

# **WORKING PSYCHOLOGICALLY WITH FEMALE GENITAL MUTILATION: AN EXPLORATION OF THE VIEWS OF CIRCUMCISED WOMEN IN RELATION TO BETTER PSYCHOLOGICAL PRACTICE**

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## **ABSTRACT**

Female genital mutilation (FGM) or female circumcision is the term given to traditional practices involving the intentional cutting or partial or total removal of the external female genitalia (WHO, 1999). This two part study used both qualitative and quantitative methods. The first part of the study aimed to explore the views and experiences of FGM amongst women who had undergone the practice. It also explored their views about what clinical psychologists needed to know and do in order to provide appropriate services. In this part of the study six participants were interviewed using a semi-structured interview. The data was analysed using interpretative phenomenological analysis (IPA). Findings indicated that participants felt that despite there being many reasons given for FGM none of them justified the continuation of the practice. Further findings suggested that participants felt that clinical psychologists needed to; understand how FGM is accounted for (e.g. reasons and contexts); acknowledge the different views towards the practice; have knowledge of the many consequences of the procedure (e.g. on physical health, psychological health and relationships) and talk about FGM in a sensitive and non-judgemental manner during consultations.

Part two of the study explored the experiences, knowledge and training needs related to FGM amongst qualified clinical psychologists. A survey was completed by 74 clinical psychologists working in a range of specialities. The findings indicated that there was minimal experience of working with FGM related difficulties amongst participants. Knowledge about FGM and the consequences of it were also limited. Furthermore, clinical psychologists had received little training about FGM and many did not feel confident in working with issues related to the practice. Implications for clinical practice and recommendations for further research are suggested including; training opportunities specifically regarding FGM and further research that explores the connections between the physical and psychological consequences of the practice.

# **1. INTRODUCTION**

The subject of this thesis is female genital mutilation (FGM) and clinical psychology. The research aims to explore the views and experiences of women who have experienced FGM in relation to the practice. Women's experiences and opinions of psychological services for issues related to FGM will also be explored. A further aim of the research is to gain a better understanding of the knowledge and experiences of FGM amongst clinical psychologists. A mixed method design will be used. Qualitative semi-structured interviews will be conducted in part one of the research these will be analysed using interpretative phenomenological analysis (IPA). The clinical psychologists participating in part two of the study will be asked to complete an anonymous survey, which will consist of both quantitative and qualitative aspects.

In introducing this topic I will begin by placing FGM in the historical, cultural and environmental context in which it commonly occurs. I will explore the many explanations/justifications given for FGM and the different political, philosophical and legal arguments for and against the continuation of the practice. Finally, I will review the current research evidence with regards to psychological aspects of FGM, which largely focus on understandings of the procedure and its affects.

There are various terms used within the literature to describe this procedure, for example, female genital mutilation (FGM), female circumcision and female genital cutting (FGC). The terminology used in this thesis was chosen following consultation with participants. The general consensus was that FGM or circumcision was preferred. These terms have therefore been used interchangeably throughout the publicity materials and thesis.

## **1.1. DEFINITIONS AND PREVALENCE**

Female genital mutilation (FGM)/female circumcision is the term given to traditional practices involving the intentional cutting or partial or total removal of the external female genitalia (WHO, 1999). As this definition suggests there are a number of

different forms of FGM practiced across the world, these have been defined by the World Health Organisation (WHO) as:

- Type 1: Excision of the prepuce with or without excision of part or all of the clitoris.
- Type 2: Excision of the prepuce and clitoris together with partial or total excision of the labia minora.
- Type 3: Excision of part or all of the external genitalia and stitching or narrowing of the vaginal opening (infibulation).
- Type 4: Is unclassified and includes pricking, piercing, or incision of the clitoris, stretching of the clitoris and/or labia; and the introduction of corrosive substances to the vagina.

(Lockhat, 2004)

The first United Kingdom Conference on FGM was held in 1989. Following the lead of Hedley and Dorkenoo (1992) it was recommended that the term female circumcision should be avoided and be replaced by the term female genital mutilation as it was felt that this more appropriately recognised the harmful consequences of the practice (e.g. physical and psychological). Cook et al (2002) suggested that the 'less judgemental' term of female genital cutting (FGC) was a more appropriate description of the procedure. Although they do point out that the term mutilation might be more appropriate to describe more extreme forms of circumcision where genitalia is either cut off or severely wounded.

The World Health Organisation (WHO) estimates that over 140 million women in more than 30 countries may have undergone FGM. As a result of immigration and refugee movements many of these women are now living in the UK and Europe. The communities who are believed to be most exposed to FGM in the UK are from Somalia, Ethiopia, Eritrea and Yemen (BMA, 2001). Powell et al (2002) suggest that 86,000 women in the UK have undergone FGM and the Foundation for Women's Health, Research and Development (FORWARD) estimates that as many as 6,500 girls are at risk of FGM within the UK every year (Dorkenoo et al, 2007). Barstow (1999) reports that traditionally FGM is often carried out on girls between the ages of

two and twelve. In some cultures however, it is carried out in adolescence, just before marriage or at childbirth. The 'circumcisor' is usually an older woman in the community, either a relative or a traditional birth attendant (Whitehorn et al, 2002). Barstow (1999) reports that the procedure is often carried out without the use of anaesthesia, antiseptics, analgesics or antibiotics, placing the individual at risk of serious health complications.

## **1.2. HISTORICAL CONTEXT**

The origins of FGM are uncertain however, evidence from Egyptian mummies suggest that female circumcision was routine practice 5000 years ago (Elchalal et al, 1997). Dorkenoo (1995) suggests that it is likely that genital mutilations were introduced when the Nile Valley was invaded by militant pastoral nomads, and culturally transformed, around 3100 BC. Dorkenoo points out that although FGM occurs in Egypt today, there is no evidence of it in Ptolemaic or earlier periods. She suggests that FGM must have developed independently amongst certain ethnic groups in sub-Saharan Africa as part of puberty rites. Whitehorn et al (2002) report that in ancient Rome female slaves had metal rings passed through the labia minora to prevent procreation. Women in medieval England wore chastity belts for the same reasons. Morris (1999) points out that these practices were not specifically associated with any particular religious faith and have been observed in Muslims, Jews and Christians. Morris also claims that female circumcision predates these religions.

Clitoridectomies were a recognised practice in 19<sup>th</sup> century Britain in the management of epilepsy, sterility and masturbation (Kandela, 1999). In 1866 the Obstetrics Society challenged proponents about the value and ethics of clitoridectomies. Whitehorn et al (2002) suggest that some of the clinical justifications in the literature at the time represented similar attitudes towards women as those in the many parts of the world where FGM is practiced today (e.g. that women needed controlling).

### **1.3. REASONS GIVEN FOR THE PRACTICE OF FGM**

#### **1.3.1 Tradition**

Tradition accounts for the most widely held justification for the practice of FGM. In many cultures FGM is said to signify the passage into adulthood and therefore serves as an initiation rite facilitating acceptance and belonging (Lockhat, 2004). However, recent reports suggest that circumcision is being performed on younger girls (e.g. two - four year olds), which might suggest that the practice is becoming less strongly linked to puberty rites and initiation into adulthood. The ceremonies that traditionally took place around FGM are also reported to be less common and many girls are now circumcised in a 'conveyor belt' manner, one after the other (Lockhat, 2004). These ceremonies are viewed by some to serve as a protective psychological factor (Dorkenoo, 1995). The status and celebration is seen to ameliorate the potential 'trauma'. Without such ceremonies the act might be regarded to be less about a celebration of the child's transition to adulthood and more of a painful, traumatic and unnecessary procedure.

#### **1.3.2. Religion**

The practice of FGM has often been linked to religion and surveys suggest that this reason is commonly used by those who insist that the practice continue (Lockhat, 2004). Despite many media portrayals of FGM focusing on Islamic communities FGM is carried out by Muslim, Jewish, Christian and Catholic religions and Atheist communities. The act has largely been attributed to the advocacy by some religious leaders, who cite modesty and chastity as justifiable reasons for the practice. However, despite male circumcision being mentioned in some religious texts FGM is not. The UN Special Rapporteur on Violence Against Women (UNSRVAW) states that neither Islam, nor any other religion, is connected to the practice of FGM. Penn and Nardos (2003) suggest that FGM has come to be regarded by some as an integral part of religious observance. The link between FGM and religion, albeit inaccurate, appears to have perpetuated the fear associated with not undergoing the procedure as it is seen as going against religious obligations.

### **1.3.3. Preservation of Chastity**

A commonly cited assumption is that FGM ensures chastity. One belief is that the clitoris drives women into making uncontrollable, insatiable demands for sex and removal of it is believed to minimise promiscuity. Penn and Nardos (2003) note that infibulation is also believed to preserve chastity by making the act of intercourse physically impossible. It also provides men with assurance that a woman is a virgin before marriage. Circumcision can result in painful sex for women resulting in less desire to have intercourse, thus less likelihood that a woman would stray and have extramarital affairs (Lockhat, 2004). Feminist texts have discussed this issue further and many claim that FGM is practiced as a means of controlling women's sexuality within a patriarchal society, this is discussed later in the thesis.

### **1.3.4. Myths and Superstitions**

Justifications for the practice are also based on a number of mythical beliefs passed down through generations. Myths about the femininity of the foreskin in males and the masculinity of the clitoris in women have led to them being associated with bisexuality perpetuating the belief that they should be removed (Lockhat, 2004). Eke and Nkanginieme, (1999) report that FGM is sometimes carried out due to the belief that without it the clitoris will grow long like the penis. Beliefs about the clitoris causing infertility and/or harm to a baby during childbirth are also common amongst some FGM practising communities.

### **1.3.5. Socio-economic**

In many communities a woman who has not undergone FGM can be ostracised from her community leaving her socially isolated and most likely living in poverty (Lockhat, 2004). Within many patriarchal societies proof of virginity remains a pre-requisite to marriage. This is likely to perpetuate female circumcision as without it a woman's chances of marrying are greatly reduced and the chances of her and her family achieving economic stability are slim. This reason appears to have created a dilemma for many women. Anecdotal evidence suggests that some women who continue to circumcise their female children, despite understanding the long-term consequences, do so out of fear that their daughter will be ostracised and left in poverty (Dorkenoo, 1995).

### **1.3.6. Hygiene**

In some communities the female external genitalia are considered unclean. A belief is held that women are naturally polluted and can only achieve an acceptable state of cleanliness through circumcision (Lockhat, 2004). In fact circumcision is reported to cause many infections for women, which in some cases results in infertility (Morison et al, 2001).

### **1.3.7. Aesthetics**

In some instances FGM is carried out because of a belief that the vagina is more aesthetically pleasing to men if the labia are removed. However, with requests for labia reductions in western societies, increasing the belief that female genitalia should look a particular way is not restricted to communities that practice FGM. The number of operations carried out in the UK to cut women's labia to a preconceived norm is currently rising steeply (Surgicare, 2009 cited in Walter, 2010). This also raises another question about how we conceptualise such surgery in the west and how one act can be regarded as cosmetic whilst another is classified as abuse. This argument will be discussed later in the thesis.

### **1.3.8. Cure**

In the past in Europe and America circumcision was performed under the belief that it helped to cure psychological problems in women (e.g. hysteria and insanity). Many of these 'psychological problems' might alternatively be conceptualised as behaviours that were regarded as 'socially unacceptable' within the patriarchal society of the time (e.g. remaining unmarried and speaking out). Ussher (1989) reports that clitoridectomies were performed as late as the 1950s in the US under the recommendation of doctors who believed that the clitoris was the source of many 'unacceptable' behaviours in women (e.g. refusing to marry).

## **1.4. PERSPECTIVES ON FGM**

Female genital mutilation is a controversial and contested practice. There are many differing perspectives that are likely to influence not only the women who are directly

affected by the procedure but also the psychologists who come into contact with them.

#### **1.4.1. Human Rights**

FGM has been defined as a violation of human rights by both the United Nations and World Health Organisation and in many countries laws have been passed to outlaw the practice (Behrendt et al, 2005). In the UK the Prohibition of “Female Circumcision” Act came into force in 1985, making it an offence to carry out, aid, abet or procure the performance by another person of any form of FGM, except for specific medical purposes. Further legislation came into force in March 2004, in the form of the Female Genital Mutilation Act 2003, which made it an offence for FGM to be performed anywhere on UK nationals or UK permanent residents. This closed the loophole in the 1985 act, which had given room for parents to take their children abroad for the procedure (Dorkenoo et al, 2007). FGM has been recognised as a denial of the girl child’s fundamental human rights to her physical integrity and natural sexuality and as a result has been incorporated into the Working Together to Safeguard Children Policy (2006). Following the mass immigration in the 1980s from countries with a high prevalence of FGM (e.g. Sudan, Somalia), it has become an issue on political and health agendas in many countries, including the UK (FORWARD, 2000). Many countries with high prevalence rates for circumcision have also enacted laws that prohibit FGM however, the practice appears to continue. This raises questions about how well enforced these laws are in some parts of the world. Barstow (1999) points out that despite FGM being made a crime in many countries few, if any, cases have been prosecuted. He suggests that FGM is now recognised as gender-specific child abuse, child exploitation and torture. However Barstow suggests that it is the dissemination of information about FGM, the emphasis on education and the realisation of equal rights for women that has ultimately proved to be more successful than legislation.

#### **1.4.2. Feminist Perspectives**

FGM has been described by some as contributing to the patriarchal oppression of women. Dorkenoo (1995) suggests that FGM has played a part in the repression of women across the world and throughout history. Penn and Nardos (2003) suggest

that it is the belief that 'powerful female sexuality' is a threat to social control that has led to extreme measures, such as FGM, being used to bring about control and preserve the honour of women and their families. These assumptions in relation to women and the need to control them have resulted in the social functions of FGM (e.g. maintenance of chastity and attenuation of female sexual desire) being prioritised over the health complications that are often consequential of the practice (McNamara, 2002). The social, economic and political powerlessness of women within many FGM practicing communities is said to be associated with the belief of "woman as incapable" (Penn & Nardos, 2003). Toubia (2004) suggests that the global campaign to eradicate FGM will be unsuccessful unless it addresses the social and economic injustices that compel women to submit to such practices as a means of social acceptance and access to fundamental necessities such as family, employment and community. Dorkenoo (1995) however warns about making generalisations about the position of women within the societies that practice FGM because of the diversity of history and cultures in which it occurs. She points out that the position of women in both Black and Arab Africa (where FGM is most commonly practiced) is influenced by many factors including; their class position and affiliation, educational level, individual consciousness about their rights, economic independence, and religious and cultural influences.

#### **1.4.2.1. Constructing the Clitoris as Bad/Mad**

Up until the last century in the United Kingdom and United States of America, genital mutilation was practiced as a treatment for excessive female sexuality (e.g. masturbation) and has been seen as recently as the 1950s in the US (Dorkenoo, 1995). Today it is reported that beliefs about insanity and promiscuity being associated with the clitoris persist amongst many FGM practising communities. Such beliefs and the fear they create appear to perpetuate the continuation of the practice, leaving many women feeling that they have little choice but to circumcise their daughters, in order to protect them and ensure their acceptance.

Ussher (1989) describes how the medicalisation of the female body has been used to justify practices (e.g. clitoridectomies) that ultimately aim to suppress female sexuality and control the lives of women, particularly those whose views and

behaviours were seen not to fit with the ideals of the time (e.g. married and homely). This reductionist approach (e.g. biological explanations often associated with the reproductive system) to explaining women's responses to the difficult, unequal social situation of the time (e.g. suppression and inequality) appeared to have served as justification for mutilating them (clitoridectomies). Lightfoot-Klein (1989) claims that women have sometimes been assumed to be sexually voracious, promiscuous and unbridled creatures, morally too weak to be entrusted with the sacred honour of the family. Circumcision is therefore performed to prevent women from bringing dishonour upon themselves or their families. By preventing women from enjoying intercourse circumcision is believed to control promiscuity and reduce the probability of them indulging in adulterous relationships (Davis, 1985). Toubia (1994) suggests that historically clitoridectomies have been advocated for a wide variety of "female weaknesses" within many parts of the world. Psychological theories in particular psychoanalytic theories, have also contributed to the beliefs about female sexuality and its links with uncontrollable women. In the early 1900s Freud fuelled fears about female sexuality with his claims that most mental and physical illnesses resulted from distortions in sexual attitudes, thinking and behaviour. Kelly (1994) notes how such ideas were used to justify clitoridectomies and incarceration as a cure for insane women. Interestingly at the time when the mutilation of women was recommended as treatment in western societies many of those professions who put forward these suggestions were male dominated. Support for the claims by many feminist writers that FGM or circumcision is used as a way of controlling women can be found in documents written by proponents of these procedures. Davis (1985) found that some proponents reported that following clitoridectomy women became more orderly, industrious, and cleanly, characteristics considered important for women at the time.

#### **1.4.2.2. Patriarchal control**

We might ask ourselves how the changes in some parts of the world (e.g. the UK) have occurred in order to better understand why the practice of FGM continues in others. Adams (2004) suggests that educating women and professionals is of the utmost importance and claims that without better educative initiatives this 'patriarchal practice' will continue. Adams points out that it is the patriarchal grandfathers and

fathers that insist on the circumcision of female children. Black and DeBelle (1995) also argue that FGM is associated with gender discrimination. They suggest that the practice is supported and encouraged by men and can be regarded as an exercise in male supremacy and the oppression of women. Lax (2002) reports that the psychoanalytic view indicates that the motive for FGM is based on men's unconscious fear of women's sexuality and the need to suppress it. FORWARD (2002) has also highlighted the beliefs arising from patriarchal societies that perpetuate the practice, such as the insistence on the procedure as a prerequisite for marriage and thus socioeconomic survival. This understanding perhaps highlights how, despite the procedure often being carried out by female members in many communities, it is perpetuated by a patriarchal social system, within which women are unequal to men. Placing FGM within the patriarchal context in which it exists provides an argument to those proponents who suggest that as it is the women who often carry out circumcision the practice is not used as a means of controlling females.

In response to western feminist arguments Okome (2006) argues that the terminology 'female genital mutilation' and the assumption that the intent of societies in which the procedure is practiced is to control women is problematic. She claims that feminist writers who suggest that women subject themselves to FGM only at the insistence of males have ignored the likelihood that for some women circumcision is a choice regarding the manner in which they want to treat their own bodies. She makes comparisons between female and male circumcision and suggests that when a practice becomes a socially acceptable norm issues such as control and power are more complex than that suggested by the western feminist literature. Dorkenoo (1995) has highlighted the similarities and dissimilarities between female and male circumcision and also between the rites of passage for girls and boys. She points out that both are widely practiced without medical necessity and in both cases children go through a traumatic experience. However, she also notes that the clitoris is biologically equivalent to the penis and therefore clitoridectomy, which is the most common form of FGM, is analogous to penisectomy rather than to circumcision. Male circumcision is also not perceived as a practice aimed at reducing sexuality, in

fact the opposite is the case. Nor is it associated with power and control or as a way of reinforcing submissiveness, which is commonly the case for female circumcision.

### **1.4.3. Culturally Relativist**

Adams (2004) reports that many proponents of FGM argue that applying western concepts of feminism, sexuality and human rights ignores the cultural values of the societies that participate in FGM. There are arguments that FGM provides cultural identity, cultural cohesion, role clarification and a sense of pride. At the same time it is believed to increase the desirability of the female as a prospective partner (Barstow, 1999). Barstow states that many proponents have argued that pressures from outside the culture to abolish the practice are evidences of ethnocentrism, cultural imperialism and cultural imposition. Hicks (1993) claims that FGM is one of the ties that binds communities, a mechanism by which communities have chosen to define roles and identities. Okome (2006) suggests that the discourse on female circumcision, where African women are thought of as benefiting from the contact with the West, is evidence of Western feminist evangelism.

Beckett and Macey (2001) have argued that the division in discourses on human rights and the efforts to embrace 'multiculturalism' in Britain have resulted in the acceptance of oppressive practices such as FGM. They concluded that 'multiculturalism' not only exacerbates and legitimises the oppression of already oppressed minority groups, but poses threats to liberal democracy and individual human rights. They report that fears about imperialism and concerns about who should involve themselves within discussions about FGM have for a long time resulted in the continuation of the practice within non-FGM practicing communities. Beckett and Macey (2001) point out that some cultural and/or religious traditions are in direct conflict with the long, and ongoing, struggle for justice and equality. They propose an alternative position, that is, to state that some traditional practices are quite simply not acceptable in postmodern, liberal democracies. Barstow (1999) highlights those other procedures that have been assumed to be important cultural practices, which have been outlawed relatively effectively, such as foot binding in China (Mackie, 1996) without resulting in the death of these cultures, contrary to what some proponents suggest. Mitchell and Russell (1994) agree that no society

can maintain a position in which anything goes at the cultural level within its various communities. Beckett and Macey (2001) suggest that to agree with this is not to slip into ethnocentrism or racism but instead to state that there are limits to the amount of diversity that any society can tolerate. They claim that “multiculturalism” has become a dominant ideology where it has permeated theory, policy and action and suggest that the resultant divisions and conflicts between movements that share a common concern for human rights has allowed an uncritical, logically incoherent brand of multiculturalism to flourish with its assumptions and possible consequences unchallenged. Feminist theorists might claim that the dilemmas suggested by these authors have facilitated collusion in the control of sexuality, particularly women’s. It might also result in a situation in which ‘white women’ have more ‘protection’ and different rights to some ‘black women’. These debates raise many ethical questions particularly with regards to ‘who decides’ what constitutes culturally acceptable, humane, ethical practices.

#### **1.4.3.1 Cosmetic surgery debate.**

Other debates have drawn parallels between practices within western societies that might be considered to contradict the message that FGM is unethical or inhumane. Some arguments have compared the practice of cosmetic surgery in western societies to that of FGM. They point to invasive western cultural practices such as breast augmentation, stomach stapling and labia reduction (Jothilakshmi et al, 2009) and suggest that the rationale for such procedures are ultimately the same as that for FGM, that is to promote a socially constructed ideal of female beauty. Barstow (1999) has raised the question of where cosmetology ends and mutilation begins. Greer (1999) suggests that practices such as piercing genitalia and breast enlargement are forms of mutilation that cannot be separated from the practice of FGM. Whilst recognising the risks posed to women who undergo FGM Greer questions how different it is to what has come to be described as ‘cosmetic surgery’ in the West. Greer highlights how genital mutilation has become medicalised in the west by doctors performing procedures such as labia reductions. Operations to change the appearance of female genitalia are on the increase and are currently justified on medical or cosmetic grounds. Authors such as Walters relate this to the increasing mainstream popularity of pornography where women are exposed to a

perceived norm (2010). Greer (1999) asks how women choosing to mutilate themselves is any different to women who mutilate each other. Okome (2006) claims that “western mutilations” which take the form of cosmetic surgery, are touted as a sign of women’s liberation. However, she suggests that these practices seem ‘sane’ only when viewed in the context of their culture and society. She suggests that issues of power are at play here whereby the more powerful scholarly discourses on FGM determine what the relevant issues are and keep issues which are considered unsuitable out. Dustin (2010) draws attention to what might be perceived as a ‘double standard’ on the part of western campaigners who fail to challenge other unnecessary surgical interventions such as cosmetic surgery in their own communities and cultures.

Many arguments for the continuation or eradication of FGM focus on the reasons given for the practice and what underlies these messages (e.g. controlling women). Perhaps what is important to consider here is the issue of power and hierarchy. Is it that medical justifications receive less scrutiny than those associated with tradition and culture? Many arguments put forward by opponents of FGM suggest that the procedure is carried out as a result of beliefs and views constructed within patriarchal systems within which women experience little power. Others might argue that the medical profession still operates under a hierarchy that is dominated by male power. Perhaps an important distinction to consider is that women who receive cosmetic surgery to their genitalia usually do so at their own request. On the other hand many women and girls who experience FGM undergo the procedure when they are children at the request of adult family members. Barstow (1999) points out that informed consent assumes that the individual is emotionally, intellectually, and developmentally able to provide informed consent, and suggests that in the case of FGM, where the recipients are usually young children informed consent cannot be assumed. However, Foucault (1997) suggests that when considering issues such as social control and power it is not necessarily as straight forward as this.

Social constructionist arguments such as those proposed by Foucault (1997) have argued that beliefs that the west is democratic and that people have choice over their minds and bodies serve to mask the social control that exists within all societies. In

Foucault's opinion we are all subject to control and discipline whether that be overtly enforced or perpetuated by less direct cultural assumptions and messages. Considering FGM from a social constructionist stance would suggest that there is little difference between the rationales for FGM and cosmetic surgery. Both would be seen to be carried out for reasons related to societal beliefs about what is expected of a woman both in appearance and behaviour. Foucault claims that the discourses and expectations in our social world perpetuate discipline through providing an often unspoken message about how people should and should not behave. He proposes that this 'disciplinary power' serves to control people, albeit through more covert methods, by providing cultural expectations that they feel forced to meet (e.g. messages through the media about how women should look). What Foucault seems to be suggesting is that whether or not a woman has mutilation forced upon her, the expectations within all societies may force women to comply with what is expected of them, even if this means self mutilating through cosmetic surgery. Might it be that arguments to abolish the practice of FGM have ignored the mutilation that is perpetuated within all societies by the power imbalances that exist?

#### **1.4.3.2. Medicalising FGM**

Shell-Duncan (2001) asks whether medicalising female circumcision through a 'harm-reduction' approach might help to protect women's health. She suggests that by considering a wide range of alternatives to the procedure that are still viewed to be culturally acceptable (e.g. nicking of the clitoris with a blade) the risk to women might be minimised. This proposition has been put forward in response to the fact that FGM has continued despite legislation prohibiting the practice. Harm-reduction strategies aim to minimise the health hazards associated with risky behaviours (e.g. intravenous drug use) by encouraging safer alternatives, including, but not limited to abstinence (Shell-Duncan, 2001). However, opponents of FGM fear that medicalisation might legitimise a practice that is not only dangerous but serves to subordinate women within patriarchal societies. Dorkenoo (1995) points out that there has been no evidence to show that policies promoting the less drastic forms of FGM have resulted in the eradication of more severe forms of the practice. She draws attention to a policy in Sudan forbidding infibulation but permitting clitoridectomy and reports that 89% of women still undergo infibulations despite such

legislation. A report by the UN commission on human rights claims that in some situations where girls undergo less radical forms of FGM they are later infibulated at the request of family members who believe the circumcision is incomplete (Dorkenoo, 1995). Dorkenoo (1995) suggests that the public might also view the medicalisation of FGM as giving a 'green light' for its continuation. The World Health Organisation (1982) has rejected propositions for the medicalisation of the practice in its recommendation that FGM should not be performed by health professionals under any circumstances. Whilst harm-reduction programmes might have been successful in other areas (e.g. needle exchange programmes) the practice of FGM is often more complex than this. The practice itself, regardless of severity, is reported by women in many anecdotal accounts to lead to feelings of abuse and mistrust in relation to their care-givers. Long-term psychological consequences (e.g. depression, flashbacks) are also reported as a result of the practice. As many justifications have been given for the continuation of the practice one might also ask whether the harm-reduction techniques (e.g. pricking the clitoris) would be regarded as a good enough alternative to some practices (e.g. in the case of infibulations to protect chastity). Whilst it might be accepted by some that harm-reduction programmes serve to address the health-hazards facing women it might not address some of the psychological and social consequences of the practice. Feminist opponents might argue that medicalisation would do little to address the gender imbalances that perpetuate and are perpetuated by FGM.

The limited literature on the psychological impact of FGM has led me to rely heavily on a few authors at times. Lockhat (2004) and Dorkenoo (1995) have been cited regularly throughout this thesis due to the limitations of the evidence base. However, where possible I have included other studies. Lockhat (2004) was also the only person I came across who had studied professionals' knowledge in the UK. A literature search was performed using the ExLibris database on the University of East London library website. A search using the terms 'female genital mutilation' and 'psychology' showed 37 articles. The terms 'female circumcision' and 'psychology' showed 21 articles and the terms 'female genital cutting' and 'psychology' showed 16 articles. Of these 74 articles only 19 of them were felt to include relevant information. These articles referred to female genital mutilation as

the practice defined by the World Health Organisation. Articles that referred to self mutilation and medical genital cutting procedures were excluded as were letters in response to articles on FGM.

## **1.5. RESEARCH STUDIES**

### **1.5.1. Physical Effects**

The health consequences reported to result from FGM are said to vary according to the type undertaken. However, all forms of FGM carry the potential for considerable health implications such as; infections, urinary complications, menstrual problems and obstetric difficulties (Lockhat, 2004). Penn and Nardos (2003) reported that 80% of women who underwent FGM experienced some form of medical complication as a result of the procedure. They noted that severe pain, haemorrhaging, shock, wound infections, abscesses, tetanus and death could occur following female circumcision. Long-term consequences were also reported to include reproductive difficulties and even kidney problems due to the complications in passing urine. Obstetric difficulties such as obstructed labour and fistulas were reported to be common amongst women who had experienced FGM (Penn & Nardos, 2003). Banks et al (2006) studied 28,393 women attending for singleton delivery at obstetric centres in Burkina Faso, Ghana, Kenya, Nigeria, Senegal and Sudan over a two year period. They found that women who had experienced FGM were significantly more likely than those without FGM to have adverse obstetric outcomes including postpartum haemorrhage, infant resuscitation, still birth, early neonatal death and caesarean section. Toubia (2004) also reported psychosexual difficulties resulting from the procedure. Dyspareunia, orgasmic delay and anorgasmia were commonly reported by women who had undergone FGM (Brighouse, 1992). El-defrawi et al (2001) found that 80% of a circumcised population experienced significant sexual difficulties such as lack of desire (45%), reduced pleasure (49%) and orgasmic failure (60.5%). Alsibiani (2010) carried out a prospective case-control study and compared the sexual function of sexually active women some of whom had undergone FGM and some who had not. They found that whilst there were no

significant differences in pain scores there were statistically significant differences in scores for arousal, lubrication, orgasm and satisfaction.

### **1.5.2. Psychological Impact**

Whitehorn et al (2002) and Behrendt et al (2005) suggest that the focus on physical complications within the research has detracted from the 'psychological morbidity' associated with FGM. In a review of the literature Lockhat (2004) found that only 20 out of 504 articles on FGM contained primary data on the psychological sequelae of the procedure. Lockhat (2004) claims that this lack of research is the result of difficulties in measuring psychological distress and the reluctance of women to discuss issues related to FGM. As a result many assumptions have been made about the effects on psychological health with most of the data being gathered from case reports, surveys and interviews with health professionals rather than direct interviews with the women themselves. Dorkenoo (1995) has also drawn attention to the lack of research in the area. She discussed the social taboos that might act as barriers to research by preventing women from reporting difficulties (e.g. psychosexual difficulties might not be reported due to fears of being perceived promiscuous). Dorkenoo (1995) does however suggest that in the minimal personal accounts and research findings that have been reported there are repeated references to anxiety prior to the operation, terror at the moment of being seized by a family member, unbearable pain during and after the procedure, a subsequent sense of humiliation and feelings of betrayal by parents.

Penn and Nardos (2003) highlighted the need for careful exploration of the emotional and psychological impact of FGM and suggested that the lack of this might be associated with cultural prohibition, whereby women are forbidden from discussing concerns regarding their sexuality. Despite the lack of data related to the psychological impact of female circumcision, psychosomatic and mental health problems have been observed. These include, mood and thought disturbances, sleeplessness, recurring nightmares, loss of appetite and panic attacks (Penn & Nardos, 2003). Further research by Barstow (1999) reported emotional trauma, depression, anxiety, psychosis, fear of sexual relations, chronic irritability, hallucinations and post traumatic stress disorder (PTSD) (1999). Lockhat (2004)

researched the subjective recollections of women and found that there was a high incidence of trauma associated with FGM. Some women reported that 'symptoms' of 'PTSD' became apparent immediately following the procedure whilst others experienced psychological 'symptoms' at various stages throughout their life. Lockhat conducted qualitative interviews and focus groups with women who had undergone FGM. She found that less than one tenth of women were experiencing "current PTSD", that is ongoing symptoms at a clinical level, and over a quarter were suffering from "lifetime PTSD" (clinical levels of PTSD experienced at some point during their lifetime). Predictors of psychological trauma were reported to be women's appraisal of their experience (negative appraisals were associated with trauma) and how they felt they had coped with the experience of circumcision (e.g. what coping strategies they had employed).

Whilst Lockhat's research has attempted to address the gap in the psychological literature in relation to FGM her findings and the way in which she has conceptualised the difficulties reported by women rest on Eurocentric definitions and assumptions. Whilst post traumatic stress disorder appears to have been the focus of much of the psychological research into FGM, difficulties might be encountered when attempting to classify the impact of such a complex, culturally embedded practice using western classification systems such as the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV) (2004). Summerfield (1999) warned about the use of Eurocentric concepts to describe the impact of culturally diverse experiences and suggested that this might divert attention from the social and cultural contexts in which experiences occur. Ignoring the context of FGM has implications for treatment. The lack of consideration of culture might be a result of the major focus in the research being on the physical effects of FGM rather than the social and psychological. This has implications for psychologists working with FGM related issues in that the difficulties that women might present with (e.g. diagnosis of depression) are likely to be embedded within a social and cultural belief system. This might impact on the ways in which the client views and chooses to treat her difficulties and could result in the experience of being misunderstood and possibly feeling judged. Without the consideration of context issues such as power, racism

and gender inequalities are less likely to be explored, which might also result in less helpful interventions.

Further research exploring how women appraise their experience of FGM has suggested that the explanations given to women at the time of the procedure can directly impact upon the psychological consequences experienced later in life. Lockhat (2004) found a link between the reasons (e.g. religion) given to individuals for FGM and their appraisal of the experience as adults. She found that negative appraisal (e.g. that the procedure was unnecessary and unjustified) resulted in increased levels of psychological difficulties. Black and Debelle (1995) found that in countries where FGM was less prevalent and negatively viewed the psychological impact was greater. This has implications for circumcised women living in the UK where FGM is illegal and little is understood about the practice. Furthermore, Black and Debelle (1995) report that the 'psychological morbidity' following the procedure in countries where FGM is culturally acceptable or prevalent is thought to be minimal. They suggest that not being circumcised in certain communities can have a greater psychological impact than the trauma caused by circumcision itself, often as a result of the stigma and potential to be ostracised. This research appears to suggest that there are protective factors for women who experience FGM, such as positive attitudes and normalisation towards the procedure in their community. This might however highlight further issues for circumcised women living in countries where the practice is less common and viewed more negatively, such as the UK.

There appears to be uncertainty within the literature about the type of support that might be beneficial to women who have experienced circumcision. This seems to have resulted from contradictory findings about the psychological implications of FGM. Lockhat (2004) reports that whilst there have been reports of phobic reactions, fear of sexual relations, loss of self-esteem, feelings of victimisation, depression and anxiety there have also been findings that indicate a lack of psychological consequences. Following her findings Lockhat made recommendations about how professionals could work effectively with the physical and psychological consequences of FGM. She drew attention to the circumcision related difficulties that could arise throughout the life-cycle (e.g. childhood,

adolescence, pregnancy and old age) and discussed the psychological and social repercussions that were often secondary to physical difficulties (e.g. the impact on concentration and learning as a result of needing to urinate more frequently at school). Psychological and psychosexual difficulties were also highlighted as were the complications arising during and after pregnancy. Lockhat's recommendations in working with women throughout the lifecycle included the need for professionals to remain culturally sensitive and non-judgemental when working with FGM-related issues. She also highlighted the need for more education and training amongst professionals and better efforts to raise awareness of FGM.

### **1.5.3. Understanding amongst Professionals**

Women have reported that a lack of knowledge and understanding amongst professionals along with the negative attitudes and inappropriate management of their needs can result in feelings of isolation and alienation when accessing services for FGM related difficulties (Lockhat, 2004). Lockhat described the impact of this lack of training on the psychological well-being of circumcised women living in the UK. She found that the distress and anxiety experienced by women who had undergone FGM could be exacerbated by professionals' lack of understanding, negative attitudes and unhelpful interventions. Lockhat explains that, in the UK, clinicians may view FGM as a cultural issue and be reluctant to talk about or address issues related to it.

Lockhat (2004) reports that there is little research exploring the knowledge and training about FGM amongst professionals in the UK, particularly psychologists. She found that many of the women who participated in her research reported that professionals did not have knowledge of FGM. However, as a result of the mass migration in the 1980s FGM is likely to be seen more amongst the clients that are referred to a range of psychological services, particularly within more diverse areas such as London. Little information is available about the extent to which psychologists in the UK receive or want to receive training on issues related to FGM and most doctoral clinical psychology programmes do not provide teaching on the topic. Other than safeguarding children training (e.g. Working Together to Safeguard

Children, 2006) little information is provided to clinical psychologists within the NHS about the practice.

Lockhat (2004) also conducted a review of the information on FGM that was available to professionals. She found that despite some guidance being issued by the government with regards to FGM these documents were sparse and lacked the 'hands on guidance' and information that professionals required. As a result of her research (which was conducted in the UK) Lockhat made a number of recommendations for professionals which included; a need for professionals to develop an understanding of the cultural context in which FGM occurs; to develop a better understanding of women's behaviour (e.g. their self expression and expectations); to address professional issues such as terminology and communication; acknowledge and address sensitive issues related to "race" and discrimination; and to address organisational issues that may impact upon services for circumcised women. Unfortunately, the recommendations from Lockhat's research appear not to have been widely disseminated amongst professionals including clinical psychologists.

Onuh et al (2006) researched the knowledge, attitude and practice amongst 182 nurses in Benin in Nigeria and found that whilst all participants identified at least one form of FGM only 6.6% could correctly identify all four types. Twenty-four percent of respondents were of the opinion that some forms of FGM were harmless and 58% viewed FGM as a bad practice. Mostafa et al (2006) explored the knowledge, beliefs and attitudes of 330 fifth year medical students in Egypt. They reported the students' basic knowledge of FGM to be unsatisfactory and found that they were unaware of the prevalence of FGM in Egypt and were poorly informed about the complications and ethical and legal aspects of FGM in the country. As a result 52% of the participants supported the continuation of the practice and 73.2% were in favour of its 'medicalisation' as a strategy for reducing the risks involved. Kaplan-Marcusan et al (2009) point out that as a result of migratory movements FGM is now an issue that many health professionals encounter in the US. They undertook a descriptive study into the perceptions of primary health professionals including physicians, paediatricians, nurses, midwives and gynaecologists. A self-report questionnaire

was administered three years apart and the findings suggested that detection of FGM rose three-fold from 2001 to 2004. However, only 16% of professionals declared detection of FGM and less than 40% correctly identified typology, furthermore 18% of professionals stated that they had no interest in FGM.

Braddy et al (2007) suggest that women may fear being judged by healthcare professionals in industrialised countries preventing them from speaking openly about concerns related to FGM. They highlight that when working with women who have been circumcised it is important for clinicians to have an awareness of and sensitivity to the cultural and historical context of the practice. Whitehorn et al (2002) suggest that some professionals might avoid discussing or intervening with issues related to FGM through fear of being perceived as racist. They advise that increased awareness of the practice of FGM is necessary amongst healthcare professionals and suggest that specialist services alongside better training in generic services might help provide a gateway to psychological services. They do however caution against the risk of pathologising circumcised women who have no complaints. Whitehorn et al recommend that it is essential for professionals to demonstrate adequate awareness of the origins, traditions and psychosocial implications of FGM with cultural sensitivity. Eke and Nkanginieme (1999) warned against professionals shying away from the issue of FGM and suggested that the fear of being culturally out of depth may cause neglect of the medical and psychological needs of women who have experienced circumcision.

## **1.6. RATIONALE FOR PRESENT STUDY**

Adams (2004) suggests that research into the psychology of women who have undergone FGM is needed, suggesting that this research should ask questions about the counselling and support systems women need. Adams (2004) suggests that the voice of western professionals (who have been most commonly consulted in the literature on FGM) is limited in understanding the culture of those who practice FGM. She recommends that research should attempt to involve those whose opinion will be authentic and meaningful to the patients. For this reason, the current study involved interviews with women who had experienced FGM, positioned as

experts. It also asked clinical psychologists about their knowledge, experience and training needs with regards to FGM.

### **1.7. SUMMARY AND AIMS OF THE RESEARCH**

FGM has affected millions of women worldwide and as a result of migration prevalence in the UK has increased. The current literature suggests that FGM has many medical consequences and the emotional impact of the practice has also been reported in some of the research. Despite this, it is believed that many clinical psychologists working in the UK appear to have little if any knowledge about the procedure and the possible psychological consequences (Lockhat, 2004). Minimal training is provided on the topic and research has suggested that the fear amongst many professionals of talking about and intervening with such a 'culturally sensitive' topic has led to many women experiencing psychological services as unhelpful in addressing their needs in relation to FGM (Lockhat, 2004).

There are differing perspectives that have been put forward in the arguments for and against the practice of FGM. These range from the feminist discourses which focus on FGM as a means of controlling women within patriarchal societies to arguments which define FGM as an important cultural practice that people in the West should not concern themselves with. Other perspectives include human rights arguments that consider the practice to be unlawful and abusive and medicalisation proponents who campaign for a 'less aggressive' form of circumcision as a way of minimalising the health risks to women.

A review of the literature has highlighted how little research has concerned itself with the psychological needs of women who have experienced circumcision and there remains minimal information about the knowledge of clinical psychologists with regards to FGM.

### **1.8. RESEARCH QUESTIONS**

1. What are the views of circumcised women, living in the UK, about FGM?

2. What do women who have experienced FGM think that clinical psychologists need to know to provide better services to them?
3. What do clinical psychologists know and understand about FGM?
4. What are clinical psychologists' experiences of working with women who have undergone the procedure?
5. What are the training needs regarding FGM amongst clinical psychologists?

## **2. PART ONE: An exploration of the views and experiences of FGM and clinical psychology amongst women who have experienced circumcision.**

### **2.1. PART ONE: METHOD**

This part of the study utilised qualitative methods in an attempt to understand the experiences and views of women who had undergone female genital mutilation (FGM). It aimed to place women as experts by exploring their views on what clinical psychologists needed to know and do to provide better services for FGM related issues. It also intended to redress gaps in the literature characterised by an absence of research into the psychological needs of women who have experienced FGM and the knowledge and training needs of clinical psychologists on this topic. A semi-structured interview was utilised, on the basis that this method is deemed to be especially useful when the focus of the research is complex, controversial and personal (Smith, 1995).

#### **2.1.1. Epistemological Position**

Epistemology is concerned with the theory of knowledge. Willig (2008) stated that epistemology is important to consider because it allows us to evaluate claims to knowledge. Henwood and Pidgeon (1992) suggest that the dominant research paradigm in psychology has been the experimental method. This assumes a realist epistemology. In contrast, relativist epistemology is concerned with the search for meanings, where knowledge is socially constructed within systems of meanings and by discursive resources and practices (Willig, 2008). The relativist position emphasises description and the representation of reality through the meaning that participants attach to their experiences. This enables concepts to be drawn from data rather than the imposition of terms from prior theory (Henwood & Pidgeon, 1992).

### **2.1.2. Interpretative Phenomenological Analysis**

Smith (2009) explains that the aim of interpretative phenomenological analysis (IPA) is to gain an understanding of how people make sense of their major life experiences. It is concerned with how people come to view and experience their world. Smith (2009) claims that IPA provides insight into the lives of people whose voices might not otherwise have been heard. IPA acknowledges that it is impossible to obtain direct, unmediated access to someone else's personal world and recognises the role of the researcher's interpretation in the process of analysis. It encourages the researcher to engage with participants' accounts to gain an insider perspective (Smith, 2009). IPA starts from the assumption that people's accounts tell us something about their private thoughts and feelings, and that these in turn are implicated in people's experiences. How participants experience the situation or event is what is important in IPA. For this reason IPA is considered to be a relativist approach. It recognises that the meanings that people ascribe to events are the product of interactions between others in their social world but unlike critical realist approaches it is less concerned with the relationship between the phenomenon and the conditions that may have given rise to it. The role of the researcher is considered important in understanding participants' thoughts. The researcher is encouraged to consider how their interpretations are influenced by their own ways of thinking, assumptions and conceptions. Researchers using IPA are advised to demonstrate how their own perspective and position has shaped the research. Willig (2008) points out that the researcher's own way of thinking is not considered to be a bias, that should be eliminated, and should instead be considered to be a necessary precondition for making sense of another person's experience.

### **2.1.3. Ethics: Approval and Considerations**

Ethical approval for the current project was gained from three bodies, the NHS Trust Research and Development Officer, the NHS Trust Research Ethics Committee and from the University of East London's Ethics Committee. Minor amendments were suggested by the NHS Trust Ethics Committee, such as a change to some of the wording in the participant information sheet.

*Informed consent:* Participants were provided with information about the project

directly from the researcher and through the use of an information sheet (Appendix 2). The researcher revisited the information sheet prior to the interview and encouraged the participant to ask any questions they might have regarding the research.

*Right to withdraw:* All participants were made aware of their right to withdraw from the project at any point. They were informed that this would not impact on any service that they were currently receiving or their attendance at any of the groups.

*Confidentiality:* A number of steps were taken to ensure confidentiality. Firstly; participants were interviewed in a quiet space where the interview could not be overheard. Secondly; participants were identified with a number rather than name and no personal details were collected from them as part of the research. Thirdly; all information (e.g. recordings and transcribed data) was kept secure in a locked filing cabinet and finally; no names or identifying information have been used in any part of the thesis write up.

*Consideration of distress:* It was possible that talking about FGM might have caused some participants distress. In consideration of this the semi-structured interview schedule was designed in order to ask individuals about their views and opinions of FGM without directly asking about their own personal experience of the procedure. It was acknowledged that participants might draw upon their own experience during the interview however this provided more choice over whether or not they chose to. All participants were made aware of the support available should they feel distressed following the interview (e.g. a referral to counselling or psychology if necessary).

*Debriefing:* All participants were debriefed following the interview and were reminded of the full aims of the research. Participants were also asked about how they found the interview and were made aware of the support services that were available if they felt distressed.

#### **2.1.4. Participants**

Six participants were recruited in total. All were women who had experienced FGM and were willing to discuss their views of the practice and what they thought psychologists should know to provide better services. The age of participants ranged from 19 to 45 years. Five of the participants were originally from Sudan and one participant was of Somali origin but had grown up in Saudi Arabia. All participants were first generation UK residents and had lived in the UK for varying lengths of time. All spoke English however, an interpreter was available for interviews and the transcription of materials if needed. This provision was aimed at making the recruitment process as inclusive as possible.

The inclusion criteria for the project were that participants had experienced female genital mutilation and were over the age of 18 years. There were no exclusion criteria although care was taken to ensure that participants were able to provide informed consent to taking part in the research.

Participants for this part of the study were recruited from two settings. The first was FORWARD, an international non-governmental organisation (NGO) that works to advance and protect the sexual and reproductive health and human rights of African girls and women. This is important to consider since their attendance at the service may suggest a particular stance towards FGM (e.g. that it should be eradicated). Information about the project was presented to the women during support groups and they were asked to contact the researcher if they wanted to discuss the project further or volunteer to take part. Three participants were recruited from this service.

The second setting that recruitment took place was a community group for Sudanese people living in the South of England. This community group does not declare any particular stance towards FGM. The researcher was invited to a family support meeting ran by the group, by a participant recruited from the above service. Information about the project was presented at the meeting and participants were asked to contact the researcher if they would like to take part. Three participants were recruited from this service.

It was intended that recruitment would also take place within the NHS in order to get a more diverse sample, however this was not a possibility (this will be discussed further in the critical review).

#### **2.1.5. Materials**

A semi-structured interview schedule was developed for this part of the study (Appendix 4). This covered the following areas: participants' views of FGM, their experience of psychological services (if any); participants' perspectives on what clinical psychologists needed to know and do in order to provide better services for FGM related difficulties and participants' views on the psychological needs of women who have experienced FGM.

The semi-structured interview schedule was developed in accordance with guidelines suggested by Smith et al (2009), for example sequencing questions from least to most sensitive and including more general and neutral questions together with more specific and explicit prompts. The interview schedule was developed by the primary researcher in consultation with the research supervisor, university supervisor and staff members in local organisations aimed at supporting women who had undergone FGM (e.g. FORWARD and The Black Women's Health and Family Service).

#### **2.1.6. Part One Procedure**

Participants were interviewed either at their own home (N=3) or in a private room within the community centre where they were attending support groups/community meetings (N=3). Participants were given a choice about where they would prefer to be interviewed. The researcher took measures to ensure that the setting for the interviews ensured confidentiality, such as ensuring that the interviews could not be overheard.

Informed consent was sought from each individual regarding their participation in the study. The researcher made clear that choosing not to participate would in no way affect their attendance at the groups. It was made clear to participants that no information given to the researcher by individual participants would be shared with

facilitators or other members of the groups. Participants were given a short explanation of the purpose of the research, aspects of confidentiality and the intended use of the data. Written consent was obtained from all participants, a copy of the consent form is included in Appendix 1. Interviews lasted for approximately one hour and followed the procedural guidelines recommended by Smith et al (2009); giving participants time to give as full an answer as possible; use of prompts if participants appeared uncertain about the question and applying flexibility to the order of the schedule if appropriate. All interviews were recorded using a digital voice recorder.

Steps were taken to ensure that participants had access to appropriate aftercare if they were distressed by any aspects of the interview. The researcher made herself aware of local services and support organisations that could provide follow up support and spoke with these services about how a referral would be made if necessary. No participants requested any further support following the interviews. However, they were made aware of how to go about seeking this should they require to in the future.

#### **2.1.7. Analysis of the Data**

The interview transcripts were typed by the researcher. All identifying details were changed or omitted from the transcripts. The qualitative methodology adopted for the purpose of analysis was Interpretative Phenomenological Analysis (IPA). This method was chosen for several reasons. Firstly; it facilitated an exploration of participants' views and perceptions of the practice of FGM and psychological services. Secondly; IPA benefits from a capacity to investigate human experience within a cultural context. Thirdly; IPA is deemed to be appropriate when the topic of research is considered to be complex and sensitive (Smith, 1995).

IPA makes particular assumptions. Firstly; it is assumed that participants will talk about issues in interviews that hold significance to them. Secondly; the meaning of participants' experiences might not be transparently available and must therefore be obtained through the researcher's engagement with the transcripts and

interpretation. Thirdly; an individual's account will reflect their beliefs or psychological constructs about the topic (Smith et al, 2009).

Analysis was conducted according to procedures described by Smith et al (2009). This involved a number of steps that are outlined below:

1. The first step involved reading and then re-reading the transcripts in order to develop familiarity with the data.
2. The second step involved 'initial noting' of potential themes, which were noted in the margins. Each theme was coded (e.g. abbreviation).
3. Theme titles were recorded as headings on a blank sheet of paper and verbatim examples from the text were added under each of the headings.
4. As the reading of the transcripts continued, material that was considered to be in support of the identified themes was noted and positioned under the appropriate title heading. An initial list of themes had been identified from the coding of the first transcript.
5. If new themes emerged from later transcripts, these were tested against earlier transcripts and any congruent material from earlier transcripts was recorded in the right hand margin under the appropriate theme title.
6. When each transcript had been read and coded in this way, the coded segments were recorded under the appropriate theme headings.
7. Each theme was then examined, using the raw material to define the theme more clearly. This involved asking questions, such as 'what process is at issue here?', 'under what conditions does it occur?' and 'what are the consequences?'

8. Comparisons were made across the themes and this allowed identification of super-ordinate themes, which appeared to link originally disparate material. When such themes were identified, they were checked against original transcripts to check whether the themes made sense in terms of the integrity of the single participant.

### **2.1.8. Owing One's Perspective**

Willig (2008) suggests that those conducting qualitative research should disclose their own values and assumptions to allow readers to interpret the analysis and consider possible alternative interpretations. I considered my own perspective on FGM and thought about the impact of this throughout the research process. Whilst I felt strongly about the negative consequences of the practice I was aware that people held a variety of views and hoped to capture this in the research. Participants were regarded as experts in this study and it was therefore important that my position remained open to being educated about differing perspectives. Through consultation with women during the development stages of the research I encountered many stances towards the practice. For instance, some women felt that the term female genital mutilation was too strong and did not consider themselves to have been mutilated. Others felt that FGM was a more appropriate description of the practice. This informed the use of terminology throughout the research. I felt strongly that as I had not personally experienced FGM I should respect the views of all women who had. I therefore attempted to remain balanced and open during the research, although I am aware that this was not always possible (e.g. when hearing distressing consequences of the practice). Interestingly, the women that participated in the study all felt strongly against the practice. The representativeness of the sample and the impact of the research on my own perspective will be discussed further in the critical review.

I was aware from the beginning of the project of my position as a white western woman with a white western female supervisor and considered the potential for white colonising views. I thought carefully about how this could impact upon the quality of the research. For instance how the questions in the interview schedule might be

interpreted by participants, how participants might feel about talking to me about FGM and how my position might impact upon the interpretations I made of the data.

In order to address these issues the following steps were taken:

1. Before the proposal for the research was developed I met with the manager of the Black Women's Health and Family Service and members of staff at FORWARD. I asked them about their views of conducting research into FGM and how they felt about me doing this research. I also asked about what research they felt needed to be conducted in this area
2. The initial ideas for the research were then submitted to them and feedback was requested.
3. A research proposal was then developed using this feedback.
4. Further thought was given to how to position women in the research. I did not want to 'study' women and instead wanted to position them as experts to be consulted on what they thought about the practice of FGM and what they felt clinical psychologists needed to know and do to provide better services.
5. Throughout the research I kept a constant dialogue. I attended groups at FORWARD and the Sudanese community meetings and discussed the research not only with the participants but also others who were related to the topic. This helped to guide my thinking at every stage.
6. Throughout this process I remained aware of my positioning (e.g. my ethnicity) and considered the assumptions that the participants and myself might have made and how these may have affected the research.

### **2.1.9. Situating the Sample**

Willig (2008) emphasises the need for researchers to describe participants and their life circumstances in order to allow the reader to access the relevance and

applicability of the findings. Many of the participants were from Sudan (N=5) although one participant was of Somali origin from Saudi Arabia. All of the participants had been living in the UK for some time. This is important in situating the sample. Another factor to be aware of is that the initial recruitment took place at FORWARD, a charity that takes a particular stance on FGM (e.g. that it should be eradicated). It might therefore be that the participants recruited through FORWARD had similar views about the practice. My contact with the Sudanese community group was facilitated by a participant I met at FORWARD. This might also suggest similarities amongst the perspectives of these participants. During the research I was aware of potential bias in the sample recruited from campaigning groups and attempted to recruit through other methods (e.g. NHS services).

#### **2.1.10. Credibility Checks**

Issues of reliability and validity were addressed in the manner suggested by Willig (2008). This involved the research supervisor reading and coding one transcript. These codes were later compared against the coding conducted by myself. Issues of validity were addressed through regular discussions with the research supervisor, considering extracts from the transcripts and their relationships to the identified themes.

Additionally the initial findings were discussed on a number of occasions with members of staff at FORWARD and one of the participants. Respondent validity was also carried out with this participant by asking her to make comments on the themes identified in the results. All participants were asked to provide respondent validity however, only one volunteered to do so. The reasons for the other participants declining were related to other commitments, such as lack of time, work commitments and childcare responsibilities. The participant who did volunteer was sent a copy of the transcript from her interview along with the themes from the part one analysis and was asked for feedback on the relevance of the themes. She reported all of the themes to be relevant. She highlighted those themes that she felt were particularly important and those where further subthemes could have been added. She felt that the super-ordinate theme 'Impact of FGM' represented a good reflection of the consequences women faced in relation to FGM. In particular she felt

that it was important that the sexual difficulties were recognised. She reported that within the super-ordinate theme of 'Accounting for FGM' "cleanliness" could have also been mentioned, possibly as a subtheme. Furthermore, she reported that the sub-theme of 'Stigma and mental health services' was particularly relevant as "some communities are shy to go to psychologists".

#### **2.1.11. Evaluating the Research**

The National Centre for Social Research (2003) suggested four guiding principles that good qualitative research should meet.

1. Contributory in advancing wider knowledge or understanding about policy, practice, theory or a particular substantive field.
2. Defensible in design by providing a research strategy that can address the evaluative questions posed.
3. Rigorous in conduct through the systematic and transparent collection, analysis, and interpretation of qualitative data.
4. Credible in claim through offering well-founded and plausible arguments about the significance of the evidence generated.

All of the above guidelines will be taken into consideration when evaluating and discussing this study in the discussion section.

## 2.2. PART ONE: ANALYSIS AND RESULTS

Interpretative phenomenological analysis (IPA) was used to analyse the data. This involved identifying subordinate themes and then the overarching super-ordinate themes that linked them. Care has been taken to use the participants' language. However, phrases such as 'it seems that' or 'it appears' illustrate the researchers' interpretations of the data.

**Key:**

... = pauses (e.g. two full stops = 2 second)

\_\_\_ = emphasis by participant

### 2.2.1. Theme 1: Accounting for FGM

All participants talked about the reasons given for the practice of FGM in their community, despite not being asked explicitly about this. They all discussed their views about the discourses around FGM and many talked about how they no longer believed that these reasons were justifications for the continuation of the practice. Many participants emphasised the importance of clinical psychologists having knowledge of the reasons for carrying out FGM.

#### 2.2.1.1. Virginitly as "a pass to marriage"

All participants reported that within their communities FGM was believed to ensure that women conformed to the social rules regarding female sexuality (e.g. abstaining from premarital sex). Whilst all participants had experienced the impact of these beliefs many felt that the procedure was unnecessary and should no longer be used as a means of preserving chastity.

Participant 1 described how FGM was used in her community to "protect virginitly". She suggested that clinical psychologists should be aware of this when working with women who have experienced FGM. What participant 1 appears to be suggesting

here is that it would be important for clinical psychologists who work with circumcised women to understand the context to people's difficulties. This might be particularly important when working with issues related to relationships and sexuality (e.g. if working with a woman who is neither married nor a virgin).

*There is an awareness about it now but it is still used in my country and culture and it is said to protect er er protects the virginity yeah yeah..it would be important for the psychologist to know about that (participant 1; pg. 2)*

Participant 2 also discussed the association between chastity and marriage in her community. She highlighted the shame that can be brought upon a family through a woman engaging in premarital acts of sex.

*The majority of ideas that I've come across are that circumcision remains her chaste and she'll remain a virgin until she gets married and that guarantees that she'll be a virgin and she won't bring shame to the family (participant 2; pg. 2)*

Many participants reported that FGM was believed to ensure chastity and faithfulness in relationships through decreasing women's sexual arousal and desire. The impact of FGM upon women's sexual desire was reported by participants to act as a means of controlling women's sexuality by acting as a prevention of both premarital and extramarital sexual activity.

*You know in my country they think it is better not to do sex before you are married..at all it is like a big problem..they think that if you do this [FGM] the girl will not go for such kind of things..it decrease her desire in sex (participant 6; pg. 3)*

*They think if they do it [FGM] she won't want sex and she won't do it and will wait for a husband (participant 4; pg. 3)*

FGM was reported by all participants to be a prerequisite for marriage in their community. Some participants reported that women were often stigmatised for not having undergone the procedure. This stigma was believed by some of the participants to perpetuate the practice.

Participant 5 described FGM as a “pass to marriage”.

*You get told that this [FGM] is a pass to marriage..you have to have it or you know or you can't get married (participant 5, pg; 3)*

Participant 5 pointed out how justifications for FGM are communicated in such a way that people have little choice but to continue to circumcise young girls.

*They sort of like put these ideas in your head that if you don't do then erm...then you you know you won't get married and men won't..erm..er..won't marry girls who have not been circumcised (participant 5; pg. 2)*

Participant 1 told a story of a woman refusing to be de-infibulated despite the benefits to her health. This seemed to highlight particular priorities for women (e.g. marriage over their health) and might represent the position of women within many communities (e.g. having to place men's needs and expectations above their health).

*She had a difficult problem from the FGM...and the doctor said I need to open you up...but she said I am not married so how can you open me up...what would I say to my husband if I married (participant 1; pg. 4)*

In contrast, participant 6 reported a shift in the views of men in her community. She had experienced some men insisting on a wife who had not undergone FGM. This might raise issues for unmarried women/girls who have undergone FGM.

*People are accepting it [non-FGM] more..boys at least in the capital the big cities...for some of them [women] they have problems when they marry and for the men they don't like this kind of things...even some men if he know that*

*this lady had circumcision he will not accept her...they say they want one that isn't circumcised (participant 6; pg 2,3)*

#### **2.2.1.2. Culture not Religion:**

All participants reported beliefs in their communities that FGM was a religious obligation. All of the participants reported however that this was not a belief that they themselves held and felt instead that the practice was more associated with cultural expectations.

*For FGM in the community it is for culture not religion just culture (participant 1; pg. 2)*

Participant 6 suggested that psychologists should have knowledge about these discourses when working with women who have undergone FGM.

*They [psychologists] need to know how it happens to people...also the reasons for it it is confusing...it's like African or it is something traditionally than anything else..people say it is religious but it is not..nothing in any religious (participant 6; pg. 2)*

*I don't think it's about religion at all it's not about religion because in Islam it's not in the Quran..it doesn't say anything about it..it's just culture (participant 1; pg. 1)*

*It's not religious you know but I can understand why my parents had me done..erm..erm..but I think it's a bad experience and I think I wouldn't want to do it to my children (participant 5; pg. 2)*

#### **2.2.1.3. Historical Context: The Origins of FGM**

The beliefs about the relationship between FGM and chastity seemed, for some participants, to be informed by historical stories about the origin of female circumcision.

*This idea comes from Egypt...the pharonic...they did this to the womans when they were going away to keep them from (laughter) doing something bad something not good...to keep them if they come back they couldn't do anything they didn't want them to do the man make sure of it (participant 4; pg. 2)*

*It is said it started in the pharonic you know for they want like to keep the woman not to do anything when they er..go to war..to keep them faithful..they think when they do this operation the woman will not have interest of doing sex or something like that and I think it start in Egypt and they you know in mummy times and they want to keep the woman not do anything with anyone else (participant 6; pg.2)*

*They would physically lock the wife...they lose weight to get out of it so to stop them all together they have to do this [FGM] permanently to stop them from you know (participant 6; pg. 3)*

#### **2.2.1.4. Maintenance through Pressure from Others**

Many participants talked about the pressure from others in their community to circumcise young girls. The pressure was reported by participants to come from a number of sources, such as other women and men in their community and family members. It seems important however to consider the higher sources of pressure that might encourage those who pressure to do so (e.g. patriarchal social systems).

Participant 6 talked about her mother's change in views about FGM and decision not to circumcise her younger sister. However, she described the pressure upon her mother to tell others in her community that she had circumcised her daughter despite not doing so.

*My sister is now 15 and my mum didn't do that for her..but you know none of my relatives know that..if they know that she didn't do that for my sister they wouldn't accept..she said that she did it for her when she was in another town but didn't..but the community would not accept that (participant 6; pg. 2)*

This highlights how despite changes to an individual's views about FGM there remains immense pressure to conform to community expectations.

Pressure to circumcise was reported by some participants to come from other women in their community. Participant 2 describes the experience of her father when choosing not to circumcise his daughters.

*My families my grandmas and my aunts you know they argue with my dad and they are conservative and they say it keeps a woman clean and you know..it keep her you know her virginity her arousal (participant 3; pg. 2)*

*The women have the idea that it is a good it's good until now..they thought it's not a bad idea at all..it's a good idea (participant 4; pg. 2)*

Some feminist authors might suggest that women who insist on FGM might do so in response to the pressures in their social system that demand circumcision for marriage (without which a woman cannot survive). This pressure might therefore represent the powerlessness of women and the pressure upon them to conform to community expectations in order to survive.

Some participants reported to have experienced pressure to circumcise from men within their community. Participant 5 describes this as a "male dominancy issue" and seems to be suggesting that the procedure is encouraged by men to fulfil their sexual needs.

*I think it's the male dominancy issue because they erm...it's an ideal you know you're a man and this is what satisfies a man (participant 5; pg. 3)*

Participant 2 appears to be describing the power of men in her community to decide and enforce "rules" associated with FGM. She suggests that there is little consideration amongst men about the impact of FGM on women.

*Men are the ones to rule and they are ruled not by law but by rules and they don't understand how those rules effect females..it's one thing saying you know in a household saying females have to be circumcised and actually lowering your level down to how these females feel (participant 2; pg. 3)*

## **2.2.2. Theme 2: Differences across Time and Place**

Most participants reported seeing a change in the attitudes towards FGM within their communities. Many felt that the practice was happening less amongst the younger generations and had significantly reduced in cities. Changes in more remote areas were however reported to be minimal by all participants. Some participants felt that the changes reflected an increased knowledge about the difficulties associated with FGM and the access to wider perspectives through education outside of communities.

### **2.2.2.1. Change over Time**

Some participants reported that over time there had been changes to the way in which FGM is viewed (e.g. people beginning to look less favourably on the procedure).

*The views nowadays I think it's changing people are more aware of the erm you know the er.err..the bad effect it has on you know the girls..but historically it was accepted]..[generally now I don't think it's encouraged anymore (participant 5; pg. 2)*

*In my country you know everyone want to make a change and want to see different views about doing FGM and after that they take a decision...or maybe they refuse this (participant 3; pg. 2)*

Participant 5 talked about how the views of those who had already chosen to circumcise their daughters can change and had in some cases lead them to seek 'reversals' (e.g. de-infibulation). This might also be associated with the changing

views of some men (described earlier) who were now asking for wives who had not undergone FGM.

*I think it's changing and there are some families who take their daughters to the doctor to have it undone (participant 5; pg. 2)*

A change in the views of men was also described by participant 2 who reported that “boys” in her community were becoming more sensitive to the difficulties that can arise as a result of FGM.

*I think it's [views about FGM] changed massively...I think opinions have changed a great deal boys are more sensitive to it especially young boys who I'm around and my brothers (participant 2, pg. 3)*

Participant 3 described changes to the procedure rather than a complete abolishment of the practice. She described how some communities had begun to carry out ‘less severe’ forms of FGM. This might represent the efforts of communities to balance the social expectations with the human rights and well-being of girls/women. Such changes have also been described by those who propose the ‘medicalisation’ of FGM.

*They go to the ‘sunna’ type..it's only pricking the clitoris without stitching (participant 3; pg.2)*

The increased opportunities for education were reported by participant 5 to have played a role in the changing views of the younger generation. She also highlights a change of opinion amongst the younger people living in the UK.

*In this community in this country I think they are against it but you would find the elders er..erm..they would erm agree but all the educated generations erm I think in the past 15 years it has changed so it is not encouraged anymore (participant 5; pg. 2)*

The increased access to technology was also reported by participant 5 to have provided a wider view point to the younger generation, amongst which the procedure was beginning to be looked upon less favourably. What seems to be being described here is that the access to differing viewpoints on FGM has provided an opportunity for people to hear about some of the issues associated with FGM that might not be discussed in their immediate communities.

*Because I think now people are you know connected more they watch lots of satellite channels they erm talk about it a lot they talk about the complications (participant 5; pg. 2)*

#### **2.2.2.2. Difference and Place: Villages versus Cities**

All participants reported that the change in views towards FGM was more significant amongst people living in cities rather than villages. Many participants felt that within most villages the changes were minimal or non-existent.

*If you go to a village and talk about it especially if you say this is not good they don't like it...maybe in the city but not in the village (participant 4; pg. 4)*

*It's still worse in countries [villages] but better in capital (participant 3; pg. 2)*

*People are accepting it more [non-FGM]...in the capital the big cities but in the rural area it's still happening (participant 6; pg. 2)*

Participant 2 reported little impact from the change in law forbidding FGM and suggested that despite this legislation in her home country the procedure continued to be carried out in villages.

*Even back home it's illegal...it's even illegal in hospitals so for you to get your daughter circumcised you have to go to the village or the bush to get it (participant 2; pg. 2)*

It might be that people in smaller rural communities have less opportunity to consider wider perspectives or make individual decisions about FGM. The strong shared beliefs and expectations that can be associated with belonging to such communities might have served to maintain 'traditional' practices that are believed to ensure acceptance. Another factor might be that there is less economic independence for women who live in more remote villages. Therefore, suitability for marriage is of high importance as it is often the only means of a woman's survival.

### **2.2.3. Theme 3: Impact of FGM**

All participants talked about the many ways that FGM can impact upon women. Many described experiencing life-long physical and emotional complications and felt that it was important for clinical psychologist to have a good understanding of these.

#### **2.2.3.1. Physical and Emotional as Connected**

Many participants emphasised that the physical and emotional consequences of FGM are inextricably linked. Many felt that clinical psychologists working with women who had undergone FGM should have an understanding about how the physical impact of FGM relates to emotional difficulties.

Participant 5 illustrates clearly how the psychological difficulties that women might consult clinical psychologists about are often linked to the physical problems associated with the procedure.

*They have problems and you know there are lots of complications..erm..so this could be one of the reasons the physical problems and they feed the psychological problems you know and that's when they speak to a psychologist (participant 5; pg. 3)*

Participant 5 highlighted the importance of connecting the physical consequences with the psychological impact of FGM. She also explained that she was unaware that she could see a psychologist about the difficulties she experienced in relation to the procedure. This highlights the lack of support and information about services

that is offered to women whose difficulties might be related to FGM. It might also demonstrate a lack of consideration, amongst professionals, about the role of FGM in the psychological difficulties experienced by some women.

*I really want to say that psychologists need to have an understanding of the physical side to understand the psychological side..you know..I don't think people would have known that someone would have cared to you know I didn't know that if I had problems that I could see someone a psychologist I didn't know I could...that was good that was interesting...I am happy to know that (participant 5; pg. 6)*

Participant 4 draws attention to the sadness experienced in response to the difficulties with sex that frequently occur as a result of FGM.

*When it happened to you to talk about this time...and the problems that happen now like feeling sad and the pain...the sex...it affects women and they will want to talk about this and have some help (participant 4; pg.3)*

The physical impact of FGM was reported by many participants as occurring throughout the lifespan; for example; as a child during and following the procedure, at puberty through problems with menstruation, when marrying associated with painful or uncomfortable sex and when giving birth. The emotional experience connected to such difficulties was also highlighted.

Participant 5 described her experience as a child, following the procedure. She highlighted the importance of clinical psychologists exploring the individual experience of the women they work with.

*From the age of 7 or 6 I had problems with cysts, cysts no cysts...and I have minor operations like 6 or 7 minor operations but they wouldn't take it all out they just tried to get the substance out you know...you know the substance...but then finally they take it out...this is one..I think one of the things that happen]...[if the psychologist knew the background of every patient*

*and how they got circumcised and erm how er what kind of circumcision it was I think that that way it would be better (participant 5; pg. 1)*

Participant 1 illustrates the physical complications (e.g. pain) that occur at times of menstruation.

*They have many problems ok, first when the period is coming, the pain not like normal, second we also suffer from discharge (participant 1; pg. 1)*

Obstetric difficulties were reported by all participants. For some who had spoken to professionals, the process of pregnancy and giving birth was the first time they had done so.

Participant 1 highlighted how the physical complications during and following labour can affect women emotionally.

*I heard about a lady who had depression and after she had her delivery because of the complications later on..and what is it called in English..when the baby is coming and the wee wee is all coming and the baby is suddenly is coming outside and the whole body is opened..erm it's split everywhere..and she had problems from that after she had a depression so it's good for psychologists to know about these things for people.the talking to someone would be good (Participant 1, pg. 3).*

Participant 2 suggests that psychologists and other professionals have a role in explaining to women the possible problems that can occur during labour as a consequence of FGM.

*The thing I want psychologists or professionals to focus on is the labour aspect of things as well because I've got a cousin who was close to death when she gave birth and she suffered haemorrhage and it was so so bad it was like a pool of blood net to her it was it was horrific (participant 2; pg. 6).*

'Traumatic' childbirth experiences were described by many participants, highlighting some of the issues that women might present to psychology with. Clear links were made by some participants between obstetric problems and emotional difficulties. Furthermore, the need for professionals to talk to women about FGM prior to labour was highlighted.

The impact of FGM on sex and relationships was described by all participants. Painful or uncomfortable sex was the most frequently reported implication and the impact upon relationships of such difficulties were described.

Participant 3 talked about her experience of painful sex and the impact of this on her relationship with her husband. She drew attention to the importance of clinical psychologists being aware of the effect of FGM on sex and relationships.

*After I married it was very difficult you know..especially in sexual relations with my husband it did effect you know because it is erm very painful...you know that people are not erm need to know that FGM effects the psychology and after I married it was very difficult you know because it's erm very painful...so it's better if psychologists know about the background (participant 3; pg. 1)*

Participant 2 talked about how the problems in relationships that can be caused by FGM can lead some women to feel responsible for their partner's infidelity.

*One friend has never been married and the other sister is 30 and her husband has cheated in her...she's got 2 sons at home and he's cheated on her and everything with her comes back to that [FGM] and she thinks that if that was ok then none of this would have happened and so the blame...to think about how it's made them feel and how it's made them sort of see themselves (Participant 2, pg. 5).*

Participant 5 talked about the importance of sex within marriage and how sexual difficulties related to FGM could lead to the breakdown of relationships.

*Because some women erm..are what is the word..are not receptive..erm receptive to erm marital to erm sex so lots of people there might be problems there they could develop problems there and obviously then there will be a problem with the marriage and erm er there will be erm...I don't know maybe the man will go somewhere else or they will divorce (participant 5; pg. 4)*

Concerns about their partners “going somewhere else” for sex appeared to place pressure on some women to engage in sexual activity despite it being painful for them. This also appeared to be the case for women who experienced difficulties with sex as a result of a loss in sexual desire, something that was reported as common amongst participants.

Participant 2 illustrated this.

*It's the whole thing about pleasing your partner with sex the whole thing about it's not about them necessarily it's about their partner..I can't feel anything but sometimes I have to fake things (participant 2; pg. 4)*

Feelings of loss were reported by many participants to be related to the physical consequences of FGM. Loss associated with something physically being removed was described by some participants as was loss in relation to missing out on particular experiences, such as sexual enjoyment and desire.

Participant 2 describes the impact upon women of having a part of their body physically removed.

*What it is it's erm everyone is aware of FGM and of their situation...they are aware that they have been mutilated I call it that...they are aware that they have been mutilated and that part of them is gone they know that and erm it effects them in many ways (participant 2, pg. 4)*

Participant 3 illustrates the role of clinical psychologists in helping women to discuss issues of loss.

*You know how you grow up...something has been taken from you and you can't take it back and nobody knows about it and you think you can't talk about it and it's better to talk you know and psychologists can help you do this (participant 3; pg. 3)*

Participant 6 reported the ways in which some women can miss out on particular experiences in the future because of the traumatic experience of FGM.

*In Sudan I saw some people they do this operation they bind the girls legs for like a few days...she cannot go to the toilet and this is really a bad experience...either some of them say we do not want to marry we do not want to have children er you know..er it's traumatic in some cases (participant 6; pg. 2)*

In particular accounts participants felt that it was important for psychologists to know that FGM is done to children. Many participants drew attention to the links between the procedure and its physical effects and the emotional experiences of women in later life.

*You know the psychologist to understand that make a connection that when something happens to the child it affects them in their late life (Participant 3; pg. 4)*

*I think they [psychologists] have to know what happened to not that woman but that kid..that child when that operation happened...they have to know what time they did this to that child (participant 4; pg. 1)*

*Maybe they don't know that FGM is a part of the problems but it's better if I think if when a person is depressed or something like that you go to the roots and find out that they might have had FGM..and er this is the important part maybe she doesn't know about it but when they put you on a bed with all the women around you and everyone and you screaming and maybe they don't*

*know and think this is all in their mind but if they talk about it they might realise that FGM is a part of that depression..the psychologist should know all these parts (Participant 3; pg. 3)*

Participant 3 clearly highlighted how the memories of undergoing FGM as a child can impact upon women's emotional wellbeing later in life.

*There is something that happens when you were a child it's there and when we get older it affects our life...we can't forget about it or know how to think about it so it is important to know..it is important that people understand (participant 3; pg. 1)*

*I think the psychologist should concentrate on how the woman how the practice was for the woman...you know you are tied and you are only a child and they bring you up and there are women around you and you don't know what's going to happen and you scream (participant 3; pg. 1)*

*Experiencing it is difficult and you can witness how the individual changes from the point that FGM happens...and the fact that their different in a sense I think that this is what psychologists need to understand (participant 2; pg.1)*

It appears that for many participants the memory of being circumcised was particularly difficult to manage as an adult. Participants pointed out that it is important for people, possibly psychologists, to explore the impact of such memories and consider how this relates to the issues women present with in later in life.

*I don't know maybe some of them won't but if they feel they can then maybe they will...talk about the difficulties and memories (participant 5; pg. 3)*

*Sometimes when they got the operation when they are a child they can remember the bleeding they remember how much they suffer they remember how they cannot pass urine for how many days some people it is like a bad bad experience in their memories (participant 6; pg. 4)*

*From my point of view I believe that what happened when you are a child affects when you are grown up..I think it's not only FGM if you are raised as though nobody loves you or cares about you it's also abuse all this stuff like FGM effects your emotion when you are older it's very painful memories (participant 3; pg. 2)*

#### **2.2.4. Theme 4: Talking about FGM**

Many participants felt that in their community women who had experienced FGM were more likely to talk to each other rather than a professional. However, there appeared to be “taboos” around talking, which placed limits on what women felt able to talk about in their community (e.g. people asked about whether they had been circumcised but did not talk about the difficulties associated with it).

*Usually in Sudan we speak to different people you speak to your neighbour you speak to your relative you speak to..you know she can talk to her mum or her aunt or her grandmother you know (Participant 6; pg. 5)*

Participant 2 illustrated the “taboo[s]” around talking that existed in her community.

*No-one discusses it at all..it's just taboo..it's just like no way no no the only time they do talk about it is when they come together and say oh my daughter's been circumcised (participant 2; pg. 6)*

*They don't talk about things like that even when a mother is about to give her daughter away..you'd expect the mother to advise her daughter but there's nothing like that they don't even talk about sex nothing...they just say to be a good wife (participant 2; pg. 5)*

Participant 3 explains that conversations about the negative consequences of FGM are avoided in her community.

*Erm I think it's better to talk yeah..but you know [laughter] in my community nobody talks about the problem of FGM (Participant 3; pg. 3)*

*It's not public in my country and nobody can read so organisations like FORWARD here...they just won't talk about any of the difficulties with FGM (Participant 3; pg. 4)*

*No one in my country thinks that FGM has effect on the woman when she gets older but there is a lot of pressure...you can't talk about anything there (Participant 3; pg. 3)*

Participant 3 reported the limits placed on talking in her community and how organisations can help to facilitate discussions about difficult issues related to FGM.

*They [people in their community] would talk about FGM but not about how it affects her when she is growing up or in her relationship with her husband or her period something like that no...only if there is like an organisation working on that issue...it's not public in my country (participant 3; pg. 4)*

The role of people outside of communities in facilitating talking about previously censored topics was emphasised by some participants. Participant 5 illustrates how clinical psychologists can offer opportunities for this.

*The..taboo of sex it's psychological so maybe this is a reason people would go to a psychologist (participant 5; pg. 4)*

Participant 4 illustrates the importance of talking about things that she might previously have felt unable to speak about.

*I would never ever talk about it never talk about it even if I have problem....not at all at all because such a bad experience I wouldn't want to talk about that but now yeah maybe it would be good to talk about it..girls ask me that girls*

*who need help now you [psychologists] can help just by talking just by talking you know (Participant 4; pg. 3)*

Some participants reported that talking might be considered differently by circumcised women living in the UK. Many felt that there was less judgement about talking to professionals in the UK, which might encourage women to seek help. Participant 6 illustrates this.

*It is completely different here..they might not tell people at home but if they live here they would [talk to a psychologist] (Participant 6; pg. 6)*

#### **2.2.4.1. Factors that Facilitate Talking**

Participants reported a number of factors that they felt would help women to talk about FGM. One of the most emphasised factors was psychologists “asking questions” about FGM.

*For me the way they [psychologists] ask questions to get answers for the person to help them to talk about FGM for them to ask questions (Participant 3; pg. 4)*

*I think the erm psychologist..ah..er.er.they should ask [about FGM] (Participant 6; pg. 4)*

Asking questions was seen by participant 5 to represent an interest from the psychologist about the issues associated with FGM. She also appears to be suggesting that a lack of exploration might suggest that the psychologist considers issues related to FGM to be “just community or minority related” and something that they choose not to concern themselves with.

*I just suppose I suppose I hope that the psychologist erm..would be interested and ask me questions and be sympathetic and not just regard it as this is another just another one of those..because some people take this as it's just*

*community related or minority related..and they're not used to it (Participant 5; pg. 5)*

Another factor that participants felt was important in helping them to talk about issues related to FGM was the way in which professionals approached and responded to the topic (e.g. in a non-judgemental, sympathetic and respectful manner).

*I'd like them to respond with me..and respect my ideas and when I talk to a lady consultant in Chelsea she respected me..when she knows I had FGM she referred me to the right place (participant 1; pg. 4)*

Participant 2 emphasised the importance of psychologists taking a non-judgemental approach. Concerns about FGM being regarded as a “cultural” issue are raised again. It appears that psychologists assuming it is simply a “cultural” matter might be experienced as invalidating by some women.

*I think that [psychologists] should not be judgemental not like er you come from a culture that does that and not being judgemental is the main sort of thing that I would want and also being sympathetic on a personal level...sympathetic on a personal level and understanding that individual person (Participant 2; pg. 6)*

Many participants highlighted that it was important that clinical psychologists had knowledge of FGM, however many felt that little was known about the practice amongst professionals

*I would hope the psychologist have erm...background about the problem about FGM some knowledge some knowledge so that they know what I am talking about...and try to help me...understanding I hope they could understand me...erm if they read about it and they understand it then they would er er..understand that it is a sensitive issue and treat it this way (Participant 5; pg. 4)*

*Understanding and having enough knowledge to deal with the persons problems...erm I think that having the knowledge at all is very important (Participant 2; pg. 6)*

*It's [knowledge] vital how can you go there and talk about FGM and they're like what? (Participant 2; pg. 6)*

*They [people in the UK] don't have any experience they have no experience...they know nothing about it..maybe the doctors..the the organisations that care about this issue but not everyone in healthcare knows about it...people just don't know...it would be good if they knew anything about it (Participant 4; pg. 2)*

*I think that women and psychologists need to be educated about FGM (Participant 3; pg. 4)*

Participant 1 reported that little is known about FGM, particularly amongst psychologists.

*Not many people know about FGM especially you psychologists (Participant 1; pg. 2)*

#### **2.2.4.2. Stigma and Mental Health Services**

Many participants described stigma associated with talking to mental health professionals. Some reported that within their communities there was little knowledge or experience of psychology and many had experienced beliefs about the association between “madness” and talking to a mental health worker.

*They go to the doctor but I think you know in my country it's a shame to go to a psychiatric doctor (participant 1; pg. 4)*

Participants 3 talked about the assumptions made about those who seek psychological support.

*I think some people might think that if they go to a psychologist that they are mad and erm but er I believe that you know inside we have things that effect the way of doing something (participant 3; pg. 3)*

Participant 6 explained that within her community people's difficulties have to be particularly severe for them to seek psychological intervention. She also described the stigma attached to seeking such support.

*In my country normally go to psychology not usually you know people don't go..the community is a little bit you know..you can find someone in the community who can find for you who can sort for you a problem and usually people go to a psychologist if it is something like erm..maybe chronic issues that they cannot solve at all..or sometimes if it is abnormal...they think if you go to a psychologist you are mad or crazy..[laughter]..if someone saw someone go to a psychologist they might say oh he's not normal he's mad (participant 6; pg. 6)*

### **3. PART TWO: Study of the experience, knowledge and training needs related to FGM amongst clinical psychologists.**

#### **3.1. PART TWO: METHOD**

##### **3.1.1. Part Two Objectives**

- 1) To explore clinical psychologists' knowledge and understanding of female genital mutilation (FGM).
  
- 2) To explore the training needs of clinical psychologists in relation to the topic of FGM.

##### **3.1.2. Participants**

Participants for this part of the study were all qualified clinical psychologists working in any service. This decision was taken because people who are affected by FGM could present in any service setting. Participants had been qualified between 0 and 30 years and both female and male psychologists participated in the research. It was not necessary for participants to have worked with a client who had experienced FGM.

##### **3.1.3. Materials**

An online survey was developed using the survey monkey website ([www.surveymonkey.com](http://www.surveymonkey.com)) which aimed to collect information about a number of areas. A brief description together with a rationale for the items included is presented below. The survey is presented in Appendix 5.

The rationale for using a survey was that it allowed data to be collected from a large number of participants. The use of a survey along with the method of recruitment also ensured anonymity of participants.

### 3.1.3.1. Designing the Survey

The survey was developed using guidelines recommended by Barker et al (2003). This involved a number of considerations:

1. Care was taken to make the experience of completing the survey as engaging as possible. The busy schedules of clinical psychologists were taken into account and anything that might be considered too lengthy was adapted or left out if not necessary.
2. The questionnaire was designed attractively with a readable layout and typeface. The language used also aimed to be understandable.
3. The survey used both open ended and closed questions.
4. Topics were ordered in a logical sequence and transitions between topic areas were made as smooth as possible.

The survey consisted of 10 questions in total, including multiple choice and qualitative sections. These were split into four sections:

1. *Demographic information:* This section asked about participants' gender and ethnicity.
2. *Professional context:* This section asked about participants' location and the length of time they had been qualified as a clinical psychologist. Participants were also asked about their therapeutic orientation and the service setting in which they worked (e.g. adult services).
3. *Experience and knowledge of FGM:* This section asked about whether the participant had ever worked with a client who had experienced FGM; whether issues related to FGM were discussed as part of the therapeutic work and what the particular issues (if any) were.

4. *Training needs:* This section asked participants about whether they had received any training on FGM; what type of training they had experienced; their confidence in working with FGM related difficulties and what training they would require in order to feel confident working with FGM.

The survey was designed by the primary researcher in consultation with the research supervisor. A pilot survey was given to 12 trainee clinical psychologists and feedback requested included; how understandable the survey was; ease of use and time taken to complete. The feedback was minimal other than minor clarifications of some of the terms and all trainees reported finding the survey straightforward and easy to complete.

#### **3.1.4. Part Two Procedure**

The email asking for participation included a link to the survey, located on the survey monkey website. If participants clicked on the link they were firstly shown a copy of the information sheet (Appendix 3). Informed consent was assumed if the participant then went on to complete the survey. The use of the survey monkey website ensured confidentiality as the responses were collated anonymously by the website rather than sent directly to the researcher.

Participants were recruited via an email that was sent by the primary researcher and research supervisor to qualified clinical psychologists in the south east of England. Clinical psychologists who received the email were also asked to forward the email to other clinical psychologists. As it is impossible to know how many clinical psychologists received the email the response rate is not known. It was initially hoped that the email could be sent to all clinical psychologists in the Division of Clinical Psychology (DCP) at the British Psychological Society (BPS) however, a change in rules at the BPS meant that this was not possible.

Exclusion criteria were unqualified psychologists (e.g. assistants and trainees). This decision was made as the aim of the research was to find out about the experiences and training needs of clinical psychologists who had completed their training.

Barker et al (2003) have discussed the use of internet based surveys for research. They point out that the internet has the advantage of providing access to a wider potential sample of respondents. They do however highlight that using any survey in research can result in data that is limited in terms of richness and description. The survey remained open on the website for participation for six months. Once a decision was made to close the survey, the researcher analysed the data.

### 3.2. PART TWO: ANALYSIS AND RESULTS

Total responses and percentages were gathered and documented for the quantitative answers. Questions that required a qualitative response were analysed using content analysis, following the guidelines suggested by Braun and Clarke (2006). This enabled patterns to be drawn from the data and then counted to establish the frequency of particular responses (e.g. training on how to talk about FGM). This process involved:

1. The researcher familiarising themselves with the data by reading and re-reading through the responses.
2. Key words were then identified and given a code.
3. Once all key words were coded the researcher counted the occurrence of these words and documented them in the results table. The process of counting was repeated four times to ensure that the numbers documented were correct.
4. Furthermore, inter-coder reliability was performed by another trainee.

#### 3.2.1. Reliability and Validity

Issues of reliability and validity were addressed in the manner described by Miles and Huberman (1994). Another trainee agreed to act as a second coder. They were provided with the qualitative responses to the question about required training (which had gained the most responses) along with a list of the researcher's codes. They then coded the responses using the existing codes and adding any others that seemed relevant. Inter-coder reliability was calculated as follows.

$$\text{Reliability} = \frac{\text{number of agreements}}{\text{Total number of agreements + disagreements}}$$

This resulted in agreement of 82%. According to Miles and Huberman (1994), agreements of 70% and above indicate acceptable levels of agreement. Issues of validity were addressed through regular discussions with the research supervisor, (who was familiar with the data) considering extracts from the responses and their relationships to the identified themes.

### **3.3. PART TWO RESULTS**

The total number of responses received for the survey was 76. Two participants were excluded as they were trainee clinical psychologists. This left a total sample size of 74.

#### **3.3.1. Demographic Information:**

##### *3.3.1.1. Gender*

The majority of participants were female (female = 82.4%, male = 17.6%). The significantly higher percentage of women participants appears to be representative of the distribution of gender within the profession.

**Table 1: Gender**

<b>Gender</b>	<b>Responses (N=74)</b>	<b>Percentage of responses (%)</b>
Female	61	82.4
Male	13	17.6

##### *3.3.1.2. Ethnicity*

Ethnicity was self-defined by participants and represented a diverse sample. Although participants appeared to be from a range of ethnicities, the majority of participants described themselves as 'White British' (56.2%).

**Table 2: Ethnicity**

<b>Ethnicity</b>	<b>Responses (N=73)</b>	<b>Percentage of responses (%)</b>
White British	41	56.2
White European	7	9.6
British Asian	6	8.2
Mixed (not otherwise specified)	5	6.8
Black British	4	5.5
Irish	2	2.7
White Irish	2	2.7
Afro-Caribbean	1	1.4
African	1	1.4
Asian	1	1.4
White Spanish	1	1.4
White Australian	1	1.4
White USA	1	1.4

**3.3.2. Professional Context***3.3.2.1. Years qualified as a clinical psychologist*

Over half of participants had been qualified as a clinical psychologist for between 2-10 years. However, the length of time participants had been qualified ranged from 0-30 years. Given the lack of knowledge and training experiences reported later it is interesting that the majority of participants were more recently qualified.

**Table 3: Years Qualified**

<b>Years qualified</b>	<b>Responses (N=69)</b>	<b>Percentage of responses (%)</b>
0-1	10	14.5
2-5	24	34.8
6-10	17	24.6
11-15	9	13.0
16-20	5	7.2.
21-25	2	2.9
26-30	2	2.9

### 3.3.2.2. Service Area

Psychologists from a range of service areas participated in the research. The majority of participants worked in adult mental health services (57.6%). Child and family services were the second most common service area (27.2%).

**Table 4: Service Area**

<b>Service area</b>	<b>Responses (N=66)</b>	<b>Percentage of responses (%)</b>
Adult Mental Health	38	57.6
Child and Family Services	18	27.2
Sexual Health	7	10.6
Learning Disabilities	6	9.1
Forensic	4	6.06
Older Adults	3	4.5
Health	2	3.0
Addictions	2	3.0
Neuropsychology	1	1.5
Trauma Services	1	1.5
Early Intervention	1	1.5
Specialist Services	1	1.5

### 3.3.2.3. Therapeutic Orientation

50% of participants described their therapeutic orientation as cognitive behavioural. Integrative and systemic approaches were the second and third most common orientation.

**Table 5: Therapeutic Orientation**

<b>Therapeutic Orientation</b>	<b>Responses (N=74)</b>	<b>Percentage of responses (%)</b>
Cognitive Behavioural	37	50
Integrative	29	39.2
Systemic	19	25.7
Psychodynamic	3	4.1
Positive Behaviour Support	1	1.35

#### 3.3.2.4. *Part of the Country*

The majority of participants worked in the south east of England, which includes areas of great diversity such as London. This is interesting when considering the finding that many participants had little knowledge and minimal experience of working with FGM.

**Table 6: Part of the Country**

<b>Part of the country</b>	<b>Responses (N=73)</b>	<b>Percentage of responses (%)</b>
South East (inc. London)	69	94.5
South West	1	1.4
East Midlands	1	1.4
North East	1	1.4
Wales	1	1.4

#### 3.3.3. Knowledge and Experience of working with FGM

##### 3.3.3.1. *Participants who had worked with a client who had experienced FGM*

Half of the participants reported that they had never worked with a client who had experienced FGM. A large number of participants did not know whether they had. Only 9.5% of participants knew that they had worked with a client who had experienced the practice.

**Table 7: Participants who had worked with a client who had experienced FGM**

<b>Worked with client who had experienced FGM</b>	<b>Responses (N=74)</b>	<b>Percentage of responses (%)</b>
No	37	50
Yes	7	9.5
Don't Know	31	41.9

##### 3.3.3.2. *Issues related to FGM discussed as part of work*

5 out of the 7 participants who had worked with a client who had experienced FGM had discussed the circumcision as part of their work.

**Table 8: Participants who had discussed issues related to FGM as part of the work**

Were Issues related to FGM discussed as part of the work?	Responses (N=7)	Percentage of responses (%)
Yes	5	71.4
No	2	28.6

### 3.3.3.3. Issues discussed in work with client

Participants who answered 'Yes' to the above question (n=5) reported the issues discussed during their work. The most common issue raised in their work related to the reversal of FGM. There were a range of other issues related to FGM that were discussed, such as negotiating sexual relationships, sexual difficulties/pleasure and trauma. Issues related to feeling oppressed by the practice, anger about being circumcised, seeking asylum and wanting to help other women were further issues discussed. One participant had discussed with a client issues related to their circumcision being misunderstood and not respected by services.

**Table 9: The issues related to FGM that were discussed during clinical work**

Issues discussed	Responses (N=8)	Quotes
Reversal	3	<i>"she was thinking about having it reversed"</i> <i>"reversal during pregnancy &amp; concerns about what family and husband would think"</i>
Sexual relationships	2	<i>"negotiating sexual relationships"</i> <i>"enjoying sexual relationships in the context of FGM"</i>
Sexual difficulties/pleasure	2	<i>"sexual problems, e.g. pain on intercourse, lack of desire"</i> <i>"routes to sexual pleasure"</i>
Trauma	2	<i>"the client explained her experience of this as traumatic"</i> <i>"post-trauma stress type reactions"</i>
Oppression	1	<i>"the clients explained her experience of this as...oppressive"</i>
Health anxiety	1	<i>"health anxiety related to possible pregnancy and STI"</i>

Issues discussed	Responses (N=8)	Quotes
Flashbacks	1	<i>“flashbacks’ during sex”</i>
Anger	1	<i>“anger about being circumcised”</i>
Being misunderstood/not respected by services	1	<i>“feelings of being misunderstood by services or not having the importance of circumcision respected”</i>
Desire to help other women	1	<i>“desire to help other women &amp; determination not to have their daughters circumcised (more than one client)”</i>
Seeking asylum	1	<i>“FGM as a reason for seeking asylum”</i>

### 3.3.4. Training Needs

#### 3.3.4.1. Source of FGM Training

This question asked participants who had received training on FGM about the source of the training. Some participants answered the question despite not having had any training (e.g. by selecting the ‘other’ option and reporting ‘none’). 72% of participants are therefore reported to have had no training although, it could be assumed that those 49 who did not answer the question had also received no training. Of the participants who had received training the majority had sourced this themselves through their own reading or contact with organisations concerned with FGM.

**Table 10: Source of FGM Training**

Source of Training	Responses (N=25)	Percentage of responses (%)
None	18	72
Independent reading	2	8
Information from organisations	2	8
Undergraduate degree	1	4
Conference	1	4
Research based training	1	4

### 3.3.4.2. Content of the previous training received

Over a quarter of those participants who answered this question reported that their training took place on a child protection course. FGM training was included as part of cultural awareness training for two participants. Independent reading was again reported as a source of training. Most of the training on FGM appears to have occurred as part of training in another area (e.g. trauma or child protection), therefore FGM has often only been “touched [up]on”. No specific FGM training was reported by participants.

**Table 11: Content of the Previous Training**

<b>Content of that training received</b>	<b>Responses (N=12)</b>	<b>Quotes</b>
Child protection training	3	<i>“discussion as part of child protection training”</i>
Training on cultural awareness	2	<i>“mentioned in some training on cultural awareness”</i>
Independent reading	2	<i>“reading articles and research about FGM”</i>
Training on self mutilation	1	<i>“regarding self-mutilation, touched on forced FGM nothing in depth”</i>
Information leaflets	1	<i>“information leaflets about the scope of FGM”</i>
Training on trauma	1	<i>“training in relation to trauma”</i>
Video and discussion	1	<i>“video and discussion”</i>
Training linked to research	1	<i>“training based on discussions with key-informants and other relevant academic professionals as part of research project”</i>
Training on working with African communities	1	<i>“the training was “working with African communities in relation to HIV prevention” – FGM was only touched on”</i>
FGM training (not otherwise specified)	1	<i>“different forms of FGM, psychological consequences, ethical considerations, UK law”</i>
Session from physician	1	<i>“very helpful session from a physician”</i>

### 3.3.4.3. Confidence in working with issues related to FGM

The majority of participants felt ‘not at all’ or only ‘somewhat confident’ in working with issues related to FGM. No participants reported that they were ‘very confident’. This might be associated with the lack of training about FGM experienced by participants.

**Table 12: Participants’ confidence in working with issues related to FGM**

Confidence Level	Responses (N=56)	Percentage of responses (%)
Not at all confident	25	44.6
Somewhat (a little) confident	24	42.9
Fairly confident	5	8.9
Confident	4	7.1
Very confident	0	0

### 3.3.4.4. Required Training

Participants reported the training they required in order to feel confident in working with the issues of FGM. Many participants suggested that training about the contexts of FGM (e.g. cultural, religious, political and legal) would be useful. Knowledge about the impact of FGM (e.g. physical, emotional and sexual) was also a common training need. How to talk about FGM appeared to be a concern for some participants and training was felt to be necessary in this area. The range of responses appears to demonstrate that participants knew very little about FGM. Most participants appeared to regard training on the topic of FGM as valuable.

**Table 13: Training required in order to feel confident in working with FGM**

Training required	Responses (N=70)	Quotes
Cultural and religious context of FGM	25	<i>“cultural and religious context of FGM”</i> <i>“relevant cultural/religious beliefs that might impact on this issue”</i>
Psychological impact of FGM	15	<i>“information about the likely psychological effects on victims of the procedure”</i> <i>“overview of the issues and what the psychological difficulties are”</i>

<b>Training required</b>	<b>Responses (N=70)</b>	<b>Quotes</b>
Physical impact of FGM	14	<p><i>“the impact it has physically...and the longer term implications”</i></p> <p><i>“training regarding the biological consequences”</i></p>
How to talk about FGM	12	<p><i>“I have had experience of but have not felt able to speak about, through my own ignorance of the subject...so training looking at ways of facilitating discussion about FGM would be helpful”</i></p> <p><i>“exploring ways of sensitively asking about experiences of FGM would be useful”</i></p>
Introduction to FGM	12	<p><i>“Practical medical info on what it exactly describes “</i></p> <p><i>“the basics – what is it”</i></p>
How to work therapeutically with FGM	9	<p><i>“specific training about working therapeutically with women who have experienced FGM would be useful”</i></p> <p><i>“some ideas on what women find most useful from psychological support/intervention”</i></p>
Trauma based training	6	<p><i>“trauma-focussed CBT for PTSD as a result of FGM”</i></p> <p><i>“understanding the trauma profile of these clients”</i></p>
Service user led training	6	<p><i>“training from women who have experienced FGM or whose community or origin practices FGM”</i></p> <p><i>“more input from women who have experienced FGM – what they would see as the important issues”</i></p>
Reasons for FGM	5	<p><i>“anything that contextualised FGM, the reasons for it”</i></p> <p><i>“why it is performed”</i></p>

<b>Training required</b>	<b>Responses (N=70)</b>	<b>Quotes</b>
Training on the support groups/organisations available	5	<p><i>“information about groups or organisations or on-line forums”</i></p> <p><i>“information about agencies in the UK who know about this issue and how to access their knowledge”</i></p>
Political and legal context of FGM	4	<p><i>“I would like to know about the political and legal contexts to FGM”</i></p> <p><i>“information about the scope for retrospective justice for women who underwent FGM illegally as children, or were taken out of the country for FGM”</i></p>
How to find literature about FGM	4	<p><i>“be interested in finding important literature in the area”</i></p> <p><i>“I would like to know where to find relevant literature on FGM”</i></p>
How to manage personal responses in therapy	3	<p><i>“how to address my feelings of the horror of it and the powerlessness of the women involved”</i></p> <p><i>“personal therapy. I would find such work extremely traumatic”</i></p>
FGM and sexual health	2	<p><i>“clear information on procedure and consequences for women experience of sex (e.g. pleasure affected)? Can retain ability to have orgasms?, pain)”</i></p> <p><i>“training on the sexual problems experienced by women”</i></p>
Training based on qualitative research in the area	2	<p><i>“Qualitative research regarding clients’ experience”</i></p> <p><i>“Qualitative research regarding community members perspectives”</i></p>
Training on the Impact on families and relationships	2	<p><i>“information about the impact on families, for example generational differences in attitude towards the issue”</i></p> <p><i>“more on relational aspects”</i></p>
Myth busting	1	<i>“information about what assumptions are made; some ‘myth busting’ about what FGM is and isn’t”</i>

## **4. DISCUSSIONS**

This chapter will review the findings from part one and two of the present study and discuss them in relation to the findings of previous research. This will be followed by a general discussion, which will summarise the findings from part one and two and make links between them. Furthermore, recommendations for clinical practice and future research will be discussed along with a critique of the study.

### **4.1. PART ONE: DISCUSSION**

Four super-ordinate themes were identified. These will be summarised and discussed in relation to the question of what women want clinical psychologists to know when working with issues related to FGM.

#### **4.1.1. Accounting for FGM**

All participants in the current study talked about the reasons given for the practice of FGM. In particular, participants emphasised beliefs in their communities about FGM ensuring chastity and fidelity. Much of the previous literature on FGM has highlighted the use of female circumcision to control female sexuality, through claims that it ensures chastity and faithfulness in marriage (e.g. Lockhat, 2004, Penn & Nardos, 2003 and Dorkenoo, 1995). All participants described beliefs in their community about a link between FGM and religion. However, all reported that FGM was not a religious obligation in Islam but was instead driven by cultural expectations (e.g. encouraged by community members rather than religious leaders). Braddy et al (2007) support these findings. They report that FGM is not espoused by a specific religion but continues to be practiced as a result of cultural beliefs about its functions (e.g. to maintain virginity and fidelity, for the social and sexual control of women and to enhance sexual pleasure for men). Morison et al (2004) also report the link between religion and FGM. They found that the belief that FGM is a religious requirement had been reported as a reason for the practice in several surveys conducted with Somalis. They did however find that this belief was less prevalent amongst Somalis who had migrated to London at a young age. Participants appeared to be highlighting that it is important for clinical psychologists to consider the impact of the justifications that are communicated to women. For example,

beliefs about FGM being a religious or cultural obligation might be associated with feelings of guilt or betrayal by women who undergo particular interventions (e.g. reversal prior to labour) or talk to professionals about the negative consequences of the practice.

In the current research participants appeared to be emphasising a need for professionals working with FGM related issues to consider the context of the practice. Their accounts suggested the importance of considering the gender inequalities in some communities that perpetuate the practice and result in many women feeling powerless to make independent decisions about FGM. Braddy et al (2007) conducted a review of the literature on FGM and recommended that as the practice is often steeped in tradition, professionals working with FGM should develop an awareness of and sensitivity to the cultural and historical context of the practice. The lack of independent choice for women regarding the circumcision of their daughters was further illustrated through participants' reports about the pressures to circumcise. Pressure was said to come from a range of sources (e.g. men, women, family and community members) and was reported by participants to be responsible for the maintenance of FGM in their communities. Within some of the previous literature it is acknowledged that decisions about circumcision often do not rest on an individual but are instead made within a social system that carries implications for not doing so, such as refusals to marry (e.g. Dorkenoo, 1995). Participants seemed to be highlighting the importance of clinical psychologists knowing about the lack of individual choice and the emphasis on marriage, chastity and fidelity within many communities that practice FGM. These issues might be particularly salient in clinical practice when working with issues that are affected by this, such as rape or consenting sex before marriage or divorce and remarriage.

#### **4.1.2. Differences across Time and Place**

A change in the views towards FGM was reported by many participants in the current research. Participants described the change in opinion towards the practice that had occurred over time and between different contexts (e.g. villages and cities). Most participants felt that the practice was beginning to be looked upon less favourably by some, for example, those who live in more urban areas.

Participants emphasised that psychologists should know about these changes when working with women who had been circumcised. One interpretation of this was that participants wanted to highlight that there were individual opinions about FGM and people should not be assumed to hold the same beliefs simply because they are from the same family, community or culture (e.g. different members of a family, particularly different generations may hold different views). It might also be interpreted as an effort by participants to demonstrate their distance from the practice. Participants appeared to be reporting that these assumptions could lead to their experiences being invalidated or dismissed by professionals who make assumptions about how they feel in relation to the practice. Participant 5 describes her concerns about the assumptions psychologists might make.

*I suppose I hope that the psychologist erm...would be interested and ask me questions and be sympathetic and not just regard it as this is another just another one of those..because some people take this as it's just community related or minority related (Participant 5; pg. 5)*

A consideration of different views and changes in personal opinions about the practice might be particularly important in clinical consultations with women who have migrated to the UK. They may come to view FGM differently and have different views towards it at different times in their lives (e.g. feelings of loss and anger associated with circumcision later in their life). Beckett and Macey (2001) highlight how assumptions about FGM being a “cultural matter” have resulted in those outside of the practice believing that it is something they should not concern themselves with.

Participants discussed the factors that had influenced the changes in views. Many reported that education had played a role in facilitating different views. The education seen as responsible for change did not appear to be solely associated with FGM awareness but also the broadening of individual perspectives through education outside of communities (e.g. amongst some of the younger generations) and an increase in the economic independence of some women. The impact of migration was also reported to have facilitated broader perspectives about FGM,

where the difficulties associated with the practice were beginning to be acknowledged. Morison et al (2004) reported the influence of migration to London upon the opinions towards FGM amongst young people originating from Somalia. They reported that participants who had moved to the UK at a younger age were more opposed to the continuation of FGM. Almroth et al (2000) conducted a community based study in a Sudanese village and found that there had been a significant shift in the practice between generations with young parents beginning to question the value of FGM.

#### **4.1.3. Impact of FGM**

Many consequences of the practice were discussed by participants. These included; physical complications, such as painful menstruation and problematic childbirth and emotional difficulties, for instance feelings of loss. The physical difficulties associated with FGM have been documented in the previous literature. Toubia (2004) and Banks et al (2006) reported similar findings to the current research; they found that women often experienced difficulties related to menstruation, infections, psychosexual difficulties and obstetric complications. Participants also highlighted the need for clinical psychologists working with adult women who had experienced FGM to hold in mind their experience of circumcision as a child. They appear to be suggesting that psychologists need to take a developmental perspective, where the meanings and understandings of the practice at the time of circumcision are considered. Many participants described traumatic memories of the procedure and the psychological impact of these, such as sadness and fear. The emotional impact of FGM has been discussed in some of the previous literature as 'PTSD' (e.g. Lockhat, 2004). However, this construction can be critiqued in relation to its Eurocentric assumptions. The current study attempted to avoid imposing such assumptions through using the language of participants, whilst some used the word 'trauma' they did not describe the consequences as 'PTSD'. Western diagnostic categories might also detract from the cultural context, which participants felt should be considered in a formulation of their difficulties. This is not to suggest that drawing from other areas of knowledge would not be useful (e.g. existing literature on difficulties in childbirth) rather that professionals should be aware of the potential to pathologise or de-contextualise through the use of psychiatric classifications. The

tendency amongst professionals to use such terminology to categorise difficulties was also evident in some of the responses to questions about training needs in the survey for part two of the study.

*[training on] trauma-focussed CBT for PTSD as a result of FGM (clinical psychologist)*

Above all participants emphasised that the physical and emotional impact of FGM were inextricably linked and should not be viewed as separate by professionals. The tendency to separate psychological from the physical can be seen in the literature around FGM, where much of the research has investigated the physical consequences of the procedure with little mention of the psychological. Psychological research into FGM, albeit minimal, has also paid little attention to the relationship between the ongoing physical complications and psychological difficulties. Lockhat (2004) made links between the psychological and physical difficulties (e.g. anxiety related to menstruation). However, the emotional impact described by participants in the current study appears to go further than psychological 'conditions'. There has been a tendency within traditional western psychological theory and medicine to view the mind and body as separate. The positivist era with its language of biomedical science brought with it descriptions of human bodies that were separated from their cultural context (Atkinson, 1995). Furthermore, as medicine became dominated by the Cartesian notion of the mind-body split, physical processes became separated from their meaning and science and medicine studied body parts as though separated from the whole person (Hudak et al, 2007). Participants in the current study appeared to be asking for professionals to approach their difficulties from a more holistic perspective, considering how the body and what is done to it play in shaping the mind (e.g. embodiment).

*I wish if I can go to the psychologist I can talk about everything...you know to connect every part of the person to get a whole picture reflect what he or she think about the whole picture (Participant 3; pg. 3)*

#### **4.1.4. Talking about FGM**

Participants described the ways in which FGM was talked about in their communities. A common experience was that whilst FGM was acknowledged the difficulties associated with it were not. Participants reported “taboos” about talking, particularly in relation to highlighting the negative consequences of the practice. Penn and Nardos (2003) described the cultural prohibition that forbids women from discussing concerns regarding FGM and sexuality. These restrictions around talking can have a number of consequences, such as possible isolation leading to a reduction in social support; a lack of language with which to name difficulties and a reduced likelihood of initiating discussions about FGM with professionals. Reder and Fredman (1996) highlighted the impact of previous experiences of help and talking on the expectations people have for future helping experiences. This could have implications for clinical practice where women might feel apprehensive about discussing issues that have previously been off limits.

Participants spoke about what helped people to talk, in particular they pointed out what psychologists could do to help women who had undergone FGM to discuss their difficulties. Many participants reported that clinical psychologists should take a non-judgemental approach to FGM and respond sensitively to the difficulties that women present with. Kontoyannis and Katsetos (2010) emphasised the need for professionals to take an uncritical, non-judgemental approach to working with FGM in order to ensure that women are not further alienated by their experiences. Whitehorn et al (2002) recommend that it is essential for professionals to demonstrate adequate knowledge and awareness of the origins, traditions and psychosocial implications of FGM. This supports the findings in the current research. A particular theme within participants’ accounts was that they wanted clinical psychologists to ask them questions about the practice. Concerns regarding professional knowledge of FGM appeared to act as a barrier for women in raising issues related to this in consultations.

*They have to ask what happened to this woman...if they ask questions the woman can talk but they don't always ask questions (Participant 4; pg. 4)*

Eke and Nkanginieme (1999) support this finding by suggesting that professionals have a tendency to shy away from the issue of FGM through fears of being culturally out of depth. They warned that this could cause neglect of the medical and psychological needs of women who have experienced circumcision. Whilst participants are clearly saying that they want clinical psychologists to ask them about FGM, it is important to consider how this would work in clinical practice. For example, should psychologists ask all women if they have undergone FGM? Should they only ask those women from communities that are known to practice FGM? This raises particular considerations for training, particularly with regards to how professionals can address FGM in clinical work.

Furthermore, participants described the barriers to talking that might be experienced by many women in relation to seeking help for issues related to FGM. A major factor in the accounts of participants appeared to be the stigma attached to seeking help from mental health professionals. Many described an association within their communities between mental health support and “madness”. However, some participants acknowledged a change in the views about mental health services amongst circumcised women living in the UK. They felt that women in the UK were more likely to seek psychological support for difficulties linked to FGM, although they suggested that there might be some secrecy about doing so. Previous research has paid little attention to the stigma associated with seeking psychological support within FGM practicing communities. However, Braddy et al (2007) highlight the concerns of some women about how FGM might be judged by healthcare professionals in industrialised countries. They suggest that this might prevent women from speaking openly about FGM.

The part two discussion will consider the experiences, knowledge and training needs of clinical psychologists. Interestingly many of the themes from part one emerged in part two of the study.

## **4.2. PART TWO: DISCUSSION**

This section will review the results from part two of the study. An anonymous survey was used to explore the experiences, knowledge and training needs amongst clinical psychologists with regards to FGM.

### **4.2.1. Experience of working with FGM amongst clinical psychologists**

The majority of survey respondents were based in London and the south east of England and reported to be working in a variety of services. Most participants were female (82.4%). Whilst this might be representative of the gender distribution in the profession it could also represent beliefs about who should involve themselves with the issue of FGM (Beckett & Macey, 2001). One respondent to the survey illustrates this view below.

*I would consider it likely to be more helpful if female therapists were available to work with women who have suffered FGM (clinical psychologist)*

The findings in the current study suggest that the participants had minimal experience of working with women who had undergone FGM. 91% of participants reported that they had not worked with or did not know whether they had worked with a client who had experienced FGM. Previous research has attempted to account for why some professionals in the west might not have encountered FGM, despite its increased prevalence. Firstly; some authors have suggested that women might avoid discussing FGM in clinical consultations through fear of being judged (Braddy et al, 2007). Secondly; some professionals might avoid discussing or intervening with issues related to FGM because of concerns about how this might be experienced by clients (e.g. as racism) (Whitehorn et al, 2002). Furthermore, the findings from part one of the study suggest that there might be barriers to accessing services for FGM related difficulties, such as women being unaware of the services that could provide support and the stigma within some communities associated with consulting mental health professionals.

Some participants reported to have worked with a client that they knew had been circumcised (N=7). Of the seven participants who reported this, five of them had discussed FGM as part of their clinical work. Participants reported that the issues discussed during their consultations were predominantly related to the impact of FGM (e.g. physical, psychological and sexual) and the reversal of the procedure. Further issues described by participants included; negotiating sexual relationships, oppression, health anxiety, flashbacks, anger about the procedure, helping other women, feeling misunderstood by services and FGM in relation to seeking asylum. Previous research reports similar varied findings about the issues that women who have undergone FGM are likely to present to services with (e.g. sexual health problems, Alsibiani, 2010; psychological difficulties, Behrendt et al, 2005 and physical complications, Penn & Nardos, 2003). The findings in the current study suggest that women experiencing FGM related difficulties are likely to present in a range of settings (e.g. primary care, adult mental health, older adult and sexual health services). This emphasises the need for clinical psychologists working in all settings to improve their knowledge about the practice.

#### **4.2.2. Knowledge of FGM amongst clinical psychologists**

The clinical psychologists who had discussed FGM in their consultations reported that they had received minimal training on how to work with the issue. The main sources of training were reported to be from independent reading and information gained from organisations associated with FGM (16%). Only 12% of participants had received what might be considered to be formal training through educational courses, conferences and research development and even these were described to only “*touch on*” the subject of FGM (e.g. as part of child protection or cultural awareness training). What participants appear to be suggesting is that most training has been self-facilitated. Some guidance for working with FGM is available through organisations such as FORWARD (e.g. Adamson, 1992). However Lockhat (2004) pointed out that these materials are sparse and lack any ‘hands on’ guidance to professionals. The current findings also suggest that professionals are likely to inform themselves about FGM only when it is encountered within their work. This could have implications for engaging women who might experience professionals in the first instance as being unknowledgeable about the practice. This is supported by

Lockhat (2004) who reported that participants in her research experienced professionals in the UK as being unknowledgeable about FGM. Whitehorn et al (2002) advise that specialist services alongside better training in generic services would help improve the knowledge amongst professionals and provide a gateway to psychological services for women presenting with FGM related difficulties.

#### **4.2.3. Confidence and training needs amongst clinical psychologists**

Many participants (44.6%) reported feeling that they were 'not at all confident' in working clinically with issues related to FGM and 42.9% reported only feeling 'somewhat confident'. In order to increase their confidence participants reported a range of training needs. The majority wanted training to include; a "*basic*" introduction to FGM, including information about the contexts within which it is practiced (e.g. cultural, religious, political and legal), and reasons for the practice. They also wanted knowledge about the impact of FGM (e.g. physical, psychological and sexual) and training on how to work therapeutically, in particular how to talk to women about the practice. Some participants reported that they would not know how to raise the topic of FGM in consultations with clients and felt that it would be useful for training to explore sensitive ways of doing so. Some participants recognised the impact upon themselves of working with such a highly emotive topic. They felt that training should address the impact of such work upon therapists and offer advice on how to manage personal responses to clinical work involving FGM. Having knowledge of the practice before working with a client might also help psychologists to feel less "*shocked*" by what they hear during clinical work. Furthermore, participants suggested that service-user led training would be helpful in improving their knowledge and skills in working with women who had experienced FGM.

### **4.3. GENERAL DISCUSSION**

The study employed both qualitative and quantitative methods in order to address the research aims. These were; to explore the views of FGM amongst women living in the UK and their ideas about what clinical psychologists needed to know to provide more helpful services to them. And to investigate clinical psychologists' knowledge about FGM, their experiences of working with issues related to the practice and their training needs. This section will summarise the findings from part one and two of the study and make links between them. Recommendations for clinical practice and future research along with a critical review will follow.

#### **4.3.1. Part One: Summary of Findings**

Part one of the study indicated that participants had been provided with a range of justifications for the practice of FGM but felt that none were acceptable as a reason for the practice. The findings suggest that participants wanted clinical psychologists to have knowledge about how the practice is accounted for (e.g. the reasons for it and the contexts within which it exists). They felt that they should improve their knowledge of the practice and subsequent difficulties and work in a way that considers how the physical and emotional consequences are connected. They suggested that psychologists should facilitate conversations about FGM during consultations by asking questions and responding in a sensitive and non-judgemental manner. Furthermore, participants wanted clinical psychologists to validate and respect their experience rather than consider it a 'cultural matter' that should be avoided.

#### **4.3.2. Part Two: Summary of Findings**

Part two of the study highlighted the experiences, knowledge and training needs related to FGM amongst clinical psychologists. The findings emphasised minimal experiences and knowledge of FGM amongst the clinical psychologists surveyed and described a variety of training needs that should be addressed in order to increase their confidence in working with the issue. This part of the study provided context to the experiences described by participants in part one of the research. In particular it shed light on the reasons why women often feel that the role of their circumcision is not acknowledged in a formulation of their difficulties.

### **4.3.3. General findings: Overlap between Part One and Part Two**

Interestingly, there was considerable overlap between the training needs reported by clinical psychologists and the recommendations made by women for improvements in psychological practice. These are reported below along with examples from the data.

#### **4.3.3.1. Accounting for FGM**

As discussed above a super-ordinate theme in part one was that of accounting for FGM. This encompassed participants' recommendations that in order to work effectively with the issues associated with FGM psychologists needed to have an understanding of the reasons for the practice and the contexts within which it occurs.

*They [psychologists] need to know how it happens to people...also the reasons for it (participant 6; pg. 2)*

The importance of understanding how and why FGM occurs was reported by clinical psychologists in part two as necessary in order to feel confident in working with women who had undergone the practice.

*"[training about] anything that contextualised FGM, the reasons for it" (clinical psychologist)*

#### **4.3.3.2. Impact of FGM**

Another theme that was reflected in both parts one and two of the current study was that of impact. Participants in part one emphasised the need for clinical psychologists to understand the range of consequences of FGM, in particular connecting the physical experience and difficulties to the emotional issues that women encounter as a result of the procedure.

*Psychologists need to have an understanding of the physical side to understand the psychological side (participant 5; pg.6)*

Again the training needs of participants in part two reflected the women's accounts of what psychologists needed to know. For instance, clinical psychologists also emphasised the importance of understanding the range of consequences of circumcision, including the physical as well as psychological.

*“[training about] the impact it has physically and psychologically and the longer-term implications” (clinical psychologist)*

#### **4.3.3.3. Talking about FGM**

The theme of talking was raised by participants in both parts one and two. Participants in part one suggested that clinical psychologists needed to help women to talk by asking about FGM in a sensitive and non-judgemental manner.

*For me the way they [psychologists] ask questions to get answers for the person to help them to talk about FGM for them to ask questions (participant 3; pg. 4)*

Interestingly, participants in part two reported a lack of confidence in talking about the topic and emphasised a need for training in order to address this.

*“exploring ways of sensitively asking about experiences of FGM would be useful” (clinical psychologist)*

One theme that was identified by participants in part one but not acknowledged in the findings from part two of the study was that of 'differences across time and place'. Interestingly, this theme reflected women's experiences of a lack of acknowledgement amongst professionals of the differences in views towards FGM and an assumption that all people from a particular culture held the same beliefs. The reasons for a lack of acknowledgement of the differences across time and place of participants in part two of the study could be for a number of reasons. Firstly; clinical psychologists might be suggesting that they require generalised knowledge from training before discussing individual views and experiences with clients. Secondly; this could represent an assumption about homogeneity amongst members

of FGM practicing communities. This finding does however support the suggestions of participants in part one that the differences in beliefs between individual members of communities are often not acknowledged by professionals.

#### **4.4. EVALUATING THE RESEARCH**

Since this was a mixed methods study, I will evaluate the study as a whole, but also include aspects specific to the qualitative and quantitative parts of the research. The guidelines for evaluating the quality and credibility of qualitative research, recommended by the National Centre for Social Research (2003) have been used.

##### **4.4.1. Contributing in Advancing Wider Knowledge**

The findings from this study contribute to the knowledge base in; understanding the experiences and views associated with FGM amongst women who have undergone the practice. It also adds to the knowledge about what circumcised women feel clinical psychologists should do to provide appropriate support for FGM related difficulties. Furthermore, it contributes to the understanding of the experiences, knowledge and training needs in relation to FGM, amongst clinical psychologists. The literature concerning the views of circumcised women towards psychological services and research into the experiences and knowledge of FGM amongst clinical psychologists is limited. There is also a lack of information and training available to clinical psychologists about the practice. This research therefore aims to address these gaps and contribute to clinical practice through its recommendations. It is also hoped that the findings from the research will be disseminated through publication and be presented back to organisations (e.g. FORWARD).

##### **4.4.2. Defensible in Design**

A qualitative method was used in part one of this research. This was considered appropriate given that little research of this type had been conducted previously. IPA was considered the most suitable method for exploring the views and experiences of FGM amongst women as well as the context in which their recommendations for psychological practice had developed. The use of a survey in part two of the study was felt to be the most appropriate approach for obtaining the required data. The rationale for using an anonymous survey was that it allowed data to be collected

from a large number of participants. Content analysis was felt to be the most appropriate method for analysing the qualitative data from the survey as it enabled patterns and frequencies to be identified.

#### **4.4.3. Rigorous in Conduct**

All procedures for data collection and analysis were followed as outlined in the method sections. Recommended guidelines for IPA (e.g. Smith et al, 2009 and Willig, 2008) were followed. An example of a transcript is provided in Appendix 6. The survey was piloted and any suggested changes were made. None of the data collected from the survey was unusable apart from two respondents who did not meet inclusion criteria (trainee clinical psychologists).

#### **4.4.4. Credible in Claim**

I have indicated where findings appear to be consistent and where they are only discussed by some participants (e.g. 'all participants reported', 'some participants reported', 'one participant reported'). In my interpretations I have attempted to avoid assumptions and thought carefully about my wording, for example, 'this suggests', 'appears to fit with'. I have highlighted factors that might have impacted on the findings (e.g. method of sampling) and discussed these further in the critical review. Furthermore, respondent-validity was carried out on the themes identified from the IPA analysis.

Overall the findings in both parts of the study reflect that training about FGM is lacking in the field of clinical psychology. This means that women who consult psychologists about difficulties related to the practice often feel that FGM is not understood or adequately addressed in a formulation of their problems. The findings have highlighted a number of recommendations for clinical practice and future research.

#### 4.5. IMPLICATIONS FOR CLINICAL PRACTICE

- 1) Awareness of FGM and its consequences should be increased amongst staff working in all service areas as women who have undergone the procedure are likely to present in a range of services. This is particularly important as many of the issues that participants in the current study described might initially result in a referral to primary care services (e.g. “depression”, sex and relationships difficulties). This does not aim to devalue the importance of specialist services for FGM rather to increase the access to appropriate help for all circumcised women.
- 2) Training should be specifically focused to the subject of FGM. The training encountered so far appears to have been adjunct to training in other areas, such as child protection. As a result little time is dedicated to the topic. Training should provide a background to FGM, with information about the reasons for the practice and the contexts within which it occurs as well as raising awareness of the range of views that may be present in communities/families. It should highlight the range of ways in which FGM can impact upon a woman’s life and encourage professionals to take a holistic approach to working with clients. Furthermore, training should help professionals to feel confident in sensitively raising the topic of FGM with clients and explore ways of talking about it.
- 3) In order to address the training needs described above a formal training package is needed. This should involve service users and circumcised women in its development. The importance of this can be seen in the current research where women have provided invaluable information about how professionals can provide better services for women who have experienced this practice.
- 4) Whilst training of currently qualified clinical psychologists is important (e.g. BPS faculties of sexual health and health might lead this), it might also be advisable to provide training about FGM on clinical psychology doctorate

courses. This would raise awareness of the issue amongst future clinical psychologists meaning that the support for women who had undergone FGM would be more informed and consistent wherever they present.

- 5) Professionals working with women who have experienced FGM should be offered support in managing their personal responses to the stories they hear within their clinical work. Awareness amongst those who supervise others is therefore crucial. This further highlights the need for all clinicians to be informed about FGM, not only those who might be working directly with the issue. One way in which this might be accomplished is through a briefing paper by BPS faculties.
- 6) Clinical psychologists should involve themselves in working with communities within which FGM is commonly practiced. This work should aim to reduce barriers to psychological therapy through increasing knowledge about what services are available, by addressing issues of stigma associated with seeking help from mental health professionals and by ensuring that the language needs of clients are met.
- 7) Whilst the current research only interviewed English speaking participants training interpreters about FGM would be important as many women who have undergone the procedure would require an interpreter during clinical sessions.
- 8) Clinical psychologists using interpreters with clients referred for FGM related difficulties should consider the gender of interpreters and their cultural background and consider the impact this might have on the client. They should also brief and debrief interpreters prior to and following sessions and consider that the interpreter themselves might have undergone FGM.
- 9) A briefing paper by the British Psychological Society (BPS) and/or training sessions provided by specific BPS faculties (e.g. sexual health faculty, race faculty) might also be useful in helping increase knowledge of FGM amongst clinical psychologists.

#### **4.6. IMPLICATIONS FOR FURTHER RESEARCH**

- 1) Previous research has focused heavily on the physical consequences of FGM. Further research should attempt to address gaps in the literature through exploring other ways in which FGM might impact upon women (e.g. psychological and relationship difficulties).
- 2) Further qualitative research could explore some of the issues raised in the current study, such as loss and how the experience of circumcision as a child might impact upon women later in their life.
- 3) Research has tended to investigate the physical and psychological impact of FGM as separate from each other. Future research should take a culturally sensitive approach and avoid traditionally western assumptions of dualism. This would enable an exploration of how the physical and emotional experiences of FGM are connected for women.
- 4) Participants in the current research all spoke English. Further research should attempt to interview those women whose voices might not have been heard in the literature (e.g. non-English speakers).
- 5) There has been little research into the views of FGM amongst men and the impact upon them of the practice (e.g. in relationships). Further research should attempt to address this gap in the literature.
- 6) Given the response towards the project of the women who participated in part one of the study, it might be useful to conduct action research, whereby service users set the research agenda. This would enable research to feedback into service development.
- 7) Participants in the current research were primarily from a Sudanese community. Future research should therefore aim to look at the views and experiences of circumcised women from other cultures as this might provide different findings.

- 8) Participants in the current research were recruited from particular settings in which a strong stance against FGM was held. It might therefore be interesting for further research to recruit from more general projects/centres and health care settings.
- 9) Women in the current research suggested that it was important to consider the changes over time and place that have occurred with regards to people's views of FGM. Future research might explore the views and experiences of women from different generations moving to the UK at different times.
- 10) It would be interesting for further research to look at the views of women who have experienced psychological services to identify what was helpful or not about this experience.
- 11) The current research conducted a brief survey with clinical psychologists who had not necessarily worked with the issue of FGM. Further qualitative research could be conducted with clinical psychologists who have worked with women who have undergone the procedure to find out about their experiences of this.
- 12) The clinical psychologists surveyed in the current research were based in London and the south east of England. It might be useful to survey outside of London to see where women who have experienced FGM are also presenting.
- 13) It would be interesting for future qualitative research to explore clinical psychologists' views of FGM and consider how these views might influence their practice.
- 14) The participants in the current research were a non-patient sample (e.g. women who had not defined themselves as having particular difficulties with FGM). Future research could look at the experiences of women who do

define themselves as having problems related to FGM. This might mean recruiting from NHS services.

## **4.7. CRITICAL REVIEW**

This section presents a reflexive discussion which applies to both parts of the study and considers specifically some of the methodological issues pertinent in the research.

### **4.7.1. Participants**

The participants for part one of the current study could be considered to be fairly homogeneous. The homogeneity of the sample appeared to be due to a number of reasons. Firstly; the initial three participants were recruited through FORWARD, an organisation that takes a strong stance against FGM. The participants' involvement with this organisation might therefore have reflected particular views towards the practice. Secondly; the other three participants were introduced to me by one of the initial participants. Whilst snowballing is recognised as a valid method of sampling (e.g. Barker et al, 2005) within the current study this might have led to further homogeneity. Finally; five out of the six participants were originally from Sudan, which might have led to a lack of diversity in the findings for example; the reasons for FGM might have been reported differently by women from other parts of the world where it is practiced.

As discussed in the part one method section, lengths were taken to broaden the sample (e.g. through gaining NHS ethics) however unpredictable obstacles prevented recruitment from taking place in NHS settings. Initially attempts were made to recruit from a NHS women's health service (that ran an African women's clinic). However, despite enthusiasm amongst many clients, some members of staff were opposed to the study and recruitment was unable to take place in this setting. Whilst the reasons for this were never made explicit, the department had its own research programme, which this study was not part of. There also appeared to be concern amongst some members of staff (none of whom were from a BME community themselves) about the impact on women of being asked about FGM. In particular, this was related to my position as a white western woman researching what was considered to be a "culturally embedded practice". This concern however, did not appear to be mirrored by the women who were consulted about the project or

by the participants. They reported that FGM should not be regarded as a “cultural matter” as this often results in the topic being avoided by professionals and women’s needs not adequately being addressed.

This experience raised particular concerns for me. Firstly; I felt that women were being disempowered through not having the option to make their own decisions about whether or not to take part in the research. This was in contrast to the other organisations from which I recruited where women appeared to feel empowered by the experience and enthusiastic to the point that they assisted in recruitment. Secondly; I felt that this avoidance of asking about FGM colluded with the secrecy that has historically surrounded the practice and has perpetuated the continuation of it. Finally; I believe that this deters research from being conducted in those areas that are often in the most need of it.

Another consideration with regards to the sample is that all participants spoke English. Whilst there was an option to use interpreters, if required, this never arose during recruitment. I wonder whether my position as a white, western researcher who spoke no other language might have been an obstacle in recruiting women who did not speak English. The representativeness of the study might therefore be considered to be compromised as the findings do not include the voices of those women who did not speak English.

It would have been useful to collect more demographic data from participants, for example, how long they had lived in the UK. However, because of concerns about confidentiality it was agreed by the researcher that participants had the choice over how much information about themselves they reported. This resulted in limited demographic information about the participants in this project.

As mentioned in the method section of part one the women who participated in the research all appeared to take a similar stance towards FGM (e.g. anti-FGM). It is important to acknowledge that the voices of women who take a different perspective towards FGM are therefore not represented in the current study. This became apparent to me during the later stages of recruitment when a woman attending one

of the support groups told me that she did not feel as strongly as others about the eradication of the practice. She declined an invitation to participate in the study through concerns that people might be upset by her perspective. This emphasises the importance of considering the dominant voices in research and in particular in the settings where recruitment takes place. It also highlights that the findings from this study cannot be assumed to represent the views of all women who have undergone FGM.

#### **4.7.2. Part One: Interview Schedule**

It is important to consider the impact of the interview on the data gathered. Within some IPA studies the personal experiences of participants are directly asked about. Whilst doing so in the current research might have led women to provide more experiential data in the interviews, it would have contradicted how the current project positioned participants (e.g. as experts to be consulted on their views rather than studied). Some of the experiences drawn upon by participants in the interviews were related to other women that they knew or had heard about. Participant 6 talked in such a way during the interview (e.g. “those women”) that I had to clarify whether or not she had been circumcised. Whilst IPA is considered to be an appropriate method in meeting the aims of the current research a discourse analysis of the data might have enabled an exploration of the ways in which women talked about FGM and how this related to their experience of it.

#### **4.7.3. Part Two: Survey**

The initial approach to recruitment for part two of the study (e.g. through the DCP of the BPS) would have enabled a response rate to be calculated for the survey. However, because of the changes to rules of the DCP (discussed in the method section of part two) the way in which potential participants were approached changed. This meant that a response rate was unavailable. It is therefore unknown how many clinical psychologists received the survey but chose to/not to participate. The results do however show that it was not only clinical psychologists who had worked with FGM who responded to the survey.

#### **4.7.4. My Position**

Willig (2008) emphasised the importance of researcher reflexivity in good quality qualitative research. This refers to an examination of how oneself as a researcher and how one's assumptions and biases might influence the research process and interpretation of the findings. In qualitative research meanings are negotiated within the social context of the interaction between the interviewer and interviewee (Smith et al, 2009). It is therefore important to consider the possible impact of myself as an interviewer. Breakwell (1995) points out that people are more likely to engage in self-disclosure with an interviewer who is more similar to them. As a white western woman participants might have assumed that I had a particular view of FGM (e.g. that it should be eradicated), which could have influenced what they talked about. Furthermore, they were likely to assume that I had not undergone FGM and I was aware that this might influence what women spoke about during their interviews. At times participants did appear sensitive to the differences between us, for example, taking time to explain particular terms.

*They go to the sunna type..it's only pricking the clitoris without stitching  
(Participant 3; pg. 2)*

However, I believe that this actually helped in positioning the participants as experts, which was an aim of the research. One factor that I do think made a difference to the interview process was that of gender. I felt that women were more comfortable talking about FGM and the consequences of it with another woman. In particular, I think that this was important when participants discussed issues specific to gender inequalities, for instance the use of FGM to control female sexuality. I also wonder about how participants might have felt discussing with a male researcher the consequences of the practice that could have been considered to be 'women's issues', such as those related to menstruation and child birth.

#### **4.7.5. My Perspective**

As discussed in the method section for part one of the study my position with regards to FGM was one of wanting to learn more about the many perspectives towards the practice. Whilst I recognised the human rights concerns with regards to FGM I

wanted to remain open to hearing from people with a variety of stances. All of the participants however, took a very strong stance against FGM and through hearing about their experiences I do think that my stance on FGM became more strongly in line with theirs. I became aware that my idealistic beliefs about being able to remain relatively neutral were somewhat unrealistic and recognised the impact of the research on my perspective. This has re-emphasised to me the impact of the research process on all people that participate in it.

To end, participant 1 summarises the areas for development that the current project has highlighted.

*Here in the UK they need to increase the information about FGM in the UK and the centres that work with it...better training for professionals..ladies don't know where to go as well..they don't know that there is help and don't go..psychologist need to know more (Participant 1; pg. 4).*

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## APPENDIX 1: CONSENT FORM

### Title of the project:

Female Genital Mutilation and Clinical Psychology.

### Name of researcher

Alison Jones

### Instructions

Please tick each box when you agree with the statement attached to it.

Please tick box

1. I have understood the information given to me about the research project and I have been given a copy of the information sheet to keep. The purpose of the research has been explained to me and I have had the opportunity to ask questions. I understand the procedures which will be involved and these have been explained to me.
2. I understand that my involvement in this study, in particular the information collected will be kept confidential. It has been explained to me what will happen to the data once the research project has been completed.
3. I understand that the research forms part of the requirements for a doctoral degree in psychology and the findings may result in publication.
4. I hereby fully and freely agree to take part in this study which has been fully explained to me.
5. Having agreed to take part, I understand that I have the right to withdraw from the research at any time without disadvantage to myself and without needing to give any reason.

\_\_\_\_\_  
**Name of participant**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Name of person taking  
consent (if different from researcher)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

\_\_\_\_\_  
**Name of Researcher**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature**

## **APPENDIX 2: PART ONE: INFORMATION SHEET**

### **FEMALE CIRCUMCISION RESEARCH**

#### INFORMATION SHEET

##### Project title

Female Circumcision

##### Introduction

You are being invited to take part in a research project. Before you decide if you want to participate it is important for you to understand why the research is being done and what it will involve. Please read this information sheet carefully and feel free to discuss the details and ask any questions about the information in this sheet. Thank you for your time.

##### About the researcher

Alison Jones

Trainee Clinical Psychologist

Department of Clinical Psychology

University of East London

London, E15 4LZ

Tel: 020 8223 4562/ 07977 402351

I am a trainee clinical psychologist on the Doctoral Degree Course in Clinical Psychology at The University of East London (UEL). For this project I will be supervised by Dr Angela Byrne (Clinical Psychologist).

##### About the study

I am interested in the development of better services for women who have experienced female circumcision.

I want to improve how we work with women who have experienced female circumcision. This is a sensitive and complex experience and may not be well understood by some psychologists. Therefore I would like to speak to women about their views and what they think psychologists need to know to provide appropriate services.

It is felt that by speaking to women who have undergone circumcision we can understand more about the practice; developing professional understanding and better ways of working amongst psychologists. I understand that not all women feel that professional/psychological help is necessary or important but their participation would still be valuable in this study. I do not want to pathologise the experience of female circumcision or assess and diagnose women who have undergone the procedure. Instead I see women as experts of their experiences and would value their views and input on this topic.

### Who has been asked to participate?

I would be interested in interviewing women who have experienced female circumcision to discuss their views on the practice and on the services/support offered in the UK. I will not be asking women details of their own personal experience of circumcision. I would like to speak to women for approximately 1 hour, in the presence of an interpreter if required.

### Do I have to take part?

Taking part in this study is entirely voluntary. If you agree to participate you are free to withdraw at any time during this research project. If you choose to withdraw this will not affect the service you currently receive.

### Consent to participate

You will be presented with a consent form to sign should you agree to participate in the research project.

### Ethical approval

This research project has ethical approval from the University of East London as well as the NHS.

### What will happen to me if I take part?

If you agree to take part you will be asked to sign a consent form stating that you are happy to take part in the study. Following this, you will be asked to take part in an interview that will ask about your views of female circumcision and your opinion of services for issues related to the experience. This can be through the service/charity you are accessing or with me directly (by telephone). It is expected that the interview should last for approximately 1 hour.

### Are there any disadvantages or risks of taking part?

Your decision to take part in this research project will not affect the service you receive.

There are no risks in taking part in this project. However, should you be uncomfortable or upset with any of the subject matter discussed during the interview in any way support will be available to you through your service/charity.

### Will my taking part in the study be kept confidential?

If you take part in this project, your details will be kept confidential. The researcher (Alison Jones) does not need to know any personal details about you (e.g. name) and you will be identified only by a number. All the information collected will be handled according to the Data Protection Act (1998). The information collected at interview will be kept confidential and stored in a locked filing cabinet.

### Will I be paid for taking part?

You will not be paid for taking part in the study. However, we can cover travel expenses.

### What will happen to the results of the research study?

After the data is collected from all participants, it will be analysed to address the aims of the study.

Once the research is completed, you will be able to request written feedback about the findings of the study. This is expected to be around July 2010.

The results of this project will be written up as part of a doctoral thesis and may be published in the future.

What support is available after I have taken part?

If you have any further questions about the research project or want to discuss any issues related to the interviews or questions asked, please feel free to contact the researcher at the contact details on the first page.

Thank you for reading this information sheet

### **APPENDIX 3: PART TWO INFORMATION SHEET**

Female Genital Mutilation (FGM)/Circumcision: An exploration of women's experiences of FGM/circumcision and psychological services.

You are being invited to take part in a research project. Before you decide if you want to participate it is important for you to understand why the research is being done and what it will involve. Please read this information sheet carefully and feel free to discuss the details and ask any questions about the information in this sheet. Thank you for your time.

About the researcher

Alison Jones

Trainee Clinical Psychologist

Department of Clinical Psychology

University of East London

London, E15 4LZ

Tel: 020 8223 4562

I am a trainee clinical psychologist on the Doctoral Degree Course in Clinical Psychology at The University of East London (UEL). For this project I will be supervised by Dr Angela Byrne (Clinical Psychologist).

I am interested in the development of better services for women who have experienced female circumcision.

We want to improve how we work with women who have experienced FGM. This is a sensitive and complex experience and may not be well understood by some psychologists. I am interested in finding out about your experiences of working with women who have undergone FGM and also in finding out about any training you have had around issues related to the experience.

So far limited information is held about the knowledge and training of psychologists around issues related to FGM. It is therefore important to gather this information in order to identify and address some of the gaps in training and development.

I am interested in the knowledge and experiences of psychologists working in all services as it is common for women who have undergone FGM to present in a range of settings. The survey is straightforward and should take no longer than 20 minutes to complete.

I am sending this survey to clinical psychologists working in a variety of clinical settings as circumcised women may present at a variety of services. I will not be asking for any personal details (e.g. name). However, I would like to gather some demographic data (e.g. type of service).

Taking part in this study is entirely voluntary. If you agree to participate you are free to withdraw your survey at any time during this research project.

### Ethical approval

This research project has ethical approval from the University of East London as well as the NHS.

### Are there any disadvantages or risks of taking part?

There are no risks in taking involved in this project. However, you have the right to withdraw the information you have provided at any point during the research.

### Will my taking part in the study be kept confidential?

If you take part in this project, your details will be kept confidential. The researcher (Alison Jones) does not need to know any personal details about you (e.g. name) and you will be identified only by a number. All the information collected will be handled according to the Data Protection Act (1998). The information collected at interview will be kept confidential and stored in a locked filing cabinet.

### Will I be paid for taking part?

You will not be paid for taking part in the study.

### What will happen to the results of the research study?

After the data is collected from all participants, it will be analysed to address the aims of the study.

Once the research is completed, you will be able to request written feedback about the findings of the study. This is expected to be around July 2010.

The results of this project will be written up as part of a doctoral thesis and may be published in the future.

### What support is available after I have taken part?

If you have any further questions about the research project please feel free to contact the researcher at the contact details on the first page.

Thank you for reading this information sheet

## APPENDIX 4: PART ONE SEMI-STRUCTURED INTERVIEW SCHEDULE

### Female Genital Mutilation (FGM) Research Semi-Structured Interview Schedule

1. Have you ever talked about this (circumcision) with anyone/a professional outside of your community?
2. We are interested in trying to help psychologists work better with the issue of female circumcision, what do you think people need to know?
  - details of the procedure?
  - consequences of female circumcision (physical/emotional)?
  - traditional, religious and cultural factors surrounding female circumcision?
  - reasons given (to girls/women) for female circumcision?
  - long-term consequences?
3. What do you think people in the UK think about female circumcision?
  - are their views different to people back home?
  - do they understand why it occurs?
  - judgments about practice?
4. What are the views about female circumcision in your culture?
  - positive/negative ideas?
  - changes in views?
  - differences between generations/genders?
  - reasons given for continuation of practice (tradition, religion, hygiene, aesthetics etc)?
5. What do you think about the practice of female circumcision?
  - should it be carried out? why?
  - should it continue? why?
  - why does it happen?
  - benefits?
  - less beneficial factors?
6. Can you think of any reasons why people might want to talk to a professional about female circumcision?

- difficulties as a result of procedure (physical, emotional, psychosexual)?
- discuss positive aspects of procedure?

7. If you were going to talk to a psychologist/counsellor, what hopes would you have about the meeting?

- issues of confidentiality?
- professionals understanding?
- professionals knowledge?
- outcome of meeting/impact on you?

8. How could the psychologist respond helpfully?

- understanding?
- knowledgeable?
- not judgmental/afraid to ask questions?
- importance placed on the experience?

9. Do people back in your home country consult people about issues related to female circumcision?

If yes,

who would people talk to (doctors, midwives, family members, senior community members etc)?

## APPENDIX 5: PART TWO SURVEY

---

### 1. What services do you work in?

- What services do you work in? Adult Mental health
- Health
- Child and Family Services
- Sexual Health
- Learning Disabilities
- Older Adults

Other (please specify)

### 2. How would you describe your therapeutic orientation?

- How would you describe your therapeutic orientation? Systemic
- Cognitive Behavioural
- Psychodynamic
- Integrative

Other (please specify)

### 3. Information.

Information.  
Ethnicity

Years  
qualified as  
clinical  
psychologist

Gender

Part of the  
country  
currently  
working in

**4. Have you ever worked with a client who had experienced Female Genital Mutilation (FGM)/circumcision?**

- Have you ever worked with a client who had experienced Female Genital Mutilation (FGM)/circumcision? Yes
- Don't Know (please go to Q7)
- No (please go to Q7)

**5. Were issues relating to FGM discussed as part of your work?**

- Were issues relating to FGM discussed as part of your work? Yes
- No

**6. If yes, how would you describe those issues?**

If yes, how would you describe those issues?

**7. If you have ever received any training on FGM, what type of training was this?**

- If you have ever received any training on FGM, what type of training was this? On Clinical Psychology Training
- NHS Training
- BPS Training

Other (please specify)

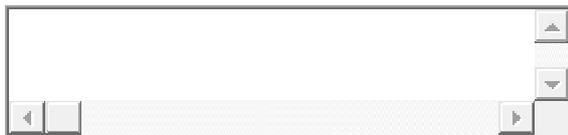
**8. If yes, what was the content of the training?**

If yes, what was the content of the training?

**9. How confident did you feel working with the issues related to FGM?**

- How confident did you feel working with the issues related to FGM?  
Not at all confident
- Somewhat (a little) confident
- Confident
- Fairly confident
- Very confident

**10. What training do you feel you would need in order to work confidently with clients who have experienced FGM?**



What training do you feel you would need in order to work confidently with clients who have experienced FGM?

## APPENDIX 6: EXAMPLE OF A TRANSCRIPT (PARTICIPANT 5)

1 I: Have you ever talked about female circumcision with anyone/a professional for  
2 example outside of your community?

3 P: What personally for myself, personally..

4 I: Yeah yeah..

5 P: Erm.. er..a doctor maybe..my GP and gynaecologist when I was having my first  
6 child..they ask you are you circumcised..they asked me..yes..that is the only time I  
7 have spoken about it

*Baby  
Labour  
being  
awake*

8 I: We're interested in trying to help psychologists work better with the issue of  
9 female circumcision what do you think psychologists need to know to do a better  
10 job?

11 P: Erm...in terms of physical how this process is done..what is involved in the  
12 process how it is done and how they can operate if she is pregnant and maybe they  
13 need to know the background the type of FGM because there are many different  
14 types..and erm..whether it has any erm..physical..er..side effects for the individual  
15 woman..because personally from the age of 7 or 6 I had problems with cysts  
16 cysts erm...and I have minor operations like 6 or 7 minor operations but they  
17 wouldn't take it all out they just tried to get the substance out you know..you know  
18 the substance..but then finally they take it out..this is one..I think..one of the things  
19 that

*details of  
procedure  
(FGM)*

*- type*

*physical  
complication*

20 happen..because it didn't just happen to me it happened to so many people in my  
21 community that it must be erm...er and erm..I think..ah ah..if psychologists knew the  
22 background of every patient and how they got circumcised and erm how er what kind  
23 of circumcision it was I think that that way it would be better..

*- individual background  
- How Circumcision  
(details of procedure)*

24 I: So each person's individual story?

25 P: Yes yes..i think in itself whether it's type one or type two or type three it doesn't  
26 really make any difference but it not the natural thing you know to happen to  
27 someone

28 I: Right ok..what do you think people in the UK think about female circumcision?

29 P: I don't think that a lot of people know about it only you know people who are you  
30 know involved with minority communities..are aware of it like GPs or solicitors  
31 because it might be one of the reasons people why people fled their country..stuff  
32 like that but every other person I don't think they would be aware of it you know I

*lack of  
knowledge*

33 don't think so..maybe they are aware of the male circumcison..it's a bit erm..there  
34 isn't much awareness

35 I: What are the views about female circumcision in your culture/community? *-changing views*  
*- awareness of*

36 P: Erm...er..the views nowadays I think it's changing people are more aware of the *negative effects*  
37 erm you know the er..err..the bad effect it has on you know the girls..but historically it  
38 was accepted..er..erm in the past it was accepted it has to have erm..they they erm  
39 they sort of like put these ideas in your head that if you don't do then erm..then you  
40 you know you won't get married and men won't..erm..er..won't marry girls who have  
41 not been circumcised and erm..but listen this..generally now I don't think that it is *-changes*  
42 encouraged anymore..in fact it's not..erm..er..maybe obviously there are still people  
43 that do it maybe in the rural areas..where there is no awareness education about the  
44 problem..but everyday in the cities I don't think it's there anymore *- difference in rural*  
45 I have forgotten the question sorry.. *areas vs education*  
*- cities*

46 I: That's ok, it was what are the views about circumcision in your  
47 community/culture?

48 P: In this community in this country I think they are against it but you would find the *change btwn*  
49 elders erm..erm.. they would erm agree but all the educated generations erm I think *generations*  
50 in the past 15 years erm..past 15 years it has changed so it is not encouraged  
51 anymore among erm the erm you know the educated families..so it's more about  
52 education yeah except I think that maybe..erm there was pressure being put on the  
53 government maybe the health minister..in my country that they have to do something  
54 there was intervention from all of these organisations..that erm..they have to do  
55 something pressure to change something to put erm stricter rules and laws but it's  
56 not worked it's not been enforced or adhered to...but I think they have done a lot of  
57 work you know to erm the proposals from the charity organisations working there  
58 because I think now people are you know connected more they watch lots of satellite  
59 channels they erm talk about it a lot they talk about the complications..

60 I: Right ok so what do you personally think about female circumcision?

61 P: I think that it's a terrible thing to happen to someone because erm.er..if there is  
62 any law erm..it's not religious you know but I can understand why my parents had  
63 me done.erm..erm...but I think it's a bad experience and I think I wouldn't want to do  
64 it to my children you know.. *- not religious*

65 I: You wouldn't want to do it to your children?

66 P: No no...you asked me earlier about psychological scars..and I think that <sup>- Psychological scars</sup>  
67 psychological scars are there but you might never be aware of it..erm..you wouldn't  
68 be aware of it..it could you know..erm you know be effect on you you know it comes  
69 out..and you know it can give you a fear of thinks and you don't know you know..I  
70 have a fear you know..the tests they do on women you know the smear test...that is  
71 my fear and my GP has sent so many notices for me to go and do the smear test  
72 and you know...I don't you know it's just the fear that you know..the doctor is going to  
73 do something..you know like erm erm ah ah...I think it affects you I don't know <sup>- Fears..</sup>  
74 maybe it affects the confidence.. I don't know..erm..er..erm..and even later on in your  
75 relationship with your partner..er..er..this is I think this is a nightmare..it's a nightmare  
76 because it's erm terrible..er..and I think some er and as I said to you I think it's  
77 changing and there are some families who take their daughters to the doctor to have  
78 it undone you know...sensible person someone who is sensible...instead of making  
79 the girl go through all of this terrible you know.. <sup>- change in news overtime</sup>  
80 I: Yes so there are changes..  
81 P: Yes you know erm..it's changed  
82 I: And so what are your views of the practice?  
83 P: It's wrong, it should stop..  
84 I: Why do you think it happens...why do you think it continues to happen in places?  
85 P: Erm.. when I grew up and I read about it...I think you know obviously that this <sup>- Pass to marriage</sup>  
86 is..er..you get told that this is a pass to marriage you have to have it or you know you  
87 can't get married..erm..and the other thing is maybe the women have told you that  
88 this is a heavy thing..er.in the family that you will abide by not having a  
89 relationship..you know before marriage and so they don't want to think about that  
90 and erm one thing the other thing that I thing when I read about it is that it has been  
91 done in Egypt..erm..er..on those days that the pharon would leave their their wife  
92 and erm..they would physically lock the wife..they use physically like a lock and they  
93 would...they would lock it around them..(demonstrates).. <sup>- History control of women chastity fidelity</sup>  
94 I: Like a chastity belt..?  
95 P: Yes..and the women would erm sort of like try to avoid that so they sort of  
96 like...they lose weight so they they lose weight to get out of it so to stop them all  
97 together they have to do this permanently to stop them from you know...this is where  
98 it all started..erm and then I think every country has their own idea of it..it's it's erm

99 I think it's the male dominance issue because they erm..it's an ideal you know you're  
100 a man and this is what satisfies a man and this is er..this is your man and it keeps  
101 him happy and for women you know..erm..in my family my mum was I mean  
102 obviously she give me the circumcision but for my all other sisters who are married  
103 and have children they will not give to the child..some families they keep doing it to  
104 their child every time..obviously for the pleasure of the male and erm..this is the thing  
105 and everything to it and then they realised that the girl will not this is not a sort of like  
106 trust thing because they could still you know free feel free and then they go back and  
107 they fix it you know and they it's like this now so it's not you know you can't build the  
108 trust like this but you know for me personally it was it wasn't a nice experience so  
109 you know.

- male dominance  
issue  
- male pleasure

- change in  
views  
- generations

110 I: Can you think of any reasons why people might want to talk to a psychologist  
111 about female circumcision?

112 P: Erm if she had a problem and she feels and feels that this problem is related to  
113 circumcision or erm..er..that erm she has erm a problem because some women  
114 erm..are what is the word..are not receptive..erm receptive to erm marital to erm sex  
115 so lots of people there might be problems there they could develop problems there  
116 and obviously then there will be a problem with the marriage and erm er there will be  
117 erm...I don't know maybe the man will go somewhere else or they will divorce...erm  
118 yeah because it effect the senses and er er even the way people were raised and  
119 erm..the..taboo of sex it's psychological so maybe this is the reason people would go  
120 to a psychologist. Also women when they go to labour and they try to cut them and  
121 erm..they mess things up and they have problems and you know there are lots of  
122 complications..erm.. so this could be one of the reasons the physical problems and  
123 they feed the psychological problems you know and the that's when they speak to a  
124 psychologist..I don't know maybe some of them won't but if they feel they can then  
125 maybe they will...talk about the difficulties and memories

- Not receptive  
to sex  
- Impact on  
relationships

connection  
between  
physical &  
psychological

- Talking

126 I: So you think that there are a range of reasons really that people might want to talk  
127 to a psychologist?

128 P: Yeah yeah..

129 I: If you were going to talk to a psychologist what hopes would you have about the  
130 meeting?

131 P: Erm..I would hope the psychologist have erm...background about the problem  
132 about FGM some knowledge some knowledge so that they know what I am talking

- professional  
knowledge

133 about...and try to help me...understanding I hope they could understand me...erm if  
134 they read about it and they understand it then they would er er..understand that it is  
135 a sensitive issue and treat it this way..

*Professional  
Understanding*

*sensitive  
issue*

136 I: So to respond sensitively to you?

137 P: Yes yes..and erm..and er I hope that it would be private..

*Confidentiality*

138 I: So confidential?

139 P: Yes yes I think that confidentiality it gives er.. you know a feel a fear of being they  
140 might not want to talk so that would make for them to feel free to feel easier to  
141 talk..because it's confidential

142 I: And how could the psychologist respond helpfully..what would you hope they  
143 would be like?

144 P: Hopefully they should be able to diagnose the issue and want to help the person  
145 and erm..if it's something like know you know what sort of things they might need so  
146 you know some sort of counselling or you know therapy or just to listen..

147 I: Are there any other factors that might be important? *- Asking questions*

*Sympathetic*

148 P: I just suppose I suppose I hope that the psychologist erm..would be interested  
149 and ask me questions and be sympathetic and not just regard it as this is another  
150 just another one of those..because some people take this as it's just community

*Questions  
community  
related*

151 related or minority related..and they're not used to it and you know in this world I  
152 don't know when you see kids and erm...you know injustices and people just get  
153 used to seeing these things and seeing it there and er..it's not there so it's not  
154 affecting them..it's normal it's normal there..so if they deal with it this is something  
155 unusual but if they deal with it.. as..deal with it as if it happened to them what would  
156 they do..and if this person was sitting there and erm..they did not have any choice  
157 when this has happened and be able to you know...take it like that you know think of  
158 it like that I think that maybe they will be able to...you know do a good job..

159 I: Do people back in your home country/community consult people about female  
160 circumcision?

161 P: I think they see professionals..I don't know about psychological issues because  
162 it's very erm maybe they could..it depends on the setting and the family and what the  
163 family as I said to you..there is some..erm it depends on if the family is

164 educated..they understand these issues they see that this is a  
165 psychological..understand the problems

166 or they might just say erm..don't make her go to the erm..professional go to some  
167 religious person who will read some versus and you know...er..different ways you  
168 know of doing it..so I think some of them would go to psychological..

169 I: And what about doctors and nurse?

170 P: They would go to doctors and nurses..I think if it's a physical issue they would go  
171 to a doctor..

172 I: And would they talk about the circumcision?

173 P: They would talk about it yes..erm..it so it's not something that people would not  
174 talk about...I am from a city..

175 I: Is it more likely that people would have access to these services in the city?

176 P: Yes I think they would..more rural areas..erm..more villages..er..er..they still have  
177 access to health services er er but it's very limited and there would be maybe

178 just one professional just one doctor for the whole of the erm..the er the village and  
179 the erm just one..that is the problem with Sudan the services are centralised so.. you  
180 know...erm it's getting to them that is the problem..but they might not get access to

181 psychological..because you know I think it's not you now I don't think it's even  
182 available on erm...on the level of just the basic services..so and even the basic  
183 services they have to be paid for so .erm..er..you it means you will go and get as

184 little as you can afford but I think that psychological help is really it's really  
185 expensive..yes yes so..

186 I: So that would be a barrier to getting that service?

187 P: Yes yeah...you know it would..

188 I really want to say that psychologists need to have an understanding of the physical  
189 side to understand the psychological side..you know..I don't think people would have  
190 known that someone would have cared to you know I didn't know that if I had

191 problems that I could see someone a psychologist I didn't know I could.. that was  
192 good that was interesting...I am happy to know that..