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Counselling & Psychotherapy

Counselling professionals' awareness and understanding of Female Genital Mutilation: training needs for working therapeutically with survivors

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Choice of Therapies in IAPT: An overview of the availability and client profile of step 3 therapies is published by the British Association for Counselling & Psychotherapy, BACP House, 15 St John's Business Park, Lutterworth, Leicestershire, LE17 4HB.

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BACP is the largest professional organisation for counselling and psychotherapy in the UK, is a company limited by guarantee 2175320 in England and Wales, and a registered charity, 298361.

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Acknowledgements:

We would like to thank Astrid Fairclough (Department of Health), Debra Sohan (Department of Health), Judy Gash (NHS England) and Vanessa Lodge (NHS England) for their support and contributions to the project.

We are also grateful to Angela Couchman, Jo Pybis and Leah Drewitt in the Research Department at BACP, Helen Coles and Victoria Heydon-Hatchett in the Professional Standards Department, Nancy Rowland (Deputy CEO, BACP) and other staff at BACP for their advice and suggestions on the survey design and earlier drafts of this report.

Finally we would like to give special thanks to all the BACP members who participated in the survey and enabled this project to take place.

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Executive summary

The British Association for Counselling and Psychotherapy (BACP) is a membership organisation of approximately 43,000 counsellors and psychotherapists. In February 2016, BACP was commissioned by NHS England and the Department for Health (DH) to undertake a survey of members to gauge their awareness and understanding of Female Genital Mutilation (FGM), as well as examples of best therapeutic practise when working with survivors of FGM and training needs.

This report summarises the findings from an online survey completed by 2,073 BACP members. It describes the key themes which emerged through analysis of qualitative data, as well as descriptive and inferential statistics from quantitative data.

Key findings

Overall, findings from the survey suggest that, in general, many counsellors and psychotherapists are lacking confidence in their awareness and understanding of FGM, including their safeguarding responsibilities.

Only a small proportion of survey respondents (approximately 10%) had knowingly worked with survivors of FGM, although these individuals had significantly better levels of confidence in their awareness and understanding of FGM than those who had not knowingly worked with survivors. Respondents felt that helpful factors when working therapeutically with survivors of FGM included having *cultural respect, knowledge and understanding,* being *non-judgemental/accepting* and *listening* to the client. The most unhelpful factor was having '*a general lack, or assumption of, awareness or understanding*'.

Less than a quarter of respondents had undertaken any training with regards to FGM, although the vast majority expressed a desire to do so.

Concluding comments

It is concluded that organisations employing counselling and psychotherapy professionals, as well as practitioners working in private practice, be aware of their responsibilities with regards to safeguarding procedures in their local areas, and ensure that these are communicated appropriately. Furthermore, organisations should ensure that all staff, including, for example, those working on a voluntary or contractual basis for the organisation, are given information and training on FGM appropriate to their role.

In addition, better signposting to existing educational and training resources would be beneficial for counsellors and psychotherapists. Where appropriate resources do not already exist, these should be developed and targeted at counselling and psychotherapy professionals, including supervisors.

Background

Female Genital Mutilation (FGM), also known as 'female circumcision' or 'cutting', is an act of deliberately cutting, injuring or changing a female's genitals, where there is no medical reason for doing so (NHS Choices, 2016). Despite FGM being a historic practice, it has only recently received widespread attention across governments, non-governmental organisations (NGOs) and national and international communities (World Health Organization, 2011). Indeed, Dr Babatunde Osotimehin, Head of the United Nations Population Fund, has recently - and for the very first time - described the practice of FGM as 'child abuse' (BBC, 2016).

The act of carrying out FGM has been a criminal offence in the UK since 1985 when the Prohibition of Female Circumcision Act was passed. This was replaced by the Female Genital Mutilation Act 2003 in England, Wales and Northern Ireland, and in Scotland with the Prohibition of Female Genital Mutilation (Scotland) Act 2005. Under these Acts, it is illegal for any person in the UK - irrespective of nationality or status of residence - to perform FGM or to assist a girl to carry out FGM on herself. It is also an offence to assist a non-UK national or resident to carry out FGM outside of the UK on a UK national or UK resident. In addition, it is also an offence for a UK national or UK resident to perform FGM abroad, assist a girl to perform FGM on herself outside the UK or assist (from outside the UK) a non-UK national or resident to carry out FGM outside the UK on a UK national or UK resident (Ministry of Justice/Home Office, 2015).

Since 31 October 2015, there has been a mandatory duty for regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18s (which they have come across in their professional work) to the police (Ministry of Justice/Home Office, 2015). The mandatory reporting duty does not apply to teachers or regulated health and social care professionals in Northern Ireland and Scotland, although they should continue to comply with their existing safeguarding responsibilities (Home Office, 2015).

Counsellors and psychotherapists are not statutorily regulated healthcare professionals and therefore are not bound by these mandatory reporting duties. However, in any circumstances where a disclosure of FGM is made, or where there is a risk of FGM to another individual, there is an expectation by the Home Office that statutorily unregulated professionals will follow the established safeguarding policies and procedures within their area (Home Office, 2015); this will most likely involve reporting the disclosure to an institution's safeguarding lead.

In February 2016, BACP was approached by the DH and NHS England to undertake a survey of BACP members' awareness and understanding of FGM, to gauge their training needs and examples of best therapeutic practice when working with survivors of FGM. BACP is a membership organisation of approximately 43,000 counsellors and psychotherapists: one of its main aims is to support counsellors and psychotherapists and help them to better serve their clients.

It is hoped that the findings from this survey will inform and underpin the DH's FGM Prevention Programme, "a national £3 million change programme to improve the way in

which the NHS responds to the health needs of girls and women who have had FGM, and to actively support prevention" (Department of Health, 2015).

Method

BACP, in collaboration with DH FGM Prevention Programme project workers, designed an online survey for distribution to all BACP members. The survey (Appendix A) included multiple open and closed questions in order to elicit the most appropriate and useful information from members. The survey covered four broad themes:

- *About me*: gender, age, geographical location, client group worked with, sector of counselling practice, core counselling and psychotherapy training and theoretical modality
- *Awareness and understanding of FGM*: understanding of what FGM is, the four main types of FGM, which communities might practise FGM, confidence in recognising indicators of FGM and understanding of safeguarding duties
- *Experience of working therapeutically with survivors of FGM*: how FGM affects survivors psychologically and what the helpful/unhelpful factors are when working therapeutically with survivors of FGM
- *FGM training*: FGM training to date, levels of interest in undertaking (further) training and preference for medium of training delivery

At the beginning of May 2016, the survey was sent out via email to 41,599 BACP members who had opted in to receive email communications from BACP. Members had up to three weeks to respond and a reminder email was sent out one week before the deadline. A total of 2,073 (5.0%) members responded to the survey, which is lower than the response rate generally obtained through BACP membership surveys; usually between 8 and 14%.

Descriptive analyses were conducted on quantitative data to give an overview of the responses as a whole. Respondents' confidence in their awareness and understanding of FGM was measured using a 5-point Likert-type scale (*not at all confident* to *completely confident*). In addition, inferential analyses were undertaken on selected quantitative data to elicit any differences in understanding between groups, such as practitioners working in different settings and those with or without prior experience of working with survivors of FGM. The Statistical Packages for the Social Sciences© (SPSS) version 18.0 was used to undertake the quantitative analyses. Thematic content analysis was undertaken on qualitative data to understand the common themes across responses, as well to give an indication of the commonality of each theme.

Results

Table 1: Overview of demographics, workplace and training of survey respondents

		n	%
Gender	Female	1804	87.0
	Male	189	9.1
	Other	4	0.2
	Prefer not to say	14	0.7
	Missing	62	3.0
Age	Younger than 30 years	52	2.5
	30-39 years	188	9.1
	40-49 years	427	20.6
	50-59 years	766	36.7
	60-69 years	472	22.8
	70 years or older	76	3.7
	Prefer not to say	32	1.5
	Missing	60	2.9
Country/region of practice*	England	1760	84.9
	Scotland	93	4.5
	Wales	79	3.8
	Northern Ireland	56	2.7
	Other UK location	5	0.2
	Outside of the UK	42	2.0
	Missing	79	3.8
Workplace setting*	Private practice	1133	54.7
	Third/charitable/voluntary sector	939	45.3
	Healthcare (e.g. primary, secondary, tertiary NHS/other healthcare settings)	396	19.1
	Primary/secondary education	305	14.7
	Workplace (e.g. Employee Assistance Programme)	260	12.5
	Universities and Colleges/Further and Higher Education (HE/FE)	184	8.9
	I am a student/trainee who has not yet undertaken a placement	36	1.7
	I have not practised in the last 3 years	15	0.7

	Other	48	2.3
	Missing	11	0.5
Level of core training*	Higher National Certificate (HNC)/Certificate of Higher Education (CertHE)	182	8.8
	Foundation Degree/Diploma of Higher Education (DipHE)/Higher National Diploma (HND)	805	38.8
	Bachelor’s Degree/Bachelor’s Degree with Honours/Graduate Diploma/Graduate Certificate	552	26.6
	Master’s Degree/Postgraduate Diploma/Postgraduate Certificate	785	37.9
	Doctoral Degree	39	1.9
	Diploma – level not specified	58	2.8
	Other	22	1.1
	Prefer not to say	55	2.7
	Missing	71	3.4
Theoretical modality trained in*	Humanistic/person-centred therapies	1509	72.8
	Psychodynamic/psychoanalytic therapies	684	33.0
	Cognitive Analytical/Behavioural Therapies (CAT/CBT)	519	25.0
	Integrative	258	12.4
	Other	241	11.6
	Missing	62	3.0

NOTE: Percentages are calculated as a proportion of the number of people who entered the survey (n=2,073).

***Respondents could select more than one response for these categories and so percentages total more than 100.**

Table 1 shows the demographic characteristics (i.e., age and gender), workplace and training information of survey respondents.

Demographics

The majority of respondents were female (n=1804, 87.0%), with just under a tenth (n=189, 9.1%) identifying as male. 76 (3.7%) respondents either did not provide a response to this question or preferred not to disclose their gender. The remaining 4 (0.2%) respondents did not identify as male or female, and instead selected ‘other’. ‘Other’ responses included ‘transgender’ and ‘non-binary’.

Over three-quarters of respondents (n=1665, 80.3%) were aged between 40 and 69 years.

Workplace/practise information

Respondents were asked to provide details about their counselling and psychotherapy practise, including: the sector(s) within which they work, the country/region(s) where they practise and the client group(s) they work with.

Sector of practice

Just over half of all respondents (n=1133, 54.7%) worked in private practice, and just under half (n=939, 45.3%) worked in the third/charitable/voluntary (TCV) sector. A smaller proportion of respondents worked in a healthcare setting (n=396, 19.2%), primary or secondary education (n=305, 14.7%), a workplace setting (n=260, 12.5%) or a higher/further education (HE/FE) setting (n=184, 8.9%). Forty-eight (2.3%) respondents identified themselves as working in an ‘other’ setting, which included residential homes, community-based services and addiction services, amongst a range of other settings.

Country/region of practice

Most respondents indicated that they practise in England (n=1760, 84.9%), with a small proportion practising in Scotland (n=93, 4.5%), Wales (n=79, 3.8%), Northern Ireland (n=56, 2.7%), other UK location (n=5, 0.2%) or outside of the UK (n=42, 2.0%). Seventy-nine (3.8%) respondents did not respond to this question, although a very small proportion (n=41, 2.0%) practised in more than one country.

Of those respondents who indicated that they practise in England, just over a third (n=588, 33.4%) practise in the South of England and just under a quarter (n=413, 23.5%) practise in the Midlands and East of England. Similar numbers indicated that they practise in the North of England (n=396, 22.5%) and London (n=390, 22.2%). Again, a small proportion of respondents (n=27, 1.5%) practise across more than one region in England.

Client group(s) worked with

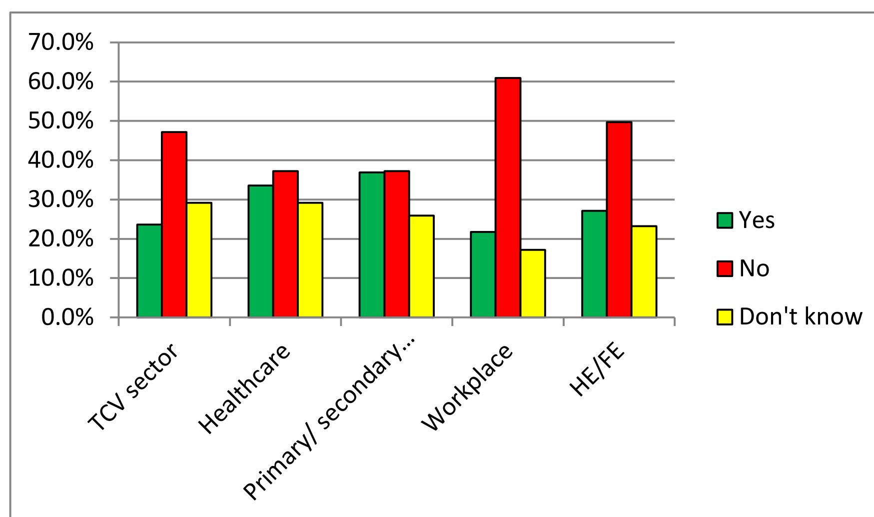
The vast majority of respondents (n=1806, 87.1%) work with adults of working age (18-64 years); approximately a quarter (n=534, 25.8%) work with young people up to the age of 18 years and around a fifth (n=418, 20.2%) work with older adults (65+ years). Respondents could select more than one option for this question and so percentages total more than 100.

This question was not applicable to a small proportion of respondents (n=80, 3.9%) as they were either retired or in training. Eleven respondents (0.5%) did not answer this question.

FGM lead/safeguarding lead with responsibility for FGM

Respondents who indicated that they worked within an organisation (TCV sector, healthcare, primary/secondary education, workplace and HE/FE) were asked whether '*there was an FGM lead, or a safeguarding lead with responsibility for FGM, within their organisation*'. Figure 1 provides a breakdown of 'yes', 'no' and 'don't know' responses to this question, further broken down by workplace sector.

Figure 1: Column graph of responses to the question, 'is there an FGM lead, or a safeguarding lead with responsibility for FGM, in your organisation?'



Those working in primary/secondary education settings were most likely to have a designated FGM, or safeguarding lead (36.9%); those working in a workplace setting were the least likely (21.8%). However, levels of uncertainty were fairly high across all sectors, with 'don't know' responses ranging from 17.2% (workplace) to 29.2% (TCV sector and healthcare).

Counselling/psychotherapy training

Almost two-thirds of respondents held either a foundation degree/diploma of higher education/higher national diploma or equivalent (n=805, 38.8%) or a Bachelor's Degree/ Graduate Diploma/Graduate Certificate or equivalent (n=552, 26.6%). A Master's Degree/postgraduate diploma/postgraduate certificate or equivalent was held by 37.9% (n=785) of respondents.

Almost three-quarters (n=1509, 72.8%) had trained in a humanistic/person-centred therapy, approximately a third (n=684, 33.0%) in a psychodynamic/psychoanalytic therapy and a quarter (n=519, 25.0%) in a cognitive analytical/behavioural therapy. A total of 258 (12.4%) respondents had trained in an integrative approach and 241 (11.6%) indicated that they had trained in an 'other' approach, which included - but was not limited to - family/systemic

therapy, Eye Movement Desensitization and Reprocessing (EMDR) and Transactional Analysis (TA).

Awareness and understanding of FGM

Figure 2 provides an overview of responses to the Likert-scale questions regarding awareness and understanding of FGM. Levels of confidence across all areas were fairly low, although respondents were least confident in their understanding of the four main types of FGM. Respondents were most confident in their understanding of what FGM is, with 25.1% of respondents being 'very' or 'completely' confident that they understood this.

Respondents were also asked about their confidence to carry out their legal responsibilities if someone under the age of 18 discloses to them that they have undergone FGM. Of the 1562 respondents for whom this question was applicable, over a third (n=571, 36.6%) felt 'not at all' or 'a little confident', just under a quarter (n=371, 23.8%) felt 'moderately confident' and just under a third (n=491, 31.4%) felt 'very' or 'completely confident'. The remaining 129 (8.3%) failed to answer this question.

Of the 2073 survey respondents, the majority (n =1420, 68.5%) stated that they had not knowingly worked with FGM survivors, 283 (13.7%) did not know whether or not they had worked with FGM survivors, and 192 (9.3%) indicated that they had knowingly worked with FGM survivors. The remaining 178 (8.6%) respondents did not respond to this question.

Mann-Whitney tests were undertaken on the data to determine:

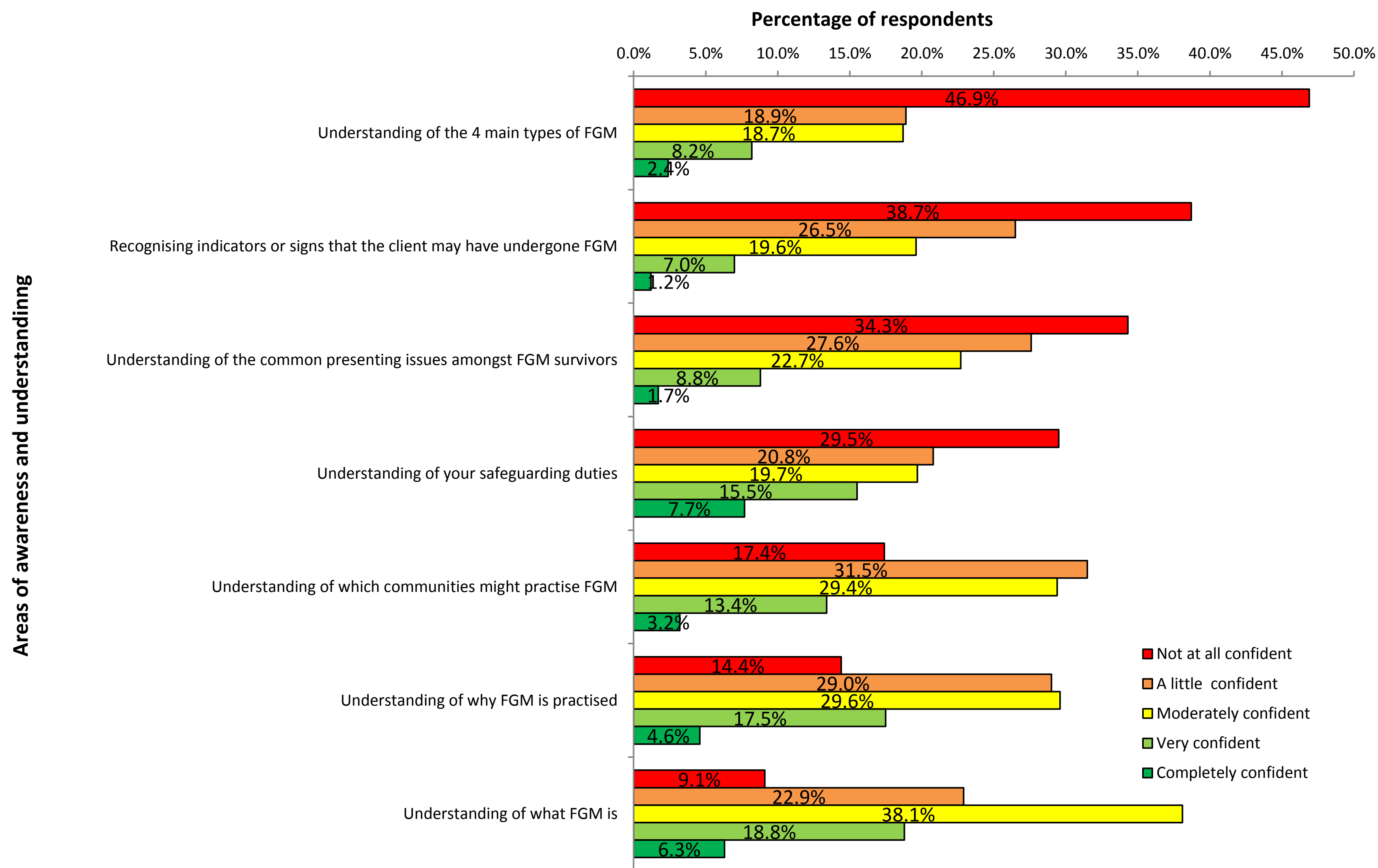
a) any differences in levels of confidence in awareness and understanding between practitioners who had knowingly worked with survivors of FGM and those who had not.

b) any differences in levels of confidence in awareness and understanding between practitioners who had undertaken FGM training and those who had not.

Results indicated that practitioners who had knowingly worked with survivors of FGM were significantly more likely to report higher levels of confidence in their awareness and understanding than those practitioners who had not; statistically significant differences ($p<.001$) were found across all domains of awareness and understanding. The greatest difference in confidence levels was reported for *understanding of the common presenting issues amongst FGM survivors* between practitioners who had knowingly worked with this client group ($\bar{x}$ = 3.4) and those who had not ($\bar{x}$ = 2.0), U = 43639.5, z = -15.9, $p<.001$. The smallest difference in understanding was reported for *understanding of what FGM is*, although this difference was still statistically significant, U = 68171.0, z = -11.8, $p<.001$.

Similarly, practitioners who had undertaken FGM training were significantly more likely to report higher levels of confidence in their awareness and understanding across all areas ($p<0.001$) than those who had not undertaken any training. The greatest difference in confidence levels was reported for *understanding of your safeguarding duties when working with survivors of FGM* between practitioners who had undertaken training ($\bar{x}$ = 3.6) and those who had not ($\bar{x}$ = 2.1), U = 116660.5, z = -20.9, $p<.001$. Appendix B contains the data tables for Mann-Whitney tests.

Figure 2: Bar chart of responses to Likert-type questions regarding confidence in awareness and understanding of FGM



Experience of working therapeutically with survivors of FGM

The following results are based on analyses conducted on the data provided by the 192 respondents who had knowingly worked with FGM survivors.

Respondents were asked: '*In your experience of working therapeutically with survivors of FGM, how do you think FGM affects them psychologically in terms of presenting issues?*' All responses were subject to content analysis; a full breakdown of the themes, supporting quotations and counts can be found in Appendix C. An overview of themes and counts is presented in Table 2. *Trauma issues*, including post-traumatic stress disorder (PTSD) was the most commonly identified presenting issue, followed by *feelings of shame, embarrassment or guilt* and *lack of, or low, self-esteem*. Below are some example responses which support the identification of these themes:

"I have worked with one case of this and in this case my adult client was suffering with severe trauma which had resulted from the procedure when she was eight years [old] in another country" (Respondent #475)

"If within their cultural family they tend not to talk about it, but if more integrated some feel it is a shameful secret…" (Respondent #1839)

"Feelings of low self-worth" (Respondent #1488)

Table 2: Overview of themes – How does FGM affect survivors psychologically?

Theme	n	%
Trauma issues, including PTSD	55	28.6
Feelings of shame, embarrassment or guilt	35	18.2
Lack of, or low, self-esteem	33	17.2
Sexual issues/anxiety around sex	27	14.1
Depression	26	13.5
General anxiety	23	12.0
Anger	22	11.5
Romantic relationship issues	21	10.9
Trust issues	19	9.9
Physical pain/discomfort	16	8.3
Body image issues	13	6.8
Social withdrawal/ isolation	12	6.3
Presenting issues not universal across survivors	12	6.3
Difficulties managing the incongruence between cultures	11	5.7
Fear, or anxiety, around disclosure	10	5.2
Feelings of helplessness, or loss of control	7	3.6
Confusion	6	3.1
Reproduction/childbirth issues	6	3.1
Affects all aspects of life	5	2.6
Acceptance	5	2.6
Difficulties expressing feelings, emotions or experiences	4	2.1
Self-loathing	4	2.1
Substance misuse	4	2.1
Re-experiencing (flashbacks/nightmares)	4	2.1

Denial/dissociation	3	1.6
Suicidal ideation/self-harming behaviour	3	1.6
Feelings/fear of being judged	3	1.6
Loss, or confusion, of self-identity	3	1.6
Attachment issues	3	1.6
Fear of medical intervention	2	1.0
Feelings of dehumanisation	2	1.0
Feeling betrayed	2	1.0
Eating-related issues	2	1.0
Feelings of loss	2	1.0

NOTE: Percentages are calculated as a proportion of those respondents who indicated that they had knowingly worked with FGM survivors (n=192). Percentages may total more than 100% as responses may have included more than one theme.

Respondents were then asked: '*What, if anything, have you experienced as being **helpful** when working therapeutically with survivors of FGM?*' A total of 154 respondents (80.2%) responded to this question. Table 3 provides an overview of the themes that emerged; the full content analysis table can be found in Appendix D. Having *cultural respect, knowledge and understanding* was identified as the most helpful factor, followed by being *non-judgemental/accepting* and *listening* to the client. The following extracts support these themes:

"…when appropriate, being able to discuss diversity between myself and clients in a context of respect; having developed some cultural awareness and knowledge as background to the work helps…" (Respondent #355)

"Being very accepting, not interpreting, but listening and believing" (Respondent #1114)

"…Have really good listening skills without leaving them in silence. Be very, very real with them" (Respondent #571)

Table 3: Overview of themes – helpful factors when working therapeutically with FGM survivors

Theme	**n**	**%**
Cultural respect, knowledge and understanding	35	22.7
Non-judgemental, or accepting, therapist	30	19.5
Listening	23	14.9
Providing a safe space to talk, reflect and explore feelings	17	11.0
Empathy	14	9.1
Therapist knowledge and understanding of FGM	13	8.4
Working at the client's pace	11	7.1
Links with medical/physical health professionals	8	5.2
Longer-term intervention	8	5.2
Being 'present' with the client	7	4.5
Understanding legal issues/ duties	7	4.5
Processing the trauma, including use of EMDR	7	4.5
Educating clients	6	3.9
Supervision	6	3.9
Congruence	5	3.2
Using body-oriented techniques	4	2.6
Cognitive-behavioural techniques	4	2.6

Understanding physical implications	3	1.9
Creative therapies	3	1.9
Ability to work with sexual identity/ sexual issues	3	1.9
Working with, or resolving, conflict/ incongruence	3	1.9
Having the confidence to ask for clarity/ask questions	3	1.9
Empowering clients	3	1.9
Prior experience of working with survivors of FGM	2	1.3
Gender-based approach	2	1.3
Therapist honesty	2	1.3
Exploring interpersonal relationships	2	1.3
Not applicable responses	9	5.8

NOTE: Percentages are calculated as a proportion of those who provided a response to this question (n=154). Percentages may total more than 100% as responses may have included more than one theme.

Conversely, respondents were then asked to consider: 'W*hat, if anything, have you experienced as being* ***unhelpful*** *when working therapeutically with survivors of FGM?*' Altogether, 128 (66.0%) respondents responded to this question. The full content analysis can be viewed in Appendix E; Table 4 provides an overview of the themes and an indication of commonality. The most common theme, by a significant margin, was having '*a general lack, or assumption of, awareness or understanding*'. The following excerpts evidence this theme:

"Assuming too much knowledge; attempting to 'help' when none is needed…" (Respondent #1899)

"Clients have identified lack of awareness and judgementalism as being unhelpful…" (Respondent #2059)

"I learned from this experience to be careful about making assumptions based on my westernised upbringing and what may be universally wrong can still be nuanced culturally" (Respondent #135)

Table 4: Overview of themes – unhelpful factors when working therapeutically with FGM survivors

Theme	n	%
A general lack, or assumption of awareness/ understanding (including being judgemental)	32	25.0
Therapist reaction or expression of emotion	9	7.0
Focus on child protection/ safeguarding/ mandatory reporting issues	8	6.3
Time-limited work	8	6.3
Assuming that clients perceive FGM negatively	5	3.9
Assuming FGM is the presenting/ predominant issue	5	3.9
Questioning, or probing, the client	5	3.9
Over-empathising with, or victimising, the client	5	3.9
Language barrier	4	3.1
Assigning blame	4	3.1
Complicity with, or agreeing with, FGM practise	4	3.1
Ignoring external influences on client e.g. family or society	3	2.3

Therapist fear/ avoidance of subject	3	2.3
Insensitivity	3	2.3
Not working at clients' pace	3	2.3
Assuming universal experience of survivors	3	2.3
Cognitive-behavioural techniques	3	2.3
Focus on physical, or aesthetic issues	2	1.6
Inflexibility	2	1.6
Inaccessible services	2	1.6
Multi-disciplinary care	2	1.6
Causing the client to re-live the trauma	2	1.6
Not applicable responses	21	16.4

NOTE: Percentages are calculated as a proportion of those who provided a response to this question (n=128). Percentages may total more than 100% as responses may have included more than one theme.

Finally, respondents who indicated that they had experienced working with survivors of FGM were asked: '*if you have experienced working therapeutically with both younger (girls aged under 18 years) and older (women aged over 18 years) survivors of FGM, how do you feel their experience and your therapeutic work differed, if at all?*' Fifty-three respondents (27.6%) provided a response, although 29 of these (54.7%) were not applicable as they had not experienced working with both older and younger survivors of FGM. Just four themes emerged from the 24 eligible responses: '*no universal differences*', '*older survivors are more likely to express concerns for younger relatives*', '*enhanced safeguarding/ disclosure issues with younger clients*' and '*more family issues for younger clients*'. The examples below support these themes:

"I worked in Lebanon where younger girls under 18 and older single women have mainly the same status, they are dependent of their family and it is the family that makes all the decisions (marriage etc.) and with the cases I encountered (teenagers over 15 and adults) there wasn't much difference in their experience and the intervention…" (Respondent #495)

"…Older people are often concerned for their own children and don't know how to stop the process and can be afraid to report or actually say what they are concerned about for fear of reprisal" (Respondent #524)

"Younger women often have more safeguarding issues…" (Respondent #1216)

"Education for the younger girls, reducing their anxiety for their family" (Respondent #1631)

FGM training

The final set of survey questions focused on training: whether any training had already been undertaken with regards to FGM; what this training entailed; whether respondents would be interested in undertaking any (further) training.

Of the 2073 respondents, less than a quarter (n=460, 22.2%) indicated that they had undertaken training in this area, with over two-thirds (n=1430, 69.0%) indicating they had not. Ten (0.5%) respondents were unsure whether they had undertaken any training in this area or not and 173 (8.3%) did not provide a response.

Of the 192 respondents who had knowingly worked with FGM survivors, 166 of these also responded to the question asking whether or not they had undertaken any training to work with this client group. Almost two-thirds of these respondents (n=107, 64.5%) who indicated that they had worked with FGM survivors had also undertaken some training in this area. Altogether, 1407 respondents who indicated that they had not knowingly worked with FGM survivors also provided information about their training; just under a fifth of these (n = 278, 19.8%) had undertaken some training to work with this client group.

The 460 respondents who indicated that they had undertaken some training in the area of FGM were asked to provide further information about what this entailed. Responses were broadly split into six categories: *duration of training*, *medium of delivery*, *content*, *location of training/training provider*, *intended audience* (if not specifically for counsellors/psychotherapists) and *reasons for undertaking training*. Table 5 provides a broad overview of each superordinate theme, including the subordinate themes, and the counts to indicate commonality of responses.

Table 5: Overview of themes – previous FGM training

Superordinate theme	Subordinate theme	n	%
Duration	1 day	17	3.7
	0.5 day	8	1.7
	2 days	5	1.1
	3 hours	4	0.9
	2 hours	3	0.7
	1.5 hours	2	0.4
Medium of training delivery	Online e.g. webinars or e-learning modules	51	11.1
	Interactive (face-to-face) workshops	48	10.4
	Lecture, conference or presentation	40	8.7
	Self-learning or study day (varying modes of delivery)	16	3.5
	Reading materials (e.g. journal articles)	10	2.2
	Podcasts or radio	3	0.7
Content of training	Legal issues e.g. safeguarding and disclosure	82	17.8
	General FGM information, such as prevalence, types and practising communities	53	11.5
	Incorporated in wider abuse/assault training	36	7.8
	Awareness raising	32	7.0
	Recognising FGM	21	4.6
	Emotional/physical impact of FGM on survivors	15	3.3

	How to work (therapeutically) with survivors	11	2.4
	Refresher training	4	0.9
	Referral pathways	2	0.4
	Childbirth support	1	0.2
Location of training/ training provider	Local council	36	7.8
	NHS	34	7.4
	Third sector organisation/charity	26	5.7
	Training provided in-house	23	5.0
	Educational setting e.g. training provider, college, school etc.	16	3.5
	National Government	13	2.8
	Police	8	1.7
	Women's organisation	7	1.5
	Oversees (non-UK location)	5	1.1
	Refugee/migrant organisation	2	0.4
	Place of worship	1	0.2
	Sexual health service	1	0.2
	British Embassy	1	0.2
	British Medical Association	1	0.2
Intended audience for training (other than counsellors)	Midwife	18	3.9
	Teacher/school staff	14	3.0
	Social worker	5	1.1
	Nurse	4	0.9
	Sexual health clinic staff	3	0.7
	Health visitor	3	0.7
	Health care support worker	2	0.4
	GP	2	0.4
	Refuge crisis worker	2	0.4
	Safeguarding officer	2	0.4
	Police	1	0.2
	Academic	1	0.2
	Childminder	1	0.2
Reason for undertaking training	Mandatory requirement	31	6.7
	Self-interest	29	6.3
	Covered in course content e.g. counsellor training, nurse training etc.	24	5.2
	CPD	19	4.1

NOTE: Percentages are calculated as a proportion of those who indicated that they had undertaken prior FGM training (n=460). Percentages total more than 100% as responses may have included more than one theme.

Those who indicated that they had not undertaken any training, or were unsure whether they had (n=1440, 69.5%), were asked if they would be interested in doing so: a large number, 1154 (80.1%) indicated that they would; 85 (5.9%) were not interested; 200 (13.9%) were unsure; one respondent declined to answer. In addition, of the 460 respondents who had already undertaken some training, 342 (74.3%) were interested in undertaking further training, resulting in 1496 (72.2% of the total survey respondents) who expressed an explicit desire to undertake (further) training. Table 6 provides an overview of preferences for future training formats, which were selected from a pre-defined list.

Table 6: Preferred training format

Preferred training format	n	%
Face-to-face, discussion-based training sessions (e.g. group workshops	988	66.0
Lectures/conference presentations	803	53.7
E-learning modules	796	53.2
Interactive webinars/online seminars	646	43.2
Other	42	2.8

NOTE: Percentages are calculated as a proportion of those who indicated that they would be interested in undertaking (further) training (n=1496). Percentages total more than 100% as respondents could select more than one option.

Respondents were also asked which areas of FGM training they would be interested in undertaking. Most respondents simply said that they would like training in 'all areas', whilst more specific responses indicated a desire to undertake training related to understanding the different types of FGM, how to recognise FGM, how to work therapeutically with survivors and training on legal issues and safeguarding.

Only a very small proportion of respondents (n=150, 7.2%) were aware of the FGM E-learning for Health Programme developed by Health Education England, with the remaining respondents being either unaware of the training (n=1724, 83.2%) or declining to answer the question (n=199, 9.6%).

Discussion

Demographics

The demographic profile of survey respondents corresponds with the profile of BACP membership with the majority of survey respondents being female (87.0%) and aged between 40 and 69 years (BACP, 2016). Similarly, the workplace settings of respondents were comparable to the overall BACP membership (BACP, 2015a), with over half of respondents working in private practice; just under half in the third, charitable and voluntary sector and smaller proportions working in healthcare, primary or secondary education, a workplace setting, or further/higher education.

Therefore, despite the low response rate, it may be assumed that these results are somewhat representative of BACP members in general. In addition, the geographical spread of respondents was comparable to the UK as whole (ONS, 2014).

Workplace/practice and implications for safeguarding

Proportionally, practitioners working in primary or secondary education settings were most likely to have a designated FGM lead or a safeguarding lead with responsibility for FGM in their organisation. This is unsurprising given the statutory guidance that 'each school and college should have a designated safeguarding lead who will provide support to staff members to carry out their safeguarding duties and who will liaise closely with other services such as children's social care' (Department for Education, 2015). However, in spite of this guidance, almost two-thirds of practitioners working in these settings explicitly stated that they either did not know, or did not have, a designated FGM lead or safeguarding lead with responsibility for FGM in their organisation. This would suggest that further work is needed by schools to ensure that 'all staff members [are] aware of systems within their school or college which support safeguarding and these should be explained to them as part of staff induction' (Department for Education, 2015). Similar levels of knowledge regarding designated safeguarding leads was reflected by practitioners working in healthcare settings (both NHS and non-NHS funded), which again suggests that more needs to be done in these settings to make sure that professionals are aware of their local safeguarding procedures and protocols with regards to FGM.

Practitioners working in workplace settings (e.g. Employee Assistance Programmes), HE/FE or the TCV sector were most likely to explicitly state that they did not have a designated FGM lead or safeguarding lead with responsibility for FGM. Statutory guidance highlights that 'there is no requirement for automatic referral of adult women with FGM to adult social services or the police' (Department of Health, 2016). Practitioners working in these settings may have less contact with under-18s and in addition to this, counsellors and psychotherapists are not statutorily regulated healthcare professionals and are therefore not subject to the mandatory reporting duty. This may go some way to explaining why they do not have an FGM lead, or someone with responsibility for safeguarding against FGM in their organisation. However, should practitioners working in these settings receive disclosures regarding a child who has undergone, or who is at risk of, FGM, there is an expectation that 'they should still share this information with their local safeguarding lead, and follow their organisation's safeguarding procedures' (HM Government, 2016). Therefore, it is vital that

practitioners working in these settings are aware of their organisation's safeguarding policies and procedures with regards to FGM.

Furthermore, the Ethical Framework for the Counselling Professions (BACP, 2016) commits members to give: *'careful consideration… to the undertaking of key responsibilities for clients and how these responsibilities are allocated between the supervisor supervisee and any line manager or others with responsibilities for the service provided…'* (Good Practice, point 55). Therefore, it is important that both supervisors and their supervisors, when the supervisee is working with a survivor (whatever age) of FGM, are clear about safeguarding procedures, and who holds responsibility for the client work. Where trainee practitioners are concerned, the weight of the responsibility lies more with the supervisor, conversely with qualified or experienced practitioners it lies more with the supervisee. As BACP's Good Practice in Action: Legal Issues and Resources for Supervision in England, Northern Ireland and Wales points out supervisors have a 'duty to bring ethical or professional concerns to the attention of the supervisee' as well as a 'certain level of professional responsibility to the supervisee's clients.' (BACP, 2015b). This highlights a potential training need for those who may not work directly with survivors of FGM, but who supervise practitioners that do.

Core counselling/psychotherapy training

The varying academic levels of core counselling and psychotherapy training across survey respondents reflect the diversity of the current training field and the lack of standardised practitioner training for counsellors and psychotherapists in the absence of statutory regulation. All practising members of BACP are required to join the BACP Register of Counsellors & Psychotherapists. They become eligible to join the Register by passing the Certificate of Proficiency (a computer based assessment) or successful completion of a BACP accredited course. Members must then agree to the Register terms and conditions which include their commitment to continuing professional development. The majority of counselling and psychotherapy training courses in the UK are at, or above, the Foundation Degree/Diploma of Higher Education/Higher National Diploma or equivalent level (BACP, 2015c), which is reflected in the levels of core training undertaken by BACP members.

Similarly, the theoretical modality of practitioners' core training was diverse, with many respondents undertaking training in more than one approach. Almost three-quarters of respondents indicated that they had undertaken core practitioner training in a humanistic/person-centred therapy, which again is unsurprising given the high proportion of counselling and psychotherapy courses that provide training in these modalities (BACP, 2015c). With this in mind, it may be reasonable to suggest that any future training which focuses on working therapeutically with survivors of FGM should include elements of humanistic/person-centred theory to complement core practitioner training.

Awareness and understanding of FGM

Overall, levels of confidence in awareness and understanding of FGM were relatively low across all areas, but confidence was specifically lacking in: *understanding of the four main types of FGM*, *confidence in recognising indicators or signs that a client may have undergone FGM* and *understanding of the common presenting issues amongst FGM survivors in the therapeutic setting*. In light of this, it is recommended that there is better signposting to existing educational resources or that any training or educational materials

developed for counsellors and psychotherapists aim to increase the level of general understanding on the types of FGM, raise awareness of the risk factors associated with FGM and identify the implications for therapeutic practice when working with this client group.

Experience of working therapeutically with survivors of FGM

A relatively small proportion of survey respondents (<10%) indicated that they had knowingly worked with FGM survivors although it is possible that that the actual prevalence of FGM across clients is higher, as some may not present to therapy with FGM-related issues, or they may not disclose it during therapy.

Overall, counsellors and psychotherapists who had experienced working therapeutically with survivors of FGM felt that *trauma issues*, *feelings of shame, embarrassment or guilt* and *self-esteem issues* were the most common presenting issues amongst FGM survivors, which is in line with findings from previous research (Behrendt & Moritz, 2005; Whitehorn, Ayonrinde & Maingay, 2002; Osinowo & Taiwo, 2003). However, respondents also identified depression, general anxiety, anger, sexual issues, relationship issues, physical pain/discomfort, fear around disclosure and feelings of helplessness or loss of control as common issues amongst survivors. Again, these issues – along with many others - have previously been reflected in the literature (Behrendt & Moritz, 2005; Whitehorn, Ayonrinde & Maingay, 2002; Utz-Billing & Kentenich, 2008). The sheer breadth of issues identified suggests that the psychological effects of FGM are not universal across survivors and, indeed, this was reflected by some respondents in the present study. Therefore, it is recommended that practitioners be aware of the 'most common' psychological issues amongst survivors and be competent to work with these, but also to remain mindful of the diversity of this client group.

In line with existing best practice guidance (Khalifa & Brown, 2016), respondents felt that being culturally competent, or having *cultural respect, knowledge and understanding*, was the most helpful factor when working therapeutically with survivors of FGM. Indeed, cultural competency should be an integral part of counselling and psychotherapy training, as the need to be culturally competent is not only essential when working with survivors of FGM but also when working with clients from all ethnic and cultural backgrounds. Unsurprisingly, due to the large proportion of respondents who identified having trained in a humanistic/person-centred therapy, the other most common 'helpful' factors were in line with best practice principles underpinning these therapeutic approaches (Roth, Hill & Pilling, 2009), such as being non-judgemental or accepting, being empathic and having the ability to help clients access, express and reflect on emotions. Again, responses to this question were diverse, which reflects the heterogeneity of therapeutic approaches and clients. Conversely – and expectedly - unhelpful factors tended to be in direct contrast to helpful factors. For example, having a general lack of, or assuming, understanding and being judgemental were seen as being unhelpful factors when working therapeutically with survivors of FGM. This further highlights the need to practise in a culturally competent, and sensitive manner, particularly in cases where survivors are supportive of FGM, which was the experience of some survey respondents.

The small number of eligible responses to the question regarding differences between younger (girls under 18 years) and older survivors of FGM makes it difficult to draw definitive

conclusions from the data. Instead, therapeutic work with survivors should be determined on a 'case-by-case' basis.

FGM training

Despite less than a quarter of all survey respondents indicating that they had undertaken some training on FGM, just under two-thirds of those who had worked with survivors had also undertaken some training. It is not possible to determine whether or not training was undertaken as a result of working with survivors or whether training in this area resulted in an increase in referrals from this client group. However, it is possible that those practitioners who had undertaken training on FGM had done so because they practice in areas where FGM prevalence is highest, although this cannot be determined from the present study as respondents were not able to specify their area of practise beyond the four NHS England regions.

Nevertheless, respondents who had undertaken some training had significantly higher levels of confidence in awareness and understanding of FGM than those who had not, suggesting that training is an essential component in educating counsellors and psychotherapists and equipping them with the necessary skills to work competently with this client group. Furthermore, the majority of respondents indicated an interest in undertaking training in this area, including those who have had training previously, highlighting the demand for such resources.

The preferred method of training delivery was face-to-face, discussion-based sessions, which is congruent with the method of training required for BACP membership. In addition, as counselling and psychotherapy are relational in nature, it is unsurprising that training consistent with this approach is preferred. However, e-learning modules and interactive webinars were also preferred by over half of the respondents, formats which have the benefit of being fairly cost-effective and wide-reaching. Despite this, only a very small number of respondents were aware of the Health Education England FGM E-learning for Health Programme, which is a free e-learning resource for some professionals and those employed by the NHS, DH, Ministry of Defence (MoD) or the National Institute for Health and Care Excellence (NICE). This highlights the need to promote and raise awareness of existing resources, alongside any development of new training initiatives.

Conclusions and recommendations

The findings from this survey suggest that, in general, many counsellors and psychotherapists are lacking confidence in their awareness and understanding of FGM, including their safeguarding responsibilities.

Despite only a relatively small proportion of respondents having knowingly worked with survivors of FGM, there was a genuine desire amongst the majority of respondents to undertake training in this area. Based on those domains where awareness and understanding were lacking, such as safeguarding policies and procedures with regards to FGM, the following key recommendations are made:

- Existing FGM training and educational resources should be promoted to counsellors and psychotherapists, such as the free online Home Office training: *Female Genital Mutilation: Recognising and Preventing FGM*, via appropriate communication channels. Where appropriate resources do not already exist, these should be developed and targeted at counselling and psychotherapy professionals, including supervisors.
- Localised training on safeguarding procedures – with a specific focus on relevance to FGM - should be made available to and be undertaken by counsellors, psychotherapists and supervisors working in a variety of settings, particularly those who work with under-18s and vulnerable adults.
- Organisations should be aware of safeguarding training in their local area, such as training provided by Local Children's Safeguarding Boards (LCSBs) and, where appropriate, encourage or insist that employees undertake such training.
- Organisations should review their safeguarding policies and procedures to incorporate FGM and this should be communicated to employees through the provision of clear guidelines of duties regarding FGM. Such guidelines should also provide clear information regarding FGM/safeguarding leads within the organisation.
- Organisations should ensure that all staff, including, for example, those working on a voluntary or contractual basis for the organisation, are given information and training on FGM appropriate to their role.
- Training, including face-to-face, should be developed to promote and facilitate cultural competency and cultural sensitivity when working therapeutically with survivors of FGM. Cultural competency should be incorporated into core practitioner training; not just training specific to FGM.
- Future research should look to triangulate the data generated through this survey with clients' and external stakeholders' views to provide a better understanding of what best therapeutic practice looks like when working with survivors of FGM.

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Appendix A: FGM survey questions

Introduction

BACP has been commissioned by the Department of Health (DH) and NHS England to undertake a survey of you, our members, to gauge your current knowledge, understanding and experience of working with survivors of Female Genital Mutilation (FGM). In doing so, we aim to identify 'best practice' when working with this client group, as well as any training requirements you may have. Whilst the subsequent guidance produced by DH and NHS England may only have direct implications for those practising in England, as an organisation we are keen to establish the knowledge, understanding and experience of all our members across the four nations in this area.

The survey should only take approximately 10-15 minutes to complete.

All responses returned will be anonymised and shared with DH and NHS England to inform and underpin the FGM Prevention Programme.

By clicking 'continue' you are consenting to take part in this survey. You may exit the survey at any time by clicking on the 'x' in the top right-hand corner of the screen. You can re-enter the survey at any point and edit your responses, up until the final page of the survey. After this point you will not be able to edit your responses. Only one survey response per computer will be permitted. The closing date for survey responses is Monday 30 May 2016.

About you

The questions below will ask you for some information regarding you, your training and your workplace. This will help NHS England and the Department of Health to develop their policy in respect of the mental health needs of FGM survivors and the types of services healthcare professionals should be providing to meet the needs of survivors.

1. **Which client group do you predominantly work with? Please select all that apply.**
   - With children and young people (up to 18 years)
   - With adults (18-64 years)
   - With older adults (65+ years)

2. **In which sector(s) do you currently practice? Please select all that apply.**
   - Primary/secondary education
   - Universities and colleges/further and higher education
   - Private practice
   - Third/charitable/voluntary sector
   - Healthcare (e.g. primary, secondary, tertiary NHS/other healthcare settings)
   - Workplace (e.g. Employee Assistance Programme)
   - I have not practised in the last 3 years
   - I am a student/trainee who has not yet undertaken a placement
   - Other (please specify)

3. **Is there an FGM lead, or a safeguarding lead with responsibility for FGM, in your organisation?**

- Yes
- No
- Don’t know

4. In which region(s) do you MAINLY practice? Please select all that apply.
- England
- Wales
- Scotland
- Northern Ireland
- Other UK location
- I practice outside of the UK

5. In which area(s) of England do you MAINLY practice? Please select all that apply.
- London
- North of England
- South of England
- Midlands and East of England

6. What is your gender?
- Male
- Female
- Transgender
- Prefer not to say

7. How old are you?
- Younger than 30 years
- 30-39 years
- 40-49 years
- 50-59 years
- 60-69 years
- 70 years or older
- Prefer not to say

8. In which theoretical model(s) are you trained? Please select all that apply.
- Cognitive Behavioural Therapy (CBT)
- Gestalt
- Humanistic
- Integrative
- Narrative
- Person-Centred
- Psychodynamic
- Other (please specify)

9. What level(s) of professional education and core training have you undertaken in counselling and/or psychotherapy? Please select all that apply. *Please note*

that short Continuing Professional Development (CPD) courses should not be included here.

- Doctoral Degree
- Master's Degree / Postgraduate Diploma / Postgraduate Certificate
- Bachelor's Degree / Bachelor's Degree with Honours / Graduate Diploma / Graduate Certificate
- Foundation Degree / Diploma of Higher Education (DipHE) / Higher National Diploma (HND)
- Higher National Certificate (HNC) / Certificate of Higher Education (CertHE)
- Other (please specify)
- Prefer not to say

Awareness of FGM

The following questions will ask you about your awareness and understanding of Female Genital Mutilation (FGM). Each question requires a response to be selected from a scale ranging from 'not at all confident' to 'completely confident'. Only one response per row will be permitted. Please answer these questions as honestly as possible.

	Not at all confident	A little confident	Moderately confident	Very confident	Completely confident
10. How confident are you in your understanding of what FGM is?					
11. How confident are you in your understanding of the 4 main types of FGM?					
12. How confident are you in your understanding of why FGM is practiced?					
13. How confident are you in your understanding of which communities might practice FGM?					
14. How confident are you in your understanding of the common presenting issues amongst FGM survivors in the therapeutic setting?					
15. How confident are you that you could recognise indicators or signs that the client may have undergone FGM ?					

16. How confident are you in your understanding of your safeguarding duties when working with survivors of FGM?					

17. **How confident are you to carry out your legal responsibilities if someone under 18 discloses to you that she has had FGM, or you have reason to believe that a person under 18 may have had FGM?**
    - Not at all confident
    - A little confident
    - Moderately confident
    - Very confident
    - Completely confident
    - Not applicable – I do not work in an organisation which has a mandatory duty to report FGM

Experience of working therapeutically with survivors of FGM

The following questions will ask you about your experience of working therapeutically with survivors of Female Genital Mutilation (FGM). Your responses to these questions will help us to identify how common it might be for survivors of FGM to seek, or be referred for, counselling/psychotherapy, and what 'best practice' might look like when working therapeutically with FGM survivors.

18. **In your practice as a counsellor/psychotherapist have you worked with survivors of FGM?**
    - Yes
    - No
    - Don't know

19. **In your experience of working therapeutically with survivors of FGM, how do you think FGM affects them psychologically in terms of presenting issues?**

20. **What, if anything, have you experienced as being helpful when working therapeutically with survivors of FGM?**

21. **What, if anything, have you experienced as being unhelpful when working therapeutically with survivors of FGM?**

FGM training

The following questions will ask you about any training you have received to work with survivors of Female Genital Mutilation, as well as any training requirements you may have. Your responses will allow us to identify where there may be gaps in the delivery and development of training resources.

22. Have you undertaken any training (e.g. workshops, online training) on FGM?

- Yes
- No
- Don't know

23. Please provide some further information about the training you received, e.g. format, content, purpose and why you undertook the training.

24. Would you be interested in undertaking any further training on FGM?

- Yes
- No
- Don't know

25. Would you be interested in undertaking any training on FGM?

- Yes
- No
- Don't know

26. What areas of FGM training would you be interested in receiving?

27. In which format(s) would you prefer training to be delivered? Please select all that apply.

- Interactive webinars/online seminars
- E-learning modules
- Face-to-face, discussion-based training sessions (e.g. group workshops)
- Lectures /conference presentations
- Other (please specify)

28. Are you aware of the FGM ELearning for Health programme which has been developed by Health Education England?

- Yes
- No

29. If you have any further comments about your experience of working therapeutically with survivors of FGM, please provide these below.

End of survey

Thank you for taking the time to complete this survey. If you would like to know more about the FGM Prevention Programme, please visit: https://www.gov.uk/government/news/new-fgm-measures-launched-to-care-protect-prevent *and about FGM more generally at:* http://www.nhs.uk/NHSEngland/AboutNHSservices/sexual-health-services/Pages/fgm-for-professionals.aspx.

Below, you will find links to further information regarding mandatory reporting duties, safeguarding and e-learning resources.

Mandatory reporting duties

If you would like to know more about the mandatory reporting duties when working with survivors of FGM, please visit: https://www.gov.uk/government/publications/fgm-mandatory-reporting-in-healthcare

Safeguarding

If you would like to know more about safeguarding for clients who have undergone FGM, please visit:
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/418564/2903800_DH_FGM_Accessible_v0.1.pdf

If you would like to know more about statutory guidance on child safeguarding, please visit:
https://www.gov.uk/government/publications/working-together-to-safeguard-children--2

FGM ELearning for Health

If you would like to access the FGM ELearning for Health programme, please visit:
http://www.e-lfh.org.uk/programmes/female-genital-mutilation/

Further questions

If you have any further questions about this survey, please contact Charlie Jackson (Research Officer, BACP) at charlie.jackson@bacp.co.uk.

Appendix B: Mann-Whitney test outputs

	In your practice as a counsellor/psychotherapist have you worked with survivors of FGM?	N	Mean Rank	Mann-Whitney U	*p*
How confident are you in your awareness and understanding of what FGM is?	Yes	192	3.7	68171.0	<.001
	No	1420	2.8		
How confident are you in your understanding of the 4 main types of FGM?	Yes	192	3.2	51260.5	<.001
	No	1417	1.8		
How confident are you in your understanding of why FGM is practised?	Yes	191	3.7	61449.5	<.001
	No	1417	2.6		
How confident are you in your understanding of which communities might practise FGM?	Yes	192	3.6	55706.0	<.001
	No	1415	2.4		
How confident are you in your understanding of the common presenting issues amongst FGM survivors in the therapeutic setting?	Yes	191	3.4	43639.5	<.001
	No	1417	2.0		
How confident are you that you could recognise indicators or signs that a client may have undergone FGM?	Yes	190	3.1	52146.0	<.001
	No	1418	1.9		
How confident are you in your understanding of your safeguarding duties when working with survivors of FGM?	Yes	192	3.6	66393.0	<.001
	No	1420	2.4		
How confident do you feel to carry out your legal responsibilities if someone under 18 discloses to you that she has had FGM, or you have reason to believe that a person under 18 may have undergone FGM?	Yes	192	4.4	107741.0	<.001
	No	1419	3.8		

	Have you undertaken any training (e.g. workshops, online training) on FGM?	N	Mean Rank	Mann-Whitney U	*p*
How confident are you in your awareness and understanding of what FGM is?	Yes	459	3.7	146893.5	<.001
	No	1428	2.6		
How confident are you in your understanding of the 4 main types of FGM?	Yes	458	3.0	108275.0	<.001
	No	1428	1.6		
How confident are you in your understanding of why FGM is practised?	Yes	457	3.6	128680.0	<.001
	No	1428	2.4		
How confident are you in your understanding of which communities might practise FGM?	Yes	458	3.4	128990.5	<.001
	No	1426	2.2		
How confident are you in your understanding of the common presenting issues amongst FGM survivors in the therapeutic setting?	Yes	458	3.0	118030.5	<.001
	No	1427	1.8		
How confident are you that you could recognise indicators or signs that a client may have undergone FGM?	Yes	454	2.9	108972.0	<.001
	No	1392	1.7		
How confident are you in your understanding of your safeguarding duties when working with survivors of FGM?	Yes	455	3.6	116660.5	<.001
	No	1394	2.1		
How confident do you feel to carry out your legal responsibilities if someone under 18 discloses to you that she has had FGM, or you have reason to believe that a person under 18 may have undergone FGM?	Yes	455	4.2	261632.0	<.001
	No	1392	3.7		

Appendix C: Content analysis – how does FGM affects survivors psychologically?

Theme	Supporting quote	n (%)
Trauma issues, including PTSD	"General post traumatic stress issues" "Effects of trauma" "Traumatised" "I have worked with one case of this and in this case my adult client was suffering with severe trauma…" "Severe trauma symptoms (PTSD)"	55 (28.6)
Feelings of shame, embarrassment or guilt	"There is a degree of shame…" "If within their cultural family they tend not to talk about it, but if more integrated some feel it is a shameful secret…" "Embarrassment and shame around talking about the issue" "Guilt"	35 (18.2)
Lack of, or low, self-esteem	"…poor self esteem…" "Feelings of low self worth" "self esteem and being judged" "Low self-esteem"	33 (17.2)
Sexual issues/anxiety around sex	"Clients have told me how painful sex now is as a result of FGM, so sex is not enjoyed…" "Confusion around sexuality…" "Issues to do with lack of sexual confidence…" "Sexual difficulties…"	27 (14.1)
Depression	"Depression" "Sadness" "The client I have worked with has presented with depression…"	26 (13.5)
General anxiety	"Anxiety" "Anxiety disorders…" "I notice it affects their confidence…resulting in low mood and anxiety"	23 (12.0)
Anger	"They feel extreme anger…" "Feelings of anger…" "…anger issues in both friendships and relationships" "Anger with caregivers when realising what was done is not normal"	22 (11.5)
Romantic relationship issues	"Relationship issues" "…a tendency to get into relationships where her needs aren't met…" "Clients can feel that something is wrong with them and this in turn impacts on their intimate	21 (10.9)

	relationships" "Not wanting to get married, not wanting her husband to get close to her"	
Trust issues	"A lack of trust in people…" "Left issues of trust to authority" "Relational trust" "Loss of trust in others, particularly her parents"	19 (9.9)
Physical pain/discomfort	"I think women are traumatised by the experience and are in constant physical pain and discomfort" "…long standing experience of physical pain…" "…physical sequelae even long term that affect them in the present, abnormal menses, pain abdominally and genitally which impacts functioning"	16 (8.3)
Body image issues	"Body dystrophy…" "Body image" "Body shame (feeling different)"	13 (6.8)
Social withdrawal/ isolation	"Isolation" "Physical and emotional separation and isolation from everyone" "Aloneness" "The client could also present themselves as withdrawn…"	12 (6.3)
Presenting issues not universal across survivors	"The effects will be varied according to the culture" "Depends upon the person, the culture, race, age and religion of the individual" "In main I believe it depends on the individuals culture and context and whether this has influenced their psychological state – I have experienced low affects through to extreme distress" "It is difficult to generalise as the effects can be influenced by the woman's ethnic or cultural background, life experiences and support networks"	12 (6.3)
Difficulties managing the incongruence between cultures	"Dealing with the sense of belonging to your community verses mutilation of your body by someone you trust…" "Circumcision can only be viewed in the total socio-cultural context…circumcision is a bonding with their age-mates/peers and a sign that they have achieved adult status. They are now being told this practise is wrong. They are stuck between two cultures with varying views and feel helpless and confused" "If someone is known to have not had it done, then slurs around reputation are common. Often a cultural norm in their home land leading to internal conflict when being told it is not ok to have through that process when arriving in the UK"	11 (5.7)
Fear, or anxiety, around	"Anxiety regarding the repercussions of disclosure"	10

disclosure	"Fear of UK authority's reaction" "Reluctance to disclose the full impact" "Fear of the effects and outcomes of disclosure…"	(5.2)
Feelings of helplessness, or loss of control	"Issues of power and control" "Issues around power and loss of autonomy" "The woman was not aware that she had undergone FGM, but her partner was convinced she had. This repeated the sense of loss of control over her body"	7 (3.6)
Confusion	"Confusion around sexuality…" "Confusion" "Feelings of…confusion"	6 (3.1)
Reproduction/childbirth issues	"Issues around childbirth…" "Long term physical ramifications including…child birth difficulties" "the reproductive issues involved"	6 (3.1)
Affects all aspects of life	"Greatly affects them as it affects all aspects of their lives" "Silly question really. It affects all aspects" "Highly affected emotionally and physically"	5 (2.6)
Acceptance	"With the few I have, they were not fussed – two said it was necessary as they would not have found a husband otherwise and the other said it's just what is done in her country" "My one client had it done in Africa over 10 years ago and she just accepted it as part of her culture" "The client group I have worked with are older and often are working on more recent trauma and so tend to 'minimise' the impact FGM has had for them"	5 (2.6)
Difficulties expressing feelings, emotions or experiences	"They find it hard to express their anger at what was done to them by those they trusted" "In my limited experience clients have…found it very difficult to talk about the FGM"	4 (2.1)
Self-loathing	"Self loathing" "Self hatred"	4 (2.1)
Substance misuse	"Feelings…hidden with alcohol" "Drug use" "They may use substances to control pain"	4 (2.1)
Re-experiencing (flashbacks/nightmares)	"Panic attacks" "Flashbacks and nightmares may also be present for some clients regarding the trauma and after effects of having FGM done" "Flashbacks" "Re-experience"	4 (2.1)

Denial/dissociation	"Dissociative symptoms" "…my client minimised the issue at the beginning of therapy. Only when she began to connect with herself at a deeper level did she begin to address what had happened to her at age 8" "Clients can range between denial/being unaware of procedure to being traumatised…"	3 (1.6)
Suicidal ideation/self-harming behaviour	"Self-harming" "Suicidal ideation" "Suicidal thoughts"	3 (1.6)
Feelings/fear of being judged	"Intense fear of rejection by family members" "…being judged" "…fear of judgement"	3 (1.6)
Loss, or confusion, of self-identity	"Impact on…sense of self" "Loss of sense of self" "Identity confusion will be a major issue"	3 (1.6)
Attachment issues	"Ambivalent attachment" "Attachment difficulties in close interpersonal relationships, specifically with partner and bonding with baby"	3 (1.6)
Fear of medical intervention	"Fear of medical examination" "[psychological issues] all heightened if followed by infections, physical examinations and hospital treatments"	2 (1.0)
Feelings of dehumanisation	"De-humanises" "Dehumanising"	2 (1.0)
Feeling betrayed	"Betrayal of parents…" "There can also be a feeling of betrayal by caregivers"	2 (1.0)
Eating-related issues	"Food issues" "Eating disorders"	2 (1.0)
Feelings of loss	"Intense feelings of loss" "Feelings of loss"	2 (1.0)
N/A responses	"The presenting problem has not been of FGM but very soon enters the consciousness" "Yes" "I have only worked with a supervisee who had undergone FGM. This was very useful in terms of my understanding but did not involve therapeutic work"	17 (8.9)

Appendix D: Content analysis – what is helpful when working therapeutically with FGM survivors?

Theme	Supporting evidence	n	%
Cultural respect, knowledge and understanding	"Respect for cultural pressures and influences" "Cultural sensitivity is important…" "Knowing that it's practised a lot in Africa for various reasons and therefore somewhat expected by women" "Understanding of partner, family and community views"	35	22.7
Non-judgemental, or accepting, therapist	"Someone who believes them with no judgement" "To be accepting of their view of it, even if it conflicts with mine" "Working with what they feel the effect of FGM is on them, rather than what we assume they may feel"	30	19.5
Listening	"…listening to their experiences…" "…listening and believing…" "I was able to listen…"	23	14.9
Providing a safe space to talk, reflect and explore feelings	"…allowing the client space to explore their feelings, experience" "…helping clients to express pain, fear, anger…" "…to give time, space and encouragement" "…enabling client to gradually tell their story, to find their voice"	17	11.0
Empathy	"Empathetic understanding" "…understanding the individuals experience" "Empathic witnessing of their experiences"	14	9.1
Therapist knowledge and understanding of FGM	"Sometimes you have to ask if they experienced FGM…and know the different types" "An understanding of the…different types of FGM" "Having a certain knowledge of what FGM is…"	13	8.4
Working at the client's pace	"Slowly, gently, at their pace…" "Working very carefully at the client's pace" "Working at the client's pace in a person-centred way…"	11	7.1
Links with medical/physical health professionals	"…perhaps contacts with sympathetic medical help, especially is pregnant and about to give birth" "bringing in a medical colleague to educate broadly about gynaecology/female anatomy" "ensuring appropriate medical referrals have been made"	8	5.2
Longer-term intervention	"Time, which can be an issue whilst working in a time limited therapy" "In my experience work in long term (more than a year)"	8	5.2

	"It can take much time to form a trusting relationship with your therapist"		
Being 'present' with the client	"…just being with her in her pain, fears, shame" "Trying to get into their frame of reference, what it's been like for them" "Being a witness to her trauma and the after-effects"	7	4.5
Understanding legal issues/ duties	"To be able to tell them that what happened was wrong and it is illegal in the UK. That they have rights" "…understanding the legal implications…" "Cultural sensitivity at the same time as being clear about safeguarding issues"	7	4.5
Processing the trauma, including use of EMDR	"Debriefing and processing the physical event" "EMDR, rewind techniques…" "I am trained in EMDR so used this with an older woman to help process the traumatic memory"	7	4.5
Educating clients	"Psychoeducation" "Signposting sources of help for when they may feel ready to work with it & try to raise awareness that, where they have daughters of their own, they do not have to be subjected to the same treatment, help is available to help prevent this"	6	3.9
Supervision	"good supervision" "Supervision with knowledgeable supervisor…" "Supervision is key to allow the counsellor to sit with the horror and emotion of the experience"	6	3.9
Congruence	"…congruent…" "Congruence"	5	3.2
Using body-oriented techniques	"Using somatic therapy, working with the body" "As a psychosexual therapist, helping them discover their whole bodies as sensual, to discover many ways to feel enjoyment and intimacy" "Some help with experiencing bodily held trauma and associated emotions through mindfulness, or just awareness of where emotions feel help in the body"	4	2.6
Cognitive-behavioural techniques	"…any cognitive behavioural work in relation to psychological trauma…" "trauma-focused CBT…" "CBT"	4	2.6
Understanding physical implications	"…awareness that on rare occasions a client may pass out" "…being aware of the physical complications as well as the psychological impact of FGM"	3	1.9
Creative therapies	"Art therapy" "Art therapy seems to help with expressing emotions that seem stuck or 'held'"	3	1.9

	"Creative therapy"		
Ability to work with sexual identity/ sexual issues	"Encouraging work around sexual identity and affirming sexual identity" "Addressing shame and sexual identity issues" "Psychosexual acceptance and a way to find what it achievable"	3	1.9
Working with, or resolving, conflict/ incongruence	"Allowing them the opportunity to find that although physically they have been mutilated, they can find self-acceptance and the courage to grow their self-esteem. Many sufferers struggle with the difference between something that may be culturally OK, but that causes them such physical and emotional pain" "…being aware of the pressures upon mothers to cut their daughters and the conflicting and ambivalent feelings this can produce in the client and helping her to express this"	3	1.9
Having the confidence to ask for clarity/ask questions	"Not being afraid to ask the question…" "…being able to have frank, but gentle conversations about sexual function, shame and idealisation" "Not be afraid to talk about it…"	3	1.9
Empowering clients	"Giving the survivor absolute control in sessions, being explicit about this especially when talking about the events of her FGM" "…empowering clients and trusting in clients' autonomy…" "Focus on self-blame and empowerment"	3	1.9
Prior experience of working with survivors of FGM	"I'm a survivor myself and can relate very well with survivors in terms of personal and professional experience" "…knowledge of working with survivors"	2	1.3
Gender-based approach	"Operating in a women-only, women friendly organisation" "A feminist and gender-based approach to counselling that recognises FGM as one of the world-wide abuses of women and girls based on their gender and position in society…"	2	1.3
Therapist honesty	"To be open, honest about limits of understanding and be willing to explore with the individual their issues of FGM" "Honesty"	2	1.3
Exploring interpersonal relationships	"Working with the perceived betrayal of family members, especially mother" "Exploring current interpersonal relationships…"	2	1.3
Not applicable responses		9	5.8

Appendix E: Content analysis – what is unhelpful when working therapeutically with FGM survivors?

Theme	Supporting evidence	n	%
A general lack, or assumption of awareness/ understanding (including being judgemental)	"Assuming too much knowledge" "Making any assumptions about an individual's experience" "I imagine my ignorance about the subject and fear that I'll offend" "Not being informed or having knowledge of FGM" "Being judgemental"	32	25.0
Therapist reaction or expression of emotion	"My first experience of working with FGM created a level of anxiety for me…" "Revealing own shock or revulsion" "Something that might be unhelpful is to act shocked…"	9	7.0
Focus on child protection/ safeguarding/ mandatory reporting issues	"Social care system" "Not to rush to report unless someone is at immediate risk" "Some have fear of being pressured to report, managing this when there are child protection issues or 'honour crime' potential"	8	6.3
Time-limited work	"Having to work in a time limited framework" "Having too few sessions" "I also realised that short-term was not very helpful"	8	6.3
Assuming that clients perceive FGM negatively	"To assume that 'survivor' is a term they identify with, or that they view their experience as abusive" "Assuming that it is a bad thing, that they are angry etc." "Being judgemental of the culture – assuming they don't agree with"	5	3.9
Assuming FGM is the presenting/ predominant issue	"An assumption that this is the presenting problem" "Attempting to 'help' when none is needed" "To focus only on the FGM"	5	3.9
Questioning, or probing, the client	"Perhaps working in a directive way as clients may not be fully ready to openly explore their experiences" "Probing questions" "Direct questioning"	5	3.9
Over-empathising with, or victimising, the client	"Also treating the client as if she has been victimised is very unhelpful" "[being] over empathic" "Sympathy"	5	3.9
Language barrier	"Lack of translator access" "Lack of language specialism" "…unless their English is really good, we often need an interpreter too, which in itself can	4	3.1

	sometimes be a problem for refugees/asylum seekers”		
Assigning blame	“‘Blame’ of the society that practises FGM” “Blaming mothers, grandmothers…” “Blaming anyone”	4	3.1
Complicity with, or agreeing with, FGM practise	“Being complicity in casting that it is OK” “…religious or culture-based counselling which in some cases supports or makes excuses for the practices” “Collusion that it is a legitimate cultural or religious obligation”	4	3.1
Ignoring external influences on client e.g. family or society	“Ignoring the family, extended as well, can be problematic as a lot of dialogue needs to take place to overcome their will to complete the ritual” “Not recognising the dilemmas faced by the victims of FGM in relation to their mothers and other family members who arranged for the FGM” “Western approach where self is seen as the focus”	3	2.3
Therapist fear/ avoidance of subject	“Avoidance of exploring FGM itself” “…fear that I’ll offend” “The most unhelpful thing that a therapist can do is ignore and ‘dance’ around the issue”	3	2.3
Insensitivity	“It should always be handled with sensitivity” “…We are talking about the woman’s genitalia, or lack of; insensitivity to the privacy of the client won’t help…” “My experience has been with asylum seeking clients, their lack of safety and security, lack of certainty about their future and their experiences of insensitive treatment in the asylum seeking process has made it very difficult for clients to feel safe enough to engage fully in exploring such sensitive areas of their experience”	3	2.3
Not working at clients’ pace	“A time when I felt that I made an interpretation about her feelings around present events, linking the feelings to her anger about FGM when she wasn’t ready to hear this” “When not working with clients at their own pace” “…not rushing the client is key”	3	2.3
Assuming universal experience of survivors	“…assuming that the experience was the same for all women” “Making assumptions. Each woman is an individual and it is important not to make generalisations or assumptions” “A one size fits all attitude…”	3	2.3
Cognitive-behavioural techniques	“CBT” “I found using CBT skills of replacing negative thoughts with positive was unhelpful”	3	2.3
Focus on physical, or aesthetic issues	“Don’t immediately start talking about what it looks like down there, it’s not our business” “Concern around medical condition and encouraging medical intervention”	2	1.6

Inflexibility	"Being too rigid" "Clients should be offered the choice of a male or female counsellor (in a counselling practice that has both) without having to disclose FGM or DSV in order for that offer to be made"	2	1.6
Inaccessible services	"…accessibility of services, barriers of accessing support within communities" "…appropriate community services not available"	2	1.6
Multi-disciplinary care	"Other professionals can undermine the work being done" "Referral to a doctor etc."	2	1.6
Causing the client to re-live the trauma	"Reliving the trauma" "Reliving the trauma – I am not CBT or EMDR trained"	2	1.6
Not applicable			16.4

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