BUILDING BRIDGES TO END FGM

The Debates of the Community of Practice on FGM

Mental Health, Well-being and FGM

What consequences do FGM have on girls and women's mental health?

Which treatment is posible for psychological complications of FGM?

How can we enhance psychological support for girls and women living with FGM?

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Mental Health, Well-being and FGM

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Mental Health, Well-being and FGM

Introduction

Health is defined by the World Health Organisation (WHO) as *"**a state of complete physical, mental and social well-being** and not merely the absence of disease or infirmity."* (1) The WHO also underlines that being exposed to traumatic events during childhood have a crucial importance on mental well-being. It defines mental health as follows:

> *"**A state of well-being in which the individual realizes his or her own abilities**, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. With respect to **children**, an emphasis is placed on **the developmental aspects**, for instance, having a positive sense of identity, **the ability to manage thoughts, emotions, as well as to build social relationships**, and the aptitude to learn and to acquire an education, ultimately **enabling their full active participation in society**" (1, p.7)*

In studies on the links between FGM and mental health, women having undergone type I and type II FGM and those haing undergone type III (infibulation), are often distinguished.

WHO includes consequences on mental health and well-being in *"FGM sanitary risks"* and identify within the psychological risks post-traumatic stress disorder (PTSD), anxious disorders and depression (3).

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In 2018, in its guidelines on the management of health complications from female genital mutilations (3) as well as in its clinical guideline (15), the WHO emphasized the importance of adopting a holistic approach and bringing psychological support to women in need.

Furthermore, **the scarce development of mental health system and psychological support** in some countries, above all in Africa, have imposed an important **limit to our research** and explain why our data and analysis focus more on Europe. Indeed, more studies, therapies, solutions are developed in Europe and the situation is very different in Africa where it is far more difficult to find services and reports on this matter.

The purpose of this thematic note is to discuss the psychological consequences of FGM, present the current solutions and highlight what is currently at stake. If it is possible to identify psychological consequences directly linked to FGM, it is crucial to understand this event into women's life path and a broader social, cultural, economic context also influencing mental well-being. This dimension has to be integrated into solutions put in place and / or recommended to cover FGM psychological complications and resolve a main issue, namely (re)construct a positive self-image and (re)connect with others. Finally, there is still much to be done to enhance psychological support to women and girls affected by FGM and to offer them support adapted to their needs.

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I - Consequences of FGM on the mental health of affected women and girls

A - Immediate, short and long terms psychological consequences of FGM

FGM is often experienced as a traumatic experience with immediate psychological consequences as well as short and long-term consequences. Nevertheless, it is important to notice that all women react differently. **The psychological consequences are not systematic nor universal and differ from a person to another. They have to be understood in the global life path of the affected girl/woman.** How the FGM was practiced, socio-demographic characteristics, the individual story and personal coping mechanisms have an influence on the psychological consequences of FGM (4; 5). The age of cut also has an influence. Girls cut before age two do not remember it whilst those cut after five years are more at risk of experiencing greater complications and pain (5; 12).

Immediate consequences are deeply linked to how FGM was performed. Thus, the more the event is lived as a traumatic experience – if the girl has not been told, prepared, aware in advance, the stronger the shock can be. The girl can feel betrayed when the ones supposed to protect become the ones who hurt. Pain, shock, use of constraint can also be translated in a feeling of fear and powerlessness. Some girls also live an episode of dissociation and see themselves, their emotion as separated from their body and physical experience. This mechanism automatically happens in moments of strong pressure or pain to mentally protect themselves.

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Dissociation is defined as follows by the psychanalyst Sandor Ferenczi (6) : "*If the quantity and nature of pain exceed the integration strength of the person, then we surrender, we stop tolerating, it does not worth any more to gather all these painful things in a unit, we get fragmented. I do not suffer any more, I even stop existing at least as a global Me.*"

In the **short term,** the cut also has consequences on the psychological well-being. Immediate **effects can be intensified by the taboo, silence surrounding the cut preventing girls from expressing their emotions, uneasiness, and pain** (5). To the event's violence is added the violence of the unsaid during the following months and years. Difficulties of adaptation or readaptation at school are also reported (12). But again, consequences depend on the exact context of the practice.

On the **long term**, consequences can be diverse and happen on different levels in a chronic, more or less frequent and repeated way. The event can be so deeply entrenched in the child's subconscious that it can finally feeds behavioural disturbances (12). Within clinical disorders we count anxiety, depression, stress and even post-traumatic stress disorder (PTSD) (5 ; 8 ; 11 ; 14, p.257).

Post-Traumatic Stress Disorder

PTSD is defined by the combination of various factors: *"the cognitive, emotional, and physiological re-experiencing of their traumatic event(s) (B-criterion), avoidance of trauma reminders (C-criterion), an alteration of mood and cognition (D-criterion), and hyperarousal (E-criterion)"* (9). PTSD includes physical manifestations symptomatic of nervousness, **recurring, intrusive and negative memories of the event**, nightmares, phobia, anxiety. People concerned will put in place coping mechanisms to limit the confrontation to elements reminding the traumatic event.

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Moreover, **dysfunctions in the declarative memory** occur and make it chaotic and difficult for the person to speak about the event. As a matter of fact, stories of the event often tend to be incoherent, incomplete.

Traumatic memory

Women living with FGM can experience flash-backs, sensitive illusions, nightmares during which they live again their excision and feel the distress or the fear as if it were happening again – that is what we call traumatic memory.

For some women, painful intercourses and delivery can also trigger traumatic memory. In the same way, being confronted directly or indirectly during a conversation, a TV report or through the vision of her own body can also recall the cutting day (5).

B - Mutual enhancement of physical, sexual and psychological complications

Physical, sexual, social complications due to FGM can also impact women's psychological well-being. The more the type of FGM is serious the more the complications can be important and thus **concern women unequally**.

- After an infibulation, pregnancy and birth are sometimes difficult (5). Some women suffer incapacitating and stigmatising complications such as incontinency.
- Somatisation, chronic pain or dysmenorrhea (strong pain and fatigue associated with menstruation cycle) affecting some women can lead them to auto isolate.

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Moreover, psychological complications of FGM can reinforce physical problems of women as they can fear being confronted to medical staff and have **difficulties to access healthcare services**. Thus, the risk of reexperiencing the event, the fear of being examined by a medical professional and possibly judged are all obstacles for women to access services. The WHO recommends for instance that *"Psychological support should be available for girls and women who will receive or have received any surgical intervention to correct health complications of FGM"* (3, Good Practice n°3). Furthermore, **health care professionals behaviour can also have an influence** on woman's well-being, on her perception of herself, her confidence and thus on her ability to seek help.

In **Somalia**, shelters for women living with FGM are directed by midwives who are themselves affected by FGM and thus more able to build a relation of trust with the women they support. (8)

Furthermore, **sexual life of women concerned by FGM can also be affected** leading to issues within the couple. In 2010, the Norwegian Centre of Knowledge on Health Services notices that women concerned by FGM are more susceptible to suffer a decrease in their ability to experience sexual pleasure and have satisfactory sexual intercourses (11). 28 Too Many draws the same assessment as women with FGM seem to have a higher propension of feeling shameful, embarrassed in the intimacy (12). The more sexuality is considered as a taboo for concerned women, the more the effects will be important and hidden. Besides, **the mere idea of having sexual intercourse is not always thought of with tranquillity but on the contrary, with apprehension, or even fear**.

It is important to **be very careful** with the studies addressing sexual consequences of FGM. **Sexual difficulties are not universal** and do not concern all women living with a FGM. Besides, FGM are not the only responsible, a forced marriage or domestic violence, for instance, also have an important influence on sexual life. It is also fundamental to consider the influence of the way excised women's sexuality is looked at, of **normalising and stigmatising discourses surrounding women's body and genitals,** of her knowledge on her own body. (17; 21)

C - Influence of migration and social norms on young girls and women's body's acceptance

Most of the currently available studies on psychological and sexual consequences of FGM have been led in Europe and North America on migrant women concerned by FGM. **Factors such as migration, the integration in host society but also cultural and social environment, norms and customs** have, thus, been integrated in the analysis. These studies put forward the influence of external factors and **life path** on psychological consequences of FGM.

Thus, it appears that **the stronger is the social norm prescribing the practice of FGM, the less FGM are questioned and their harmful effects recognised as such**. In **Senegal**, for instance, where only 20% of women are cut and where sensitisation campaigns inform on harmful consequences of FGM the event is lived as more traumatizing (11) as in **Somalia**, for example, where FGM are highly prevalent and considered as desirable for Muslim women (4). Thus, in this second context, women develop efficient coping mechanisms and live the ritual as normal and positive (4).

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In low prevalence countries, where FGM is not the norm, the situation is different. Studies led on migrant women living in Norway and The Netherlands show that the **migratory journey can be a new hardship affecting women's well-being** (10). Some women can, then, discover that FGM have harmful effects on physic and mental health and that they are considered as a violation of Human rights. Thus, **between the home and host society, the paradigm is reversed: whilst FGM was the norm, they become the exception,** far from being mandatory and surrounded by a positive meaning, they are perceived as abnormal and illegal (20). Women can, then, feel betrayed, angry or disoriented by what they learn. New questions can be raised on the justifications of their excision. To be in a society where most of women are not cut can also create a feeling of incompleteness, inferiority, of being different or diminished as if a part of themselves was lacking. **To reconsider a social norm as strong as FGM and to be out of the norm can be lived as a second trauma for concerned women** (20).

A study conducted in Germany (5) also indicates a link between integration in host country and the report of psychological problems due to FGM: the more the women are integrated in the host society, able to speak in the national language, the more they are susceptible to report what they suffer and express their emotions.

→ To conclude, psychological complications of FGM are various and very different. All psychological, physic, sexual and social, consequences of FGM are fed back by each other and affect concerned women's well-being on an individual as well as on a social or familial point of view. Together, they will affect her identity's construction, self-confidence, and self-image. Thus, the main stake in concerned women's care is to help them to reconnect with herself and others, and enhance their well-being.

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II - Therapeutic support for girls and women suffering psychological and sexual consequences of FGM: review of current solutions

A - Good practices and objectives of therapeutic support

The WHO (14) as well as therapists (15; 16) supporting FGM survivors agree on the necessity to adopt an h**olistic approach dealing in the meantime with mental and physical health and with psychological, physical, sexual, social considerations** to better work with women. Nevertheless, the support has to be individualised, adapted to each women whose path life, coping and resilience mechanisms are singular (16). It is also important to **be sensitive to woman's culture as well as her prejudices on psychiatry** to be able to work more easily on an equal ground with her (15; 16).

Therapeutic care of women living with FGM aims to *"**support the progressive identity reconstruction** and allows the consulting person to regain ownership and conscience of her life story, her feelings, her resources and her autonomy"* (15), to help to **(re)construct a positive self-image and social relations**.

"Therefore, the quality of the attachment to the main caregiver is critical to emotional and psychological development, shaping the resources that the individual develops in order to deal with emotional and psychological stress in their lifetime" (16, p.28). In a guideline (16), four British therapists argument in this way, noting the importance of the *"attachment theory"* applicable to the relation patient – therapist. **The therapist has to be a trustworthy person, a support for the concerned woman** allowing her to feel safe, listened and thus more able to speak out.

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Welcoming the woman kindly and warmly and adopting a **non-judgemental approach** are, in this way, essential to forge an alliance with the woman and begin a progressive work, respecting her rhythm and needs. ***"Therapeutic work is developed on the ground of the links forged between the therapist and the consulting woman."*** (15, p.92)

Various therapeutical approaches, individual as well as collective can answer to woman's needs and help her in her work on her emotions, state of mind as well as on her body and social relations. All therapies for women with FGM have common aims, namely developing mechanisms of protection and emotional regulation, addressing traumatic memories, restructuring key significations, changing memorising processes, enhancing knowledge of the anatomy, body and sanitary consequences of FGM (3; 16).

The three-stage approach developed by Judith Herman for therapeutic care of survivors of trauma and can be applied to therapies with FGM survivors (16, p.30). It has three stages:

1. Stabilisation: create a secure space through practical support and internal stabilisation to enable the consultant to speak and unveil her emotions
2. Trauma processing and mourning: give support in processing traumatic memories
3. Reconnection: help in reconnecting with others and herself

B - Some examples of existing psycho-sexual therapies

Psychocorporal approach aim to deal with physical and psychological trauma by reconnecting and reunifying body and psyche. It *"invites the person to take more conscience of her corporal perception"* (15, p.96) namely to know herself, listen and trust her body. It is especially appropriated for women victim of gender-based violence and help them to address obstacles linked to the things left unsaid though corporal and behavioural exercises.

The brief therapy can complement other approaches. It focuses on understanding the positive resources women have fixing small aims and concrete exercises of stress management and exit. It *"allows women to feel like they regain control over their life despite a reality still difficult"* (15, p.99) and thus to reinforce their optimism.

The EDMR (Eye Movement Desensitisation and Reprocessing) directly works on traumatic memory and tries to reprogram and displace the memorised event in the autobiographic past memory where reminiscences of the event will be less emotionally marked. In this way, the therapist uses sensitive stimulations when the traumatic event comes back and repeats them until attenuating or even neutralising associated emotions.

Art-therapy (creativity) facilitates communication and expression of the consultant using symbols, figures instead of language sometimes insufficient or hard to use.

Psychosexual therapy can be suitable to help woman to reconnect and reappropriate her sexuality as pleasurable, enhance her self-esteem, her self-image and her perception of her genitalia. It is especially recommended to accompany reconstructive surgery's process.

Corporal expression activities is one of the collective approach that can be used to work on corporal conscience namely *"the subjective conscience of her body's sensations from internal as well as external body's stimulations"* (15, p.113) through dancing for instance. It allows to regain control over her body and interact more easily with others.

Support groups is based on women's confrontation and share of experiences. They help to break with social isolation and learn how to trust others. They are especially useful in contexts where FGM are taboo to free individual voices through the individual empowerment created by the group.

Reconstructive surgery can be adapted for some women in continuity of a psycho-sexual follow-up. It can fall within an identity (re)construction process, be a way to (re)connect with her femininity. It can also act as a symbolic and voluntary restitution of what has been removed without consent during childhood and reparation of the visible stigma that can recall the trauma. The physical, esthetical, symbolic rehabilitation can also contribute to enhance sexual and private life (18; 15).

With the increase in requests for clitoral reconstruction, the question of why was quickly raised. It has, thus, been evidenced t**he importance of stigmatising and victimising discourses around excised women's sexuality, the will to fill into social standards around female genitalia** (17). **Resort to surgery is not a solution in itself and is not adapted to every woman** as stated by a growing number of researches (17; 18; 19). Sometimes the psycho-sexual therapy alone is enough to answer women's needs without going through surgery. It underlines the necessity of not underestimate the **importance of holistic and multidisciplinary approaches.**

C - The role of prevention

To prevent efficiently psychological consequences of FGM, fight against their perpetuation is also a useful tool. To do so, alerting on potential psychological consequences (as well as on physical and sexual ones) of FGM can help to sensitise on the issue and advocate for their abandonment underlining how harmful they can be for women's health. The International Centre for Research on Women (22) states that it is important to **fight against FGM as a social norm, to deal with gender norms motivating them and stigma associated to intact girls**. It underlines the necessity of understanding gender norms' impact on young girls' mental health as well as obstacles to their well-being, address them and then to enhance factors protecting girls and increasing their well-being.

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III - Current issues for an enhanced therapeutic support for women and girls living with FGM

A - Lack of reliable studies

There is very little research focusing specifically on FGM and mental health, and there are even less in developing countries. Most research was done on migrant girls and women in developed countries. In this way, **it is difficult to draw conclusions on FGM consequences on mental health as the migratory journey and the confrontation with new social norms and beauty standards have a strong influence** on the perception of herself, on the general well-being and mental health of concerned women (23). Indeed, as stated by Helen Smith and Karin Stein, migration exposes women to new information and cultural norms and can then challenge their identity and beliefs (10). Furthermore, researches as they are led within members of diaspora concerned by FGM, only concerned a restricted number of women.

Adelufosi A. et al , in their paper (6) concluded that future studies need to focus on well-designed interventional for the management of the psychological consequences of women and girls living with FGM.

It is also important to notice the lack of studies on psychological consequences of FGM on young girls and on their evolution, variations all over the life and through ages of girls and women concerned. Thinks to such researches we would be able to study at which periods psychological disorders use to appear. For instance, it seems that girls cut at a very young age in their home country but who grow up in another socio-cultural environment where social norms condemn FGM and laud a standardize model of intact female genitalia are more susceptible to develop disorders (18).

B - Lack of adequate therapies

There is evidence that many girls and women who have undergone FGM present various forms of mental health problem, but there is not enough adequate therapy to help them navigate through life and heal the trauma. A study done by the WHO on health consequences of female genital mutilation (14) expressed that the alarmingly high rates of psychiatric disturbance among circumcised women provide important evidence that researchers, as well as clinicians, have an obligation to focus more attention on the urgent needs of survivors.

The fact that there were no guidelines to mental health cases caused by FGM made it difficult to help the survivors. The authors of Female *Genital Trauma: Guidelines for Working Therapeutically with Survivors of Female Genital Mutilation* (16) also realised that there was a gap in the literature and training, namely a lack of good practice guidance for working therapeutically with survivors of FGM. The guidelines they wrote and shared to be accessible to other practitioners aim to remedy to this lack.

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C - Lack of services and difficulties in seeking help in Africa

Mental health is still not openly discussed in many societies and there is great deal of stigma attached to that. In most parts of the African continent, people's attitudes towards mental illness are still strongly influenced by traditional beliefs (22) or mental health is simply not given enough importance. This causes delays in seeking appropriate care for mental health problems causing conditions to worsen.

In her opinion piece, Venoranda Rebecca Kuboka says that **adolescent girls and young women find it difficult to seek help when they experience traumatic situations** (24). Culture narratives suggest brushing horrifying experience off and move on. As a matter of fact, girls suffer in silence of fear, shame, stigma and victimisation associated with their experiences. She underlines that as Kenya commited to end FGM by 2022, there is need to focus on providing psychosocial support to FGM survivors which is currently unavailable.

African survivors of FGM advocated for mental health services as they are one of their biggest need and urged governments and charities to provide support for dealing with long-term trauma (26). *"We don't have mental health services for survivors of FGM — that is a big thing that is missing in Africa",* Virginia Lekumoisa, a survivor from Kenya. Their point of view is that if more survivors received mental health support they would be strong enough to add their voice, speak up and help end the practice.

Therapeutic approaches presented above come from the work of European psychotherapists because there is a **complete lack of resources for excised women above all in Africa.** Nevertheless, Helen Smith et Karin Stein (10) present in a 2017 article the example of support services in Somaliland ensured by midwives concerned by FGM and thus more able to understand women's experiences and share their own ones. If they observe that women develop coping mechanisms such as the use of religion, religious activities, confidence to friends, many women do not seek help. Poverty, lack of access to services for technical or financial reasons, by fear or shame to speak out urge them to hide their problems.

Furthermore, **the mere development of mental health services in Africa is very poor and does not ensure an adequate support for people suffering psychological disorders** as stated in *The Lancet* for instance (20; 22). Indeed, the budget allocated to mental health is weak, hardly reaching 1% against 6 to 12% in Europe and North America, and the structures as well as practitioners are rare, mainly in cities, hard to reach for most of the population. **Psychiatry still suffer important prejudices and is always today associated with madness**. Psychiatric trouble perceived as supernatural are supposed to be cured by traditional or spiritual medicine.

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D - Need of training for health care workers

Women and girls who have undergone FGM do not all suffer the same way, with the same symptoms or cases. It would be important to look at each case as a unique experience. **Social context, the type of procedure, social and emotional needs vary**. Vloeberghs et al. (12) mention three categories of FGM survivors with mental health issues.

1. The *adaptive* overcome the FGM experience
2. The *disempowered* feel angry and defeated
3. The *traumatized* feel pain, sadness with chronic stress

These cases should be seen differently and the approach to treatment and management should be different as well. Thus, professionals should be able to adapt their reaction, the therapy they propose to each specific situation and woman they receive.

A study on Mental health problems associated with female genital mutilation recommends that *"when treating women who experienced FGM one must be able to discern the various types of FGM, be knowledgeable about the related symptoms and the effects these may have on the woman, and have awareness regarding the taboo surrounding the practice"* (4). The same study also advises health professionals to consider that the FGM survivor could have gone through other forms of violence and traumatic experience that could as well affect her mental health. T**hus, being trained on FGM also means being trained on gender-based violence and in European or North American contexts, have knowledge on migratory journey and asylum seeking.**

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What do you think?

Do you know of any specific programmes dealing with FGM and mental health in your countries?

Which grassroot solutions exist that offer mental health care?

How could governments improve the access to mental health care for FGM survivors?

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