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### Coping and chronic psychosocial consequences of female genital mutilation in the Netherlands

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## Coping and chronic psychosocial consequences of female genital mutilation in the Netherlands

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**Objective.** The study presented in this article explored psychosocial and relational problems of African immigrant women in the Netherlands who underwent female genital mutilation/cutting (FGM/C), the causes they attribute to these problems – in particular, their opinions about the relationship between these problems and their circumcision – and the way they cope with these health complaints.

**Design.** This mixed-methods study used standardised questionnaires as well as in-depth interviews among a purposive sample of 66 women who had migrated from Somalia, Sudan, Eritrea, Ethiopia or Sierra Leone to the Netherlands. Data were collected by ethnically similar female interviewers; interviews were coded and analysed by two independent researchers.

**Results.** One in six respondents suffered from post-traumatic stress disorder (PTSD), and one-third reported symptoms related to depression or anxiety. The negative feelings caused by FGM/C became more prominent during childbirth or when suffering from physical problems. Migration to the Netherlands led to a shift in how women perceive FGM, making them more aware of the negative consequences of FGM. Many women felt ashamed to be examined by a physician and avoided visiting doctors who did not conceal their astonishment about the FGM.

**Conclusion.** FGM/C had a lifelong impact on the majority of the women participating in the study, causing chronic mental and psychosocial problems. Migration made women who underwent FGM/C more aware of their condition. Three types of women could be distinguished according to their coping style: the adaptives, the disempowered and the traumatised. Health care providers should become more aware of their problems and more sensitive in addressing them.

**Keywords:** African immigrant women; FGM/C; chronic mental problems; psychosexual problems

### Introduction

Female genital mutilation/cutting (FGM/C) is a procedure involving cutting of the external genital organs, for which there is no medical necessity (Box 1: different types of FGM/C). FGM/C occurs in many communities in a large part of Africa. In

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## Box 1. Types of FGM/C.

Female genitalia can be cut in a number of different ways. Variations occur depending on which part of the genitalia is mutilated and the extent to which this is done. The World Health Organization distinguishes the following four types (WHO 2012a):

- *Type I:* Partial or total removal of the clitoris and/or the clitoral hood. This type is known as ‘clitoridectomy.’
- *Type II:* Partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. This is also known as ‘excision.’
- *Type III:* Narrowing of the vaginal orifice by cutting and closing the labia minora and/or the labia majora, with or without excision of the clitoris. This is also known as ‘infibulation.’
- *Type IV:* All other harmful procedures to the female genitalia for non-medical purposes, such as pricking, piercing, incising, scraping and cauterization. Sometimes the word ‘sunna’ is used to refer to this type.

Somalia as many as 98% of women aged between 15 and 49 years are circumcised. FGM/C also occurs in Asia (Indonesia) and the Middle East (Kurdistan, Yemen) and recently also among groups of migrants in Australia, North America and Europe (WHO 2012b). The circumcision is usually carried out before the girl has reached puberty. Ages differ widely, with girls being circumcised soon afterbirth in Eritrea, whereas in Guinea-Conakry women may be circumcised just before marriage. There is a higher incidence among Muslims, but the custom itself is not Islamic. According to estimates by the World Health Organization (WHO 2012b), at present about 140 million women and girls worldwide have undergone circumcision. In Africa, some 3 million girls are at risk annually of being circumcised – which comes down to some 6000–8000 girls per day. In the Netherlands, some 60,000 women and girls originate in regions where FGM is common and are either at risk of being circumcised or have been circumcised (CBS 2010).

Female circumcision can cause serious physical health problems. Research by the WHO Study Group on Female Genital Mutilation and Obstetric Outcome (2006) found that women in Africa who had been circumcised experienced more complications during childbirth, including a larger incidence of Caesarean sections, haemorrhaging and a higher infant mortality rate. Chronic urinary complaints, cysts, ulcers, fistulas and infertility may develop later on (Almroth 2005; Morison et al. 2004).

In addition, long-lasting sexual problems are reported, including dyspareunia and vaginismus (Livermore, Monteiro and Rymer 2007), not only in infibulated women (Type III, whereby the vagina is stitched closed except for a small opening) but also in women with less severe cutting (Alsibiani and Rouzi 2008). Pain during intercourse is frequently mentioned and can have a negative impact on the relationship between men and women (Aydoğan and Cense 2003).

However, little is known about the psychosocial and relational consequences of FGM/C. While some research points to the fact that FGM/C may lead in the long term to trauma-related complaints, anxiety disorders, a distorted or negative self-image and feelings of incompleteness and distrust (Chibber, El-Saleh and El Harmi 2011; Lax 2000), a review of 17 studies into the psychological, social and sexual

consequences of FGM concludes that the evidence is 'insufficient to draw conclusions' (Berg, Denison and Fretheim 2010, 3).

Most of these studies were carried out in countries with a high prevalence of FGM, but even less is known about the psychosocial and relational problems associated with FGM in circumcised migrant women in Western countries. The migration of large groups of African refugees to Europe and the USA introduced the phenomenon of FGM/C and its consequences to these countries.

Migration has its own dynamic, and the process of acculturation itself may cause stress and influence health and well-being (Berry 2008; Bhugra 2004). This migration-related stress is also responsible for the high prevalence of mental health problems among migrants (Carta et al. 2005), including depression (Vega, Kolody and Valle 2000) and post-traumatic stress responses (Silove et al. 2005). The prohibition of FGM/C in most Western countries may have a considerable impact on circumcised migrant women, since what was once regarded as normal, even indisputable, is now labelled deviant and repulsive (Johnsdotter 2007).

However, until recently only one qualitative study on the psychosocial and relational problems had been conducted in Europe, among Sudanese and Somali women in Manchester (Lockhart 1999). Three quarters of the respondents in this study mentioned recurrent intrusive memories and loss of impulse control. The type of circumcision, the associated physical complaints and the use of an anaesthetic were the determining factors for the development of a post-traumatic stress syndrome (Lockhart 2004). Overall there seemed to be a dearth of targeted research into this matter (Gruenbaum 2005; Obermeyer 2005; UNICEF 2005), even in the Netherlands, where the government has supported several FGM prevention projects within the migrant communities at risk of circumcision. This lack of knowledge was the main reason for our study. The problems faced by these victims needed to be more clearly identified for providers to be able to offer better health services. The study further aimed at generating empirically based conclusions about the impact of migration on long-term psychosocial consequences of FGM/C. As such the study is relevant to this special issue on chronicity.

## **Methodology**

The study into the mental, psychosocial and relational problems of circumcised migrant women in the Netherlands was performed in 2008/2009 (Vloeberghs et al. 2011). Our research questions were: does FGM/C lead to mental, social and/or relational problems? And if so, what is the nature of these problems, and which factors contribute to the development of problems? Thirdly, what are the coping mechanisms these migrant women develop in relation to their problems and the above-mentioned factors?

## ***Study design***

A mixed-methods design was used (Creswell 2008) which is a highly appropriate method for difficult-to-reach populations (de Jong and van Ommeren 2002). We combined a quantitative approach, using culturally validated structured questionnaires, with qualitative participatory methods, involving in-depth interviews with circumcised migrant women from different countries performed by peer researchers.

Using Grounded Theory, triangulation was sought in understanding the mental, social and relational consequences of FGM/C in a migration context, and how the women deal with those consequences. Hammersley and Atkinson use the term ‘filling in the gaps’ (1983), meaning that in the course of the investigation it *becomes* clear which elements are important and which are not. As such the understanding of the material and the answers to the questions develop step by step.

### **Study population**

In the Netherlands, the largest relevant communities originate from Egypt, Eritrea, Ethiopia, Sierra Leone, Somalia and Sudan (CBS 2010). For this study, we used a purposive sampling strategy, including 66 women with variations in country of birth, age, marital status, education and type of circumcision (see Table 1).

Since access to the Egyptian immigrant women appeared to be impossible at the time, respondents were recruited from the other five countries only. A comparatively larger number of respondents (18 rather than 12) were recruited from Somalia and Sudan, as the most severe type of circumcision (infibulation, Type III) is practised in these countries, and the highest prevalence of psychosocial problems were expected. Respondents were recruited by the so-called ‘snowball’ method, which is effective in including marginal, hard-to-reach populations (Crescenzi et al. 2002). Snowball

Table 1. Socio-demographic characteristics of the research sample ( $N=66$ ).

Variable	<i>M</i>	SD	Range
Age	35.5	10.5	18–69
Age at circumcision	6.4	4.1	0.8–16
Years in the Netherlands	10.9	6.3	2–20
	<i>N</i>	%	
Country of birth			
Somalia	18	27	
Sierra Leone	12	18	
Sudan	18	27	
Eritrea	12	18	
Ethiopia	6	9	
Type of circumcision			
Clitoridectomy (Type I)	21	32	
Excision (Type II)	9	14	
Infibulation (Type III)	35	54	
Civil status			
Single, divorced, widowed	33	57	
Married with children	25	43	
Level of education			
No education/primary school	9	16	
Secondary school	24	43	
Higher education	23	41	
Source of income			
Job, social benefit	37	66	
No independent income	19	34	

sampling involves insiders in a particular group selecting individuals (based on certain characteristics) who are used to contact others who meet the same criteria. In this case, the interviewers approached women within their circle of friends and acquaintances, sometimes with the help of key people. The respondents were informed about the aim of the study by means of an information sheet (which was read out by the interviewer for illiterate respondents). Participants were reassured about confidentiality, asked to sign the Informed Consent form and told that they were not obliged to answer questions that they did not wish to answer.

To gain the women's trust and co-operation, it was important to actively involve the research population in the research process, both in terms of data collection and in interpreting and analysing data. Representatives of the communities were consulted on preferred terminology and phrasing of the questions and the acceptability of research instruments. Interviews were performed orally by seven peer researchers from the same country who had undergone circumcision themselves. These peer researchers were specifically recruited and trained for this study. The training provided by the research team concerned the aim of the study, the way in which the interviews should be conducted and how to handle possible risks and deal with ethical aspects concerning the process of collecting personal data. The interviewers met regularly to discuss extensively how questions were formulated, how answers were noted and how special situations were dealt with (such as respondents who refused to answer or did not understand certain questions). During these meetings they could share their experiences and reflect on possible effects of the interview process. Recruitment, coaching and monitoring of the interviewers were done in close co-operation with the Federation of Somali Associations in the Netherlands (FSAN) and other community women's organisations.

### ***Instruments***

The survey consisted of four questionnaires including:

- the *Harvard Trauma Questionnaire* (HTQ-30; Mollica et al. 1992), a 30-item transculturally validated screening instrument for post-traumatic stress disorder (PTSD) symptomatology (Cronbach's  $\alpha = 0.96$  in the current sample);
- the *Hopkins Symptom Checklist* (HSCL-25; Mollica et al. 1996), which measures anxiety (10 items) and depression symptoms (15 items) and has proven to be useful as a screening instrument in several cross-cultural studies and patient studies (Hansson et al. 1994; Kleijn et al. 1998; Tinghog and Carstensen 2010) (Cronbach's  $\alpha = 0.96$  for the total HSCL-25 score);
- the *COPE-Easy* (Carver, Scheier and Weintraub. 1989), which measures different coping styles by means of 32 items (Cronbach's  $\alpha$  varying between 0.67 for avoidance behaviour and 0.91 for active problem-directed coping); and
- the *Lowlands Acculturation Scale* (LAS; Mooren et al. 2001), which assesses the level of cultural adaptation with 20 items and distinguishes between a global orientation towards the past (and land of origin) as opposed to the orientation towards the future (and country of current residence) in terms of integration skills and culture bound traditions (Cronbach's  $\alpha$  for the subscales varies between 0.61 and 0.69).

All instruments were translated into the different languages, applying a back-translation procedure. A preliminary version of the questionnaires was pilot tested with 10 women, and both content and format were revised on the basis of the results.

### *Cultural validity of the questionnaires*

For HTQ and HSCL excellent cross-cultural psychometric results have been reported (see Kleijn et al. 1998; Mollica et al. 1992). Reliability and validity of the LAS with different cultural groups are reported (see Knipscheer et al. 2009; Mooren et al. 2001). No data have been reported yet concerning the cross-cultural validity of COPE-Easy.

### *Semi-structured interview (topic list)*

In addition to these structured questionnaires, semi-structured in-depth interviews were conducted with all respondents. The topic list used was developed in a gradual process using focus group discussions with peer researchers and local informants from the migrant communities involved. This resulted in a concept topic list that was adapted, amended and pretested during the training. The final topic list included questions about the circumcision itself, changes due to migration to the Netherlands, women's first sexual encounter, the impact of education and information about FGM/C, whether they have contact with non-circumcised women, and about their experiences with service providers in the Netherlands.

### *Data collection and analysis*

The semi-structured interview was conducted during the first meeting with the respondents. Shortly (mostly one week) after, the questionnaires were administered. The interviews took place in the respondents' language of origin and at their homes. The duration of the interviews varied from 40 to 180 minutes. The semi-structured interviews were recorded and written down in Dutch by the peer researchers, sometimes with help from an official interpreter (with back-and-forth translation). Among all ethnic groups oral texts and the written transcriptions were checked by native speakers, showing little to no difference. The qualitative data were analysed using ATLAS.ti, a computer program used for the coding of qualitative data (labelling). The interviews were read and analysed separately by two researchers; important items were identified and coded. Afterwards the researchers' findings were compared and discussed with the research team to achieve mutual understanding and to reach conclusions.

The quantitative data for the five questionnaires were imported into SPSS (Statistical Package for the Social Sciences). All variables were summarised using standard descriptive statistics such as frequencies, means and standard deviations. Dichotomised variables were analysed with the  $\chi^2$  test or Fisher's exact test if any expected cell frequency was lower than 5.

Provided that the distributions were approximately normal or non-skewed (criteria  $< 0.5$   $\alpha > 1.5$ ), mean scores on continuous variables were analysed with parametric methods using Student's *t*-tests for independent samples and one-way analyses of variance (ANOVAs).



The framework analysis developed and used included the different factors (e.g. socio-demographic characteristics, migration factors, health care in the Netherlands, coping), the way these factors are related to, respectively, the mental, social and relational consequences of FGM/C and the direction of the relations (reciprocal or unidirectional).

In line with the ethical standards of the research institutions involved, we formed a steering committee of external experts and appointed a doctor who could be approached at any time by respondents with questions or problems resulting from the research.

## Results

### *The cutting experience*

All respondents were asked about the type of FGM/C, at what age, who performed it and how they look at it now while living in the Netherlands. Most respondents from Somalia and Sudan were circumcised Type III, the infibulation, while most women from Sierra Leone and Eritrea had undergone Type I, the clitoridectomy. Younger respondents from Somalia and Sudan, however, underwent Type II, the excision, while none of the respondents remember undergoing Type IV, the *sunna*. For 25 (41.0%) of the subjects, the event was performed unexpectedly and without any preliminary explanation.

Table 2 shows the different demographic- and circumcision-related variables. Quantitative analyses show some interesting results with regard to these variables in relation to mental health. Women who were infibulated, women who remembered clearly the event of the circumcision and women who had had education concerning the circumcision reported more PTSD symptoms [ $F(2,46) = 4.67, p < 0.05$  resp  $F(2,56) = 14.48, p < 0.001$ ] and [ $t(45.15) = 2.12, p < 0.05$ ] and more anxiety/depression [ $F(2,51) = 4.37, p < 0.05$  resp  $F(2,56) = 6.10, p < 0.001$ ] and [ $t(48.22) = 2.37, p < 0.05$ ] than the other women. Women who were older at the

Table 2. Number, means and standard deviations of HTQ and HSCL scores.

Variables	N	HTQ		HSCL		
		M	SD	M	SD	
Type of circumcision	Type I – clitoridectomy	20	42.65	11.59	34.50	7.59
	Type II – excision	8	51.14	16.38	43.75	17.81
	Type III – infibulation	26	59.00	21.41	47.19	17.30
Memory of event	Good	33	2.04	0.61	1.94	0.70
	Some	13	1.54	0.24	1.45	0.29
	Not at all	14	1.21	0.31	1.38	0.47
Source of income	Job	37	1.64	0.60	1.59	0.57
	No independent income	19	1.96	0.64	1.98	0.71
Discussed before event	No	25	1.57	0.57	1.59	0.62
	Yes	34	1.87	0.60	1.78	0.64
Education about event	Yes	28	1.93	0.71	1.90	0.69
	No	34	1.60	0.47	1.53	0.50

\* $p < 0.05$ .

time of the circumcision or with whom the circumcision was discussed before it happened reported more PTSD symptoms ( $r_{\text{ptsd}}=0.30$ ,  $N=60$ ,  $p < 0.05$  resp  $t(57) = -1.94$ ,  $p < 0.06$ ) but no more anxiety/depression. Women without independent sources of income reported more anxiety/depression compared to those with a job or social benefit,  $t(30.37) = -2.09$ ,  $p < 0.05$ . When women were older when migrating to the Netherlands, they reported more complaints ( $r_{\text{ptsd}}=0.38$ ,  $N=63$ ,  $p < 0.01$ ;  $R_{\text{anx/depres}}=0.37$ ,  $N=63$ ,  $p < 0.01$ ).

### *Mental problems*

But regardless of the association with these demographic- and FGM-related variables, respondents among all communities reported recurrent bad memories and nightmares at times, as well as pain, tension and fear or feelings of powerlessness and apathy. Anger, shame, guilt and feeling excluded were commonly mentioned emotions. Indeed, most women reported having long-lasting problems of some kind.

An indication for PTSD was present in almost one in six subjects ( $n=11$ , 17.5%), as they had an HTQ scale score that exceeds the threshold value for PTSD. Almost a third ( $n=20$ , 31.7%) showed an HSCL anxiety score above the threshold value, and one-third ( $n=22$ , 34.9%) scored above the threshold value on the HSCL depression scale.

When asked what the mutilation meant to her, an unmarried 25-year-old woman from Sierra Leone who underwent FGM/C at the age of 12, answered:

For some reason I became a frightened woman because of what they told me during my genital mutilation. They said 'you will be visited by a deceased person during your sleep.' They made it seem so real, I believed it. Since then I'm just scared all the time, and I cannot be home alone... This is all due to my circumcision. If a man makes a scary joke, it can get to me that hard it just ruins my whole day. Then I get really pissed off. Therefore, I say to my boyfriend that he may never surprise me or touch me from behind, nor should he address me secretly. And he does not dare make scary jokes with me.

Only one respondent claimed to be proud of being circumcised. An increased awareness about the health and legal consequences and many women's wish to prevent their daughters from misery and pain resulted in not having them mutilated when they were born in the Netherlands. The huge amount of media information – particularly since the Dutch government heightened its efforts to prevent FGM/C in the Netherlands in 2005 – awareness-raising campaigns and meetings among members of their own communities made the women more familiar with the consequences of FGM/C. Learning that it was not prescribed in the Quran, Hadith or Bible to genitally mutilate women fuelled the resistance of many of the respondents. They claimed that because FGM/C is related to culture, not to religion, it can and must be abolished. Media attention reinforced the conviction that they do not want the same to happen to their daughters. When asked how women around her had reacted when they had found out that FGM/C was not something that is done everywhere, a 34-year-old unmarried respondent from Eritrea with one son said:

Women ask: 'why me, why us? We are all women. We all have the same organs, the same bodies, don't we?' Then when you start asking more questions, you find out why. And

the response is anger. Angry with your traditions, your culture and mindset. Until I came to live here, I had no objection to the circumcision of young females. If I had lived in Eritrea and had a daughter, I would have had her circumcised. But whilst living here, I have learned so much that I keep asking myself: 'why, why not other people as well?' Did they do this on purpose, and if so, why? I now realize that something was taken from me. That I am disabled. That's not a good feeling. Even when the pain has gone, there is the awareness. And that makes you angry with yourself.

### *Social and sexual relations*

All but a few of the respondents said that they felt good about living in the Netherlands; they might feel homesick from time to time but overall felt safe and at home. Most respondents had regular contact with Dutch women. When the issue of FGM/C was brought up – some were asked at school, others when talking to the neighbours or to a colleague – feelings of being different, isolation and loneliness were reported frequently. Three out of 12 respondents from Sierra Leone replied to the question what FGM/C meant to them since they migrated that 'you start to isolate yourself' from people who have not been through it. A number of respondents felt that Dutch people they talked to about FGM felt sorry for them or pitied them. Accordingly, many respondents admitted to feeling ashamed. When asked why women who have been circumcised find this so difficult to talk about, a 47-year-old divorced Eritrean respondent with seven children reacted by saying:

Because this is about feelings and more than that; it is about sex. You cannot share that with other people. You feel terribly embarrassed. That is why circumcised women become isolated, mentally ill or mad. Either that or she stops talking; she keeps her mouth firmly shut. And nobody understands why. It sounds shallow, but it goes really deep. The difference is that a woman who has been circumcised will blame any pain she feels on the circumcision. That is all we know. And because we feel ashamed, we stay home with our problems.

Migration to the Netherlands has not only led to a major shift in how the women regard FGM/C but to some also their own sexuality. Two respondents with children were reluctant to even have further sexual contact due to the pain it provokes and the demands of a lawful father. A 48-year-old respondent with two children who migrated from Sudan eight years ago answered the question about what influence FGM/C has on her as follows:

FGM/C has a major influence on me. When I have guests at home I have to run to the toilet, which is really embarrassing... I never let my daughters be circumcised. I take care no one persuades them to have it done, and I will not leave them to choose.

Interviewer: As for sex, do you think there is a difference between a circumcised and an uncircumcised woman?

Yes, at least an uncircumcised woman has a normal life. A circumcised woman needs so much help. And eventually you never feel at ease.

Interviewer: *How do you feel about uncircumcised woman?*

I'm jealous of them; they are lucky. They have a normal life.

In a number of cases, together with the knowledge of being circumcised came suffering and anger. Migrating to the Netherlands had caused things to change with regard to sexuality. Some respondents said that a number of the men were now no longer satisfied with the women taking a passive approach to sex and were wanting their wives to act with a little bit less reserve. The women's partners had been influenced by the media and by the Internet – and in a number of cases also by having sex with women who had not been circumcised. A Sudanese respondent recounted how her husband would watch porn movies while having sex and would want her to try all sorts of positions: 'But I cannot possibly do what she is doing. I have been circumcised – she hasn't. So I will say to him, 'don't ask me to do the impossible.'"

Some women were troubled by or even angry with men. Eight respondents reported feelings of despair, frustration and anger towards men in general, and their frequently self-centred behaviour in particular. In at least one case a divorce resulted from the inability of the infibulated woman to comply with her husband's sexual demands. Overall, however, there seemed to be acceptance of the changes due to migration and to the fact that men and women should be allies in bed.

### ***General health and health providers***

Women most frequently mentioned regularly having abdominal and menstruation-related complaints. Three respondents mentioned recurrent urinary tract infections ('every three to five months'). One respondent said that she was incontinent as a result of complications during childbirth and that she had been under treatment for 10 years.

Only three out of 66 respondents said that they had never visited a doctor in the Netherlands. Three respondents indicated that they were seeing or had been to a psychiatrist or ambulatory mental health provider.

When asked how they experienced health care in the Netherlands, many respondents answered that they often felt embarrassed, sad or guilty because of the way service providers behaved. The mere fact that the doctor saw their private parts during the physical examination and asked them questions was difficult for respondents. When asked why she did not discuss her circumcision with the doctor, a 32-year-old unmarried respondent from Sierra Leone with one daughter responded by saying that she was 'pigheaded.' She said doctors or service providers 'sometimes ask whether I have been circumcised, but I don't respond to that.'

When asked why she did not go and see a doctor about her complaints, a 35-year-old unmarried Somali woman with two children replied:

My family doctor is a man, and I don't feel like showing him my private parts. That means having to explain everything all over again, and that is something I absolutely don't feel like. I don't want to be reminded of the pain.

*Interviewer: What does the pain do to you?*

I start to tremble all over, and all the memories come flooding back. I cannot do anything for the next few days, and all I want to do is sleep.

During childbirth or when suffering from medical or mental problems, some respondents still felt reluctant to attend a health professional. Difficulties with speaking Dutch and an unwillingness to talk to non-family members about private

matters (such as sexuality) are holding them back. However, previous bad experiences with health workers and their lack of knowledge about FGM/C were equally important. For a number of respondents the look of surprise or shock on the face of the person carrying out the examination was enough to make respondents blush or make them feel as if they had done something wrong. Being looked at in an invasive manner ('medical gaze') provoked a lot of shame. A 40-year-old married Sudanese respondent with four children of whom two were born in the Netherlands said about her first delivery in the Netherlands:

Many health workers saw me during labour. They went outside to talk to each other, returned and then looked at me again. It took a long time. Finally I told them they should do a Caesarean section, but they said there was no reason for it. There were six or seven doctors in the delivery room with me. I was afraid for myself.

An Ethiopian respondent said that she thought her first visit to the doctor was terrible, and that she felt 'abnormal.' A 38-year-old married respondent from Somalia with three children said:

You can see the facial expressions of the nurse, the doctor, the midwife. You can see their faces, the range of emotions and how they are looking at my body. That hurts... Those people's eyes make you feel sick.

Feelings of shame could reach the point where women did not seek help for their problems. But Dutch medical professionals who, in a careful way, show confidence in their actions and show sensitive behaviour and respect towards the women were able to smooth the tension and provide help. Overall two women spoke to the treatment provider about the psychosocial problems they were experiencing as a result of having been circumcised. Both said that they felt better after talking about it. One of them was an unmarried 26-year-old woman from Sierra Leone who had been circumcised at age 16. When asked with whom she discussed this, this mother of two children replied by saying:

I do talk to my friend about it sometimes. She is a Dutch woman. And I also talk to a counsellor with the RIAGG [ambulatory mental health services] to alleviate the pain. That helped a little bit. Sometimes I have nightmares about what happened that evening. It still affects me to this day, but there is nothing I can do about it. Fortunately I am not in Africa anymore.

### ***Coping with FGM/C***

Respondents were asked what they did in case of problems or complaints. Respondents from Eritrea, Sierra Leone and Sudan often answered this question firmly and succinctly; however, most of the Somali and Ethiopian respondents were not very forthcoming. Somali respondents seemed to have more problems communicating about FGM/C. Talking causes harm according to some respondents. One Somali respondent put into words what in fact appeared to be the standard view among these women: 'I have to carry on with my life now and look ahead.' However, when asked what she did, when she was having a hard time, one respondent from this group, who was married with three children, replied that she would 'rather get into

some form of physical exercise; that is more of a release. A lot of women watch TV or listen to music, but I find exercise more beneficial.'

Seven Somali respondents referred to religious activities as a means of achieving comfort and strength. Religion was also an important coping mechanism for women from other countries. Four respondents from Sierra Leone indicated that they would read the Bible whenever they were going through a bad patch. One respondent from this group said that she had forgiven her parents for having her circumcised: 'I would not have been able to do that without my faith.' Five of the Sudanese respondents and two of the Eritrean women sought comfort in prayer.

In the quantitative study, we found that a more avoidance-oriented coping style is correlated with the reporting of more PTSD symptoms and anxiety/depression ( $r_{\text{ptsd}}=0.42$ ,  $N=58$ ,  $p < 0.001$ ;  $r_{\text{anx/depres}}=0.47$ ,  $N=60$ ,  $p < 0.001$ ) and more substance abuse ( $r_{\text{ptsd}}=0.48$ ,  $N=52$ ,  $p < 0.001$ ;  $r_{\text{anx/depres}}=0.58$ ,  $N=54$ ,  $p < 0.001$ ).

Some respondents said they would talk when things were bothering them. In many cases, they would seek out friends or talk to them over the phone. When asked what she would do at difficult times, a Sudanese respondent (39-years-old, married with one daughter) who had been living in the Netherlands for more than 30 years replied:

Because I came to the Netherlands reasonably young, and because I studied here, I have learned from Dutch people and through my training that I need to talk when something is bothering me. I talk about it to my husband, girlfriends and colleagues at work. I treat myself to a sauna or a jacuzzi or I do some exercise.

We expected the use of support-seeking coping to result in a decline in mental health complaints. However, a more support-seeking coping style is correlated with more anxiety/depression ( $r_{\text{anx/depres}}=0.32$ ,  $N=60$ ,  $p < 0.05$ ), so women who sought support did not present fewer PTSD symptoms but in fact presented more complaints of anxiety or depression than women who did not seek support. The interviews showed that a number of respondents had indicated that they did not receive a lot of support from people who were important to them, such as their partners or mothers (in-law). A considerable number of respondents felt lonely and felt like a spectacle when seeking the help of service providers in the Netherlands, particularly when they were giving birth.

## Discussion

Mental, psychosocial and relational effects as a result of FGM/C were found among all the respondents of this study. Symptoms of anxiety and depression were found among one-third of the respondents. One in every six respondents suffered from trauma-related symptoms. Respondents who underwent a milder form of FGM/C also reported post-traumatic symptoms. A combination of infibulation, vivid memory, migration at a later age, little education and language skills and inadequate support from the partner are concomitant with serious symptoms. In particular, women who were infibulated, who came to the Netherlands at a later age and do not hold a job indicated feeling depressed and anxious.

Migration to the Netherlands in many cases brought about more awareness, including about the possible health problems related to FGM/C. To most women

migration appears to be liberation from the social pressure to comply with a harmful tradition, while at the same time some women seem to feel lost or experience a life of shame and pain. Confrontation with an environment that shows little understanding of FGM can result in feelings of shame and guilt. Problems with health care providers are common also in other Western countries: pregnant immigrant circumcised women in Sweden preferred to stay at home, even if they knew they had health problems, to avoid alleged insults from the midwives because they felt they were 'being stared at and being looked down on' (Berggren, Bergstrom and Edberg 2006, 54).

According to the 'mutual maintenance model' (Asmundson et al. 2002), pain may trigger the memory of what caused the pain, while this memory in turn may lead to experiencing the pain again. Migration and with it awareness about the consequences of FGM/C seem to trigger the recollection of the event and experience of pain. This coincides with previous findings indicating that circumcised women experience more pain after migrating to a Western country than prior to migration (Johansen 2002).

In general, it can be concluded that FGM/C is associated with chronic mental health problems, even many years after the event. Living with pain, particularly among infibulated women, appears to cause impediments and problems on the physical as well as mental and social levels. At the same time it became clear that serious mental health problems, such as PTSD and depression, are found among a relatively small sample.

When we discussed and compared our data, we started to see a taxonomy of different ways in which the individual immigrant woman copes. Apparently a combination of context conditions (such as relational aspects, the level of isolation and previous experiences with Dutch health care providers), combined with the perception of the cutting, the coping style of the women involved and whether she is capable of (self-)acceptance all influence the development of chronic mental problems associated with FGM/C.

The taxonomy implies a categorisation of groups of women based on how they dealt with having been circumcised and whether they sought help or avoided seeking help. We also looked at the degree of influence a woman said she felt she had over her situation: did she dare to say 'no'? Did she stand up for herself? The taxonomy identifies and points to some urgent aspects and in part implies options for service providers as to what can or cannot be addressed. This taxonomy was shared with the interviewers, who came from similar ethnic backgrounds as the respondents.

We distinguish three types of how circumcised women living as migrants in the Netherlands cope with the consequences of FGM/C: the adaptives, the disempowered and the traumatised.

*The adaptives* are overcoming the FGM experience. This group consists of women who are adapting, with different rates of success, and activists. The adaptives are troubled by problems (of a physical and sexual nature), but they are able to cope with these. They talk about what bothers them and, if needed, go and see a health provider. Some of them are in contact with their family in their country of origin, but in general they take an independent position. They might use religion as a key to adapt, as they know that it is not prescribed by any of the holy books. Among these adaptives are also religious women whose discourse about FGM/C (their reason for denouncing the present code of behaviour) had its roots in the Quran or the Bible. Religion determines their identity and the way they cope. In the case of Muslim

women, the opinion of the *umma* (the religious community) is important. Sexuality is a private matter, and comfort and strength are found in prayer and in attending services. As a group, the religious women report less fear and depression than non-religious women, and this may have been reflected in their adaptive coping. This coincides with the findings of earlier research (for example, Brune et al. 2002; Khawaja et al. 2008). Religion may also give these women opportunities to relate to or become friends with other Muslim or Christian women (for example, Bos 2012). Then there are women who actively oppose circumcision within the Netherlands. Their agency but also activities such as walking, reading a book and talking about it gave them strength.

*The disempowered* feel angry and defeated; they bear their grief and do not see any way out. There are indications of substance abuse, eating qat or watching television endlessly. They do not talk about what was done to them; they feel ashamed, alone and disempowered. They either avoid sexual contact or dissociate during sex. This often contributes to the poor relationships they have with their husbands. However, they do not wish to divorce; they leave things to their husbands. These women behave in a manner which is inhibited emotionally, and they face trouble letting go of their negative experiences. Sometimes they have serious mental health problems but either feel inhibited or their husbands simply do not allow them to discuss these with a service provider. A tendency to fatalism can be found among these women.

*The traumatised* have mostly been infibulated and suffered a lot of pain and sadness. They are either divorced or have a bad relationship with their husbands. They are often troubled by recurrent memories, sleep problems and chronic stress (at the thought of having sex, when reproached by their husbands, etc.). They feel misunderstood by their immediate environment and sometimes by health providers as well. Women in this group consciously isolate themselves to avoid confrontation. Shame, anger and reproach (also aimed at their mother or mother-in-law) play a major role; however, these women do not know how to cope with these feelings. As a group, the traumatised report a significantly higher incidence of anxiety and depression than other groups, which illustrates the difficult situation in which they find themselves.

### ***The broader picture***

A circumcised woman leaving her country of origin and settling in a Western country has to cross a difficult bridge. Migration apparently triggers the momentum and speed of change. But change also takes place in the respective countries of origin. In most countries, FGM/C is now forbidden by law, projects are running and information is spread throughout many localities. Policy-makers, NGOs and media in Africa are promoting the eradication of FGM/C. According to COSPE and UNICEF (Landinfo 2008), families in Sudan and Somalia now choose the less severe type of FGM/C so as 'to protect their daughters from infibulation and in order to avoid that their daughters become victims of social stigmatisation.' With the long-lasting effects of the problems related to infibulation, this means healthy progress.

On the other hand, however, FGM/C appears to be a deep-rooted cultural practice. Even nowadays among many ethnic communities in Africa an uncircumcised



woman still bears the risk of being considered an outcast (IPPF 2008). A study in Nigeria shows the difference in prevalence between Yoruba mothers and daughters only slightly lowered from 75% to 71%, even though 53% of the respondents are aware of the health hazards (Akinsanya 2011). Change will come step-by-step, rather than suddenly. Stigmatising the targeted women and cultures is, however, not a way forward. According to a UNICEF (2004) advocacy paper on FGM/C, 'rather than judging and condemning Somali society, a sensitive long-term approach is needed that takes into account the local context.' Regarding the topic of this article – the way women cope with the chronic consequences of FGM/C – our study shows the struggle of some respondents and their ineffective dealing with their complaints, but also that others learned to talk about their problems, broke the taboo and often find consolation, support and strength with each other. For the mothers the harm may already have been done, but many want to protect their daughters from enduring the same suffering. In some places in Africa a temporary transitional compromise is sought instead, and a less severe type of circumcision is done in hospitals or clinics and with the use of anaesthetics: the medicalization of FGM/C (e.g. Rasheed, Abd-Ellah and Yousef 2011). Whether that is a positive development remains an issue of debate. According to the WHO, even if health complications at the time of the operation diminish, the human right of the child is still breached, its physical integrity is damaged and the underlying subordinate position of women is untouched (Cook 2008). And at what cost? Instead: 'African health ministries that invest in curbing the practice of FGM are likely to recover a large portion of the investment by saving money from prevented obstetric complications... [and] of treating FGM-related psychological and sexual health problems' (Adam et al. 2010).

### **Methodological considerations**

Although the results of this study support the claim that FGM/C exerts a major negative impact on mental health beyond somatic complications, some caution is warranted in interpreting these results.

The small group size presents an important limitation, and the results do not allow general conclusions about the prevalence of psychiatric disorders after FGM/C. The composition characteristics of the group (i.e. the low age and the high level of education) might also have an influence on the findings of this study. The attempt to interview women with lower education levels with a female interpreter did not work out because of the sensitive subject and the highly secretive nature of FGM/C.

We tried to enhance the reliability by seeking the same information in different questions. Ethnic matching of the interviewers may work out positively (people may be more open-hearted and more honest toward an ethnically similar interviewer, and this may contribute to a more contextualised and in-depth understanding of the challenges the women face) as well as negatively (it is harder talking honestly about taboo issues, also because of the fear of gossip, which may bias the data). Selection bias influencing the results seems a probability, as all respondents were willing to talk to the interviewers about their FGM/C and its effects. It is possible that women who do not want to talk about the issue and were not included in this study suffer more or other symptoms. There is also a chance that those women advocating for the practice were either not approached or were unwilling to be interviewed for fear it would

cause them trouble (see Knipscheer & Kleber (2004a, 2004b) for similar findings concerning the effect of ethnic matching in dyads).

Notwithstanding the limitations, our study undoubtedly has a unique and innovative character. The way we recruited respondents, the active and motivated participation of the target population as well as the mixed-methods strategy through which we obtained our data provide sufficient grounds for answering the research questions validly.

## Conclusions

A selection of data from our study in the Netherlands was used to show that FGM/C is associated with mental, psychosocial and relational problems for a considerable number of migrant women. Under certain circumstances, these problems may develop into a poor mental health condition of a chronic nature. Migration appears to be an influence, but also of great importance is the way in which the women cope with their new situation and how their intimates, health care providers and the people with whom they have contact react. The way the women cope with the migrant situation and the problems they have differ considerably. Health care providers should be alert to what cues may be indicative of chronic problems and enhance their (intercultural) communication skills in relation to these problems.

## Key messages

- (1) Migration influences the perception of the immigrant women of the consequences of FGM/C.
- (2) In a number of cases migration to a Western country may result in chronic psychosocial and sexual problems.
- (3) Attentive communication skills are required when providing care or cure.

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