

ORIGINAL ARTICLE

Counselling professionals' awareness and understanding of female genital mutilation/cutting: Training needs for working therapeutically with survivors

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Abstract

Background: There is a dearth of literature that has looked at the psychological impact of female genital mutilation/cutting (FGM/C), and little is known about the understanding and awareness of FGM/C amongst counselling professionals. *Method:* An online survey was completed by 2073 BACP members. The survey covered four broad themes: demographics; awareness and understanding of FGM/C; experience of working therapeutically with survivors; and FGM/C training. Descriptive and inferential analyses were undertaken on quantitative data, and thematic content analysis was undertaken on qualitative data. *Results:* Only a small proportion of respondents (10%) had knowingly worked with survivors of FGM/C. Overall, respondents lacked confidence in their awareness and understanding of FGM/C, including their safeguarding duties. Having cultural respect, knowledge and understanding was perceived as the most helpful factor when working with this client group. Less than a quarter of respondents had undertaken any training with regard to FGM/C, although the vast majority expressed a desire to do so. *Discussion:* This research has highlighted the importance of improving signposting to existing training and educational resources around FGM/C, as well as the need to develop new resources where appropriate. The importance of embedding cultural competency into core practitioner training, not just training specific to FGM/C, is paramount.

Keywords: counselling, counsellors' experience, female genital mutilation/cutting, helpful/unhelpful factors, training

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Introduction

It is estimated that at least 200 million women and girls worldwide have undergone female genital mutilation/cutting (FGM/C), with the practice being most common in some African, Middle Eastern and Asian countries (UNICEF, 2016). Estimates suggest that approximately 137,000 women and girls who have undergone FGM/C permanently reside in England and Wales, with the majority—but not all—living in large cities where migrant populations are more clustered (Macfarlane & Dorkenoo, 2015).

Female genital mutilation/cutting 'comprises all procedures that involve partial or total removal of the

external female genitalia, or other injury to the female genital organs for non-medical reasons' (WHO, 2016). The World Health Organization (WHO) has classified FGM/C into four main types:

Type 1: Also referred to as a 'clitoridectomy'. This involves the partial or total removal of the clitoris and/or the clitoral hood.

Type 2: Also referred to as an 'excision'. This involves the partial or total removal of the clitoris and the labia minora, with or without the excision of the labia majora.

Type 3: Also referred to as 'infibulation'. This involves narrowing the vaginal opening by cutting and repositioning the labia minora, or labia

majora, with or without removal of the clitoris (clitoridectomy).

Type 4: This includes all other harmful procedures to the female genitalia for nonmedical purposes, for example pricking, piercing, incising, scraping or cauterising. (WHO, 2016)

The physical implications of FGM/C have been well documented and can include incontinence, reproductive tract infections, urinary tract infections, dysmenorrhoea (painful menstruation), dyspareunia (painful sexual intercourse), infertility and difficulties during pregnancy and delivery amongst other issues (Morison et al., 2001; Utz-Billing & Kentenich, 2008). Furthermore, detrimental effects on women's sexual functioning, for instance, less sexual arousal and desire, less satisfaction and lower frequency of orgasm, have also been reported (Berg & Denison, 2012).

Psychological implications of FGM/C have also been cited, for example in a study interviewing 47 Senegalese women—23 of whom had been circumcised and 24 who had not—over 90% of the circumcised women described feelings of intense fear, helplessness and horror and over 80% continued to suffer intrusive re-experiencing of their circumcision. Furthermore, nearly 80% of the circumcised women met the criteria for affective disorders, for example, depression, bipolar disorder and anxiety disorder, and almost two-thirds presented with post-traumatic stress disorder (PTSD), compared to just one woman in the uncircumcised group (Behrendt & Moritz, 2005). Kizilhan (2011) undertook a similar study looking at the rate of psychiatric disorders in 79 Kurdish girls from Northern Iraq who had undergone FGM/C compared to 61 uncircumcised girls. Again, the prevalence of PTSD, depressive disorder, anxiety disorder and somatic disturbance was significantly higher in the circumcised group.

Similarly, Vloeberghs, van der Kwaak, Knipscheer and van den Muijsenbergh (2012) reported that women from migrant groups in the Netherlands who had undergone FGM/C described re-experiencing and feelings of powerlessness, shame, guilt and exclusion. Moreover, many women reported that they 'often felt embarrassed, sad or guilty because of the way service providers behaved' (p. 686). Despite this evidence, a systematic review undertaken by Berg, Denison and Fretheim (2010) did not find sufficient evidence to support a causal link between FGM/C and psychological or social consequences.

The available literature exploring the knowledge and attitudes of healthcare professionals towards

women who have experienced FGM/C indicates a need for specific training in this area. Leye et al. (2008) investigated the knowledge, attitudes and practices of 334 Flemish gynaecologists in Belgium. Less than a third of respondents had heard about FGM/C during basic or postgraduate medical training, and just 1.2% of respondents were aware of hospital guidelines or FGM/C information. Under half knew that FGM/C was illegal in Belgium, with almost two-thirds wanting more information on legislation.

Rolph, Inamdar, Singh and Yoong (2013) surveyed 79 obstetricians, paediatricians, midwives, students and trainees on their knowledge of FGM/C classification and complications, experience of working with survivors and UK legislation. Less than two-thirds were aware of the four types, and only 40.5% felt confident in diagnosing FGM/C. Senior doctors were significantly more likely than their junior counterparts to be aware of the four types of FGM/C, but they were also significantly more likely to have received formal training in this area. Just over 40% of respondents had never encountered FGM/C survivors in a professional capacity.

Statutory guidance in the UK (HM Government, 2016) states that 'local commissioners must consider the provision of mental health support and services, and that girls and women who have undergone FGM are able to access this treatment as required' (p. 70). Despite this, there has been no research conducted, to our knowledge, which has looked at counselling professionals' awareness and understanding of FGM/C in the UK, or their training needs to work with this client group. Indeed, this lack of research has been echoed by Mulongo, McAndrew and Hollins Martin (2014) who state that 'there appears to be limited research relating to psychological interventions for women who experience negative consequences of FGM' (p. 300).

Research undertaken outside the UK (e.g. Isman, Mahmoud Warsame, Johansson, Fried & Berggren, 2013) suggests that healthcare professionals providing counselling services to FGM/C survivors are met with a number of challenges when working with this client group, such as the perception that FGM/C is an important part of their culture.

Due to the high prevalence of psychological issues amongst survivors of FGM/C, it seems logical to suggest that counselling professionals in the UK may—unknowingly perhaps—come into contact with clients who are survivors of FGM/C. In addition, existing literature suggests that healthcare professionals in general lack understanding and awareness of FGM/C and to our knowledge, there has

been no research conducted in the UK regarding counselling professionals' awareness and understanding of the issue. Ultimately, this has important implications for practice and training requirements for this professional group, yet more research is needed to understand what exactly these requirements might be and what training should look like.

Due to the lack of UK-based, counselling-oriented research, this study aimed to provide some preliminary answers to the following questions:

- 1 How confident are counselling professionals in their awareness and understanding of FGM/C?
- 2 How do counselling professionals experience working therapeutically with FGM/C survivors in terms of presenting issues and helpful/unhelpful factors?
- 3 What training needs do counselling professionals have to work with FGM/C survivors?

Method

Design

The British Association for Counselling and Psychotherapy (BACP), the Department of Health (DH) and National Health Service (NHS) England designed an online survey for email distribution to all BACP members in May 2016. The 29-item survey comprised four sections: *about me* (demographics and work details); *confidence in awareness and understanding of FGM/C*; *experience of working therapeutically with survivors*; and *FGM/C training*.

Open and closed questions were utilised to elicit the most appropriate information from respondents. Closed questions most often consisted of predefined options with an 'other' category for free text responses. An example question of this format asked 'which client group do you predominantly work with?' with 'children and young people (up to 18 years)', 'adults (18–64 years)' and 'older adults (65+ years)' being potential responses. Five-point Likert-type scales were used to determine respondents' levels of confidence, ranging from 'not at all confident' to 'completely confident', for questions such as 'how confident are you in your understanding of what FGM is?'

Participants

The survey was distributed via email to 41,599 BACP members who had opted in to receive email communications from BACP, which represents

approximately 95% of the entire BACP membership (BACP, 2016). A total of 2073 members responded to the survey, indicating a response rate of 4.98%; markedly lower than the 8–14% response rate generally obtained through BACP membership surveys.

Procedure

The survey was piloted by ten BACP staff members who had undertaken counsellor training at or above diploma level. They were asked to provide feedback on the content of the questions, the appropriateness of the predefined responses and the time taken to complete the survey. Following the pilot, some minor changes were made to the survey, which was then sent out to BACP members.

Participants had a total of three weeks to respond to the survey, and a reminder email was sent out one week before the deadline.

Data analysis

Descriptive analyses were undertaken on quantitative data to indicate the frequency of responses in each category. Inferential statistics, such as contingency table analysis and Mann–Whitney *U*-tests, were also conducted on selected quantitative data to investigate differences between groups, such as respondents who had knowingly worked with FGM/C survivors compared to those who had not. These data were analysed using the Statistical Package for the Social Sciences (SPSS) version 18.0. (SPSS Inc., Chicago, IL, USA)

Qualitative data gathered through open-ended questions were subject to a thematic content analysis. This enabled common themes to be identified, as well as indicating the frequency of each theme.

Ethical considerations

The survey did not request personally identifiable information from respondents, nor did it require them to submit such data about their clients. Moreover, the study did not require participants to be randomised to different groups or change their treatment from accepted standards. In line with NHS Health Research Authority (HRA) recommendations, this does not require ethical approval and therefore was not sought for this study. However, the study was conducted in line with BACP's ethical guidelines for researching counselling and psychotherapy (Bond, 2004).

Results

A summary of the demographic and workplace characteristics of survey respondents is shown in Table I.

The majority of survey respondents were female ($n = 1804$, 87.0%), aged between 40 and 69 years ($n = 1665$, 80.3%) and practised in England ($n = 1760$, 84.9%). Over half of respondents ($n = 1133$, 54.7%) indicated that they work in private practice (defined here as practitioners who work independently) and/or the third/charitable/voluntary (TCV) sector ($n = 939$, 45.3%). Almost three-quarters ($n = 1509$, 72.8%) had trained in a humanistic/person-centred therapy. Despite the relatively low response rate, the demographic and workplace characteristics of survey respondents are broadly reflective of the wider BACP membership (BACP, 2016), suggesting that the sample was fairly representative of BACP members more generally.

Awareness and understanding of FGM/C

Figure 1 provides an overview of responses to the Likert-type questions regarding respondents' confidence in their awareness and understanding of FGM/C.

Overall, levels of confidence were fairly low across all areas, although respondents were least confident in their understanding of the four main types of FGM/C; 46.9% were *not at all confident*; and a further 18.9% were only *a little confident* in this area. Collectively, although still low in relative terms, respondents were most confident in their understanding of what FGM/C 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 a client under the age of 18 discloses to them that they have undergone FGM/C. 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%) respondents did not answer this question.

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

Table I: Demographics.

	<i>n</i>	%
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 ^a		
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 ^a		
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
Theoretical modality trained in ^a		
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

Percentages are calculated as a proportion of the number of people who entered the survey ($n = 2073$).

^aRespondents could select more than one response for these categories and so percentages total more than 100.

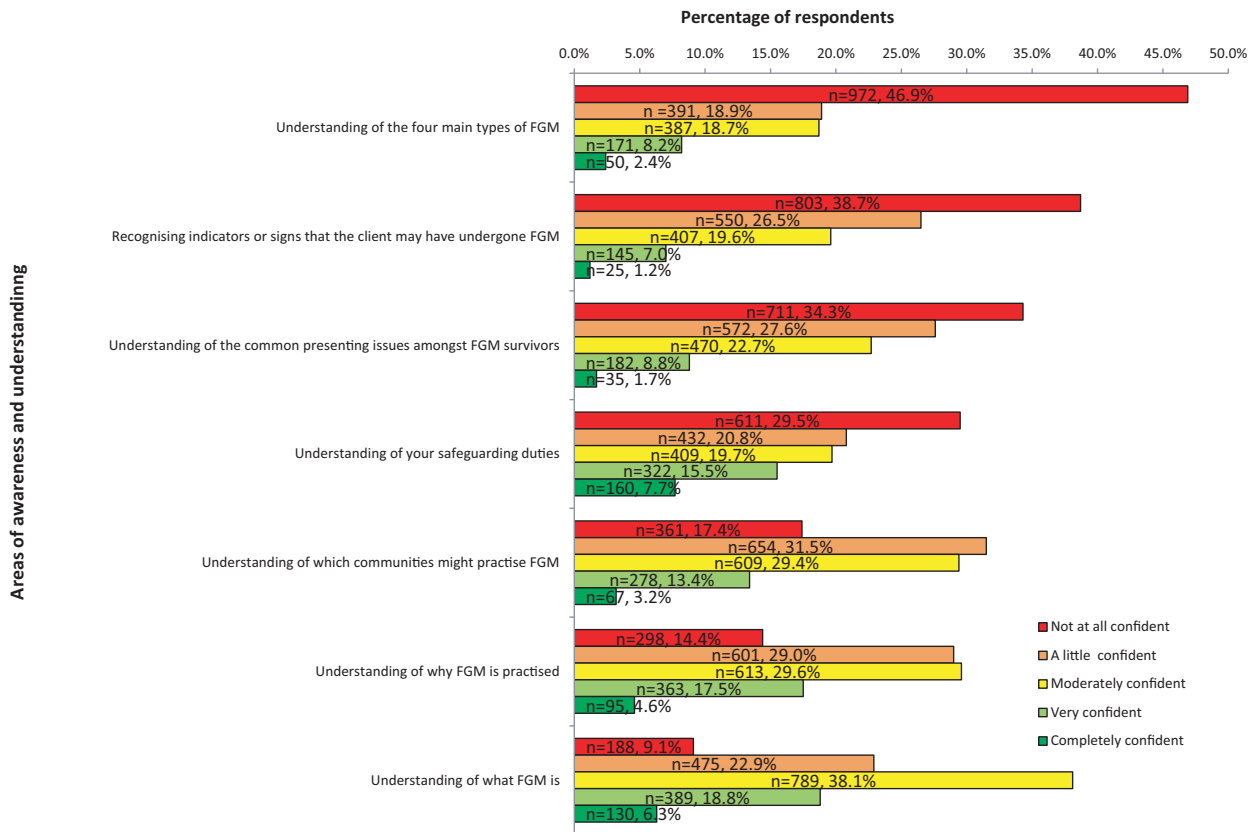


Figure 1: Confidence in awareness and understanding of FGM/C. [Colour figure can be viewed at wileyonlinelibrary.com]

Less than a quarter ($n = 460, 22.2\%$) of respondents indicated that they had undertaken training in FGM/C, with over two-thirds ($n = 1430, 69.0\%$) indicating that 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.

Mann–Whitney U -tests were undertaken on the data to determine any differences in levels of confidence in awareness and understanding of FGM/C between those who had knowingly worked with survivors of FGM/C and those who had not and those who had undertaken training compared those who had not. Tables II and III provide an overview of the statistical outputs.

Results indicated that practitioners who had knowingly worked with survivors of FGM/C 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/C 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/C is*, although this difference was still statistically significant, $U = 68171.0$, $z = -11.8$, $p < .001$.

Similarly, practitioners who had undertaken FGM/C training were significantly more likely to report higher levels of confidence in their awareness and understanding across all areas ($p < .001$) 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/C* between practitioners who had undertaken training ($\bar{x} = 3.6$) and those who had not ($\bar{x} = 2.1$), $U = 116660.5$, $z = -20.9$, $p < .001$.

Experience of working therapeutically with survivors of FGM/C

Presenting issues

The following results are based on analyses conducted on the data provided by the 192

Table II: Mann Whitney U output: Experience of working with survivors and knowledge of FGM/C.

	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 four 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		

respondents who had knowingly worked with FGM/C survivors.

Respondents were asked 'In your experience of working therapeutically with survivors of FGM/C, how do you think FGM/C affects them psychologically in terms of presenting issues?' *Trauma issues*, including post-traumatic stress disorder (PTSD), were the most commonly identified presenting issue ($n = 55$, 28.6%), followed by *feelings of shame, embarrassment or guilt* ($n = 35$, 18.2%) and *lack of, or low, self-esteem* ($n = 33$, 17.2%). An additional theme which emerged was the *difficulty survivors faced managing the incongruence between cultures* (the general culture in the UK and their culture). Below are some example responses which support the identification of these themes:

I think women are traumatised by the experience and are in constant physical pain and discomfort. So it's always there, no escape (Respondent #84)

There is a degree of shame, trauma, and the sexual and reproductive issues involved. There can also be a feeling of betrayal by caregivers (Respondent #379)

So many ways to do with valuing self. All the PTSD symptoms. Body issues, pain in all parts of body.

Unable to enjoy sex – many more (Respondent #1572)

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 practice is wrong. They are stuck between two cultures with varying views and feel helpless and confused (Respondent #25)

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 (Respondent #123)

A plethora of other presenting issues was also provided by respondents, including *depression* ($n = 26$, 13.5%), *anxiety* ($n = 23$, 12.0%) and *physical pain and discomfort* ($n = 16$, 8.3%). Some respondents ($n = 12$, 6.3%) were also keen to express the notion that presenting issues are not universal across survivors. One respondent highlighted this by noting: 'In main I believe depends on the individuals' culture and context and whether this has influenced their psychological

Table III: Mann Whitney-U output: FGM/C training and knowledge.

	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		

state – I have experienced low affects through to extreme distress’.

Helpful factors

Respondents were then asked ‘What, if anything, have you experienced as being helpful when working therapeutically with survivors of FGM/C?’ A total of 154 respondents (80.2%) responded to this question.

Almost a quarter of individuals who provided a response ($n = 35$, 22.7%) identified *having cultural respect, knowledge and understanding* as the most helpful factor. The following examples illustrate this theme:

FGM holds potential for cultural misunderstanding and the essential part is to first ascertain where the client’s understanding of what has happened, is... it is very easy to assume the traumatic experience has the same meaning as I would interpret (if it were me). For some it is seen as completely normal and positive (Respondent #339)

Ability to understand and work with the cultural aspects... (Respondent #1461)

An understanding of the religious and cultural background of the client... (Respondent #1876)

Other helpful factors included having a *nonjudgemental, accepting attitude* ($n = 30$, 19.5%) and *listening to the client* ($n = 23$, 14.9%), as demonstrated through the following extracts:

Accepting the individual reassuring them giving permission to express what is in their hearts and heads (Respondent #724)

Listening & following them (Respondent #1277)

Understanding and empathy not to judge (Respondent #1436)

Unhelpful factors

In contrast, respondents were also asked which factors they felt were *unhelpful* when working with FGM/C survivors. Overall, 128 individuals responded to this question and a quarter of these ($n = 32$, 25.0%) felt that *having a general lack, or assumption, of awareness and understanding of FGM/C* was the most unhelpful factor.

Not being informed or having knowledge about FGM (Respondent #84)

Interpretations - makes the clients very angry and feel that they are not understood (Respondent #983)

Making any assumptions about an individual's experience (Respondent #1352)

All other unhelpful factors were noted significantly less frequently; in fact, all other categories were mentioned by <10 respondents each. Other unhelpful factors included the following: *therapist reaction or expression of emotion* ($n = 9$, 7.0%); *focusing on child protection, safeguarding or mandatory reporting duties within sessions* ($n = 8$, 6.3%) and *time limited work* ($n = 8$, 6.3%). Some examples which illustrate these themes are provided below:

Letting your own feelings overwhelm you (Respondent #1436)

Having to make safeguarding referrals when the client does not yet want this to happen because of the negative impacts on relationships in family and wider community (Respondent #1913)

Having to work in a time limited framework (Respondent #365)

FGM/C training

Finally, individuals were asked about FGM/C training: whether any had been undertaken; what the training entailed; and whether respondents would be interested in undertaking (further) training.

Overall, less than a quarter ($n = 460$, 22.2%) of total respondents ($n = 2073$) indicated that they had undertaken FGM/C training. Over two-thirds ($n = 1430$, 69.0%) indicated that they had not and a further ten (0.5%) were unsure, although 1154 (80.1%) of these respondents expressed a wish to undertake some training, particularly related to understanding the different types of FGM/C, how to recognise FGM/C, how to work therapeutically with survivors, legal issues and safeguarding.

The duration, mode of delivery, content of training, training provider, intended audience and reason for undertaking previous training varied vastly across participants, although content was most often reported as covering *legal issues around disclosure and safeguarding* ($n = 82$, 17.8%).

Discussion

Awareness and understanding of FGM/C

Despite the survey being distributed to a large audience, the response rate was markedly lower than for BACP membership surveys. A possible explanation for this could be due to the survey content: FGM/C does not affect a large proportion of women and girls in the UK, and therefore, counselling professionals may not have knowingly come into contact with clients from this group. They may not have felt that it was appropriate to respond to a survey on the topic if they had not knowingly worked with survivors of FGM/C. Furthermore, just a very small proportion of respondents indicated that they had knowingly worked with survivors; far fewer than has been indicated by medical professionals (Relph et al., 2013). This finding is not surprising given that medical professionals are more likely to become aware that a patient has undergone FGM/C due to the physical health issues which may be present and the increased likelihood that a medical practitioner will perform a physical examination. Counselling professionals, on the other hand, would likely only become aware that a client has undergone FGM/C if an explicit disclosure is made, and a lack of confidence in their ability to recognise signs or indicators of FGM/C may limit their ability to present themselves as open to a disclosure by a client. Another potential explanation for the low response rate could be down to counselling professionals' own discomfort about FGM/C, due to the stigmatising and often shame-inciting nature of the issue, which may warrant further investigation.

In line with previous findings (e.g. Relph et al., 2013), respondents in the present study were least confident in their awareness and understanding of the four main types of FGM/C, as well as recognising indicators or signs that a client may have undergone FGM/C. This suggests that low levels of understanding and awareness are evident across both medical and counselling professionals in the UK.

Similarly, low levels of awareness and understanding were presented by survey respondents in terms of their legal responsibilities if a client under the age of 18 discloses that they have undergone FGM/C. Again, this is reflective of previous research undertaken by Leye et al. (2008), albeit amongst gynaecologists as opposed to counselling professionals. Whilst counsellors and psychotherapists are not statutorily regulated professionals—and therefore not bound by the mandatory reporting duty

(Ministry of Justice/Home Office, 2015)—they are expected to follow the established safeguarding policies and procedures in their local area (Home Office, 2015). Hence, both counselling organisations and practitioners have a responsibility to ensure that they are aware of and provide appropriate training for staff on the safeguarding procedures within their practice or organisation.

Working therapeutically with FGM/C survivors

In line with previous research (e.g. Behrendt & Moritz, 2005; Morison et al., 2001; Utz-Billing & Kantenich, 2008; Vloeberghs et al., 2012), the present study suggests that trauma issues, feelings of shame, embarrassment or guilt, affective disorders and physical issues are common presenting issues amongst FGM/C survivors. Educating counselling professionals about some of the most common presenting issues and indicators that a person may have undergone FGM/C may increase their awareness and facilitate communication with clients about the issue. However, a plethora of other presenting issues were provided by respondents in the present study and therefore, whilst it is suggested that counselling professionals are aware of the common presenting issues—and be competent to work with these issues—they should remain mindful that the experience of survivors is not universal.

Respondents in the present study felt that having cultural respect, knowledge and understanding was the most helpful factor when working therapeutically with survivors of FGM/C. This is in line with existing best practice guidance (Khalifa & Brown, 2016) and highlights the importance of not only being competent to work with FGM/C, but with the wider cultural issues which may be present. Indeed, the importance of working with the potential incongruence between cultures which may support FGM/C and the general UK culture has been highlighted as an issue in the present study as well as in previous research (Isman et al., 2013), further exacerbating the need to work in a culturally competent and sensitive manner. In the light of this, it is recommended that 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/C but also when working with clients from all ethnic and cultural backgrounds.

Many of the additional 'helpful' factors identified were those which are congruent with the core underlying principles of person-centred/humanistic

theory, which is unsurprising given that almost three-quarters of respondents had trained in these modalities. Equally, the unhelpful factors tended to be those which were in direct contrast to those factors identified as helpful. Again, as with the presenting issues, counselling professionals' perceptions of helpful and unhelpful factors were varied, reflecting the heterogeneity of client experiences.

Training issues

Despite only a small proportion of survey respondents indicating that they had undertaken FGM/C training, those who had undertaken some training had significantly higher levels of confidence in awareness and understanding of FGM than those who had not. Therefore, it is proposed training is an essential component in educating counselling professionals and equipping them with the necessary skills to work competently with this client group. Moreover, the high proportion of respondents who indicated that they would like to receive FGM/C training further emphasises the demand for such training and highlights the need for better signposting towards existing resources.

Respondents in the present study indicated that they had trained in a variety of theoretical modalities, with many having trained in more than one approach, which reflects the diversity of the counselling and psychotherapy training field. However, almost three-quarters of counselling professionals indicated that they had trained in a humanistic/person-centred approach. This is unsurprising given the vast number of courses that provide training in these modalities (BACP, 2015). Thus, it may be logical to recommend that future training for counsellors and psychotherapists working therapeutically with survivors of FGM/C should include elements of humanistic/person-centred theory to complement core practitioner training.

Considering the findings, the following recommendations for counselling professionals' training are proposed:

- Improved signposting to existing educational resources around FGM/C.
- Training or educational materials developed for counselling professionals around FGM/C should aim to increase general levels of understanding and raise awareness of the risk factors associated with it.
- Working in a culturally competent manner should be an integral part of core counselling and psychotherapy training.

- 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.

Future research

Future research should aim to triangulate findings from the present study with data from clients of counselling and psychotherapy who have undergone FGM/C to better understand what best practice looks like when working therapeutically with this client group. Similarly, qualitative studies which explore the issues facing this client group and the challenges counselling professionals may encounter when working with FGM/C should be undertaken to further our understanding of therapeutic work with this group, such as barriers to access.

In addition, the effectiveness of psychological interventions when working with this client group has yet to be determined and therefore should be explored in future research, as highlighted by Mulongo et al. (2014). Furthermore, more targeted exploration of awareness and understanding of FGM/C amongst counselling professionals should be undertaken to determine the extent to which those who need to know about the issue do.

Research limitations

The low response rate may limit the generalisability of the findings from the present study. However, the similarities between the survey respondents and the wider BACP membership in terms of demographic profile suggest that the sample was representative of counselling professionals more generally. Furthermore, whilst the survey elicited the understanding and experiences of counselling professionals, it was not designed to capture client's views, which may mean that findings are not necessarily reflective of their experiences.

Due to the preliminary nature of the present study, it is not known to what extent survey respondents worked with clients who came from cultural backgrounds where FGM/C is most prevalent. For example, counselling professionals working in large cities may be much more likely to come across FGM/C than those who practise in more rural settings. Therefore, future research should look to determine levels of awareness and understanding of FGM/C in

those who need to know about it, not just all practitioners.

When interpreting the findings from the present study, it is also important to note that FGM/C is not an isolated practice and may be part of a wider set of oppressive practices towards girls and women, such as honour-based violence and forced marriage. Indeed, Monagan (2010) states that 'female genital mutilation should not be addressed in terms of being a single act isolated to certain parts of the world but as a global issue of human rights, freedom from violence, and economic equality' (p. 176). Therefore, it should be kept in mind that results may be reflective of oppressive practices more generally, rather than FGM/C specifically.

Conclusion and implications for practice

The findings from the present study suggest that, in general, many counselling professionals are lacking confidence in their awareness and understanding of FGM/C, including their safeguarding responsibilities. Both organisations and practitioners working in private practice should be encouraged to provide or undertake training appropriate to their role, particularly when working with vulnerable adults or under-18s where safeguarding issues around FGM/C may arise.

Having an understanding of some of the 'typical' presenting issues when working therapeutically with survivors of FGM/C may alert counselling professionals to some of the indicators that a person may have undergone FGM/C and therefore facilitate sensitive discussion around the topic. However, the present research emphasises the need to remain mindful that a 'one size fits all' approach may not always be appropriate when working with this complex group.

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Biography

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