies that will facilitate the eradication and perpetuation of the pernicious FGM practice that beleaguers women. Such an approach is hence unique not only because it targets men about a women's issue perpetrated by women; but because it also seeks to harness the subjugating power of men to help women and uplift society.

CHAPTER THREE

REVIEW OF THE LITERATURE

This chapter identifies the existing research on FGM, which as mentioned before, tends to focus on the individual medical, psychological, and sexual effects of FGM. From there, the chapter addresses the key relationship characteristics that have yet to be explored with this population. Published empirical studies focused on FGM are scrutinized, and gaps in research requiring investigative attention are identified. In doing so, this chapter shall also analyze weaknesses of the identified works and propose how to strengthen them. Finally, this chapter shall relate relevant themes in the literature considered with variables identified in the research methodology.

Female Genital Mutilation

The existing empirical literature on FGM can be broadly grouped into the following categories; a) FGM Prevalence, b) Reasons for FGM, c) Sexual Impacts of FGM, d) Psychosexual and Psychological Impacts of FGM, e) Medical Impacts of FGM.

FGM Prevalence

The majority of empirical studies regarding FGM are prevalence studies. These studies are conducted in regions that have been statistically reported in literature, (e.g., WHO (2008) as having relatively high prevalence rates of FGM. In these cases, the study by Afifi and Bothmer (2007) involving a group of pregnant Egyptian women yielded a prevalence rate of 95.6%—which is strongly comparable to 95.8% prevalence given by WHO (2008). The prevalence in Guinea involving a sample of women aged

15–49 years was 97.9% (Rossem & Gage, 2009), which is also comparable to 95.6% prevalence by WHO. Kenya currently shows a radical decrease in FGM prevalence rates of about half in the past two decades according to the 2008 Kenya Demographic Health Survey (KDHS, 2008). Prevalence decreased from 38% in 1998 to 32 percent in 2003 and to 27% among women between 15-49 years in 2008. An even greater decline is seen in FGM women age 15-19. In 1998 26% were circumcised but in 2008, only 14.6% (KDHS, 2008). This decline is attributed to significant efforts aimed at increasing awareness of the health risks and other complications associated with FGM, through educational programs and anti-FGM campaigns. Scholars generally agree that education is one of the most effective and relevant methods for reducing Gender Based Violence (GBD) as well as FGM (Livermore, Monteiro, & Rymer, 2007; Simister, 2010). In addition to the overall prevalence rates of FGM, it is interesting to note the prevalence rates in regards to the various types of FGM:

Type I—Clitoridectomy tends to be the most common type of FGM. For example, the study by Elgaali et al. (2005) in Scandinavia showed that 78% of the FGM victims had undergone clitoridectomy. Similarly, studies conducted in Nigeria (Adinma & Agbai, 1999 ; Dare, 2004) indicate a prevalence of 74.7% and 75% respectively. Type I prevalence rates for urban women in Kilimanjaro Tanzania were 97% (Msuya et al., 2002); and, 46% for Sudanese women doctors (Magied & Shareef, 2003).

Type II—Excision tends to be the second most common type of FGM. For instance, prevalence rates of this form of FGM are 49.4% in Nigeria (Adinma & Agbai, 1999; Snow, 2002), and 21.1% in Sudan (Magied & Shareef, 2003).

Type III—Infibulation and Type IV consisting of other types of vaginal scraping, piercing, and pricking of the clitoris or vulva are lesser practiced forms of FGM.

However, infibulation is identified as the dominant form of FGM in a study carried out among Somali women living in Canada (Chalmers & Hashi, 2000).

Taken as a whole, women living in female oppressive countries are at the greatest risk of FGM. The World Health Organization (WHO) and Amnesty International have declared FGM a human rights violation (Elwood, 2005; WHO, 2008).

FGM literature shows that the mean age at which girls are genitally mutilated fluctuates among different studies. For instance, the mean age at which FGM was conducted is 12.3 years among women studied in Chad (Leonard, 1996) and 6.9 years among women in South-Western Nigeria (Dare, 2004). In addition, Litorp (2008) studied immigrants in Sweden and found that the average age at which girls underwent FGM was 6.1 years. However, the lowest and highest mean ages at which FGM is performed on girls are 5.7 years among Somali women living in in Canada (Chalmers & Hashi, 2000) and 15.5 years among rural multi-ethnic inhabitants in Tanzania (Klouman et a., 2005). This seems to indicate that the average age for performing FGM is dependent on the community concerned, which in turn is motivated by the cultural and religious influences.

Reasons for FGM

According to feminists, practices such as FGM contribute towards the maintenance of oppression of women. Cultural and traditional requirements dominated the reasons many communities practice FGM (e.g. Elgaali et al., 2005; Adinma & Agbai,

1999; Litorp, 2008; Dare, 2004). Though no religious scripts prescribe to FGM (Bikoo, 2007; Baron & Denmark, 2006), religious reasons closely follow or are intertwined with cultural motivations for FGM (Dandash et al., 2001; Chalmers & Hashi, 2000; Magied & Shareef, 2003). Psychological and Psychosexual reasons such as reduction of sexual desires, preventing sexual immorality, and so on are also noted (e.g. Dandash et al., 2001; Magied & Shareef, 2003).

While cultural motivations for FGM are difficult to fight, increased level of education among women seems to reduce the practice of FGM. For example, mothers with higher educational levels are less likely to allow their daughters to undergo FGM (Igwegbe & Egbuonu, 2000; Msuya et al., 2002). In addition, women in the rural areas were shown to be more likely to carry out FGM on their daughters than women living in the urban areas (Dandash et al., 2001; Hassanin 2008).

The amount of oppression toward women varies based on the level of education and the extent of urbanization of their areas of residence. Another perspective of the feminist theory states that the decreased level of education and rural residency contributes to the maintenance of oppression of these women. Additionally, FGM is initiated in girls between ages 5.7 and 15.5 years of age. Feminist theory recognizes how early in life this oppression and strife emanates.

Sexual Impacts of FGM

When viewed through the feminist framework, FGM unnecessarily perpetuates women's sexual oppression. Recently Alsibiani and Rouzi (2008) conducted a sexual function comparison between women who had undergone FGM and those who had not in

Jeddah, Saudi Arabia using Arabic translated version of the Female Sexual Index questionnaire (FSFI). In this investigation, FGM was found to be highly likely to negatively impact woman's sexual experience by affecting her arousal, lubrication, orgasm, and satisfaction. Additionally, approximately 70% of genitally mutilated females were fearful of their initial sexual encounter because they expected it to be painful (Magied & Ahmed, 2002). Infibulated women in the Chalmers and Hashi (2000) study experienced long-term painful sexual intercourse and menstrual periods. More than 21.6% of mothers in Sharkia governorate, Egypt considered FGM to be a cause of sexual dissatisfaction for them (Dandash et al., 2001).

Psychosexual and Psychological Impacts of FGM

According to the study on psychosexual impact of FGM conducted on Egyptian women in Ismailia, Egypt (El-Defrawi et al., 2001), circumcised women reported significant psychosexual difficulties such as less sexual activity, decreased enjoyment of sex, decreased frequency of orgasm, less synchronization of orgasm with their husbands and a general sexual phobia. Additionally, women in the Niger Delta in Nigeria who had undergone FGM described the practice as painful, causing frigidity and lack of sexual satisfaction and wished they never had gone through the experience (Mukoro, 2004).

Victims of FGM were found to exhibit frustrations and psychological disorders (Magied & Ahmed, 2002) and further experienced increased vulnerability and marginalization as foreigners according to Somali FGM victims in Pennsylvania (Upvall et al., 2009). A greater pervasiveness of Post-Traumatic Stress Disorder (PTSD) and other psychiatric syndromes were exhibited among circumcised Senegalese women than

uncircumcised ones (Behrendt & Moritz, 2005). In addition to PTSD, memory problems were also experienced by victims of FGM. Other psychological effects such as sexual phobia (El-Defrawi et al., 2001) and fear of gynecological examination and horrible memories (Litorp, 2008), were also recorded among FGM victims.

Of particular interest is the observation made by Refaat et al. (2001) in which women that had undergone FGM were not only likely to perpetuate FGM; but also accept and justify wife battering. This implies that FGM strongly exacerbates psychological challenges that beleaguer the female gender in most societies. The psychological and psychosexual types of oppression stemming from the investigations highlighted here are effortlessly recognizable via the feminist framework. Moreover, these psychological and psychosexual oppressive impacts of FGM further contribute to the maintenance of the oppression e.g. FGM victim's desire to circumcise their daughters.

Medical Impacts of FGM

The medical impacts of FGM clearly articulate the oppressive nature of FGM recognized through the feminist lens. Additionally, the varying medical traumatic impacts associated with the four types of FGM procedures are synonymous with levels of oppression. Consequently, infibulated women are perceived to be more oppressed than those who have undergone a clitoridectomy or excision procedure.

Diverse medical complications are reported in the FGM literature. Chalmers and Hashi (2000) noted the following immediate health consequences in genitally mutilated women; “severe pain, bleeding, vaginal or urinary fluid retention, bodily edema, or swelling, and infection. Long-term health consequences included “perineal tears, perineal

scaring and cysts, urinary retention, infections, and pelvic infections" (p. 231). Other observed medical problems were: dyspareunia, dysmenorrhea, obstetrical difficulties and urinary tract-related problems (Tamaddon et al., 2006); severe pain and hemorrhaging, labia adhesion, excision of a paraclitoral cyst (Dare, 2004); adnexal pathology (Almroth et al., 2005); urinary problems, defecation problems, immobilization, menstrual problems and tearing in the scar resulting in a new infibulation (Litorp, 2008). Other studies (Banks et al., 2006) have found that "deliveries to women who have undergone FGM are significantly more likely to be complicated by caesarean section, postpartum hemorrhage, episiotomy, extended maternal hospital stay, resuscitation of the infant, and inpatient perinatal death than deliveries to women who have not had FGM" (p. 1839). Therefore, severe bleeding and pain are the main short-term medical complications associated with FGM with the long-term effects varying significantly.

Relationship Impacts of FGM

While much of the research on the effects of FGM have focused on the individual in regards to physical, psychological and psycho-sexual outcomes, there is a need to examine the effects on relationships. Currently many gaps exist in the literature in regards to how the practice of FGM influences relationships health. Before identifying these specific gaps, it is important to frame the concept "relationship health". One such definition can be found in feminist theories. Feminist theory advocates gender equality as the agent of overall relationship success. Relationship success cannot take place without equality as these two are closely linked (Knudson-Martin & Mahoney, 2009).

One of the foremost feminist concerns is the heavier burden women carry in caring for the relationship (Bø, 2008). With the carrying of this heavier load, along with power issues ingrained in couple relationships, women's personal health and wellbeing are jeopardized, leaving the woman feeling overwhelmed, stressed, and isolated in the relationship (Bø, 2008; Knudson-Martin & Mahoney, 1998). Therefore the link between equality and relationship success is crucial because inequality in the relationship results in partners hiding their innermost thoughts and feelings (Beavers, 2000).

Recent research on gender has focused on how gender role attitudes explain the connection between spousal support and relationship satisfaction (Mickelson, Claffey & Williams, 2006). In their 2006 study, Mickelson, Claffy and Williams "examined the interaction of gender and gender role attitudes on spousal support and marital quality (p. 73)". They found that:

> "Emotional spousal support predicted better marital satisfaction and less conflict for traditional women and egalitarian men, whereas both instrumental and emotional spousal support predicted better marital satisfaction for egalitarian women and traditional men" (p. 73).

The results of their study suggest that spousal support contributes significantly to relationship satisfaction and quality. This research shows that more often than not, "emotional work" is driven by women, negatively impacting the woman's psychological and physical wellbeing. Women taking on this emotional work is often associated with societal expectations of women "to be caring and nurturing" rather than be "cared for" (Ciccocioppo, 2009). Aside from the "emotional work", Hochschild and Machung (1989) coined the "second shift" to describe the dual responsibility women have in earning income on top of running an efficient household. They also detailed the negative impact this burdening dual role has on women while shedding light on the negative

impact of traditional belief systems around gender roles and "men's and women's work" (Knudson-Martin & Huenergardt, 2010). Spousal support therefore extends from instrumental (i.e. division of household labor, financial etc.) to emotional support (i.e. caring and mutual relational responsibility) in understanding relationship satisfaction. Acitelli & Antonucii (1994) found emotional support to be a significant predictor of couple relationship satisfaction and decreased conflict for women than for men. In their study Mickelson, Claffey & Williams (2006), concluded that when it comes to understanding relationship satisfaction and quality, knowing an individual's gender alone is insufficient. It is vital to know his or her gender role attitudes in order to understand the link between spousal support and relationship satisfaction.

When viewing the literature on FGM through this lens of feminism there are a number of concerns to be addressed and explored empirically. The following areas are issues that are proposed to be affected by the practice of FGM.

Relationship Satisfaction and FGM

Cultural reasons for FGM include: initiation of girls into womanhood, prevention of promiscuity, suppression of libido in females, better marriage prospects and enhancement of male sexuality. Generally, FGM practicing communities believe that undergoing FGM "guarantees" premarital virginity and post-marital monogamy (Baron & Denmark, 2006). These ideas are then generalized in these cultures to relationship health and satisfaction. Across diverse cultures and throughout history, FGM and other similar detrimental rituals have been reported to result in marital and relational problems in families (Candib, 1999; El-Defrawi et al., 2001). Cultural feminists would argue that

practices such as FGM are oppressive in nature and are cultural manifestations of gender-based oppression that violate women's rights (Tobin, 2009). Due to the paucity in the literature with regards to the impact of FGM on relationship satisfaction, this study purposes to explore this phenomenon.

Sexual Satisfaction and FGM

FGM continues to have significant negative effects on families, and couples' sexuality (El-Defrawi et al., 2001). A study on the psychosexual impact of FGM (El-Defrawi et al., 2001); found circumcised women to have significant psychosexual difficulties such as less sexual activity; less enjoyment of sex; less frequency of orgasm; less synchronization in the timing of orgasm with their husbands and a general sexual phobia. Additionally, women in the Niger Delta in Nigeria who had undergone FGM described the practice as painful, causing sexual aversion and lack of sexual satisfaction; and wished they never had gone through the experience (Mukoro, 2004).

Using the Female Sexual Index questionnaire (FSFI) translated into Arabic; Alsibiani & Rouzi (2008) compared sexual function between women who had undergone FGM and those who had not in Jeddah, Saudi Arabia. No statistical significant differences existed between the two groups in the desire and pain score. However, there were statistically significant differences in the arousal, lubrication, orgasm, and satisfaction scores. Furthermore, approximately 70% of genitally mutilated females had fearful and painful initial sexual intercourse expectations in another study by Magied & Ahmed (2002). Infibulated women in the Chalmers & Hashi (2000) study experienced long-term painful sexual intercourse and menstrual periods. More than 21.6% of mothers

in Sharkia governorate, Egypt, considered FGM to be a cause of sexual dissatisfaction for them (Dandash et al., 2001).

In the investigation of effects of FGM on the onset of sexual activity and marriage in Guinea (with a 97.9% FGM prevalence), Rossem & Gage (2009) found that only a minority believed that FGM is important as either a means of sexual control and to enhance marriageability. Hence, FGM, appears to fall short of its purported objectives such as sexual control and enhancing marriageability, but unnecessarily contributes toward women's sexual dissatisfaction.

Intimacy and FGM

In a study done in Ismailia, Egypt (El-Defrawi et al., 2001), 250 women patients of Maternal and Childhood Centers (a family planning center), were randomly selected, gynecologically examined, informed of the nature of the study and interviewed to investigate their intimate sexual activity. The study showed the following: 80% of circumcised women had dysmenorrhea (no menses), 48.5% had vaginal dryness during intercourse, 45% had a lack of sexual desire, 28% had less frequency of sexual desire per week, 11% had less initiative during sex, 49% were less pleased by sex, 39% were less orgasmic, 25% had less frequency of orgasm, and 60.5% reported difficulty reaching orgasm. These reports point clearly at the negative impact of FGM on couples' sexual intimacy (El-Defrawi et al., 2001).

Women who experience painful intercourse have been known to "fake orgasms," (Longmans et al., 1998), wishing that the sexual activity was over quickly to bring an end to the physical and emotional pain they feel. Enjoyment for both the woman and her

partner is diminished during intercourse, reducing the woman to a masturbatory object during sex (Longmans et al., 1998), and robbing the couple of true and mutual relational intimacy.

This assault of the female organs may have a profound effect on both the woman's psyche and consequently on her intimacy with her partner, as it leads to psychological disturbances and impaired sexual desire and performance (Longmans et al., 1998). When a woman believes that a part of her is missing and it is irretrievable her self-esteem is decreased and her self-worth diminished. As a result, a couple may experience relational problems in their intimacy if their sexual activity consists of intercourse and the woman is reluctant to do so based on clear and understandable reasons (El-Defrawi et al., 2001).

Gender Role Attitudes and FGM

Akin to other socio-cultural preferences, FGM is practiced under the implicit or explicit blessings of the patriarchal authority structures that ubiquitously prevail over most societies. Throughout history and across diverse cultures, the structural context of FGM and other types of harmful rituals, e.g., abortion of female fetuses, female infanticide, foot-binding, etc., has been accepted and acknowledged privately or publicly both by laymen and political patriarchal powers (Candib, 1999). Kenya being predominantly a patriarchal society, men continue to hold dominant positions in the political arena, whereas women are relegated to the private-domestic sphere, in which their activities are limited to childcare, and household chores (Omwami, 2011).

Women are therefore relegated to subordinate positions and males to influential positions of power and decision-making at large (Omwami, 2011). The perpetuation of FGM is closely linked to a woman's survival within her community, and family in a multi-generational context of male dominance. Considering that some of the reasons put forth for the perpetuation of FGM are marriageability, male pleasure and loyalty to her husband, it is of paramount importance that the eradication of FGM be considered within a broader context that integrates patriarchy in eradicating it. Even a cursory glance reveals men to be at the helm of the hierarchical power structure in most societies that practice FGM (Omwami, 2011). Consequently, this study has integrated the gender role attitudes variable as it has been known to have a substantive influence in efforts of eradication and perpetuation of FGM.

Spousal Support and FGM

In addition, the majority of health care providers in FGM prevalent countries are either victims of the practice, FGM practitioners, or, if males, condone and perpetuate the practice (Magied et al., 2003; Magied & Shareef, 2003). No studies have been conducted on the role of spousal support and FGM. This study will fill this gap in the literature. This study hypothesizes that couples who demonstrate mutual support are more likely to have a healthier and happier marriage as opposed to those who do not. Knudson-Martin and Huenargardt (2010) indicate four components healthy couples demonstrate in their interactions: mutual attunement, shared vulnerability, shared relationship responsibility, and mutual influence. Through the investigation of the spousal support variable, it is hypothesized that individuals with higher scores of spousal

support will also have a higher level of marital satisfaction.

Location, Education, SES and FGM

Socio-economic status, geographical locations and ethnic backgrounds are among the chief factors that largely influence the eradication and perpetuation of FGM (Baron & Denmark, 2006). The Kenya Demographic and Health Survey (KDHS 2008) showed that regions with lower educational and lower SES had higher FGM prevalence. Communities with more than a secondary education had a prevalence of 26.0% in 1998 and 19.1 % in 2008, as opposed to no education (50% in 1998 and 53.7% in 2008). An increased level of education among women is observed to decrease their tendency to perform FGM on their daughters as investigations by Igwegbe & Egbuonu (2000) and Msuya et al. (2002) reveal. In addition, women in the rural areas are shown to be more likely than women living in the urban areas to carry out FGM on their daughters (Dandash et al., 2001; Hassanin 2008).

Geographically, levels of FGM prevalence were higher in rural than urban areas. Ethnically, there were specific groups that were known to practice FGM more than others. In Kenya, an example of such are the Masaai, Kisii and Somali at approximately 96% in 2008 versus the Luhya, Luo and Mijikenda at lower than 10% in 2008 (KDHS 2008).

Consequently, the reasons for undertaking female circumcision vary greatly depending on factors like geographical location, cultural heritage, demographic description, and social-economic status. In addition, women in the rural areas were

shown to be more likely than women living in the urban areas to carry out FGM on their daughters (Dandash et al., 2001; Hassanin 2008).

Summary

Overall, a review of available published empirical investigations on Female Genital Mutilation (FGM) reveals the literature to be relatively dominated by empirical studies on the prevalence, psychological, and medical consequences of FGM. Currently there are no empirical studies investigating how FGM impacts marital satisfaction. Consequently, the relational effects of this practice are unknown. This lack of knowledge may be contributing to the global perpetuation of this practice. This study addresses most of these issues by studying how FGM impacts the marital satisfaction of Kenyan females residing both in Kenya and the USA. This affords the opportunity to investigate FGM within the context of an international (USA and Kenya) sample within the same study.

CHAPTER FOUR

METHODS

This study used a quantitative, survey methodology to test research hypothesis. The study used Kenyan and Kenyan born US immigrants, as well as FGM versus non-FGM sample groups with the level of analysis being married females, with the aim of investigating whether there are relational differences among circumcised and uncircumcised married females. The following section will outline the research design while providing details about sample selection, and data collection procedures. Finally, a description of measures and variables as well as analytical strategies for data analysis is given. Particular attention to the role of culture in assessment standardization and application are also addressed.

Research Design

This study utilized self-administered paper-pencil surveys on a convenience sample. The surveys took approximately 20-30 minutes to complete. The role of culture was given particular attention in the standardized instruments construction and research methodologies in general.

Participants

Participants were recruited from workshops that were presented at Seventh Day Adventist churches in Minnesota, USA, and Nairobi, Kenya. There were 136 married women (18 years and older) with the mean age being 39.28. Twenty seven or (19.4%) of these participants resided in the USA and 106 or (76.2%) in Kenya. To be included in the

study, participants had to be married and English speaking. Sixty-one or (44.85%) of these women were circumcised versus 72 or (52.94%) non-circumcised. This design yielded four groups of individuals with each group consisting of at least 27 individuals. A power analysis based on an MANOVA test with 4 groups and an a priori planned small effect size ($f^2 = 0.2$) shows that a total sample of more than 80 individuals will yield a more than satisfactory power level of $\alpha > 0.95$. Therefore this study over sampled at N = 136 to ensure that the type II error (the failure to reject a false null hypothesis) is reduced as much as possible. Data collection for this study occurred over approximately seven months.

Variables and Measurements

Some of the items in the standardized instruments have not been validated with a Kenyan sample, therefore the instruments were piloted in an exploratory focus group consisting of a Kenyan marriage and family therapist, family life educator, a public health professional, a nurse and an FGM Kenyan activist and professor. All of these individuals are Kenyans with relevant cultural familiarity and academic competence. The feed-back from these individuals helped confirm suitability of such questionnaires to this sample population. These assessments created five dependent variables:

Relationship Satisfaction

Relationship satisfaction was measured by the Dyadic Adjustment Scale (DAS) (Spanier, 1976). The DAS is a 32 item scale used to assess the quality of cohabiting or married couples. The purpose of the four subscales on the DAS is used to determine

dyadic or couple adjustment in research or therapeutic purposes. The four subscales on the DAS are:

1. Dyadic Consensus (13 items)
2. Dyadic Satisfaction (10 items)
3. Dyadic Cohesion (5 items),
4. Affectional Expression (4 items)

Individuals are asked to rate how often they agree or disagree with their spouse. The regularity of specific behaviors, the degree of happiness in the couple relationship, and their feelings about the future of their relationship are also rated. With an overall Cronbach's alpha of .96 , this instrument has evidence indicating construct, content and criterion-related validity of the scale (Spanier, 1976). For the Dyadic Consensus, Dyadic Satisfaction, Dyadic Cohesion and Affectional scales, the Cronbach's alpha scores are .90, .94, .86 and .73 respectively (Spanier, 1976). An overall satisfaction/adjustment score is the goal for the four subscales. It uses a Likert Scale format: 1 (All the Time) to 5 (Never), with the range of scores being 32 to 154. The higher the score, the better the relationship quality. This scale has been used successfully on non-American populations, for instance a study by Rakwena (2010) in Botswana where he investigated marital satisfaction and intimacy among married couples both in urban and rural areas.

Sexual Satisfaction

To assess sexual satisfaction, participants completed the Index of Sexual Satisfaction (ISS) (Hudson, 1998). This scale by Hudson (1991) is designed to measure the level of satisfaction an individual has in the sexual relationship. The total subscale

reliabilities range from 0.92 to 0.96. It is constructed in a 7-point Likert scale format, consisting of 25 items. An example of the items is: "I feel that my partner enjoys our sex life", "Our sex life is very exciting", "Sex is fun for my partner and me", etc. Participants are to indicate 1 (None of the time) to 7 (All of the time). Scores range from 0-100, with higher scores indicating the gravity of problems in the sexual relationship. The ISS has been used in other countries outside of the United States such as Poland (i.e. Agnieszka et. al., 2007), to measure the quality of marital sexual satisfaction in women with polycystic ovary syndrome.

Intimacy

The Personal Assessment of Intimacy in Relationships inventory (PAIR) (Schaefer & Olson, 1981) was used to measure the level of intimacy. The PAIR is used to evaluate closeness of many forms of relationships including premarital, cohabiting and marital relationships (Schaefer & Olson, 1981). It is a 36-item self-report inventory providing information on perceived martial intimacy in five areas of intimacy:

1. Emotional Intimacy (6 items),
2. Social Intimacy (6 items),
3. Sexual Intimacy (6 items),
4. Intellectual Intimacy (6 items),
5. Recreational Intimacy (6 items) and 6 items of the Conventionality Scale.

With a Cronbach's alpha values on all five scales >0.70, similar to the overall alpha (Schaefer & Olson, 1981). The PAIR is reported to have high reliability and validity is supported with significant correlation with other marital satisfaction scales. It

also uses Likert scale (1 strongly agree to 5 strongly disagree). The overall intimacy scores range from 36-180 with a high score indicating higher levels of intimacy. This scale has been used on non-American populations (i.e., Rakwena, 2010), who used it to investigate marital satisfaction among couples in rural and urban areas in Botswana.

Spousal Support

This is an eight-item scale used to investigate emotional and instrumental spousal support (Mickelson et al., 2006; Purdom et al., 2006). This scale consists of six items that measure emotional spousal support, while two items on the scale measure instrumental spousal support. Emotional support pertains to one partner being attuned and responding to the emotional needs of the other. Instrumental support addresses the physical needs of the other. Respondents were required to indicate responses to statements such as: "My partner cares about me," "My partner asks me regularly about my day," "When I am tired after a demanding day, my partner is willing to help at home". Like the previously mentioned instruments the range of scores is from 8 to 40, in which higher scores indicate better spousal support. It is also in a Likert format.

Gender Role Attitudes

To assess gender ideologies, Gender Roles Attitudes a scale created by Cunningham (2005) consists of eight items. Participants indicate their responses to statements such as: "It is perfectly alright for women to be very active in clubs, politics, and other outside activities before the children are grown up", "Most of the important decisions for the family should be made by the man of the house", "There is some work

that is men's and that is women's, and they should not be doing each other's work"), on a Likert Scale to which they indicate the level of agreement from 1 (strongly agree) to 5 (strongly disagree). With scores ranging from 8-40, a high score indicates more of an egalitarian attitude and a lower score indicates a traditional attitude.

Independent Variables

The study consists of two independent variables: Location (Kenya or USA). For this variable, participants indicate their current country of residence by checking Kenya=2 or USA=1. For FGM status, women indicate whether or not they are circumcised. The variable was coded as 1 equal to "yes" and 2 equal to "no". Further, women indicate type of FGM which is coded as 1 equal to "clitoridectomy", 2 equal to "excision", 3 equal to "infibulation" and 4 equal to "other". An attempt was made to determine whether the type of FGM had any predictive ability, but the data revealed that most women had difficulties understanding the fine distinctions between each type. Therefore results for this study simply used the data indicating whether they had undergone FGM or not.

Other Demographic Variables

a) Annual Household income

This consisted of annual pay of household. Respondents were asked to indicate their annual household income. Kenyan shillings are converted into US dollars at the going market rate to obtain US dollar equivalent.

b) Age

Participants were asked to indicate their current age in numerals and also enter their birth date in the DD/MM/YYYY format.

c) Education

Respondents indicated their highest educational qualification.

d) Gender

Participants indicated their gender: “Male” or “Female. The variable was coded as 1 equal to “female” and 2 equal to “male”.

e) Number of children living at home.

Respondents indicated the number, age, and gender of children living in the home.

f) Religion/spirituality

Respondents indicated their religious preference e.g. Christian, Muslim, Hindu, etc. Additionally were asked to indicate the number of times they attend religious activities (1 = twice daily; 2 = once daily; 3 = at least once a week; 4 = less than weekly; 5 = seldom).

g) Occupation

Respondents were asked to indicate their main economic occupation e.g. Clerical, Laborer, Pastor, Homemaker, Professional, Self-employed, University/college student, Retired, etc.)

h) Length of marriage

Respondents reported how long they have been married in number of years categorized in five segments 1 to 5 years, 6 to 10 years, etc.

i) Respondent’s ethnic community

Respondents were asked to indicate the ethnic community they identify with e.g. Kisii, Maasai, Meru, Luo, etc.

Data Analysis

This study tested the following hypothesis: 1) Marital satisfaction varies by whether the individual has FGM (versus non-FGM) and whether the individual currently resides in the US (versus Kenya): 2) Sexual Satisfaction varies by whether the individual has FGM (versus non-FGM) and whether the individual currently resides in the US (versus Kenya); 3) Intimacy varies by whether the individual has FGM (versus non-FGM) and whether the individual currently resides in the US (versus Kenya); 4) Spousal support varies by whether the individual has FGM (versus non-FGM) and whether the individual currently resides in the US (versus Kenya); 5) Gender role attitudes vary by whether the individual has FGM (versus non-FGM) and whether the individual currently resides in the US (versus Kenya).

Statistical Package for the Social Sciences (SPSS) is used to analyze data. Initially, descriptive statistics were used to examine the data. Frequency distributions, means, standard deviations and other descriptive methods are used to ensure that the data conform to the multivariate assumptions of MANOVA and linear regression. The data was cleaned and pre-screened to identify and effectively manage missing data and outliers (Cohen et al., 2002) prior to analysis. To test the assumption of homogeneity of variance-covariance and homogeneity of regression slopes, a preliminary MANOVA was conducted. A factorial MANOVA was used to test the interaction among factors on the DV (Mertler & Vannatta, 2010).

Box's Test for homogeneity of variance was utilized to Determine that Wilks' Lambda should be utilized when interpreting the test for homogeneity of variance and the MANOVA analyses.

CHAPTER FIVE

RESULTS

Table 1 presents descriptive statistics about variables used in this study.

Table 1.

Demographic Characteristics of Participants (N = 136).

Characteristic	n	%
Age (Years)		
<20	1	0.8
20 - 29	19	15.4
30 - 39	48	39.0
40 - 49	35	28.5
50 - 59	19	15.4
60 - 69	0	0.0
70 - 79	0	0.0
80 - 89	0	0.0
90 - 99	0	0.0
100 - 110	1	0.8
Number of Years Together		
1 - 5	27	20.0
5 - 10	26	19.3
>10	82	60.7
Religious Affiliation		
No Response	17	12.6
None	8	5.9
SDA	67	49.6
Christian	41	30.4
Church of God	1	0.7
Catholic	1	0.7
Religious Services Attendance		
At least Once a Week	89	67.4
More than Once a Week	28	21.2
2 to 3 Times Per Week	14	10.6
Once Every Month	1	0.8

Characteristic	n	%
Highest Level of Education		
Elementary Education	1	0.7
Secondary Education	8	5.9
High School	4	3.0
Other	5	3.7
Diploma	27	20.0
College Graduate	35	25.9
BA/BS/LLB	10	7.4
Graduate Degree	38	28.1
Post-Graduate Degree	7	5.2
Occupation		
Teacher	28	21.2
Nurse	13	9.8
Business	11	8.3
Accountant	9	6.8
Other	71	53.8
Family Worship Occurrence		
Once Daily	66	50.4
Twice Daily	18	13.7
At least once a week	17	13.0
Less than weekly	7	5.3
Seldom	23	17.6
Monthly Household Income (KShs)		
0-20,000	37	29.4
20-40,000	31	24.6
40-60,000	19	15.1
60-100,000	18	14.3
More than 100,000	21	16.7
Number of Children		
0	14	10.4
1	22	16.3
2	26	19.3
3	35	25.9
4	29	21.5
5	3	2.2
6	5	3.7
7	1	0.7

Characteristic	n	%
Circumcised		
Yes	61	45.9
No	72	54.1
Ethnicity		
Kisii	61	45.5
Luo	27	20.1
Kamba	5	3.7
Meru	4	3.0
Kikuyu	8	6.0
Luhya	5	3.7
Kalenjin	4	3.0
Bemba	1	0.7
Suba	3	2.2
Kuria	13	9.7
Jita	1	0.7
Nandi	1	0.7
Mbeere	1	0.7

A two-way Multivariate Analysis of Variance was employed to determine the effect of female genital mutilation and location on the level of 5 marital satisfaction variables among circumcised and non-circumcised married females living in the USA and Kenya. Data was first screened and cleaned. Outliers were eliminated and missing data were replaced with the mean. Since Box's Test was not significant, Wilks' Lambda criteria were used. MANOVA results indicate that circumcision [Wilks' $\Lambda = .95$, F (5, 125) = 1.22, $p = .30$, $\eta^{2 =} .04$] and Location [Wilks' $\Lambda = .926$, F (5, 125) = 1.99, $p = .08$, $\eta^{2 =} .07$] do not significantly affect the combined DV of sexual satisfaction, gender role attitudes, spousal support, intimacy, and relationship satisfaction. The interaction between location and circumcision is also non-significant [Wilks' $\Lambda = .98$, F (5, 125) = .49, $p = .78$, $\eta^2 = .01$]. Additionally, the multivariate effect sizes are very small.

In summary the MANOVA results indicated that only gender role attitudes significantly differ for presence or absence of circumcision but not for location (Kenya or USA). More specifically, this study found that presence or absence of circumcision does not make a significant difference on marital satisfaction.

Although the MANOVA omnibus test was not significant overall I chose to proceed with individual univariate ANOVA to determine if any separate DV was significant. The summary of the ANOVA results are presented in Table 2.

Table 2.

Summary of ANOVA results.

			Circumcision			Location		
	df1	df2	F	*p*	η^2	F	*p*	η^2
Gender-role Attitudes	1	129	4.35	.03	.03	4.71	.06	.03
Sexual Satisfaction	1	129	.006	.94	.00	.53	.46	.00
Spousal Support	1	129	.05	.81	.00	1.17	.28	.00
Intimacy	1	129	.86	.35	.00	.70	.40	.00
Relationship Satisfaction	1	129	1.82	.17	.01	.20	.65	.00

For the first DV (relationship satisfaction), a two-way analysis of variance was employed to determine the level of relationship satisfaction among circumcised and non-circumcised married females living in the USA and Kenya. The means and standard deviations are presented in Table 3. The two-factor analysis of variance showed no significant main effect for the circumcision factor, [F=(1.82), p=.17, η^2=.01]; no significant main effect for the location factor , [F= (.20), p=.065, η^2=.00]; and there was no interaction between circumcision and location, [F= (.34), p=.55, ,η^2=.00].

Table 3.

Mean of Relationship Satisfaction.

			USA	Kenya
Circumcised	Yes	Mean	103.41	104.09
		Std Dev	26.27	21.58
	No	Mean	113.32	107.99
		Std Dev	23.98	18.83

For the second DV (sexual satisfaction), a two-way analysis of variance was employed to determine the level of sexual satisfaction among circumcised and non-circumcised married females living in the USA and Kenya. The means and standard deviations are presented in Table 4. The two-factor analysis of variance showed no significant main effect for the circumcision factor, [F=(.000), p=.*998*, η^2=.000]; no significant main effect for the location factor , [F=(.482), p=.489, η^2=.005]; and the interaction between circumcision and location, [F= (.850), p=.359, ,η^2=.009]. Therefore, the presence or absence of circumcision does not make a significant difference on sexual satisfaction, and neither does location.

Table 4.

Mean Level of Sexual Satisfaction.

			USA	Kenya
Circumcised	Yes	Mean	33.72	33.46
		Std Dev	18.74	17.91
	No	Mean	37.38	30.54
		Std Dev	23.25	21.33

For the third DV (intimacy), a two-way analysis of variance was employed to determine the level of intimacy among circumcised and non-circumcised married females living in the USA and Kenya. The means and standard deviations are presented in Table 5. The two-factor analysis of variance showed no significant main effect for the circumcision factor, [F = (.675), p=.*413,* η^2=.006]; no significant main effect for the location factor, [F= (.859), p=.356, η^2=.008]; and the interaction between circumcision and location was not significant, [F = (.204), p=.653, ,η^2=.002]. Given this finding we concluded that the presence or absence of circumcision does not make a significant difference on intimacy, and neither does location.

Table 5.

Mean Level of Intimacy.

			USA	Kenya
Circumcised	Yes	Mean	126.54	121.51
		Std Dev	24.29	20.36
	No	Mean	132.00	127.06
		Std Dev	23.20	27.05

For the fourth DV (spousal support), a two-way analysis of variance was employed to determine the level of spousal support among circumcised and non-circumcised married females living in the USA and Kenya. The means and standard deviations are presented in Table 6. The two-way factor analysis of variance showed no significant main effect for the circumcision factor, [F=(.004), p=.*949*, η^2=.000]; no significant main effect for the location factor , [F=(3.230)=, p=.075, η^2=.030]; and the interaction between circumcision and location was not significant, [F= (.063)=, p=.803, ,η^2=.001]. Therefore, the presence or absence of circumcision does not make a significant difference on spousal support, and neither does location.

Table 6.

Mean Level of Spousal Support.

			USA	Kenya
Circumcised	Yes	Mean	18.53	16.61
		Std Dev	6.36	6.10
	No	Mean	18.00	16.39
		Std Dev	7.09	7.16

For the fifth DV (gender-role attitudes), a two-way analysis of variance was employed to determine the level of gender-role attitudes among circumcised and non-circumcised married females living in the USA and Kenya. The means and standard deviations are presented in Table 7. The two-factor analysis of variance showed a significant main effect for the circumcision factor, [F = (4.45), p=.*037*, η^2=.04]; no significant main effect for the location factor, [F= (3.563), p=.062, η^2=.034]; and there was no interaction between circumcision and location, [F= (.014), p=.905, η^2=.00].

Given this finding we concluded that the presence of circumcision makes a significant difference on gender-role attitudes, but location does not. Meaning that individuals who scored lower on the gender role attitudes scale were likely to maintain traditional gender role views and consequently were likely to be circumcised and in support of circumcision.

Table 7.

Mean Level of Gender Role Attitudes.

			USA	Kenya
Circumcised	Yes	Mean	28.53	26.80
		Std Dev	3.14	7.02
	No	Mean	33.00	28.41
		Std Dev	5.32	6.08

Summary

This study used MANOVA for analysis and found that circumcision (*p = .30*) and location *(p = .08)*, do not have a significant effect on the combined DV of marital satisfaction. The interaction between the two variables was also non-significant. An individual DV ANOVA however, revealed that gender-role attitudes differ for circumcision *(p = .03)*, but not for location *(p = .06)*.

Factors such as religious devoutness, resilience, advanced age (mean age = 39.28 years), FGM acceptance, knowledgeable and supportive spouse, and, counseling may have been responsible for circumcision not significantly affecting marital satisfaction. An advanced age in participants indicates that they may have had sufficient time to adjust and live with the problem. Moreover, false reporting by the participants could also influence the results to show that circumcision does not significantly affect marital satisfaction.

The possible reason why location did not significantly affect marital satisfaction could be because both populations were located in an urban setting—Nairobi and

Minnesota. Furthermore, though geographically separated, both communities had similar religious backgrounds and followed a common family life educational curriculum at their SDA churches.

Traditional views on gender roles that tend to favor men were possibly responsible for the lower scores by circumcised individuals on the gender-role attitudes measurement. Circumcised women generally tend to subscribe to patriarchal-biased traditions and culture which includes practicing FGM.

CHAPTER SIX

DISCUSSION AND IMPLICATIONS

The results obtained from this study primarily supported the null hypothesis. All efforts were made to avoid type II error, i.e. ANOVA as a follow-up test. The results indicated that there is no major difference in the level of relationship satisfaction among the circumcised and non-circumcised residing either in the USA or Kenya. An exception of significance was found in gender role attitudes for both location and circumcision. This may suggest that those with FGM more than likely also experience gender inequity in societies with power disparities hidden in social and cultural expectations and this may also affect relational expectations. A qualitative study would be useful in confirming and delving into this finding. As Hare-Mustin (1978) suggests that women are predominantly placed in disadvantaged positions through the socialization of traditional gender roles. Even though the findings of this study did not significantly support all of the researcher's hypothesis, the analysis used (MANOVA) to arrive to the results was useful in pointing out the differences and means between groups to demonstrate that the practice of FGM yields no significant difference on marital satisfaction as proclaimed by its perpetuators.

The researcher realizes that the non-significant results may be due to the following limiting factors:

1) A Small US sample group is not sufficiently representative of the US residents, and therefore may have negatively affected the analysis for comparison.
2) The collected data was from urban cities only. This presents as limitation because the data is not representative of the rural population. Future studies should include data from rural communities where this practice is reportedly rampant.

3) The data was collected from a religious organization that is predominantly SDA. This raises the question of whether spirituality may have led to resilience and effective coping of the impact of this practice with no reported effects. It at least can be argued that the sample was somewhat homogeneous in regards to religion, and future studies might explore how SDA religious backgrounds might vary from other religious backgrounds.
4) The majority of the women came from a community (Kisii) that is known to have embraced and practiced FGM for many years. This raises the question of being socialized to perceive FGM as a "normal".

For future replication of this study to be more effective, researchers should ensure that the women know the type of FGM they underwent. This will allow for more useful data to answer the question of whether a severe form of FGM such as infibulation has a greater negative impact on marital satisfaction.

Strengths and Limitations

Design

This study examined several contributions i.e. the gaps of FGM literature and lack of empirical studies on the impact of FGM on couples. However it is important to note some of its limitations. First, it is a cross-sectional study. A cross-sectional study is convenient and time efficient. However it has an inherent limitation in that conclusions will be based on one-time observations. Therefore a longitudinal study examining the same married women across different lifecycles, towns and countries would prove beneficial. The longer observation period of diverse populations in a longitudinal study—

will provide information about individual change; separate aging effects; and, subjects will serve as their control. This will lead to a more accurate and reliable findings. This study could have drawn on a continuity of previous studies as a means of validating its findings, but unfortunately there are no other such studies. This is an inherent limitation, but on the other hand strength as it is the first of such a study. Therefore, it is imperative that future studies replicate this study's findings with a different research design.

Measures

In this study the measures used have been found to be suitable instruments with high Cronbach alphas along with content and criterion validity. Although these instruments have been found to be accurate measures of marital satisfaction in several studies, most of them have not been used on investigating FGM and marital satisfaction on a Kenyan population. Therefore, the replication of this study by other investigators in Kenya or Africa, using the same instruments, would further evaluate their reliability as instruments for measuring martial satisfaction among FGM victims and similar populations. Consistent multiple use of these instruments is likely to expose their strengths or weaknesses which may necessitate the design of more reliable and valid instruments for FGM and related populations. Additionally, a qualitative study interviewing women and their husbands about their perception of the impact of FGM, and their conceptualization of relationship satisfaction would reveal useful relational information. This is because a qualitative study encourages and stimulates participants individual responses; fosters openness; and, captures more details.

Generalizability

Even though this study attempted to generate a deep, clear, and reasonably accurate understanding of the impact of FGM on marital satisfaction of Kenyan married females, this study is limited in its generalizability as results found in this study, may not readily reflect those found among Middle-Eastern females or even different communities in Africa. This study's findings primarily supported the null hypothesis stating that there are no significant effects of location and female genital mutilation on the DV of marital satisfaction. Some of the reasons for this finding may be due to a small USA sample and a large Kenyan sample. Additionally this sample is predominantly SDA/Christian in nature. The sample was also collected from large cities i.e. Minnesota and Nairobi. Subsequent studies should also lay emphasis on non-religious communities in rural areas. An equal amount of participants may also yield significant results.

Contribution to the Field

Global Activism

Despite inter-governmental agencies declaring FGM a human rights violation and a disparaging practice, between 100-140 million girls and women presently deal with the consequences of FGM (WHO, 2008). In Africa alone, for example, three million girls are annually at risk of being genitally mutilated. This study sought to dispel some of the myths used as reasons for FGM i.e. FGM''s negative impact on marital satisfaction. This study therefore contributes to the concerted global campaign to reduce this practice.

Existing Literature

From the literature review, it is evident that there is a need to conduct a scientific

empirical investigation on the impact of FGM on the relationship satisfaction and intimacy between a woman who has undergone FGM and her spouse. No published empirical study on this subject was obtained in the extensive literature search conducted across more than eight leading social science publication databases. Consequently, results from this work will partially fill this gap in the published work arena and contribute towards addressing this generally traumatizing practice that besieges women mainly in industrially developing countries.

Religious Communities in Kenya and US

Inherent religious reasons conspicuously stood out as the overwhelming impediment to the eradication so FGM in the literature (Momoh, 1991). This study focused on the relationship quality of Christians in Kenya and in the US. The non-significant results within this study lead one to wonder whether spirituality is a resilient factor in these religious women. Future research should be conducted with non-religious groups for comparison.

FLE's and MFT's

The findings of this study have implications in some areas of family life education, cross-cultural education, and the attitudes and actions of healthcare providers along with their competency to deal with FGM cases.

The prevailing 21 century global immigration trends have increased the likelihood of American marriage and family therapists (MFTs) and family life educators (FLEs) to come in contact with victims of FGM. The latest statistics from an estimate done in 2000

by the African Women's Health Center at Brigham and Women's Hospital reveal that 227,887 women and girls in the U.S that year were at risk of being subjected to FGM. This figure had grown by 35% between 1990 and 2000. California had the highest prevalence among the individual states with 38,353 females at risk of FGM in 2000 (Brigham, 2000). Consequently, it is imperative that American MFTs and FLEs broadly understand the FGM practice and be particularly cognizant with the relevant literature on the impacts of FGM. This empirical investigation on how FGM impacts couple relationships will hence serve to enlighten and sensitize MFT's and FLE's on the FGM issue and enhance their knowledge when dealing with women who have undergone FGM. Further, the study will help to fill the gap in literature on the psychosexual impacts and closely related themes of FGM on the women and their spouses. Furthermore, this study stimulates the need to explore the role of culture in standardized instruments used to evaluate relationships in general.

Attitudes and Actions of Healthcare Providers

Feminist theory facilitates the recognition of both the presence and absence of knowledge on FGM to mutually contributing to the oppression of women. A number of authors (e.g. Lavender, 2009; Magied & Shareef, 2003; Tamaddon et al., 2006) have addressed the attitudes and actions of health care providers towards women who have undergone FGM. These studies found that some health care providers were not sensitized or were completely unaware of how to appropriately deal with FGM victims residing in non-FGM practicing countries. For instance, adverse results from a study by Lavender (2009) conducted in Liverpool England, among health professionals and lay members;

prompted the FGM National Clinical Group in United Kingdom to identify areas that need to be improved on. Consequently, the United Kingdom FGM Clinical Group developed coordinated strategies to support education, practice, and research initiatives targeted at healthcare providers. In addition, the majority of health care providers in FGM prevalent countries were either victims of the practice, FGM practitioners, or, if males—condoned and perpetuated the practice (Afifi & Bothmer, 2007 ; Magied & Shareef, 2003).

The encountering of patients with evidence of FGM performed relatively earlier in life by majority of Swedish health care providers (Tamaddon et al., 2006) highlights increased likelihood of any healthcare provider encountering FGM. Therefore, health care providers everywhere should be sensitized and educated about FGM. In Sudan, a survey among female doctors revealed the overwhelming role of inherent culture and traditions that resist change of attitudes irrespective of the professional and level of education. The majority of the respondents (80%) had undergone FGM, some expressed willingness to be circumcised or even be re-circumcised (Magied & Shareef, 2003). Moreover, Magied et al. (2003) in a research to establish the role of midwives and Traditional Birth Attendant (TBAs) in the medicalization and perpetuation of FGM in Sudan found that 55% of the respondents acknowledged FGM to have no hazards. Therefore, for the global campaign against FGM to be successful, health care providers on the forefront must not only be equipped with the right information and skills, but their attitudes and actions must also be rightly aligned. Otherwise, they will inherently be perpetuating the very same practice they endeavor to curtail. This issue is explicitly observed via the second theme of the feminist framework that highlights contributing

factors that perpetuate the maintenance of the oppression. The commitment by healthcare providers to end the unjust practice as advanced by the third theme of the feminist theory can achieve the desired outcome through continued development of coordinated strategies that enhance healthcare providers' knowledge and skills.

The results of this study are to be interpreted cautiously with a recommendation of carrying a similar study with diverse non-religious samples.

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APPENDIX A

INSTRUCTIONS

You will be answering six sets of questions making it at total of 165 items: (a) the Demographic Questionnaire (24 items), (b) Dyadic Adjustment Scale (32 items), (c) the Spousal Support Scale (8 items), (d) Gender Role Attitudes (8 items), (e) Personal Assessment of Intimacy in Relationships Inventory (72 items), (f) Index of Sexual Satisfaction (25 items). As you will see, most items have 5 possible responses ranging from "Always agree to Never agree," "All the time to never," "Strongly agree to Strongly disagree" and so on. You are to pick the answer which best describes the way you feel about your relational experience at this time.

Please, answer all of the questions. Do not make any other marks on the sheet or write your name anywhere on the survey so that remain anonymous. Take as much time as you need. Answer sheets will be collected once you are done.

APPENDIX B

DEMOGRAPHIC QUESTIONNAIRE

Instructions: Please put an X and or fill in your responses. For the results to be used, please answer all questions.

1. GENDER*:* ☐ M ☐ F	**2. AGE:** **3. DOB (mm/dd/yr):**
4. MARITAL STATUS: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	
5. AGE OF SPOUSE: **6. SPOUSE'S DOB (mm/dd/yr):**	
7. DATE OF MARRIAGE (mm/dd/yr): **Or** **DATE WHEN RELATIONSHIP BEGAN (mm/dd/yr):**	
8. TOTAL OF YEARS TOGETHER (*Check one*): ☐ 1-5 years ☐ 5 to 10 years ☐ More than 10	

RELIGION INFORMAION

9. RELIGIOUS AFFILIATION: **NONE: ☐**
10. SPOUSE'S RELIGIOUS AFFILIATION: **NONE: ☐**
11. HOW OFTEN DO YOU ATTEND SERVICES AT YOUR PLACE OF WORSHIP? *(Check one)* ☐ At least once a week ☐ More than once a week ☐ Two to three times a week ☐ Once every month ☐ Less than once a month

12. HOW OFTEN DOES YOUR FAMIILY HAVE FAMILY WORSHIP? *(Check one)*

☐ Once daily
☐ Twice daily
☐ At least once a week
☐ Less than weekly
☐ Seldom

EDUCATION, OCCUPATION & INCOME INFORMATION

13. WHAT IS YOUR HIGHEST LEVEL OF FORMAL EDUCATION? *(Check one)*

☐ Elementary education
☐ Primary education
☐ Secondary education
☐ High school
☐ KCPE Certificate
☐ Other:_____
☐ Diploma
☐ College graduate
☐ BA/BS/LLB
☐ Graduate degree
☐ Post-graduate degree

14. WHAT IS YOUR SPOUSE'S HIGHEST LEVEL OF FORMAL EDUCATION?
Check one)

☐ Elementary education
☐ Primary education
☐ Secondary education
☐ High school
☐ KCPE Certificate
☐ Other:_____
☐ Diploma
☐ College graduate
☐ BA/BS/LLB
☐ Graduate degree
☐ Post-graduate degree

15. WHAT IS YOUR OCCUPATION?

_____

16. WHAT IS YOUR SPOUSE'S OCCUPATION? _____

17. HOW OFTEN DOES YOUR FAMIILY HAVE FAMILY WORSHIP? (*Check one)*

☐ Once daily
☐ Twice daily
☐ At least once a week
☐ Less than weekly
☐ Seldom

18. WHAT IS YOUR FAMILY'S MONTHLY HOUSEHOLD INCOME IN KSHS/= or US $?

☐ 0-20,000
☐ 20,000-40,000
☐ 40,000-60,000
☐ 60,000-100,000
☐ More than 100,000

ETHNIC COMMUNITY AND CIRCUMCISION INFORMATION

19. WHICH ETHNIC COMMUNITY DO YOU IDENTIFY WITH? (I.E. KISII, LUO, KAMBA, MERU,)

_____

20. WHICH ETHNIC COMMUNITY DOES YOUR PARTNER IDENTIFY WITH? (I.E. KISII, LUO, KAMBA, MERU,)-

21. ARE YOU CIRCUMCISED? ☐ Yes ☐No

22. IF YOU ARE A WOMAN? WHAT TYPE OF CIRCUMCISION?

☐ Clitoridectomy (removal of the clitoris)
☐ Excision (removal of the clitoris and the labia manora)
☐ Infibulation (complete removal of the clitoris and labia manora, and labia majora sown together)
☐ Other (Please describe):

CHILDREN INFORMATION

23. HOW MANY CHILDREN DO YOU HAVE?

_____

24 (a) CHILDREN	**GENDER**	**AGE**	**LIVES AT HOME**
	☐ M ☐ F		☐ Y ☐ N
	☐ M ☐ F		☐ Y ☐ N
	☐ M ☐ F		☐ Y ☐ N

24(b) CHILDREN	**GENDER**	**AGE**	**LIVES AT HOME**
	☐ M ☐ F		☐ Y ☐ N
	☐ M ☐ F		☐ Y ☐ N
	☐ M ☐ F		☐ Y ☐ N
	☐ M ☐ F		☐ Y ☐ N

APPENDIX C

DYADIC ADJUSTMENT SCALE

Instructions: Most people have disagreements in their marriages. Please indicate below the approximate extent of agreement or disagreement between you and your partner for each item on the following list. Mark choices by filling in the circles, 0.

	Almost Always agree	Always agree	Sometimes agree	Hardly ever agree	Never agree
1. Handling family matters	0	0	0	0	0
2. Matters of recreation	0	0	0	0	0
3. Religious matters	0	0	0	0	0
4. Demonstration of affection	0	0	0	0	0
5. Friends	0	0	0	0	0
6. Sex relations	0	0	0	0	0
7. Conventionality (correct or proper behavior)	0	0	0	0	0
8. Philosophy of life	0	0	0	0	0
9. Ways of dealing with parents or in-laws	0	0	0	0	0
10. Aims, goals, and things believed important	0	0	0	0	0
11. Amount of time spent together	0	0	0	0	0
12. Making major decisions	0	0	0	0	0
13. Household tasks	0	0	0	0	0
14. Leisure time, interests and activities	0	0	0	0	0
15. Career decisions	0	0	0	0	0

	All the time	Most of the time	Sometimes	Hardly ever	Never
16. How often do you discuss or have you considered divorce or separation?	0	0	0	0	0
17. How often do you or your spouse leave the house after an argument?	0	0	0	0	0
18. In general, how often do you think that things between you and your spouse are going well?	0	0	0	0	0
19. Do you confide in your spouse?	0	0	0	0	0
20. Do you ever regret that you married your spouse?	0	0	0	0	0
21. How often do you and your spouse quarrel?	0	0	0	0	0
22. How often do you and your spouse really annoy each other?	0	0	0	0	0

How often:	Every day	Almost every day	Sometimes	Hardly ever	Never
23. Do you kiss your spouse?	0	0	0	0	0
24. Do you and your spouse engage in outside interests together?	0	0	0	0	0

How often do you:	At least once day	Once or twice a week	Once or twice a month	Less than once a month	Never
25. Have an interesting conversation?	0	0	0	0	0
26. Laugh together?	0	0	0	0	0
27. Calmly discuss something?	0	0	0	0	0
28. Work together on a project?	0	0	0	0	0

Indicate if the items below were problems in your marriage during the past FEW WEEKS by filling in a circle for YES or NO.

29. Being too tired for sex 0 No 0 Yes

30. Not showing love 0 No 0 Yes

31. Please fill in one circle that best describes the degree of happiness in your marriage.

0Very unhappy 0Somewhat unhappy 0Fairly happy 0Mostly happy 0Very happy

32. Which one of the following statements best describes how you feel about the future of your marriage (Please fill in the circle for the most appropriate statement)?

0 I want desperately for my marriage to succeed, and would go to almost any length to see that it does.

0 I want very much for my marriage to succeed, and will do all I can to see that it does.

0 I want very much for my marriage to succeed, and will do my fair share to see that it does.

0 It would be nice if my marriage succeeded, but I can't do much more than I'm doing now to help it succeed.

0 My marriage can never succeed, and there is no more that I can do to keep the marriage going.

APPENDIX D

PERSONAL ASSESSMENT OF INTIMACY IN

RELATIONSHIPS INVENTORY

Instructions: Please mark response by filling in the circles (0) according to how you fell about your marriage at present. For the results to be used, you must answer all the questions.

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
1. My partner listens to me when I need someone to talk to.	0	0	0	0	0
2. We enjoy spending time with other couples.	0	0	0	0	0
3. I am satisfied with our sex life.	0	0	0	0	0
4. My partner helps me clarify my Thoughts.	0	0	0	0	0
5. We enjoy the same recreational Activities.	0	0	0	0	0
6. My partner has all of the qualities I've always wanted in a mate.	0	0	0	0	0
7. I can state my feelings without Him/her getting defensive.	0	0	0	0	0
8. We usually "keep to ourselves."	0	0	0	0	0
9. I feel our sexual activity is just routine.	0	0	0	0	0
10. When it comes to having a Serious discussion, it seems we Have little in common.	0	0	0	0	0
11. I share in few of my partner's Interests.	0	0	0	0	0
12. There are times when I do not Feel a great deal of love and					

Affection for my partner.	0	0	0	0	0
13. I often feel distant from my partner.	0	0	0	0	0
14. We have few friends in common.	0	0	0	0	0
15. I am able to tell my partner when I want sexual intercourse.	0	0	0	0	0
16. I feel "put-down" in a serious conversation with my partner.	0	0	0	0	0
17. We like playing together.	0	0	0	0	0
18. Every new thing I have learned about my partner has pleased me.	0	0	0	0	0
19. My partner can really understand my hurts and joys.	0	0	0	0	0
20. Having time together with friends is an important part of our shared activities.	0	0	0	0	0
21. I "hold back" my sexual interest Because my partner makes me feel Uncomfortable.	0	0	0	0	0
22. I feel it is useless to discuss some things with my partner.	0	0	0	0	0
23. We enjoy the out-of-doors together.	0	0	0	0	0
24. My partner and I understand each other completely.	0	0	0	0	0
25. I feel neglected at times by Partner.	0	0	0	0	0
26. Many of partner's closest friends are also my closest friends.	0	0	0	0	0
27. Sexual expression is an essential					

part of our relationship.	0	0	0	0	0
28. My partner frequently tries to change my ideas.	0	0	0	0	0
29. We seldom find time to do fun things together.	0	0	0	0	0
30. I don't think anyone could be possibly be happier than my partner and I when we are with one another.	0	0	0	0	0
31. I sometimes feel lonely when we're together.	0	0	0	0	0
32. My partner disapproves of some of my friends.	0	0	0	0	0
33. My partner seems disinterested in sex. Religious matters	0	0	0	0	0
34. We have an endless number of things to talk about.	0	0	0	0	0
35. I feel we share some of the same interests.	0	0	0	0	0
36. I have some needs that are not being met by my marriage.	0	0	0	0	0

APPENDIX E

SPOUSAL SUPPORT

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
1. My partner cares about me.	0	0	0	0	0
2. My partner asks me regularly about my day.	0	0	0	0	0
3. My partner accepts me completely.	0	0	0	0	0
4. When I have a tough day, my partner tries to cheer me up.	0	0	0	0	0
5. When I am frustrated, my partner listens to me.	0	0	0	0	0
6. My partner is sympathetic when I am upset.	0	0	0	0	0
7. When I am tired after a demanding day, my partner is willing to help at home.	0	0	0	0	0
8. Who spends more time taking care of responsibilities at home?	I do	My partner		Both equal	

APPENDIX F

GENDER ROLE ATTITUDES

	Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree
1. Most of the important decisions for the family should be made by the man of the house.	0	0	0	0	0
2. It is perfectly alright for women to be very active in clubs, politics, and other outside activities before the children are grown up.	0	0	0	0	0
3. There is some work that is men's and some that is women's, and they should not be doing each other's work.	0	0	0	0	0
4. A wife should not expect her husband to help around the house after he comes home from a hard day's work.	0	0	0	0	0
5. A working mother can have just as good a relationship with her children as a mother who does not work.	0	0	0	0	0
6. It is much better for everyone if the man earns the main living and the woman takes care of the home and family.	0	0	0	0	0
7. Women are much happier if they Stay at home and take care of their children.	0	0	0	0	0
8. It is more important for a wife to help her husband's career than to have one herself.	0	0	0	0	0

Strongly Agree	Somewhat Agree	Neutral	Somewhat Disagree	Strongly Disagree

APPENDIX G

INDEX OF SEXUAL SATISFACTION

This questionnaire is designed to measure the degree of satisfaction you have in the sexual relationship with your partner. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows:

1 = None of the time
2 = Very rarely
3 = A little of the time
4 = Some of the time
5 = A good part of the time
6 = Most of the time
7 = All of the time

1. ___I feel that my partner enjoys our sex life.
2. ___Our sex life is very exciting.
3. ___Sex is fun for my partner and me.
4. ___Sex with my partner has become *a* chore for me.
5. ___I feel that our sex is dirty and disgusting.
6. ___Our sex life is monotonous.
7. ___When we have sex it is too rushed and hurriedly completed.
8. ___I feel that my sex life is lacking in quality.
9. ___My partner is sexually very exciting.
10. ___I enjoy the sex techniques that my partner likes or uses.
11. ___I feel that my partner wants too much sex from me.
12. ___I think that our sex is wonderful.
13. ___My partner dwells on sex too much.
14. ___I try to avoid sexual contact with my partner.
15. ___My partner is too rough or brutal when we have sex.
16. ___My partner is a wonderful sex mate.
17. ___I feel that sex is a normal function of our relationship.
18. ___My partner does not want sex when I do.
19. ___I feel that our sex life really adds a lot to our relationship.
20. ___My partner seems to avoid sexual contact with me.
21. ___It is easy for me to get sexually excited by my partner.
22. ___I feel that my partner is sexually pleased with me.
23. ___My partner is very sensitive to my sexual needs and desires.
24. ___My partner does not satisfy me sexually.
25. ___I feel that my sex life if boring.