

Veiled pain

A research in The Netherlands into the psychological, social and relational effects of female genital mutilation.

Erick Vloeberghs, Jeroen Knipscheer, Anke van der Kwaak, Zahra Naleie, Maria van den Muijsenbergh¹

Summary

Introduction

Veiled pain is the result of exploratory research into the psychological, social and relational consequences of female genital mutilation (FGM). The research took place between January – July 2009 and aims to improve the (psychosocial) treatment of victims of FGM living in the Netherlands. The Netherlands count some 56,000 girls and women who run the risk of being or have been circumcised. 25,000 of them are under 20 years of age. Estimates vary, but it is assumed that around fifty girls are subjected to the ritual every year. Although neither the Quran nor the Bible prescribe FGM as a religious duty, many people in the risk countries believe it is a religious requirement. In addition, many are of the opinion that circumcised girls have a better chance of finding a suitable husband, will remain a virgin until their wedding and will remain faithful to their husband afterwards. People also feel that FGM contributes to creating of a sense of identity for both women and men, and that it provides women with status in their community.

The World Health Organisation recognises four types of FGM:

Type I: Partial or total removal of the clitoris – clitoridectomy

Type II: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora - excision

Type III: Narrowing of the vaginal orifice by cutting and appositioning the labia minora and/or the labia majora, with or without excision of the clitoris – infibulation

Type IV: All other harmful procedures to the female genitalia for non-medical purposes, for example, pricking, piercing, etc.

Existing research

Since the beginning of the 1990s, much research has been carried out into the somatic effects of FGM. Excessive haemorrhaging, shock and severe infections may occur immediately after the procedure; long-term effects may include obstruction of the flow of urine, cysts, fistulas and infertility. There is a higher incidence of caesarean sections, haemorrhaging and infant death during delivery among mothers who have undergone FGM. The effects of genital cutting on female sexual behaviour and perception remains unclear. Over the past ten years, several studies were published on FGM in the context of migration. Most of these publications deal with the medical effects of FGM on migrant women, in particular with complications in relation to childbirth. In the past, there has been relatively

¹ A Pharos publication, realised with financial contributions from the Achmea Victim & Society Foundation (Stichting Achmea Slachtoffer en Samenleving) and the Victim Support Fund (Fonds Slachtofferhulp)

little attention for the psychological, social and relational effects of the procedure. The scarce literature that is available shows that FGM can cause emotional damage to girls and have psychologically adverse effects. The first coitus and childbirth are experienced as extremely painful by women who have undergone FGM. A number of these women are traumatised by the procedure or its painful effects. Chronic pain and traumatising can have a mutually reinforcing effect: pain triggers memories of the FGM and thinking or talking about the mutilation can cause the pain experienced at the time to be relived (*mutual maintenance*).

Experiences with healthcare in the Netherlands

According to the model of Dr. Haseena Lockhat the type of FGM and the related symptoms determine whether post-traumatic stress disorder (PTSD) is likely to ensue. FGM in its most extreme form (type III – infibulation) not only carries the highest incidence of medical complications, but also an elevated risk of developing PTSD. Lockhat's research also shows the importance of gaining a better insight in circumcised women's experience with care, as three quarters of the respondents indicate negative experiences with care workers. Women tend to not seek help because they feel misunderstood. Genitally mutilated women coming to the Netherlands may be confronted with healthcare workers showing insufficient understanding of their situation, as FGM is viewed as morally reprehensible in this country, as well as being banned by law. Women confronted with such views can feel burdened with shame and guilt. Lack of understanding of these sensitivities, or seeing revulsion in a relief worker's face gives these women the feeling they are ill understood. In this context, it is important to know whether discussing FGM is rendered more difficult because of migration, or whether talking about it becomes easier because the taboos from their countries of origin are perceived as less coercive here.

Research framework

Operationalisation

Our research questions were:

- 1 Does FGM have psychological, social and relational effects? If so, what are they?
- 2 What are the factors contributing to the development of symptoms in said areas? These may include influences related to migration, cultural mindsets and experiences with care.
- 3 What are the coping mechanisms these women develop in relation to their symptoms?

For the purposes of this research, *psychological effects* are understood to include the various symptoms and problems related to FGM and the psychological mindset of the woman or girl concerned and manifesting either at that time or in the longer term. These may include anxiety, depression, frigidity and psychosis.

Social effects refer to the effects of FGM on the victim in relation to her surroundings. These may include shame, alienation and distrust, and experiences of social exclusion and stigmatisation.

Examples of *relational effects* are communication problems in the relationship with their partners, including the sexual relationship, but also in social relations with family, acquaintances, colleagues, etc.; psychosexual effects; and insecurity and embarrassment over one's own body. *Coping* is understood as the ability to deal with difficult situations, such as an illness or disability. This research also deals with coping with limitations in relation to sexuality.

Methodology

To gain more insight into the psychological, social and sexual-relational effects of FGM and the coping mechanisms of women who have been subjected to FGM, we sought to let their opinions, experiences and behaviours take centre stage. How did they experience their FGM and how are they dealing with resulting symptoms? We therefore opted for a *mixed methods* approach, using both quantitative and qualitative research methods. Previous research among migrants showed that this kind of approach tends to yield productive and practical results. In order to ensure an optimal match between the conceptual framework, the applicable method and the research instruments and the study population, the representatives of the communities concerned were involved in the research at an early stage.

For the quantitative analysis, we used a general socio-demographic questionnaire and four standardised questionnaires. The qualitative analysis comprised semi-structured interviews using a topics list, focus group discussions (FGDs) and several other meetings, which were all recorded and transcribed. The topics list was compiled with the aid of two focus groups (one male, one female). The FGDs provided information from the communities concerned regarding the crucial issues in relation to FGM.

The results from both groups were compared and the distinguishing themes were later converted into questions. The first version of the topics list was subsequently discussed with the interviewers in a three-day training, following which a final version was compiled. The questionnaires that were used comprise the Dutch Harvard Trauma Questionnaire (HTQ-30) to screen for PTSD; the abbreviated Hopkins Symptom Checklist (HSCL-25) to screen for anxiety and depression; de COPE-Easy to identify coping mechanisms and coping styles; and the Lowlands Acculturation Scale to determine the respondents' level of acculturation.

Initially, we planned to select interviewers and respondents from among the five largest communities from 'risk countries': Egypt, Eritrea, Ethiopia, Sierra Leone, Sudan en Somalia. However, it turned out to be impossible to gain access to the Egyptian community, so that it was eventually decided not to include Egyptian women in our research. We included a larger number of women from those countries – Sudan and Somalia - where the most severe form of FGM (type III – infibulation) is common practice. All of our respondents had been subjected to FGM and were of reproductive age (18-50 years old). The seven interviewers, all originating from the five communities, approached women in their circle of friends and acquaintances, asking them to take part in our research. They also asked potential respondents whether they knew of others who might be approached (the *snowball* method). The data were collected between August 2008 – April 2009. Generally, two house calls sufficed to obtain all the necessary information.

The transcriptions of the interviews were checked and subsequently analysed by the researchers, using the research programme ATLAS.*ti*. The quantitative data from the five questionnaires (a general questionnaire and four standardised questionnaires) were fed into SPSS. This programme was used to compile an initial inventory of the respondents' socio-demographic data. Next their socio-demographic background, traumatic reactions and psychological problems, coping scores and acculturation scores were subjected to a univariate analysis. All independent variables that showed a significant relation to the dependent variables at the univariate level were then subjected to various multivariate regression analyses.

Results

Socio-demographic data

Of the 66 women in our research, 18 originate from Somalia and Sudan, 12 from Sierra Leone and Eritrea and 6 from Ethiopia. The most frequently occurring form of FGM is type III (infibulation), which is particularly common among Somali and Sudanese women. The second most common form is cliteridectomy, a form of FGM which in our research group only occurred among the Eritrean and Sierra Leonean respondents. The majority of respondents were enrolled in secondary or higher education. Around 60 percent were once married, and 70 percent have children. From those who were married, some 20 percent are divorced.

Qualitative results

Psychological effects

Only five out of 66 respondents indicate that they are proud or glad to have been circumcised. Most suffer adverse consequences and report a number of psychological effects:

Bad memories and pain – Many of our respondents indicate that they regularly suffer from bad memories, which surface during or following situations in which the women feel confronted with their FGM. These include pain during sexual contact, the memory of the FGM itself or its after-effects. Painful memories also surface when they are witness to the FGM of girls in their country of origin, or when they hear of a woman getting married or giving birth. A woman from Eritrea says: 'It often resurfaces when I see an item on FGM on TV. Or when the subject is broached or even if the word 'FGM' comes up, then everything just resurfaces, my memory comes back to me. Sometimes I dream about it. I feel really angry then, and sometimes I get nervous and start shaking.' Eleven of our 66 respondents say that their memories resurface at night to keep them awake or give them nightmares.

Avoidance, stress and taboos – For fear of bad memories re-emerging, a third of our respondents avoids talking about their FGM. In particular the women from Sierra Leone, Somalia and Ethiopia are very tense during the interviews. For the women from Sierra Leone, it is not only taboo to talk about FGM, but some even fear they will be punished if they break this taboo, as one woman said: 'They said that in your sleep you'd be visited by someone who had passed away and they made it seem so real that I believed it ...' The women from the other communities did not report any taboos, but they too find it hard to talk about their FGM. For Somali women, talking about it is either regarded a private matter, or they feel it is too painful. 'Talking about it causes harm', says one of them. About half of all the Somali women say that they do not want to talk about FGM with anyone other than their husband, sisters or mother. Some respondents from Somalia also do not want to discuss questions relating to sexuality, and the same goes for several Ethiopian women.

Among the Eritrean and Sudanese respondents, there are significantly fewer women who indicate that they suffer from stress when discussing or thinking about FGM.

Anxiety – Thirteen respondents talk about anxiety and being scared as a result of their FGM. In particular those women who were infibulated, indicate that it was a 'shocking and terrible experience' and that they will never forget the day they were circumcised. These women were also anxious on their wedding night and/or when they went into labour, as a Sudanese woman said: 'Yes, you're terribly scared, in particular on your wedding night. You're completely sown up, what is going to

happen? ... It took 30 days before he managed to penetrate me. Because I was circumcised, penetration did not succeed at once.' Six of the women interviewed indicated that since their wedding night they have been anxious about sex. Some of the women say that following an initial period of aversion to sex, they managed to come to terms with it. For two unmarried women, however, the fear of sex is a reason to renounce family life.

Listless, powerless, worthless – The majority of respondents only came to realise that their FGM has had a negative physical, psychological and social impact after they came to the Netherlands. For most women, the realisation that FGM is not universally endorsed, as well as the confrontation with women who had not been circumcised, caused feelings of insecurity and confusion. Once they had been informed that FGM is a cultural practice rather than a religious requirement, many women felt cheated, sad, confused, disillusioned and angry. 'Why did they do this to me, why, why?', eight of our respondents exclaimed during their interviews. Some women feel damaged and even inferior, as a Sudanese woman says: '...It damages something deep inside when you find out that not all women are circumcised. You then find out that there is a part of you that is missing. That you are incomplete. You have lost a part of you that was given to you by God.'

Many respondents from Somalia, Sierra Leone, Ethiopia and some women from Sudan are resigned and passive. Their view tends to be 'what is done, is done'. Apparently, some of our respondents have perforce accepted the situation and are trying to make something of their lives, despite years of infections and inconveniences. For many infibulated women, their menstruation is a time of lingering infections and much physical discomfort. For two women from Somalia and one from Sudan, their period makes them feel so exhausted and miserable that they tend to seclude themselves and feel temporarily incapable of looking after their family.

Social effects

Almost all respondents say that they feel good in the Netherlands; although they occasionally suffer from feeling homesick, they generally feel safe and at home. At the same time, the interviews show that some women struggle with social problems related to their FGM. These include anger, embarrassment, feelings of guilt, exclusion and loneliness.

Anger – A number of respondents says to (have) be(en) angry with their parents, their culture or religion when they found out that FGM is not a universal or necessary practice. In addition, respondents feel angry because of the discomfort and pain resulting from their FGM. In particular for women from Sudan, Eritrea and Sierra Leone, the sexual limitations and the pain during intercourse are reason to feel anger at their partner or at men in general. An Eritrean woman says: 'You sleep with a man and he experiences pleasure while you suffer. I cannot accept that in my mind and that is why I am angry.' Some ten respondents are angry at their partner because he shows no or too little consideration for the fact that they have been circumcised. Strikingly, none of the Somali respondents indicate that they are angry at their husbands or at men in general.

Embarrassment and guilt – At some point during their interview, almost all respondents indicate that they feel embarrassment. Two respondents indicate that they feel so ashamed that they simply deny having been circumcised when explicitly asked. However, there are marked differences between the communities in the way in which respondents talk about their embarrassment. Ethiopian and Somali respondents are not very communicative; in general, they tend to be rather terse in their answers. Women from Sudan are much more explicit and can be quite outspoken about when and where they

feel embarrassed. The respondents from Sierra Leone and Eritrea move between these two extremes. Most women feel embarrassed when confronted with the fact that they are different, for example when going swimming, going to see a doctor, or when a non-circumcised friend, colleague or neighbour asks them about it.

Exclusion and loneliness – Social exclusion as a result of FGM occurs in two ways. On the one hand, women exclude themselves by not wanting to talk about it; on the other hand, some respondents feel they are being excluded as if they do not belong. These respondents feel excluded because they deviate from the prevailing standard that women in the Netherlands are not circumcised. In relation to this, an Eritrean woman says: ‘Someone who has not been subjected to FGM cannot understand your feelings. This makes you feel isolated.’ Several respondents indicate that when FGM comes up in conversations with Dutch people, they notice that they are regarded with pity. Somali women in particular prefer to keep their distance and avoid contact with people with a different background. They refuse to be pitied.

Loneliness is mentioned as an after-effect of FGM by four of our respondents. Sudanese respondents report fewer feelings of exclusion in their contacts with the Dutch or isolation as a result of their FGM than respondents from other communities.

Relational effects

Having been subjected to FGM in the past can influence a person’s relations with their partner, children and other relatives in their country of origin.

Relationship with one’s partner – According to the majority of our respondents, FGM has significant effects on family life. A number of respondents has distinct problems in the relational sphere. For five respondents, their FGM has been such a determining factor in their family life that it caused major marital problems, in particular in relation to sex. Other women also indicate that there is a correlation between FGM and problems with sex. A Sudanese woman says: ‘I hear from many circumcised women that relations with their husbands are often very tense because of difficulties with sexual relations. Women need time, but their husbands show no consideration and get angry.’ For many women, in particular those who have been infibulated, their wedding night is their most painful experience. The response of their husband and more importantly, whether or how he goes about penetration, can define how the spouses experience the start of their marriage. Five respondents from Ethiopia, Sudan and Somalia report that the start of their marriage was very painful and that it took four days to a month before penetration was achieved.

Fortunately, the wedding night does not prove traumatic for all respondents. Ten respondents from Sudan, Somalia and Sierra Leone say that they were anxious in advance, but that their husbands proved very considerate.

Twenty two respondents indicate they feel pain during love-making and sixteen do not feel like sex or feel no sexual urge. But there are also fifteen women, mainly from Ethiopia, Eritrea and Sierra Leone, who indicate that they have no problems in relation to sexuality. Together with their husbands, they have worked out a sexually satisfying modus vivendi, in which both partners make time for each other.

Relationships with children and relatives in the country of origin – In answer to the question whether they plan to have their daughter(s) circumcised, all but one of all the women resolutely respond that they do not want to. In addition, all but one of the women would like their son to marry a girl who has not been circumcised. Of the seven respondents whose daughter(s) were circumcised in the past, all

but one regret the decision. Neither of these children were circumcised in the Netherlands, but in the respondents' countries of origin. In three instances, the daughters were circumcised against their mothers' will, often through the agency of family or in-laws. Respondents from all groups indicate that their views on FGM have changed as a result of their migration to the Netherlands. When visiting their country of origin, the subject at times provokes heated debates and arguments. A Somali woman: 'Everyone kept asking me: When are you going to have your daughter circumcised? To them, I am no longer of any interest, because I am married with a child. But my daughter, she must be circumcised. People are put under a lot of pressure.'

Migration factors, coping and religion

Relevance of age – Age is relevant in two ways. First of all, there is the age at which FGM took place, and secondly the age at which the respondent migrated. Women who were circumcised at a very young age, like most of the Eritrean women, do not remember being circumcised. Sometimes they only realise later on in life that they even were circumcised. Most respondents think it matters at which age a person migrated. Older women take a different view of FGM than younger women, they feel. A Somali woman says: 'Young people who came to the Netherlands at an early age and went to school here are very much aware that FGM is a cultural tradition. ... Therefore they are much more likely to oppose FGM than their parents.'

Media attention – Respondents generally respond positively to reports on FGM in the papers and on TV. The attention from the media strengthens their conviction that they will not subject their daughters to the procedure. The majority of the respondents say that they feel supported in their objection to FGM, in particular vis-à-vis their relatives in their country of origin. Nevertheless, there are also less positive views on the role of the media, in particular among the Somali respondents. Six women in all felt offended by the shocking images, the negative reports, the hurtful remarks and the fact that circumcised women are portrayed as pitiful.

Information in the Netherlands – Most of the respondents say they were advised regarding FGM in the Netherlands. The Sudanese and Eritrean women are generally positive about the information they received; all of them confirm it was very helpful. Of the Somali women, only a small number say they were provided with information. The same goes for Ethiopian women. One of the three Somali women who did receive information on FGM, says: 'We learned how to stand up for ourselves and how to say 'no' to FGM. I found the meeting very useful. But I would have preferred to have had this information before I was circumcised.'

Coping and religion – When asked what action they take when they experience discomfort or problems, in particular the Somali and Ethiopian women reply that they prefer not to discuss these matters with others. Some women take up sports and others seclude themselves. Many respondents refer to religious rituals as a source of consolation and strength. By reading the Quran or the Bible and/or by praying they try to lighten their burden. For six of our respondents, listening to music was quoted as a way to cope with discomfort and ailments. Two women admit that they raid the larder when they are finding it hard to cope, while another indicates she drinks a lot of coffee. Remarkably, only one of our respondents mentioned qat as a coping strategy, given that the consumption of qat is a widespread tradition in East Africa and that this mildly intoxicating substance is also imported and consumed in the Netherlands.

Experiences with health care in the Netherlands

Three respondents in total indicate that they are or have been treated by a psychiatrist or by a regional institute for outpatient mental health care. Two of these women discussed the effects of their FGM with their consultant. Both say they felt better after having done so. Bar three, all respondents have had experience with Dutch health care. Their most frequent symptoms include menstrual and abdominal pains. Three respondents mention recurring cystitis and one respondent has been receiving treatment for incontinence as a result of complications during childbirth for the past ten years.

All in all, both positive and negative experiences with health care workers were reported in the course of our investigation. Respondents indicate they have positive experiences with health care workers having become increasingly knowledgeable about FGM. Negative experiences include the fact that they often feel embarrassed or experience distress or guilt when being treated by health care workers. Respondents indicate that they find it particularly difficult to cope with the fact that a doctor may see their genitals during a physical examination and ask questions. For a number of respondents, a baffled or shocked look from the person carrying out the investigation is sufficient to trigger feelings of guilt or to make them blush with shame, as one Eritrean woman recounts: 'When I was admitted to hospital to give birth, several nurses came by to look at my private parts. They came and went, came and went. I felt as if I were on display. ... I felt so embarrassed, so humiliated. I did not want people to see me like that.' The shame can be so great that women prefer to ignore their discomforts and avoid the health care system all together.

Respondents from Eritrea and Sierra Leone less frequently indicate that they feel embarrassment in their dealings with health care workers than respondents from other communities. This may be because a clitoridectomy is less noticeable and brings fewer complications than an infibulation or excision.

In four cases, one or more deliveries took place in the country of origin, where the women's vagina, in case of a type III FGM, was automatically sown back up after childbirth. Fifteen women in total report that one or more of their children were born by means of a caesarean section. For infibulated women who gave birth the normal way, their vagina had to be opened up first (de-infibulation). At their own request, three respondents who were delivered of their child in the Netherlands had their vaginas stitched up again. Two women who declined to have this done at the time, indicate their regret; however, two others are very glad that they were not re-infibulated after giving birth.

Quantitative results

Our univariate analysis showed that almost one in six of our respondents has an HTQ scale score that exceeds the threshold value for PTSD. Almost one third show an HSCL anxiety score above the threshold value and one third scores above the threshold value on the HSCL depression scale. Respondents who underwent an infibulation report more PTSD-related symptoms and more anxiety and depression. This concerns mainly Sudanese women. Respondents who are in education or have a job or are on benefits report fewer anxiety and depression-related symptoms. The older women were at the time of their migration, the more psychological symptoms they report. Respondents who were older when they underwent their FGM report more traumatic complaints. Women who remember their FGM well, report more anxiety and depression. Respondents with whom FGM was discussed prior to the procedure report more PTSD-related symptoms than respondents with whom the procedure was

not discussed. The same goes for women who received targeted information about FGM; they too report more anxiety and depression.

Respondents indicating a tendency to avoid the subject of FGM as well as an elevated use of substances report more psychological symptoms. Respondents seeking additional support only show a correlation with anxiety and depression. As respondents possess fewer capabilities to function in Dutch society, they report a higher incidence of psychological symptoms, including PTSD, anxiety and depression.

A multivariate analysis of the variables showing a significant correlation with PTSD, anxiety and depression in the univariate analyses indicated that the variables *memory* (good), *country of origin* (Sudan), *coping* (substance abuse) and *type of FGM* (infibulation) are significant predictors of post-traumatic health symptoms). The variables *coping* (avoidance and substance abuse), *country of origin* (Sudan), *type of FGM* (infibulation) and not being *gainfully employed* proved to be predicting variables for anxiety and depression.

Discussion

Psychological, social and relational problems

Central to this investigation is the objective to gain insights into the psychological, social and relational effects of FGM in the context of migration. Literature studies led us to expect that many African women in the Netherlands who had been subjected to FGM would suffer from anxiety, depression and/or post-traumatic stress-related symptoms. And a substantial group of women does indeed report suffering from psychological problems as a result of their FGM or other related key events, such as their wedding night or childbirth. Our quantitative analysis shows that almost one in six women meet the criteria for PTSD, while a third meet the criteria for anxiety disorder or depressive illnesses. However, the majority does not show scores above the threshold values for psychopathology and the PTSD, anxiety and depression scores we found were lower than in other surveys. The most likely explanation for this latter finding is a persistent underreporting of symptoms.

In particular women who remembered their FGM in detail, suffered an infibulation and who reverted to an increased substance use (drugs) as a coping strategy reported increased posttraumatic symptoms. There is a direct correlation between an avoidance coping style, a higher use of prescription drugs, infibulation and not being in work or in education and a higher reported incidence of anxiety and depression. More than trauma-related symptoms, anxiety and depression-related complaints appear to correspond to factors not directly related to the women's FGM. There are significant differences between the different ethnic origin groups in terms of the reporting of symptoms and openness in discussing FGM and sexual problems. Respondents from Sudan show the highest scores on the HTQ and HSCL questionnaires, while Somali respondents score much lower. As the majority of respondents from both Sudan and Somalia are infibulated and FGM takes place at roughly the same age, it must be considered remarkable that Somali women present with significantly fewer symptoms. It is possible that Somali women have better ways of coping with their FGM; the interviews show that they more frequently tend to seek solace in their religion when they experience problems. It is equally possible that they are less aware of the effects of their FGM because of a lack of education on the subject. Another explanation may be that Somali respondents find it harder to openly discuss their FGM, as the interviews indicated.

In memories of the FGM or events directly relating to it, experiences of pain and frustration appear to play an important role in the development of symptoms. The *mutual maintenance* model referred to earlier appears to apply: physical pain keeps the memory alive and thinking or talking about the experience brings back the pain.

The interviews show that the effect of FGM on family life is substantial. The relationship with their partner appears crucial to the (sexual) well-being of the women, in particular when they have undergone an infibulation. The pain that accompanies penetration, in particular on their wedding night, gives the partner a substantial role in how a woman experiences her FGM and the extent to which she develops psychological and relational symptoms. Men who put their own interest (and pleasure) first by adhering to the tradition and who display an egocentric attitude, make it hard for women to enjoy sex. But when both partners are attentive and take their time, sexual satisfaction remains possible.

Migration factors

Their migration to the Netherlands set much in motion for our respondents. They generally feel at home here, but feel excluded when their FGM plays a role in their contacts with people who do not come from a risk country. They seem to have gone from accepting FGM as being the obvious course to outspoken resistance against this ritual. The realisation that FGM is not a religious requirement has influenced their change in attitude, as well as the ban on FGM and the media exposure on the subject in the Netherlands. Through reports in the media and targeted information campaigns some of our respondents came to recognise and acknowledge the effects of FGM. They have become more aware of the symptoms relating to their FGM. However, the results show that respondents experiencing symptoms do not always succeed in finding the right words and therefore fail to receive the support they are looking for. A particularly humiliating experience was not being able to indicate their needs during childbirth and not being able to understand what was said to them. Their adverse experiences with Dutch health care workers are in part attributed to the fact that they did not understand or speak Dutch at the time.

The quantitative results confirm a correlation between the occurrence of psychological problems and one of the aspects of acculturation, namely (language) skills. Respondents who did not have the necessary skills – in particular fluency in the Dutch language – report more symptoms, in particular anxiety and depression. This outcome corresponds to the results of earlier research into this aspect of acculturation and psychological well-being.

Experiences with health care

The respondents report good and bad experiences with health care workers. Bad experiences tend to be connected to feelings of embarrassment and exclusion. For respondents who have been infibulated, embarrassment and insecurity surface in particular in cases where their private parts are too closely scrutinised or when bystanders show an expression of misgiving or revulsion. In addition to difficulties with the *medical gaze*, many women who have undergone FGM do not want to be seen as victims. Both approaches are experienced as humiliating and hamper the provision of health care; they negatively influence the motivation to get in touch with health care workers when experiencing symptoms. An understanding of the traditions and respect for the circumcised woman's personal integrity and identity are crucial to ensure the possibility of effective communication.

Coping

The expectation was that an assistance-seeking coping strategy would lead to a reduction in psychological symptoms. A striking result was that women who seek support do not present fewer

PTSD symptoms and show more anxiety and depression-related symptoms than women who do not seek assistance. It may be that seeking support has a negative effect if the assistance received does not fulfil one's needs. The interviews show a number of respondents indicating that they experience insufficient support from important figures in their lives, such as their partner or mother(-in-law). A dissatisfying assistance-seeking coping strategy may then change into an avoidance mechanism: for example, some women refrain from visiting their GP after a humiliating experience. Although ostensibly contradictory, according to our findings both the assistance-seeking and the avoidance coping styles are concomitant with increased symptoms of depression and anxiety.

The typology below characterises groups of women in terms of how they cope with their FGM and whether they seek or avoid help. This typology can offer care workers a handle on how to approach women who have been circumcised. Four general types can be discerned:

- 1 the adaptors;
- 2 the religious;
- 3 the disempowered;
- 4 the traumatised.

The adaptors – The 'adaptors' experience symptoms (both physical and sexual), but have found ways to cope. They talk about what ails them and, when necessary, consult a health care worker. Crucial for this type of circumcised woman is a good relationship with her husband; he is attentive to her needs when making love. This small group of women views FGM as a *fait accompli* and is often actively engaged in the fight against the practice in the Netherlands. They draw strength from this, as well as from activities such as going for walks, reading a book and talking about it.

The religious – This group of women also suffers symptoms, but what typifies them is that they maintain that they know best how to deal with these. These women seek out like-minded people (adherents of the same faith) and tend to have less satisfying relationships with people with different perceptions. They hold the firm view that sexuality is a private matter, which makes it hard to talk about. The religious take much comfort and strength from prayer and religious services. On the one hand they accept what is expected of them as religious women and fight against FGM, based on the fact that it is not a custom from the Quran or the Bible, but rather a cultural practice. As a group, the religious report less anxiety and depression than the non-religious, which possibly underscores their adaptive coping.

The disempowered – Women belonging to this group feel angry and defeated. But they carry their burden and see no way out of their situation. They report a high incidence of substance abuse, watching TV to excess and binge eating. They do not talk about what was done to them, they are embarrassed and feel lonely and impotent. They avoid sexual contact or experience dissociation when it occurs. As a result, they often have a poor relationship with their husband. But divorce is considered undesirable, as is talking about the issue; these women's attitude tends to be one of dependence on their husbands. They are emotionally inhibited and experience great difficulty in letting go of their negative experiences. They sometimes experience severe psychological symptoms, but feel inhibited or are outright forbidden by their husbands to take this up with a health care worker. Inarticulate stress and a tendency to fatalism are what characterises this category of women.

The traumatised – Of each of our subgroups, this group of women has the hardest time of it. It concerns a small number of respondents experiencing symptoms of a physical, social, relational and sexual nature. These women, who have often been subjected to infibulation, suffer much pain and sorrow. Their relationship with their husband tends to be dysfunctional or they are divorced. They experience recurring memories, sleeping disorders and chronic stress (at the thought of sex, the recriminations of their husbands, etc). They feel misunderstood by their surroundings and sometimes also by health care workers. These women consciously seeks to isolate themselves in order to avoid confrontations. Shame, anger and reproach (also against their mother or mother-in-law) play a major role, but these women have no idea how to cope with such feelings. As a group, the traumatised report a higher incidence of anxiety and depression than the non-traumatised, which illustrates their distressful situation.

Methodological considerations

We would draw special attention to a number of methodological issues in relation to our study. The sample survey may not be optimally representative. The respondents were selected from among a group of women who had indicated they were willing to talk to the interviewers about their FGM and its effects. It is possible that women who do not want to talk about the issue suffer more or other symptoms. There is also a chance that advocates of the practice were either not approached or were not willing to be interviewed for fear it would cause them trouble. In addition, the chosen selection method (*snowball sampling*) may limit generalisation of the findings. An *at random sampling* was not an option for our research, as there is no way to trace the places of residence of women from risk countries in the Netherlands. There was also no control group, so that there is no comparison to women who have not been circumcised. All in all, this warrants some reserve in drawing generalised conclusions based on the findings of our research. Nonetheless, we feel that the data derived from the focus groups, the topical interviews and the structured questionnaires yielded sufficiently sound information to justify the conclusions answering our research questions.

Findings

1 Psychological symptoms are concomitant with FGM – but not by definition

Psychological, social and relational effects as a result of FGM were found among our respondents. Symptoms of anxiety and depression were found among one third of the respondents. One in six respondents suffers from trauma-related symptoms. Respondents who underwent a milder form of FGM also reported post-traumatic symptoms. For a substantial group of women, the fact that they were circumcised coincides with an incidence of psychological symptoms, but not all circumcised women seem to suffer these symptoms.

2 Serious symptoms are explained by a combination of factors

A combination of infibulation, vivid memory, migration at a later age, little education and language skills and inadequate support from the partner are concomitant with serious symptoms. In particular women who were infibulated, who came to the Netherlands at a later age and do not hold a job indicated feeling depressed and anxious. Whether or not these women have a vivid recollection of their FGM plays a role. When experiencing symptoms, these women may not be able to find the right words to express themselves. They feel embarrassed and inhibited and fail to receive the support they

are looking for and need. The relationship with their partner is crucial to their experience of sex. When their husband is considerate of her pain and limitations and demonstrates the patience to follow his wife's hints, then satisfaction is possible. When the wife experiences no support from her husband, frequent and violent rows may occur. The inability of the wife to meet the (sexual) demands of her husband can lead to chronic stress and exhaustion, and may on occasion even result in divorce.

3 Pain triggers much distress

Recurring pain and infections affect the occurrence of psychosocial and relational problems by triggering memories of either the FGM as such, or of situations adversely affected by this event (first coitus, childbirth). Chronic pain and bad memories mutually reinforce each other and make for a situation of *mutual maintenance*. In a number of cases, pain during love-making had an adverse effect on the relationship with the partner, and as a result on occasion also on family life.

4 Taboo on talking about FGM is a major influence

The impact of being circumcised on a woman's psychosocial well-being and reporting the operation when experiencing symptoms is highly influenced by difficulties in the women's ability to talk about it. The social imperative (taboo) and the fact that FGM influences the way a woman experiences sex (private matter) makes respondents more inclined to keep symptoms to themselves and to avoid (the effects of) FGM as a topic of conversation. These women are used to keeping silent, which, even after their migration to the Netherlands, is the socially acceptable thing to do within their community. Keeping silent may offer more of a sense of security than talking about the issue. In other words, talking about it causes insecurity and/or stress. Underreporting of symptoms appears to be a major factor in explaining the relatively low number of women reporting serious psychopathologies. The taboo on talking about FGM and its effects may play a role. That would mean that the figures are relatively low and that more depression, anxiety and trauma-related symptoms occur than are reported.

5 Hinge moments are crucial to symptom development

In addition to the FGM, subsequent experiences also have a bearing on the development of symptoms. These may include the first sexual experience or childbirth. Women who have been infibulated in particular brand these experiences as traumatising. Especially when, as is common practice in their country of origin, the women were sewn up again after the birth. Unbiased attention during childbirth is important to avoiding humiliating experiences with health care workers and subsequent reduced therapy compliance.

6 Disfunctional coping is linked to higher symptom reporting

Our research shows a high incidence of avoidance and substance abuse, but also of excessive snacking and watching TV. This is a coping style which is disfunctional in dealing with the symptoms. Avoidance is an important coping mechanism for our respondents. They tend to show a certain reluctance to discuss their FGM, because this opens old wounds. Others actively avoid talking about the issue after having experienced feeling misunderstood or because they feel it is too personal.

7 The influence of acculturation skills is a crucial factor

In addition to the findings relating to our research questions, the conclusion is warranted that the social position and level of social integration of the groups is one of the deciding factors. Their level of fluency in the Dutch language and the extent to which they feel comfortable in the Dutch (health) care

system co-decides whether women do or do not talk about their symptoms and the social problems resulting from their own FGM or that of their daughters. If the issue is discussed, the subject appears to be broached in an indirect manner; this 'veiling' of the pain occurs to a greater or lesser extent across all communities. This makes clear that different integrated care models and interventions must be used in order to reach these women.

8 Whether FGM is a religious requirement is of key importance

Despite having been infibulated, Somali respondents report fewer psychological symptoms than all other respondents. This may be explained by underreporting. On the other hand, what attracts attention is that many of them name the Quran as their most important coping mechanism and frame of reference. A number of Christian respondents from Sierra Leone and Eritrea also indicate that they feel supported by their religion and fellow believers. An additional statistical analysis showed that the 'religious' subgroup reported fewer feelings of anxiety and depression than any of the other subgroups. Both Muslim and Christian respondents felt morally and socially supported by the fact that FGM is not mentioned in their Holy Books and discuss the issue among themselves.

9 Media attention is meaningful

Media attention and targeted information help respondents recognise the effects of FGM. The attention in the media and debates among themselves and with third parties have helped strengthen respondents in their rejection of FGM. In the Netherlands, none of the respondents' daughters have been subjected to FGM. Their new-found knowledge is used to argue against FGM in discussions with relatives in the country of origin.

10 FGM appears to be a dying practice in the respondents' families

Their migration to the Netherlands set much in motion for our respondents. Their previous acceptance of FGM as the obvious course appears to have changed into active resistance against this ritual. The realisation that FGM is not a religious requirement has influenced their change in attitude, as well as the ban on FGM in the Netherlands. The changes as a result of their migration, their increased awareness of the effects and the desire to spare their daughters the suffering, have resulted in FGM apparently becoming an obsolete practice in the respondents' families.

Recommendations for care workers

The findings of this research yield a number of recommendations for care workers:

- 1 Care must be taken not to put women who have been circumcised in the corner of 'psychiatric' or 'problem' cases, as clearly not nearly all respondents suffer serious symptoms. In addition, the role of other migration-related and social factors must be expressly taken into consideration. In order to achieve this, it is advisable to ensure extensive cooperation between health care facilities and social services.
- 2 It is important that the new insights cited above be explicitly incorporated in the treatment of these women. This includes structural attention for their experiences and providing them with coping mechanisms to help them come to terms with their experiences. In addition, it is advisable to help them gain practical skills (language competency) to help them hold their own in Dutch society.

- 3 Using therapy to equip the women with instrumental skills to help them cope in day to day life and promote social integration (for example, by enrolling in education/training) in order to avoid social isolation, is also a good starting point for improving mental health.
- 4 There is a need to provide better information regarding the kind of services the public (mental) health facilities can and cannot provide. Therapies must be tailored to the clients' social and cultural environment. However, therapists must take care not to focus exclusively on culture and adjustment problems as an explanation for the symptoms presented so as to ignore underlying pathologies. At the same time, they must be open to the idea that the client's condition is not necessarily an indication of a psychological affliction resulting from their FGM, but rather of social, political and economic pressures.
- 5 It is the combination of acculturation issues and socio-demographic characteristics that in addition to the FGM itself prove an additional risk factor, warranting extra attention from care workers and policy-makers. Enhancing care workers' intercultural competences and enabling a more flexible combining of material (including assistance with financial, work-related issues) and immaterial aid is recommended. As for therapy, the role of acculturation can be explicitly incorporated in the treatment.

This research also provides a number of practical leads for professional care workers:

- 1 It is important to have the right knowledge regarding FGM. A care worker dealing with FGM must be able to discern the various types, be knowledgeable about the related symptoms and the effects these may have, as well as have some awareness regarding the (cultural) background and the taboo surrounding the practice.
- 2 Having the right attitude enables a meaningful dialogue. An understanding of the tradition and respect for the individual are crucial. In addition, decisiveness is expected of a professional, in particular regarding acute medical care and internal examinations.
- 3 In examination rooms, limit the number of people present to those who are indispensable. Preferably have only women attend internal examinations. Also limit the number of non-experts. Students and interns need to have had prior contact before assisting at an internal examination. Curiosity alone is not sufficient reason and can be highly confrontational for the patient (stigmatisation).
- 4 Traditionally, the reluctance to talk about the effects of having been circumcised is substantial. Discussing these issues can cause substantial distress, so a relationship of mutual trust is of the utmost importance. In order to achieve that trust, care workers must confer with their patient as to the next steps in their treatment.
- 5 If there is a language problem, it is advisable to contract an interpreter. Care workers must never assume that they can quickly arrive at the core of the problem; generally, this requires several patient encounters and sufficient time to arrive at the heart of the matter.
- 6 Specific attention to patients' pain experience is required. Pain can recall memories of previous traumatic experiences and vice versa (*mutual maintenance*). Pain during sex can have an effect on the entire family. Therefore, it is important to try to involve – in close consultation with the patient – the patient's partner when discussing pain in relation to sexual problems whenever possible.
- 7 Care workers must be attentive to specific events, including:

- Marriage. Thoughts of the patient's wedding night can trigger anxiety. The time following the wedding requires significant adjustments on the part of the bride. Pain and injuries as well as psychological symptoms may occur.
 - Childbirth. During labour or when a woman has allowed herself to be 'closed up' afterwards, complications are liable to occur. A childbirth in their circle of relatives and friends is generally a key event, which may trigger both positive and negative connotations.
 - Visits to the country of origin. A visit to the country of origin can be distressing because of the patient's own recollections or the threat of another FGM in case they are accompanied by a daughter.
- 8 Medical disciplines confronted with FGM, including professionals working in public (mental) health care, ought to be capable of discussing circumcised women's sexual behaviour. Sexuality is crucial to their sense of well-being and their functioning as a member of their family.
 - 9 Be attentive to the fact that an increase in information on (the effects of) FGM can (temporarily) raise the level of symptoms. An increased *awareness* can cause painful feelings to 'surface'. Support your patient in this process and if needed, contact a mental health care worker.
 - 10 FGM is but one of a range of possible traumatising experiences. Therefore, do not focus exclusively on FGM and check whether there are other factors which may be causing the symptoms presented by the patient, such as sexual assault, a lack of meaningful occupation or the (financial) circumstances of the family. Feelings of depression may well result from those.
 - 11 A number of respondents indicated they resorted to snacking when feeling agitated and distressed; some reported consuming qat and possibly other substances. Obesity and substance abuse may be included as a topic for discussion when women from these risk countries indicate suffering from tension or stress-related symptoms.

Contact: Erick Vloeberghs (e.vloeberghs@pharos.nl)
 International Affairs
 Pharos
 P.O.BOX 13318
 3507 LH Utrecht

Hard copy of *Versluierde Pijn* (in Dutch only) available via <http://www.pharos.nl/>