Are UK psychologists ready, willing and able to assist women, girls and families impacted by Female Genital Mutilation / Circumcision?

Charmaine Elliott

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To all those who have come before me, to those who stand beside me, and those who will follow, thank you. This is my contribution to our knowledge.

# ABSTRACT

Female genital mutilation/circumcision (FGM/C) is defined as the partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons (World Health Organisation, 2008). The practice is recognised in the UK as a form of violence against girls and women with serious physical and mental health implications (UNICEF, 2016). Worldwide more than 200 million women have experienced FGM/C (UNICEF, 2016). It is estimated that 140,000 women in the UK have experienced FGM/C. However, little research has been conducted on the psychological effects of FGM/C, and the literature on evidence-based psychological interventions is even more scarce. Psychologists are concerned about their ability to work effectively with FGM/C (Jones, 2010). The current study aimed to explore clinical psychologists’ views on FGM/C and FGM/C affected communities and their perspectives on the opportunities and barriers to working with this client group. Eighteen psychologists working in London and Bristol across a range of services were recruited. Semi-structured interviews were conducted and analysed using Thematic Analysis informed by discourse analysis. Three major themes were identified: ‘FGM/C: ‘Other’ Cultures’ Abuse of Women’, ‘Barriers to Working with FGM/C’ and ‘ “It’s like I almost feel it myself”: Psychologists’ Responses to FGM/C’. Findings suggest that psychologists feel unskilled and unsupported by employing and training organisations to work effectively with FGM/C. Participants reported the employment of various strategies to create and maintain therapeutic engagement despite the perceived limitations imposed by a lack of training and resources. Participants largely regarded FGM/C as a traumatic cultural practice that is rooted in sexist beliefs belonging to communities that traditionally practice FGM/C. The findings are discussed in relation to relevant literature, and several possible implications for theory and clinical practice are put forward.

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# CHAPTER 1: INTRODUCTION

The subject of this thesis is Female Genital Mutilation/Circumcision (FGM/C) within psychological therapy in the UK. The research aims to explore the views, awareness, and perspectives towards FGM/C among clinical psychologists in the UK. Psychologists’ views on how ready they feel to serve those impacted by FGM/C will be explored, along with their thoughts and ideas about how they can be better supported professionally and through training. Qualitative semi-structured interviews will be conducted and analysed using a discursive form of the thematic analysis as outlined by Braun and Kitzinger (2001).

The drive for this study comes in part from the call made by women who have experienced FGM/C for healthcare provision that is appropriate, suitable and responsive to their needs. Many report negative experiences with healthcare services in this country and for some this has deleteriously impacted their wellbeing. For some women it has been a determining factor in their development of post-traumatic stress disorder (Lockhat, 2004). This thesis will not attempt to present any singular and absolute truth, instead it is recognised that there are several potential plausible interpretations of the data (Mishler, 1986). Above all it is hoped that arguments put forward in this thesis will provoke debate and conversation about how ready, willing and able clinical psychologists in the UK are to serve women and communities impacted by FGM/C.

This chapter will provide a concise overview of FGM/C to include a description of the various FGM/C procedures, global epidemiology of the practice and its prevalence in the UK. A background of the current theoretical approaches and discourses relating to FGM/C in the UK will be illustrated in order to present some of the dominant approaches to FGM/C that help to inform people from non-practicing communities about the practice, which would include the majority of the clinical psychological profession in the UK. A very brief account of clinical psychology in the UK will follow to help situate clinical psychology in relation to FGM/C, to outline the activities and ways of working of the clinical psychologist and how clinical psychologists might encounter FGM/C professionally. It will also offer concise argument for the consideration of diversity in relation to clinical psychology and clinical psychologists’ work with women and communities impacted by FGM/C. This chapter will also cover the health consequences of FGM/C, particularly focussing on psychological health consequences to illustrate the types of FGM/C-related mental health concerns women with FGM/C might present with.

Leading on from this will be a discussion of the literature on healthcare practitioners’ and psychological practitioners’ knowledge and awareness of FGM/C and psychological problems that might be related to FGM/C to begin to offer some insight into the kinds of interactions with healthcare practitioners some women with FGM/C have experienced.

Lastly, an argument will be put forward for the role of healthcare practitioners in the reduction and elimination of the practice, as well as for increased support for psychologists in fulfilling this role and working effectively with FGM/C-related issues. This will into the rationale, aims and objectives of the the current study.

## What is FGM/C?

Female genital mutilation/circumcision (FGM/C) is defined as the partial or total removal of the external female genitalia or other injury to the female genital organs for cultural or other non-therapeutic reasons (World Health Organisation, 2008). The practice is recognised in the UK as a form of violence against girls and women with serious physical and mental health implications (UNICEF, 2016).

FGM/C has been classified into four major types, though in practice the type of FGM/C that has been performed cannot be easily categorised.

Type 1 is known as clitoridectomy and involves the removal of part or the entire clitoris. In a small proportion of cases only the prepuce (clitoral hood) is removed.

Type 2 involves excision, which consists of the removal of some or all of the labia minora (inner folds of vulval skin) and/or the removal of the labia majora (outerfolds of vulval skin).

Type 3 is referred to as infibulation, which includes practices, such as stitching, that repositions the labia minora or labia majora to narrow the vaginal opening.

Type 4 is a category of injurious procedures on the female genitalia such as pricking, piercing or cauterising the genital area.

Deinfibulation refers to the opening up of a vagina that has undergone a narrowing process, such as for childbirth, sexual intercourse or to improve the female’s wellbeing and physical health.

Reinfibulation refers to the closing of the vagina following deinfibulation and is typically performed after childbirth.

A note on terminology

FGM/C is also known as ‘female genital cutting’, ‘cutting’ or ‘female circumcision’. The term ‘female circumcision’ was widely used initially by workers and commentators as in some communities circumcision is a part of both female and male initiation rites. It has since declined in use as some activists against the practice objected to the inference that the practice for females was analogous to that of males, when the practice and impact on women is often more extensive, invasive and dangerous. The term ‘female genital cutting’ conveys a similar sentiment, however ‘cutting’ is commonly used among communities impacted by FGM/C when discussing the practice. The term female genital mutilation (FGM/C) was adopted by the Inter-African Committee on Traditional Practices Affecting the Health of Women and Children in 1990 and in 1991 the World Health Organisation encouraged the United Nations to adopt the term to emphasise the potential harmful effects of the practice. The practice is referred to as ‘Female genital mutilation/cutting’ (FGM/C) in this thesis to emphasise the potential severity of the practice and consequences for girls’ and women’s physical and mental health and human rights, and also to communicate respect for communities impacted by the tradition.

Global epidemiology

Worldwide more than 200 million women have experienced FGM/C (UNICEF, 2016). It is practiced traditionally in at least 29 African countries, as well as Indonesia, Malaysia, Yemen, Iraqi Kurdistan, Syria, Turkey and Iran. Though FGM/C is associated with these countries today, it has been practiced in all countries at some point historically. In ancient Rome, metal rings were passed through the clitoris of female slaves to prevent intercourse and in medieval Britain women were forced to wear chastity belts. More recently clitoridectomy was used as treatment for mental and physical health conditions in Britain and the USA (Whitehorn, Ayonrinde, & Maingay, 2002).

## FGM/C in the UK

FGM/C is increasingly found in the United States, Australia, Canada, Europe, and in the UK. This is mainly due to migration. As well as residents of the United Kingdom’s former colonies in Africa seeking to settle in the UK, the UK has become home to refugees from the Horn of Africa fleeing civil unrest and war. It is therefore inevitable that FGM/C is increasingly being seen by health professionals in the UK caring for individuals from communities where FGM/C is frequently practiced. Despite the legal status of FGM/C in the UK, the practice continues on British shores (Morison, Dirir, Elmi, Warsame, & Dirir, 2004).

A statistical report on the prevalence of FGM/C in the UK was produced by Macfarlane et al., (2015). Between 1996 and 2013, 187,000 girls in England and Wales were born to mothers from FGM/C practising countries and more than 17,000 girls were born to mothers with evident FGM/C between 2011 and 2013. If FGM/C is experienced among them at a similar rate to the country of their mother’s birth, 10,000 will undergo the procedure. Currently, an estimated 100,000 women in the UK aged between 15 and 49 years of age and 24,000 aged 50 or more have experienced FGM/C and this number is rising.

FGM/C was first made illegal in 1985 and reinforced in 2003 with the FGM Act (2003). The Serious Crimes Act of 2015 further reinforced the 2003 FGM Act by extending its reach to habitual UK residents as well as UK nationals and permanent UK residents, providing anonymity to victims of FGM/C, and making it an offence to fail to protect a girl from risk of FGM/C. The 2015 Serious Crimes Act also provided for the creation of FGM/C Protection Orders. Provisions available under these orders include removal of the girl at risk from her family and forced surrender of passports of individuals suspected of breaking or intending to break the law with regards to FGM/C. Lastly, the Serious Crimes Act (2015) places a legal duty upon teachers, social workers and healthcare professionals, including psychologists, to report an act of FGM/C that has been carried out on a girl under 18 years of age.

Genital surgery in the UK

A crucial part of the definition of FGM/C is that it is a cultural practice performed for non-therapeutic reasons. Though FGM/C has been illegal in the UK since 2003, it is legally possible to request excision which is commonly known as Type 2 FGM/C as a form of cosmetic surgery called ‘labiaplasty’ privately and in more restricted cases under the care of the National Health Service. This can be achieved if the woman can successfully argue that her labia cause discomfort during exercise, sexual intercourse, or that it causes unhappiness and self-consciousness. Unhappiness and self-consciousness are also two reasons given for the continued practice of FGM/C among practicing communities, among other negative impacts to the psychological wellbeing of girls who are not cut. This raises questions of when the procedure becomes perceived as part of culture, a ritual or a custom (Berer, 2010) as the labiaplasty procedure fits the WHO definition of FGM/C (Earp, 2015). A growing number of women and girls in Western countries are seeking to alter their genitals through surgery, such as piercing, and parallels are inevitably being drawn between these procedures and FGM/C (piercing is included in the WHO definition of Type 4 FGM/C), and also in terms of the direct and indirect pressures that lead women to consider genital modification which some consider to be cultural in genesis (Kelly & Foster, 2012).

The UK law also makes provisions for the genital alteration of children in the case of individuals who are deemed ‘intersex’; where an infant’s genitalia are ambiguous in terms of sex. In these cases parents are able to make a decision with medical professionals regarding the alteration of the infant’s genitalia to make the child ‘normal’ or unambiguous in terms of sex (Dustin, 2010; Krivenko, 2015). Again, it can be argued that this decision is unlikely to be free of cultural influences. Parents have reported regret at consenting to the intervention (Liao, Wood, & Creighton, 2015), yet numbers of clitoral surgeries on minors under the age of 14 in the UK have been increasing since 2006 (Creighton, Michala, Mushtaq, & Yaron, 2014) at a time when public awareness of FGM/C is growing and the UK is strengthening its laws against the practice.

In the UK there have been no successful prosecutions of carrying out, aiding or abetting FGM/C. FGM/C was first made illegal in 1985 and reinforced in 2003 with the FGM Act (2003). The Serious Crimes Act of 2015 places a legal duty upon teachers, social workers and healthcare professionals, including psychologists, to report an act of FGM/C that has been carried out on a girl under 18 years of age. Therefore psychologists need the ability and skills to identify any safeguarding risk of FGM/C to avoid criminal charges and professional disciplinary procedures. In the UK FGM/C is defined as a cultural practice that is performed for non-therapeutic reasons. This definition therefore includes female genital alterations that are traditionally performed by ethnic minority communities in the UK and excludes several other types of female genital alterations that are frequently performed on women and girls in the UK that are not considered cultural.

## Perspectives on FGM/C

The responses to FGM/C among both practising and non-practising communities are varied. There is a growing body of literature exploring attitudes and belief systems underpinning the practice of FGM/C in Africa, Asia and the Middle East. It is not possible to provide a thorough discussion of the reasons that have been given for FGM/C among practicing communities in the current thesis. However, a short list of justifications is offered here (UNICEF, 2013):

* Cleanliness and hygiene
* Social acceptance
* Increased marriage prospects
* Preservation of virginity and reduction of sexual desire in women
* Increased sexual pleasure for the male partner
* Religious adherence
* Increased self-esteem in women

FGM/C is a contested practice, and it is often controversial. Despite the reasons given for the continuance of the practice, beliefs are changing. In 19 of the 29 countries where FGM/C is most prevalent, the majority of women and girls think the practice should end and in nine countries the majority of men and boys favoured the abandonment of FGM/C (UNICEF, 2013).

### Feminist perspectives

Feminist approaches to FGM/C are many, and debate has raged about the impact of FGM/C on women for decades. This thesis will very briefly outline just two of the main trends in feminist thought with regards to FGM/C – feminists who perceive FGM/C as an injurious practice to women and used as a tool by men in patriarchal societies to control women and feminists who argue that FGM/C is one of many forms of oppression wrought upon women across the world, followed by a human rights perspective on the practice.

Feminists have argued that FGM/C is used to socially control women, to consign women to the role of child-bearer (Lightfoot‐Klein, 1989) and that the removal of genitals controls women through their bodies, specifically through their sexuality by precluding all potential for sexual pleasure (Morrison, 2008). This is thought to discourage women from engaging in sexual relationships outside of marriage, and thereby deter them from ruining their family and community honour (Davis, 1985).

Other feminists have responded to the portrayal of FGM/C as a specific abuse inflicted upon women in black and brown societies by highlighting the existence of forms of FGM/C across the world the world and throughout history (Dorkenoo, 1994). Toubia (1988) specifically accused feminists from Western countries of using FGM/C as a political weapon against developing countries. This position finds support in a study by Khaja, Barkdull, Augustine and Cunningham (2009) of 17 Somali women who had immigrated to North America. Though all of the women reported that they wanted the practice to end, they also voiced a sense of aggrievement at the use of the term ‘mutilation’ as they felt it was racist, and conferred a status of inferiority upon them and their communities as ‘flawed’ and ‘uncivilised’. Okome (1999) also finds the term ‘female genital mutilation’ problematic, and argues against feminist theorists who delineate a picture of women undergoing FGM/C solely to placate or please men. A study by Berggren, Ahmed, et al., (2006) explored re-infibulation in Sudan through focus groups and interviews with men and women and found that even in families where men forbade FGM/C and re-infibulation many wives organised both re-infibulation and FGM/C on their daughters anyway.

### Human rights perspective

International activism against FGM/C has increased in pace in recent years. UNICEF issued its first statement on FGM/C in 1979, and in the same year FGM/C appeared on the agenda of the World Health Organisation. Also in 1979 the UN General Assembly adopted the Convention on the Elimination of All Forms of Discrimination against Women which specifically recognised FGM/C. In 1993 FGM/C was recognised as a human rights violation at the World Conference on Human Rights in Vienna and in 2008 UNFPA and UNICEF launched the largest global programme on FGM/C with Kenya, Egypt, Senegal and Burkina Faso among the first countries to join. Legislation has followed and in 2015 The Gambia and Nigeria joined 22 other African countries in banning FGM/C.

While legislative moves to reduce the prevalence of FGM/C are widely celebrated, some commentators have argued that this represents an ethnocentric and neo-imperialist pressure coming from outside practising communities to capitulate those communities (Barstow, 1999). On the other hand, some feminists have argued for communities that practice FGM/C to be allowed to develop and move away from the practice in their own way, just as they perceive Western societies have abandoned it.

In sum, there are several perspectives on FGM/C that are frequently espoused by both practicing and non-practising communities that can ultimately have impact on the way public bodies are guided to respond to the practice. These perspectives are widely espoused in the media and are likely to have effect on clinical psychologists as they come into contact with FGM/C–related issues at work.

## Clinical psychology in the UK

Presented here is a brief overview of clinical psychology today in order to situate the profession in the UK in relation to FGM/C. This will include discussion of the approach of clinical psychology towards diversity particularly with regards to race and culture in the UK today. While it accepted that FGM/C could be discussed in relation to a number of social, economic and political issues it is not possible to exhaust the many perspectives on FGM/C in this thesis, though it is hoped that research will follow which will also focus on these. It is argued that it is imperative for race and culture to form part of the discussion about how psychologists view and perceive FGM/C not least because ‘culture’ is part of the working definition of FGM/C in the UK. Additionally, women who have experienced FGM/C and sought care from healthcare practitioners in the UK have identified issues of race, ethnicity and culture in the service they have received. They have reported feeling distressed by the cultural insensitivities of healthcare practitioners in the UK, and that their families and communities are looked down upon by healthcare professionals who are from non-practising communities (Lockhat, 2004; Khaja, Lay, & Boys, 2010). In addition, the British Psychological Society has published at least one consultation paper which presents FGM/C as a type of violence that affects women from BAME communities, which demonstrates the common association of FGM/C with ethnic minority communities and cultures in the UK. That FGM/C is seen as a cultural issue in the UK is supported by a body of literature which has identified the association within Western societies of FGM/C with particular ethnic, racial and cultural groups (Toubia, 1988; Wade, 2011). Moreover, a study by Elliott, Creighton, Barker and Liao (2016) showed that psycho-sexual therapists view FGM/C as a gendered abuse that happens in non-Western cultures. Therefore to exclude matters of diversity and culture when discussing clinical psychologists’ views and perspectives on a practice widely portrayed as one that affects ethnic minority groups in the UK would be to continue to neglect issues of diversity at time when psychologists are being urged to raise them with colleagues and with clients (Dos Santos & Dallos, 2012; Goodbody, 2012).

Much has been written on the development of the clinical psychological profession in the UK. What is now presented is a very short historical overview of clinical psychology as it might relate to FGM/C service users. First will be a brief general outline of clinical psychology, followed by a short discussion of clinical psychology and diversity in the UK.

Early clinical psychology in the UK drew upon Social-Darwinism, Eugenics, Socialism, Materialism, Idealism, Psychoanalysis and Behaviourism (Hearnshaw, 1964). Clinical psychology was at first in a subordinated position to psychiatry and was heavily influenced by its medicalism. In the early days of clinical psychology the role of psychological therapy within it was contested as therapy was then known to be closely identified with psychoanalysis, Freudian and Object Relations theories. This was at odds with the positivist and scientific direction of clinical psychology at the time. Clinical psychology came to accept the inclusion of therapy in the 1950s and 1960s with the advent of Behaviour Therapy (Pilgrim & Treacher, 1992).

The professionalisation of clinical psychology accelerated after the Second World War, though initially the bulk of clinical psychologists’ work was with children. As the NHS was established, clinical psychology spread as a more autonomous profession, providing therapy to adults as well as children.

Psychological explanations for human distress gained in traction in the 1960s and 1970s but in the 1980s the socio-political context in the UK, compounded with an emphasis on psycho-pharmaceutical medication, resulted in a lack of gravitas for psychology (Cromby, Harper, & Reavey, 2013). Since then clinical psychologists have been active in challenging the dominance of psychiatry in mental health by working with critical psychologists and service-user groups to help give voice to more perspectives on mental health but criticisms of the profession for being non-reflective and failing to attend to the local and contextual needs of the public remain (Patel, 2003).

Currently there are 12,000 clinical psychologists registered to practice in the UK (BPS, 2016). Clinical psychologists continue to work in a variety of services in the NHS and beyond. As the numbers of women and girls in the UK from practicing communities increases year by year, so too do the opportunities for clinical psychologists to encounter FGM/C-related matters in their work. Clinical psychologists working with children in any service will also have specific safeguarding duties with regards to children, as FGM/C is legally considered a form of child abuse in the UK. With regards to FGM/C any of the women who are impacted by it are likely to be identified in health settings such as perinatal and maternity services, pain and trauma services, sexual health and gynaecological services. However, as with all women, any of the 140,000 women impacted by FGM/C could also present to psychologists working in any mental health or physical health setting available to women and relevant to their concerns.

### Clinical psychology, diversity and culture

It is useful here to briefly describe the concepts of race, ethnicity and culture. Race is a social construct that has roots in ‘pseudo-science’ which portrayed ‘people of colour’ as inferior to people who are white. This idea was used to justify slavery, colonisation and apartheid (Durrheim, Hook, & Riggs, 2009), it therefore underpins and is couched in a relationship of dominance and power. Though socially constructed, race is largely perceived as permanent and determined by genetic lineage, unlike ethnicity which is related to a group identity and can involve an element of choice (Fernando, 2010). Finally, culture is typically understood as group ways of being and practices that are contextual and evolving (Fernando, 2010). Though culture is created and sustained by individuals, it has been argued that both culture and ethnicity are often seen by the White majority as only relevant to and relating to ‘the other’ (Frankenberg, 1993).

The roots of clinical psychology in the UK have been criticised as reflecting these assumptions of ethnocentricity through the prominence of empiricism and the philosophical backdrop of eugenics (Patel, 2003). Clinical psychology was thought of as well-placed to provide solutions for social problems as a profession of scientist-practitioners. The lens was firmly on ‘others’. However, with the advent of more critical, feminist and anti-psychiatric approaches from the 1960s onwards, the ‘reflective practitioner’ model (Schon, 1983) rose in prominence. This encouraged psychologists to take into account critical, perspectival and cultural influences on themselves, the client and their interaction. In recent decades critical clinical psychologists have spoken out to advocate the position that politics and discussions of power are inseparable from psychology and must be considered together when discussing opportunities for improving wellbeing using psychology (Fox & Prilleltensky, 1996). Psychologists are becoming increasingly interested in relatively new branches of psychology, such as community psychology, which aim to address the potential power imbalances between psychologists and clients through assessment, formulation and interventions largely designed at a collective level in effort to engage marginalised communities and to address their wellbeing. The concept of professional competence for the clinical psychologist has been recalibrated to include awareness of how the personal, professional and practical knowledge bases interact in the work of the psychologist. It is argued that within clinical psychology generally there is not enough reflection on the socio-historical context out of which clinical psychology developed, nor how it has contributed, and in some ways still may, to oppression or social inequalities and the impact this might have on psychologists as well as service users (Patel, 2010).

In addition, criticisms have been made of the clinical psychologist’s ability to reflect upon themselves as part of the therapeutic relationship with clients. Today, ‘Clinical Psychologist’ is a protected title that is conferred upon individuals at the completion of a three-year doctoral training programme where a range of competencies must be satisfactorily met (BPS, 2015). This includes competence in “The skills, knowledge and values to work effectively with clients from a diverse range of backgrounds, understanding and respecting the impact of difference and diversity upon their lives. Awareness of the clinical, professional and social contexts within which work is undertaken and impact therein” (BPS, 2015, P. 20). This is typically met through the mandatory Personal and Professional Development (PPD) elements of the clinical psychology doctoral courses. Horner, Hughes and Youngson (2009) conducted a review of PPD across courses in the UK and found great variation in how they were constructed and taught which raises the possibility that some clinical psychologists might complete their training without sufficient training to equip them for working with issues of diversity, such as FGM/C. This is supported by studies by Buckley, Hardy, Buchan and Lewis (2004) and Lago (2004) which found that when working cross-culturally white psychologists experienced powerful emotional issues; challenges to their fundamental assumptions; feelings of shame and guilt; emotional disconnection from the issues presented; the imperative of sensitive and appropriate language use; and extended time to build therapeutic trust and their own avoidance of issues. The therapists reported perceived cross-cultural work to be more of a struggle. While these studies did not specifically address training for clinical psychologists, the implication is that there is more that can be done to support and prepare clinical psychologists to address issues and concerns they might encounter when working with issues of diversity such as FGM/C.

In short summary, clinical psychology developed as a profession during various socio-political contexts which influenced the direction and character of the profession leading some commentators to critique the ethnocentric genesis of the profession. Clinical psychology has evolved to become a profession that is steeped in therapy and allied closely with research. There have been moves to distance clinical psychology from its historically deep association with medicalism and diagnosis, but these trends still continue in some branches of the profession, as do philosophical approaches such as positivism and empiricism which largely assume the objectivity of psychological and practitioners in the field. Some commentators have celebrated the emergence of critical approaches in clinical psychology which identifies the subjectivity of practitioners as people with values, perspectives and beliefs that they bring to clinical psychological work, but have also raised caution about the quietness with which clinical psychology as a whole has treated its origins and its role in the subjugation and oppression of some communities.

Clinical psychology also appears to remain quiet on the subject of FGM/C beyond safeguarding concerns. While the BPS does make clear the intent for all clinical psychologists to be trained to work with a diverse range of clients and to reflect upon their values in their work, courses for clinical psychology may be falling short of adequate provision for training clinical psychologists on these issues, which invariably impact on psychologists’ readiness for working with diversity. With regards to FGM/C this suggests that clinical psychologists might lack the skills required to meet some of the needs that women and communities impacted by FGM/C could present with, such as the ability to interact with them in a way that is not seen as condescending, judgemental or dismissive as some have reported (Khaja, Lay, & Boys, 2010). It is hoped that an exploration of the knowledge, awareness, views and perspectives of clinical psychologists on FGM/C will lend some insight into why clinical psychologists have said little on the subject.

## FGM/C-related health complications

Both the physical and psychological health consequences of FGM/C are of importance to clinical psychologists as these consequences can have massive impacts on women’s lives. Clinical psychologists work with a range of psychological concerns that might result from or be related to both physical and mental health (Wahass, 2005). As such, a short summary of the possible physical health consequences relating to FGM/C will be presented, followed by an overview of the literature on the possible psychological complications which clinical psychologists might encounter in their work with women impacted by FGM/C.

The physical health complications resulting from FGM/C can be severe and life-threatening. The immediate health complications include infection, severe pain and bleeding, and haemorrhage which can be fatal (Adam et al., 2010). Deaths from FGM/C have been reported but there are no figures for direct deaths due to FGM/C. Other immediate reported complications include damage to other adjacent organs and incomplete healing (Reisel & Creighton, 2015). For some, the long-term complications are often less obvious, though potentially life-threatening.

Reisel and Creighton (2015) have reviewed a range of long-term physical sequelae which include gynaecological problems, infection, infertility and obstetric complications. Gynaecological problems include infection of the urinary tract, genitourinary tract, abscess formation, septicaemia, and clitoral neuroma. Genital scarring is common, as are menstrual difficulties, fistula and urethral complications. FGM/C can also increase the likelihood of transmission of sexually transmitted infections such as Hepatitis B, Herpes as well as HIV particularly among women who have been infibulated (Iavazzo, Sardi, & Gkegkes, 2013).

Obstetric difficulties can also arise. This is more frequent if access to effective antenatal care is compromised which can be the case if women lack access to antenatal care, or in the case of women with FGM/C living in countries where FGM/C is not traditionally practiced, distrust of the medical services or inability to access care due to language difficulties or lack of awareness (Murray, Windsor, Parker, & Tewfik, 2010). A large multi-country study based in hospitals showed that women who had experienced FGM/C were significantly more likely to suffer postpartum haemorrhage, caesarean section, extended stay in hospital following childbirth, stillbirth, infant resuscitation and early neonatal death (Banks, Meirik, Farley, & Akande, 2006).

### FGM/C-related mental health complications

The health hazards associated with FGM/C are well-known to many women who engage in and encourage FGM/C (Alo & Gbadebo, 2011). For those who have undergone FGM/C, the taboo surrounding FGM/C can make it especially difficult for them to access support and treatment.

The literature base focussing specifically on the mental health consequences of FGM/C is young. As many women cannot remember the event, the condition of their genitals before the procedure, and are not aware of women who have not had similar experiences, the collection of information relating to health consequences of FGM/C is impeded by their ability to identify FGM/C as a factor contributing to any distress. In addition, some women have also experienced the hardships of poverty, social upheaval and war, which can also impact on psychological wellbeing. As a consequence it is not always possible to specifically attribute psychological or emotional distress to FGM/C. This does not make the impact of FGM/C upon women’s lives any less profound and deserving of academic interest.

A recent literature review by Mulongo, McAndrew, & Hollins Martin (2014) unearthed only 10 papers that reported psychological effects out of 1034 studies. Of the 10 studies identified, five addressed psychological consequences solely and five studies identified PTSD as a consequence of FGM/C. None of the 1034 papers focussed specifically on therapeutic psychological interventions. Women have reported feelings of incompleteness, fear, inferiority and suppression following FGM/C (Utz-Billing & Kentenich, 2008). Psychological difficulties are exacerbated the older the female is when the procedure is performed, and if she is fully aware of what is being or has been done to her (Momoh, 2005). Studies have shown that some women respond to changes in the appearance of their vulva following de-infibulation with distress (Safari, 2011) and that surgery related to FGM/C can elicit emotional responses in women who are reminded of the initial trauma (Vloeberghs, van der Kwaak, Knipscheer & van den Muijsenbergh, 2012).

Though studies such as Behrendt and Moritz (2005) report that 47.9% of women developed affective and anxiety disorders following FGM/C, and Chibber, El-Saleh, & El Harmi (2011) report that 58% of the women in their study experienced affective problems, Kizilhan (2011) found no difference in affective disorders between women who had undergone FGM/C and controls who had not. With contradictions in findings such as these it is difficult to make conclusive statements about the harmful psychological impact of FGM/C, particularly in communities where FGM/C is normative and where it facilitates social integration and acceptance.

Girls who have undergone FGM/C and are growing up in countries such as the UK where FGM/C is illegal are caught in the crossfire between conflicting narratives and may face a particular set of psychological challenges (Whitehorn et al., 2002). On the one hand, they have some familiarity with an ancestry whereby female genital cutting is ‘normal’. On the other hand, the cultural practice to which they and their family members have been subjected to is considered as ‘mutilation’.

In a UK study of women who had experienced FGM/C Lockhat (2004) found that less than 10% suffered from current Post-Traumatic Stress Disorder (PTSD), but that over 25% had experienced lifetime PTSD. All of these women had experienced infibulation. In the Netherlands Knipscheer, Vloeberghs, van der Kwaak, & van den Muijsenbergh (2015) studied the mental health of 66 women from African countries who had been cut. While one third of the women reported scores that would suggest affective or anxiety disorders, 17.5% reported scores indicative of PTSD. Of the women who experienced infibulation, those who could recall the event, those with low income and those who employed coping strategies such as avoidance or substance misuse reported greater levels of pathology. Vloeberghs et al (2012) also found that women became more aware of their condition upon immigration to the Netherlands, and that negative feelings about FGM/C among these women increased during childbirth and when suffering from physical problems relating to FGM/C.

Sexuality is considered to be influenced by psychological, neurological, biological and physiological factors that can also be impacted by cultural conditions (Levine, 2003). FGM/C can adversely alter sexual functioning for women. A study of 280 Kurdish women in Iran showed that those who had undergone type 1 FGM/C experienced less sexual desire, sexual arousal, lubrication, arousal, satisfaction, orgasm, and more pain than women who were not cut (Biglu, Farnam, Abotalebi, Biglu, & Ghavami, 2016). In a study by Griffith (2005) a lack of interest in sex was the most common problem reported by couples where the female partner had experienced FGM/C. In a recent study involving 1230 women in Nigeria, 600 attributed their inability to achieve orgasm to FGM/C (Idowu, 2009). In another Nigerian study 47% reported feeling fear when their husbands initiated sex (Oyefara, 2015). When asked about sexual pleasure, some women who have experienced FGM/C have referred to their husband’s pleasure only (Berggren, Ahmed, et al., 2006). However, a recent study in Europe also showed that more than 30% of women do not consistently achieve orgasm during sex (Catania et al., 2007). Therefore it is difficult to attribute difficulties with sexual functioning solely to FGM/C.

A systematic review of the literature of the psychological, social and sexual effects of FGM/C in 2010 concluded that the evidence base was insufficient and too low quality to make a meaningful statement on the issue (Berg, Denison, & Fretheim, 2010). The psychological morbidity associated with FGM/C often goes unreported and unremarked upon where FGM/C is commonplace, culturally acceptable or normalised (Black & Debelle, 1995). This could reflect a lower incidence of psychological distress where the FGM/C practice is predominant. Alternatively, it could reflect lack of insight about emotional and psychological distress, or lack of access to confidential services, particularly in communities where women are frequently chaperoned by a male relative. In contrast, the potential for psychological distress from being socially penalised for not being cut is much reported and feared.

## A potential role for psychologists

The British Medical Association (2011) published guidelines on FGM/C for medical care providers, but beyond training regarding the safeguarding of children, information provided to psychologists in the UK is scarce. Psychologists have been overlooked in literature that could offer guidance to their practice, report examples of best practice, or offer suggestions for effective psychological interventions for women impacted by FGM/C. This situation is disagreeable for psychologists who look to published research for guidance on how they can work with communities affected by FGM/C or on the role they can play in preventing or reducing FGM/C. A literature search was performed using the Exlibris database on the Royal Holloway University library website. Searches using the terms “female genital mutilation”, ‘female genital cutting”, or ‘female circumcision” and “mental health” yielded 40, 1 and 22 results respectively. Substituting “mental health’ for ‘psychological’ yielded 176, 42 and 101 results respectively, none of which substantially addressed the role of psychologists in working with FGM/C.

A paper by McChesney (2015) categorises interventions into six broad areas, of which ‘psychosocial approaches’ is one category. In the paper it is reported that when employed, psychosocial approaches have largely failed to alter attitudes towards FGM/C among practising communities in countries where FGM/C is prevalent. Psychologists in the UK should not be deterred by McChesney’s assessment of the utility of psychological interventions for several reasons. The first is that at the current time, there are no reported psychosocial programs that have been led by professionals with substantial and specific psychological training, so it is not clear whether the specific skillset of psychologists such as formulation and theory-informed intervention would improve the effectiveness of the programs. Second, McChesney (2015) assessed the effectiveness of the previous and existing interventions on large-scale change in attitude across the community, however the value in psychologists working effectively with individuals and families to safeguard family members and particularly children should not be overlooked, understated or dismissed. Thirdly, psychologists in the UK are working in social environments where FGM/C is illegal and is not widely practiced in the general population in contrast to campaigners working in communities were FGM/C is customary and widespread. Therefore, change in attitudes towards FGM/C in small communities, families and individuals could be possible where they have the potential to resist cultural pressure to continue the practice of FGM/C as they are supported by the immediate wider society. In addition, psychologists are well-placed to work at the level of organisations, processes, systems and social policy to empower women to intervene directly to address social problems affecting them (Szymanski & Carr, 2011) as psychologists have worked successfully with women and communities who have experienced other forms of gendered abuse such as intimate partner violence and sexual abuse.

McChesney (2015) also cautioned psychologists from unwittingly adopting two unhelpful stances in their roles when working with FGM/C-related issues. The first is cultural absolutism (imposing the beliefs of one society on the other) and the second, cultural relativism (which does not challenge FGM/C but rather views it as a cultural practice that should not be artificially altered). Much like individuals from practicing communities living in the UK, psychologists are also caught in a position of conflict. On the one hand psychologists will want to build a therapeutic relationship and not alienate the client by bombarding the client with the therapists own opinions on the issue of FGM/C which is likely to be part of the psychologists own cultural tradition. On the other hand the psychologist is tasked with upholding the law and their duty under the law to make clear FGM/C is illegal in the UK and a serious crime that must be reported. This might be a difficult balance to strike.

Psychologists need reliable and credible guidance. Clinical psychologists in the UK are tasked with providing interventions and/or working with clients in ways informed by an evidence base. Without a body of literature to guide their working, psychologists are left to appropriate the evidence base generated for other client groups and to seek knowledge to underpin their work from elsewhere.

## Knowledge and awareness of psychological practitioners

Two studies in the UK have attempted to address the knowledge, awareness and perspectives of FGM/C among psychological practitioners. Jones (2010) surveyed 74 clinical psychologists in London about their knowledge and training needs relating to FGM/C. More than 41% were unaware of whether their clients had experienced FGM/C and 44% felt not at all confident in their ability to work with FGM/C-related issues. Only 9.5% of participants knew that they had worked with a client who had experienced FGM/C. More than 70% of psychologists taking part in the study had received no training at all on FGM/C and where training had occurred, more than a quarter experienced training on FGM/C as part of child safeguarding training.

This study is useful in pinpointing some of the FGM/C training needs of psychologists, as well as the knowledge and experience of clinical psychologists working with FGM/C. The study offered valuable insight into the type of professional and therapeutic exposure clinical psychologists have had with FGM/C. However, it was limited in its scope and depth of analysis and as such offered little guidance to clinical psychologists wanting to learn more about how to work with FGM/C-related issues, or to develop their practice in relation to working with diversity as is now required by the British Psychological Society and the Serious Crimes Act (2015). The survey was not able to elicit responses that addressed how psychologists think and feel about FGM/C, the communities that practice it, or the women who might present to services. However, the impact of clinical psychologists’ perspectives and attitudes towards FGM/C and the communities that traditionally practice it should not be overlooked in the current context of FGM/C and clinical psychology in the UK where research interest in the psychological impact of FGM/C is low, clinical guidance from psychologists’ professional body is almost completely absent, and where women from impacted communities continue to report negative experiences within the health service.

While not involving clinical psychologists exclusively, the knowledge, attitudes and awareness of FGM/C among 49 psychosexual therapists was explored in a recent repeated-measures questionnaire based study by Elliott et al, (2016). Fifteen participants (30%) expressed a wish to know more about FGM/C out of interest, and 34 (69%) expressed a need to be better informed for their professional work. In terms of exposure to the topic, two participants (4%) reported that they had no information on the topic at all prior to attending the workshop. A proportion had informally been exposed to the topic via the mass media: 15 (31%) via television coverage; 17 (35%) radio broadcast, and 24 (49%) articles in the press. As for professional exposure, 19 (39%) reported having attended a professional event such as a talk or seminar. In terms of clinical practice, 33 (67%) of the participants said they had not worked with clients known to have experienced FGM/C, and 12 (24%) reported having worked with clients from FGM/C-affected communities. Regarding attitudes towards FGM/C, strong disagreement was expressed towards mild circumcision on girls under 16 (55.1%); re-infibulation after childbirth (47%); cosmetic genital surgery on girls (53.0%); and cosmetic genital surgery on boys (36.7%). Strong agreement was expressed towards allowing circumcision on consenting adult men (30.6%) and towards the prosecution of parents who allow their daughters to be circumcised (26.7%). Following a brief workshop and discussion on FGM/C (which did not cover male circumcision in any way), the only significant difference in strength of attitude toward circumcision or other genital cosmetic surgery was that participants expressed stronger views against male circumcision.

While the participants of this study were psychosexual practitioners and not clinical psychologists, these findings suggest that many practitioners with a psychological component to their work believe they are under-informed about FGM/C, though many have come into contact with clients impacted by the practice. These practitioners wanted to know more about the practice to assist their work, but only a minority had professional exposure to the issue.

As the first study to look at attitudes towards FGM/C among UK practitioners the study by Elliott et al., (2016) has use in highlighting the strength of feeling against FGM/C and cosmetic surgery on girls and parents who allow it. The findings also suggest that the attitudes towards FGM/C of relatively low-informed psychosexual practitioners were not significantly impacted by a short training workshop on the practice. The findings instead suggest that the participants’ perspectives and opinions on FGM/C, which were largely informed by the media and other non-professional sources, were relatively robust and unaffected by discussion of FGM/C-related issues among peers. Like Jones’ (2010) study, the Elliott et al., (2016) study did not explore further the participants’ thoughts, ideas and experiences which informed their positions on any political, legal, cultural or personal issues, so this remains unknown and a continued gap in the literature.

## Knowledge and awareness of other health professionals

Existing research demonstrates that knowledge and awareness of FGM/C among health professionals is hugely varied and, in many instances, inconsistent (such as Hess, Weinland, & Saalinger, 2010; Leye, Powell, Nienhuis, Claeys, & Temmerman, 2006; Surico, Amadori, Gastaldo, Tinelli, & Surico, 2015). An overview of a selection of studies is outlined here.

Literature focussing on practitioners’ knowledge of FGM/C in the UK is lean, but a recent study by Purchase et al., (2013) assessed knowledge of the FGM/C guidelines of the Royal College of Obstetricians and Gynaecologists (RCOG) among RCOG-affiliated doctors working in obstetrics and gynaecology in the UK. Of 3027 members, trainee and fellows contacted, 607 valid responses were returned. With regards to experience of working with women who had experienced FGM/C, 87% reported caring for patients with FGM/C. Of the respondents 21.4% were not aware of the FGM Act (2003) and 6% did not know that FGM/C is always illegal in the UK. Awareness of the prevalence of psychiatric syndromes as a result of FGM/C was weak and only identified by 9.8% of respondents. More than half of all respondents did not know how to refer women to specialist services and many could not identify the types of FGM/C procedure. British doctors were also typically unaware that deinfibulation was possible for women during pregnancy to prepare for childbirth. The disparity in knowledge among obstetrics and gynaecology in the UK suggests that the quality of care and the clinical awareness of the physician a woman who has experienced might encounter is hugely varied, even among those doctors who had worked with FGM/C.

Studies focussing on knowledge and awareness of FGM/C have also been conducted with medical professionals in Europe, Australia, and the United States. Leye et al., (2006) conducted a large scale cross European study of health professionals, to assess knowledge and awareness of the practice. In this study, nearly all respondents were aware of the definition of FGM/C, 40% knew the detail of the FGM Act and 84% respondents knew the complications of FGM/C. However, the response rate was low. Of 1800 respondents, only 300 responded, perhaps reflecting a lack of interest or perceived importance of FGM/C among health professionals. In a study of healthcare professionals in Italy by Surico et al., (2015) only 55% of midwives and 50% of paediatricians were aware of the law on FGM/C. A study by Hess et al., (2010) found only 57% of midwives in the USA knew it was illegal to circumcise a girl under 18 years old, 30% could not identify infibulation and less than 20% were aware that both Christian and Muslim women are tradtionally circumcised. Moreover, the midwives reported that discussions with clients known to have experienced FGM/C about FGM/C and related issues were minimal. The findings of these studies highlight possible avoidance of tackling issues related to FGM/C with clients, and a lack of knowledge about the practice among medical professionals working on the clinical frontline with patients.

One study conducted in Spain touched upon the attitudes of primary care doctors towards FGM/C. In a survey carried out in Barcelona, 17% of respondents said they were not interested in the subject (Kaplan-Marcusan, Torán-Monserrat, Moreno-Navarro, Fàbregas, & Muñoz-Ortiz, 2009). A survey of paediatricians’ knowledge, attitudes and practice in Australia by Sureshkumar et. al, (2016) showed that of the 497 (38%) that responded, few asked about or examined for FGM/C, though most (93.9%) knew it was illegal in Australia and 10% had seen at least one case in girls younger than 18 years old. Most (87.6%) perceived FGM/C as a cultural practice and 11.6% thought it was required by religion.

An approach by health professionals marked by misinformation, lack of knowledge, awareness or interest in FGM/C could result in inadequate or dangerous healthcare provision for this client group. This is no less the case for psychological practitioner. As the small but growing literature base on medical professionals’ knowledge, understanding and attitudes towards FGM/C suggests that healthcare professionals require more and better training, and that many lack both knowledge and interest in FGM/C, it is important to investigate whether this is also evident among clinical psychologists.

## Training needs of psychologists

Many UK psychologists are undertrained or completely untrained in the area of FGM/C Jones (2010). This is a potentially dangerous oversight as the Serious Crimes Act (2015) places a legal obligation on healthcare professionals, including psychologists, to report an act of FGM/C that has been carried out on a girl under 18 years of age. The lack of training can also create barriers to effective working with individuals and families affected by FGM/C. In Jones’ (2010) study, psychologists’ noted the need for training in how to work therapeutically with FGM/C such as what women would find most useful, appropriate language, training from women with a lived experience of FGM/C, the impact on family and sexual relationships, and the political and legal context. These cultural topics are outside the scope of child safeguarding training which is the full extent of training provided to many psychologists.

Unfortunately Jones’ (2010) survey did not extend to further exploration of the psychologists’ need for cultural training relating to FGM/C. We can be guided instead by women who have experienced FGM/C who have called for better cultural insight from healthcare practitioners in the UK. Beyond the lack of basic awareness and knowledge about FGM/C, women from communities that practice FGM/C have highlighted a lack of cultural sensitivity, judgements about FGM/C and why it is done, being made to feel different and therefore isolated (Lockhat, 2004) and that responses from healthcare practitioners hurt them and make them feel shame (Vloebergs et al, 2012).

## Rationale for the current study

Psychological research on FGM/C is timely for the following reasons:

The UK is increasingly recognising minority cultures in law and policy especially that which enforces social inclusivity such as the 2010 Equality Act. All healthcare professionals, including psychologists, need to be aware of the different practices and beliefs of clients and patients they work with. The Division of Clinical Psychology of the British Psychological Society has responded with an Inclusivity Strategy (BPS, 2015) outlining three goals:

* To increase access to the clinical psychology
* To ensure compliance with equality and diversity regulation
* To improve development of research and practice informed by wider knowledge bases that are applicable to diverse social groups

The impact of the strategy will become more evident in future. To date however, research on FGM/C has focused upon the effects on physical health and more recently on medical practitioners’ awareness and skills gaps. The psychological effects of FGM/C have not been extensively researched, nor has the awareness and skills of psychological practitioners.

There is evidence that many women affected by FGM/C receive inadequate healthcare treatment in the UK (Khaja et al., 2010; Lockhat 2004). Thus far however no study (conducted in English) has explored the understanding and experiences of psychologists working with FGM/C-affected communities and what may be their needs for support and skills development.

The current research is the first to investigate UK psychologists’ perspectives on FGM/C. It follows on from the gaps identified in previous research (Jones, 2010; Elliott et al, 2016) and is responsive to the DCP Strategy of 2010. In this thesis, the literature review provides a detailed analysis of what is already known (or conjectured) about health and social care professionals’ perspectives on FGM/C. It cited literature that found low levels of interest in FGM/C among health professionals (Kaplan-Marcusan, 2009), lack of motivation to explore potential FGM/C-related health problems among women (Sureshkumar et. al 2016) and a general lack of knowledge and awareness of safeguarding need (Purchase et al., 2013).

The current study aims to add an exploration of psychologists’ perspectives, attitudes and ways of working with communities impacted by FGM/C. FGM/C is a practice that primarily impacts the lives of ethnic minority women in the UK. It is no longer acceptable to treat therapeutic interactions as devoid of issues of power and privilege when health professionals report feeling unmotivated or unskilled to work with diversity issues, and the client groups report being deterred from seeking help due to feeling judged and alienated. Researchers have looked into psychologists’ attitudes towards members of minority groups who have reported negative experiences with healthcare services such as patients with AIDS (Lawrence, Kelly, Owen, Hogan, & Wilson, 1990), same-sex parents (Crawford, McLeod, Zamboni, & Jordan, 1999), and transgendered young people (Bowers, Lewandowski, Savage, & Woitaszewski, 2015) and have found similar prejudices and tolerance relating to these groups as evident in the general public. As 100,000 women in the UK are living with the impact of FGM/C, this client group is no less deserving of efforts to improve understanding of the barriers they might encounter when receiving clinical psychological care.

## Summary and aims of the research

FGM/C affects millions of women around the world and an estimated 100,000 in the UK. The practice can have profound and long-lasting consequences on women’s physical and mental health. Women and girls have died as a result of FGM/C. The current body of literature on the impact on women’s mental health and the wellbeing of other members in practising communities is still in its infancy, but is gathering momentum. However, research into psychological practice as it pertains to FGM/C and communities affected by it, including treating the mental health sequelae of FGM/C, and psychologically informed interventions for individuals, families and communities is sparse. Compounded by this is the lack of professional guidance on policy and best practice, and training for psychologists in the UK on FGM/C (Jones, 2010). As a result many psychologists are uninformed and feel deskilled when it comes to working effectively with FGM/C-related issues. Women affected by FGM/C are deleteriously impacted by the lack of knowledge and awareness of FGM/C among practitioners and they call for more culturally sensitive and informed healthcare (Lockhat, 2004).

FGM/C is a traditional practice underpinned by a range of cultural beliefs. There is a long history of FGM/C in many communities, but on coming to the UK that history must be broken as the practice is illegal in the UK and deemed an act of child abuse. As such, health care practitioners, including psychologists, have a safeguarding duty of care and legal obligation to girls under 18 to report any instance of FGM/C. Therefore, psychologists must be equipped to identify FGM/C and work effectively with communities that practice it.

A review of the literature has demonstrated a dearth of attention to the needs of psychologists in working with FGM/C, both to effectively address issues and mental health problems that can result from FGM/C, as well as play a role in safeguarding and preventing the continuation of the practice on girls. Instead, the literature suggests that clinical psychologists struggle to work effectively with diversity, and feel deskilled and unconfident working with these issues.

This study will acknowledge the concerns of communities impacted by FGM/C and address the training and development needs of psychologists’ and explore clinical psychologists’ views on FGM/C and related issues, as well as their experience and perceived capacity to work with FGM/C-affected clients and communities.

## Research questions

Primary research question

1. What views do UK clinical psychologists have about FGM/C?

Secondary research questions

1. What are UK clinical psychologists’ experiences of working with FGM/C-affected communities and what strengths / barriers do they perceive of working with FGM/C-related issues? What are the challenges / opportunities?
2. What are training needs regarding FGM/C among UK clinical psychologists?

The current study will explore in-depth psychologists’ knowledge of and views about FGM/C and experiences of and barriers to working with FGM/C-related issues. It will explore any need for better understanding, clinical and professional training.

# CHAPTER 2: METHODOLOGY

This aims of this study were to explore the views that clinical psychologists have about FGM/C including any challenges, opportunities, strengths or barriers clinical psychologists perceive of working with clients impacted by FGM/C. Clinical psychologists would also be able share any experiences of working with FGM/C-related issues and any needs they have for working better with this client group.

In the introduction I presented literature which shows that the views clinical psychologists have about FGM/C may be influenced by a number of factors. These include the historical development of clinical psychology in the UK, current ways of working as a clinical psychologist, the treatment of diversity issues in clinical psychology - particularly its treatment of culture and training in diversity issues - as well as widespread and commonly espoused perspectives on FGM/C, such as the human rights and feminist perspectives that are frequently seen in the media and academic writing, as well as the experiences and values that clinical psychologists bring to their work.

Research has demonstrated many women impacted by FGM/C feel a sense of distrust and lack of understanding among healthcare practitioners in the UK (Lockhat, 2004), and that many clinical psychologists do not feel sufficiently equipped to work with FGM/C-related issues (Jones, 2010).

There are huge gaps in the literature. There is a marked absence of any in-depth investigation into the clinical psychologists’ views about FGM/C and professional, organisational and training experiences and needs of UK psychologists who work with or can potentially work with individuals and families affected by FGM/C. The current study aims to redress this gap using qualitative methods to facilitate an in-depth examination of the views and experiences of clinical psychologists relating to FGM/C for the first time in the literature.

## Epistemology

The main aim of this study is to explore the ways in which clinical psychologists view and understand FGM/C. For the purposes of this study it was considered that the ability to claim a reality to experience was important. The judgement or alienation some women perceive when encountering British healthcare practitioners (Lockhat, 2004), or the lack of confidence some clinical psychologists feel when working with FGM/C are treated as ‘real’ so that these issues can be explored and addressed as material concerns. If these concepts are treated as real, the knowledge produced in this thesis could potentially be used to contribute to future guidance for clinical working with FGM/C-related issues and could possibly make a difference (Rogers & Rogers, 1997). A strict realism which assumes that the truth about a knowable world can be unveiled only through empirical research approaches that presume the objectivity of the researcher is rejected as incompatible with a study which aims to explore and give space to a range of views and multiple experiences. Instead ‘knowing’ is treated as something subjective and socially located. This way of treating the relationship between the world and our interpretations of it is well represented by a critical realist position which assumes that there is an independent reality (or real world) but that the very production of knowledge about it is subjective (Madill, Jordan, & Shirley, 2000).

Another attractive feature of critical realism for the current study is the argument that the social (and natural) worlds are driven by causal processes and as such, research seeks to explain the multiple causal interactions that produce events in the world (Elder-Vass, 2012). This is useful for the current study which is interested in understanding the views, experiences and perspectives of clinical psychologists about FGM/C and in exploring any factors that might contribute to these positions on FGM/C.

Critical realism is often referred to as a type of moderate constructionism or as a combination of realist and constructionist positions. In general, proponents of constructionist positions argue that there is no one true world out there that can be researched or ‘known’, rather what we understand about the world is constructed through discourses and systems of meaning (Braun & Clark, 2006). A strict constructionist position was not taken in this thesis as in the most extreme forms of constructionism it can be argued that everything becomes a construction which can undermine the reliability of all knowledge claims including its own (Elder-Vass, 2012). It was considered that this possibility would be less useful for the current study than the critical realist approach which suggests the research produces subjective knowledge about reality, and that can also invite other research to produce competing and/or supporting knowledge claims about this under-researched topic.

From a critical realist position it is possible for humans to have a role in constituting the social world, and also that people’s actions can be influenced by personal and societal mechanisms that are independent of our thoughts. For critical realists, there is a complex non-linearal relationship between non-discursive or ‘real’ elements, and discursive elements such as discursive practices (talk activity that constructs and reflects social realities) and discursive resources (tools that guide our interpretations of experience) that are available to make sense of experience real’ (Sims-Schouten, Riley, & Willig, 2007). When a critical realist perspective is applied to an analysis of clinical psychologists views about FGM/C, possible factors such as clinical psychology training, government policy towards FGM/C, access to literature and research to guide practice, are understood as potentially having a role in producing contexts where certain discursive constructions are more easily enabled or disenabled (Sims-Schoten, Riley & Willig, 2007) which in turn allows an examination these factors. This is particularly appropriate for the current study that aims to explore the role that these and/or other relevant factors play in clinical psychologists’ approaches to FGM/C (Jones, 2010).

## Thematic Analysis

Qualitative methods are becoming increasingly popular among clinical psychological researchers. Thematic Analysis was selected as the most suitable method of analysis, but several methods of qualitative analysis also seek patterns across data (Braun & Clarke, 2013). Interpretive Phenomenological Analysis was considered as an alternative qualitative method of analysis, however IPA is wedded to a phenomenological epistemology which focuses on capturing individual experience and exploring its meaning in great detail. The current study uses thematic analysis which is compatible with a critical realist epistemology and also allows for manageable analysis of a larger dataset. The use of Grounded Theory was considered for its attention to social processes and influences that underpin a phenomena. However this method of analysis is also less suitable than thematic analysis as it is an inductive approach which aims to produce a ‘theory’ from data-driven analysis, with very little direction from existing theory. Thematic analysis allows the researcher to draw upon both deductive and inductive analysis. In this study existing literature informed the research questions and interview outline.

Thematic analysis provides a framework for the systematic pursuit of uncovering prevalent themes in the data through organising and describing the data. The result is a depiction of the most salient constellations of meaning in the data set (Joffe, 2012). When used within a critical realist framework, it attempts to report experiences and meanings of participants and also how these are impacted by broader social context. In this study I am interested in the views of clinical psychologists on FGM/C, but also from a critical realist perspective, the social and material conditions that give rise to them, sustain them or shape them. In line with Braun and Kitzinger’s (2001) research on women’s talk on vagina size, the thematic analysis in the current study draws on insights offered by discourse analysis. As such, this analysis will look at thematic patterns of talk, and in some detail at what those objects construct and how participants constructed them. This approach is compatible with critical realism in the sense that theoretically it is underpinned by the idea that language creates meaning. A Foucauldian informed understanding of discourse is that discourse is a means of constructing objects, events and subjects through a system of practices, of which those practices are situated historically and within hegemonic systems of power (Wickham & Kendall, 1999). Generally, discourse analysis focuses on patterns of meaning, and the effects and implications of these patterns of meanings (Braun & Clark, 2006). Being able to analyse the talk of clinical psychologists about FGM/C and communities impacted by it with consideration to social power and how that helps to give meaning to and shape their understandings of it could be important in the current study, particularly as communities that traditionally practice FGM/C in the UK are typically ethnic minority communities that are subjugated in a variety of ways, and the clinical psychologists speaking about them are typically drawn from backgrounds that are privileged in terms of race and class.

The interview method and Thematic Analysis

The verbal interview method is popular with researchers using thematic analysis (Joffe, 2012) as data that can be collected through verbal discussion is often more limited in detail when using quantitative data collection methods. Themes capture interesting aspects of the data in relation to the research question, and represent a patterned response or meaning in the data (Braun & Clarke, 2006). A semantic inductive approach will be taken so that themes are closely linked to the data they are drawn from. In this way, the mixed format of the semi-structured portions of the interview will enable any novel ideas from participants to be taken into account.

This study followed guidance for good quality thematic analysis from Braun and Clarke (2006):

1. Familiarising with the data through transcription preferably, with reading and re-reading the data to identify initial ideas
2. Generating initial codes through coding interesting aspects of the data
3. Searching for themes by gathering codes into potential themes
4. Reviewing themes by checking the themes fit with the coded extracts and have not become divorced from them
5. Defining and naming themes
6. Producing the report

Braun and Clarke (2006) argue that it is important to be transparent about the methodological choices that are made when conducting a thematic analysis. In some versions of thematic analysis such as Joffe (2012) what can be treated as a theme is largely defined by quantity such as how many times a concept is present or mentioned in the data set. Partly due to the sensitive - and in some ways taboo - nature of FGM/C what constitutes a theme is given a more flexible treatment in this study as it is possible that context and other factors could influence some participants in such a way to encourage or discourage explicit mentions of certain matters. For this study a theme was defined as an idea that captures an important feature of the data in relation to the research question and represents a patterned response in the data.

As the perspectives of psychologists on FGM/C is an under-researched area this exploratory analysis will focus on as rich a description as possible of the entire dataset so to delineate predominant themes rather than to produce a detailed analysis of a narrow field of themes. The analysis will also be responsive to the data as Joffe (2012) recommends so that themes are not restricted to a function of confirmation of ideas about healthcare workers’ approaches to FGM/C but also open to avenues of change or opportunity.

## Design

The current study employs semi-structured interviews to explore FGM/C-related issues in the UK. This qualitative approach is advantageous when exploring participants’ views on FGM/C for several reasons:

1. The qualitative method allows for detailed exploration of the interwoven issues relating to FGM/C that could be challenging to explore in detail using a quantitative approach. The matter of working in the UK clinically with FGM-related issues could raise ethnic, racial, gender, class and other issues in complex, contradictory or ‘messy’ ways (Braun & Clarke, 2013). The interview method will give participants the opportunity to express and represent their responses in a way that is their own choosing, through their own language and choice of description which quantitative methods could restrict (Frith & Gleeson, 2011).
2. Interactive discussion in interviews can elicit diversity in ideas and thoughts and encourage reflection in both the participant and researcher (Frith & Gleeson, 2011). It also allows for the researcher to be responsive to any ethical considerations that might arise, such as the participant feeling distress, or practical issues such as the participant not understanding a question or an issue.
3. The interview method has the advantage of reflecting the clinical therapeutic setting which will be familiar for the participants and provide the opportunity to practice discussing, learning about and addressing the issue of FGM/C away from the responsibility of client work. The context of the data collection is ecologically closer to the phenomena being investigated than quantitative methods would typically allow.
4. A qualitative study encourages exploration of the researcher’s contribution to the research process, particularly accepting responsibility for their own interpretive roles (Strauss & Corbin, 1998) a factor considered important for enhancing the quality of qualitative work. The researcher will actively consider the effect her position as a British, working class, ethnic minority, female trainee clinical psychologist could have on participants, the study, data collection, analysis and discussion of the findings.

### Ethical approval and considerations

Ethical approval for the current study was gained from the NHS Health and Research Authority (Ref: 16/HRA/5675) and the Royal Holloway, University of London’s Research and Ethics Committee (self-certified).

Informed consent

Participants received information about the study direct from the researcher at the beginning of each interview and in the form of the information sheet (Appendix A) during the recruitment process. Participants were encouraged to ask questions about the research at the time of recruitment as well as at the beginning of each interview.

Right to withdraw

Participants were made aware of their rights to withdraw in the information sheet and this was repeated at the beginning of the interview. They were informed that their decision to participate would not impact their employment in any way.

Confidentiality

Several precautions were taken to ensure participants confidentiality. At recruitment participants were asked to email the researcher directly to arrange the interview or for further information about the project. As some participants did say their own names during the interview, the recordings of the interviews were transcribed by the researcher only, with names and identifying information such as places of work omitted. The interviews were then numbered to ensure anonymisation. The recordings were kept in a secure cabinet. No identifying information has been used in the write up of this study. All participants were located in a private room while being interviewed.

Consideration of distress

It is possible that discussing FGM/C could cause participants distress, particularly if participants had any previous experience of FGM/C either personally or professionally that they found traumatic or difficult. In consideration of this it was reiterated during the interview that should the participant feel any distress the interview could be stopped and information would be given regarding support available to them (such as local counselling groups). Psychologists are now required to know about FGM/C for safeguarding purposes as part of their work. FGM/C is considered a form of child abuse in the UK and as such all participants would have experienced discussion of this broader issue in training and during continued professional development exercises. In addition, some psychologists have now completed safeguarding exercises on FGM/C since the 2015 Serious Crimes Act. No participants reported distress.

Debriefing

All participants were debriefed following the interview. Some participants used the opportunity to learn more about the practice by asking questions during the interview or requesting further information through email.

### Interview procedure

The interviews were conducted face-to-face or via telephone. Face-to-face interviews have the benefit of increasing the potential for rapport between researcher and participant. Interviews conducted took place in a private room at the participant’s place of work. The use of telephone interviewing enabled access to participants located in different areas, thereby providing a potentially larger number of participants. It also provided the opportunity for participants who might have found the interview inconvenient otherwise (due to working conditions such as shift work). Telephone interviews could also have encouraged disclosure in participants due to greater anonymity which is useful when working with sensitive topics (Trier-Bieniek, 2012). Twelve interviews were conducted in person and six were conducted over the telephone.

Verbal informed consent was sought from each participant at the time of the interview, and a signed consent form was collected at the time of the interview or prior to the interview via email for telephone participants (Appendix B). The right to withdraw was reiterated along with assurance that their participation or withdrawal would not affect their employment in any way.

A semi-structured interview schedule was developed **(**appendix F). Participants were informed the interview would take the following structure:

1. Brief questions about the participant’s working experience and demographic details
2. Discussion about their thoughts around FGM/C
3. Any follow up questions that either the researcher or participants had about the research or topic area

Employing the semi-structured interviewing technique put forward by Joffe (2012), participants were be asked to jot down four words or groups of words, or images regarding their thoughts around FGM/C to talk about during the interview. As FGM/C is currently a sensitive and under-researched topic in the UK, this is a more naturalistic interviewing method that encourages the interview to be led by the participants.

Closed-ended questions were used initially to gather basic demographic and professional information. Open-ended questions followed to glean specific information relating to the research questions. Open-ended questions were used so as not to restrict participants’ answers and enable in-depth exploration of complex experiences, thoughts and ideas (Kvale, 1996) and allow for a conversational approach to be taken which can be useful when exploring sensitive issues (Corbin & Morse, 2003).

All interviews lasted less than approximately 75 minutes. This allowed time for the researcher to explore areas of discussion that arose and also provided the participants with an opportunity to ask questions of the researcher about the research which participants were invited to do before and after the interview. The researcher asked each participant if they would like information about local services that could assist them with any distress that arose from the interview. No participants requested any further support following the interviews.

### Participants and recruitment

Qualified clinical psychologists currently working in a psychological role the UK in all disciplines and practice areas within psychology were targeted for recruitment. As more than 100,000 women in the UK have experienced FGM/C, it is reasonable to expect that psychologists working in a variety of contexts and locations could encounter clients impacted by FGM/C. Trainee and retired psychologists were excluded from recruitment as were any participants who would not be able to speak fluent English as interpretation services were unavailable. The cities of Bristol and London were particularly targeted as it was deemed important to recruit psychologists who work in locations in the UK with large communities that traditionally practice FGM/C as these are the locations that women who have experienced FGM/C are most likely to seek help. Two psychologists were approached to assist with recruitment of psychologists through snowballing in their respective Trusts: University Hospital Bristol NHS Foundation Trust and Camden and Islington NHS Foundation Trust. The psychologists each sent an email to introduce the study along with the information sheet to the Trusts’ email list of psychologists. Thirteen participants were recruited across these two Trusts. The introductory email was shared with other psychologists which yielded four participants from a private service and one other from University College London Hospitals NHS Foundation Trust.

Eighteen psychologists were recruited in total. Ten participants had 5 years or less clinical experience. Two participants had between six and ten years experience, and 10 to 15 years experience respectively, four participants had 15 – 20 years and two participants had more than 20 years experience of clinical work. Several participants had worked in different areas of the country, and at the time of the interview five participants were working in Bristol with the remaining 13 in London. The five participants recruited from Bristol were interviewed over the phone, along with one London-based participant. The remaining 12 participants were interviewed in person. The duration of phone and face-to-face interviews were of similar length and ranged from 45 minutes to 75 minutes. Two participants identified as male and 16 as female. Ten participants identified as White British, two as White South African and White Irish respectively, one as White European and three identified as Mixed Heritage. The participants had worked in a range of services including health settings including paediatric care and neurological services, community mental health teams, child and adolescent mental health teams, early intervention services, pain management services, trauma related services and women’s refuges.

Of the 18 participants, four had experienced training focussed solely on FGM/C, three in NHS settings and one in a private setting. Seven participants recalled training on FGM/C as a small part of safeguarding training. Ten participants had received information about the practice through broadcast media and newspapers. One participant worked on a campaign to raise awareness of FGM/C, one encountered clients impacted by FGM/C through voluntary work and one reported reading about FGM/C in academic journals. Only four participants were aware that they had worked directly with a client impacted by FGM/C.

## Owning one’s perspective

In their paper on publishability guidelines for qualitative research Elliott, Fischer and Rennie (1999) outlined ‘owning one’s perspective’ and ‘situating the sample’ as two key components. To help the reader to interpret the researcher’s data, researchers are encouraged to disclose their orientations and expectations of the research to recognise how their values, interests and assumptions might shape their own understanding.

Researchers are also urged to share their reflexive considerations. Morrow (2005) defines reflexivity as the researcher dealing with biases and assumptions that come from their own life experiences or interactions with research participants. To this end, a description of how I came to the topic of FGM/C is appropriate.

I first heard about FGM/C as child during the 1990’s from classmates who had immigrated to the UK as refugees from Somalia. Later as an adult I actively campaigned against FGM/C as part of a black women’s group which included members who had experienced FGM/C. I have worked professionally in mental health with women who have undergone the practice and I count women from practising communities among my friends. I feel strongly about all practices that women and girls undertake for cultural reasons that can have profound negative consequences and I regard FGM/C as one of those practices. However, I understand that for some women it is a choice and I understand that for some girls the alternative also carries risks. I expected the participants to take a range of positions on FGM/C, some conflicting like my own, some very different. Though I have spoken openly about women’s bodies both professionally and personally I expected some participants to regard the topic as sensitive and for this to impact the interview. Therefore, I introduced the interview as a discussion between psychologists who had experienced training in the UK to build rapport with the participants. I disclosed my interest in FGM/C and that I was not from a practicing community as I expected that the suggestion that I might have experienced FGM/C could impact participant’s disclosure (Braun & Clarke, 2013). However, as a black female researcher I also recognised that I would be “interviewing across difference” with a predominantly white participant group of psychologists with varying levels of experience and knowledge of FGM/C. I reflected on the impact my presence could have on the data during the interview, transcription and in the write up of this thesis. Though I encouraged questions from the participants and I also asked questions to clarify my thoughts during the interviews, I paid attention to how understanding between myself and the participant could have been assumed when it was actually not well understood.

As a trainee psychologist who was being helped by qualified psychologists volunteering for the study the participants could be seen to hold an element of power. As a researcher with a level of knowledge and awareness about an under-researched topic I could be argued to hold some power in the interaction. This appeared to contribute to open conversation where participants and the researcher shared their thoughts and ideas. Conversely I was also mindful of the potential socio-economic, cultural or academic privilege of all involved in the study in relation to some members of the communities we were discussing and how language could impact the interview and therefore the quality of the data, as well as my own personal feelings as a minority ethnic woman in the UK. The impact of these issues will be discussed further in the critical review.

Reflexive considerations

I was aware of my position as a British person who was not from a community that traditionally practices FGM/C and considered how my own political, spiritual, cultural and social positions could impact my views upon the practice of FGM/C and the quality of the research. I took the following steps in attempt to raise my own awareness of any bias towards the practice and those who engage in FGM/C:

1. I discussed the proposal for the research with a member of the self-help and activist group Daughter’s of Eve. I asked about her thoughts about the research and my ideas for the study. For example, I openly wondered with her about whether the topic was one that women from impacted communities also cared about and whether this issue formed part of their ‘reality’, or whether the topic was important for me because of my personal endeavour to see equality in mental healthcare.
2. Consultation on the interview schedule was sought with a member of the activist, campaigning and advocacy organisation FORWARD. Subsequent amendments were made to the interview schedule particularly around language used to refer to communities impacted by FGM/C. As suggested by Morrow (2005), this individual served as a mirror to my responses to the practice of FGM/C and my beliefs about it. I was able to discuss my drive to undertake the research and my concerns about the safeguarding of children and vulnerable adults. It was impressed upon me that although FGM/C is regarded as mutilation in the UK, in communities that traditionally practice FGM/C the practice is often conducted out of love and care for their daughters. This individual talked about child obesity in the UK as result of the excessive consumption of sugar and sweet foods which parents allow or encourage out of love for their children. Reflecting on this impacted my conduct in the interviews, when analysing the data and in considering discussion points as I was keen to think about the data and findings in relation to cultural difference, particularly as a researcher with a largely Western social perspective. I hope this resulted in a more balanced research position and enhanced my ability to critique the existing literature base, the collected data, the findings of the study and the eventual critical discussion which includes, for example, a discussion on mainstream Western feminist approaches to FGM/C and Whiteness.

## Situating the sample

Elliot et al., (1999) recommended researchers describe the research participants to assist the reader in appraising the range of situations to which the findings might be germane.

In situating the sample, particularly with regards to the concerns women have about the knowledge and awareness of healthcare workers about FGM/C, an important characteristic of the participants is their training in the area. Four participants (22%) had experienced training focussed solely on FGM/C. Four participants (22%) were aware that they had worked with clients who had experienced FGM/C. Two participants had no exposure in a personal or professional context to FGM/C. That most of the participants worked in cities with large communities that traditionally practice FGM/C but had little training and had not identified clients with FGM/C is important in situating the sample. As expected from a sample of psychologists in the UK most participants were White non-British (22%) or White British (56%) and no participants were from practicing communities. Another factor to consider is the possibility that the psychologists who volunteered to participate in the study had a particular interest in working across diversity and FGM/C or in learning more about it than those participants who did not directly contribute to the study. These participants therefore might share similar views about FGM/C and related issues. This is further addressed in the Discussion.

## Credibility checks

As suggested by Elliott et al., (1999) the credibility of the data was undertaken with the support of a member of FORWARD (referred to as ‘the co-analyst’ hereafter). Consultation on sections of the analysis was sought from a member of the team who is a psychotherapist and a woman who has experienced FGM/C. She was able to consider the data from the perspective of someone personally impacted by the practice and also as a therapist working with women impacted by FGM/C. This was a fruitful exercise. The co-analyst focussed on the codes and themes generated from the data. The co-analyst suggested that two themes should be emphasised. The first was the importance of culture in the way that clinical psychologists view FGM/C, particularly that perceived cultural differences between the clinical psychologist and clients impacted by FGM/C often has a negative effect on the therapeutic relationship. She emphasised the lack of reflection in the clinical psychologists’ talk about gendered abuse across all cultures, as well as within FGM/C communities. The co-analyst also wished to emphasise the importance of the subtheme about safeguarding. She commented that both in her personal experience of therapy as a woman with FGM/C, as a therapist and as reflected in the psychologists’ talk, this issue also negatively impacted the direction of therapy, and that often it overshadows much of the therapeutic work that could potentially be done with clients impacted by FGM/C. The co-analyst was also keen to underline the importance of recognising therapists who showed a willingness, openness and curiosity to learn more about FGM/C.

## Evaluating the research

Lucy Yardley (Yardley & Smith, 2008) argued for four ‘open-ended flexible’ quality principles that qualitative researchers should strive to meet. The current research is evaluated using this framework:

1. Sensitivity to context including relevant literature, sensitivity to the social context and to participants’ perspectives as well as being sensitive to ethical issues and the data set

This research study was grounded in the relevant literature base that demonstrated a lack of knowledge and awareness of the issues related to the practice among psychologists in the UK and healthcare professionals at large. Sensitivity to the social context was shown through the use of interviews to elicit participants’ thoughts, ideas and experiences related to FGM/C as previous research typically used the survey design, thereby restricting the responses of participants. This was important given the sensitive nature of the topic for some participants and the potential for distress caused by discussion. Also, as psychologists were participating as registered members of a profession, sensitivity to this was shown through the rigorous use of anonymity and the appropriate use of confidentiality for participants.

1. Commitment and rigour in data collection, analysis, methodological skill and engagement with the topic

Attention was given to all aspects of the research process. Participants were recruited from two UK cities, using the most convenient format for participants; either face to face or telephone interviews. In-depth analysis of the data was undertaken by the researcher as well as a female psychotherapist from an FGM/C practising community.

1. Transparency and coherence including a clear and persuasive argument, methodological congruence with the research questions and aims of the research, transparency in data collection and analysis and consideration of the researcher’s impact on the research

Participants were informed of the topic under study and its aim to explore their perspectives, awareness and knowledge of FGM/C as well as any barriers or opportunities for working with this client group.

Thematic analysis was chosen as an analytical method, with an explanation of three alternative methods of analysis that were rejected. The researcher’s impact on the study has been considered in line with her professional status as a trainee psychologist, her ethnic status as a black woman with a working class background, her political persuasions as a feminist, and as a possible ‘insider’ and ‘outsider’ on the participants, on the inception, design and data collection, analysis and in discussion of the data.

1. Impact and importance – whether the research met its practical, theoretical or socio-cultural goals.

The research met its practical goal of exploring psychologists’ perspectives on FGM/C. Theoretically, this research makes a coherent argument for the use of whiteness to describe and explain psychologists’ perspectives on FGM/C and impacted communities, as well as their approach and work with ethnic minority client groups. This contributes to the body of literature on whiteness, but also raises awareness of the importance of research on the psychological work of psychologists in the UK who are predominantly white, on clients who are not white, which focuses not only on the ethnic minority client but also the approach of the white psychologist.

It is intended for this research to be published, presented at relevant conferences and highlighted to the British Psychological Society to raise awareness of the issues and the concerns of women impacted by FGM/C.

# CHAPTER 3: RESULTS

In this chapter an account of the Thematic Analysis conducted using the methods detailed in the previous chapter is provided. The purpose of this chapter is to give rich detail to the themes generated from the interviews with participants. As with recent research using Thematic Analysis (Hunter, Lewis, Noble, Rance, & Bennett, 2017) discussion of how some of the findings relate to theory is covered in-depth in the discussion, with an overview of some theoretical links and mechanisms of discourse given here.

The participants expressed many diverse views on FGM/C and on working with FGM/C-related issues. As well as sharing their thoughts, feelings, experiences, hopes and fears about working with clients impacted by FGM/C, many of the psychologists appeared to use the interviews as an opportunity to talk about FGM/C as part of learning about the issues and discuss their positions to it. As such, the psychologists’ talk was at times contradictory, complex and at times, it seemed, incomplete. Participants would frequently revisit ideas they had expressed earlier in the interview.

Thematic analyses of the data yielded three over-arching themes that frequently overlapped in reach:

1. FGM/C: ‘Other’ Cultures’ Abuse of Women
2. Barriers to Working with FGM/C
3. “It’s like I almost feel it myself”: Psychologists’ Responses to FGM/C

These are illustrated in Table 1 below. Generation of these themes was influenced by several factors. In line with Joffe (2012) the themes were not restricted to those that would confirm existing theories about healthcare workers or psychologists approaches to FGM/C. Theme generation was grounded in the data to ensure sensitivity to the data set as recommended by Yardley and Smith (2008) with a focus on themes that were unique and relevant to the research aims. The themes represent as rich a description as possible of the entire data set. Finally, themes were considered with consideration of the co-analyst’s suggestions.

The extracts from participants are presented verbatim. Often, several extracts reflected themes very well. An attempt was made to present extracts that best characterise the themes to enable evaluation of the degree of ‘fit’ between the data and interpretation (Elliott et al., 1999).

Quotes are represented in entirety wherever possible, however, in a small number of instances this was not possible. Any omissions are indicated by ‘…’.

**Table 1: Generated themes and sub-themes**

|  |  |
| --- | --- |
| **Theme** | **Sub-theme** |
| FGM/C: ‘Other’ Cultures’ Abuse of Women | * Women as victims of sexual oppression |
|  | * Women as perpetrators |
|  | * Women as survivors |
|  | * The racialised sexism of FGM/C |
| Barriers to Working with FGM/C | * The Whiteness of Clinical Psychology |
|  | * “I’d hate to meet someone who’s had it themselves”: The Unprepared, The Unready and The Unwilling Psychologist |
|  | * Safeguarding vs. therapy |
|  | * Client Disclosure |
|  | * Professional and organisational barriers to working with FGM/C-related issues |
| “It’s like I almost feel it myself”:  Psychologists’ Responses to FGM/C | |

## THEME ONE - FGM/C: ‘Other’ Cultures’ Abuse of Women

FGM/C was seen by most participants as an abusive practice that exists in cultures that are different to Western cultures. Gendered violence and discrimination was largely talked about as something that happens in other cultures. Though a small number participants also reflected on instances of gender discrimination in Western societies, most participants consigned the most cruel and aggressive acts of gender discrimination to the historical past in Western communities. The very worst instances of gendered violence were reserved for other communities, such as those practicing FGM/C.

The three main ways participants distinguished between cultures that practice FGM/C and British cultures were through talk about the use of FGM/C to oppress women, women as perpetrators of gendered abuse and women as survivors of FGM/C.

Women as victims of sexual oppression

Many participants considered a lack of choice and consent over whether females should undergo FGM/C to be an important demonstration of control being exercised over females from early childhood and one which they vehemently objected to.

P11:

*I mean if people have chosen to do something that's different. But in this case is not choice and trying to be balanced and calm about that you know that's the challenge, I think.*

‘Choice’ and the ability to ‘choose’ were constructed as rights that children should have over what happens to their bodies.

P7:

*It's an attack on a woman's body. It's you know, it's not even. But before a woman really chooses but not when, it's when the woman is a child before they choose it.*

Though some participants acknowledged that some females might have made the decision to undergo FGM/C, for most participants it was seen as a choice enforced by a sexist culture.

P9:

*In my view sort of like they are seeing it as this is the place the woman, this is a way of actually controlling the place of women in our culture.*

Choice over what happens to the body was constructed as something that each person should have, and as something that was personal to the individual. The lack of choice over what happens to (women’s and girls’) bodies was talked about as cultural. However, participants appeared to talk about the right to consent and choice as something that was universal.

P5:

*Well for me choice is the most important thing... If somebody made that personal choice I would try to respect it but I think I would find it very hard because I feel like the choice is so heavily influenced by really misogynistic ideas around women.*

As seen in here, culture was constructed as such a strong force in the women’s lives that some participants found it difficult to contemplate that personal choice to have FGM/C done was possible among the women.

This reflects a feminist perspective that some commentators have highlighted as problematic (Okome, 2006) as it portrays women as being done to, rather than having agency to choose for themselves.

P1:

*The last one here is an image of distress of a client who disclosed to me in just her description as she talked about her, but also her absolute like just shame and distress in recounting what happened to her and her complete lack of control and powerlessness.*

Some participants believed the intention behind FGM/C was to control women physically and psychologically through targeted attack on their bodies in early life.

P13:

*Well I would imagine I would imagine that one of the things that happens is exactly what the process is supposed to do is that women feel smaller you know more powerless and controlled. I can't imagine not being cowed by this process if I was the person and feeling like it was something bigger than me that was able to sanction this and allow this that made me small and unimportant.*

Participants constructed communities that traditionally practice FGM/C as oppressive cultures (‘cultural systems’) in which women are ‘submissive’ and ‘passive’. Not being able to choose was constructed as antithetical to empowerment.

P18:

*They're forced to do something which is horrific, traumatic and painful. So that's the kind of idea. They are not mastering their body. They are not empowered. They are just submissive and just passive into a cultural system.*

The idea that FGM/C is used to oppress women through physical disablement reflects another feminist perspective on FGM/C (see Morrison, 2008). This understanding of the function of FGM/C has been used by some feminists to draw parallels between FGM/C and other practices such as footbinding. In the case of FGM/C feminists highlight clitoridectomy as a specific type of abuse because of the impact to the women’s sexuality (Morrison, 2008).

Nearly all participants discussed the impact of FGM/C on the sexuality of women and most regarded pleasurable sexual activity an element of life that was of universal importance for all women and men. The vast majority of participants believed FGM/C removed opportunities for women to enjoy sex and engage fully and equally in sexual activity.

P7:

*I think it is taking it's taking something really really really really important to, to you know the essence of human beings, sexuality. It’s just taking it's just you know violently, taking it away when there is, in my understanding, very little choice involved.*

P10:

*Because women should be allowed to experience sexual pleasure. How could that be taken away from someone? Who decides? So it seems like a definite human rights abuse.*

P13:

*The impact on relationships where a man is getting pleasure from something which should be a pleasurable experience for both people is now it's become really one sided and that is putting a huge pressure on their families, on their relationship, on the decision about whether or not they then do that to their own children.*

In their talk about sex, enjoyment was often presented as a bodily sensation that women ‘should’ have or pursue, particularly for themselves. However, in a study by Berggren et al., (2006) some women with FGM/C reported sexual pleasure through that of their husbands’ pleasure, showing different ways of thinking about sex and sexual pleasure than those constructed by participants in this study.

Specifically, FGM/C was seen as a method for men to control women’s sexuality and pursuit of sexual experiences through the removal of sexual enjoyment and the affliction of chronic genital pain.

P11:

*I think there's probably a, something about like why, why the sort of level of control of female sexuality and that somebody is not going to seek out a sexual relationship of their own accord. So it completely changes the dynamic between men and women.*

P9:

*I think it's linked to culture that cultural belief around for example the view that women should not get any enjoyment out of sex. And probably it's linked to views about males being dominant in the culture or males wanting to have some control over whether the female has gets access to sex with anybody else or not.*

FGM/C was understood by participants in the study as a cultural practice that is oppressive to women. Participants constructed choice over what happens to one’s own body, and the physical enjoyment of sex as important for all people. In doing this, participants appeared to extend their understandings of basic human rights in the UK to contexts and communities elsewhere.

Women as perpetrators

FGM/C is legally considered a form of child abuse in the UK and this idea was prevalent in the participants talk. Participants discussed the effect of FGM/C on family relationships, particularly the relationships between parents and children. Some participants hypothesised a loss of trust in parents and a sense of betrayal in parents in them allowing the procedure to go ahead.

P3:

*You may feel that you've been betrayed by them. If the basic function of parents is to keep you safe and intact and so on, let you make your own decisions. You’d think.*

The participants distinguished between Western cultures and cultures in which FGM/C is practiced through talk about family relationships and the way families function. In doing so participants also appeared to transpose their understandings of families and healthy family functioning in the UK to contexts and communities elsewhere. In the quote above, the participant has represented their own expectations and understandings of parenting (the ‘basic functions’) as the standard of all forms of parenting across all communities.

P13:

*I think also the psychological pain that goes with having something like that done to you, having something removed from you. That kind of psychological pain, knowing that relationships are going to be affected by this. Knowing that you are treated like this by the people that you most trust in the world.*

Some participants imagined women and girls would examine their parent’s decision and motivations.

P7:

*It's like having it you know question 'Why did my parents allow that to happen to me they were there to protect me'. So many things that I would wonder about.*

P3:

*Parents do all sorts of things that their children end up thinking what were you thinking and “why were you not strong enough” and “why did you not take another route”?*

None of the participants talked about positive impacts FGM/C might have on the family and family relationships. In general, FGM/C was viewed as something negative that parents chose for their daughters. Some participants directly questioned and critiqued the parenting of caregivers who authorised FGM/C on their daughters.

P13:

*I find it really hard to understand from the father's point of view, if he's married to someone who has FGM and who has first hand, second hand experience of sleeping with a person that it is painful to do that for them. Why on earth would they want to have that happen to their children?*

When no longer cast as the recipient or ‘victim’ of FGM/C as girls, adult women in the family and wider caregiving network were constructed as colluders in the practice.

P16:

*I kind of think it is one of the aspects of brutality to me, about your own mum or women in your community who are doing that. And I guess because of the culture it happens. It is just so difficult to accept that other women would do that, cause me harm.*

It appeared in the psychologists’ talk that the role of parents was to protect and care for children, keeping them from harm to the best of the parents’ ability. However, FGM/C was constructed as something negative that happens to children at the will of parents who have ‘caused harm’. As a result, it can be argued that implicit in this kind of view of FGM/C is that parents, particularly mothers, of girls who have had FGM/C are not fulfilling their parenting responsibilities. Two participants appeared to express this view concisely:

P15:

*If I was a mother and I had to save up everything to get that child out of that then that’s what I would do. I don’t understand how someone could watch that.*

P7:

*You know does it really come from them? Do they really want to do it if you really, you know, talk to them? If we were not to, you know, just if there was a choice then they didn't have to do it? How, you know, what, what mother would really want her baby to go through that?*

These participants’ comparisons of what they ‘would do’ and what mothers in FGM/C community are able to ‘watch’ can be argued to reflect a discourse around what is acceptable parenting. This constructs parenting as something that is independent of context and ideas about FGM/C appeared to be absolute in negativity – ‘harmful’ and ‘painful’. For some participants, parents were constructed as autonomous actors ‘wilfully’ having FGM/C performed on their daughters.

Some participants expressed dismay at women undertaking the procedure as they themselves had experienced the consequences of FGM/C. Perhaps reflecting the sense of betrayal and confusion that some participants imagined children would feel towards their parents as a result of FGM/C, some participants talked about their difficulty in understanding the actions of women involved in the practice. These participants appeared to be attempting to reconcile the concept of a respected female elder with someone who would perform FGM/C.

One participant withdrew the construction of elder women who perform FGM/C as ‘midwives’ and ‘wise women’ in the assertion that those women in UK society wouldn’t perform an act like FGM/C.

P7:

*We look upon midwives as real you know elders, wise women who do things. And actually then there's a similar group of women who do this. It's not similar. There is a group of women who this, is doing something really horrendous to women and it just feels like there's nothing healing or kind or anything about it.*

Many participants attributed the responsibility of protecting the welfare of children to women.

P14:

*My anger is towards the people who actually do the FGM, maybe the women in the local community who do it, and I understand that that can be a job for people and that they can be a highly respected member in their community, and they are very interested in keeping the practice going for lots of different reasons. They believe what they are doing is right and important, but I still feel like doing that to somebody else makes me feel quite angry.*

In the following extract, the participant is empathising with the mother, but as the mother is constructed as powerless in her culture, the participant begins to feel a lack of compassion for her.

P13:

*At the same time, imagining a mother taking a child through something which you yourself have definitely experienced. I think that must be unbelievably hard and maybe they have no choice in the matter because it's so cultural. I think it goes against the grain, it feels hard to feel compassionate toward the parents for me. But again I think that's just through complete ignorance rather than anything else.*

In contrast, a small number of participants reflected on the social pressures upon parents, particularly mothers, to allow FGM/C.

P18:

*If you're a woman, and that something is done to you, that horrific thing is actually telling you that you’re welcome in that community. You're included and you have a place and a role. If you don't do it, you will be excluded or you will be a black sheep or whatever you want to say. It's about really being part of that.*

P11:

*So I talk a lot about different ideas that there might be in this client's grandmother's environment and that would have meant that from her point of view. The best thing she could possibly do for the child is to arrange to FGM.*

Women who have experienced FGM/C have made calls for healthcare providers to demonstrate awareness of the reasons why FGM/C is performed (Lockhat, 2004). Several research studies have explored the beliefs around FGM/C and reasons why it continued. Social pressures upon the family, rather than members of the family wanting the procedure, has been well documented (such as UNICEF, 2013).

Women as survivors

Some participants discussed women’s efforts at resistance, their possible feelings of conflict about FGM/C, and prejudice that they might face in the UK. Participants who had experience of working with women impacted by FGM/C told stories of these women resisting FGM/C (such as by running away from home), campaigning against FGM/C, or refusing to have the procedure performed on their children. They were talked about as ‘feisty’ campaigners, rather than ‘cowed’. In this way it appeared that exposure to women who had been impacted by FGM/C broadened the way women were constructed.

P8:

*Yeah my client, I think she was form the Ivory Coast and she was campaigning against FGM. And then the war broke out and they came after her, they didn't like that she was campaigning against it and they did FGM on her, and she was an adult woman, because they didn’t like her campaigning against FGM.*

P10:

*She was adamant that she would not have any of that for her children and has been very feisty about it.*

Another participant who had not worked with FGM/C directly was eager to learn about modes of resistance among women:

P4:

*Like I think it's much more nuanced than that. I think I would be interested to learn a bit more about kind of more indigenous forms of like yeah resistance or kind of being you know kind of, yeah, different perspectives rather than just kind of monolithic view of culture.*

Participants also considered the lived experience of women who had experienced FGM/C in their home countries and in the UK.

Some participants thought about the potential conflict of living in the UK where FGM/C is practiced by a small minority and is an illegal practice, and also within communities and families were FGM/C is seen as necessary or normal and is experienced by most or all women.

P5:

*I think it's confusing especially if you were born in this country where you're told it's illegal and it's wrong but people within your community and family tell you its the right thing to do.*

Some participants talked about a form of emancipatory influence of Western culture on women impacted by FGM/C and the process of grief, loss and self-discovery that living in the UK.

P6:

*There's a lot of women that are more exposed to Western ideology who think that this is not such a good thing for them to be experiencing.*

The construction of the ‘West’ as having a freeing effect on women from non-Western communities has been criticised by feminists as belonging to a mainstream and non-critical feminism that is prejudice, as assuming the superiority of the ‘West’ and that black and brown women need to be ‘saved’ (Abu-Lughod, 2002).

Some participants instead contemplated prejudice some women from communities impacted by FGM/C face in the UK due to oppressed social and economic living situations and legal status.

P1:

*I think particularly when you're thinking about some of this vulnerable people in our society so often women from minority ethnic backgrounds who may or may not have stable immigration status in this country, and children who have no capacity to make decisions or consent for themselves. I mean they are about the most vulnerable a group as you get. And no one is interested in their problems or the issues that affect them.*

One participant succinctly summed up what they considered ‘othering’ of communities impacted by FGM/C spawned from the current broader social context of prejudice against minority groups in the UK that could influence the approach of public sector workers towards members of communities impacted by FGM/C in the UK.

P2:

*There is an increasing fear of the ‘other’ again isn't it, fear of other and it's strange ways and this could fall into that. These are the strange ways of the other. And I think that's apparent and less tolerance of that than hitherto the answer to everything there is to build a wall. So it's their problem. Let them deal with it.*

The racialised sexism of FGM/C

When most participants drew parallels with gendered violence in Western society to contribute to their understanding of FGM/C, these reflections often took the form of comparisons to acts of sexism that had occurred in the past or that the participants considered less extreme or severe than FGM/C.

P7:

*That's what it feels like it's about. In the Crusades women were sort of strapped up in their chastity belts to make sure they were untouched. And I just see it as you know as that, that's why it was done. I mean that's the way I understand it.*

P11:

*And so that was a really you know it's a different type of invasion of women but it is I think comparable in many ways although it didn't happen to everybody. It (*forced hysterectomy*) happened to women who were particularly disadvantaged, it sometimes happened to women who would they grow up in care and would be regarded as good looking and therefore more likely to get pregnant without being married. And instead of actually protecting them from predators they would have to take away their fertility. And so that's one of the unpleasant aspects of Irish history.*

P14:

*I think I’m quite interested in FGM because I grew up in a culture that was very Catholic where women, historically, didn’t have a lot of autonomy or control of their own bodies. Sex was seen as something that was a problem, it was problematic. Sex was only to make babies, essentially. People weren't allowed to have sex outside the marriage, etcetera. So that’s the sort of context of old Ireland. It’s only in the last 20 years, women have a bit more of -- control, I guess, or freedom.*

P8:

*But I think in all societies and all cultures they oppress women in some way. Like in this country, we're still not paid the same as men, for example. But in some communities it’s an actual physical act of altering someone's body which has really long term consequences for that person.*

Some commentators have critiqued feminist perspectives on FGM/C that construct the practice as different to, and typically, worse than gendered abuse that occurs in Western cultures. Theorists have used the term ‘racislised sexism’ to refer to the construction of sexism as being typical of ‘other’ cultures (Gianettoni & Roux, 2010). Theorists have stated that constructing FGM/C in this way enables it to be used against practising communities and works to invisibilise progress that women (and men) from practising communities have made towards more gender equal societies (Toubia, 1988; Wade, 1999). However, some participants identified structures of sexism across cultures. Importantly, some participants were able to use that to identify with women from communities impacted by FGM/C.

P5:

*I have to admit I'm from a quite traditional Irish background, well my fiancé*

*is from quite a traditional Irish background, I'm not and I am really struggling at the moment with er kind of realising there is a lot expected of me as a woman within that context and what a wife should and shouldn't be. So I get a lot of things about kind of being the one that wears the trousers and that kind of stuff. There's a lot around gender role implications which I find really difficult because I wasn’t raised with it and I've been in England for quite a few years where it's not as dominant within the social groupings I have here. So I think when I go home it's a bit like 'Oh my God!' and you really feel if you go against the tide you really know you're doing it.*

P6:

*FGM is a way of talking about women but only in sex you know as in their procreation opportunities and in their in their innocence or virginity. I think we have exactly the same thing across the board… So I think that you know that that patriarchy hasn't changed at all where women are seen first and foremost almost as their sexuality and their sexual attractiveness.*

Overall, psychologists constructed cultures that traditionally perform FGM/C as different to UK cultures according to: their treatment of women, who were represented as controlled, submissive and lacking in agency, and family relationships, where parents in FGM/C communities were seen as wilfully subjecting their children to harm, and women particularly not fulfilling their duties as protectors and carers of children. Participants appeared to transpose norms of standards of UK society onto other communities when making these appraisals of ‘other’ cultures. However, some participants, particularly those who had worked with FGM/C clients constructed broad depictions of women in communities that traditionally practice FGM/C as campaigners, as resistant to the practice and active negotiators in determining whether FGM/C should be performed on children.

## THEME TWO - Barriers to Working with FGM/C

All participants spoke about how ready they felt to work with issues related to FGM/C with clients. Overall, participants reported feeling ill-equipped to work with clients impacted by FGM/C. Many participants negatively rated training received on cross-cultural issues and specifically FGM/C. They did not feel prepared to encounter clients with FGM/C-related concerns, and felt unsupported professionally and organisationally.

The Whiteness of Clinical Psychology

FGM/C was largely seen as a cultural practice and something that required special treatment. As such, many participants expressed concern about approaching cultural topics with clients. Ultimately several participants expressed a lack of confidence in working with diversity and particularly with FGM/C-related issues as they had no training, personal or professional exposure to the topic.

One participant talked about culture as something that was ‘untouchable’. In this description culture seemed to be constructed as something that had a life of its own, with ‘exceptions’ and ‘nuance’. This description of culture appeared to draw on ideas that it was not predictable, almost unworldly in character, as something that exists separately from the participant, with the psychologists as observer of culture rather than an active participant in it.

P4:

*It's like we're not allowed to touch it kind of thing and it's like actually you know engaging with that as a living organic thing and it is a thing that, that is, that has exceptions and that has nuance.*

Many doubted their competence in addressing the issue due to what they considered formidable issues of cultural and language barriers. In this way FGM/C was presented as an impregnable cultural issue that generated anxiety in therapists.

P6:

*The cultural difference and language differences and barriers, intergenerational understanding of the practice and what it means to have it and not have it. And yeah I just think it's it's a hugely difficult area to talk about.*

P10:

*Well the anxiety is my anxiety about it. And to some extent it's an anxiety about approaching it in the right way with the client.*

Other participants speculated that for some psychologists working cross-culturally might be particularly difficult as working with diversity would involve issues of religion, race and power.

P8:

*I guess some people might feel uncomfortable because they're working with people of colour and I don't know, I think it opens up a different subject about race and power and stuff like that.*

One participant talked about working differently with clients from what they deemed to be non-white cultures compared to white cultures, as working with diversity would require an extra measure of sensitivity.

P6:

*As a white woman and as a white South African I've got to be very careful about how I tackle any topic that's got a cultural and you know kind of race issue attached to it. You know it's different if it was you know white and then another white culture. But I think as a white kind of to non-white cultural practice you know we've got to be very sensitive to a whole kind of conversation, of its religious connotation.*

This participant was one of just a few psychologists who attributed a culture to themselves. In general, most participants spoke about the culture of communities that traditionally practice FGM/C when talking about working cross-culturally. There was a pervasive absence of talk about ‘British’, ‘UK’ or ‘white’ cultures in most participants’ talk, thus constructing culture as belonging other communities.

Two participants who had not worked with the issue of FGM/C talked about the reluctance of women affected by FGM/C to approach white British psychologists due to the women’s pre-conceived ideas, and doubts, about the help that white therapists would be able to offer them. These participants touched on how ‘white’ or the ‘whiteness’ of psychologists might impact clients from communities that traditionally practice FGM/C.

P17:

*Maybe a lot of people in this they want to help and maybe they don’t want the help of White women from the North East of England. This is the cultural barrier, that is ignorance. The question is why the ignorance gap.*

P14:

*I really think that maybe people think all you guys, you don’t understand, you are all prejudiced white people who want to sanction us and give us rubbish medication, and you just don’t understand… I think it feels like there is a huge gap between where we are in mental health services, and then communities that might be affected by FGM. I just feel like there is a huge distance, and that we are very far away from one another. It will take concerted work to try and bridge that gap.*

The participants constructed culture as an obstacle for their clients whom they believed might perceive the racial and/or cultural differences as potentially insurmountable.

Participants also talked about the European origins of psychology as creating inherent barriers to working with non-European communities connected to the historical treatment of ethnic minorities in the UK and elsewhere. These constructions of clinical psychology in the UK reflect the critical commentary of theorists such as Patel (2003). Participants 6 and 8 discussed the importance of psychological practitioners who reflect African communities as a result of any possible suspicions held by ethnic minorities about mental health professionals in present day UK.

P6:

*I think you know and I think probably largely the problem with that is that you know psychological therapy it kind of comes out of Europe and being always to be able to train you have to either be incredibly tenacious and poor or you know fairly affluent and white educated and so not there's just not enough people who are from African, historically African families who are training.*

P8:

*I am very aware of how when people did colonise a lot of other countries, there was this mentality, but this is more related to mental health they would bring in their systems of understanding illness and mental health problems and set up asylum systems and took care of mental health issues in a very different way. So it doesn't relate to FGM but is something that I think it is a very sensitive area. FGM is practiced predominantly in black and brown communities and most of the psychologists and therapists are white, British usually, maybe people don't feel comfortable.*

It can be argued that these extracts suggest that these participants associated clinical psychology in the UK today with a history of discrimination in clinical psychology, as well as socially. In this way clinical psychology as a profession is being constructed as both produced in discriminatory contexts, as well as reproducing acts of discrimination in the past as well as the present day. This was ultimately used by some participants to explain an element of the inaccessibility of clinical today for ethnic minority clients today.

By extension, most participants had no exposure to communities impacted by FGM/C professionally, socially or personally, which could increase the perceived difficulty of working with FGM/C-related issues and the perceived strangeness of the practice.

P7:

*I suppose in my life you know I talked about all sorts of things to different groups of friends and that but this is just not something I've talked about in a group for women who I know that somebody has had FGM or and I guess I think I would avoid it if I was in a mixed group.*

Several psychologists felt that along with teaching about working cross-culturally, psychological training courses largely ignored FGM/C.

P14:

*The courses need to take this very seriously. We even had teaching about physical difference, if someone was disfigured by accident, injury, surgery, whatever, so they can talk about those kind of things.*

Doctoral training courses were constructed as white spaces, where cross-cultural issues were largely ignored. Specifically, psychological training courses were criticised for a lack of effective and consistent training on cultural differences that psychologists might encounter as qualified professionals. Courses were accused not only of insufficient attention to cross-cultural working, but also for contributing to self-doubt and a lack of perceived efficacy among psychologists when working cross-culturally as qualified professionals.

P16:

*I know so little about that kind of -- it's so horrible, it's awful and I know so little of other cultures, really. I know what I know but I don't know very much.*

P6:

*I think I would feel disempowered because I'm not you know I'm not Muslim and I'm not familiar enough with all the cultural beliefs and religious beliefs of that population group. So I would feel very out of my depth… I feel we need to have a lot more cultural training you know about different cultures that live in England. We need to stop thinking about England as populated by white people.*

Another participant felt set up for failure by poor teaching on the pre-qualification psychological training course.

P5:

*I think there is something about confidence as well. I don’t know if this, I'm newly qualified so training it’s still fairly clear in my head and I'm not sure if it's how we were taught or I'm kind of aware that we were very much a cohort mainly white women. But I think we used to find a little bit when we had more training related to cultural diversity but a message we kind of inadvertently got back was we will never get it right or we can never know if we're getting it. Which I think it is good to kind of hold that position to an extent. But I think it also felt like it really knocked people's confidence.*

A participant who had received personal therapy identified this lack of confidence in their therapist.

P8:

*I also notice people feel very uncomfortable about racism. A lot of people don't like talking about black and white privilege and things like that and I notice that even when I've had therapy and I am talking about things relating to race and culture people feel uncomfortable and I think that’s because we don't have a dialogue around that on our training.*

For some participants this led to a feeling of being deskilled in cross-cultural work.

P4:

*I think it might be because of these kind of issues both because it's traumatic because they might not have a very good understanding of what it actually is or have the language or the kind of skills to talk about it and uncertainty about, dunno.*

In Jones’ (2010) study, clinical psychologists also talked about a lack of effective training in cross-cultural working that left them feeling unconfident and incompetent to work with FGM/C. In the current study, psychologists working in services with few clients with trauma-related issues, or other needs that were deemed to be directly related to FGM/C expressed feeling out of their depth.

P17:

*I would be worried about the personal trauma of that failure or the impact. I don’t even know where the work is…I think there’s hopelessness around it. Like how could I possibly help?*

“I’d hate to meet someone who’s had it themselves”: The Unprepared, The Unready and The Unwilling Psychologist

All of the participants felt unprepared for work with issues related to FGM/C upon qualification as clinical psychologists. Participants reported knowing little or nothing about FGM/C when they first qualified, and many psychologists first learned about FGM/C through direct exposure to clients impacted by it. Most psychologists went on to receive very little training on FGM/C through professional training as qualified practitioners unless they were working specifically in the area of trauma, or in organisations with services specifically for refugee communities. The lack of training on FGM/C was seen as a barrier to working effectively with the issues relating to the practice.

P8:

*I think the barriers are that many people still don't know what FGM actually means. Like how can you identify it? I don't think we have any training on it actually unless maybe it's different for some psychologists…We need more training, we need to know more about FGM.*

As a result, many participants professed to knowing very little about FGM/C. The lack of training on FGM/C appeared to leave participants feeling unsupported, let down by training providers and unsure of how they would work with FGM/C-related issues if presented with a client impacted by it. As such, the doctoral clinical psychological training was presented by participants as a significant, if not the main, source of professional learning available to them on the issue of FGM/C.

P13:

*I think it both is sad and also the frequency. I've not dealt with it before, really. It feels like a completely new area for me. I feel like I don't know.*

Those who had experienced training on FGM/C discussed the benefits of greater awareness and appreciation of the practice, showing that training can have good effect.

P2:

*I think I've got much better appreciation of the scale, the impact on people's lives, which I really never thought through and just how profound an impact it had. The huge cultural pressures around it a sense of shame and guilt on both of those who if you like have the FGM procedure and also within the families and the pressures around them if they resist it.*

However, even with training participants still felt FGM/C was a difficult issue to work with.

P13:

*I think it definitely raised my awareness of it, which is a good thing. I don't know, I don't know if anybody would ever feel confident in the area of FGM. It's an area that is -- it's very difficult for anybody involved.*

Participants who had received training on FGM/C critiqued the relevance of much of the material to psychologists’ work as it focused largely on medical, rather than psychological, aspects of FGM/C.

P8:

*Most of the training I've gone on they're showing literally just what the FGM looks like with anatomical diagrams and it's been more factual.*

Where the training was relevant to psychologists, it was often deficient in guidance beyond basic safeguarding instructions.

P11:

*There was a lot of emphasis on safeguarding which there has to be. But for me it ended up not being massively relevant you know the safeguarding part of it just in terms of my work.*

As well as participants feeling unready to work with FGM/C, several participants also felt unable to work therapeutically with FGM/C effectively. Some participants reported having little faith in the application of basic skills on communication and engaging clients with this client group. Participants varied in their ideas about the role of psychologists when working with FGM/C, what they should be doing and how they should proceed therapeutically. The psychologists were unsure as to whether they should raise the issue of FGM/C, or wait for clients to bring the issue to therapy. In addition, some psychologists expressed uncertainty about the potential effects of their interaction with clients impacted by FGM/C. They were worried about upsetting clients, unintentionally overlooking the issue or forcing the topic into therapy.

All of the participants discussed how they would raise the issue of FGM/C in therapy. Some were adamant they would broach the issue of their own volition because of the potential importance of FGM/C in the client’s wellbeing and any subsequent therapy:

P1:

*I need to be the one to put it on the table sometimes and to ask about it because if we if we don't take those opportunities maybe that person will never have a conversation about it in our life.*

As well considering their ability to work with FGM/C in future, some participants were concerned that they had overlooked FGM/C in past work with clients because they were not properly equipped to identify it:

P8:

*So it could be, it might be an error on my part, I probably should bring it up. But I think it is about what the client feels comfortable talking about as well. And then she didn't bring it up so I'm guessing it's probably not a problem for her.*

P9:

*It certainly makes a lot of sense to me that it is mandatory that it is taken high up the agenda. Because actually I was shocked to realise how common it was. So there has to be people I have seen in the past.*

Many participants considered FGM/C an area that they, and others, might avoid raising in therapy with clients due to a fear of ‘failure’, as a result of lacking the vocabulary to talk about it, or the capacity or resources to attend to it effectively. FGM/C was talked about as a difficult issue that could easily be ignored in therapy.

P4:

*Even if they are aware they might think 'I'm not going to go there because it might re-traumatise my patient' or something like that. Yeah probably, so a bit of therapist avoidance. And also like yeah either quite explicitly or implicitly deciding that that's just kind of you know how we all make decisions about like this is OK to bring to therapy and this is not in the realm of what I talk about in therapy for whatever reason it's like people may be implicitly or explicitly putting that on the side.*

P15:

*When you've got that long, long list of problems that person's struggling with and they're not sharing it with you, it's like, "Oh, do we delve a bit deeper here and talk about other things?" When I've got enough things on my problem list I don't want to find something else. I'm not going to have time to do all of these things. I think there's that as well. It closes it off.*

Here the participants talked about how certain topics can be bypassed or evaded by psychologists who feel ill-equipped, unready, or uncomfortable to work with them. This approach to issues of race, ethnicity and culture is reflected in the literature on cross-cultural working which suggests that clients take cues from therapists that therapy is not a place for talk about race, with therapists feeling too uncomfortable to raise and talk about the these issues (Dos Santos & Dallos, 2012). As a result race and cultural issues were typically not raised in therapy and therapy becomes constructed as somewhere talk about culture and race should not happen.

Other participants felt overwhelmed by FGM/C, and talked about avoiding the issue for their own comfort. For these participants avoiding the issue of FGM/C was a strategy of self-care.

P6:

*I mean I'd hate to have to meet someone who's had it themselves.*

P2:

*It's terrifying. So it's a sort of horror and terror is my overriding feeling, which in part again may explain why people are so “oh my god I can't”. It's just too awful. So there is something. And you you know, actually think about it. Well what's flashing my head is had a programme come on TV would I, and I was watching TV, would I watch it? And I might not have done for that very reason. I might have thought "my God I can't face that”.*

Safeguarding vs. therapy

All participants spoke about safeguarding as part of their role as psychologists. Safeguarding requirements were constructed as barriers to creating or maintaining a therapeutic relationship with clients. Some psychologists felt safeguarding requirements transformed the role of the clinical psychologist from that of therapist to policing risk and that the therapeutic role was demoted.

P5:

*I think we then forget about the therapeutic end sometimes. I think from their point of view it could very much we could be seen just as just kind of policing it, rather than there to offer support.*

P12:

*And the second thing is the legality you know what my role is there. I always find that quite stressful when you think about OK building up a therapeutic relationship versus when you have to report things and actually how those are often in direct contradiction to one another.*

Safeguarding activities were constructed as separate to and incompatible with therapeutic activities. Some participants felt safeguarding duties overshadowed other psychological work that they could be doing with women affected by FGM/C.

P5:

*I think we get focussed on the safeguarding aspect…*

In addition, the little training available to psychologists was often deficient in guidance beyond basic safeguarding instructions.

P11:

*There was a lot of emphasis on safeguarding which there has to be. But for me it ended up not being massively relevant you know the safeguarding part of it just in terms of my work.*

Several participants were unsure of the legal obligations of psychologists with regards to FGM/C.

P3:

*I guess I don't know what I should do legally. I don't know what position to take in terms of is it a good thing it's a bad thing. Not is it a good thing but is it a bad thing? Is it an acceptable thing? I don't know what would be considered a non-offensive position. And I want some advice on that actually.*

P12:

*I think I admit I don't fully understand all the legal implications.*

Client Disclosure

Several participants spoke about possible challenges with disclosure from clients. As well as the recollection of FGM/C being traumatic, participants also predicted some women would feel shame and embarrassment, or wish to avoid judgement of themselves, their families and their communities. Participants constructed challenges around disclosure as a barrier to working with women that psychologists faced.

Some participants also considered reservations clients might have about engaging in therapy for problems related to FGM/C, such as talking about traumatic events in the past.

P1:

*But even then I've had a lot of clients who will tell you it happened but they won't go further than that because they find it too traumatic or the impact is so far reaching they just don't know where to start with their own understanding of the professionals sometimes.*

Other participants spoke about healthcare professionals failure to notice signs of FGM/C in patients. This was compounded by women feeling unable to raise the issue with practitioners, leaving problems untreated for years.

P11:

*I mean one lady I saw last year was for a medico-legal report she’d gone to her GP about 20 times for a urinary tract infections and couldn't bring herself to say this is the root of it.*

P10:

*I think that some clients who have had it talked about being ashamed. They feel shame that they feel disfigured. That they feel less a woman, disfigured.*

Participants also thought some women would be reluctant to disclose FGM/C through fear of prosecution for members of their family or the intervention of social services regarding the welfare of their children.

P9:

*I suppose as well possibly a sense of hopelessness. You know “What's the point. Because it's been done now.” And fear that you know” well are they going to call the police? Are they going to follow some safeguarding procedure, you know we hear about the NHS sometimes on the news so often that something has gone wrong. To tell them this would it let the cat out of the bag here. So it is in some way that would then take away control that I've got so, I've already got no control for when it happened. Would I just lose any control?”*

P12:

*You know just they might just think “well I'm not even going to talk about it”. In fact if they don't fully understand the law, even if it's not something someone might have to report they might not come forward because it's illegal.*

P14:

*They know that if they tell us anything about their kids, we’re on the phone social services straight away. There is a lot of fear, there is a lot suspicion, then there is a -- I think it’s just a belief that “they wouldn’t understand us” or “they are not interested enough in trying to understand me and my family and my background. They are just too busy doing whatever they usually do”, and you know there’s probably a lot of truth to that.*

Professional and Organisational Barriers to working with FGM/C-related issues

Many participants cited a lack of professional support and unaccommodating organisational structures which impact the quality of service offered to clients impacted by FGM/C. Professionally psychologists felt unsupported by a system of colleagues in other disciplines who ignored, overlooked or actively avoided attending to FGM/C in a compassionate and informed way. This resulted in a dearth of referrals to psychologists, but also a scarcity of attentive colleagues to confidently signpost clients to. Here participants describe a further aspect of the professional context that creates barriers to working effectively with issues relating to FGM/C.

P10:

*You know she had another experience with someone at (specific hospital) that had been awful. And the person wasn't empathic so we didn't go there again... She felt ashamed, she felt uncomfortable. I think it was a man that saw her!*

Otherwise participants had observed well-meaning colleagues in other services work indelicately with their clients who have returned to them re-traumatised and distressed:

P11:

*There's a lot of professionals say in FGM clinics and connected to them who are very interested in doing a good job but who don't fully appreciate the PTSD picture a lot of women present with. So there's a standard practice within clinics of looking at photos of different types of FGM. Most of my clients have taken several weeks to recover from this because it's triggered difficult memories.*

Participants also noticed that access to services for clients who had experienced FGM/C were impacted by organisational processes and policies such that women’s needs for psychological care were overlooked.

One participant who worked in a service for women expressed surprise at not coming across any women affected by FGM/C, while white middle class British women were over-represented due a lack of diverse referrals from colleagues.

P5:

*Generally the vast majority of those referred to me are white middle class British which doesn't fit with general, er, even if you look in the waiting room and wonder around it doesn't fit with the demographic of* those (using the service)*.*

Psychologists were at times constructed as lone actors in their efforts to address FGM/C. In this instance, participants talked about a lack of support from colleagues, training courses and other professionals.

Participants also described challenges of working within strict guidelines imposed upon psychologists due to cuts in public funding leading to a lack of resources and programmed dedicated to outreach activities. Some participants illustrated the effect of this on accessibility of their services for minority groups.

P14:

*Because people have no time at all, that work has just been pared back massively, which is such a shame. I think I am very interested in this, I’m really interested in getting out there with people and talking to them. I’m very interested in it, but we literally aren’t given the time to do that anymore, which is such a shame.*

P15:

*I think there's that as well. It closes it off. I guess the expectation, you're not expected to work on that. Here the expectation is to treat the things that your service is treating. We're not in a service to treat people with FGM and you have the consequences of that.*

## THEME THREE - “It’s like I almost feel it myself”: Psychologists’ Responses to FGM/C

All of the participants shared their own personal views on FGM/C which influenced but could also exist separately to the professional position they would adopt when working with clients. Some participants considered the impact that learning about and working with FGM/C would have on them emotionally, and some made links between the social factors that drive FGM/C and sexist aspects of Western cultures.

All participants, but one, spoke at length about physical pain when asked about their thoughts on FGM/C. For most participants, pain was expressed through empathy with the young girl at the time of the initial procedure or de-infibulation upon sexual intercourse. No participant talked about re-infibulation on adult women.

P4:

*Pain. I think just when I think FGM like it's the first thing that comes to my mind, it's like it just sounds incredibly painful. Yeah. Yeah. It's just kind of like the first association I think that I have to have you know. There's so many different kinds of FGM. But I think that even the most simple or like the most kind of the least invasive one sounds like it would be painful.*

As a sensation that most people will have experienced at some point, the construction of FGM/C as a painful experience provided a route for participants to empathise, or to identify, with women who had experienced FGM/C.

P7:

*I mean pain. I'm even thinking about it or hearing about it or every time. It's just like you I almost feel it myself you know not I don't feel I know but it's like you know it's. I. The sensation the physical sensation I feel. Which makes me want to brace myself.*

Women with FGM/C have spoken about feeling alienated, like ‘specimens’ when seeking help from healthcare practitioners in the UK (Khaja et al., 2010). The construction of FGM/C as an extremely painful experience could be seen to contribute to women’s feelings of difference and strangeness. Some participants appeared quite animated when discussing ‘pain’, and for many the topic was elaborated on or emphasised. When talking about pain some participants used words such as ‘horrific’ and ‘barbaric’.

P6:

*The process was done against the kind of child crying and screaming and then the kind of tortuous few weeks that she had afterwards of kind of pain and in untreated pain. So to me barbaric.*

P15:

*Just the intensity of the pain. Some of the images I have seen, I think I have probably seen on telly as well, they just stick in your mind, and it just being horrific. A horrifying thing to happen to somebody, when they are not sedated.*

P14:

*I'm kind of a squeamish person, I actually hate violence. I hate people being hurt in any way, so the thought that someone would do this to somebody else, and actually, the harm, physically, the long-term effects, the pain, blood loss, anything could happen during this procedure, so the whole thing is just so cruel and horrible and just awful.*

However, much like trauma, though pain is something that does appear in accounts of FGM/C, pain is not something all women who have experienced FGM/C report feeling. This could represent differences in the way ‘pain’ is treated across cultures, for example biopsychosocial models of pain include psychological and emotional factors in the experience of pain (Adams, Poole, & Richardson, 2006). A participant remarked upon the British approach to pain:

P7:

*It's interesting because I think our own relationship to pain would have an impact. I think in the UK you have a lot of pain clinics and pain thinking and pain management, which is very interesting…Pain is very individual and cultural again.*

While participants’ interest in pain could reflect cultural differences in the treatment of ‘pain’, it could also reflect the sources of information available to psychologists about FGM/C. Some reports of pain were related to graphical images of FGM/C in the media or encountered during training.

P5:

*I think the image you see in terms of raising awareness tend to be quite graphic and they look painful.*

Women who have experienced FGM/C have spoken about the way FGM/C is sensationalised in the UK which contributes to the construction of their ‘difference’. Ironically, participants in this study appeared to largely reproduce this treatment of pain in practice of FGM/C which enabled them to express empathy with the women who have experienced FGM/C.

The construction of FGM/C as a painful practice can also work to consolidate FGM/C as an abusive practice. When FGM/C is understood as an abuse certain positions towards the practice become more accessible and unproblematic, such as constructing FGM/C as ‘bad’, implicating parents in the practice, constructing women as ‘victims’ or abusers, and use of terms such as ‘cruel’ and ‘horrific’.

One participant attended the surgical deinfibulation of a client and was overwhelmed by the visceral pain that the woman felt.

P10:

*Pain for her because it was painful having it undone. Pain because the whole business was painful. Everything all the consequences were painful. Pain for me because when I think about it I just feel my own -- the very thought of it which is painful and sad and horrible. And yeah. So that's pain. Sort of a in a visceral sense of what that must be like.*

This participant spoke about the psychological consequences of supporting the client through the deinfibulation procedure, which included flashbacks and a sense of haunting for the therapist.

P10:

*I mean the horror, but I think that I was having flashbacks myself to the experience of this girl being, having, so it was horror and the reason it was horror was because it felt as if she was reliving a rape. And I couldn't do anything. I was able to be there for her but I was not I wasn't prepared for it in my head.*

Another participant also shared their emotions about working with clients impacted by FGM/C and how this could be harnessed into effective psychological intervention with the client.

P11:

*I felt very angry with them even though it's not my story at all. But of course if you get involved in that you are going to have these feelings and it's trying to remember and hold in mind at all times that they're her loving parents who she has now not seen in several years and you know I think it's using that emotion and reflecting it back and thinking about how that connects with what that person is feeling themselves.*

Another participant considered the use of effective psychological work as a method of self-care or to discharge unwanted emotions resulting from working with FGM/C.

P1:

*When you can give different perspectives and people can engage with them and start to see what happened to them in maybe a slight different light or you can offer them support while linking them into services like the FGM clinic it changes that person's experience and understanding of their body in themselves. And that is very powerful and actually maybe because you've done something useful it does give you less of a sense of helplessness in that lack of control maybe that ameliorates in some way that stress that it causes you as a therapist.*

# CHAPTER 4: DISCUSSION

This aims of the current study were to explore the views of clinical psychologists on FGM/C including any challenges, opportunities, strengths or barriers clinical psychologists perceive in working with clients impacted by FGM/C. An in-depth analysis of the psychologists’ talk during interviews generated three main themes that are reported in the Results section: ‘FGM/C: ‘Other’ Cultures’ Abuse of Women’, ‘Barriers to Working with FGM/C’ and ‘ “It’s like I almost feel it myself”: Psychologists’ Responses to FGM/C’. The Results are deliberately descriptive in line with recent research employing Thematic Analysis (Hunter et al., 2017). In this Discussion section, a theoretical analysis is developed to make sense of the expressed views of the research participants’ perceived challenges, opportunities, strengths or barriers in systemic terms. The theoretical discussion places the findings in the context of research to date of FGM/C survivors’ reported experiences of healthcare workers.

It is acknowledged that the researcher’s long-standing interests in gender and culture have shaped the theoretical interpretation of the research. However, these interests are not unique to the researcher. Within the British Psychological Society, there are strong interests in feminism and ongoing debate about whether the profession is addressing the psychological perspectives and needs of today’s culturally diverse Britain (Davidson & Patel, 2009; Newland & Patel, 2004).

This discussion will be guided by the data collected in this study. The issue of culture, particularly cross-cultural working, will be given focus as it was evident and substantial across all three main themes. It is also the researcher’s hope to open up debate and encourage dispute to garner attention to the topic. In this way, the theoretical links made in the discussion will include, but not be limited to, clinical psychological literature so as to encourage diversity in debate and future research and generate new insights. Research has shown that clinical psychologists lack confidence when working with FGM/C. This is a valuable finding, however this qualitative study will be leveraged to probe further into the views of psychologists into the interaction between psychologists’ ability, willingness and readiness and how this can be understood in the clinical psychological and socio-political context of today. This discussion will end with the provision of theoretical and clinical implications, strengths and limitations as well as an evaluation of the study.

It is important to qualify the need for this study. Approximately 150 psychologists were invited to participate in the study, and approximately 120 were invited to attend a separate training session on FGM/C specifically for psychologists. Eighteen psychologists came forward to take part in the study, and 10 attended the training session that was offered. There are many possible explanations for the low take up rate among psychologists invited to participate in either the study or the training session, with some intimated by participants in the study such as lack of time and resource to engage in any activity that is not core to psychological work. However one psychologist reported that a colleague shuddered and grimaced when asked whether they would attend the training session. An inference that can be made is that some psychologists avoided training that might be relevant to working with ethnic minority communities such as FGM/C. If this is happening it is all the more important for qualitative research to investigate why and how these reactions exist and what can be done to improve engagement on issues of diversity.

## The need for more resources

Across the interviews, the participants made references to the constraints of inadequate resources and support, such as supervision, funding of services and inadequate links with other services and professionals. Participants constructed these difficulties against the background of a lack of psychological training on FGM/C and this appeared to culminate in the presentation of psychologists as inadequately supported and unable to perform in their therapeutic roles.

It is argued that the power of this construction of the unsupported clinical psychologist in relation to working with FGM/C-related issues is made more clear when put in the context of clinical psychology in the UK today. The scientist-practitioner model continues to be frequently positioned as key to the values, competencies and contributions of clinical psychology to the NHS and the public (Shapiro, 2002). Though there is debate about the applicability of this model to clinical psychology today it can still be observed in the emphasis on evidence-based working, particularly in some psychological services where large numbers of psychologists are employed such as IAPT, and it still shapes how psychologists are supervised and evaluated. In the context of very limited research and guidance on the psychological consequences of FGM/C (Mulongo, Hollins, Martin and McAndrew (2014), clinical psychologists working with FGM/C are not able to work fully as scientist-practitioners and the model is undermined, along with professional bodies’ statements regarding the importance of equality of service for all. The impact has not been missed by women who have experienced FGM/C who report a lack of competence among healthcare practitioners, and distrust of them as a result (Lockhat, 2004), and also not missed by clinical psychologists in this study who called for FGM/C to be moved higher up the agenda.

These ideas and beliefs about clinical psychology contribute to a discourse about what a clinical psychologist is and what they do. However, the psychologists largely constructed themselves as restricted by the lack of resources to actually fulfil their roles adequately, with guidance and resources available focussing on safeguarding.

## Conflicted positions within a culture of safeguarding

The participants talked about how the incorporation of safeguarding duties to work with FGM/C-related issues impacts psychologists’ ability to offer an effective service to clients. The recent Serious Crimes Act (2015) underlined the central role of healthcare practitioners, including psychologists, to report instances of real or suspected cases of FGM/C, with failure to do so punishable with a large fine and possible professional disciplinary action. The safeguarding imperative influenced the way psychologists’ viewed FGM/C and how they constructed possible opportunities for working with FGM/C in several ways. The psychologists reported that it constrained the development of the therapeutic relationship which all participants represented as being critical to therapy. However, it also framed their therapeutic work, in that most psychologists constructed FGM/C as an abuse. There were very few instances where participants problematised this representation of FGM/C and this informed many of the positions they took up on issues relating to the practice such as the ways in which psychologists constructed parenting (as lacking in fundamental expectations of parents such as protection and care for children), family (inferring negative impacts to family relationships) and the role of women (as victims or colluders) in practicing communities.

## Palpable critical psychology

Critical psychology is an array of approaches that challenge mainstream approaches to psychology in fundamental ways. It can be understood as offering an alternative to mainstream psychologies that present psychology as a science in which researchers make use of objective methods to understand human behaviour and to shape interventions to treat individuals’ distress. Critical psychology eschews this approach as having a “narrow view of the field’s ethical mandate to promote human welfare” (Fox, Prilleltensky, & Austin, 2009).

Fox et al., (2009) outline three core concerns with mainstream psychology: a focus on the individual rather than the group and larger society which bolsters unjust institutions, underlying assumptions and institutional allegiances that hurt members of marginalised groups, and that these are the inevitable outcomes regardless of psychologists’ intentions to the contrary. These ideas have gradually been taken up in clinical psychology and are now evident in the work of clinical health psychologists such as Michelle Crossley who advocated looking beyond the ambition of heath psychology to ‘control’ or ‘change’ behaviours to seeing them as ‘real’ people (Crossley, 2008), as well as by clinical psychologists concerned with issues including race, culture, sex and gender such as Patel who produced an award winning training manual on ‘race’ and culture (Patel, 2000), and Ussher on women’s reproductive and sexual health (Ussher, 1992).

The research participants have kept pace with debates within the profession to be relevant to all segments of society and to design equitable services that are also available to ‘hard to reach’ social groups that the profession still struggles to serve, and this was evident in the psychologists’ talk. Their perspectives on women were varied and fluid in awareness of how FGM/C affects females and the role of women in the practice, taking positions that championed the rights of women and girls. However, women were also constructed as (at least partly) responsible for the practice, as passive recipients; but also activists or instigators.

It is not surprising that most of the psychologists in the current study constructed FGM/C as abuse, oppression and violence against of women in FGM/C communities. This perspective is prevalent in coverage of FGM/C on the television and media and in training provision and is echoed in studies looking at attitudes towards FGM/C among those in practicing communities residing in their home country (Berggren, Ahmed, et al., 2006) as well as those that have emigrated to countries in the West (Reisel, Alhassan, Barrett, Brown, & Kwah, 2016). However, this is a construction of FGM/C that can be complex when unpacked because of the way it can shape inferences about communities that traditionally practice FGM/C against those that do not. One inference for example, is that abuse, oppression and violence against women in communities that traditionally practice FGM/C is worse, or more severe than in the UK, which was evident in some of the psychologists’ talk. This point of discussion deserves further examination with a broad reference to relevant literature, first with regard to FGM/C explicitly, and then in the way that women were constructed by participants.

Respected activists and scholars who have spent decades at the forefront of campaigns against FGM/C recognise how sexism in the form of control of women can underscore the compulsion to have young women and girls cut, but they also reflect upon ways that genital mutilation has featured in the social control of women around the world and through the ages (Dorkenoo, 1994). Among the psychologists, FGM/C was constructed as a problem in ‘other’ communities and cultures, and it can be argued that this contributes to the perpetuation of the essentialising and polarising of communities and cultures (Wade, 2012). When FGM/C is constructed as a problem attached to a culture, it becomes constructed as a speciality issue and one that requires additional resources. For example, in this case participants constructed it as requiring sensitive language, and a knowledge of the culture. As an extension, the clients impacted by it need ‘more’. Relating this to one of the research questions of this study, that very construction becomes a barrier to working with clients impacted by FGM/C, particularly in current professional and organisational contexts where participants constructed services as being narrowed in scope, and of having funding cut. In an environment where there is little scope for additional resources, the risk is that issues such as FGM/C are not addressed and this was explicit in participants’ talk about therapists’ avoidance of FGM/C or of FGM/C being ‘closed out’ of therapy.

The polarising of FGM/C practicing communities was also illustrated through the construction of women. Participants explicitly referred to women in practicing communities as ‘submissive’, ‘passive’ and controlled and this was directly associated with the culture of FGM/C practicing communities. Where some participants did draw parallels with abuses in the UK these were of past practices such as practices in the Crusades. Other psychologists were explicit in their representation of Western communities’ practicing of sexism as not ‘attacks’ on the body. In defining sexism in communities impacted by FGM/C as ‘different’, some psychologists were also defining it as worse because it was constructed against sexism in the UK which was not about ‘attacking bodies”, for example (Davidson & Patel, 2009). Commentators have argued that constructing FGM/C as an abusive practice in non-Western cultures works to project the image of Western cultures as civilised and advanced in comparison (Wade, 2009). While it is not argued that psychologists in this study were deliberating denigrating communities that traditionally practice FGM/C, language such as ‘barbaric’, ‘horrific’ and ‘cruel’ is not value-free and it is in this kind of talk that some commentators find evidence of an insidious prejudice.

This is a potentially sensitive and contentious point to make, so it is important to discuss this in relation to existing psychological literature and research. In a recent study by Lavinia Gianettoni & Patricia Roux (2010), Swiss nationals were asked their opinions on two stories involving forced marriage that were identical, but with one featuring a Swiss family and the other an African immigrant family. Participants attributed a higher level of sexism to the African family than to the Swiss family. An interpretation of this perhaps relevant to the current study was that the participants in Gianettoni and Roux’s study considered acts of sexism as ‘extraordinary’ (worse) when enacted by immigrant communities, but ‘ordinary’ (not as bad) when considered in the context Western society (Gianettoni & Roux, 2010). If applied to the current study it could help to explain how gendered oppression in the UK today, which includes attacks on women’s bodies and genitals, was minimised in the psychologists’ talk compared to FGM/C which was constructed as ‘barbaric’. In making parallels with sexism many psychologists were empathising and identifying with communities impacted by FGM/C to forge connections with FGM/C practising communities and to show understanding, and this should not be overlooked. However, there is potential for negative unintended effects in the way psychologists do this, and some ways of doing this could further alienate ethnic minority clients (Dallos and Santos, 2012).

Some participants carved out representations of women as being ‘feisty’, campaigners, and resistant to cultural pressures to continue FGM/C, and others were constructed as negotiators with the best intentions for their daughters. However, most psychologists constructed females as either victims of the culture and FGM/C, or colluders in the practice. One client explicitly stated that even where there appeared to be a choice it could not be a choice because the cultural pressures were so pervasive. This kind of portrayal of women is one that some feminists have criticised as denial that non-Western communities have agency (Zimmerman, 2015). Others have constructed this as the misguided approach that ethnic minority women need to be saved (Abu-Lughod, 2002). Drawing on Newland, Patel and Senapati (2015), this constructs culture as a factor in the lives of the women, rather than constitutive of the concept and experience of the self.

## The limits of critical psychology: highlighting ‘whiteness’

So far this discussion has demonstrated that the views of clinical psychologists appear to be constructed with and, at least in part, informed by feminist perspectives on FGM/C and the position of women in some communities. However, this is not an unproblematic perspective and could lead to some uncomfortable outcomes for therapy if applied uncritically. In part, what has been discussed is the presence of ‘whiteness’ in some aspects of feminism as it has been applied to FGM/C and adopted as a position by some participants in this study. Whiteness is a system of entitlement and privilege that facilitates access to social, economic and political resources for the dominant group. It can be considered a culture – a way of thinking, doing, believing and behaving – of the dominant group that goes unexamined and often unacknowledged by those who partake in and benefit from it. Nylund (2006) writes that dominant forms of ethnicity, namely whiteness, are made ‘invisible’ in discussions of culture as the critical lens is firmly on the ‘Other’. This has been touched upon previously with regards to the treatment of FGM/C as belonging to other non-Western cultures. Direct exploration is now undertaken with regards to what is argued here as ‘whiteness’ within the psychologists talk about training needs, and as it is implicated in the psychologists’ constructions of clinical psychology as a white institution and in the profession’s ability to effectively address FGM/C.

Nearly all psychologists talked about the need for cross-cultural training to work confidently and effectively with FGM/C-related issues and well as more generally. Participants directly called for FGM/C and cross-cultural working to be better addressed during professional training, through continued professional development opportunities and professional training. This is echoed in Jones’ (2010) study, where participants suggested receiving training from members of communities affected by FGM/C. It has been argued in this thesis that the underlying assumption here is that FGM/C is a practice that exists in other cultures. Additionally, participants constructed cross-cultural training as training that is needed to understand non-white cultures. To again reference Nylund, to do this renders the dominant culture invisible. It can be further argued that the psychologists’ ways of thinking, doing, believing and behaving were centrally involved in (but invisibilised and not critically engaged with) their constructions about parenting and motherhood, family relationships, the roles of women in FGM/C, the importance of sexual pleasure for women, and the autonomy of women over their bodies. These cultural assumptions and values were implicit in the psychologists’ constructions when talking about ‘other’ cultures but appeared to go undetected by most of the participants.

Nylund (2006) argues that the critical lens must be turned upon the therapist to begin any cross-cultural process. This approach was evident in the talk of a small number of psychologists who constructed themselves as ‘white’, or as representing a ‘white’ profession, or as being part of a profession that has its historical and philosophical roots in philosophies that were implicated in imperialism and colonialism. Some psychologists represented the whiteness of clinical psychology as a barrier to working with clients impacted by FGM/C. Participants 6 and 8 discussed the importance of psychological practitioners who reflect African communities as in some communities there are suspicions about mental health professionals due to past abuses, as well as the impact of being South African, and what that might mean to clients and how to work with this in therapy. The literature on whiteness in clinical psychology is young, but growing. Recent studies include Santos and Dallos (2012) which focussed on whiteness in psychologists’ approach to cross-cultural therapy, and Goodbody (2012) on clinical psychologists’ whiteness in talk on PPD, and across other areas of therapy such as counselling (Lago, 2005) and systemic therapy (Nolte, 2007). Whiteness is considered an important issue to discuss in this thesis in relation to clinical psychologists’ talk as whiteness is easily overlooked precisely because of its invisibility as representing an apparent ‘norm’, and no less because of its visibility to some clients impacted by FGM/C (Khaja et al., 2010).

## Professional readiness to work with FGM/C

The willingness among the psychologists’ to offer an effective service to clients impacted by FGM/C was profound. Psychologists’ concern and efforts regarding the comfort of women who might seek their care expressed in this study should not be dismissed. It is important to remember that most psychologists had no known experience of working with clients impacted by FGM/C, no training on FGM/C, and no exposure to literature or professional guidance. In the current study a small number of participants engaged in discussion of their privilege, questioned the exercise of power in therapy bestowed by whiteness and critiqued their own cultures so as to redraw the cultural boundaries between themselves and minority ethnic clients. This approach is in line with Giroux’s (1997) model of oppositional whiteness which in its most simple form encourages therapists to bring an examination of their whiteness to therapy, to invite clients to be curious about it and for that interaction to potentially create a pathway towards the therapist realigning themselves with an anti-racist approach, rather than to neglect the issues and race and culture completely. It also echoes Dos Santos and Dallos’ (2012) recommendation that clinical psychologists take on the responsibility to bring the conversation of race, culture and ethnicity to the therapeutic context.

## Theoretical Implications

Some of the discussion of this study has been concerned with the theory of whiteness. The findings of this research resonate with studies that have examined the impact of whiteness on psychological therapy and psychological practitioners (Goodbody, 2012; Santos and Dallos, 2012).

It was argued that whiteness operated in many of the participants’ talk about FGM/C and facilitated the portrayal of sexist practices in the UK as distinct from sexist practices in FGM/C practicing communities, and it functioned as a barrier between psychologists and their ability to work effectively with ethnic minority clients. Members of the psychological community have been highlighting the obstructive functions of whiteness in psychology for many years (Sue, Bingham, Porché-Burke, & Vasquez, 1999). The current study contributes to this field with a rich and detailed exploration of the impact of whiteness in the reports of psychologists’ regarding work with FGM/C-related issues.

## Clinical Implications

Nearly all psychologists in this study called for better training in cross-cultural working. While psychologists in this study requested training on the non-white cultures in the UK, it has been argued in this thesis that white cultures also need to be focussed on in cross-cultural training. Participants wanted to receive a more thorough training on cultural issues during pre-qualification training, as well as through CPD as qualified practitioners. Practically, there was a call for training to be delivered by service users or members of the community who had experienced FGM/C. In the cities of London and Bristol there are several advocacy organisations that offer this service, such as FORWARD and Daughters of Eve who have partnered with healthcare trusts to deliver services, and it is argued here that pre-qualification training courses should incorporate training from these organisations into the syllabus.

The recommendation is also made for specific training around developing appropriate language to use when working cross-culturally which echoes Nolte’s (2007) study into the perceived risks of cross-cultural therapy. Nolte (2007) also found that therapists felt they lacked the language to raise sensitive subjects around race and culture with clients and that this deleteriously affected their confidence when working with visible racial difference in therapy.

Debate about what might constitute effective training is still alive in the British Psychological Society, nearly 30 years after the BPS first conducted surveys on the role of cultural issues in clinical programmes in 1991. Since then commentators have posited that it is not just the responsibility of courses to didactically teach cultural competence, but that the onus should also be on trainees and supervisees in seeking out support in their own efforts. This suggestion also applies to psychologists wanting to learn more about FGM/C and it requires the existence of a robust literature base as well as accessible detailed guidance from professional bodies for psychologists to consult. Currently there is very little research attention on the psychological impact of FGM/C on women, and even less directed at developing and publishing an evidence base for psychological intervention or guidance on working therapeutically with clients who have experienced FGM/C.

## Critical Review

### The researcher’s role and experiences in the research process

I approached this study with an awareness of my political and cultural positions towards FGM/C and its impact on women. That the participants could learn about FGM/C and also be reflexive about their positions towards it was encouraged through the use of semi-structured interviews. Participants were able to ask questions, share experiences and where they had significant exposure to FGM/C previously, to share and exchange best practice ideas such that I learned alongside my participants.

The interview process also had an impact on me. While conducting the interviews I felt empathy and understanding with the clinical psychologists. For example, as a trainee in the field, I was familiar with some of their frustrations with the organisational and professional structures that impeded work with a diverse range of clients. This appeared to enhance the flow of the interviews, and the participants were able to ask questions of themselves and their own practice, as well as being critical of their work and their skills base. This increased the richness of data. I noted this advantageous impact and discussed this with my supervisor and co-analyst. During reflection aided by these conversations I also began to consider also my position towards clinical psychology, particularly the challenges that clinical psychologists currently encounter, such as changes to their role, expectations of the profession, and changes to services. While it is possible that this approach facilitated disclosure from the participants, it is also possible that rich data was missed due to my position as a clinical psychology ‘insider’ rather than a potentially more critical ‘outsider’, and if not missed, my position could have influenced my understanding and analysis of that data. This could be addressed in future with the use of a co-researcher to interview a selection of the participants to enable comparisons of the direction and content of interviews and a better assessment of how the personal style, political, professional and cultural positions of the interviewer could have impacted the interview and the data collected.

As well as my identity as a member of the clinical psychological community, my identity as an ethnic minority was important to the shape, process and outcome of the study. There was discussion with my supervisor and co-analyst around race, culture and ethnicity at each stage of the research – inception, design, data collection and analysis. Each member of the research team felt it important to ensure this this element of working with FGM/C was not overlooked as race and ethnicity has been shown to be neglected in much psychological research (Patel, 2003).

The research team was comprised of ethnic minority women working in mental health with a shared interest in advocacy for women who have experienced FGM/C. In comparison, the participants were predominantly White non-British, White British or White-mixed heritgists. While this might appear to be an inverse of the more common structure of a research team in the UK where white researchers engage in the study of ethnic minority participants this would be a superficial assessment. The ethnic minority researchers were also long-standing members of the psychological community and experienced in research, therefore they share many professional and cultural similarities with the participants, just as the participants differed among themselves in terms of cultural and ethnic background. For example, one non-British White participant spoke at length about her personal encounters with racism in the UK from members of British White communities. For this reason seeking the contributions or reflections of a White research team member would not be appropriate. However, I am aware that my presence as a black female researcher could have helped to elicit certain areas of discussion such as racism and racial discrimination, just as it could have deterred participants from making certain observations or comments. It is possible that being interviewed by a black researcher influenced the content of the interviews in that the subject of race and culture were not omitted by any participant Also, it is possible that a research team of non-minority ethnic researchers might have produced research that highlighted different or fewer aspects of race and culture in its discussion and conclusions. To this end, it is vital that further research by a range of individuals and teams is conducted on this topic so that a broad understanding of the issues can be achieved.

### Strengths and limitations of the current study

The sample size of this study was small with a low response rate, and therefore not especially representative of psychologists in the UK. It should not be overlooked that some potential participants could have been discouraged from participating by the recruitment method. The researcher was assisted by an email from a senior psychologist to the recruitment pool. Some psychologists could have felt this compromised anonymity leading to unwillingness to participate. As a result, any generalisations from the findings of this study to the other psychologists should be made with caution. However, this does not weaken the study as the aim of the study was not to glean data that would be generalisable to all psychologists, but to explore views and perspectives of psychologists on FGM/C as well as any opportunities, barriers or training needs relating to the issue which has been achieved. A strength of the study is that it turned the lens on a dominant group to highlight ways that a minority client group could be better engaged with and better served by healthcare professionals. The study also opened the arena for psychologists to be among the first to contribute their voices to an under-researched area.

One feature of this study is the richness of the data that was gleaned. Participants were typically very willing and keen to talk. It was the intention of the researcher to be clear about her professional background as a trainee clinical psychologist, as well as her interests in FGM/C as a researcher. This approach of openness through self-disclosure is borrowed from feminist interviewing techniques where there is an emphasis on intimacy to facilitate data gathering through interviewing (Oakley & Roberts, 1981). Other advantages to placing oneself as an insider (someone with a priori knowledge of the community and its members) were the possibilities for enhanced rapport and communication, the ability to gauge the honesty and accuracy of responses, and the potential for participants to respond to the empathy of the researcher with increased detail of their thoughts and experiences (Hockey, 1993). However, this does not preclude the possibility of ‘politically correct’ responses from participants, particularly as senior psychologists were employed to help with recruitment of participants.

Roulston (2010) urges all interviewers to consider the way their different conversational styles, position on pertinent topics, theoretical perspectives, as well as their subject position in terms of race, class, gender, culture, language and status in relation to the interviewee might impact the interviewing process. All of the participants were qualified psychologists, and this could have impacted power in the interaction between the researcher with some or all participants. The researcher also identifies as a black British person. Most of the participants identified as white. The researcher’s professional status and ethnic group could also have functioned to cast her as an outsider which could have negatively impacted rapport and the openness with which participants responded to her. On the other hand it could have assisted the researcher in critiquing the participants’ talk from the perspective of an ethnic minority person.

### Implications for further research

No other study has qualitatively assessed the perspectives and knowledge of UK psychological practitioners on FGM/C. As such, there are several implications for further research that can be drawn from this study.

The current study was not comparative, however there is possible value in grouping participants along a range of characteristics such as gender, experience of working with FGM/C-related issues and cultural or ethnic identity as it is possible that these factors, among others, could influence how psychologists position themselves in relation to FGM/C.

While one strength of this study is the contribution of a woman who has experienced FGM/C to the analysis of the data, it would have been valuable to also solicit the reflections of the participants on the findings of the study. It would have been valuable to have heard their responses to the themes and the consequent discussion not solely as a credibility check of the data, but to see what effect, if any, seeing a discussion of their perspectives would have had on their reflections. Therefore, further research could include feedback to participants to garner their responses.

London and Bristol are areas where there are strong and vibrant advocacy groups and communities that traditionally practice FGM/C have been long established there. This study should be repeated in other geographic locations beyond London and Bristol, particularly in areas where communities that traditionally practice FGM/C are large in number, such as Leicester, Birmingham, Bradford and Leeds to see whether local characteristics might influence the attitudes, perspectives and knowledge of psychologists about FGM/C in these locations.

## Conclusions

The present study explored psychologists’ knowledge of and views about FGM and experiences of and barriers to working with FGM/C-related issues. Eighteen psychologists based in London and Bristol, working in a range of services and settings were interviewed and thematic analysis informed by discourse analysis was used to analyse the transcripts.

In summary participants reported a range of barriers to working with communities and women impacted by FGM/C. Participants felt unsupported by their organisations, colleagues and the wider healthcare professions and unskilled due to a lack of effective and relevant training on cross-cultural working and work with FGM/C related issues in particular. Participants largely regarded FGM/C a traumatic cultural practice, that is rooted in sexist beliefs and ways of being that are quite distinct from the way sexism and patriarchy operate in UK society. Several psychologists talked about the role of women in the continuance of the practice, seeing them either victims of the abuse or colluding perpetrators, though some participants gave consideration to the social and familial pressures applied to parents to continue the tradition. The approach of the psychologists was discussed against theories of whiteness, and the impact of whiteness among mental health services and wider psychological work with ethnic minority clients.

The contribution of some psychologists who interrogated their own identities led to a consideration of ways that psychologists can better address issues they determine as cross-cultural or requiring skills specific to working with diversity with implications for training and guidance in cross-cultural work as well as the production of guidance from relevant bodies.

Overall, the good intentions of the participants were palpable. They showed great concern for women and communities impacted by FGM/C, with commitment to safeguarding children who might be at risk in line with current legal and professional guidance.

Female genital mutilation is hotly debated amongst healthcare professions not just in the UK, but across Europe and the US and Australia, as well as countries where it is frequently practiced. Healthcare professionals are constantly responding to changes in policy and the law with regards to the practice, so the challenges that many psychologists face in the UK mirror those experienced elsewhere. There are than 140,000 women in the UK who have experienced some form of FGM/C. The current study contributes to a small but growing body of literature that can help orient healthcare professionals when working with those women, their families and communities.

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# APPENDICES

APPENDIX A: PARTICIPANT INVITATION LETTER

APPENDIX B: CONSENT FORM

APPENDIX C: INTERVIEW TRANSCRIPTION EXTRACT

APPENDIX D: HRA ETHICAL APPROVAL CONFIRMATION

APPENDIX E: DRAFT SAMPLE CODING FRAME

APPENDIX F: INTERVIEW SCHEDULE

**APPENDIX A: PARTICIPANT INVITATION LETTER**

**Information Sheet: RHUL – Working with FGM/C-affected communities effectively in mental health**

I would like to invite you to participate in a study about how we currently work with communities impacted by female genital mutilation or cutting (FGM/C).

We are interested in understanding how you think and feel about working with clients impacted by FGM/C, particularly whether you feel well-equipped and what you might need, if anything, to work better with them. If you feel you are working well with this group, what are you doing that you believe is successful? Your thoughts are equally welcome and valuable whether or not you have prior exposure and experience of these issues. More than 130,000 women in the UK have experienced FGM/C (WHO, 2008), however, many of us are not sure whether we have worked with affected clients.

Taking part is entirely voluntary. Before you decide whether you would like to participate, you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully.

**What is the purpose of the study?**

The aim of the project is to establish an understanding of psychologists’ experiences of FGM/C-related issues and to explore ideas about how psychologists can effectively work with FGM/C-impacted communities. The project is being carried out by Charmaine Elliott, a Trainee Clinical Psychologist in the NHS, as part of her Doctorate in Clinical Psychology at Royal Holloway University.

**Why have I been invited to take part?**

All clinical psychologists currently employed by “ “ NHS Foundation Trust will be invited to participate.

**Do I have to take part?**

It is up to you to decide whether you want to take part in the study. The interview process will be described in detail during the workshop and again at the start of the interview. The interview will be semi-structured which means you will be asked some standard questions to support a conversation about working with communities affected by FGM/C. If you agree to take part, you will be asked to sign a consent form to confirm your agreement. The consent form will be kept separately from any data collected. You are free to withdraw at any time, without giving a reason. Whether or not you decide to take part will not in any way affect your employment.

**What will taking part involve?**

If you agree to take part, you will be asked to share your experience and thoughts about FGM/C and FGM-related issues. The interview will last up to an hour.

**Am I likely to experience any problems in taking part?**

In a similar study on the awareness of FGM/C among psychosexual practitioners (Elliott et. al., 2015) no problems were encountered or reported by participants. However, FGM/C can be a very sensitive topic. If you would like to talk about your experience of participating in the interviews or the study in general, please email me with any questions at charmaine.elliott3@nhs.net.

**What will happen to the information I provide?**

All interview data are totally anonymous. There is no way of tracing your interview back to you personally. The recordings and transcripts of interviews will be kept securely. Results from all interviews conducted will be analysed and stored on a computer (but remember that because all the data collected will be anonymised, nobody will be able to identify your particular interview). The results from all the interviews combined are expected to increase our understanding how clinical psychologists can work effectively with FGM/C-related issues. The results of the interviews will be written up for peer-reviewed publication and made available via email to all participants in the form of a journal article.

**Will I personally benefit from taking part?**

Participating in the project will have no direct benefit to you personally. Because the data collected will be anonymised, your answers cannot be identified. However, we hope that the project will help professional bodies that influence training and continuous professional development among clinical psychologists to provide effective best practice guidance for clinical psychologists and mental health services. This should benefit all clinical psychologists and their clients.

**Who is funding this research?**

Royal Holloway University are sponsors of the research, and have funded this study.

**What if I’d like more information?**

Ask us if there is anything that is not clear or if you would like more information. Take time to decidewhether or not you wish to participate. If you decide to take part, we would be grateful if you would sign the attached consent form.

**APPENDIX B: CONSENT FORM**

**CONSENT FORM: Working with FGM-affected communities effectively in mental health**

**Name of Researchers:** Charmaine Elliott

|  |  |
| --- | --- |
|  | Please initial |
| I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. |  |
| I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. |  |
| I agree to take part in the above study. |  |

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Name of Participant Signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person taking Signature Date

consent

**APPENDIX C – INTERVIEW TRANSCRIPT EXTRACT**

I: [00:00:03] What kind of exposure Have you had professional or otherwise to information about FGM.

P: [00:00:10] I think I first learned about it even when I worked in a refugee health centre about well, longer ago than I want to admit, about eighteen nineteen, about 15 years ago.

And when I first learned what FGM was but in a very a very abstract way you know I read some information about I think it was part of the training there and I was kind of like "oh my goodness, this is terrible, but this is happening to women". And then particularly the way that the information was it is very much like you know women not having awareness or consent in this and there's and I guess through that I always maintained, I guess I always had an issue, an interest in, issues that affect women and women's rights. And so I guess it's something that informally I have also sought out programs articles those sorts of things. And in terms of professional training I'm not sure how much professional training I've actually had on the issue. It's much more when through supervision and clinical experience, maybe some academic papers that I've read. But I guess my knowledge is quite piecemeal, quite on the job. Well on the job and also quite informed or informally informed I suppose through hearing about other women's experiences maybe reading more journalistic articles rather than academic papers about it. I guess I have much more of an interest in hearing how women experience it understand it than necessarily what an academic person has to say about it. But I guess there is a lot of overlap in terms of people doing qualitative research to hear that so I say professional like that, that's my experience, but i have worked with a few women who have been affected by that and have disclosed it to me and dealt with them in risk and safeguarding issues and round that. Not in the way that you know there's a legal obligation I haven't had anybody in that situation. So I haven't had to.

I: [00:02:19] So you don't work with anyone under the age of 18 here.

P: [00:02:21] We very occasionally work with age disputed people, but it's rare. And they normally would be close, they're normally like 16/17 because they're age-disputed. And no I haven't come across any women that we've had here. So no I don't here and when I was working in CAMHS I was in there for a short period time and it wasn't raised as an issue with any of my clients in that context just coincidentally I imagine.

I: [00:02:56] Which CAMHS were you in?

P: [00:03:04] (redacted)

I: [00:03:06] How would you describe your ethnicity?

P: [00:03:09] White British.

I: [00:03:12] All right. Any questions before we move on?

I: [00:03:18] No not at all.

I: [00:03:19] Okay. So what I need now is a bit different and it involves a bit of activity from you. Okay. So what I need is for you to have a pen and a piece of paper.

P: [00:03:29] Is this going to involve me drawing?

I: [00:03:31] No (laughs) Well not unless you want to. So it's just feeds a jot down for words or phrases or images that come to mind when you think about FGM or working FGM impacted communities and then we'll talk through them.

P: [00:03:51] Okay.

I: [00:04:42] Yeah. Okay. Let's go for it. What's number 1?

P: [00:04:44] Human rights. That might have been prefaced by a conversation that we are in today, but yeah.

I: [00:04:52] Yeah. What makes that come to mind human rights.

P: [00:04:56] Because I think it's a fundamental issue that people should have control over what happens to their body. And personally I have issues even with male circumcision at an age where men, where they're babies and can't consent and there's no medical reason for it so I have a general issue with people not being able to make decisions about what happens to their body and really consider it on in line with other forms of child abuse. And I think they should, you know, women I guess are particularly vulnerable group because in many societies that are subjugated or there is a sense of kind of patrilineal, like patriarchy. And I think that the equality of women is very important. And I think that this is a very visceral very concrete example of women not having equality in control.

I: [00:05:59]. Yeah. Okay. Which was second?

P: [00:06:08] An image of the picture of the types of FGM which I've seen many times. I think that often pops in my mind because it's very visual.

I: [00:06:21] How do you feel when that comes up in your mind?

P: [00:06:23] Well this is what I have here. Physical sensation of horror and disgust. Yeah. That is the next one down.

I: [00:06:28] What does, what's the horror?

P: [00:06:32] Young of young women suffering like I guess I have a sort of slightly like enacted version of what that must be like and having heard different accounts of like of the girl being held down and the real violence of it. Many of you know most on lot of occasions it is very violent.

I: [00:06:50] And is this from clients that you've spoken to? or is this the journalistic stuff or a medley?

P: [00:06:50] I think it's just a mishmash.

I: [00:06:57] The last one here is an image of distress of a client who disclosed to me in just her description as she talked about her but also her absolute like just shame and distress in recounting what happened to her and her complete lack of control and powerlessness. So I think it's just a mix of all different emotions really. But I think there is something about you know being a woman knowing how I have no ability to tolerate pain and thinking how does a seven year or a 5 year old young girl get through that? It's absolutely terrible but also the actual act now the idea that maybe the idea and doing that my genitalia, does bring that real sense of a kick to the stomach like you know. So there is an element of disgust in horror that the actual physical act, what it must look like.

I: [00:08:00] So that real sense of empathy as well as having it in your mind as in a scene that you're hearing about that physical sensation and how about disgust?

P: [00:08:12] I think about I don't know if disgust is the right word, I think I am trying to find it quite hard to place what that sort of sensation, I say it's like being kicked in the stomach, it feels like quite sick. But I'm not sure discuss is the right word, but I think it is something about, someone could do like ether bloodiness and you know the actual acting cutting someone's genitalia in that very violent way I think does give me a sense of somewhere between horror and disgust. Yeah.

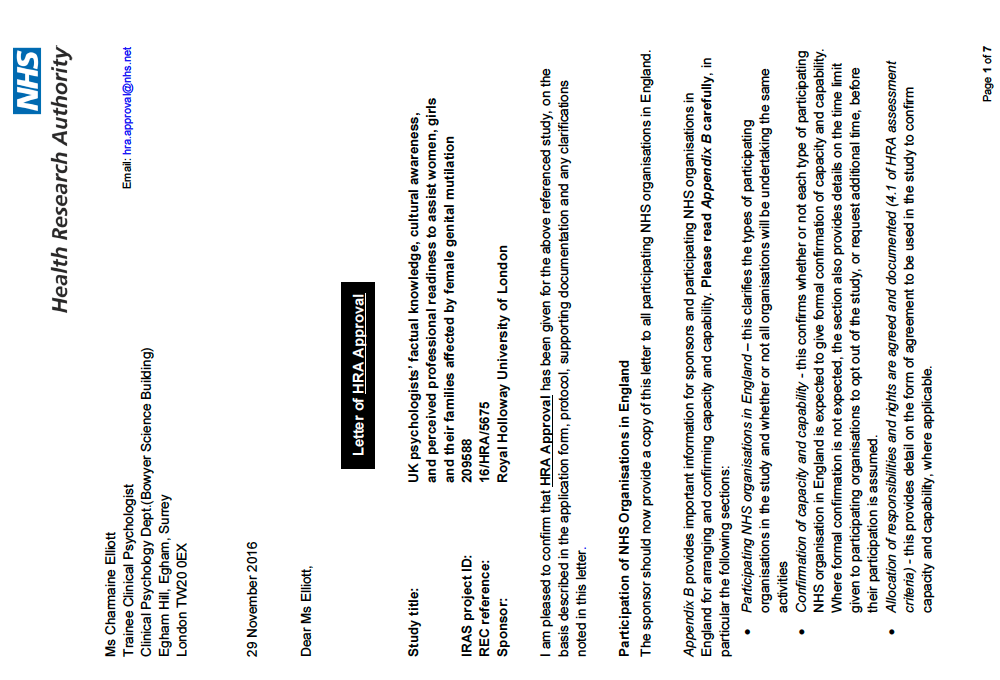
I: [00:08:44] So now you're kind of putting yourself in the person of the in that position of the person who is doing it and you're thinking.

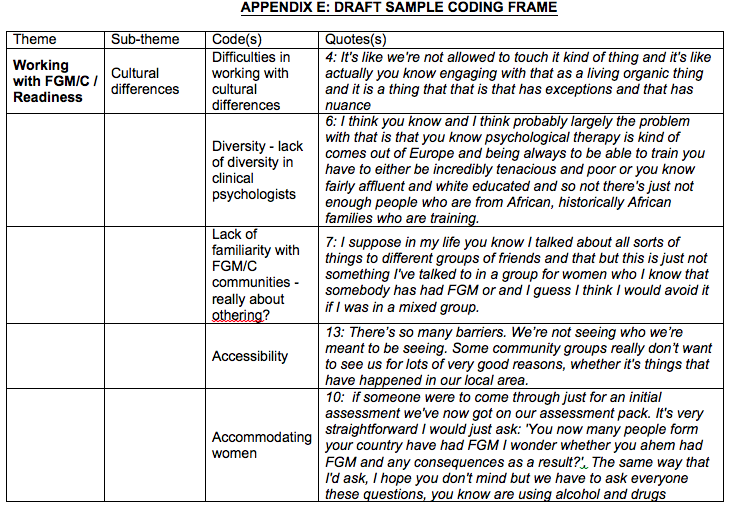
P: [00:08:53] Well I don't know. I think it's more just as if I was an observer I think, I haven't seen films of it being done. But I've heard very few descriptions and I've watched documentaries and films where women recount their experiences. So maybe it's something that I have put together from that collection of experiences to create a scene that really is quite traumatic.

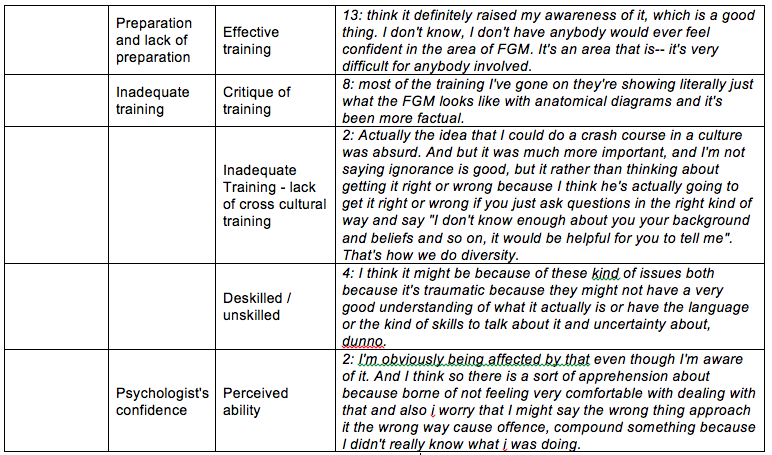
I: [00:09:19] Yeah. Yeah. Okay. And how does this impact in anyway, your work with women who have experienced FGM, when you have such a strong reaction one reaction to it.

P: [00:09:42] I like to think to a certain extent in all the work I do that I park my own stuff at the door. And when you're in a room with a client that you are really hearing their perspective you're genuinely hearing it, trying to understand where they're coming from. And to get really just try to get alongside them and to workout what how where they're at in terms of relating to fgm or whatever it is they would call it. And I guess you have to be mindful of Professional Responsibility as you talked about the legal responsibilities you have. You can't let this go. And that's always there and I work in a human rights organization So my stance is always people need to be aware of what their rights are. And actually that's something I have to bring in and I work in a number of things so we'll know when the woman's been trafficked or raped. Sometimes you have to state the obvious and say 'Do you know that in this country it is illegal for a good partner to abuse you or for someone to have sex without consent". That's not... And some women genuinely don't have knowledge of that because that's not something that they've been brought up with. They haven't had access to formal education or the laws are different in different countries. And so, I think if I am getting a sense that the person is very ashamed about the disclosure or they really don't have a concept of how widely it happens to people or that other women find it distressing or that they don't seem to have a knowledge of the fact that other people would consider that to not be an okay thing to do to another person then I probably would bring in some of those ideas and say from my perspective or more widely as a society this is how we see it here. What do you make of that. So I hope that I can bring in this perspective that would be different in a way that doesn't feel too intrusive and doesn't show closed our conversations where they might have a very different perspective. So, I hope that my, I think they are there. You can't deny that when someone's described that to you particularly they're distressed about it that is getting under your skin a little better and makes me quite angry. But I hope I don't let that affect the work that I'm doing I'm doing. Yeah.

**APPENDIX D: HRA ETHICAL APPROVAL CONFIRMATION**







**APPENDIX F: INTERVIEW SCHEDULE**

Interview schedule

**PART 1) (max 10 minutes)**

General questions

1. Just to begin, it’s useful to have some information about you and your practice experience. If you would prefer not to answer any questions, please let me know and we can move on to the next question.
2. How long have you been practising as a clinical psychologist?
3. How would you describe your therapeutic orientation?
4. What kinds of services have you worked in and what kind of service are you working in now? Which areas of the country have you worked in and where are you working now?
5. What kinds of exposure have you had, professional or otherwise, to information about female genital mutilation?

(Probe for TV, radio programmes, newspapers, academic books / articles / conferences, working with FGM-affected people / communities, training)

1. How would you describe your ethnicity?
2. Do you have any questions?

Thank you!

Part 2) (max. 50 minutes)

Now for something a little different. I would like you to jot down four words, or phrases, or images that come to mind when you think about FGM and working with FGM-related issues as a psychologist. We will then spend some time talking about them.

Part 3)

Supplementary questions:

1. Knowledge and awareness of FGM and FGM-affected communities

* Please tell me about what you know about FGM
  + Prompt for types of FGM, communities impacted, physical and psychological consequences
* How did you come to learn about FGM?

1. Views about FGM and FGM-related communities

* How do you feel about the practice of FGM?
* What is your strongest feeling about FGM?
* What made you want to take part in this study?

1. Experiences of working with FGM-related issues and FGM-affected clients and communities

* How have you encountered FGM in your work?
* What are your thoughts about working with FGM-related issues?
* What were your biggest concerns, if any?

1. Barriers encountered in working with FGM-related issues and FGL-affected clients and communities / what has helped / useful resources, / learning points

* What would you say are the biggest barriers to working with FGM-affected communities?
* How have you dealt with these barriers

1. Training needs regarding FGM among UK counselling and clinical psychologists

- What do you think would help psychologists to work more effectively with FGM-related issues?