FEMALE GENITAL TRAUMA:

Guidelines for Working Therapeutically with Survivors of Female Genital Mutilation

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Foreword

I am delighted to be able to write a few words of introduction to these guidelines to Female Genital Trauma: Guidelines for Working Therapeutically with Survivors of Female Genital Mutilation.

FGM/C is a form of child abuse and violence against women and girls that causes harm to their genitals and results in the control of their future sexuality. These guidelines will provide evidence of such and recommendations for therapeutic interventions.

There is still an enormous amount to be understood about how these harmful practices affect women and girls and about the links of this practice to culture-based tradition– and not just for ourselves. Research and subsequent changes in societal cultural norms are particularly hard to shift. A very effective way of promoting awareness and change is by asking questions, sometimes very difficult questions.

Useful understandings can flow.

Implicit in our work are many aspects of the trauma related to FGM/C and included in these guidelines are useful tools for identification of the consequences, being medical, psychological, psychosexual and physical. There are new bodies of psychological and social knowledge – from trauma related psychological interventions, social sciences, medical science, that can draw on to reflect on our practice. Increasing our therapeutic literacy can improve our ability to think about how these harmful practices affect women and girls, and how to prevent and identify them; these guidelines will provide a set of safeguarding steps as well as contextual considerations for therapy.

These guidelines are to be published at a very important social and political time: a time where there is an imminent need for clarity and information for the therapeutic community, medical staff, social workers, the general population and local child protection services who are dealing with the affected population. There is clearly an upsurge of interest in the study of trauma related to FGM/C research within the profession and this document proposes a much-needed tool for identification and psychological intervention.

We can all benefit from the development of thinking and dialogue surrounding the prevention and reporting of FGM/C in our communities. I believe these guidelines will provide an increase in our developing relationship with the associated professionals, including application of current UK legislation, and in identifying the negative psychological consequences of such practice and potential tools for trauma interventions.

There are many challenges when dealing with FGM/C and as a therapist, I am delighted to find effective tools for the integration of methods and approaches included in these guidelines, with the inclusion of clear assessment questions, trauma and PTSD questionnaires, guidance for group therapy, and an extensive list of resources.

I believe these guidelines to be an extremely useful tool for practitioners and for most of the affected population, mainly women and girls.

We experience its effectiveness for improving our action in the world.

Claudia Celadon, MA
Psychologist and Clinical Supervisor
June 2019

About the Authors

Christie Coho is committed to increasing social justice for individuals and wider society. As a BABCP accredited and qualified EMDR psychotherapist, she currently works in several FGM/C clinics and NHS trauma therapy services as well as in private practice. Christie also provides clinical supervision and reflective practice facilitation with therapists and with non-clinical staff at community-based organisations.

Additionally, Christie has been a mental health social worker for over 20 years, during which time she developed local and county-wide service networks for young people struggling to transition into adulthood, whilst providing case management, therapy and education to clients and their families. She holds a Masters in Social Work and is a former National Chair/ Co-chair of the progressive Social Welfare Action Alliance.

For many years Christie has used her professionalism and passion for people's well-being whilst volunteering with numerous charities working to improve the lives of people who are homeless and/or refugees; advocating for social change and peace; and reducing the impacts of violence, on women in particular. She is currently a volunteer Home Visitor for Refugees at Home.

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Leyla Hussein, OBE is a psychotherapist, disrupter and international lecturer on female genital mutilation (FGM) and gender rights. She is recognised globally and her work has been presented at Oxford, Cambridge, UCL, Leeds, Exeter, Coventry University, International School of Geneva and many Ivy League faculties in the US including Columbia, Harvard, Georgetown, George Washington and Pennsylvania universities. Her passion is to empower women and girls and her achievements include:

- Founder of ground-breaking anti-female genital mutilation charities/organisations Daughters of Eve, Hawa's Haven and the Dahlia Project which is a pioneering support service for survivors of FGM
- Global Ambassador for The Girl Generation, an African-led global collective of members and organisations working together to end FGM
- Presenter and lead contributor for the Bafta-nominated documentary "The Cruel Cut"
- Leading UK and International campaigner against FGM who has contributed to UK and International policy development on tackling FGM
- Advisor on FGM to UK Department of Health, Her Majesty's Inspectorate of Constabulary advisory group on Honour Base Violence, the Home Office FGM Working Group and the NHS Clinical Advisory Group on FGM
- Consultant to the World Health Organisation on the development of a person-centred communication toolkit for nurses and midwives working with girls and women affected by FGM
- Writer and commentator on women's rights and health with regular articles published in The Guardian, Cosmopolitan and The Huffington Post as well as blogs in Newsweek, Mumsnet, Stylist magazine and the Department of International Development website
- Accomplished public speaker with regular appearances at international conferences including the Oslo Freedom Forum and several TEDx talks.

Cabby Laffy brings a refreshing and unique approach to psychosexual health, integrating over 20 years of personal and professional development. Her book *LoveSex: An Integrative Model for Sexual Education* (Karnac 2013) aims to redress our lack of sexuality education, address social and cultural issues, and to promote psychosexual health.

Cabby set up CPH (the Centre for Psychosexual Health) in 2006 to provide training based on the Homeodynamic Model for Psychosexual Health. She is a psychosexual psychotherapist and a supervisor, working with individuals, couples and groups. She has facilitated a range of trainings and workshops since 1991. Cabby is a UKCP registered and NCP accredited psychotherapist, a COSRT accredited psychosexual therapist, a supervisor, a group facilitator, and a member of PCSR.

› psychosexualhealth.org.uk

Roxana Parra Sepúlveda is a Psychotherapist, Clinical Supervisor and Feminist who combines academic excellence with practical international experience and knowledge. Specialised in working with abuse and violence survivors, she has worked leading counselling services for diverse women's organisations in the UK. Roxana continues developing and executing therapeutic programmes for service users with a range of mental health difficulties and conducting psychotherapy within the higher education, community environments and in her private practice in London.

Currently she is the Chair of the International Attachment Network, which promotes the understanding of the Attachment Theory developed by John Bowlby and Mary Ainsworth. Roxana is keen on continuing the work to influence social change towards a society without abuse.

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Introduction

While finding ourselves working with women who had experienced FGM/C, we discovered a gap in the literature and training, namely a lack of good practice guidance for working therapeutically with survivors of FGM/C. Through this shared dilemma, we managed to link with each other across London in 2016, as a multi-disciplinary group of professionals. Ultimately, we decided to write the needed guidelines ourselves, readily agreeing that we would put them online so they would be accessible to other practitioners finding themselves in the same situation.

From the beginning we have conceived this as an evolving project, and indeed, in the three years we have been writing it, much has changed in the discourse and understanding of the challenges of working therapeutically with the impacts of FGM/C. Our hope is that this will continue to be a living, evolving work, which is updated and expanded over time by us and new contributors.

We acknowledge that this is not a comprehensive work; for instance, we did not believe we had the necessary expertise to address working therapeutically with girls under 18. We also would love to delve into related discourses like feminist theory applied to psychology, gender-based violence, etc. Ultimately, we chose to remain directly focused on the impacts of FGM/C, although there is so much more that can be said about the contexts in which the practice exists and early interventions.

We believe the therapeutic interventions you will find in these guidelines will be best placed coming from a culturally sensitive approach that will lead you to not only think about what you do but how you do it.

We believe the stepping stone into good practice involves keeping up with emerging literature, therapist self-awareness and the development of reflective and learning spaces around harmful practices.

If you, as a therapist, are not prepared to ask relevant questions to your clients, how can you open healing conversations with women about their physical, emotional and psychosexual experiences?

With these ideas in mind we invite every therapist working with adult women to take the time to open up and expand your capacity to work alongside your clients in a healing process that enables a better, healthier future for your clients and their families.

The Authors
September 2019

Executive Summary

These guidelines provide recommendations for psychological therapists and counsellors working with women who have undergone female genital mutilation / cutting (FGM/C). They are designed to facilitate therapy with adult women and not children.

FGM/C refers to all procedures that intentionally alter or cause injury to the female genital organs. FGM/C is a violation of the human rights of women and girls, and is illegal in the UK and many other countries. In the UK, it is considered a form of child abuse. Nevertheless, 200 million women and girls alive today have undergone some form of genital mutilation. It is estimated that in London 2.1 percent of women are affected.

FGM/C is classified into four main types: clitoridectomy, excision, infibulation, other. These types are explained in section 2e. Consequences of the practice can range from severe pain, shock, infections and death in the short term, to post-traumatic stress symptoms, depression, anxiety, lack of arousal, difficulties with menstruation and passing urine, as well as significant complications during childbirth.

Therapists are encouraged to:

- Stay up to date with latest information about FGM/C and fully understand the background, context and reasons for practicing FGM/C
- Undertake pre-therapy assessment including discussing potential risk explicitly, confidentiality and the limits thereof
- Assess and deliver (or refer on to) suitable therapy for the client's presenting needs, rather than assuming the need for trauma-focused therapy
- Locate and refer clients to suitable additional services, and support the client in knowing what to expect
- Be aware that a client's distress or symptoms may temporarily increase during therapy
- Be alert for events that may trigger or intensify symptoms or distress
- Adapt the therapy to the client's community background, both the culture of origin and the culture in which she resides
- Be aware of their own cultural biases, incorporating practices from culturally sensitive counselling
- Attend to the needs of the particular client
- Engage in conversations about sexuality and be aware that it may change the therapist's own attitudes and beliefs
- Ensure adequate and suitable training and supervision for the types of therapy being carried out
- Respect and empower their clients
- Work skillfully with interpreters, where relevant, and offer them time to debrief
- Develop personally meaningful self-care strategies

In regard to deinfibulation (reversal – see Section 2f), therapists are encouraged to:

- Understand the women's personal reasons for deinfibulation
- Support her by helping her identify what support she needs during the procedure
- Not assume that after the procedure, all problems have been resolved
- Engage in pre- and post-operative psychosexual therapy
- Liaise with relevant professionals

Clinicians must apply the usual criteria for identifying safeguarding or risk issues and use clinical criteria to decide whether procedures need to be enacted.

Therapists are encouraged to:

- Be well informed about the ethical framework and good practice guidelines of the organisations they work for
- Ensure their duty of care is applied
- Follow safeguarding children policies and procedures when they believe a child might be at risk of undergoing FGM/C
- Understand if you are a mandatory reporter and, if so, comply with these requirements
- Explain to their client that they have a duty of care towards her children/female relatives
- Explain to their client that FGM/C is considered child abuse and is illegal
- Treat the situation as they would when working with clients at risk of self-harm, domestic violence or other safeguarding concerns
- Consult with any Safeguarding Lead in their organisation and Social Services if there are concerns about a risk to children

As clients may experience FGM/C as a trauma, therapists are encouraged to apply attachment-informed therapy in their work. Attachment is a bond that connects one person to another across time and space and during their lifetime. Attachment theory concerns the regulatory functions and consequences of maintaining proximity to significant others. An individual's attachment style represents the way that person perceives and relates to themselves, others, and the world, and is different from one attachment figure to another. The setting of the therapeutic relationship aims to provide a secure base that facilitates a sense of safety to the client. As such, the attachment-informed therapist will strive to be reliable, attentive, empathic and sympathetically responsive. The therapist will also facilitate the client's reflection on and exploration of their internal working models, and the impact that FGM/C and any other traumatic experiences have had in the client's life. The paradox of trauma experience in the core of the family may also lead to the development of a series of coping mechanisms or attachment strategies related to the avoidance or suppression of emotions.

Therapy needs to identify with their client the coping mechanisms the client has developed to learn to live with the impact of her abuse. Individual clients may not presently be carrying the abuse experience as trauma in a strict sense, but rather as depression, anxiety, mistrust, anger and betrayal, low self-esteem or body image, relationship and sexuality issues, etc. She may present with dissociation, denial or grief. However, where abuse happens within the family, this may lead to a much higher incidence of post-traumatic stress. Remembering the traumatic event can trigger the same physiological activation and emotions as at the moment of the event, making it feel as if the event is happening again, which is very frightening and confusing. Therapists are encouraged to follow a practical three-stage approach for carrying out therapy with survivors of trauma: stabilisation; trauma and mourning; and reconnection. This is widely recommended for treating complex trauma. Furthermore, integrative psychotherapy, eye-movement desensitization and reprocessing, trauma-focused cognitive behavioural therapy, compassion-focused therapy or narrative exposure therapy may be suitable for individuals. Group therapy may also be valuable and women may seek psychosexual therapy.

1. Purpose And Scope Of The Guidelines

These guidelines provide good practice and evidence-supported recommendations for psychological therapists and counsellors working with women who have undergone female genital mutilation, as well as information to raise clinicians' knowledge and understanding.

In this document, 'FGM/C' is used to acknowledge variations in terminology, e.g., female genital mutilation/cutting/circumcision.

The guidelines are intended for use across a variety of presentations. Clients' presentations will not always fall into the specific criteria of a diagnostic classification (e.g., post-traumatic stress disorder (PTSD)). Women who have undergone FGM/C may have a wide range of issues that need to be addressed (e.g., feelings of anger or helplessness, sexual difficulties, flashbacks or negative self-image). The therapist's aim is to support women to fully integrate their experiences to become psychologically healthier.

The guidelines provide therapists with:

- Background and contextual information on FGM/C
- Understanding of the possible psychological and physical consequences of FGM/C
- Information on how to respond to safeguarding concerns and how to navigate these within the therapeutic relationship
- Contextual considerations
- Theoretical perspectives on working therapeutically with survivors of FGM/C
- Therapeutic modalities
- Therapist skill set
- Recommendations for:
  - When and how to ask clients if they have experienced FGM/C
  - Theoretical considerations
  - Stages of therapy, including extended engagement/pre-assessment and assessment, therapeutic modalities, group therapy, and psychosexual therapy
  - Support and supervision for therapists engaged in this work
- Signposting to further information, including specialist support services for survivors of FGM/C (see Appendix 4: Resources)

The guidelines are designed to facilitate therapy with adult women (not children). The specific legal and safeguarding framework discussed applies to the United Kingdom.

These guidelines draw on evidence and guidance published by leading national and international authorities on FGM/C and trauma therapy, which are referenced throughout. They also draw on learning from The Dahlia Project, the UK's first specialist counselling service for survivors of FGM/C, and on the authors' experience in their respective services.

There is little coverage of the psychological/mental health issues experienced by women who have undergone FGM/C in peer-reviewed, journal-based literature, and even less regarding psychological therapy for survivors of FGM/C. This was a key reason for drafting these guidelines. Mulongo, Hollins Martin, & McAndrew[1] completed a literature review in May 2013 on the psychological impact of FGM/C. This identified 10 relevant studies (from 1034 studies about FGM/C). In brief, eight out of 10 reported/identified negative psychological consequences, such as PTSD and affective disorders (primarily anxiety, depression and somatisation). Two out of 10 were inconclusive regarding psychological impacts. Overall, 'such contradictions in findings between these reports make it difficult to draw meaningful conclusions' (p 10); and none of the reviewed studies focused specifically on therapeutic interventions. At the time of writing these guidelines, further literature searches retrieved few additional articles related to psychological/mental health, all of which indicate a lack of existing guidance for professionals working with women who have undergone FGM/C.

Terminology in the guidelines:

We have carefully considered the terminology used in these guidelines, with an awareness that words can be an aid and/or a hindrance to understanding. Even the term 'female genital mutilation' has historically been a source of debate, although it is beyond the scope of these guidelines to address this debate.

FGM/C:

Female Genital Mutilation or Female Genital Cutting/ Circumcision. In the UK, FGM/C may be referred to as 'cutting/being cut', '(female) circumcision' or 'initiation', or other community-specific terms.

The terms 'FGM' or 'cut' may not be understood by individuals within some affected communities because these are English-language terms. Worldwide, FGM/C is known by many different names, as almost every affected country and ethnic group has a specific name for it. Terms often used include 'sunna' (Arabic meaning 'law', 'pharonic' (in context, Arabic for Type 3), 'the tradition', 'gudnin' (Somali), 'tahur' (Sudanese), and many others.

Affected/Practising:

The international development language is currently (2019) 'affected', e.g., 'affected communities', and we acknowledge that historically/generationally communities along with individuals have been affected. Therefore we are using the term 'affected'. However, 'practising' is more typically the language used by many campaigning groups and women who have been undergone FGM/C, e.g., 'practicing communities'.

Client:

The woman who is engaging in therapy; also to mean the patient, woman, FGM/C survivor.

Therapist:

The qualified professional providing the therapy; may also go by the title counsellor, psychotherapist, psychosexual therapist, psychiatrist, clinician, etc.

Therapy:

The psychological talking treatment of psychological/ emotional/mental distress, disorder, or desire for personal growth and development; elsewhere called counselling, (psycho)therapy.

Acronyms in the guidelines:

BABCP	Board of Behavioural and Cognitive Psychotherapies
BACP	British Association for Counselling and Psychotherapy
BPS	British Psychological Society
CBT	Cognitive behavioural therapy
CFT	Compassion focused therapy
COSRT	College of Sexual and Relationship Therapists
EMDR	Eye movement desensitization and reprocessing
FGM	Female genital mutilation
FGM/C	Female genital mutilation/cutting/ circumcision
ISTSS	International Society for Traumatic Stress Studies
NCP	National Council of Psychotherapists
NET	Narrative exposure therapy
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
PO	Protection order
PTSD	Post traumatic stress disorder
TF-CBT	Trauma-focused cognitive behavioural therapy
UKCP	United Kingdom Council for Psychotherapy
UK	United Kingdom
WHO	World Health Organization

2. What Is FGM/C, Why Is It Practiced And What Are The Consequences?

This section defines FGM/C; describes why it is practiced and the scale of the issue in the UK and globally; defines the different types of FGM/C; outlines the health and psychological consequences of FGM/C; and explains who is at risk of FGM/C. The should remember that although the clients treated are women, they typically underwent FGM/C as girls.

2a. Defining FGM/C

FGM/C refers to all procedures that intentionally alter or cause injury to the female genital organs, involving partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons, as defined by the World Health Organisation (WHO).[2] FGM/C has no health benefits and only causes harm to women and girls. It involves damaging healthy and normal female genital tissue, interfering with the natural functioning of the female body. In 2016, the head of the United Nations Population Fund (UNPF) declared that female genital mutilation (FGM) is "child abuse".[3]

FGM/C is a 'harmful practice':

'Harmful practices' are abusive culture-based traditional practices. These include FGM/C, and breast flattening/breast ironing, child or forced marriage, honour killings, and abuse (often physical) to children who are believed to be possessed by spirits.[4,5] Regardless of a basis in culture, belief or tradition, these are actions which are harmful to an individual's physical and/or mental health; if acted out on a child, it is child abuse.

Related harmful practice: Breast Flattening/Ironing: Females who present with breast flattening are likely to have undergone FGM/C as well (Hall, 2017). Breast flattening is practiced in a few countries, mostly in Africa, by pressing down breasts using objects such as hot stones, hands, irons or tape in an attempt to make them develop slowly.[6] This is done to try to avoid a girl being sexually harassed/assaulted, pregnancy, and leaving due to pregnancy, forced marriage, sex slavery, etc. As with FGM/C, this is typically done by female relatives (including the mother).

This harmful practice is less well known and has received less public attention and addressing. As such, there is even less guidance on how to approach it than with FGM/C. Some authors of these guidelines have experience working with breast flattening, and would recommend approaching it in the same way as these guidelines outline for working with FGM/C, until such a time that more specific guidelines might be developed.

FGM/C as a global human rights violation:

Internationally, FGM/C is recognised as a violation of the human rights of women and girls, and it is illegal in the UK and many other countries.

> *'...[FGM/C] reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death' (WHO)[2]*

Globally, 200 million women and girls alive today have undergone some form of genital mutilation in 30 countries in Africa, parts of the Middle East, Asia and beyond; and as a result of migration, there are women in countries throughout the world who have undergone, or are at risk of undergoing, FGM/C.[2]

2b. Why is FGM/C practiced?

FGM/C is practiced for varied and complex reasons. Many of the reasons given by communities practicing FGM/C relate to social acceptance and status, virginity and marriageability, a feminine ideal, and perceived religious requirement. In most cases, it is practiced in the context of loving and caring families who believe

they are doing the best for their daughters.

In communities, where FGM/C is a cultural tradition or social convention, the social pressure to conform provides strong motivation to perpetuate the practice. FGM/C is often considered a necessary part of raising a girl properly, preparing her for marriage, and ensuring her status and identity in her adulthood. In fact, many families perceive that girls need to undergo FGM/C in order to be accepted and respected in practicing communities; they are otherwise ostracised and seen as unmarriageable.

FGM/C is often motivated by beliefs about what is considered proper sexual behaviour. It is perceived to help ensure premarital virginity and marital fidelity, as it is believed to reduce a woman's libido. FGM/C is also associated with cultural ideals of femininity and modesty, which include the notion that girls are 'clean' and 'beautiful' after removal of body parts that are considered 'male' or 'unclean'. Psychological grooming may be part of the FGM/C process. For example, positive expectations may be built up for the girl about to undergo FGM/C, such as through holding a social gathering and/or giving her special clothes and presents.

Though no religious/holy books prescribe the practice, practitioners often believe FGM/C has religious support or is a religious requirement. Religious leaders take varying positions with regard to FGM/C: some promote it, some consider it irrelevant to religion, and others contribute to its abandonment.

FGM/C is often carried out by traditional cutters/practitioners within the community, but statistics surveying 25 practicing countries report that 26 percent of all cases of FGM/C are performed by medical professionals, indicating a trend towards increased medicalisation.[7]

2c. FGM/C in the UK

In the UK, FGM/C is considered a form of child abuse and violence against women and girls.

Significant numbers of women and girls in the UK have undergone or are at risk of experiencing FGM/C.[8] Seminal research from 2011 estimated that 137,000 women and girls living in England and Wales were believed to have undergone or be at risk of experiencing FGM/C, as they were born in countries where it is practiced.[9]

No London local authority area is likely to be free from FGM/C. London has the highest prevalence of FGM/C of any UK city, with an estimated 2.1 percent of women affected by FGM/C.[8]

These figures were up-to-date at the time of going to editing (March 2019). We encourage professionals to update themselves regularly, as information changes over time. Updated information is always available on the UK Home Office website (see Appendix 4: Resources).

2d. Female sexual physiology

Before discussing types of FGM/C, it is important to acknowledge that - like most of the public - many therapists are generally not well informed about female genitals or women's sexuality. This lack of knowledge can bring difficulties to therapeutic work, as it sits within a culture of shaming of women's sexuality. Women's sexual organs are cut in FGM/C, and cut out visually and linguistically in many societies. For example, we teach children that boys have a penis and girls have a vagina, but often don't name the vulva, as if females do not have external genitals. Reclaiming knowledge and a language can help redress the shame for both therapists and clients.

That women have separate (but obviously linked) reproductive and sexual organs and processes is rarely discussed. Women's reproductive organs (the uterus, fallopian tubes, ovaries and vagina) are inside the body. Women go through their monthly fertility cycles regardless of whether they are sexually active or not, and equally women's sexual arousal processes work regardless of their state of fertility (during phases of the menstrual cycle, when breastfeeding or menopausal). The confusion between sexual and reproductive functioning in women has led to an erroneous focus on the vagina as the female sexual organ. 'Sex' is talked about as meaning vaginal penetration, with other sexualised behaviours being called 'just foreplay', which also marginalizes diverse sexualities. Discussing which types of sexual play are preferred by each woman can help them reclaim their sexual pleasure after FGM/C.

We have a cultural dislike of talking about women's external genitals - the vulva. Within the vulva is the clitoris, women's sexual organ, which includes smooth muscles and the same erectile tissue that is inside the penis.

The diagrams below show details of the true size and structure of the clitoris and the external and internal structure of the vulva, from Laffy (2013).[10]

Figure 1: The Internal Structure of the Clitoris

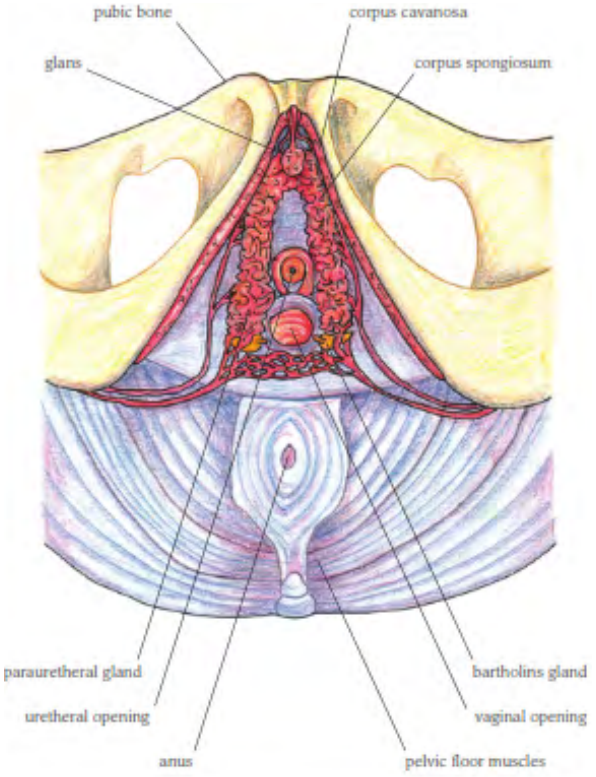

Figure 2: Outline of the Vulva showing the Internal Structure of the Clitoris within

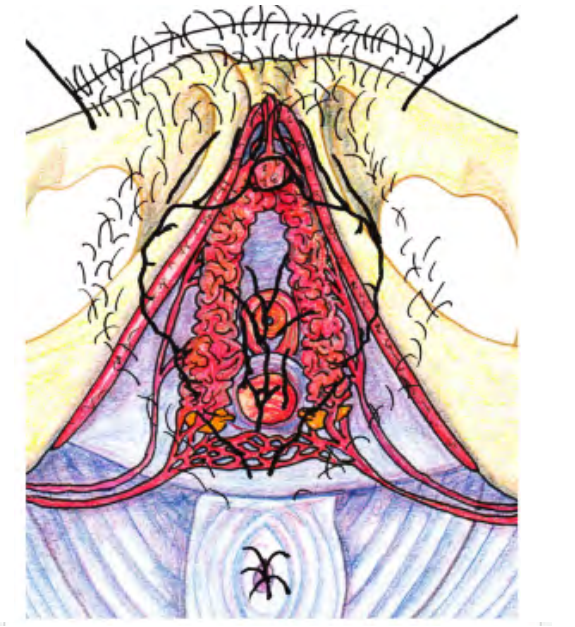

Figure 1 and 2 Copyright C.Laffy and T.Gaynn 2013

2e. Types of FGM/C

FGM/C is classified into four main types. There are many variations within each type, and each woman needs to be individually assessed by a qualified medical specialist in order identify the exact nature of the type of FGM/C she has undergone. Information and reference for visuals below were produced by Safe Hands for Mothers for public domain: 》 http://www.dofeve.org/types-of-fgm.html.[11]

Type 1:

Clitoridectomy: Partial or total removal of the clitoris, or, in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

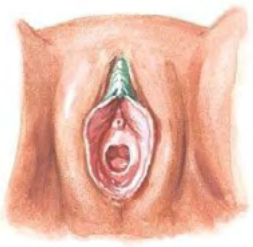

Figure 3: Type 1 FGM/C

Type 2

Excision: Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora (the labia are "the lips" that surround the vagina).

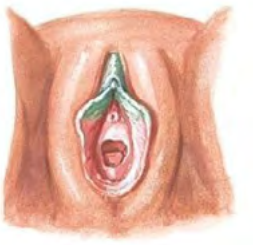

Figure 4: Type 2 FGM/C

Type 3

Infibulation: Narrowing of the vaginal opening through the construction of a covering seal. The seal is formed by cutting and repositioning the inner, or outer, labia, with or without removal of the clitoris. In this case women are typically left with a very small hole to urinate and menstruate; this could be the size of a match head.

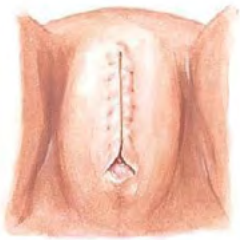

Figure 5: Type 3 FGM/C

Type 4

Other: All other harmful procedures to the female genitalia for non-medical purposes, e.g., pricking, piercing, incising, scraping, cauterizing and stretching the genital area, labiaplasty.

2f. Consequences of FGM/C

Many people from affected communities are unaware of the harmful physical and psychological consequences of FGM/C. These can be classified into short- and long-term consequences.[2]

Short-term consequences:

- Severe pain
- Emotional and psychological shock, particularly from being subjected to this trauma by people who are close to the girl, e.g. parents and extended family
- Infections
- Bleeding and/or haemorrhage
- Tetanus and blood-borne viruses like HIV
- Urinary retention
- Injury to adjacent tissues
- Fractures or dislocations as a result of being restrained
- Death

Long-term consequences:

All types of FGM/C can be extremely harmful to the physical and mental wellbeing of women and girls. Health problems caused by Type 3 can be more severe and/or long-lasting, and risk causing severe complications during childbirth, including to the infant. Any girl or woman who has undergone FGM/C could go on to develop traumatic stress symptoms. Some of the long-term consequences include:

Psychological:

- Post-traumatic stress symptoms, including flashbacks during pregnancy, childbirth, sex and gynaecological examinations
- Depression
- Chronic anxiety
- Nightmares
- Low self-esteem
- Self-disgust, shame, or humiliation
- Difficulties with relationships
- Control issues — angry or critical towards self and/or others
- Intimacy and trust issues
- Compulsions or addictions
- Despair and despondency
- Self-harm
- Suicidal feelings or plans
- Substance misuse

See also 'The impact of FGM/C on women's psychological wellbeing' on page 19.

Psychosexual:

- Pain during sex
- Lack of arousal or pleasurable sensations
- Low desire due to fear of pain
- Low libido
- Loss of intimacy due to sexual difficulties
- Trauma flashbacks in response to touch
- Pelvic pain disorder
- Negative perception of the body or other impacts due to deinfibulation

See also 'The impact of deinfibulation on a woman's sexual life and perception of her body' on page 18, including for explanation of deinfibulation.

Physical:

- Chronic vaginal and pelvic infections
- Difficulties with menstruation
- Urinary problems - pain when passing urine, urinary tract infections (UTIs), slow passing of urine, other urinary problems.
- Renal failure or impairment

- Damage to the reproductive system, including infertility
- Complications in pregnancy and in the latest stages of pregnancy
- Chronic pain; chronic body tension
- Disrupted sleep and eating patterns
- Greater vulnerability to somatic illnesses, including sexual and gynaecological issues, compounded by stress
- Cysts, abscesses
- Complications during delivery including tears and fistulae
- Death of mother and child during childbirth

Referring for additional services

Medical, psychosexual and psychological services exist in the UK which can help women and girls address the range of impacts of FGM/C. These services may or may not be FGM/C-specific. Therapists are encouraged to locate and refer clients to these services, and to find out the particular pathway/process of referral to a given service, to support the client in knowing what to expect (see Appendix 4: Resources).

The impact of deinfibulation on a woman's sexual life and perception of her body

As noted above, FGM/C can involve infibulation (sewing together vulval tissue, often covering the urinary and vaginal openings). Deinfibulation, more commonly called 'reversal', is a minor surgical procedure to re-open the vulval tissue. Reversal may be carried out to help a woman safely deliver her baby; to make sex more possible, comfortable and enjoyable; and in response to medical complications/health problems, including to allow urine and menstrual (period) blood to flow more easily and reduce pain. The therapist should not lose sight of the woman's personal reasons for choosing to be deinfibulated.

Some women will not have the reversal done (through choice or lack of information or access). Some women will be forcibly opened during sex on their wedding night or over the course of days or months of sexual activity (J.Albert, personal communication, July 19, 2018).

Deinfibulation is typically performed by midwives or surgeons. Usually done with local anaesthesia, the scar tissue is opened vertically so that the urinal and vaginal openings are no longer covered. Then the edges are over-sewn (outward) so that the skin cannot fuse back together, and to reduce the risk of infection and bleeding. In the UK, a growing number of obstetric/maternity and gynaecology services have a medical practitioner trained in deinfibulation.

In some cultures (e.g. historically in Sudan), women may be re-infibulated, that is infibulated (stitched/sewn up) again after giving birth. This re-opening, re-closing cycle can continue for as long as the woman bears children. This can place further strain or trauma on their genital tissue.

Research on this subject indicates that the cultural meaning and social acceptability of deinfibulation affects a woman's lived experience after deinfibulation in the UK. Single women who undergo deinfibulation before marriage may face difficulties in terms of social acceptability within their community. Women who had discussed deinfibulation with their husbands in advance, and who reported that the partners had agreed to the procedure, reported fewer problems afterwards.[12]

Some women may feel that deinfibulation is a necessity for childbirth rather than a choice. Their experiences of FGM/C may influence their decisions to undergo deinfibulation or caesarean section. Many women choose to delay deinfibulation until labour to avoid undergoing multiple operations if an episiotomy is anticipated. Many report negative feelings about the appearance of genitalia post-deinfibulation (as the genitals now look different to how they have looked throughout most of the woman's life), and also negative thoughts on reinfibulation.[13]

Whatever lies behind the client's decision to undergo deinfibulation, the therapist can support her by talking about it with her both before and after: beforehand, by helping her identify what kind of support she needs, e.g., who could she take with her for support during the operation to hold her hand, help her to breath and keep calm. In some specialist services, the client may be able to ask the therapist to provide this support, which can be especially beneficial if the client disassociates or has no one else to be with her in order to make this process emotionally and psychologically safe. After the deinfibulation,

the therapist should not assume that this problem, with long lasting consequences, has been resolved. Based on our experience, we recognise that after deinfibulation women need to (re-)adapt to the new sensations of their body. For example, she may need to come to terms with the shock of hearing the noise of the fast flow of urine, or how her vulval tissue now feels and looks different. Some women have reported being scared that their organs may fall out, and may need education that this is not the case.

The impact of FGM/C on women's psychological wellbeing

One study of 55 survivors of FGM/C living in the UK[14] found that the majority of women interviewed had experienced years of distressing, intrusive memories and/or emotions related to their FGM/C experiences, and that this was still occurring for between one-quarter and one-half of the women. Fewer than 10 percent had PTSD (related to FGM/C) at the time of the study, but over 25 percent had had it at some point in their lives (compared to a general lifetime prevalence of approximately eight percent). Of note is that all who had PTSD had experienced Type 3 FGM/C. Lockhat proposes that primary mediating factors influencing whether women who have undergone FGM/C go on to develop traumatic stress include viewing the event as negative, the absence of the use of anaesthesia, and an absence of community support (about the event/its impacts) either in the original community or due to moving away.

The psychological impacts of FGM are as varied as the women (children) who have experienced it.[15,16] Not all women who have undergone FGM/C will perceive it to be a source of psychological or physical harm/trauma. Some women may report no problems as a result of having undergone FGM/C. However, the therapist should be aware that the process of therapy could cause a client to change the way she perceives her experience of FGM/C, e.g., she may realise that certain physical problems she has experienced were actually the result of FGM/C, or she may develop anger at realising her rights were violated by those who were meant to protect her from harm.

3. Risk & Safeguarding Considerations

This section covers legal, risk and safeguarding aspects related to FGM/C. First is information about related UK laws, including a brief overview of mandatory reporting and FGM protection orders (PO). The following section addresses risk factors, including how a victim has the potential to become a perpetrator and the clinician's roles in assessing and addressing this. Safeguarding steps make up the final section, covering risk assessing and protecting from harm; mandatory reporting in detail; the NHS' mandatory recording; and a summary of safeguarding steps.

FGM/C is a form of child abuse and sexual assault, in that it is an act of harm to the genitals with the function of controlling the girl's (future) sexuality. Clinicians must therefore apply the usual criteria for identifying safeguarding or risk issues, and use their clinical criteria to decide if safeguarding procedures or risk management procedures need to be enacted.

We encourage all clinicians to be well informed about the ethical framework and good practice guidelines of the organisations they work for and the registered bodies of which they are members (e.g., BACP, UKCP, BPS, etc.) in order to ensure the duty of care is applied.

3a. Legal Framework Regarding FGM/C

Information in this section is the most up to date available as of March 2019, as obtained from HM Government, Scottish Government and National FGM Centre websites.

FGM/C is child abuse, and it is illegal in the UK. For legal purposes in England, Wales, Northern Ireland, and Scotland, FGM/C is the mutilation of the labia majora, labia minora, or clitoris. UK legislation[17,18] says that it is an offence for any person, regardless of nationality or residence status, to:

- Perform FGM
- Assist a girl to carry out FGM on herself (England or Wales)
- Assist a non–UK person to carry out FGM outside the UK on a UK national or permanent UK resident

It is also an offence to:

- 'Perform FGM abroad [...]
- Assist a girl to perform FGM on herself outside the UK [...]
- Assist (from outside the UK) a non-UK person to carry out FGM outside the UK on a UK national or a permanent UK resident'[17(p16)]

Northern Ireland follows the same two statutes: Female Genital Mutilation Act 2003 and Serious Crime Act 2015. In Scotland the law is generally the same, although it does not specify actions related to the last two points above.[18,19]

Any person found guilty of an offence under the Female Genital Mutilation Act 2003 or the Prohibition of Female Genital Mutilation (Scotland) Act 2005 is liable to a maximum penalty of 14 years imprisonment; they may also or instead be fined.

FGM Protection Orders:

Individuals or local authorities (e.g., social services) can apply to court for a protection order (PO) to try to prevent FGM/C, e.g. by preventing a girl being taken out of the UK, or a relative who presents a risk coming in; or to support a victim who is trying to return to the UK. These can be applied for here: » www.gov.uk/female-genital-mutilation-protection-order.

These POs can be flexible and can be similar to POs used in domestic violence situations.

Mandatory Reporting:

Mandatory reporting of Female Genital Mutilation (FGM) Duty was introduced via the Serious Crime Act 2015 and came into effect on 31 October 2015. It outlines the duties of certain professionals when FGM/C is self-disclosed by, or medically identified on, minors. The Home Office has published guidance with procedural information on the mandatory reporting of FGM/C, and consequences of not reporting.

It currently applies only in England and Wales. Northern Ireland and Scotland have no mandatory reporting laws nor FGM POs.

Professionals who must comply with mandatory reporting include all regulated teachers, health care staff and social workers in England and Wales only. Counsellors and psychotherapists are not included. However, all clinicians are responsible for implementing safeguarding and risk policy actions when potential/actual harm to a child is identified.[17,18,19] Mandatory reporting is covered in further detail in section 3c.ii.

For a detailed list of relevant professionals, please see Appendix 4: Resources.

3b. When is there risk of FGM/C?

Supporting FGM/C victims to be non-perpetrating survivors: A theoretical overview

Figure 6: Potential states of an individual affected by FGM/C

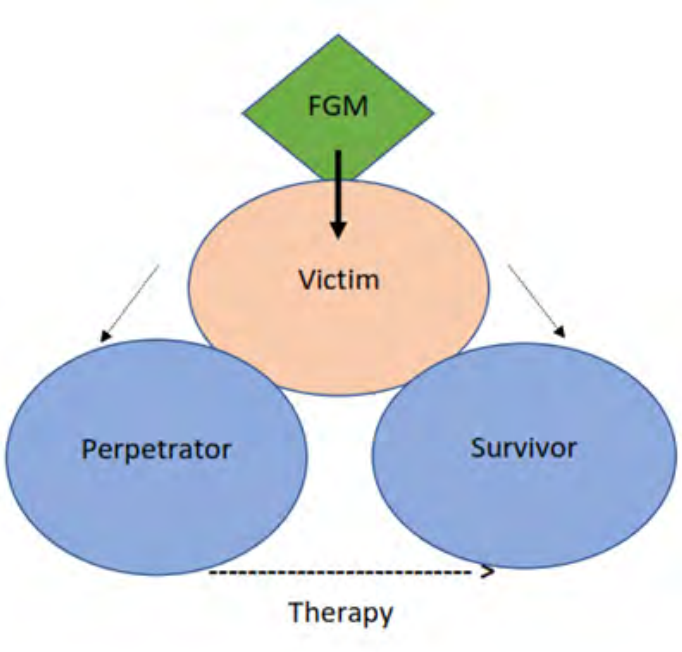

Figure 6 Copyright Leyla Hussein, 2017, unpublished

A child undergoes FGM/C, becoming a victim. In the victim state, the individual suppresses her feelings toward her perpetrators and/or family, and may not be aware that she is a victim of child abuse.

As an adult, the individual may be a (potential) perpetrator and intend to have her daughter(s) cut, whether as a result of believing the tradition must be continued and/or due to a lack of recognition of the harm done. She may also be a survivor who has recognised the harm caused by FGM/C and the risk of harm to her daughter, and who has therefore decided not to have her daughter cut. (NB: it could be a daughter or another female relative/community member).

A task of assessment and therapy is to determine which state the client is in. It may be a further task of therapy to help potential perpetrators to move to the survivor state.

Common risk factors

According to the National Society for the Prevention of Cruelty to Children (NSPCC)[20] and several Home Office guidelines[17,21,22] there are specific factors that may highlight the possibility that a girl or woman in the UK is at risk of FGM/C:

- A girl comes from a community that practices FGM/C
- Females relatives have been subjected to FGM/C
- A client discloses that she wants her daughter to undergo FGM/C
- A client discloses she is, or was, under pressure from her family for her daughter to undergo FGM/C
- A girl/family/community has limited/is lacking integration into mainstream British society or their wider community
- The family indicate that there are strong levels of influence held by elders and/or elders are involved in bringing up female children
- A woman/family believes FGM/C is integral to cultural or religious identity
- Parents have limited access to information about FGM/C and do not know about the harmful effects of FGM/C or UK law
- A girl/woman/family has little/no knowledge of their rights
- Parents state that they or a relative will take the girl out of the country for a prolonged period

FGM/C may be carried out when a girl is an infant, during childhood or adolescence, at marriage, or during the first pregnancy. The majority of cases, however, are thought to take place between the ages of five and eight years old; therefore girls in that age bracket are considered at higher risk.

3c. Safeguarding steps

3c.i. Assess risk and take steps necessary to protect minors

All clinicians must follow 'safeguarding children' policies and procedures when they believe a child might be at risk of undergoing FGM/C, or when they suspect that FGM/C may have been performed on a child. In these scenarios, the usual safeguarding procedures and existing pathways would apply, e.g., raising concerns with local child protection social services and with the safeguarding lead of the clinician's service.

The clinician will remind the client that the clinician has a duty of care towards the client's children/female relatives (which the clinician will have explained at the beginning of the therapy). The clinician will explain to their client that in the UK, FGM/C is considered child abuse and is illegal, and that if, during the course of therapy, it becomes apparent that a child is at risk of FGM, the clinician therefore has a duty to report this.

This may result in challenging situations to manage in the therapeutic relationship, and clinicians are encouraged to treat this situation as they would when working with clients at risk of self-harm, domestic violence or any other safeguarding concern. For instance:

- The clinician will endeavour to gain a clear idea of any risk and protective factors of their client's family circumstances.
- The risk reported may be historical and the abuse (cutting) already done. Although in these cases there may be no further/immediate risk to that particular individual, other female relatives may be at risk. In addition, the individual who has been cut may be experiencing physical and/or psychological consequences which need assessment and treatment.
- The clinician will give as much information as possible to the client in order to help her to understand the legal, physical and psychological implications of FGM/C.
- Overall, the duty of care for safeguarding children, and mandatory reporting (where applicable) will prevail, and the clinician should promptly seek supervision in order to manage the risk and the relational aspect of the therapy with the client.

3c.ii. Understand Mandatory Reporting

Clinicians are not, as a profession, 'mandatory reporters' of FGM/C, that is, they are not legally required to report to the police if FGM/C has occurred. Nonetheless, it is important that all clinicians understand the mandatory reporting process, as safeguarding steps they take may lead responsible others (e.g., social services or medical staff) to mandatory reporting, and/or a client may otherwise be undergoing this process while they are in therapy. The clinician can play a further helpful role by informing the client that mandatory reporting may occur, and what the processes are likely to be, why it is occurring (e.g., the child may experience physical/psychological negative effects from FGM/C); and supporting the client in subsequent sessions as these processes unfold.

According to the British Association for Counselling and Psychotherapy (BACP), 'counsellors and psychotherapists are not statutorily regulated healthcare professionals and therefore are not bound by these mandatory reporting duties. However [...] there is an expectation by the Home Office that statutorily unregulated professionals will follow the established safeguarding policies and procedures within their area.'[23(p5)]

Mandatory reporting - When there is disclosure by or identification of cutting on a minor

As noted, some professionals also have a legal duty of mandatory reporting, limited to *known* FGM/C cases only. 'Known' means cases involving young women under 18 years old:

- Who themselves disclose that they have undergone FGM/C, or
- Where a medical professional has identified FGM/C in the course of a physical examination of that individual.

Disclosure from an adult about a child
If an adult makes a disclosure to the clinician about a minor having been cut, it does not fall under the mandatory reporting remit. Nonetheless, existing safeguarding and risk policy plans must be enacted, including discussing the disclosure with the relevant Safeguarding Lead and referring it to local social services. Although that particular child may not be at risk of further abuse, she may need medical and/or psychological care, and this may be the only way for her to get this help; additionally, other female relatives may be protected from harm through the assessment and intervention that follows a report to Social Services.

What To Do If You Are A Mandatory Reporter:
Report the situation to police by ringing 101 (a non-emergency number)

- 101 call handlers should report the case to the police's CAIT division (Child Abuse Investigation Team). Consider prompting the call handler to do so; ask the call handler for the crime reference number.
- Best practice is to report within 48 hours, but you have up to a month (to ensure reporting does not escalate a child's risk).
- Even if you have referred to Child Protection Social Services, you must report it to the police; this duty must be carried out by you, if you are the person who first received the information (e.g., if a girl disclosed FGM/C to you)

Once you have reported the case to the police, the duty to comply with mandatory reporting has been met. However, you should also refer to Child Protection Social Services.

The Department of Health and NHS England have published a useful flow chart, here: ⟫ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/525405/FGM_mandatory_reporting_map_A.pdf (see also Appendix 4: Resources).

3c.iii. Mandatory Recording (FGM Prevalence Dataset) — for those working in NHS England (as of March 2019)

Acute NHS trusts, NHS General Practitioners and NHS mental health trusts are now expected to submit demographic data on adult and child clients with FGM/C. Trusts should be working to establish how they will gather and report this data; this can be discussed with Safeguarding Leads and other designated staff. See: ⟫ http//digital.nhs.uk/fgm.

Summary of Safeguarding:

- Have an in-depth discussion with the client to assess further risk
- Consult with any Safeguarding Lead if there are concerns about risk to a child (or vulnerable adult)
- Consult with Child Protection Social Services if there are concerns about risk to a child/children
- Consider/Make a referral to Child Protection Social Services when
  - A woman has a personal or family history of FGM/C
  - A girl under 18 discloses a concern that she will be cut
  - Anyone expresses concern that a girl will be cut
  - Anyone discloses plans for a girl to be cut
  - A girl under 18 discloses that she has been cut*
  - In the course of a medical examination signs of cutting are identified*

*In these two cases, if you are a mandatory reporter, you MUST ring the police on 101 and report the situation.

4. Contextual Considerations For Therapy

The following broad recommendations are drawn from a review of the available literature and research, and from the authors' professional experiences. They apply across all stages and types of therapeutic interventions with clients affected by FGM/C. The recommendations address informed consent enhancing safe spaces, client and therapist cultural contexts, ensuring an individualised approach, addressing sexuality, and awareness of key life events.

Use informed consent to help create a safe space

No therapy is free from the risk of distress. This potential risk should be explicitly discussed with the client during the assessment or treatment-planning phase, giving the client the opportunity to be fully informed when they consent to or decline a course of therapy and agree on the therapy goals. Therapists must be aware that a client's distress or symptoms may temporarily increase, particularly when working with any potentially traumatic material. The client may more frequently recall events she had avoided remembering or thinking about. If therapy includes new explorations of relationships or providing the client with information about FGM/C that is new to her, this may have a negative impact on her views of her mother/relatives, or on how she views herself (e.g., damaged, not 'whole', etc.).[24]

During therapy, therapists must be on the alert for life events that may lead to a triggering or intensifying of symptoms/distress, such as marriage, childbirth, or visits to the client's country of origin.[24]

Incorporate the client's cultural context

Ignoring the client's cultural context risks alienation of the client from the therapist. A failure by the therapist to acknowledge and work within the client's cultural framework in the therapy setting can lead the client to feeling isolated and misunderstood, causing further separation.[24,25] She may feel isolated from both her culture of origin, in which the FGM/C happened (i.e., no longer respected as she is talking about this experience), as well as from her current culture, especially if this is the first time she becomes aware that the majority of women within the dominant culture have not undergone FGM/C. Therapists should adapt the therapy work to the client's community background: the approach may be different depending on whether the client is Somali, Senegalese or Ethiopian (P. Mulongo, personal communication, January 18, 2016).

Therapists must remember to take into account sociocultural factors from both the client's culture of origin, and her place in the culture in which she currently resides.[26] Therapists should be aware of their own potential cultural biases and the client's when talking about FGM/C and related aspects including sex, sexuality and naming genital parts. Therefore, it is recommended to practice or incorporate principles from culturally sensitive counselling.[25] If the client is new to the country/culture, therapy can be helpful if it incorporates ways for her to cope with daily life and promote social integration. This can be especially important if she is seeking asylum/refugee status.[24]

Lockhat[14] provides a wide range of guidance for approaching FGM/C on an individual, family, community and political/policy level, including a useful outline of the psychological/physical FGM/C-related difficulties clients may be facing. Included below is a condensed summary of Lockhat's guidance for working therapeutically with females across all age ranges (pages 146-176), much of which incorporates general cultural considerations. Therapists need to be prepared to enact this guidance whatever their role or the stage of the engagement with the client:

- Use diagrams or visual rating scales as a means to facilitate clients' communication; and drawings to help discuss/explain relevant physical issues.
- Inform them of treatment options that are available to meet their medical and psychological needs.

- Respectfully enquire about traditional healing practices, including any potential secondary effects.
- Remember to be highly aware that non-verbal cues and verbal communication can vary greatly depending on a person's family, culture, roles, etc., and be mindful of Eurocentric assumptions about meanings of communication or lack of communicating.
- Explore cultural differences, and even taboos, that exist around talking about feelings/problems and seeking help.
- Decisions may be made by the husband/male head-of-household or by an older female relative, thus requiring family engagement and/or extra time.
- Sensitivity may be needed regarding whether the client is in favour of or against the practice.
- If the client does not want to talk, but is clearly struggling psychologically, consider referring to other sources of support, which requires the therapist to be familiar with relevant services, e.g., African women's or other groups.

Ensure a holistic, individualised approach

While bearing in mind the above guidance related to cultural context, a genuinely holistic approach will focus on the client in the room, and therapists should endeavour to find out what works for each individual woman. One larger study[27] reported that the women interviewed found a variety of things helpful for coping with the impact of FGM/C, including exercise, watching television, music, religious activities and attending religious services, and prayer; this highlights how each individual has her own ways of building resilience. Acculturation can be explicitly incorporated into the therapy if and as needed; however, work should not focus solely on these issues. Therapists should attend to the needs of the particular client, which will be as varied as they are with any other therapy client (P. Mulongo, personal communication, January 18, 2016).

Each client will have experienced this trauma and its consequences in her own personal, unique way. Similarly, FGM/C may be only one of many traumas that the client has experienced, so do not focus on it exclusively. Taking the above into account, it is vital that the therapist explores the client's experiences with her, in order to gain a shared understanding. The wide range of relevant factors and context may include the extent of suffering and of post-traumatic stress; complications that developed during/due to FGM/C; and the 'social-cultural context of her belief system, marital relationship, and support networks [or lack thereof].'[11(p14),24]

Address sexuality issues

Another key area to explore with the client is her relationship to her genitals and sexuality. This is strongly influenced by her own cultural attitudes, as well as those of the people around her.[10] This work, for many clients, is largely about her vulva, sex and sexuality. The therapist needs to be willing to engage in these conversations with clients, to address the subject in supervision, and to be aware that it may well challenge the therapist's own attitudes and beliefs. Please see Section 2d: Female Sexual Physiology, Section 8c: Integrative Psychosexual Therapy and Section 9: Supervision for further guidance.

Key Life Events

FGM/C-related complications may arise at key life events, namely menstruation, becoming sexually active (in many cultures assumed to be at the time of marriage), and childbirth. These events may trigger explicit or implicit traumatic memories of being cut, physical pain, or physical harm to mother and/or baby during childbirth. Implicit traumatic memories refer to sensations or presentations that may be unprocessed, and not integrated into the explicit narrative and felt experience of the client.

For example, being physically examined and assuming the positions required for antenatal exams and birthing can trigger explicit traumatic memories from FGM/C (as per the authors' experiences, and reports in obstetric/midwifery journals). If a woman is sutured/stitched after birth, this may be the first time she experiences flashbacks. Prolonged/difficult labour can lead to PTSD in general.[28] Women who have undergone FGM/C are potentially at higher risk of this, particularly if their medical professionals are not familiar with managing labour in this group of women.

Lockhat[14] makes recommendations specific to working with pregnant women:

- Acknowledge an awareness of the client's FGM/C, in a calm and confidence-inspiring manner.
- Women who are to have deinfibulation or other reparative interventions (e.g., clitoral reconstruction) should be provided pre- and post-operative psychosexual therapy.
- Educate regarding relaxation techniques and available anaesthesia.
- Liaise with relevant professionals as needed.
- Antenatal maternity clinics exist that address both medical and psychological needs.

5. Theoretical Perspectives On Working Therapeutically With Survivors Of FGM/C

This section discusses theoretical perspectives relevant to therapists working with clients affected by FGM/C, due to the nature of the psychological consequences that FGM/C may have. This starts with a definition of trauma, as this is going to be a central issue for many in this client group. Trauma can be experienced in varying ways and degrees. Where a formal diagnosis of PTSD has been established, evidence-based trauma-focused therapies should be offered (see below for details). Following this are discussions on attachment theory; the impact of trauma on the brain; and Judith Herman's three-stage framework for the treatment and healing of trauma. Based on these, support to women survivors of FGM/C is looked at as a process of growth that focuses on the client's needs and personally meaningful aims/goals for therapy.

Defining Trauma

The working description of trauma for these guidelines is as follows: 'Psychological trauma is the unique individual experience of an event or enduring conditions, in which:

- The individual's ability to integrate his/her emotional experience is overwhelmed, or
- The individual experiences (subjectively) a threat to life, bodily integrity, or sanity'[29(p60)]

Thus, a traumatic event or situation creates psychological trauma when it overwhelms the individual's ability to cope, and leaves that person fearing death, annihilation, mutilation, or psychosis. The individual may feel emotionally, cognitively, and physically overwhelmed. The circumstances of the event commonly include abuse of power, betrayal of trust, entrapment, helplessness, pain, confusion, and/or loss.[30]

5a. Attachment-informed therapy

Within these guidelines, we propose that in order to understand the quality and dynamics of the therapeutic relationship, and the psychological developmental pathway of the client after sexual assault, therapists will benefit from understanding the applications of attachment theory to clinical work. We call this attachment-informed therapy. The clinical application of attachment theory is based on the similarities between childhood development and change, and the changes that occur during psychotherapy.[31]

Attachment is the bond that connects one person to another across time and space during their lifetime.[32] Attachment theory is concerned with the regulatory functions and consequences of maintaining proximity to significant others.[33] This theory was developed by the British psychiatrist John Bowlby, based on extensive observation of the behaviours displayed by young children separated from their main caregiver. These observations were conducted initially with children who were either hospitalised or separated from their families for diverse reasons.[34]

Bowlby argued that humans consistently display behaviours to seek and maintain proximity to supportive others (attachment figures) when they identify an increase in risk in their environment. This is known as 'attachment behaviour', which is designed to protect an individual from physical and psychological threats, and to alleviate distress.[35] The individual 'attachment style' is developed over time, based on the many responses the child receives from the caregiver when seeking proximity. The attachment style represents the way the person perceives and relates to themselves, others, and the world, and is different from one attachment figure to another. These interactions support the development of self-regulatory abilities at an emotional level, and also support the development of Internal Working Models, which contain ideas, beliefs and emotions that determine the way an individual behaves in the

world, relates to others, and how they think and feel about self.

Mary Ainsworth was John Bowlby's colleague and collaborator. She developed the 'Strange Situation', which is a research tool to observe the attachment pattern of children to their main caregiver in laboratory conditions. She is also responsible for creating the notion of a secure base.[35] She contributed to defining the attachment styles as we know them: secure, insecure (ambivalent and avoidant). Later on and through the development of another test, the Adult Attachment Interviews (AAI), Mary Main and her collaborators described the disorganised attachment style. These diverse attachment styles are organised strategies used to regulate felt emotions in order to achieve a sense of 'felt security'.

Bowlby[35] explained that the successful accomplishment of the affect regulation results in a sense of attachment security - a sense that the word is a safe place, and that others are trustworthy, accompanied by positive ideas of self and own strengths and capabilities. Therefore the quality of the attachment to the main caregiver is critical to emotional and psychological development, shaping the resources that the individual develops in order to deal with emotional and psychological stress in their lifetime.

The caregiver that is sensitive, responsive, and consistent provides a sense of safety and security that will allow the child (and later, the adult) to venture in exploration, knowing that she has someone who will acknowledge and understand her emotions; will be responsive when she is scared, anxious, or upset; and will be consistently available over time. In other words, humans are social, and we not only need others, but also create strong emotional bonds with significant others from the moment we are born.[34]

The setting of a therapeutic relationship aims to provide a *secure base* that facilitates a sense of security and safety to the client, which eventually allows them to talk openly about topics that are meaningful and relevant to them. This contributes to the processing and integration of their experiences, emotions and beliefs, as well as the review, reshape and eventual change of Internal Working Models that are no longer relevant and useful for the person in the present.

During this exploration, the attachment-informed therapist will strive to be reliable, attentive, empathic and sympathetically responsive, and will also encourage the patient to explore the world of her thoughts, feelings, and actions, not only in the present, but also in the past.[35] The therapist will also facilitate the client's reflection on and exploration of their attachment style, and the impact that FGM/C and any other traumatic experiences, including loss, have had in the client's life.

The therapist who adopts attachment theory as a basis of their practice will view the misrepresentations or misunderstandings expressed by the client not as unreasonable, but as the result of what she has internalised during childhood. They will validate the feelings emerging from the client's experiences, and will also recognise stories of abuse as real events, not as the irrational offspring of autonomous and unconscious fantasy.[35]

In cases of child abuse in which the caregiver is the abuser, or is complicit in it, the child is left with an unresolved paradoxical dilemma: the child is bound to seek the main caregiver's proximity when in distress, but if the main caregiver is the source of distress or is perceived as colluding with the abuser, this creates a conflict for the child which is difficult to comprehend and resolve. This situation leaves girls with overwhelming uncontained feelings that are negated and not recognised.

The high emotional activation that is not contained or processed in a way that allows her to eventually learn how to self-regulate and contain her emotions, may lead to the development of different levels or manifestations of self-soothing that are detrimental in the long term such as dissociation, as a way of 'hanging into a semblance of psychological integrity in the face of overwhelming attachment anxiety'.[36(p33)]

In the case of FGM/C survivors, the lived experience of horror is surrounded by a confusing sense of cultural importance and celebration.

The paradox of trauma experience in the core of the family may also lead to the development of a series of coping mechanisms or attachment strategies related to the avoidance or suppression of emotions. The denial of emotional pain resulting from FGM/C can shape the way clients see themselves, how they view the world, and how they relate to others later in adulthood, all of which are aggravated by any long-lasting physical consequences of FGM/C and development of complex mental health difficulties

such as Complex PTSD.

The attachment-informed therapist will be able to identify and understand aspects of transference and countertransference present during each therapeutic session, and how these represent the way a client expects to be treated by the therapist as an attachment figure. As Holmes explains, 'the attachment viewpoint suggests that the therapeutic relationship is shaped both by the dynamics of its actuality and the distorting effects of transference'.[36(p34)] As the therapy proceeds, the soothing presence of the therapist enables the client to expose herself to, tolerate, and learn from increasing levels of anxiety.

The attachment theory has an extensive body of research that can assist therapists in understanding the client's psychological development, the dynamics present in the therapeutic relationship and the essential considerations to provide a therapy that embraces human connection, all of which, in the authors' experience, will be useful in working with survivors of childhood trauma, including FGM/C.

5b. Trauma and the Brain

This section discusses brain processing during and after traumatic experiences, and how this is relevant to persisting trauma. FGM/C, as a form of childhood sexual assault, is experienced by many women as traumatic, and can go on to affect psychological development throughout life. Therapy needs to identify and evaluate the coping mechanisms the client has developed to learn to live with the impact of her abuse. She may also have experienced other forms of trauma and violence, and have a complex presentation.

Please see Appendix 2 for guidance on explaining trauma/PTSD and its symptoms, including dissociation, to clients.

It is important to recognise that FGM/C is genital trauma that happens to a child who cannot consent to the act, and who has a limited set of internal resources for responding to the experience. Therefore, this is a form of historic trauma when presented in therapy by an adult woman.

Humans have a natural capacity to recover from trauma by going through a series of reactions, usually starting with shock. This can take many forms, including dissociation or denial. There will probably be phases of grief, sadness, and anger. This natural recovery process is about coming to terms with powerlessness, and the ensuing feelings that this brings: usually more grief and anger. Eventually, the individual is usually able to find some way of accepting or living with what has happened. This process may be interrupted in complex trauma like FGM/C or incest, where the abuse happens within the family, which can lead to a much higher incidence of post-traumatic stress.

Contemporary neuropsychological theories of trauma (e.g., Brewin, 200137) suggest that memory processing in the brain occurs primarily in the hippocampus and the amygdala, which are part of the limbic system, shown in red in Figure 7 below. These two parts of the brain work in different ways, but in concert with one another, giving us adequately complete memories. The hippocampus takes in the details of an event quite methodically, including marking memories for time and place, setting them in the context in which they occurred, and, like a librarian, files them in roughly the right order. This is important because it lets us know that something happened in the past and is over now. Hippocampal memories are also typically retrieved by us voluntarily, and are updated over time (e.g., with new information or as our perspective changes) (K.Young, personal communication, January 19, 2017).

The Brain

Figure 7: The Limbic System

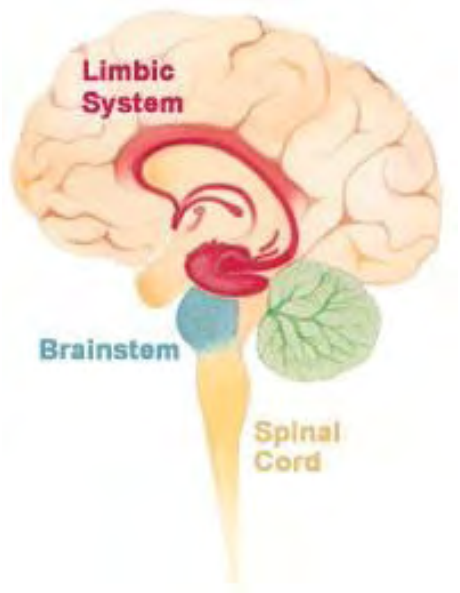

Figure 7 Copyright Laura Dahl. Accessed 29th July 2018 from https://www.flickr.com/photos/lauradahl/3054998586/. Licensed under Creative Commons CC BY-NC 2.0 (https://creativecommons.org/licenses/by-nc/2.0/).

The amygdala is the brain's rough-and-ready alarm system: always on the lookout for potential danger, and raising the alarm when a perceived threat is found by switching on our 'fight or flight (or freeze)' response. Unlike the hippocampus, memory elements stored in the amygdala are triggered involuntarily, are not typically set in a context, and do not usually update over time. The sensitive amygdala reacts quickly, and is not good at telling the difference between a perceived threat and a real threat, such as something that happened in the past versus something happening now. Therefore, it sometimes sets off a false alarm.

When our threat system is active, such as during a traumatic event, the hippocampus does not operate at its best. It is unable to tag memories with all the usual details, like time and place, so there is incomplete information stored about the event. Trauma memories tend to have more images and sensory information than our usual memories. Thus, the memory of the event, and in turn the 'danger alarm', is easily triggered because there are so many external reminders (e.g., things we see, hear, or otherwise sense) and internal reminders (e.g., a feeling in the body, an emotion, a memory). Therefore, remembering the traumatic event can trigger the same physiological activation and emotions as at the moment of the traumatic event. This makes it feel as if the event in that memory is happening again (called flashbacks or reliving), which is very frightening and confusing. Schauer and Elbert[38] suggest a person may go through up to six phases during the traumatic event: freeze, flight, fight, fright, flag, faint. Experiencing such feelings is a common part of traumatic stress and PTSD (see the International Classification of Diseases — ICD-10 — or Diagnostic and Statistical Manual V for full details on the diagnostic criteria for PTSD).

5c. The Three-Stage Approach

Developed by Judith Herman[39], this is both a theoretical underpinning and (as detailed in Section 7c) a practical approach for carrying out therapy with survivors of trauma. The stages are:

- Stabilisation
- Trauma and mourning
- Reconnection

The framework aims to give simplicity, order, and a sense of direction to the therapist. The stages are not intended to be treated as a linear process, but one that flows according to the client's needs, i.e., it is possible that all three stages may be worked on in one therapy session.

Stabilisation:

The work of this stage is to create a secure space in which clients can begin to talk about their life stories, and to support them with the management of their emotions. Stabilisation can include support for practical matters (e.g., housing, access to disability-related needs, etc.); it can also mean stabilising internally, via regulation work on emotions, interpersonal relationships, attention (e.g. dissociation), beliefs, and somatic distress/disorganisation.

Trauma processing and mourning:

The focus of this stage is to support the client in the processing of her trauma memories related to the FGM/C event, or other traumas experienced. This second phase involves the 'review and appraisal of traumatic memories'[39(p9)], such as via the therapeutic approaches discussed further below.

Reconnection:

The aim of this stage is to support clients to reconnect not only with others, but with themselves (in body, mind, and spirit) in a meaningful way. The client is supported in the discovery of their current sense of identity, and integration into their wider community, in pursuit of a better quality of life.

Herman's approach is widely recommended for treating complex trauma, including by such bodies as the National Institute for Health and Care Excellence (NICE) and the International Society for Traumatic Stress Studies (ISTSS). Complex trauma, as defined by the ISTSS, typically develops from repeated, prolonged or multiple traumatic experiences (especially from which there is no escape) such as 'childhood sexual assault, domestic violence or political violence' (torture, genocide, etc.).[40(p3)]

6. Therapeutic Skill Set For Therapists Working With Women Who Have Experienced FGM/C

Important foundational skills for the therapeutic work are outlined, including professional training, respect and empowerment, communicating confidently about FGM/C, being informed and educating clients, and working with interpreters. Additional skills are noted which are significant but beyond the scope of these guidelines to address in detail.

Ensure professional therapeutic training

Providers should start with the basic foundations of any good therapy. This means having proper professional qualifications and therapeutic skills, as required for any kind of psychological therapy (P. Mulongo, personal communication, January 18, 2016). If trauma-focussed work is being undertaken, therapists should ensure adequate and suitable training and supervision in how to work effectively with trauma.

Respect and empower

Therapists should be sensitive and compassionate,[25,26] and validate and respect the experiences the client has undergone.[26,25,41] The client should have every opportunity to define and empower herself, which can help her self-esteem to grow as well.[25]

Ask and talk confidently about FGM/C

In all studies where clients with FGM/C were asked what they wanted from professionals (including from other fields, e.g., midwifery), women have responded that they want to be asked about FGM/C, and to be given the opportunity to talk about their experiences and views.[26,27,41,24] Therapists should ask and talk confidently about FGM/C and clients' experiences of undergoing the procedure, while remaining respectful, sensitive, and non-judgmental.

Be educated about FGM/C

To help the client develop confidence in the therapist's understanding and empathy, therapists are urged to educate themselves fully about FGM/C before having these conversations with the client.[26] This means learning about the background, context and reasons for practicing FGM/C, along with the range of traditions of how FGM/C is performed; views across communities and families; and impacts on a woman's life, including (or at least) in that particular client's culture and community.[25,26,24] It means developing an understanding of the psychological, physical, sexual, and relationship impacts of the practice. Work to understand that it is practiced because parents love their daughters, and believe it is in the girl's best interests (e.g., makes her more marriageable).[1,42] Families may be following tradition without considering the justification, or to prevent negative social consequences. Nevertheless, FGM/C is a form of child abuse which is performed to control female sexuality, whether or not this was intended by the practicing family.[43]

Be prepared to educate when needed

Most therapists will need to do a great deal of learning, both in terms of general information, and from the client with whom the therapist is working. Ideally, both therapist and client will recognise that there may be different ways of viewing or representing the client's experiences, and achieve a co-building of knowledge as the work progresses.[44] There may be times, though, when the therapist discovers that it may be helpful or necessary for them to educate

the client on certain issues. Safeguarding issues and laws must be clearly explained (see Section 3: Safeguarding Considerations). It is important to be sensitive and non-judgmental, to avoid a sense of blame being imparted to a client who is herself a victim. Many women have not linked their physical/psychological problems to FGM/C; therefore they may need to be given information about the risks and health consequences of the procedure. Therapists should advise the client, and her family if she is willing to have them involved, that the practice is not a religious requirement, and that concerns about the practice are related to its mental and physical impact on her and her daughters.[44,25]

Work skillfully with interpreters

Interpreters are important partners in this work. Interpreters should have undergone or be provided with training about FGM/C, much as therapists and their supervisors should.[45] Preparatory time needs to be scheduled ahead of the assessment/first session, as interpreters need to be warned that FGM/C will be discussed. Time must also be taken to discuss what questions will be asked of the client and what terminology will be used. Both the client and the interpreter may come from cultures that do not talk explicitly about body parts, sex, relationships, etc., and they may even deem such talk as unacceptable or taboo. It is important to ensure that the interpreter feels able to carry out their professional role of accurately interpreting what is said by all parties. Consider that the interpreter may have also undergone FGM/C.[45] After each session, interpreters should be offered some time to debrief with the therapist they just assisted.[46]

Wherever possible, the client's preferences regarding the interpreter should be discussed ahead of time. The interpreter's gender and cultural background should be considered for each individual — someone from the same background may not necessarily be better for that particular client.[45] Working with a trusted interpreter that is present in every session will provide a vital sense of continuity to the therapeutic work.

Additional skills:

The authors have identified the following additional skills as important in this work yet beyond the scope of this document to discuss in detail.

- A willingness to be open and egalitarian
- Experience of working therapeutically with refugees and migrant communities
- Understanding of the prevalence and impact of violence against women and girls
- In-depth understanding of the psychological consequences of traumatic childhood experience
- Awareness of the impact of multiple and complex needs
- Experience of and commitment to the adaptations needed for working in community settings
- Being aware of pacing and timing during the therapy and when is appropriate for the client to start talking about her experiences of FGM/C

7. Preparation And Considerations For Therapy

This section outlines considerations and recommendations in relation to preparing a client for therapy (pre-assessment intervention), undertaking an assessment, and the three-stage framework for working with clients who have experienced trauma.

7a. Pre-therapy Assessment

We recommend that therapists conduct a pre-therapy assessment for women who have been referred to therapy services for FGM/C-related issues. Historically, FGM/C survivors originate from communities where mental health is typically still a taboo subject. In many of these communities, the phrase 'mental health' does not even exist in the vocabulary of their mother tongue, and words used to describe mental health difficulties may have negative connotations (e.g. 'crazy'). In some communities, women experiencing mental health difficulties may even be considered 'witches'. Experience has shown that many women do not attend their first therapy appointment because they do not understand why they have been referred, what therapy is or what it entails, are concerned about accessing mental health services, or face barriers (e.g., transport, childcare, FGM/C-related menstrual/health issues) to accessing the service.

The pre-therapy assessment prepares clients to walk into a safe environment, and ensures that they understand what therapy is and how it works, as many have never experienced such a process. This is an opportunity to begin to develop a relationship with the client, so she understands the therapist role and how therapy can help. Therapists should find out the client's views on talking about her experiences, as she may not see the purpose, or may believe that talking could be harmful.[27]

Steps for the pre-therapy assessment:

- An administrator, or ideally the therapist, makes a phone call to let the client know that their referral has been received, and to ask if the client is aware of the referral, and if they want to continue to an assessment to receive therapy. **We recommend therapists provide a script for administrators who are carrying out this step.**
- Explain briefly how the therapy process works, to ease any anxiety about what it means to be in therapy.
- Before making any appointments, ensure that the client can get to the service, as she will not necessarily read or write English or her mother tongue.
- If she has children, try to provide childcare, as many clients will be isolated from their families. For those with children who attend full-time school, ensure that assessments or therapy sessions take place while the children are at school.
- Ask if she has any needs due to disability.
- Ask if she will need an interpreter. Ask if she has any preferences related to the interpreter. Please refer to Section 6 regarding working with interpreters for more guidance.
- Agree on a face-to-face assessment appointment time.

Although many of these tasks may seem administrative, experience suggests it is helpful for the therapist to make this initial contact, in order to better engage the client and lay the foundation for therapy.

7b. Assessment

The assessment is the formal process used to identify the client's needs, in order to establish the appropriateness of the service for them, and to allow the client to make an informed decision about committing to therapy. The information collected during assessment helps to form the support plan developed collaboratively by the therapist and the client.

Assessors are encouraged to read and gather information about the client's case before conducting the assessment, in order to identify any potential issues, including risk, safeguarding, complex needs, and harmful practices such as FGM/C. The first step of the assessment must be a discussion about confidentiality and the limits of confidentiality. For instance, therapists should explain that confidentiality will have to be breached if the client is at risk of harming herself, or if others (including children) are at risk of harm.

Ask ALL women about FGM/C at assessment

Because of the widespread and unpredictable nature of risk (occurrence) of FGM/C, we encourage therapists to consider asking every female client assessed about FGM/C. This could also be incorporated into the assessment form.

The assessment phase must include a risk assessment. An individualised risk-management plan is formed by identifying, evaluating, and putting into action the risk management protocols and procedures of the therapist's organisation. For all therapists (whether working in private practice or for an organisation), this should be taken to clinical supervision, and any legal obligations must be enacted (see Section 3: Risk & Safeguarding Considerations).

It is important to consider that clients who may have undergone FGM/C may not see this as the main cause of their problems when they ask for support from the service/therapist. A gentle and sensitive exploration of the different types of abuse or trauma the client has survived in her life is encouraged. The assessor should be particularly sensitive to issues of ethnicity, culture, gender, religion and sexuality, to avoid stigmatising women or girls from practicing communities.

When preparing for the assessment, consideration needs to be given to which questions will be asked and when, and the potential impacts on the client (e.g., triggering trauma reactions, raising issues requiring safeguarding actions). These may have further impacts on the client, her family, and on the newly-forming therapeutic relationship and rapport.

Some helpful ways to ask about FGM/C during the assessment can include:

- Can you tell me if you are from a community where girls are circumcised or have their genitals cut at a certain age? [NB: ensure the client clearly understands what the 'genitals' are]
- Have you experienced circumcision or cutting of your genitals?
- What do you call this practice in your community?
- Are there other women in your family/ community who have experienced this practice?
- Are you concerned that this may happen to you or someone you know? **Please ensure a clear understanding of Section 3 (Safeguarding Considerations) above regarding risk and safeguarding, to accurately assess potential risk level and immediacy.** As with any risk assessing, the actual level and potential timeframe on risk must be determined, to ensure that only a relevant response is enacted. E.g., few practicing communities cut their girls soon after birth, so safeguarding does not need to be put into motion for every woman with FGM/C who gives birth to a girl. Similarly, not every woman with FGM/C is going to have her daughter cut.

Please see Appendix 1 for sample FGM/C-related assessment questions.

The outcome of the assessment is a clinical decision that includes a treatment plan suited to that particular client, outlining relevant therapeutic interventions and/or any referrals for other treatment or support.

7c. Framework: The Three-Stage Approach

Using Judith Herman's three-stage approach as a framework for working with clients who have undergone FGM/C, therapy involves stabilisation, trauma processing, and reconnection.[39]

Stabilisation:

The central task is safety. The work includes:

- Stabilisation and support of emotional self-regulation
- Teaching and testing grounding techniques
- Practical safety, e.g., ensuring the client knows her rights, is physically safe or has a safety plan, etc.

- Support for the client in the development of healthy coping mechanisms
- Support for the client by understanding and validating her emotions
- Support for the client to start connecting the missing links between her physical and mental health problems and the consequences of FGM/C
- Recognition of the physical, emotional, and psychological pain the client is in and has experienced
- Recognition and encouragement of the healthy coping strategies the client has already created or begun using

Trauma processing and mourning:

The central task is remembrance and working through trauma, grief and loss. The work includes:

- Assisting the client in finding meaningful and safe ways to express emotions
- Working with anger, ambivalence, and any other emotional material
- Understanding of the impact of FGM/C on the mother/daughter relationship
- Acknowledgement and recognition of the client's feelings towards her mother and older female relatives
- In some cases, having conversations with sisters and/or the mother may help the client to understand her story, and could help the resolution of grief and loss. A feminist approach to understanding FGM/C and female oppression in society may be helpful in this process.
- The age at which FGM/C took place will have implications for what a client remembers; therefore, in some cases, the main component of these trauma memories will be non-verbal. The body remembers.
- The FGM/C event constitutes a great challenge for a secure attachment, with consequences for future relationships in the client's life. In many cases, loving and caring mothers perform FGM/C, or allow it to be carried out on their daughters. Therapists should accompany the client to find a meaningful resolution with regards to her relationship with her mother/ parents and the rest of the family.

Reconnection:

The central task is reconnection with the ordinary life. The work includes:

- Support for the client to reconnect with her body and her own genitals
- Support for the client to reclaim aspects of her sexual life (by this we mean the reconnection with her sexual self)
- Support for the client to find meaningful activities
- Support for the client to identify healthy relationships that will enrich her life
- Support for the client to find further support in the form of engagement with, for example, specialised groups
- Support for the client to express her own voice in the form of a meaningful personal resolution

8. Therapeutic Modalities

This section outlines trauma therapies, group therapy and psychosexual therapy. They can be ways of addressing Stage 2: Trauma processing and mourning, in the three-stage approach above (Section 7c). The approaches outlined below have been chosen as they are within the authors' scope of knowledge and expertise and/or are supported by the literature as effective trauma therapy interventions.

The therapist must be trained in the particular approach utilised and have assessed the modality as matching the client's needs; the choice may be further determined by the approach of the service in which the therapist works. Integrative psychotherapy, eye movement and desensitization reprocessing (EMDR), cognitive behavioural therapy (CBT) and the related compassion focused therapy and narrative exposure therapy (NET) are discussed below, as well as a summary of characteristics shared across effective trauma-focused therapies.

NICE Guidelines & Evidence-based Therapies:

NICE, the National Institute for Health and Care Excellence, sponsored by but separate from England's Department of Health, sets out evidence-based quality standards for health and social care treatment (see 》www.nice.org.uk). Treatments provided by the National Health Service (NHS) in England are to be in line with NICE guidelines. For diagnosed PTSD, the guidance is for a course of either trauma-focused CBT or EMDR. There is also guidance for the limited use of medications for adults, but this is aimed at those who cannot currently undertake psychological treatment. Please see Appendix 4: Resources for a link to NICE's full guidance on PTSD.

8a. Trauma Therapies

Common features across trauma therapies
Schnyder et al[47] is a follow-up to a panel discussion, held at the International Society for Traumatic Stress Studies 2014 conference, in which the founders of seven different approaches identified common features and goals across empirically supported psychotherapies for trauma. They outlined the following elements:

- Psychoeducation
- Emotion regulation and coping skills
- Exposure to the trauma memory (e.g., imaginal, verbal)
- Making meaning or cognitively processing/ restructuring key meanings
- Processing of key emotions
- Changing memory processes — 'the reorganisation of memory functions and the creation of a coherent trauma narrative'[58(p8)]

8a.i. Integrative Psychotherapy

According to the Institute of Integrative Psychotherapy,[48] this approach implies an attitude towards the practice of psychotherapy that affirms the inherent value of each individual. The Integrative approach brings together diverse elements from different schools of therapeutic knowledge and practice into one, allowing individualised interventions selected according to the client's needs and particular presentations. This is a unifying psychotherapy that aims to respond appropriately and effectively to the person at the affective, behavioural, cognitive, and physiological levels of functioning, as well as addressing the social and spiritual dimensions of life.

The term 'integrative' has a number of meanings in the context of integrative psychotherapy: on the one hand it refers to this integration of approaches coming from diverse schools of psychotherapy, and on the other hand refers to the process of integration of the personality (or individuality) as a whole. The therapy aims to attend to various dimensions of the individual - the affective, cognitive, behavioural, physiological and spiritual, along with relationships and the socio-political context and constraints within which the individual lives.[48,49]

Within this framework, it is recognised that therapists also need to commit themselves to the process of integration. It is generally believed that the most effective model requires the therapist to be non-judgemental and able to establish a supportive and cooperative relationship with their client.[49] They must also engage in deep, attentive listening whilst aiming to avoid pre-conceptions and being aware of assumptions that can distort understanding.

The therapist working from this model and approach establishes a supportive, strong, and trusting working alliance allowing the client the space needed to explore and recognise patterns of behaviour that need to be addressed through change and the supporting of new goals. The therapeutic relationship and the focus on self-exploration and integration aim to empower clients through the changes that are emerging for them.

When working with clients who have experienced FGM/C or trauma, the goals of therapy are to develop meaningful engagement and to allow the client to tell her story, leading to an integration of past and present experiences and relationships, with new views toward the future. It is within this framework that a trusting working alliance is built, which will allow depth of exploration and space to work through the trauma of the client's experiences. The final process of an integrative approach is to support the client in ways which allow empowerment and resilience to develop.

8a.ii. Eye Movement Desensitization and Reprocessing (EMDR)

EMDR works on unprocessed or 'stuck' traumatic memories.[50] The client is asked to bring to mind an image of the traumatic memory, and a related belief with associated emotions and sensations. The therapist then guides the person to focus on a left-to-right external stimulus such as following the therapist's moving finger, or sounds played alternately, or tapping on their own legs, whilst holding the image in mind. This bilateral stimulation is similar to what occurs during rapid eye movement (REM) sleep, when the brain does much of the sorting out and healing from experiences. While it has long been held that the bilateral stimulation is what facilitates the memory processing, current research indicates that this occurs via the taxing of the working memory.[51] The two tasks (attending to the trauma memory and the bilateral stimulation or other adequately taxing activity) compete for the client's emotional processing resources, resulting in a lessening of the vividness and/or emotional intensity of the memory. Clients are thus able to develop updated, more positive or neutral perspectives about the original events and themselves in relation to those events.[50]

8a.iii. Trauma-Focused Cognitive Behavioural Therapy

Trauma-focused CBT (tfCBT) is framed by psychoeducation, and has a co-created, individualised case formulation based on the cognitive model of PTSD by Ehlers and Clark.[52,47] TfCBT uses a framework of altering unhelpful maintenance cycles. These cycles are generally maintained by memories that are unprocessed, and therefore experienced as intrusive and disturbing; by beliefs and related emotions about the trauma event, the self, others/the world, and the future; and by maladaptive coping, particularly avoidance. Therapeutic components involve updating traumatic memories, through exposure via reliving, and through cognitive reprocessing.[53] 'Reliving' is intentionally talking through the traumatic event in sessions, which helps contextualise the components of the event, as well as the overall experience (see Section 5b: Trauma and the Brain). Reprocessing is done by identifying significant moments and meanings from during or after the trauma, i.e., beliefs and evaluations that have become 'stuck', that is, strongly held, even if not accurate or helpful (e.g., 'I'm dying!', 'I'm ruined forever').[54] An updated, current understanding of each of these 'hotspots' is developed, taking into consideration the particular experiences and needs of the individual client,[55] thereby shifting the meaning and emotional impact of these aspects of the trauma. Additional therapeutic

components may include 'reclaiming your life' (re-/engaging in meaningful activities and relationships); decreasing unhelpful behaviours and cognitions; and learning to discriminate between present sensations, emotions, and cognitions (belonging to the current, often safe, reality), versus those associated with the trauma situation.

8a.iv. Compassion Focused Therapy (CFT)

CFT draws largely on CBT approaches, combining them with mindfulness approaches and contemporary research on the brain and human development.[56] Its aim is to enable clients to develop self-compassion, which serves as a way to understand their developmental life story, and as an antidote to shame and self-criticism/-loathing. As such, it can be a valuable framework for working with traumatic experiences and their impacts, including many of the FGM/C-related issues identified above, and for helping clients develop resilience through a healthier relationship with themselves.

8a.v. Narrative Exposure Therapy (NET)

Related to tfCBT is narrative exposure therapy. NET was developed to help reduce the impact of trauma for people with multiple, complicated, and/or persisting traumas, e.g., people living in refugee camps.[57] There is good emerging evidence for the use of NET as a treatment for complicated trauma in refugees.[58,59] In sessions, a chronological narrative of the person's life is developed, fostering a sense of personal identity and cohesive life story. The majority of the sessions focus on talking through traumatic experiences, reconnecting with the related emotions, thoughts/images and sensations, while staying grounded in the present; the aim is to integrate meanings and emotions into a broader understanding of one's patterns and development. The person's narrative is written up by the therapist, and can be kept by the person and/or used for testimony in human rights advocacy.

8b. Group therapy for survivors of FGM/C

This section is based on group work provided at the Dahlia Project, the UK's only counselling service specifically for survivors of FGM/C. It includes an overview of and aims for this type of group work, along with a case example.

A therapy group is usually comprised of six to eight women who meet face-to-face, weekly, with one or two trained facilitators and talk about what is concerning them most. Members listen to each other and openly provide each other with feedback. These interactions give members an opportunity to increase understanding, try out new ways of being with others, and learn more about the ways they interact. The content of group sessions is confidential; members agree not to identify other members or their concerns outside of the group.

It is important that all therapists remain sensitive and mindful of not forcing or pushing any particular issues forward, as this may mirror or raise feelings from past experiences, and therefore be seen as imposing. For example, always referring to FGM/C as "abuse" may feel oppressive to a client, as this may not be how she conceptualises the experience, and she may otherwise have a loving relationship with her family. Or, assuming that women who have undergone FGM/C have do not have fulfilling sexual relationships.

FGM/C remains a very difficult subject for many survivors to discuss, therefore therapists will need to be patient and sensitive to allow individuals to process their feelings and talk about their experiences or the consequences of it. Many clients do not connect their physical and emotional trauma to FGM/C, and it is the role of the therapist to facilitate this understanding and encourage a conversation with medical professionals.

Clients affected by FGM/C often present with highly complex needs, and they may also be facing other issues when they attend group therapy. These may relate to experiences in their countries of origin, or their migration route into the UK, or their experiences as children affected by FGM/C in the UK.

It is unlikely that many of these clients will have accessed mental health services or group therapy before. Whilst therapists should hold the boundaries of the therapeutic space, they will likely find that allowing some flexibility in the running of the group

can help clients feel more comfortable, safe, and not judged. This will decrease anxieties and facilitate opening up about the wide-ranging emotional aspects of this subject.

A recurrent theme expressed by survivors is a feeling of shame associated with FGM/C, and in turn, the difficulty of talking with others about it. Many clients also feel anger, not just towards perpetrators, but also at their communities of origin and at being failed by systems in the UK, which may have done relatively little to protect them when they were young and unable to protect themselves, or to provide suitable support and care to them as adults.

Aims of group therapy :

- Offer a safe and confidential space to acknowledge the harm they suffered as children
- Allowing women to recognise and name FGM/C as a form of child abuse and therefore a violation of their basic human rights
- To allow issues to be explored in a personal context that accurately reflects real life
- To provide clients an opportunity to observe and reflect on their experiences of undergoing FGM/C, and to connect with other clients' experiences
- To offer an opportunity for the client to give and receive immediate feedback about concerns, issues and problems affecting her life
- To work through personal issues in a supportive, confidential atmosphere, and to help others work through theirs
- To decrease feelings of isolation and increase sense of support
- To decrease self-criticism and negativity
- Greater ease in identifying feelings and self-disclosure
- A deepened trust in oneself and one's instincts and abilities
- Greater resourcefulness in finding solutions and confidence to try out possible solutions

Case Example: Outreach group therapy

Based on the principle of making services more accessible, the Dahlia Project in London began running 'Outreach group therapy' in 2016. The outreach group therapy aims to provide safe spaces for women and girls to unpack the effects of FGM/C. Many potential clients had barriers to attending at the Project's central location, e.g., distance, time, lack of childcare, anxiety/fear about traveling to unfamiliar parts of the city. Thus the Dahlia Project began partnering with grassroots organisations around the city who were familiar with this client group. Group therapy was held at locations chosen by the group, such as at the premises of those local organisations, children's centres, libraries, churches, African Well Women's clinics, maternity departments, sexual health clinics, or schools (for those under 18 years). Building an outreach counselling service proved an effective way of increasing engagement in counselling.

The outreach project has further developed to include pre-group workshops, to build trusting relationships with community members and the grassroots organisations. These organisations also help identify potential clients, as do former group members. Workshops are held at these host organisations, attended by both potential clients and staff from the organisation.

Three pre-group workshops are held, covering the following topics:

- What is mental health?
- Understanding FGM/C and other harmful practices
- How to access mental health services

Feedback has been positive and attendance has been high, in part due to the client-centred locations and funds provided by the Dahlia Project for childcare, transport and refreshments. There has been encouragingly high demand for further groups in different parts of London and the UK.

Please see Appendix 3 for further information for staff and clients about group therapy.

8c. Integrative Psychosexual Therapy

The material in this section is drawn from the course notes and teaching practices on 'working with women who have undergone FGM/C' on the two-year Diploma in Integrative Psychosexual Therapy, where sexual issues are considered in terms of medical factors, psychological factors, relating to partners and relationships and due to socio-cultural, political or economic factors.[10] This Diploma is led by one of the authors, Cabby Laffy, and has Course Approval with the NCP (National Council of Psychotherapists) and COSRT (College of Sexual and Relationship Therapists). Addressed below are trauma and cultural considerations, assessment and treatment approaches.

Women who have undergone FGM/C may seek psychosexual therapy to address the sexual or physical difficulties listed in Section 2f (Consequences of FGM/C). In our experience, a common concern of clients is perceptions about the appearance of genitals, especially after deinfibulation. Female genitals are shamed in many cultures, but all genitals, like human faces, are unique. Our bodies are also unique yet we are bombarded with things to buy to improve them. Even though female sexuality is generally culturally shamed, our right to sexual pleasure is a gift, and a happy sexual life brings many physical and psychological health benefits. The role of a psychosexual therapist in the context of working with survivors of FGM/C is to support clients to reconnect with their sensuality and sexuality as a source of pleasure, and to reclaim their sexual self-esteem. This will include paying attention to reconnecting with their body and their own genitals, a review of thoughts and beliefs about themselves and their sexuality, and therapeutic support for their psychological experiences.

Therapists should conduct their work with two primary considerations:

- **Trauma:** Clients may have experienced various degrees of trauma from the incident of FGM/C, and from its physical and/or psychological consequences. The therapist should assess the degree of complex trauma for each individual client, and ensure safety protocols before introducing any specific psychosexual work. If the psychosexual therapist does not feel that they have the experience to work safely with recovery from sexualised trauma, they should refer the client to another professional.
- **Cultural Awareness:** Therapists should inform themselves of the cultural sensitivities needed to work with survivors of FGM/C (see Section 4: Contextual Considerations). Trauma may be experienced within a systemic context, resulting in clients having complex feelings and beliefs. These issues should be thoroughly explored with each individual client to encourage her to ascertain her own beliefs and values, including on social, religious and cultural issues, so as to support her to make choices about her sexual future.

History taking and assessment should be thorough to ensure the appropriate use of any psychosexual tasks. Topics to cover should include:

- What does the client think and feel about her experience of FGM/C?
- What were the circumstances when she underwent FGM/C? How old was she?
- What type of genital mutilation has she experienced?
- What physical sexual/reproductive difficulties does she have?
- Has the client experienced deinfibulation? Does she know? If so, how does she feel about it?
- Has she been re-infibulated (e.g. after giving birth)? How many times? What were the circumstances, was it her choice?
- How does she feel about her body and her genitals?
- What is her relationship to her own sexuality now? What would she like it to be?
- If she is in a relationship:
  - What does her partner think and feel about her experience of FGM/C and/or deinfibulation/ re-infibulation?
  - Do they have a good ability to communicate?
  - What is their sexual relationship like?
  - What does her partner think and feel about physical sexual/reproductive difficulties she has?

- How would she/they like things to change?

– Anything else that is important to the client

Treatment approaches

It is vital to approach psychosexual work relationally, with each individual client, rather than with any presented sexual dysfunction. Many traditional psychosexual therapists suggest the use of vaginal dilators for women with pelvic pain or pain during penetration. This may not be considered appropriate when working with survivors of FGM/C or deinfibulation, and should be discussed with each client. FGM/C is not necessarily an impediment to sexual function, and in our experience many women report that they do not have difficulties experiencing orgasm. It is important to work psychosexually with a client on her own, before considering couple work. Exploring the specific concerns of each client — what she would like to change and her priorities — will guide the pace of the work.

Exploring each client's beliefs and values as expressed during the history-taking will provide the framework. Many clients will want a vocabulary and space for an emotional intimacy with their own sexuality before being ready to engage in exploration exercises at home with their partner. Psychoeducational work is important to encourage a good body image and physical and emotional self-care should be prioritised.

Treatment approaches should initially focus on sensualising exercises before inviting clients to explore their difficulties through any sexualising exercises. Therapists should work slowly to identify and care for any physical triggers. Sensualising exercises should start with safe places: hands, arms, face, moving to more erogenous parts of the body, before exploring genitals.

Couple work can further support women in their relationships and help couples to develop good communication skills. Any use of sensate focus should focus first on emotional intimacy between the couple before sensualising exercises. All psychosexual interventions should be employed appropriately within each individual's or couple's cultural and religious beliefs.

Psychosexual work supports clients to explore their beliefs and values and to consolidate what is right for them. It can provide exercises exploring sight, taste, sound, smell, touching and being touched. It can support clients with any emotional turmoil triggered through this work. Learning what is pleasing, sensually and sexually, can give clients more self-awareness and self-acceptance, and give them a language to better communicate with their sexual partners.

9. Supervision and Self-Care

This section puts forward the importance of being aware of the potential impact of secondary traumatisation and the importance of having meaningful self-care strategies including clinical supervision.

Working with survivors of trauma is emotionally demanding for therapists. In order to minimise the impact of secondary traumatisation, the therapist needs to consider developing personally meaningful self-care strategies, support-seeking, and engaging in personal therapy and clinical supervision. Supervision is crucial, as with any good clinical practice.

Therapists need to ensure they are regularly getting support via supervision to manage their responses to what they are hearing.[45] Clinical supervisors must therefore ensure that they too educate themselves all about FGM/C. As with any personal issues that may arise in therapy, clinicians need to be looking at what arises for them as they undertake this work. They would also benefit from using supervision as a place to ensure they are not shying away from what the client is bringing (which may be anger, sexual issues, or descriptions of very painful or terrifying experiences), but remaining open to it and to the client.

The therapist needs to be aware of, and willing to challenge, their own cultural beliefs and context, particularly regarding gender roles and sexuality. The mainstream model of sexuality in most countries remains patriarchal and heterosexual: penetrative, rather than consent and pleasure-focused; e.g., the medical model of sexual dysfunction focuses on heterosexual intercourse.[10] The work in therapy will activate a parallel process in which the therapist's feelings about sex and sexuality will be triggered. This should always be worked through in clinical supervision, which will further support culturally sensitive clinical work.

APPENDIX 1: FGM/C-related Sample Assessment Questions

This appendix contains FGM/C-related questions that could be added to existing assessment forms. Be aware that terminology may need to be explained or revised, e.g., ensuring the client knows what is meant by 'female genital mutilation/circumcision/cutting', asking the client what she calls it or how it is referred to in her culture.

NB: Assessment can be a useful time to provide clients (and their families) with information about FGM/C-related health and emotional problems, about FGM/C and the UK law, and about how to recognise mental health issues such as depression, anxiety and trauma.

Making a clear transition into the stage of the assessment focused on FGM/C can help the client feel more ready to discuss the issue; and it is worth repeating at this point that information about her experiences will be kept confidential (with the exception of any risk issues that may arise), and that the client does not need to answer any questions she does not want to answer.

Sample introduction:

Being cut [use client's words for FGM/C] can be a very difficult experience for a person, and it can lead to difficulties later in her life. I'd like to ask you some questions about your experiences being cut, and about your history of physical and mental wellbeing.

General Recommendations:

1. Ask ALL female clients if they have undergone FGM/C
2. Explain briefly how the therapy process works, to ease any anxiety about what it means to be in therapy
3. Make contact with the potential client pre-assessment, to increase likelihood of engagement (see Sections 7a: Pre-Assessment and 7b: Assessment)

General Pre-Assessment/Assessment Questions:

Even if a pre-assessment is not possible, these questions are useful to ask at assessment or if a client has been unable to attend:

- Are you able to get to the service? (as she will not necessarily read or write English or her mother tongue, so possibly not appointment letters or transport directions)
- Do you have children who need childcare or collecting from school at a certain time?
- Do you have any needs due to disability?
- Do you need an interpreter? Do you have any preferences related to the interpreter, e.g., gender, dialect? (Please refer to Section 6 regarding working with interpreters for more guidance.)
- Can you attend at [appointment day & time]?

FGM/C-related Questions

NB: They do not have to be in this, or any predetermined, order.

- Can you tell me if you are from a community where girls are circumcised or have their genitals cut at a certain age? [NB: ensure the client clearly understands what the 'genitals' are]
- Have you experienced circumcision or cutting (of your genitals)?
- What do you call this practice in your community?
- Are there other women in your family/community who have experienced this practice?
- Are you concerned that this may happen to you or someone you know?

Please ensure a clear understanding of Section 3 above regarding Risk and Safeguarding, to accurately assess potential risk level and immediacy. As with any risk assessing, the actual level and potential timeframe on risk must be determined, to ensure that only a relevant response is enacted. E.g., few practicing communities cut their girls soon after birth, so safeguarding does not need to be put into motion for every woman with FGM/C who gives birth to a girl. Similarly, not every woman with FGM/C is going to have her daughter cut.

- What type of FGM/C [use client's preferred terminology] do you have (if you know)?:
  Type of FGM/C: ☐ Type I ☐ Type II ☐ Type III ☐ Type IV:

  NB: If the woman/girl does not know the type, it is suitable to recommend that she see a medical professional trained in identifying FGM/C to find out. Suitable medical professionals can be identified through the NHS (e.g., FGM, gynaecology, obstetrics, maternity, or possibly sexual health services) or via charitable sector well-women clinics. This process can enable a woman to better know her body, and any difficulties she is having with it. It also helps identify areas of potential future difficulties, such as intercourse or childbirth. See also Section 2f re: deinfibulation.

- Was any anaesthetic used when you were cut? If so, what type?
  ☐ Local ☐ General ☐ Spinal/epidural ☐ Other ☐ None
- How old were you when you were cut?
- Was anyone else cut at the same time as you? Who was this? (Particularly look out for other female relatives)
- Do you know why you were cut? (Prompts: Who wanted it done; Reasons: religious, health, marriage, chastity, other)
- Do you remember your cutting as a positive or negative experience at the time of the event?
- Would you have your daughter cut? / What's your view of having your daughter cut?
- Are you under pressure from anyone to have your daughter* cut? This pressure could come from your husband/partner, your family members, his family members, or other community members. Do you think you will be pressured about this in the future? (*or any other female relative)
- What would you do if you came under pressure to have your daughter cut? Who would support you in dealing with this?
- Being cut is often linked with physical and emotional difficulties. Have you experienced any of the following physical problems or emotional difficulties at any time in your life?

Type of problem	Details	Believed/Known to be related to FGM/C?
Heavy bleeding		
Severe pain		
Infection/septicaemia		
Pain when urinating/ urinary infections		
Painful periods		
Painful sexual intercourse		
Fear of sexual intercourse		
Problems conceiving		
Fear of giving birth		
Anxiety (feeling scared / worried all the time)		
Depression (describe depression to client)		

*Flashbacks of traumatic events/Feeling like those events are happening all over again now		
*Sudden, strong upsetting memories of traumatic events		
*Nightmares about traumatic events		
Problems in relationships with husband/partner		
Problems in relationships with family		
Feeling uncomfortable in your body or any other problems following deinfibulation		
Other		

* If these problems are identified, consider further assessing for post-traumatic stress difficulties. An initial step could be to administer standardised self-reporting questionnaires such as the Traumatic Screening Questionnaire (TSQ).[60]

Trauma Screening Questionnaire - PTSD[60]

Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened to you. Please indicate (Yes/No) whether or not you have experienced any of the following AT LEAST TWICE IN THE PAST WEEK:

	YES, AT LEAST TWICE IN THE PAST WEEK	NO
1. Upsetting thoughts or memories about the event that have come into your mind against your will		
2. Upsetting dreams about the event		
3. Acting or feeling as though the event were happening again		
4. Feeling upset by reminders of the event		
5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event		
6. Difficulty falling or staying asleep		
7. Irritability or outbursts of anger		
8. Difficulty concentrating		
9. Heightened awareness of potential dangers to yourself and others		
10. Being jumpy or being startled at something unexpected		

Scoring: Six or more positive responses mean that the client is at risk of having PTSD according to the DSM-IV (American Psychiatric Association, 1994) and requires a more detailed assessment.

APPENDIX 2: Explaining Trauma/PTSD Memories to Clients

Therapists should help clients affected by PTSD to understand what is happening to them. This includes understanding the processing in the brain and memories, as discussed in Section 5b: Trauma and the Brain. An illustration that can be helpful comes from the Oxford Guide to Metaphors in CBT: Building Cognitive Bridges[61]: The Guard Dog.

- It's as if the **amygdala is a guard dog** and the **hippocampus is the security guard** responsible for him. The dog barks if something sounds, looks, or smells dangerous. The security guard then comes and takes a look. The dog barking is quick (so it raises the alarm and gets our attention), but the slower security guard is needed to prevent **lots of false alarms**. Over time, the dog learns to bark less and less, and only when something really dangerous is happening. So in normal times, they work well together.
- During **trauma**, it is as if the security guard and the dog *aren't communicating* any more — the dog just keeps barking, with no one to calm him down.
- There is nothing wrong with either the dog or the security guard, they just need to get together. The dog needs to be re-trained not to keep barking at something that isn't a threat.

Clients should also be educated about the three main symptom groups that make up PTSD:

- Re-experiencing (flashbacks, nightmares, intrusive memories, due to the memory processing issues discussed above)
- Hyperarousal (hypervigilance, anger, anxiety)
- Avoidance (staying away from things in an attempt not to experience the above symptoms)

Again, help clients to understand the fight/flight/freeze/fright fear-response mechanism. For example, when we feel threatened or hurt, our body's natural reaction is to prepare for action: to run, to fight, or to freeze! This can lead to many of the following physical experiences:

- **Heart pounding** — to pump the blood around the body faster
- **Rapid breathing** — to get more oxygen to the muscles
- **Digestive system closes down** — allows body to concentrate on the immediate threat
- **Increased adrenaline and cortisol** — more alert and focused on the perceived danger at hand
- **Shaking, sweating** — from muscles tensing, the body heating up, and dumping unneeded water
- **Confusion** — as there is less oxygen in the brain to process things there

This is the body's normal, healthy reaction to situations where we feel under threat. It is the body's alarm system. We can experience fear and anxiety as a result of *how we interpret or evaluate a situation (our thoughts)*. Some reminder of a traumatic event, even a minor one, can trigger the alarm. The body then reacts as though it is about to be attacked, when in reality, it is not. It is a false alarm, like a car alarm being triggered when there is no danger.

Dissociation can be another distressing symptom of trauma, which can be described to the client as follows:

- Sometimes the mind and body become very frightened, and if you are unable to physically escape, your mind has no choice but to temporarily stop acknowledging what is happening. In a sense, you 'leave your body' in order to keep yourself safe.
- When we have PTSD, our minds and bodies often continue to react in a similar way to how we felt when the trauma was happening. Therefore, if you dissociated during the traumatic event, you may well dissociate when you are re-experiencing the trauma memory.

APPENDIX 3: Further Guidance on Group Therapy from the Dahlia Project (see Section 8b.)

Confidentiality in group therapy

Maintaining confidentiality is often a concern for those considering group therapy. Facilitators should ensure that the issue is discussed thoroughly in a recommended pre-group meeting and in the first session, and that ground rules or guidelines are agreed by the group before any work commences. Due to the small number of these specialist services, facilitators should also try to ensure that the likelihood of group members knowing each other is minimised. Experience shows that as each member expects their own issues to remain confidential, confidentiality is respected.

A therapist will conduct initial assessments of participants individually to ensure that their different emotional needs are recorded, in order to support the facilitators delivering the sessions.

Can groups be harmful?

Group therapy cannot address everyone's problems, and could exacerbate an individual's distress, if conducted in an inappropriate way, e.g., if the therapist stereotypes or uses offensive terminology (regardless of intent) or makes statements without checking them out with the clients. Before advising membership in a group, a very careful assessment must be undertaken to determine whether an individual would benefit from group work. Great care must be taken in forming the group membership. If a group member feels they are struggling in a group week after week, it should be possible to meet with a group facilitator individually to talk this through.

Because these are therapy groups for FGM/C survivors only, potential clients are advised in their individual assessment that there may be someone they know or recognise in the group, and that if this occurs and makes them uncomfortable, they are free to leave the group at any time.

Effectiveness of group therapy

Although most people find their group experience rewarding, it can be uncomfortable at times. Clients may temporarily feel worse, particularly in the early stages. This is often a sign that the process is working rather than an indication that it should be stopped. Facing up to and exploring one's self and past may, at times, feel difficult and upsetting but this is often a necessary step in the process of growth.

There will also be times when individuals feel they are getting nowhere and that it would be easier to give up. They may feel angry, or they may feel like they do not care about the group. They may begin to wonder if the effort is worthwhile. Such feelings should always be discussed openly in the group.

Many of the clients attending the group will present with a complex case history, including experience of living in conflict-affected areas, and sexual and domestic violence.

Although it can be useful to have a therapist from an FGM/C-affected community, it is not essential. Therapists from other backgrounds can also provide useful opportunities for clients to acknowledge the role of other women and society more generally in shaping their experiences.

Our experience of working with groups suggests that only a few people find exactly what they are looking for in the first couple of weeks, but it is rare for those who stay for longer than this to fail to get some benefit. A common concern of clients is that listening to so many other people's problems will make their own worse, but this very rarely happens.

APPENDIX 4: Resources

Many of the resources cited throughout this document (along with a host of others) also contain useful insights into non-therapeutic issues related to working with FGM/C. These are worth exploring, especially if a service is new to working with individuals who have experienced FGM/C, those at risk of it, or those from practicing communities. Issues addressed include approaching FGM/C as a human rights, health and/or gender equality issue; making the way for change to be owned and led by community members; giving individuals a voice as a means of empowerment; working with groups and involving everyone's diverse views about the practice in discussions; involving men and boys in understanding and ultimately advocating against FGM/C; and running non-therapeutic groups.

The resources below more directly link to the information in these guidelines

A place to continue the conversation together- the FGM Specialist Network

› www.fgmnetwork.org.uk/

National FGM Centre, including The Knowledge Hub:

› nationalfgmcentre.org.uk/
› nationalfgmcentre.org.uk/knowledge-hub-resources/
› nationalfgmcentre.org.uk/uk-fgm-services/ - By geographic area

World Health Organization (WHO) - Care of Women and Girls Living with FGM: A Clinical Handbook

› http://apps.who.int/iris/bitstream/handle/10665/272429/9789241513913-eng.pdf?ua=1
(also accessible through the National FGM Centre's Knowledge Hub)

FGM eLearning

E-learning for Healthcare: › www.e-lfh.org.uk/programmes/female-genital-mutilation
Videos: › www.nhs.uk/fgmguidelines
Home Office training package on FGM: › www.fgmelearning.co.uk/

FGM/C Animations

› https://www.wovenink.co.uk/endfgm-animations

Documentary

› http://www.channel4.com/programmes/the-cruel-cut

Protection Orders

› https://www.gov.uk/female-genital-mutilation-protection-order
› https://www.gov.uk/government/publications/fgm-protection-orders-factsheet

UK government booklet on FGM

› https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/482799/6_1587_HO_MT_Updates_to_the_FGM_The_Facts_WEB.pdf

Mandatory Reporting

Home Office guidance on Mandatory reporting:

› https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/469448/FGM-Mandatory-Reporting-procedural-info-FINAL.pdf

Department of Health and NHS England mandatory reporting flow chart and FAQ:

› https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/525405/FGM_mandatory_reporting_map_A.pdf

Mandatory reporters

"The duty applies to all regulated professionals...working within health or social care, and teachers. It therefore covers:

- Health and social care professionals regulated by a body which is overseen by the Professional Standards Authority for Health and Social Care (with the exception of the Pharmaceutical Society of Northern Ireland). This includes those regulated by the:
  - General Chiropractic Council
  - General Dental Council
  - General Medical Council
  - General Optical Council
  - General Osteopathic Council
  - General Pharmaceutical Council
  - Health and Care Professions Council...(including social workers in England)
  - Nursing and Midwifery Council
- teachers
- social care workers in Wales"

from

› https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/573782/FGM_Mandatory_Reporting_-_procedural_information_nov16_FINAL.pdf

National Institute for Health and Care Excellence (NICE) guidance on:

PTSD: › www.nice.org.uk/guidance/cg26/chapter/1-Guidance

Working with pregnant women with complex social factors:

› https://www.nice.org.uk/guidance/cg110/chapter/1-guidance

UK Psychological Trauma Society (UKPTS)

› http://www.ukpts.co.uk/guidance.html

Complex PTSD Therapy Guidelines

› http://www.ukpts.co.uk/guidance_11_2920929231.pdf

Royal College of Midwives FGM Guidelines

› https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf

Trust for London- FGM

› https://www.trustforlondon.org.uk/issues/society/female-genital-mutilation-fgm/

The Tackling FGM Initiative

› http://www.preventingfgm.org/practical-guidance/mental-health/#1467213382651-58a3aeff-5e8e

Recommended additional reading

Forced Migrant Review (journal)

Brochmann E & Støkken Dahl, E. *The Wonder Down Under*. London, UK: Yellow Kite; 2018

Esho T, Enzlin P & Van Wolputte S. (2011). The socio-cultural-symbolic nexus in the perpetuation of female genital cutting: a critical review of existing discourses. *Afrika Focus*, 2011;24:53-70. [https://www.researchgate.net/publication/263363781_The_socio-cultural-symbolic_nexus_in_the_perpetuation_of_female_genital_cutting_a_critical_review_of_existing_discourses]. Investigates 'the socio-cultural-symbolic nexus surrounding the practice of FGC, its meaning and implications'

Robinson-Wood, T. *The Convergence of Race, Ethnicity, and Gender*. CA: Sage; 2017

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