

What are the psychological effects of Female Genital Mutilation?

How can psychiatrists support survivors of the practice?

A discussion delving into Female Genital Mutilation
and the role of psychiatrists

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Words: 6025

“It was on a Sunday night when my Mum called me and she said “my daughter, come” in a low voice. I went quietly. Suddenly my Mum said “my daughter tomorrow is your d day”. I was shocked to hear that but I was not expected to say anything. In the morning I was dragged and pinned on the ground when three women sat and crucified me on the floor. I cried until I had no voice. The only thing I said was Mum ‘where are you?’ and the only answer I got was ‘quiet, quiet girl’. The pain I had experienced was one I will not forget for the rest of my life and I would not wish the same to happen to my friend. I had sleepless nights. I could see an old lady doing it again and again and again. I screamed and my Mum came to check on me. My loving parent is this really what I deserve? ”

- Fouzia, 10, Somaliaⁱ

Introduction

Female Genital Mutilation is a practice that the WHO estimate affects 200 million women around the world. The World Health Organisation defines Female Genital Mutilation as *“all procedures that involve partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reason.”*ⁱⁱ Whilst the practice of FGM is often attributed to the Middle East, Sub-Saharan Africa, North Africa and to a lesser extent Asia it is now being witnessed in cities across the globe with high numbers of FGM practicing communitiesⁱⁱⁱ.

The World Health Organisation divides Female Genital Mutilation into 4 categories with **type 1 (clitoridectomy)** consisting of the partial or total removal of the clitoris and prepuce in rare cases. **Type 2 (excision)** is the partial or total removal of the clitoris and the labia minora with or without excision of the labia majora. **Type 3 (infibulation)** is the narrowing of the vaginal opening through the creation of a covering seal which is created by cutting and repositioning the labia minora, or labia majora or via stitching. The clitoris is not always removed. **Type 4** includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area and some sources include female genital cosmetic surgery in this category^{iv}.

Female Genital Mutilation offers no health benefits for girls and can cause severe immediate physical complications such as haemorrhage, shock and death. It can also lead to long term consequences such as urinary problems (painful urination, recurrent UTIs), menstrual issues, infections, complications during birth and psychological and emotional trauma (ibid). The practice is often carried out by traditional female circumcisers who are survivors of the practice themselves and increasingly is performed by health care providers in a bid to sanitise and medicalize the practice.

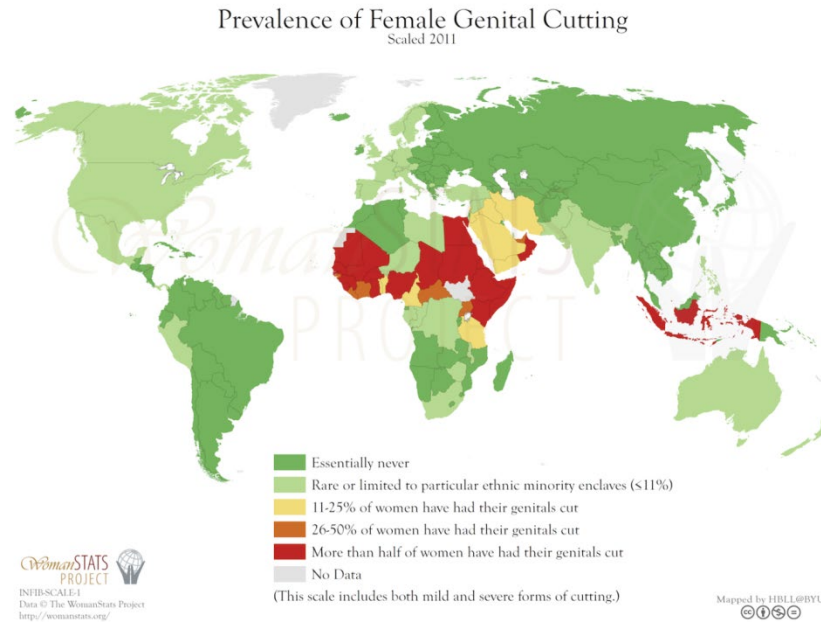


Figure 1: Map showing the prevalence of Female Genital cutting world wide^v

Cultural and social factors for performing FGM

Whilst FGM represents a prima facie case of human rights violation the practice is so much more complex than this. The practice of Female Genital Mutilation is entrenched within many cultures and societies throughout the world. From the ‘Bondu Society in Sierra Leone^{vi}’, in which FGM initiates a girl into womanhood, to Somalia, in which it is estimated that 95% of the female population has been circumcised^{vii}, the practice has been continually perpetuated as a method of preserving virginity, preserving family honour and initiation among other reasons. As one Kenyan Masai tribe member stated *“when you cut a girl, you know that she will remain pure until after she gets married, and after marriage, she will remain faithful.”^{viii}* ⁹ In cultures that practice Female Genital Mutilation, the ritual confers upon women full social acceptability, integration into the community, and serves as a rite of passage to womanhood. For many women in these cultures, the practice enables them to identify with their heritage and to enjoy recognition as full members of their ethnic group enjoying social benefits and privileges.^{ix}

The reasons why female genital mutilations are performed vary from one region and include a mix of sociocultural factors within families and communities. Some of the more commonly held reasons will be explained.^x In some societies Female Genital Mutilation is a social norm and so there is social pressure to conform to social standards in order to be a member of the community. In these communities Female Genital Mutilation is so ubiquitous that it is performed without question and to change the status quo is to challenge the community's very cultural identity.

Another reason that is often cited is the fact that Female Genital Mutilation can be considered an essential part of a woman's identity and can mark a girl's ascent into womanhood in order to prepare her for adulthood and marriage. Within certain community's a girl has no social currency if she has not been cut and can become ostracised. The practice is also often motivated by beliefs about the female sexual identity and is utilised to preserve a woman's virginity prior to marriage. It is thought to reduce a woman's libido and thus reduce any temptation to engage in extra marital sexual acts. With type 3 Female Genital Mutilation the vaginal opening is narrowed or covered and so this serves to act as a physical barrier to a woman having sex prior to marriage as any disruption to this covering shows that a woman has not remained chaste.

In some communities a man will only marry a woman if she has been cut. It is a way of increasing her social value and becomes essential if a girl is taught her main aim in life is to be a wife. In cases where Female Genital Mutilation is likely to increase marriageability the practice is more likely to be carried out. The practice is also intertwined with cultural ideals of femininity and modesty and the idea that the clitoris and other parts of the female genitalia are masculine and unclean.

It must be said that whilst religion is often cited as a prime reason for why Female Genital Mutilation is carried out the practice is not supported by any religious texts. It is often upheld by community figures of authority such as religious leaders, community leaders and elders, circumcisers, and even some medical personnel through its recent medicalisation. In some countries medical personnel have begun to carry out the procedure in hospitals and other health care settings in a bid to sanitise the tradition. This just serves to reinforce the idea that Female Genital Mutilation is medically endorsed and encourages its practice.

In most societies, where FGM is practised, it is considered a cultural tradition, which is often used as an argument for its continuation. This should be especially considered in immigrant communities where it could be thought that the maintenance of the practice is a means by which a cultural identity and tradition can be maintain in a foreign land, In order to eradicate the practice it is essential that the reasons for its existence are well understood.

Female Genital Mutilation in the United Kingdom

Chart one: Number of newly recorded FGM cases in London during the year April 2015 to March 2016

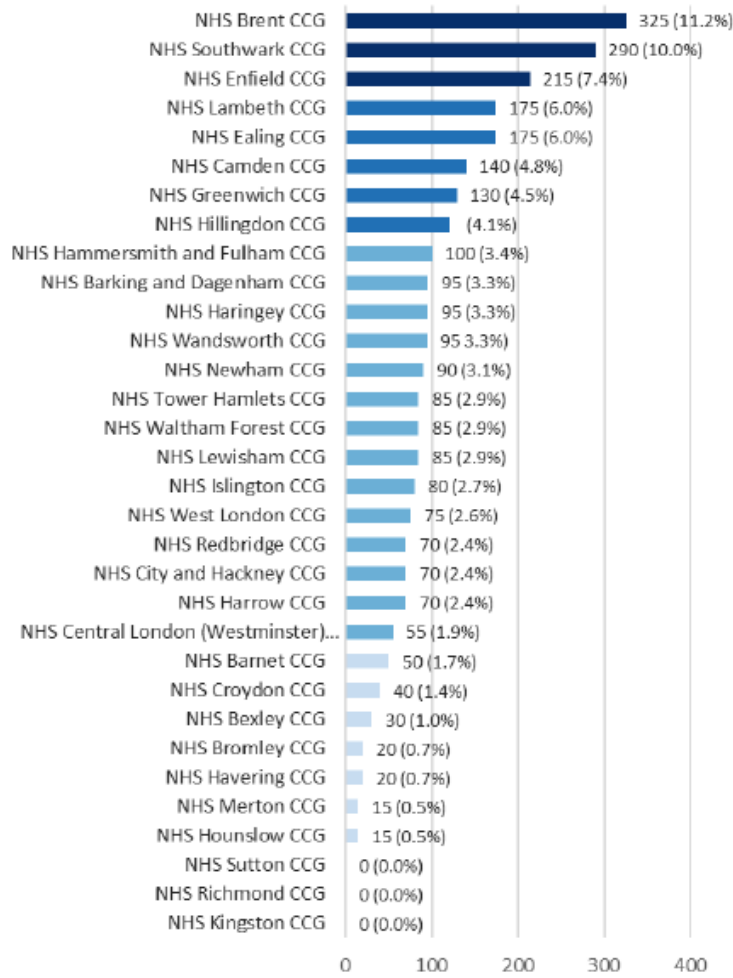
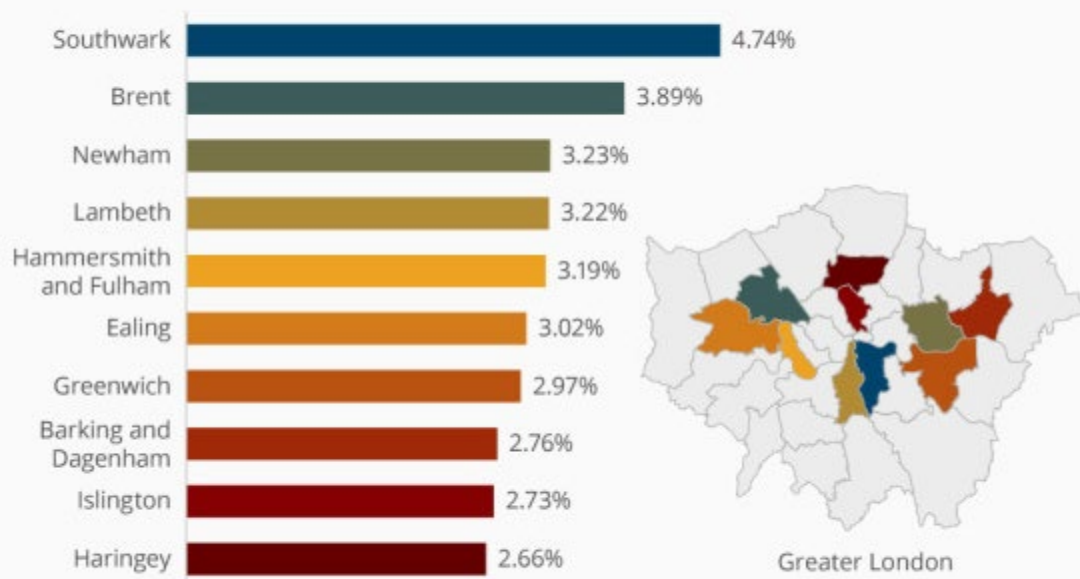


Figure 2: Diagram showing newly recorded Female Genital Mutilation cases in London ^{xi}

Top 10 UK boroughs by FGM prevalence

Estimated percentage of women that have undergone female genital mutilation



Source: City University London/
Equality Now

THE HUFFINGTON POST **statista**

Figure 3: A diagram from a British mainstream media outlet showing the ten London boroughs with the highest prevalence of Female Genital Mutilation ^{xii}

Currently in the United Kingdom there is a prolific campaign underway which aims to eradicate the practice of Female Genital Mutilation by developing a groundswell of opinion which will hopefully have a 'domino affect' and propel the sensibilities of those who perpetuate the practice towards its unequivocal condemnation. This slow change in the sensibilities of the British public could be due to a number of reasons such as the politically correct nature of British society in which people fear being perceived as a 'cultural imperialists' and adopt a 'culturally –relativist' approach and choose not to comment or interfere^{xiii}. In an era where it is estimated that 66,000 women in the UK^{xiv} have been victims of FGM it is time for a real dialogue about FGM to occur.

The Mayor of London (Sadiq Khan) declared in 2017 that he wanted the prevention and eradication of FGM to be on the political agenda. He has vowed to make London a 'zero cutting city' through the education of the population as well as professionals on the frontline such as doctors and the police^{xv}. Whilst FGM was made illegal in 1985^{xvi} it was only in 2019 that the first successful prosecution took place. This case is centred around a mother who was prosecuted for cutting her three year old daughter at their London home and whilst this is a landmark case in the UK it is thought that 65,000 girls under the age of 13 are currently at risk of undergoing the procedure. It is thought that whilst 170,000 *women* in the UK have experienced FGM, half of all of England's recorded cases are in London^{xvii}. This means that psychiatrists and health care professionals within London are more likely to encounter women that have undergone FGM than their counterparts in other areas of the United Kingdom. This essay aims to explore the psychological impact of Female Genital Mutilation on survivors of the practice and their family dynamics whilst highlighting the role of the psychiatrist when encountering such patients.

The psychological impact of FGM on the individual

Throughout the literature on Female Genital Mutilation the psychological consequences of the practice are often highlighted. Much of the data focuses on psychological sequelae such as depression, anxiety and post-traumatic stress disorder. In a literature review focused on the psychological impact of Female Genital Mutilation 80 percent of analysed studies reported psychological consequences, such as Post-Traumatic Stress Disorder (PTSD) and affective disorders in those who were FGM survivors^{xviii}.

This is further supported by a study of 47 Senegalese women which has shown that there was a higher prevalence of PTSD (30.4%, n=7/23) in 23 cut women as opposed to 24 uncut participants. The group sample's high prevalence of Post-Traumatic Stress Disorder is comparable to the observed percentage of cases of PTSD documented in literature that focuses on PTSD percentages seen in survivors of early childhood abuse (usually between 30% and 50%)^{xix}. Whilst these women in the aforementioned study fulfilled the DSM IV criteria for PTSD other studies have shown that some FGM survivors do not meet the diagnostic threshold but still experience psychopathology. In a cross sectional study of 4800 pregnant women 85 percent of the women who had been circumcised experienced vivid flashbacks to the cutting event^{xx}.

Depression also remains a much documented psychological consequence of FGM according to the literature. A Dutch cross-sectional study on 66 African female survivors of FGM showed that a fifth of the women (20%, n=13) met the criteria for PTSD and a third met the DSM IV criteria for depression (33%, n=22)^{xxi}. This is further supported by an Egyptian cross sectional study that collected data from 204 adolescent girls aged 14 to 19 years old and found that those who had undergone FGM demonstrated a significantly higher level of depression as well as anxiety and somatization than their peers without FGM^{xxii}.

Further evidence can be found in a study of women who had undergone Female Genital Mutilation and were seeking asylum in the United States. The frequency of anxiety, depression and PTSD was evaluated via a retrospective qualitative descriptive study in which cases that had been observed in an asylum clinic over a 2-year period were analysed. Candidates were given standardized questionnaires which enabled them to provide quantitative scores for anxiety, depression and PTSD. Out of all these particular cases anxiety and depression were exhibited by 92 percent and 100 percent of women respectively and all the women screened for PTSD had symptoms^{xxiii}.

The evidence in favour of the fact that Female Genital Mutilation has adverse psychological effects is well documented and the aforementioned studies serve to cement this fact. Whilst these studies all talk about the long term psychological impact of the practice and focus on adult survivors there is evidence to suggest short term psychological consequences can be seen in children. Evidence suggests that the trauma of Female Genital Mutilation can often manifest itself in social withdrawal, low mood and inattention in class children who have been cut. Thus the practice of Female Genital Mutilation does not just leave physical scars but for many women, as the literature shows, it can be the trigger for a lifelong psychological burden.

The psychological impact of FGM on the family dynamic

Whilst a discussion has taken place about the psychological impact of Female Genital Mutilation on the individual it would not be right to ignore the impact of the practice on the family dynamic.

Ironically it is mainly women who perpetuate Female Genital Mutilation, albeit with the tacit consent of men, and this can be understood using Gramsci's concept of Hegemony^{xxiv}. Gramsci argues that the ruling class manipulate and construct culture so that a ruling class perspective becomes universally accepted by the lower classes, even to their disadvantage, and becomes the cultural norm. In this instance it is men who have acted as the ruling class colouring the social views so that women perpetuate the practice of FGM in the belief that it is the only method by which they and their daughters can be integrated into society. Whilst FGM has become increasingly medicalised it is more often than not carried out by women known to the victim and evidence suggests this has led to increasing distrust in the family unit and disruption of the mother-daughter bond^{xxv}

When analysing many of the societies in which Female Genital Mutilation occurs it is clear a patriarchal social framework is in place. When considering this fact it is essential to reflect on the prescribed roles for women and men and the social value and currency the fulfilment of these roles brings. Women, often, find their role is to be a wife and mother thus any factor that prevents the fulfilment of these roles can have severe consequences.

A Saudi Arabian cross-sectional conducted on a sample of Sudanese women who had experienced Female Genital Mutilation aimed to observe if sexual dysfunction was linked to the practice through the use of the Female Sexual Function Index (Figure 4). 107 eligible women completed the survey and the gynaecological examination and 39% of the women had FGM/C Type I, 25% had Type II, and 36% had Type III. The results showed that 92.5% of the women scored lower than the Female Sexual Function Index cut off point. Interestingly sexual function was lower the more severe the type of cutting across all sexual function categories: desire, arousal, lubrication, orgasm, satisfaction, and pain^{xxvi}.

Domain	Questions	Score Range	Factor	Minimum Score	Maximum Score	Score
Desire	1, 2	1 – 5	0.6	1.2	6.0	
Arousal	3, 4, 5, 6	0 – 5	0.3	0	6.0	
Lubrication	7, 8, 9, 10	0 – 5	0.3	0	6.0	
Orgasm	11, 12, 13	0 – 5	0.4	0	6.0	
Satisfaction	14, 15, 16	0 (or 1) – 5	0.4	0.8	6.0	
Pain	17, 18, 19	0 – 5	0.4	0	6.0	
Full Scale Score Range				2.0	36.0	

Figure 4 : Female Sexual Function Index^{xxvii}

The link between female sexual dysfunction and Female Genital Mutilation is further compounded by a case-control study in which a sample of 280 Kurdish Iranian married women who had been referred to the healthcare centres for various reasons were recruited. 140 of the women had undergone some form of

Female Genital Mutilation and the other 50 percent had not. The Female Sexual Function Index was utilised to assess female sexual function. Non-circumcised women had significantly higher FSFI total score (25.3 ± 4.34) compared to the circumcised women (17.9 ± 5.39) suggesting that sexual function is adversely impacted by FGM^{xxviii}. When thinking about womanhood within different cultural frameworks there is often a sexual aspect that involves a woman being a vehicle by which her husband can obtain sexual pleasure in the context of a marital union. If a woman is unable to obtain pleasure from sexual activities or positively engage in the sexual experience this may be perceived as a woman showing an inability to sexually engage with and thus satisfy her husband which may lead to her identity as a woman being questioned.

When conducting reviewing the literature pertaining to Female Genital Mutilation much of it was centred on the obstetric complications that the practice can cause. It is well documented that Female Genital Mutilation can lead to reduced fertility, prolonged labour/complications during labour as well as increased risk of maternal haemorrhage and death^{xxix}. This is important to note when considering the role of a woman in certain communities as the giver of life. A woman failing to produce a large number of healthy children could be perceived as a woman failing to fulfil her role. This coupled with the well documented psychological impact of Female Genital Mutilation as well as the mental anguish that many women experience when there are complications giving birth can cause an insurmountable mental burden for a woman at a time when she is extremely vulnerable.

Female Genital Mutilation and cultural identity

When considering Female Genital Mutilation within the context of modern British society it would be a mistake to deny its link to the migration of multiple ethnic groups and their cultural identity. It is a practice, as mentioned previously, that for some has become synonymous with stepping into adulthood and entering society whilst for others it provides a vehicle by which a woman is marked as being suitable for marriage. When considering the intention behind the practice it is important to consider the impact that not undergoing the procedure could have on a woman's psyche. In a survey of 282 female Egyptian nursing students 60 percent of the women considered circumcision for their daughters as it was deemed to be beneficial^{xxx}. Now it has been shown that Female Genital Mutilation confers no health benefits whatsoever and so it is evident that the benefits from the practice are social in nature. This need to ensure one's daughter remains part of the social fabric drives the practice forward and it is essential to think about what the implications of not partaking in the practice can mean for a woman.

This need to maintain an identity and remain part of the social fabric is further heightened within the context of an immigrant community that strives to maintain its culture. Whilst Female Genital Mutilation has been illegal in the United Kingdom since 1985 it is still practiced covertly as the landmark first FGM prosecution in the UK shows. In that particular case a three year old was cut by her mother and instructed on how to attempt to obscure the truth from social services and health care professionals. This evidently shows a dichotomy in social consciousness as the girl's mother is aware of the laws of the United Kingdom and so instructs her daughter to cover the truth yet feels a strong pull to maintain traditional cultural practices and perpetuate the cycle of cutting. Immigrant populations may find their ethnic identity challenged by the process of migration and subsequent assimilation and so a struggle to terminate cultural practices like Female Genital Mutilation ensues. Much of the literature shows that there is an increase in risk of mental health issues such as depression and anxiety in first generation migrants in comparison to the native population^{xxxi} and this could be attributed to social isolation, adapting to a new environment and issues of identity and perception of the self. The impact that a change in cultural context and questioning of identity can have on mental health are factors that should be considered in the

discussion surrounding Female Genital Mutilation. If one considers what FGM could possibly represent for a community and the social currency that hinges on maintaining the practice then an attitude of empowering a community is empowered to adopt different cultural behaviours can be adopted.

In considering Female Genital Mutilation from a cultural perspective and the eradication of the practice parallels can be drawn between FGM and foot binding. Gerrie Mackie^{xxxii} references the fact that foot binding ended within 'a generation' in China and served a similar purpose to FGM: *'both were necessary for proper marriage and family honour, both were sanctioned by tradition [and] both were said to be ethnic markers'*. Mackie highlights the three steps used to eradicate foot binding which were: 1) an education plan highlighting the world's perception of China due to this practice and its deviation from the universal norm, 2) an education plan highlighting the dangers of the practice 3) and benefits of natural feet and forming natural foot societies in which women vowed not to allow their daughter's feet to be bound and refused to allow their son's to marry women with bound feet. These methods led to the end of the practice of foot binding and could have the same effect if utilised correctly in regards to FGM; the key to all of this is education and cultural understanding. We must remember that *'culture does not make people, people make culture'*.^{xxxiii} Culture is fluid and can be adapted and changed.

The role of the Psychiatrist

Psychiatrists bring an important perspective to the leadership of an organisation. This includes their expertise regarding the prevention, cause and treatment of mental and physical illness

-Safe patients and high-quality services Job descriptions for consultant psychiatrists Royal College of Psychiatrists Nov 2017^{xxxiv}

When discussing Female Genital Mutilation and the role of the health care professional in the eradication of the practice there is often not much discussion about the role of the psychiatrist^{xxxv}. The literature discusses the need for the Multidisciplinary team, the Obstetrics and Gynaecology Physician, the paediatrician, the social worker etc. but I am yet to see a discussion that specifically analyses the role of the psychiatrist. This is very striking as there is a plethora of literature about the adverse psychological impact of the practice on women.

In a study exploring the psychosocial issues experienced by African immigrant women who had undergone Female Genital Mutilation and were now living in the Netherlands it was found that 1/6 of these women suffered from Post-Traumatic Stress Disorder and 1/3 reported symptoms associated with depression and anxiety. These findings, unfortunately, are not surprising but what was striking is the fact that these negative psychological sequelae became worsened during pregnancy and childbirth. Many women in the study also reported that migrating to the Netherlands led to a shift in their perception of Female Genital Mutilation and left them feeling ashamed about having FGM and reluctant to engage with physicians^{xxxvi}. This highlights the need for supportive and culturally sensitive perinatal psychiatric care in those women who known to be survivors of Female Genital Mutilation.

This need for perinatal psychiatric involvement in women with Female Genital Mutilation is further demonstrated by a recent study that looked into the development of obstetric fistulae following the practice in Kenya. It is estimated that 28% of the Kenyan female population has been cut (12,418,000). The study involved the conduction of interviews with thirty women who had experienced FGM and were living with obstetric fistulae. It was found that amongst nearly all of the women interviewed there had been a clear pattern of rejection from their social community (spouses, friends, family) which then led to depression and lowered self-esteem. This low mood is followed by a loss of work, rejection from spouses,

friends and family and so these obstetric complications have been a trigger for deteriorating mental health^{xxxvii}. This was a clear example of how the need for perinatal psychiatric support is extremely

. It is important that psychiatrists remain sensitive when engaging with these vulnerable women and create a safe space for these women to acquire the support they need.

One aspect of health care that psychiatrists are desperately needed for is in the field of research. It has been found that studies that look into the psychological consequences of FGM are often designed poorly; feature small sample sizes and inconsistent results which make it difficult to come to clear conclusions.^{xxxviii} There is a need not just for conclusive studies that examine the psychological consequences of FGM but also investigate the relationship between psychological outcomes and the circumstances around the cutting event in order to individualise the psychological support provided to women. It is also important to emphasise the negative psychological after effects of the practice so that psychiatrists can adopt an appropriate approach when dealing with FGM survivors^{xxxix}.

There is also not much knowledge in place in regards to what treatment works best in women who have had Female Genital Mutilation. The World Health Organisation literature^{xl} suggests that cognitive behavioural therapy (CBT) may work with survivors of Female Genital Mutilation who have experienced symptoms of anxiety, depression, and/or PTSD. However there are no studies that directly investigate the effectiveness of CBT in women with FGM but rather this has been inferred and extrapolated from the use of CBT to successfully treat PTSD following wars and sexual violence^{xli}. It is thought psychological support is also indicated for women who undergo any surgery related to complications related to Female Genital Mutilation as well as childbirth in order to avoid a relapse in mental health symptoms related to Post Traumatic Stress Disorder. This means psychiatrists have an important role in galvanising the MDT in order to ensure psychological support is provided for these women not when recovering from the initial cutting but in all the subsequent stages that could trigger a psychological relapse.

Finally a conversation must be had about the ways in which psychiatrists can engage in key conversations with survivors of FGM. Safeguarding and child protection remains a prime concern to ensure that those at risk are protected but this should not be a barrier to a woman accessing the health care that she needs. Due to the upsurge in anti-FGM propaganda and education many families are aware of the penalties that perpetuating the practice can carry. It is important that the psychiatrist, along with other health care professionals, does not alienate these communities but rather educates and empowers them to turn away from the practice. The law can act as a barrier to communication and women may be scared to disclose what has happened for fear of the legal implications it may have for their family and community. Women who are recent immigrants to the United Kingdom may fear deportation if they engage with healthcare providers when their legal status has not been confirmed. This is an extremely sensitive topic and psychiatrists must tread with care and consideration when engaging with women and their families.

FGM is a sensitive and complex matter, and talking about it can make health professionals feel uncomfortable. Our reluctance to engage with women about FGM may be caused by embarrassment, uncertainty about how to frame the questions, or anxiety about being perceived as culturally insensitive
 - British Medical Journal^{xliii}

When considering how to broach the topic of FGM, the British Medical Journal provides some excellent advice that may serve psychiatrists well. The publication stresses that it is important to create an optimum environment to cultivate discussion through privacy and providing adequate time for sensitive discussions to be had. The use of a female professional and trained interpreter may serve to put patients at ease. It is also important for psychiatrists to use the correct terminology and not utilise any phrases that have negative connotations. A woman sharing about her experiences being circumcised is an extremely brave and vulnerable act and it is essential to ensure she is treated with the utmost dignity. It is important to remember that women, in the majority of cases, have not chosen to undergo FGM and are victims whose needs must be assessed so that they can be met.

Conclusion



Figure 5: Art work from the Female Genital Mutilation themed photography exhibition entitled the Unsterile Clinic by Aida Silvestri ^{xliiii}

Throughout this essay the psychological impact of Female Genital Mutilation on the individual and their family has been considered. With an understanding of this impact the role of the psychiatrist was

analysed through the use of World Health Organisation guidelines and academic literature. It is evident that within the United Kingdom FGM has emerged recently as a key talking point in the political and social arena and a lot of dialogue is being had about how to eradicate the practice. It is important that the cultural context in which the practice continues to survive is taken into consideration. Psychiatrists, when dealing with patients who are survivors of Female Genital Mutilation, must be sensitive and acknowledge the difficulty a woman might have when sharing her story and the emotions that this may evoke for her.

When looking at the photography featured in figure 5 by Aida Silvestri one cannot help but to be struck by the way in which each of the woman captured is stripped of her individuality and portrayed as genitalia. This poignantly captures the impact that the practice of Female Genital Mutilation may have on the identity and psyche of a woman and it is essential that psychiatrists remember that. It is important that each woman is recognised as an individual with her own story to tell, her own lived experience and her own humanity.

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