QUALITATIVE EVIDENCE SYNTHESIS

**Psychological and counselling interventions for female genital mutilation**

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**Synopsis:** This qualitative evidence summary provides an insight into why psychological and counselling interventions may be beneficial for women and girls living with FGM.

**Abstract**

Women and girls living with female genital mutilation (FGM) are more likely to experience psychological problems than women without FGM. As well as psychological support, this population may need additional care when seeking surgical interventions to correct complications of FGM. Recent WHO guidelines recommend Cognitive Behavioral Therapy (CBT) for women and girls experiencing anxiety disorders, depression, or Post Traumatic Stress Disorder (PTSD). The guidelines also suggest that preoperative counselling for deinfibulation, and psychological support alongside surgical interventions, can help women manage the physiological and psychological changes following surgery.

This synthesis summaries evidence on women’s values and preferences, and the context and conditions that may be required to provide psychological and counselling interventions. Understanding women’s views, their own ways of coping, as well social and cultural factors that influence women’s mental well-being, may help identify the types of interventions this population needs at different times and stages of their lives.

**1. Introduction**

Women and girls living with female genital mutilation (FGM) are more likely to experience psychological problems as a result of the procedure—and have a psychiatric diagnosis—than women without FGM1. Several studies document negative psychological outcomes in women who have undergone FGM, including post-traumatic stress disorder (PTSD), anxiety, and depression.2, 3, 4, 5 However, there is little research available on the prevalence of mental health effects, or evidence to demonstrate the influence of FGM on the mental health of women.6 Perhaps as a result of this, research directed at understanding which types of psychological support or interventions would benefit women living with FGM, is also limited.

As well as psychological support for women experiencing mental health problems, women living with FGM may need additional support when seeking surgical interventions to improve their health and well-being, including the correction of complications of FGM. For example, there is evidence to suggest that women are often disconcerted by the physical changes and appearance of deinfibulated labia7, or that undergoing any surgery related to FGM may remind women of the initial trauma caused by FGM.8 For these reasons there is increased interest in considering the benefits or otherwise of psychological support or counselling for women alongside surgical procedures.

The recently published WHO guidelines on management of health complications of FGM identified, appraised, and summarized all available evidence on the effects of psychological and counselling interventions for women living with FGM.6 One systematic review conducted to help inform the guidelines investigated the effect of cognitive behavioral therapy (CBT) for PTSD, depression, or anxiety disorders in women living with FGM, but found no direct evidence (see Adelufosi et al., contained in this volume).9 Therefore, the guidelines draw on existing (indirect) evidence of the benefit of CBT for PTSD, anxiety, and depression in other populations, and based on this recommend that CBT be considered for women and girls with FGM who are experiencing symptoms consistent with anxiety disorders, depression, or PTSD.

In addition, based on indirect evidence, the WHO guidelines include two best practice statements recommending that: (1) women and girls who are candidates for deinfibulation should receive adequate preoperative counselling on the possible benefits and risks of the procedure; and (2) psychological support should be available for girls and women who will receive or have received any surgical intervention to correct health complications of FGM.6 Such interventions were judged by the guideline development group to be important in helping women to manage the physiological and psychological changes that can be expected after surgical procedures to correct health complications from FGM.

This commentary summaries women’s values and preferences, along with other evidence on the context and conditions that may be required to provide psychological and counselling interventions, derived from a systematic review of the available qualitative research. Understanding how women experience negative psychological effects of FGM provides important justification for why psychological interventions may be needed for these women. While understanding women’s values and preferences in relation to psychological support, their own ways of coping, as well social and cultural factors that influence women’s mental well-being, may be helpful in identifying what types of psychological and counselling interventions may help women and girls at different times and stages of their lives.

**2. Summary of the evidence**

The qualitative synthesis (detailed methods described in Stein et al.10 in this Supplement) included two studies describing the context of psychological intervention provision for women living with FGM8, 11 and three studies on women’s views and providers’ experiences of counselling interventions.12, 13, 14 Three studies were conducted in low-income countries (one in the Gambia and two Somaliland) and two in high-income countries (one in Switzerland and one in the Netherlands). The study from the Gambia included women who had migrated to Norway as well as traditional practitioners in the Gambia and explored the traditional folk psychology and care provided to girls undergoing FGM and compared this with mainstream psychological care. The two Somaliland studies were conducted in the same FGM support center at a maternity clinic in Hargeisa—one included women’s views on counselling for problems related to FGM12 and the other midwives’ views on providing care and counselling.13 The study conducted in the Netherlands included women who had migrated from Somalia, Sudan, Eritrea, Ethiopia, or Sierra Leone8 and explored their experience of mental/psychosocial problems and coping mechanisms, and the Swiss study explored FGM complications, care, and counselling with women from Eritrea and Somalia.14 We found no studies relating to women’s direct experiences of any psychological interventions, or the outcomes of these interventions, in any setting.

**3. Context and conditions of implementation**

3.1. Women’s and providers’ experiences

The limited evidence we found suggests that women have positive experiences of counselling interventions available to them. In one study of women seeking care at an FGM support center in Somaliland,12 women reported that they felt better, their health was improved, and they stressed that women should be informed and encouraged to seek help in a timely way. The study involving migrant women from Eritrea and Somalia living in Switzerland indicated that women would appreciate more informed discussion about FGM, including advantages and disadvantages of being cut and learning about “what is normal” for Swiss women,14 although this study was not about a specific counselling intervention per se.

Providers described positive experiences of delivering counselling services to women. Midwives providing counselling in an FGM support center in Somaliland described feeling confident and motivated by their perception that society generally considered their work beneficial, especially those who understand the problems of FGM.13 In providing counselling at the FGM support center, midwives described the importance of gaining women’s trust and how sharing their own FGM experience helped their relationship with women. For example, having undergone FGM themselves, midwives explained that they could “relate to women and understand their problems,” and they felt that women were more likely to listen to them “knowing they have had the same experience.”13 One midwife described how sharing a common experience with women she was counselling was positive, saying “we are in the same boat…perhaps that can be positive in the sense that deep down they know I can understand what they are feeling.”

In relation to psychological support for women living with FGM, we did not find any studies of women’s direct experiences of psychological interventions. However, a study conducted in the Gambia and among migrant populations in Norway11, and another in the Netherlands, provide evidence of negative psychological outcomes experienced by women who have undergone FGM. For example, African migrant women in the Netherlands reported bad memories, feelings of fear and powerlessness, as well as anger, shame, and guilt, with most women having “long lasting problems of some kind.”8 Women from the Gambia, now living in Norway, also reported occasional post-traumatic stress symptoms as adults that became more pronounced and more frequent after migrating.11 Despite the apparent mental health problems experienced by women, the study with women living in the Netherlands indicates that women have developed ways of coping with these problems. The authors distinguish between women who adapt, those who feel disempowered, and those who remain traumatized by the experience of being cut.8 Women discussed different coping mechanisms including taking strength and comfort from their faith and religious activities, talking to friends, as well as alternatives to talking when this was deemed inappropriate or difficult for some women.

3.2. Health system and service context

Available evidence from Somaliland indicates that women tend to delay health seeking and hide health problems connected to FGM for a long time.12 Women were hesitant to seek help, and described how “out there, there are many sick women who are hiding their problem.”12 Reasons for not seeking care related to poverty and shame as well as knowledge, as one woman explained “…had I had the knowledge and support from somebody who knew what to do, I would have come earlier, but I had neither.”12 Providers tended to echo women’s views, that women endure and hide their health complications (sometimes for decades) and “as a rule do not seek help as soon as they experience problems.” Midwives were also of the view that the poorest women suffer more intensely due to lack or access to doctors and money to pay for treatment.13 Delay in health seeking is likely to be an important barrier to timely access to counselling for women.

Women’s reluctance to discuss FGM and health complications with family or providers is another potential barrier to adequate counselling services for women prior to surgical or other procedures to correct complications of FGM. Women accessing an FGM support center in Somaliland13 and migrant women in Switzerland14 were ashamed of publicly confessing their problem. For migrant women accessing health services in Switzerland, FGM and complications are “not commonly talked about” in their private lives or with husbands and even among women themselves it was deemed a “taboo topic.”14 Midwives described how it often requires lengthy explanations and counselling regarding FGM and its health consequences before a woman can “tell the truth of her problem.”13

Women’s reluctance to seek help for mental as well as physical health problems resulting from FGM was also evident in one study of migrant women residing in the Netherlands.8 Women described difficult encounters with health professionals, especially being looked at in an invasive manner, and how the facial expressions of the nurse, doctor, or midwife can “hurt” and “make you feel sick.”8 Such experiences provoked feelings of shame, to the extent that women did not seek care.

3.3. Social and cultural context

Midwives providing counselling in an FGM support center in Somaliland faced challenges in providing counselling, and explained how both culture and religion were used as arguments against counselling women with FGM.13 Midwives were told that they were “interfering in family affairs” and “subverting the Somali culture.” According to the midwives interviewed, women are unaware of the health consequences of FGM and believed that midwives providing counselling were attacking their culture. One such belief midwives encountered in their work was that abandoning the tradition of FGM will cause “Allah’s anger.” However, the available evidence from the study in Somaliland suggests there may exist a contradiction between midwives’ personal beliefs and professional actions. In their work counselling women, midwives were personally against the practice, yet had still performed FGM on girl relatives to satisfy mothers or grandmothers.13

Women accessing the FGM support center in Somaliland discussed how attitudes toward FGM were changing, influenced mainly by religious leaders and the media. Some women said they had heard from religious leaders that “sunna” (FGM is referred to by two names in Somaliland: the sunna and the pharaonic. The sunna correlates with FGM type I and II) is approved by Islamic law and so they had started to oppose the more intrusive “pharaonic” form of FGM (equivalent to WHO classification type III).12 Women also mentioned that increased awareness of the harmful effects of FGM via media campaigns as well as their own experiences of FGM-related physical problems were important motives for shifting their attitudes against FGM. Attendance at the FGM support center had also influenced women’s views on FGM especially when they became aware, through counselling, that having genitals “cut and closed” was the cause of their health problems and pain.

Two studies that report on the psychological effects of FGM among migrant women living in Norway11 and the Netherlands8 suggest that migration exposes women to new information and cultural norms, which can challenge their identity and beliefs about the procedure. Once immersed in a different culture, women become aware that FGM is harmful psychologically and physically and “establish a connection between their symptoms and FGM.” For example, one woman described how, when she received information about FGM, she saw herself as “a victim of a harmful tradition” and suffered from depression as a result.11 Others described feeling angry, with their “traditions, culture and mindset,”8 to the extent that since migrating some women have isolated themselves through feeling embarrassed or ashamed. On the other hand, some women appear to view migration as liberation from the social pressures surrounding FGM.8

**4. Conclusion**

This qualitative research synthesis provides convincing evidence as to why psychological and counselling interventions may be beneficial for women and girls living with FGM. There is evidence that women suffer long-term mental health problems related to FGM, that when seeking help to correct complications women may be reminded of the original trauma caused by FGM, and that women may also need support to cope with the physical and physiological changes following procedures such as deinfibulation. The evidence points toward the types of interventions that may be helpful, but also highlights some of the challenges in delivering psychological and counselling support interventions. However, these insights are derived mainly from populations of migrant women living in high-income settings. We know very little about the experiences of women living with FGM in high prevalence settings, especially whether and how they experience adverse mental health effects of FGM, how they cope with these effects, and whether psychological or counselling support would be acceptable to them.

The evidence from high- income settings reveals that women and girls living with FGM experience long-lasting adverse mental health effects from the procedure, and those effects may intensify over time and with exposure to new cultural norms and information. Living in a context where FGM is viewed as a violation of human rights could lead to isolation and mental ill health linked to shame and guilt. In addition, women tend not to seek help for physical or mental problems connected to FGM in a timely way and are reluctant to discuss their health problems with health staff who are unfamiliar with FGM. These factors could have implications for timely provision of counselling or psychological support. Conversely, with exposure to new cultural systems and norms, some women may feel free of social pressure to comply with tradition, and may become more aware of the linkage between FGM and health problems so become more inclined to seek care.

What is clear from the limited evidence from high-income settings is that women have developed ways of coping with the adverse mental effects of FGM. The evidence around coping mechanisms and the taxonomy of women based on how they have dealt with complications of FGM provides important insight into what types of intervention may help women who experience mental health problems, and options for service providers as to what can or cannot be addressed. Again there is a gap in our understanding of how women in high prevalence countries cope, especially as mental health problems may be less well recognized and there is less capacity to deliver mental health interventions in these settings.

We found no studies relating to women’s direct experiences of any psychological interventions, or the outcomes of these interventions, in any setting. As and when psychological support and counselling interventions are developed and tested, it would be prudent to collect qualitative data on women’s and girls’ experiences and perceptions of the interventions, as well as acceptability, appropriateness, and their feelings about the outcome.

The available evidence provides some insight into women’s experiences of general counselling in an FGM support center in Somaliland, and midwives’ experiences of providing that counselling in the same center. Women generally experience positive outcomes, and midwives find it rewarding to deliver counselling. Midwives highlighted the positive effect of having personally been through the FGM procedure and how this shared experience seemed an important bridge to building trust with women. The converse is true in high-income settings where healthcare providers are likely to struggle to gain respect and trust of women without receiving formal training and better understanding of the procedure, and the social and cultural factors that often prevent women from openly discussing health problems. The evidence of provider experiences is from just one study with midwives; it would be important to explore whether other cadres of professional have similar positive experiences as this has implications for who may be best to deliver counselling.

This review of qualitative research also provides some indication of challenges to providing counselling interventions to women living with FGM. The evidence from Somaliland shows women’s tendency to delay seeking help and hide health complications of FGM. This is an important barrier to being able to offer timely access to counselling, and is likely to be the case in high-income settings too. The pattern of reluctance to discuss FGM in both high-prevalence and high-income settings could also have implications for how counselling interventions are delivered, but again the evidence is limited to two studies. Midwives in Somaliland were challenged in their counselling work by cultural and religious views on FGM, and this highlights the need to provide support to midwives and other cadres to provide high quality counselling and care to women as well as the potential need to involve religious leaders in awareness campaigns.

We found no studies specifically on women’s experiences or preferences for counselling alongside surgical procedures, for sexual function, or specifically for deinfibulation. As countries begin to implement counselling interventions, supported by the best practice statements in the WHO guidelines, it is important that evaluations of the interventions document women’s experiences, perceptions, and feelings about the outcomes, alongside measuring the impact on health outcomes.

**Contributions**

HS designed the qualitative synthesis, led the data extraction, analysis and interpretation of the data and wrote the manuscript. KS contributed to data extraction, analysis and interpretation of data and commented on drafts of the manuscript.

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**Conflict of interest**

The authors declare that they have no conflict of interest.

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