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**Abstract**

Female Genital Mutilation (FGM) refers to procedures involving partial or total removal of the external female genitalia for non-medical reasons. Practiced in at least 28 African and a few Asian and the Middle East countries, data regarding FGM have been systematically collected from only 27 developing countries. In western society FGM is considered a breach of human rights and one that has been outlawed in a number of countries. With immigration trends, FGM is now prominent in Europe, Northern America, Canada and Australia, among practicing communities. Whilst the last decade has seen an increase in studies and recommendations and health care support related to the physical health consequences of FGM, little is known about the psychological impact and its management. For many girls and women, experiencing FGM is a traumatic practice that can affect their mental health. This discussion paper focuses on available evidence relating to the mental health consequences of FGM, including existing specific therapeutic interventions related to this practice and considers how mental health nurses are best placed to address the psychological needs of this group of women. (181)

Key Words: Female Genital Mutilation, interventions, mental health, nursing, psychological consequences

**Introduction**

Global estimates suggest that 100 million to 140 million girls and women have undergone FGM, with more than 3 million girls being at risk of the practice each year on the African continent alone (World Health Organisation (WHO), 2008; Population Reference Bureau, (PRB) 2010). FGM is practiced in at least 28 countries in Africa and a few others in Asia (for example Indonesia) and the Middle East (Kurdistan, Yemen). However, to date, data have only been systematically collected from 27 developing countries (PRB, 2010).

Whilst it could be suggested that FGM is mainly a sub Saharan problem, migration trends have played a major role in transferring cultural and traditional beliefs attached to the practice to the Western world (Johnsdotter, 2004; Matthews, 2011). The social convention of those originating from practicing countries is said to be strongly rooted and moving to live in the West does not simply change the perceptions of migrants, but rather FGM has become a reality in Europe, Northern America and Australia (Johnsdotter, 2004; Denison et al., 2009; Matthews, 2011). In England and Wales it is estimated that there are almost 66,000 women who have undergone FGM and 21,000, under the age of eight, will be at risk of FGM (Dorkenoo et al., 2007). With migration trends to the UK from Sub Saharan Africa, where FGM prevalence is high (often 95%+ in some areas), it is suggested that instances of FGM are significantly higher now in the UK than the estimates above which were based on the 2001 census (PRB, 2010).

During the last decade there has been an increase in the number of studies focusing on the health consequences of FGM, with many denouncing the practice (Dorkenoo et al., 2007; Yoder and Kahn, 2008; Berg et al., 2010; PRB, 2010). While many of the studies are contextualised within a historical perspective, policy development, and/or procedural descriptions, there is very little documentation on the emotional repercussions of FGM. The World Health Organisation (WHO) (2008) referred to the emotional traumas relating to FGM, stating that the possible shame or complications are not addressed, or treated, by health and social care professionals. Although the psychological impact attached to the practice of FGM is described in many studies (Dare et al., 2004; Behrendt & Moritz, 2005; WHO, 2006), there is a dearth of evidence on its direct consequences on the mental wellbeing of women who have, or who are at risk of having FGM.

**Origins of FGM**

Primarily FGM is associated with Africa, however, WHO (1996) suggest that it has existed in all countries at one time or another. For example there were several reported cases in the UK and the US during the early 20th Century, where FGM was performed by physicians to “treat hysteria, lesbianism, masturbation and other so called female deviancies” (Toubia, 1994, p225). There are a number of socio-cultural factors that impact on the practice of FGM, particular beliefs, behavioural norms, customs, rituals and social hierarchies inherent in religious, political and economic systems (Momoh, 2005). For example, in Somalia there is a strong belief that FGM is a religious requirement (Keizer, 2003; Nienhuis et al., 2008), although there is no description of the practice in the Quran or the Bible, although it was in existence prior to Christianity and Islam (WHO, 1996; WHO, 2006). In some practicing countries, uncircumcised girls and women are not welcome in their society. The Masai of Tanzania refuse to call a woman "mother" if she has children and has not been circumcised (Boyle, 2002:36). A more common reason for FGM, particularly for those communities living in Western Society, is that of preserving a girl’s or woman’s virginity (Berggren et al., 2006; Gruenbaum, 2006; Talle, 2007). For some practicing communities, FGM is a way of ensuring marital fidelity and preventing sexual behaviour that is considered deviant and immoral (Ahmadu, 2000; Abusharaf, 2001; Hernlund, 2003; Gruenbaum, 2006).

The stigma inherent in the above is likely to further compromise women’s mental wellbeing, particularly for those who are opposed to FGM, yet reside in communities where it is part of the cultural practice.

**FGM and Human Rights**

According to WHO (2008), FGM of any type is a harmful practice and a violation of the human rights of girls and women. Across the world, the migrant population is strongly represented by vulnerable groups of refugee and asylum seeker families, where girls and women experience various gender issues (Burnett & Peel, 2001; Correa-Velez et al., 2005). In considering FGM as being a serious breach of human rights, the United Nations High Commissioner for Refugees (UNHCR) and other agencies of the United Nations have stated that refugee and asylum status should be granted to women and girls fleeing their country to escape the practice; a statement reiterated by the British Medical Association (BMA) (2008). However, globally there are very few records of girls and women granted refugee status on the ground of FGM. In 1998 one case of successful asylum application was registered in Canada, another one in the US and two in Sweden (Amnesty International, 1998). In 1999, one further application was registered in the US (Amnesty International, 2000). In the UK, there are no statistics available reporting successful asylum applications on the basis of FGM, while Article 3 of the European Convention on Human Rights (1984) defends the right to be free from torture and inhuman or degrading treatment (Home Office Immigration & Nationality Directorate, 2001). The Female Genital Mutilation Act (2003) ([www.legislation.gov.uk](http://www.legislation.gov.uk)) makes it an offence for UK national or permanent residents to carry out FGM, or to aid, abet, counsel or procure the carrying out of FGM abroad, even in countries where the practice may be legal (Gordon 2005). More recently, the United Nation General Assembly’s Human Rights committee 2012 ([www.amnesty.org](http://www.amnesty.org)) placed FGM in a human rights framework, highlighting the need for a holistic approach that includes; recognising the importance of empowering women; promotion and protection of sexual and reproductive health and breaking the cycle of discrimination and violence (Diaz, 2012).

**Psychological impact of FGM**

Whilst the physical health consequences of FGM are well documented (Dare et al., 2004; Behrendt & Moritz, 2005; WHO, 2006; Royal College of Obstetricians and Gynaecologists [RCOG], Green-top guidelines, 2009), the emotional affects remain elusive. WHO (2000) found that only 15% of studies focusing on the health effects of FGM considered mental health, and most of these were case reports, highlighting an important gap in the literature. Where studies on psychological consequences of FGM have been undertaken, factors such as severe forms of FGM, immediate post-FGM complications, chronic health problems and/or loss of fertility secondary to FGM, nonconsensual circumcision in adolescence or adulthood, and FGM as punishment have all been identified as causes of distress (Lockhat, 2004). Likewise, depression, posttraumatic stress (PTS) and symptoms of impaired cognition comprising of sleeplessness, recurring nightmares, loss of appetite, weight loss or excessive weight gain, panic attacks and low self-esteem have been attributed to FGM (Osinowo & Taiwo, 2003; Behrendt & Moritz, 2005; Elnashar & Abdelhady, 2007; Kizilhan, 2011; VIoeberghs et al, 2011).

 For many girls and women, undergoing FGM is a traumatic experience that has been found to have lasting psychological consequences (WHO 2011). Berg et al., (2010) undertaking a systematic review of the literature pertaining to psychological problems resulting from FGM indicated that there is a high probability that women who have been subjected to FGM suffer emotional disorders such as anxiety, somatisation and low self-esteem, and are at greater risk of psychiatric diagnosis. These findings were re-iterated by Chibber et al (2011). A controlled study undertaken by Behrendt and Moritz (2005) in Senegal, compared the mental status of 23 circumcised and 24 uncircumcised females, and found that almost 80% of circumcised females met criteria for psychiatric disorders, with 90% of circumcised women describing severe pain and feelings of intense fear, helplessness, and horror at the time of the trauma. More than 80% continued to have flashbacks, a common phenomenon of PTS (Behrendt & Moritz, 2005). This study re-iterates previous findings. Lockhat (1999) conducted a study in Manchester, UK, amongst Somali and Sudanese women, of which 75% of participants recognised that they suffered recurrent intrusive memories, and loss of impulse control. More recently, Zayed and Ali, (2012) undertaking a prevalence study of female circumcision in Egypt, after a change in the law banning the procedure, found 63.9% of the sample had experienced circumcision, of which 94.9% had emotional trauma. In the UK, young women receiving psychological counselling for FGM report feelings of betrayal by parents, incompleteness, regret and anger (WHO, 2000). In addition, a pilot project undertaken in the UK by an organisation providing cultural counselling to women who have experience of FGM, described the overwhelming trauma, the long-lasting emotional damage it causes and the difficulty of suffering in silence, reported by the women (New Step for African Community (NESTAC), 2012).

Whilst FGM is condemned within western society, the psychosocial implications of not undergoing FGM could adversely impact on females living in practicing communities. Not undergoing the practice could lead to a dis-identification with the culture, resulting in mental distress, manifesting as anxiety due to fear of becoming socially excluded from their community. A number of studies report that women who have been subjected to FGM have minimal psychological morbidity, often feeling proud and believing that they are better person (Mwangi-Powell, 1999; Chalmers & Hashi, 2000). In a study of 432 Somali women living in Canada, memories of FGM, included intense fear, severe pain, and being seriously ill at the time of mutilation, but also participants reported a sense of pride, happiness and enhanced purity and beauty (Chalmers & Hashi, 2000). The strong belief that a woman needs to be circumcised to be seen as good is often inherent within the culture and passed from one generation to another (Nienhuis et al., 2008), presenting a challenge for those in Western society whose concern is that of mental wellbeing.

The complexity of FGM in the cultural context is demonstrated in a pre and post intervention study of 100 women undertaken by Ekweme et al., (2010). Knowledge, attitude and behaviour pre and post FGM was explored. The women were recruited by systematic sampling from the General Outpatient Department at the University of Nigeria Teaching Hospital. Results showed that prior to undergoing FGM, the knowledge of the respondents on the true meaning of the practice was 54%; with 70% believing that FGM is good and, based mainly on culture and tradition should be continued. Respondents displayed a high negative and stigmatizing attitude toward the uncircumcised women; 74% said they are promiscuous; 49% said they are shameful, 14% cursed/outcast, and 66% would not recommend them for marriage. After the women had been circumcised, results showed 85% of the respondents had a better understanding regarding the meaning of FGM, 71.3% knew the complications, 11% supported FGM, but 83% were against the practice. The stigmatizing attitudes held against uncircumcised women decreased significantly post-intervention; beliefs of promiscuity fell from74% to 22%, shameful 49% to 12%, outcast/cursed 14% to 2%, and not good for marriage from 66% to 19% (Ekweme et al., 2010).

**Psychosocial interventions to address the emotional consequences of FGM**

Although there are now extensive studies in the clinical field of psychosocial interventions for mental illnesses experienced by the BME population, including groups of refugees and asylum seekers (DoH, 2005; Kieft et al., 2008; Mind, 2009), there is still a lot to do to provide specific emotional support for women exposed to FGM. While a number of studies (Osinowo & Taiwo, 2003; Behrendt & Moritz, 2005; Elnashar & Abdelhady, 2007; Kizilhan, 2011) have made recommendations for adapted psychological interventions and training for mental health professionals on how to provide an adapted therapy, none have implemented and evaluated appropriate psychological interventions specifically addressing the needs of women who have experienced or who are at risk of FGM.

The dearth of research relating to the psychological consequences of FGM, coupled with the nuanced context of tradition and cultural beliefs, will impact on the way in which mental health services might provide support for women exposed to the practice. When developing therapeutic interventions for women exposed to FGM, account needs to be taken of the deep-rooted belief in the practice of FGM, as well as the cultural and social pressures women from practising communities are likely to experience.

A successful therapeutic relationship is fundamental to good mental health care (Cleary, 2003; Warne & McAndrew, 2005). To promote healing, cognisance needs to be taken of both the physical consequences of FGM and the cultural issues surrounding it in order to provide sensitive care (Daley, 2004). A number of countries, such as the UK, Germany, Belgium and Sweden, have established guidelines on FGM for medical providers (Nour, 2004; BMA, 2011), however, there is little attention paid to effective interventions addressing psychological needs (Mind, 2009). Only one study carried out in the Netherlands (Vloeberghs et al., 2011) looked at participants’ experiences of mental health provision, the results indicating both positive and negative experiences. Positive experiences indicated that their interactions with mental health services were positive, as practitioners were better informed about circumcision and aware of its existence in the Netherlands. Participants also reported positive interaction with doctors and nurses when in the Reception Centre (for asylum seekers and refugees); with mental health professionals showing understanding, providing correct information and the referral of women to appropriate services to address specific problems (Vloeberghs et al., 2011).

In the UK current mental health provision for asylum seekers and refugees includes: a limited number of specialist services for asylum seekers located in Trusts or run by independent bodies; trauma services that include survivors of torture or violent conflicts in their patient population; Freedom from torture, formerly the Medical Foundation for the Care of Victims of Torture; inter-agency partnerships developed specifically to provide services for this group; and specialist general practices of in-house sessions with community mental health nurses or counsellors (Aspinall & Watters, 2010). Drawing on an evaluation of the impact of the introduction of a community psychiatric nurse in a large refugee camp, Kamau et al., (2004) argue that even a small amount of mental health care can have a dramatic impact on the mental well-being of refugees. However, Ward and Palmer (2005) found that only five of the eleven Mental Health Trusts based in London provide specialist services that are specifically designed with the needs of refugees and asylum seekers in mind. They also found that, with the exception of a small number of PCTs, there appears to be a general lack of awareness that refugees and asylum seekers are a group that have distinct needs which are multiple, complex and require specialist knowledge. In these circumstances the effectiveness of psychological interventions for mental health difficulties can be compromised, and especially for those at risk of FGM whose cultural beliefs are at odds with legal system of the country they are now residing in.

**Making sense of the evidence**

While there are only a small number of empirical research studies on the psychological consequences of FGM, what is evident is that the mental health of women who have undergone, or who are at risk of FGM, will be compromised (Nnodum, 2002; Osinowo & Taiwo, 2003; Behrendt & Morritz, 2005; Elnashar & Abdelhady, 2007; Chibber et al., 2011; Kizilhan, 2011; VIoeberghs et al., 2011). Common mental health problems, such as affective disorder, anxiety and somatization (Behrendt & Morritz, 2005; Elnashar & Abdelhady, 2007; Chibber et al., 2011) were evident for women who have undergone FGM and have implications for those mental health professionals working in primary care. In addition, it would appear that women exposed to FGM are more likely to report symptoms commensurate with PTS, and in particular recurrent flashbacks (Behrendt & Morritz, 2005; Chibber et al., 2011; Kizilhan, 2011), the latter being more common among women exposed to more severe forms of FGM (Lockhat, 2004).

Regardless of type of FGM and its psychological consequences, Berg et al (2010) reiterates the importance of considering the fact that the practise is culturally embedded and this may well form a protective factor against the emergence of psychological distress in its aftermath. Berg et al (2010) suggest that future research should take the possible protective element of FGM into account when examining the short term and long term psychological consequences of the practice. Alternatively, it has been suggested that FGM should be viewed as a social convention and the taboo surrounding the practice might account for why circumcised women do not complain about their emotional distress (Vloeberghs et al., 2011). However, Behrendt & Morritz (2005) argue that despite the fact that FGM constitutes a part of the participants’ ethnic background, the results of their study imply that cultural embeddedment does not protect against the development of PTS and other psychiatric disorders.

Coping strategies are also important to consider when developing services for those exposed to FGM. Vloeberghs et al. (2011) explored coping factors and concluded that both support seeking and avoidance coping styles appear to be associated with higher levels of anxiety and depression. Vloeberghs et al. (2011) in identifying four categories of women; the adaptive woman, the religious woman, the disempowered woman and the traumatised woman, provides information about women’s ways of coping in terms of whether or not they seek support. Their findings showed that ‘adaptive’ women were able to cope with their problems, which were mainly physical and of a sexual nature. ‘Religious’ women also revealed that they knew how to deal with their problems related to FGM and preferred not to talk about it, considering sexuality as a private matter. This group reported less fear and depression than non-religious women. The group of ‘disempowered’ women’s behaviour was prone to emotional reticence, anger and defeat. Refusing to talk about their experience of FGM, they developed negative ways of coping, developing problems such as substance misuse, binge eating, watching too much television, and sometimes experiencing serious psychological problems. Hidden tension and a tendency to fatalism were characteristics of these women. Finally, those in the category of ‘traumatised’ women (mostly women who had been infibulated) appeared to be either divorced or in a bad relationship, and suffering a lot of pain and sadness. Within this group there was a higher incidence of psychological problems including recurrent memories, sleep problems, chronic stress and higher levels of anxiety and depression.

**Translating the evidence into practice**

Holistic approaches taking into account socio-cultural factors (Ward & Palmer, 2005; DOH, 2009) could contribute to a better understanding of the psychological traits of women exposed to FGM, whether they remain living in practicing countries or have migrated to Western countries, ensuring valuable resources are directed to those at greatest risk. While it is important for mental health professionals to demonstrate adequate knowledge and awareness of the origins, traditions and psychosocial implications of FGM (Whitehorn et al., 2002; Utz-Billing, 2008), it is equally important to put the acquired knowledge into practice through the use of sensitive therapeutic approaches that address the needs of circumcised women.

There appears to be a dearth of research relating to psychological interventions for women who experience negative consequences of FGM. To date, talking about psychological interventions for those exposed to FGM is limited to recommendations and guidance on how to provide adapted existing emotional support (Whitehorn et al., 2002; Behrendt & Morritz, 2005; Elnashar & Abdelhady, 2007; Applebaum et al, 2008; Kizilhan, 2011; VIoeberghs et al, 2011). In her unpublished doctoral thesis, Jones (2010) explored the theme of FGM and clinical psychology in London and the South of England. Jones’s study was divided into two parts, the first part using semi structured interviews to explore the views and experiences of six women who have undergone FGM in relation to their use of clinical services. Using a questionnaire, the second part surveyed 74 qualified clinical psychologists working in a range of specialities, regarding their experiences, knowledge and training needs in relation to FGM. The findings from part one of the study showed that what participants wanted from clinical psychologists was; for them to have knowledge about how the practice is accounted for (e.g. the reasons for it and the contexts within which it exists); that psychologists should facilitate conversations about FGM during consultations by asking questions and responding in a sensitive and non-judgemental manner; and finally they wanted clinical psychologists to validate and respect their experience rather than consider it a “cultural matter” that should be avoided.

Part two of the findings highlighted minimal experiences and knowledge of FGM amongst the clinical psychologists and the need for a variety of training in order to increase their confidence in working with women who have experienced FGM. Although there was a small sample of participants in the first part of the study, it demonstrated some overlap between the two groups, particularly with regard to the lack of awareness amongst clinical psychologists and how this has the potential to compromise the provision of emotional support for this group of women. In light of this Jones (2010) makes some strong recommendations for improved knowledge of FGM within clinical practice. The findings from the study are pertinent for such knowledge to be common among mental health nurses as they are often on the frontline and more likely than psychologist to be the first point of contact for women exposed to FGM.

As previously indicated, there is no substantial research and/or evaluation of the effectiveness of interventions that have been developed to meet the emotional needs of those who have experienced FGM. The majority of women who have been exposed to FGM will be from an asylum seeker or refugee background, and as such could potentially make use of the limited number of specialist services available for the BME population (DoH, 2005; Kieft et al., 2008; Mind, 2009), while waiting for a more appropriate therapeutic interventions to address their special needs. In the UK specialist services include trauma services for survivors of torture or violent conflicts are delivered by Freedom from Torture organisation. However, these specialist services exclude victims of FGM as they do not meet the organisations criteria. Freedom from Torture considers torture as 'Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of, or with the consent or acquiescence of, a public official or other person acting in an official capacity’, as defined by the Article 1.1 of the United Nations General Assembly (1984) ([www.freedomfromtorture.org](http://www.freedomfromtorture.org)). FGM does not fit within this definition, although it has been recognised as a violation of the human rights of girls and women (WHO, 2008).  The majority accessing help from Freedom from Torture are people who are tortured during conflicts, where torture is used to introduce a climate of fear and to force people to flee ([www.freedomfromtorture.org](http://www.freedomfromtorture.org) ). Other services that might provide interventions would include specialist general practices that provide in-house sessions with community mental health nurses or counsellors (Aspinall & Watters, 2010). However, like the psychologists in Jones’s (2010) study they also may need a tailored training for them to support women exposed to FGM.

**Providing mental health care in a multicultural world**

As the world becomes intensely close, complex, and multicultural cultural awareness and transcultural care are becoming increasingly important (Seisser, 2002). In keeping with the ethos of transcultural nursing, mental health nurses are required to provide culture specific and universal care that promotes the health and well-being of people by enabling them to face unfavorable human conditions, illness or death in culturally meaningful ways (Leininger & McFarland, 2002). To achieve this, nurses need to be prepared in transcultural nursing by being able to identify culturally vulnerable populations and to develop professional competencies that will enable them to address their needs (Leininger & McFarland, 2002). It is important that mental health nurses can identify cultures that are neglected or misunderstood in order to help health care systems assess how they serve, or fail to serve, diverse cultures in local communities (Wenger, 1999; Seisser, 2002). To achieve transcultural nursing, Leininger (2000) emphasised the need for research that focuses on discovering largely unknown and vaguely known cultural care and health concerns from two perspectives: The emic perspective focusing on the local, indigenous, and insider's culture; and the eticperspective focusing on the outsider's world and especially professional views.

In keeping with such transcultural developments in health care, the NESTAC project, referred to earlier, started gathering evidence from those who have experience of FGM, some of them describing the long-lasting emotional implications FGM has had on their lives (NESTAC, 2012). More recently NESTAC has secured funding for a collaborative three year project, under their Wellbeing Programme, with a local university. The wellbeing centre is a community based programme supporting mainly refugees and asylum seekers by attending to their socio-cultural needs. The new project will develop a specialised service for cognitive and emotional support, aiming to provide three FGM drop-in clinics and accredited training for peer mentors. The project is to be established in areas with a high prevalence of women from the practicing communities. For the purpose of this programme, an existing model of transcultural therapy (Kieft, 2008) benefiting refugees and asylum seekers has been adapted for women affected by or at risk of undergoing FGM. It is anticipated that this project will add to the small, but growing body of knowledge relating mental health nurses addressing the emotional effects of FGM and the types of interventions that are most effective in alleviating the distress experienced by many women who undergo this practice.

**Conclusion**

 While tradition and culture play a central role in the practice of FGM, it is never-the-less a breach of women’s’ human rights that impacts on their mental and physical wellbeing. It would appear that the number of studies relating to the psychological consequences of FGM remain low compared to the considerable number of research studies on the physical and sexual consequences of FGM, suggesting that more needs to be done if the mental health needs of this group of women are to be appropriately met. It is evident that young girls and women who have undergone FGM are more likely to suffer psychological consequence than those not exposed, and that the level of distress is likely to be determined by important factors such as the severity of FGM, the socio-cultural contexts and their psychological predisposition. While research solely exploring the psychological aspects of the different types of FGM should be sought, specialist education and training that take account of the factors above have the potential to provide mental health professionals with a greater understanding of the issues facing women from practising communities. Globally, transcultural nursing is a facet of the 21st century and while the sociocultural aspects of FGM bring an associated complexity in addressing the needs of this group of women, mental health nurses, often the first point of contact, are best placed to explore how service provision can be improved. Moreover, there is an urgent need for further research in regard to the types of psychological interventions that would be sensitive and appropriate for women from the FGM practicing communities if mental health nurses are to meet the psychological health needs of a high proportion of the estimated that 100 million to 140 million plus girls and women worldwide who have undergone FGM

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