



FGM CONFERENCE  
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## Psychological research in 'female genital mutilation' (FGM)

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**Aim:** Introduce new directions for psychological contributions relating to FGM

## Objectives

- 1) Report on a piece of pilot work to explore feasibility of psychological research with clinic attenders
- 2) Report on a piece of evaluative research

## Barriers to collecting psychological evidence against FGM

(see: Liao, FGMNCG website)

- Difficulty in recruitment of participants: language barriers; cultural taboo, representativeness of samples and generalisability of results, etc.
- Concerns about pathologising women with FGM
- Concerns about cultural interference - misplaced political correctness?
- Women who have undergone FGM also suffer other problems that could lead to mental health difficulties
- The link from memory of FGM as traumatic event to its having caused any mental health problem tenuous
- Time lag between any psychological problems and FGM defies simplistic linkages

*“It” [FGM] finds support in the ignorance of the negative aspects of the practice and the relative value granted to the positive ones. Most of the consequences become evident only several years after the operation; as a result the connection between cause and effect is not made by all of the women.” (Gallo, 1985)*

The 2 studies presented are examples of methodical work suggested in Liao, FGMNCG website

## Study 1

*Liao LM, Elliott C, Ahmed F, Creighton SM. Journal of Obstetrics & Gynaecology in press 2013*

### ● METHOD

- 17 women attending African women's clinic in London
- 30-60 min structured interviews with bi-lingual English/Somali researcher

### ● PARTICIPANTS

- Of 17, 10 referred by GP, 3 by midwife, 4 self referred
- 13 in relationship, 4 had children
- Seven women with Type 3, three with Type 2, one with Type 1

## RECALL OF FGM

- The majority of the women had undergone FGM in early childhood:
  - 7 (41%) aged 3 to 5, 7 (41%) aged 6 to 8, 1 (6%) aged 9 to 12, and 2 (12%) aged 13 to 16.
- None of the women reported that they had consented to FGM:
  - 8 (47%) mothers wanted the procedure
  - 5 (29%) said parents instigated the FGM
  - 3 women (18%) said it was a female relative
  - 1 (12%) was unsure
  - 2 women (12%) stated that their mother did not want the procedure for them
  - 6 (35%) stated that their father had not wanted the procedure
  - 2 (22%) women said siblings did not want the FGM to be performed
- For six women (35%) a doctor had performed the operation:
  - 4 women (24%) had the procedure performed by a friend
  - 4 women (24%) had the procedure performed by a traditional woman
  - A pharmacist performed the procedure for one woman (6%)

# PERCEIVED LONG TERM EFFECTS OF FGM

## ● Long term health problems

- 4 women reported no long term problems following FGM
- 7 attributed physical health problems of some sort to FGM
- 7 attributed mental health problems to FGM
- None of the participants had ever accessed psychological services

## ● Sexual problems

- 4 women reported no sexual problems due to FGM
- 2 reported fear of men
- 4 women experienced emotional or family problems related to FGM
- 1 woman stated that FGM had affected her in every way
- 8 women appraised their overall physical and mental health to be good
- 9 women said family life and personal relationships were going well

# KNOWLEDGE AND ATTITUDES

- Knowledge of the law:
  - When asked, only 5 women knew reinfibulation was illegal after childbirth
  - Only 3 knew it was illegal for a midwife to reinfibulate after childbirth
  - 4 women thought it was illegal to operate on genitals for cosmetic reasons
  - 15 women were aware that even mild FGM is illegal in UK on consenting adult women
  - But only 12 women thought it was illegal to perform mild FGM on a girl in the UK
- Attitudes towards FGM
  - 14 of the 17 women agreed categorically that FGM should be eradicated as soon as possible.
  - ALL of the women disagreed that adults should have the right to circumcise daughters even if it were made safe, hygienic and pain free
  - But, only 11 women disagreed that doctors should reinfibulate after childbirth

## Conclusions

- This study shows that once language barriers are removed attendees at specialist clinics are very willing to share perceptions and thoughts around FGM
- A significant proportion of participants reported mental health difficulties which had not been explored by previous health care providers
- Most of the women had limited formal education about FGM which signposted to service improvement strategies



## Study 2

*Elliott, Barker, Creighton, Barker & Liao (in preparation)*

### Aims:

- To educate sexual and relationship therapists (SRTs) about

### Objectives

- To estimate SRTs' baseline knowledge and attitudes relating to FGM
- To evaluate the immediate impact of a 90-minute brief intervention on knowledge and attitudes

## Background to study: Generic information

- Practitioners who work with individuals and families from FGM practicing communities can play a central role in the prevention of FGM as they have privileged access to families with girls who might be at risk (Jaeger, Caflisch & Hohlfeld, 2009)
- An educational intervention conducted with women at a hospital in Enugu state, Nigeria showed that post-intervention support for FGM fell to 11% from 70% (Ekwueme, Ezegwui & Ezeoke, 2010).
- Large scale cross-European study of health professionals, to assess knowledge and awareness of the practice (Leye et al, 2006)
  - Of 1800 respondents, only 300 respondents returned completed questionnaires but of these practitioners, nearly all respondents were aware of the definition of FGM, 40% knew the detail of the FGM Act and 84% respondents knew the complications of FGM.

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## Background to study: Transnational feminist perspective

- A transnational feminist methodology and analysis highlight the ways in which disadvantage due to gender, as well as 'race', ethnicity, sexual orientation and other geo-political factors intersect to influence the lives of women affected by FGM
- Transnational feminist scholarship has at its core transformational action; it challenges the knowledge produced under largely White, patriarchal conditions

## Methodology and Analysis

- **Bespoke pre- and Post-workshop questionnaires comprising multiple choice questions and visual analogue scales**
- **Interviews**
  - Analysis of the five telephone interviews and the repeated measures questionnaires is guided by thematic analysis and Social Representations Theory (Moscovici, 1961; 1973).
- **Intervention: A 90-minute workshop within COSRT annual conference of 2012**
  - Of 54 participants, 39 provided feedback to COSRT on the content, with 24 (62%) rating as EXCELLENT and 15 (38%) as VERY GOOD. No participants rated the workshop as GOOD, FAIR or POOR.

## Participants

49 participants completed pre/post questionnaires to enable comparison:

- 39/49 (80%) female
- 36/49 (74%) White British
- Mean age of 57 years (SD=8)
- Mean years in therapeutic practice of 16 years (SD=9.2)
- 33/49 (67%) of the participants reported not having worked with clients with FGM-related difficulties
- 12/49 (24%) reported having worked with FGM-affected communities
- 34/49 (69%) would like more information on FGM for professional needs

# Questionnaire results

## Baseline

- 14/49 (29%) aware FGM was made illegal in 1985
- 17 /49 (35%) aware FGM classified into three to four types
- 12/49 (25%) estimated more than 100,000 women in the UK were living with FGM
- 40 (42%) used term FGM, 12 (12.8%) used FGC, 9 (9.6%) used female circumcision (others said 'depends' or 'not sure').

## Main finding

- A 90-minute workshop managed to significantly improve knowledge in care providers

## Results: factual information

Specifically, after the workshop, participants were significantly better at:

- Correctly identifying which FGM practices are illegal ( $p < 0.005$ )
- Identifying physical difficulties associated with FGM ( $p, 0.001$ )
- Naming practising ( $p < 0.001$ ) and non-practising communities ( $p < 0.015$ )
- Estimating the number of women with FGM in the UK ( $p < 0.001$ , one-sided)
- Knowing the classifications of FGM types ( $p < 0.001$ , one-sided)

## Results: How opinions changed

Opinion statement	Most strongly disagree	
	Pre-workshop	Post-workshop
'With informed consent from parents and daughter, mild circumcision (e.g. a symbolic pin prick) by a doctor on girls (under 16) should be allowed'	55.1%	60.6%
'Mild circumcision (e.g. a symbolic pin prick) on consenting adult women by a doctor should be allowed'	44.9%	47.9%
'After childbirth, re-infibulation by a doctor on consenting adult women who had been infibulated before the birth should be allowed'	47.0%	64.6%
'With informed consent from the parents and daughter, cosmetic surgery on girls (under 16) to change the external genital appearance should be allowed'	53.0%	58.3%
'With informed consent from parents and son, cosmetic surgery on boys (under 16) to change the genital appearance should be allowed'	36.7%	56.3%



## Results: How opinions changed

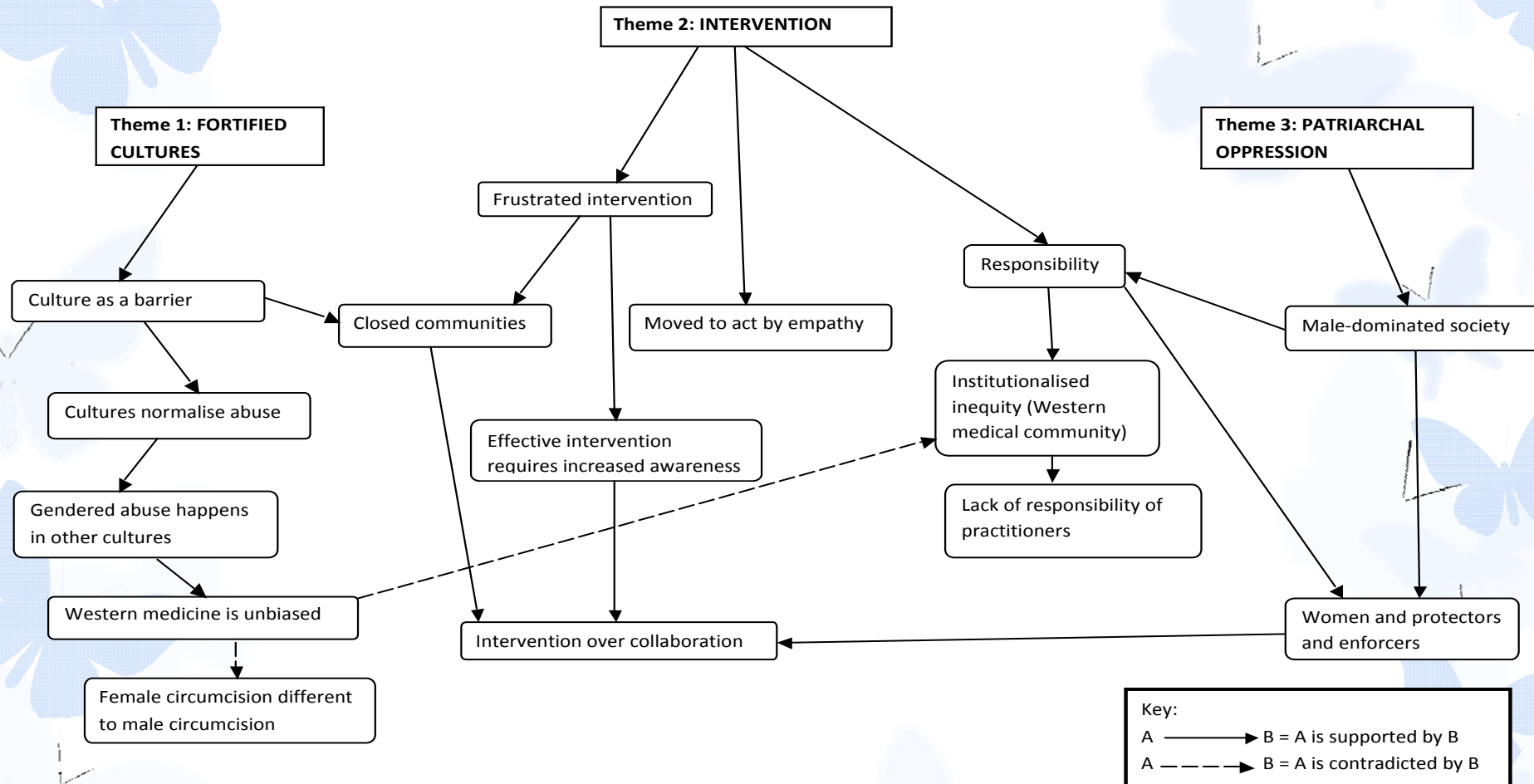
Opinion statement	Most strongly agreed	
	Pre-workshop	Post-workshop
'Male circumcision on consenting adult men should be allowed'	30.6%	19.5%
'Parents who allow their daughter to be circumcised in anyway should be prosecuted'	26.7%	14.6%

## Results: To whom, what and how it is done is what matters

	Pre-workshop						Post-workshop						Status of significance level
	M	SD	W	z	p	r	M	SD	W	z	p	r	
'With informed consent from the parents and daughter, cosmetic surgery on girls (under 16) to change the external genital appearance should be allowed'	6.02	1.47	89.5	-0.223	0.838		6.15	1.38	85	-0.754	0.471		Remains non-significant
'With informed consent from parents and daughter, mild circumcision (e.g. a symbolic pin prick) by a doctor on girls (under 16) should be allowed'	5.95	1.7					5.98	1.6					
'Cosmetic surgery on consenting adult women to change the external genital appearance should be allowed'	4.4	1.62	75	-0.828	0.448		4.82	1.66	85	-1.903	0.059		Remains non-significant
'Cosmetic surgery on consenting adult men to change the genital appearance should be allowed'	4.34	1.85					4.34	1.81					
'With informed consent from parents and son, cosmetic surgery on boys (under 16) to change the genital appearance should be allowed'	5.42	1.84	12	-3.009	0.002	0.45	5.91	1.56	50	-0.938	0.358		Becomes non-significant
'With informed consent from the parents and daughter, cosmetic surgery on girls (under 16) to change the external genital appearance should be allowed'	6.02	1.47					6.15	1.38					
'With informed consent from parents and daughter, mild circumcision (e.g. a symbolic pin prick) by a doctor on girls (under 16) should be allowed'	5.95	1.7	97.5	-3.167	0.001	0.49	5.97	1.6	99	-3.438	0.0001	0.51	Remains significant
'Male circumcision on boys (under 16) should be allowed'	4.51	1.71					4.78	1.64					
'With informed consent from parents and son, cosmetic surgery on boys (under 16) to change the genital appearance should be allowed'	5.42	1.84	22.5	-3.557	0.0001	0.55	5.91	1.56	30.5	-3.619	0.0001	0.55	Remains significant
'Male circumcision on boys (under 16) should be allowed'	4.51	1.71					4.78	1.64					
'Male circumcision on consenting adult men should be allowed'	2.86	1.88	5.5	-4.448	0.0001	0.68	3.85	3.28	72	-2.455	0.0001	0.36	Remains significant
'Cosmetic surgery on consenting adult men to change the genital appearance should be allowed'	4.34	1.85					4.34	1.82					

# INTERVIEW RESULTS: Themes

Figure 2: FGM thematic network



## Hopes for the future



-Psychological research with affected women and care providers is possible

-Psychological practitioners are committed to developing their role vis a vis FGM

-Psychological care providers are responsive to low-cost educative interventions