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Knowledge, Experience, and Attitude of Portuguese Psychotherapists about Female Genital Mutilation

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KNOWLEDGE, EXPERIENCE, AND ATTITUDE OF PORTUGUESE PSYCHOTHERAPISTS ABOUT FEMALE GENITAL MUTILATION

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"VIOLENCE AGAINST WOMEN ISN'T CULTURAL, IT'S CRIMINAL. EQUALITY CANNOT COME EVENTUALLY, IT'S SOMETHING WE MUST FIGHT FOR NOW.

SAMANTHA POWER"

Acknowledgments

I want to thank my parents and my brother for all the unconditional support they have given me throughout these 6 years, for listening to my complaints and my low moments, for always pulling me up, believing in me, and celebrating all my big moments louder than me. I wouldn't be here if I didn't have all the love and support, they have given me during these long years.

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Dictionary

Clitoridectomy: Involves the removal of the clitoris either partially or totally.

Excision: Process where the clitoris is removed along with partial or total removal of the labia minora.

Infibulation: Excision of part of the external genitalia and stitching of the vulvovaginal opening to partially cover the vaginal opening.

Defibulation: Incision of the vulva to open the vagina of a woman who has undergone infibulation.

Re-infibulation: The re-suturing of the vulvar opening that has been opened with defibulation.

Resumo

A Mutilação Genital Feminina (MGF/C) é uma prática mundial e recorrente em território nacional, independentemente de haver uma lei que a proíba. Estima-se que cerca de 6575 mulheres residentes em Portugal já tenham sido mutiladas e que cerca de 1830 jovens, com idades inferiores a 16 anos, corram este risco todos os anos. É de ressaltar que esta prática traz consequências negativas para a vida da criança/mulher, afetando a sua saúde física, mental, sexual e relacional. O foco deste estudo é contribuir para a melhoria do atendimento em saúde mental das mulheres mutiladas em Portugal, na medida em que tenta compreender os conhecimentos, experiência e atitudes de psicoterapeutas da região da Grande Lisboa, onde esta prática mais ocorre. Para tal, foram realizadas 10 entrevistas semiestruturadas a psicoterapeutas (8 mulheres e 2 homens). O conteúdo do discurso dos participantes foi sistematizado de acordo com análise temática, da qual emergiu o organizador central ‘‘Emoções e Perceções dos Profissionais da Saúde Mental face à MGF/C’’, que se desdobrou em 3 temas, ‘‘Conhecimentos sobre a Prática’’, ‘‘Sentimentos face à Intervenção’’ e ‘‘Opinião pessoal sobre a MGF/C e suas implicações’’. É possível verificar que os psicoterapeutas detêm um conhecimento apenas geral do que é a MGF/C e têm inseguranças sobre o tema. Espera-se que este estudo contribua para uma maior clarificação da MGF/C em Portugal e sensibilize para a importância de preparar os profissionais de saúde mental para a eventualidade de terem de lidar com as consequências psicológicas e emocionais desta prática.

Palavras-chave: Mutilação Genital Feminina, Psicoterapeutas, Intervenção Psicológica, Conhecimentos e Atitudes

Abstract

Female Genital Mutilation (FGM/C) is a worldwide practice and recurrent in Portugal, regardless of the existence of a law prohibiting this act in Portugal. It is estimated that about 6575 women living in Portugal have already been mutilated and that about 1830 young girls, under the age of 16, are at risk every year. It is noteworthy that this practice brings negative consequences in the life of the child/woman, affecting their physical, mental, sexual, and relational health. This study aims to contribute to the improvement of the mental health care of mutilated women in Portugal by trying to understand the knowledge, experience, and attitudes of psychotherapists in the Greater Lisbon Region, where this practice is most prevalent. For this purpose, 10 semi-structured interviews were conducted with psychotherapists (8 women and 2 men). The content of the participants' discourses was systematized according to thematic analysis, from which emerged a central organizer ‘‘Emotions and Perceptions of Mental Health Professionals regarding FGM/C’’ which was divided into 3 themes, ‘‘Knowledge about this Practice’’, ‘‘Feelings regarding Intervention’’ and ‘‘Opinion about FGM/C and its implications’’. It is possible to verify that psychotherapists hold a general knowledge of what FGM/C is and have insecurities about the topic. It is hoped that this study will contribute to a greater understanding of FGM/C in Portugal and raise awareness of the importance of preparing mental health professionals for the possibility of having to deal with the psychological and emotional consequences of this practice.

Keywords: Female Genital Mutilation, Psychotherapists, Psychological Intervention, Knowledge and Attitudes

Résumé

Les mutilations génitales féminines (MGF/C) sont une pratique répandue dans le monde entier et récurrente sur le territoire national, indépendamment de l'existence d'une loi les interdisant. On estime qu'environ 6575 femmes vivant au Portugal ont déjà été mutilées et qu'environ 1830 jeunes filles, âgées de moins de 16 ans, sont menacées chaque année. Il convient de noter que cette pratique a des conséquences négatives dans la vie de l'enfant/femme, affectant sa santé physique, mentale, sexuelle et relationnelle. L'objectif de cette étude est de contribuer à l'amélioration des soins de santé mentale pour les femmes mutilées au Portugal, en essayant de comprendre les connaissances, l'expérience et les attitudes des psychothérapeutes sur le sujet dans la région du Grand Lisbonne, où cette pratique est la plus répandue. À cette fin, 10 entretiens semi-structurés ont été menés avec des psychothérapeutes (8 femmes et 2 hommes). Le contenu des discours des participants a été systématisé selon une analyse thématique, d'où a émergé un organisateur central "Emotions et perceptions des professionnels de la santé mentale concernant les MGF/C'', divisé en trois thèmes, "Connaissance de cette pratique'', "Sentiments concernant l'intervention'' et "Opinion sur les MGF/C et leurs implications''. Il est possible de vérifier que les psychothérapeutes ont une connaissance générale de ce que sont les MGF/C et qu'ils ont des insécurités à ce sujet. Nous espérons que cette étude contribuera à une meilleure compréhension des MGF/C au Portugal et sensibilisera à l'importance de préparer les professionnels de la santé mentale à la possibilité d'avoir à traiter les conséquences psychologiques et émotionnelles de cette pratique.

Mots-clés: Mutilations génitales féminines, psychothérapeutes, intervention psychologique, connaissances et attitudes

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1. Introduction

1.1 Gender-Based Violence

Gender-Based Violence (GBV) is a form of violence inflicted on an individual because of his or her gender, and disproportionately affects women compared to men. GBV affects women's lives in a variety of contexts, including their sexual lives and their mental and physical health. Gender roles and stereotypes differ according to each culture, but in general, women are seen as inferior to men, having a passive role while men have an active and participating role in society, some activists and feminists see this as a form of violence against women (Olofinbiyi, 2021). And according to the European Commission (n.d.), violence against women is understood as a violation of human rights and discrimination against women.

Female Genital Mutilation/Circumcision (FGM/C) is one of the many forms of gender-based violence that perpetuates the cultural aspect of how men have power over women and how asymmetrical normative roles can affect and most often harm women (Teixeira & Lisboa, 2016).

1.2 Definition of FGM/C

Female Genital Mutilation is also known as female genital circumcision or cutting, or as *sunna or fanado*, and according to the World Health Organization it was described as ‘‘all procedures involving the partial or total removal of the external female genitalia or other injuries to the female genital organs whether for cultural, religious, or other nontherapeutic reasons’’ (Rouzi & Alturki, 2015), it's a ‘‘traditional social practice of cutting parts of the external genitalia of girls or young women to uphold a cultural practice of a rite of passage to womanhood and to curb sexuality’’ (Toubia & Sharief, 2003).

There are different classifications and subclassifications within FGM/C, ranging from ‘‘nicking’’ or ‘‘pricking’’ the foreskin to the complete removal of the clitoris or infibulation (Zurynski et al., 2015).

Type I is called *clitoridectomy* and its classification is partial or total removal of the clitoris and/or the prepuce. Type I is divided into two subclassifications: *Type Ia* is the

removal of the clitoral hood or prepuce only, while *Type Ib* is the removal of the clitoris with the prepuce;

Type II is called *excision* and its classification is partial or total removal of the clitoris and the labia minora, with or without excision of the labia majora. Type II is divided into three subclassifications: *Type IIa* is the removal of the labia minora only, *Type IIb* is the partial or total removal of the clitoris and the labia minora, and *Type IIc* is the partial or total removal of the clitoris, the labia minora and the labia majora;

Type III is called *infibulation*, this is the narrowing of the vaginal orifice with the creation of a covering seal by cutting and the apposition of the labia minora and/or the labia majora, with or without excision of the clitoris. *Type IIIa* is the removal and apposition of the labia minora and *Type IIIb* is the removal and apposition of the labia majora;

Type IV is unclassified. This is every other procedure done to the female genitalia for non-medical purposes (Mishori et al., 2018).

The most performed types of FGM/C are Type I and II, which can account for 80% of this practice while Type III is reported at 15%, but these statistics can change depending on the country (Buggio et al., 2019).

UNICEF (United Nations International Children's Emergency Fund as cited in Buggio et al., 2019) recognizes FGM/C as an international human rights violation and has its own classification of the practice. Type 1 is defined as ''cut, no flesh removed/nicked'', Type 2 is ''cut, some flesh removed'', Type 3 is ''sewn closed'' and Type 4 is ''type not determined/not sure/does not know''.

This practice is performed at different ages depending on the country and/or culture, but it's performed at ages when women are unable to give consent over their bodies (Momoh, 2005), usually between the ages of three and fifteen or from earlier ages until marriage. For example, in countries such as Ethiopia, Eritrea, and Yemen, most girls have been mutilated before their first birthday (Simpson et al., 2012).

The reasons behind FGM/C vary from country to country, culture to culture, and beliefs associated with different ethnic groups. According to different studies we can observe common motivations as to why this practice exists, finding four main justifications, namely tradition, religion, social pressure, and women's sexuality. We can also find customs, rituals,

social hierarchies, political and economic systems, and hygiene among them. Even if there's nothing in the Koran, Sunnah, or Bible that can link or defend this, there's a great belief that FGM/C is recommended in some religions, especially in countries where there's a greater prevalence of Muslim and Islamic communities, where they use religion to justify this practice (Momoh, 2005).

FGM/C is a procedure that is intertwined with culture and ethnicity, where women are highly defined by this practice by the society that surrounds them through this practice. Women who have not undergone this procedure are considered immature, unqualified for marriage and childbearing, and are rejected by their communities (Momoh, 2005). It is a way to fulfill a ritual of passage, that guarantees their virginity, virtue, fidelity, and increased male pleasure, and it helps ensure social acceptance and family honor (Mishori et al., 2018). For these reasons, mothers who submit their daughters to this ritual believe they are protecting them from society and guaranteeing a better future for their children.

1.3 Health Complications

FGM/C is typically performed without anesthesia or sterile conditions, being performed by non-medical personnel, older women from the community, known as *''fanatecas'', ''excisadoras''* or midwives. The child is usually restrained while the external genitalia is removed or damaged with unsafe instruments, including knives, scalpels, razor blades, or other sharp objects (Creighton & Hodes, 2016).

This mutilation can have several consequences for the woman's health. These consequences can vary depending on the type and extent of the cut, the experience of the person performing the procedure, the aseptic conditions during and after the cut, and the physical condition of the mutilated woman (Barreto et al., 2013).

According to previous reviews and meta-analyses, some consequences are immediate**,** such as pain, infection, hemorrhage, or even death. FGM/C has been implicated in the transmission of blood-borne infections such as hepatitis B and C and HIV as a result of the instrument used. Some effects may occur in the medium term, such as difficulty in draining menstrual secretions and blood, recurrent urinary tract infections, scar fibrosis, fistulas, or even chronic pelvic infections.

It also affects women's sexuality, decreasing sexual sensitivity and pleasure, and can cause dyspareunia, which can hinder vaginal penetration and anorgasmia. The practice causes obstetric complications such as obstructed labor, tissue rupture, prolonged expulsion period, an increased number of cesarean sections, prolonged and painful labor, postpartum hemorrhage, episiotomy, prolonged maternal hospitalization, and can cause fetal distress or even death (Creighton & Hodes, 2016; Rouzi & Alturki, 2015; Little, 2015). According to Buggio et al. (2019), it has been estimated that for every 100 deliveries by a woman who has undergone FGM/C, there are 1-2 perinatal deaths. And if a woman has been subjected to Type III, WHO recommends that deinfibulation be performed by healthcare providers, before or during labor, as a method to ensure safe vaginal delivery and a safe passage of the infant (Rouzi & Alturki, 2015; Little, 2015).

If physical complications are ignored, these women are more likely to develop psychological trauma (WHO, 2008 as cited in Mulongo et al., 2014), as well as develop short and long-term psychological effects and complications, including, low self-esteem, loss of confidence, anger and irritability, fear, helplessness, nightmares, hypervigilance, insomnia, and overwhelming emotions (Ahmed et al., 2017). Women who have undergone this procedure are more likely to develop physical or mental illnesses, including chronic anxiety, stress, phobias, depression, post-traumatic stress disorder (PTSD) (Little, 2015), and memory problems, and may attempt suicide (Obaid et al., 2019). Having vivid memories of the event or being infibulated has been significantly associated with psychopathology (Buggio et al., 2019).

They may also be at risk of developing a disturbed personal identity as a side-effect of emigrating women who have been cut. After emigrating, these women may realize that FGM/C is not a universal tradition and that it is mostly viewed negatively in other countries, which can lead to internal conflicts regarding their identity and negative feelings towards their family, country, and themselves. In addition, they may develop dysfunctional family processes that affect their family relationships (Jiménez-Ruiz et al., 2017). According to Campos (2010), some women fear having sexual intercourse and try to avoid it.

Despite the existence of prohibition laws in many countries, approximately 200 million women have suffered from this procedure and its consequences, making FGM/C a global problem. FGM/C is practiced in more than 30 countries, mainly in Africa, the Middle

East, and Southeast Asia. Its prevalence can vary from country to country, for example, Somalia has a prevalence of 98% while Uganda has only 1% (Cerejo et al., 2017).

Although this practice is ingrained in the culture of certain countries, it continues to take place in the rest of the world as a result of migratory movements. Thus, emigrating families tend to take their daughters back to their country of origin, usually during school vacations, to have their daughters undergo this procedure.

1.4 Data regarding Europe and Portugal

The European Institute for Gender Equality (2013) estimated that about half a million women living in Europe have been subjected to this practice and about 180,000 are at risk every year due to migration (Alhassan et al., 2016).

The Centro de Estudos de Sociologia da Universidade Nova de Lisboa in 2015 estimated that about 5246 women, between the ages of 15 and 49 years, had been subjected to this practice and are currently living in Portugal (Paixão et al., 2021). If we also consider the female migrant population, living in Portugal, older than 49 years and born in countries that practice FGM/C, we can extrapolate that 6575 women have been mutilated and that 1830 women under the age of 16 are at risk of being mutilated (Cerejo et al., 2017).

Most of the women who have undergone this procedure live in the district of Lisbon, about 14% live in Setubal, a third in Sintra, 14% in Loures, 12% in Odivelas, 12% in Amadora, and 11% of them in the Lisbon metropolitan area.

In the last 9 years, it is estimated that 835 women were mutilated in Portugal and these cases were mainly detected during pregnancy surveillance by health professionals (Público, 2023; SIC Notícias, 2023). Since 2014, a total of 668 cases of FGM/C have been reported in Portugal, with 63 cases in 2018, 126 in 2019, 99 in 2020 and 138 in 2021. And, according to a report by Direção-Geral da Saúde, 433 cases of FGM/C occurred between 2018 and 2021. The report indicates that, most cases were identified in Lisbon and Vale do Tejo, and that this procedure occurred at the age of 8.4 years. Of these 433 cases, 1 was performed on Portuguese territory, in 2021. Of these 433 women, 196 confirmed that they suffered from health consequences, of which 120 were related to sexual response, 120 to

psychological complications, 113 to obstetric consequences, and 87 to urogynecological sequelae (Sábado, 2022; Diário de Notícias, 2022).

In 2022, 190 cases of FGM/C were identified last year, reporting an increase of 24% compared to the same period of the previous year, and were mostly reported in Amadora and Sintra. Of these women, most cases were of Type II (49,5%) and Type I (44,7%), while Type III (3,7%) and Type IV (2,1%) were less common. They also reported that 75 women suffered psychological complications, 64 with obstetric consequences, 55 related to their sexual response, and 51 with urogynecological sequelae (Diário de Notícias, 2023). Therefore, we can conclude that Portugal is a country at risk due to migratory movements where FGM/C is widespread (Teixeira & Lisboa, 2016), although, since 2015, this procedure has been defined as a crime in Portugal, according to Article 144º of the Penal Code, with a penalty of two to ten years in prison (APAV, n.d).

1.5 Knowledge, experience, and attitudes about FGM/C

Zaidi et al. (2007) conducted a study with the participation of 45 healthcare professionals, where they wanted to understand their level of knowledge about FGM/C through a questionnaire based on the Royal College of Obstetricians and Gynecologists (RCOG) guidelines. The main findings were a knowledge gap, a greater need for better education on this subject, and a need for staff training on the impact of FGM/C on mutilated women.

Reig-Alcaraz et al. (2016) gathered a total of 17 different studies on the knowledge, attitudes, and experiences of health professionals regarding FGM/C, with the main goal of synthesizing all the available information. They concluded that most healthcare professionals knew what FGM/C was, but they couldn't give a complete definition, nor could they differentiate between all the types of FGM/C, however, they knew how to recognize Types I and II (Medicos del mundo, 2012; Garcia-Aguado & Sanchez-Lopez, 2013 as cited in Reig-Alcaraz et al., 2016), and knew how to identify the immediate and long-term consequences. This study also found out that some of these professionals, located in Spain, didn't know how to correctly treat these women, and would hardly identify cases at risk (Kaplan-Marcusan et al., 2009, Vazquez Moya & Almansa Martinez, 2012 as cited in Reig-Alcaraz et al., 2016).

In a study conducted by Barreto et al. (2013) in Portugal, they wanted to see how much healthcare professionals, including nurses, doctors, and administrative staff, knew about FGM/C: its classifications, identification, clinical experience, and knowledge about the clinical approach. Through this study, they found that almost all the participants knew about this procedure, but still, didn't know how to identify which type and how to properly address the procedure correctly in their clinical practice. Of these, 44 health professionals (39%) had already been in contact with at least one woman who had undergone FGM/C, and one of them had been asked to perform this practice in Portugal.

The lack of knowledge among healthcare professionals has a negative impact on mutilated women, and accordingly, previous studies have stated how unprepared these professionals are. Healthcare professionals have a great role in reducing the prevalence of FGM/C (Simpson et al., 2012 as cited in Reig-Alcaraz et al., 2016), and with more knowledge about this practice, it will be easier to make a correct diagnosis, which will allow women to have more accurate interventions to cope with the consequences of this practice (Berg & Denison, 2012 as cited in Reig-Alcaraz et al., 2016).

Women who sought help in a support center, located in Somaliland, ‘‘reported that they felt better, their health was improved, and they stressed that women should be informed and encouraged to seek help in a timely way’’. Therefore, psychotherapists play a key role in helping these women by identifying mutilated women, helping them through all the emotions and feelings, complications and consequences associated with the act, and providing counseling on the risks or benefits of certain procedures, such as, deinfibulation. (Smith & Stein, 2017).

Information on how to intervene in FGM/C is limited, however, Paixão et al. (2021) defined that there are four main options when FGM/C is detected, such as supportive care in case of bleeding and/or infection immediately after the practice; defibulation in situations of Type III and sometimes in Type II situations; surgical treatment for other long-term consequences, e.g. fistulas, and therapeutic options in the area of mental health. There’s evidence that cognitive behavioral therapy (CBT) has helped treat anxiety, depression and/or PTSD in women who have undergone FGM/C, but there is no scientific evidence that CBT is effective in these women (Buggio et al., 2019).

Female Genital Mutilation has a significant impact on women's mental health, putting them at risk of developing mental illness, therefore, it's important to reinforce the need to seek psychological support, to help them heal, recover, and ensure their psychological well-being, as well as to understand how mental health professionals can intervene with this population.

The main aim of this study was to understand if Portuguese psychotherapists, working in the Lisbon metropolitan area, have knowledge about what Female Genital Mutilation is, understand if they can identify and intervene with a woman who has undergone this procedure, and their opinion on this procedure. Above all, this study will be important to understand how and if Portugal is prepared for psychological intervention in Female Genital Mutilation/Cutting, as well as contribute to the improvement of mental health care for mutilated women living in Portugal.

2. Materials and Method

2.1 Participants

The present study involved ten individuals, of which eight were females and two males, ranging in age from 24 to 47 years old (M = 38.7) all working in the mental healthcare field. Of the ten participants, nine were psychologists and only one was a psychiatrist. Information on sociodemographic and further professional characteristics can be found in Table 1.

Table 1

Sociodemographic and professional information about participants

N	Assigned Code	Company	Position	Years Working	Area of Lisbon where they work	Sex	Age	Education
1	E1F	Private Practice	Psychologist	23	Almada; Margem Sul;	Feminine	46	Clinical Psychology
2	E2F	Private Practice	Psychologist	18	Campo Pequeno; Almada;	Feminine	39	Clinical Psychology
3	E3F	Private Practice	Psychologist	20	Almada; Odivelas;	Feminine	42	Clinical Psychology
4	E1M	Learn2Be	Psychologist	4	Almada; Lisboa;	Masculine	30	Clinical Psychology
5	E4F	Private Practice	Psychiatrist	21	Campo Pequeno;	Feminine	47	Medicine
6	E5F	Endopsi;	Psychologist	19	Lisboa; Mafra; Loures; São Domingos de Rana;	Feminine	42	Clinical Psychology
7	E2M	Private Practice	Psychologist	6	Seixal;	Masculine	40	Clinical Psychology
8	E6F	Private Practice	Psychologist	16	Carnaxide; Alfragide;	Feminine	39	Clinical Psychology
9	E7F	Associação Vertíces	Psychologist	1	Entre Campos;	Feminine	24	Clinical Psychology
10	E8F	Private Practice	Psychologist	16	Oeiras;	Feminine	38	Clinical Psychology

2.2 Instrument and Data Collection Procedures

This research was carried out using a theoretical and methodological framework of a qualitative nature. The first step was to create a semi-structured interview (Attachment 1), in which the script was developed according to the literature on the knowledge, experience,

and perceptions of healthcare professionals regarding Female Genital Mutilation, as there is little information available on knowledge, experience and perceptions and/or role of mental health professionals, or any other information regarding their intervention.

The next step was to identify clinics, hospitals, and mental health facilities in the metropolitan area, and through these entities establish contact via email or telephone with the mental healthcare professionals who work there. The inclusion criteria that had to be respected were that these professionals had to be working in the mental health field, with a preference for psychologists and psychiatrists, and living and/or working in the Greater Lisbon Region.

The interviews were conducted remotely via the Zoom platform, at the participant's convenience, and by prior arrangement, and lasted approximately 40 minutes each. These sessions took place between January and March and were fully recorded and transcribed, with the prior consent of each participant. Each interview began with warm-up questions regarding sociodemographic information and professional characteristics and was followed by various topics, such as thematic knowledge, perception, psychological intervention, and diagnosis and treatment.

2.3 Data Analysis

The interviews were fully analyzed using a thematic analysis procedure, which is a ''method for identifying, analyzing, and reporting patterns (themes) within data'', that organizes and details our data set and contributes to a deeper interpretation of the data, following the 6-phase guide (Braun & Clarke, 2006).

The first phase is ''familiarizing yourself with your data'', reading and re-reading all the interviews you have conducted and jotting down ideas for possible codes. Phase 2 is ''generating initial codes'', where you start to organize your data into smaller groups, resulting in codes, phase 3 consists of ''searching for themes'', this is where you gather all the relevant data to create a potential theme. The 4th phase: ''reviewing themes'', this step is important to understand if a theme is really a theme or if a theme should be split into two themes, overall, it's a revision of your themes. As well as understanding if a theme is intertwined with the coded extracts and the data set, resulting in a thematic map of analysis.

Phase 5 is ‘‘defining and naming themes’’ where you decide and define your themes generating clear definitions, and the final phase consists of ‘‘producing the report’’, where the main goal is to best describe and explain all the previous analysis (Braun & Clarke, 2006).

Therefore, themes and codes were developed following the previous phases, as can be seen in Table 2.

Table 2

Thematic Analysis Framework

Central Organizer	Themes	Codes
Emotions and Perceptions of Mental Healthcare Professionals Regarding FGM/C	Knowledge about this Practice	In-depth Theoretical Knowledge
		General Knowledge
	Feelings regarding Intervention	Belief in their professional capacity
		Recognition of insufficient skills
	Opinion about FGM/C and its implications	Total reproval
		Understanding of the cultural issues that underlie it

2.4 Ethic Procedures

This study was submitted and approved by Comissão de Ética da Faculdade de Psicologia e de Ciências da Educação da Universidade do Porto (Ref.ª2023/02-05b) (Attachment 3).

The participants were found through different institutions in the Lisbon metropolitan area and were contacted by email or telephone. Each received detailed information about the interview, the theme, and the purpose of this research, as well as information about how their involvement would be anonymous and how they could quit at any time. Each participant

received a consent agreement document (Attachment 2), to be filled out to participate, in the same document, they received a method of contact in case they needed further clarification.

In addition, and if necessary, they would receive any additional information, as well as the names of various institutions and Non-governmental Organizations (NGOs) that work with this issue, in order to obtain more knowledge on the subject, as well as support in it. It is worth mentioning, in an honorable way, some of the institutions in Portugal that work with this population/issue: CIG, UMAR, AFAFC, Associação Mulheres sem Fronteiras, AJPAS, A Casa Árabe Portuguesa, APF, and many others.

All documents and interviews were carefully translated from Portuguese to English, in order to clarify results and further discussion.

3. Findings

Following Braun and Clarke's (2006) thematic analysis, the Central Organizer ''Emotions and Perceptions of Mental Healthcare Professionals regarding FGM/C'' was created, according to the interviews conducted, which was divided into three themes: 1) Knowledge about this Practice, 2) Feelings regarding Intervention and 3) Opinion about FGM/C and its implications.

1) Knowledge about this Practice

Interviewees shared their definition and knowledge of what they knew Female Genital Mutilation to be. It was essential to understand what they define this mutilation to be, as well as everything else that this implies, from what ages this practice is most common, the countries where it's more prevalent, the different types of FGM/C, and the reasons behind it. Most healthcare professionals knew what FGM/C was but had different levels of knowledge between them.

In-depth Theoretical Knowledge

Throughout the interview these professionals stood out, showing that they detained a wealth of theoretical knowledge on what FGM/C is, knowing and exploring different aspects of what this procedure encompasses, without giving a definition on what they knew this practice to be.

> *E3F: So, this is phenomenon that has very strong cultural base, isn't it? […] it happened mainly in Guinean communities […] and at the time we realized that besides the countries of origin, and it's not only in Guinea, there are others, aren't there? […] this was a very common ritual in Muslim and Islamic communities if I'm not mistaken […] From what I know female genital mutilation is a ritual that is done with girls, I don't know around what age, but probably at the age when they enter preadolescence so this then varies here doesn't it? […] but I know that there are even shelters for girls who have had excisions done and then have problems, vaginal, uterine, others […] because they are done in a completely non-medical way […] because they are left with significant consequences for the rest of their lives, fissures, discharge, sores, infections, etc., etc. […] I remember at the time with sticks, with pieces of glass, anything you can get your hands on.*

> *E1M: I know that it is a surgical procedure of removal, very aggressive […] I know that it's also practiced in many countries on the African continent above all, and then these immigrants end up transforming Portugal into this... […] I know that the age group is very young, isn't it? […] So I know that in general that there are four, there are four types, I know that the names end in excision, ''ion'' and things like that. I know they are distinguished a little bit by this, right? Which one is removal of everything, the other is removal of just one part, the other is removal of the internal part, another external part, I don't know if I got it right, if it's close… […] I would say maybe three years, or four years, correct?*

General Knowledge

Psychotherapists understand that FGM/C is a phenomenon that involves cutting or scrapping a part of the genital area of female women, but lack the theoretical development on what this concept encompasses.

> *E1F: Female genital mutilation is the excision of the clitoris and the labia minora performed on young girls for cultural reasons […] with the intention of removing sexual pleasure, and therefore confining them to the husband, to the control of the tribe, etc.*

> *E7F: Female genital mutilation is the mutilation, the scraping, the torture of the genital area of women and this normally happens when they are children or teenagers. […] maybe from five/six until sixteen. […] I know that there are several, there are several types of […] I don't know the exact names. I know there is scraping, I know there is even the total cut, I know there is taking off only the labia, I think or taking off only the clitoris or taking off the whole thing, I know there are those, exactly. I don't know exactly, more.*

> *E2M: The simplest way of saying this, I believe that it has to do with cutting one, some parts, or the totality of the female genitalia […] The only thing that I can say that I really know for sure is that there is a, for example, in the case of women, the labia majora or the labia minora can be cut, as the clitoris can also be cut, so that's all I can say, I can't say more specifically […] Ages I would say, and as much as it pains me to say it, I would say that, maybe, we are talking about ages between, maybe, in the second childhood, already around 5/6 years old, I don't know, I don't know an age limit, but I think that maybe the biggest number I would say between five and fifteen years old, maybe […] There are two geographical areas in the world that immediately come to mind. The first is Africa, that is, Central Africa, around there, and then some part of the Asian continent, namely the area around Afghanistan, Iran, and Turkestan, perhaps, because here are all the former Soviet countries that are more oriented towards Asia, not towards Europe. I think these two, these two parts of the globe, I think is where there's the biggest number.*

E4F: It is a practice of mutilation, usually associated with religious factors, in which there's the extraction of some part of the genital areas, clitoris, or labia majora, of young girls.

E2F: […] therefore, it's something done to women to not have pleasure and that is to cut if you can say so, the clitoris. That's the only thing I know.

E8F: Genital mutilation, if I'm not mistaken or because of what I sometimes saw in documentaries, has a lot to do with it, in fact, I think that it is a procedure that is very deeply rooted in a certain culture and where they make an alteration, I can't tell you exactly, but an incision in the genital area, which inhibits women from being able to exercise their sexuality in a pleasurable way.

Some participants tend to recognize that Africa is one of the many places where FGM/C is present, however, some of these participants tend to guess where this practice is performed, with little assertiveness behind their answer. As well as a lack of knowledge of where this practice is also practiced.

E1F: African countries, but do you want a specific name for countries where it is more common? I can't say.

E7F: I know it's mostly in African countries and African cultures.

E4F: I think it will be in Africa, in African countries, but I don't know what the culture is.

E2F: The only thing I've heard about is that, so, I always associate it, maybe badly, probably with African cultures, I don't know why, but I do. Maybe because the person I met was African, I don't know. […] No, I imagine that it's only in African countries. But probably it is in other places too, but in my mind, it's only in those countries.

E8F: I don't have the faintest idea, but it is African, African countries essentially, I don't know if it is the Middle East.

There are participants who are only aware of this practice being focused on cutting the clitoris. This knowledge is not entirely incorrect, because the act of cutting the clitoris occurs in all types and some subtypes of FGM/C but excludes all the other possibilities within what FGM/C is.

> *E5F: I'm cheated, right? Because my initial idea when I was thinking about it, I thought, "Okay, I thought it was just cutting the clitoris," but then when I read it, I realized that it's cutting the labia as well, right? […] But that's my answer, if I hadn't researched it, if I hadn't looked, I would find it only related to the clitoris.*

Even if the age of this procedure changes according to each culture or country, there is an idea among these professionals that this practice is related to puberty or related to menarche/menstruation.

> *E1F: I think around the time of puberty, I don't know if it coincides with the appearance of menarche, but I think it is around the time girls hit puberty,*
>
> *E4F: I would aim for around the age of ten, but it is a vague idea, little girls, maybe before menstruation.*
>
> *E2F: I have an idea that it is when girls are menstruating, I have that idea.*
>
> *E8F: I think that it is very early. I don't know if it is also related to the…, I may be saying something stupid here, but the process of initiation of menstruation, I don't know if it is a strict age or if it is according to the biological cycle of each woman, I can't say.*

2) Feelings regarding Intervention

None of these mental healthcare professionals had contact with any mutilated women, but when confronted with a hypothetical situation about their intervention with these women, most of these professionals affirmed they would be able to intervene and give the right help to each woman.

Belief in their professional capacity

There's a belief among these professionals that they are able to intervene with these women, asserting that this intervention would be similar to any other intervention, not acknowledging the cultural aspects behind this practice.

> *E2M: These issues whether it's mutilation, whether it's deaths, mourning, that I... […] fully capable of that, of helping.*

> *E7F: I think I could, but I like... it's just that since, well, I'm also very interested in criminal psychology, so it's an area that I'll eventually get there, so I really like that part, I'm very interested in that area and I think I could intervene with that person, yes.*

> *E1F: Well, I think it's possible to intervene within my context and my clinical practice because one can always intervene in trauma, right? It could be considered an intervention in which there was an actual trauma that we could identify [...] But in the intervention, if we think only of the psychological intervention, I feel that I would be able to intervene if there was no medical situation to resolve already, of course I had to ask for help for the person to be seen, by a person in the medical field.*

Some of these professionals still concur that their intervention is enough, but question what would be the right way to handle this situation, if they need to report this practice to authorities, as this is a violation of women's rights.

> *E1M: Yes, I mean, I think I would be prepared, but that's it, I always have to report it, don't I? Sometimes the person can come with that problem and have problems of something else and that can make me confused, but I think so.*

> *E1F: In terms of ethics, I think it would raise questions for me, wouldn't it? In the sense of understanding what happened to that girl or if she was already a woman. If she was a woman, I think it would be different than if she was a minor, I say this*

in ethical terms. Because we have to report situations, we have to overcome our issue of confidentiality, if we feel that there has been abuse or mistreatment of minors, especially, right? In ethical terms, it would raise some questions and I would probably ask others for help, share the issue with colleagues and try to figure out what I could do, to report the situation. Either to report or not to report and to whom. Or to the ethics board of the psychologists' association, eventually.

E8F: […] with my practice, my principle is, regardless of the trauma or the issue that brings her to me, is to understand how there is that reciprocity. What I also do in my practice, particularly, is to always have a first contact so that we can talk, and not assume that "okay, the first psychologist I meet in front of me (or whether it's a deliberate act), I want to understand, I want to really know her''. It's still an interpersonal relationship, even though it's therapeutic […] making sense to the woman? Of course, I wouldn't deny it, but I would be honest, and I would tell her that she would have to help me, to take me into her world, and her whole reality. In parallel, knowing this lack of information, I would also develop this work.

E3F: Within my area, if I noticed that the person really needed, for example, more psychopharmacological issues, etc. But within our area, I wouldn't direct them.

Recognition of insufficient skills

There is optimism among these professionals that they would be able to intervene with this population, but they are aware that there is a possibility that the case may need to be referred to another professional, either because of the issue raised by the client or because of the lack of information they have about FGM/C.

E6F: I think I would feel prepared, depending on the psychological consequences that this would have. That is, for example, if it is something to do with sexuality, maybe I would pass it on to a colleague in that area, who had more, who is more specialized and has more studies and more practice, if it is perhaps a question of anxiety, self-esteem, dealing with the other, I think yes, I think I would know how to deal with it and study that part even more, wouldn't I? So that I can also accompany, but yes, I think so.

E5F: It's what I usually do in cases that are very specific, isn't it? Which is, if the person manages to look for an answer, that is, if I manage to help the person to look for a specialized answer, I'll direct them. Or for some reason, there is no chance of resorting to that specialized answer, then I will inform myself as much as possible because at this moment I don't feel informed enough to do that follow-up, so I will inform myself as much as possible and study as much as possible and interact with people who know, in this sense, to be able to give the best answer, but when they are very specific cases what I do is, I try to give myself, that is, I look for what is specialized in the country […] So I always try to direct them, because I think a specialized answer is much better than my own answer, which is a more generic answer, isn't it? But if by chance the person is left unprotected, they wouldn't be. So, I would intervene, studying the subject as much as possible.

3) Opinion about FGM/C and its implications

In Portugal, when asked about their opinion on Female Genital Mutilation, participants disapprove of this procedure, showing negative feelings, although some understand that this practice is intertwined with cultural values.

Total reproval

There's an uprising among Portuguese psychotherapists, having, overall, negative feelings regarding FGM/C, who are against this practice and how it affects woman's lives.

E7F: I think that shouldn't even be a question. Totally against it, obviously, I can't understand, like, and I'm very, very fond of knowing other cultures, getting to know their practices and all that kind of stuff, but there are things that I think are not tolerable and this is clearly one of them. I don't think this should happen. So, deep down I guess that's my opinion.

E1F: It's a horrible thing, in my opinion it has to be criminalized, it has to be worked on to end it, right? I'm not sure in what way, but, because it has this very deep-rooted cultural issue, very..., that mothers themselves do to daughters, families, this is done

to women by women, isn't it? Women. It's horrible, it's an unimaginable thing to do that to a child, to a woman, it's horrible.

E8F: Something that is completely absurd and traumatizing and that, unfortunately, is spreading from generation to generation, that is, what is reinforcing more and more this behavior and the way it is seen and even more frightening, which is this question of self-reflection, of questioning. Maybe it's very rooted in what defines that person in terms of identity, "I am a woman, I am a woman of this culture, as such, in order for me to feel integrated and part of it, even by my mother, by my grandmother, by all those who went through this, I will be supportive and I will also integrate in some way," or I run the risk that they may even respect my decision, but I continue to be ostracized or suddenly I start to feel displaced.

However, this does not mean, that these professionals don't respect women who have undergone FGM/C or even the cultural aspect of it.

Understanding the cultural issues that underlie it

There's a sense of respect among these professionals regarding the cultural values that underlie this practice. But they recognize that this practice is harmful to women, both physically and mentally, and that it should end. Overall, they don't agree with FGM/C, but they do comprehend the cultural aspect of why it still happens nowadays.

E2F: Obviously that it's highly negative, isn't it? That's why there is also legislation […] I see it almost as a violation, it's an abuse that it is. For me what shocks me the most is the question of it being permanent, well, it's something that is forever. In quotes, the only thing that I think ends up being less serious, I don't know if that's the right word, but not so harmful is because it is circumscribed within a culture. And as we know, something that is cultural is, in quotes, better accepted.

E2M: It's like, from zero to a hundred, a hundred, right? Totally against it, so I think, no! I am sure. That... we live a little bit in a culture of wishful thinking, but we also have to make a stand, otherwise, we all walk in limbo, we should make our stand, above all, as people and then as health professionals. We should be totally against this kind of issue, very often associated with the culture of a country or

countries, I even understand that part of it, but that doesn't take away from the idea that we should be, in fact, against it, right?

E1M: Look, I'm always very careful when it comes to these aspects of culture and because I think, I mean, we're going to respect all of this, especially when we work with people, right? It doesn't matter much what the opinion is, we have to, we have to respect cultures, in my opinion. One thing is for sure, I think they should eliminate this, deep down there are some customs that, although we respect and try to understand, there are things that are above this, right? Like human rights and things like that, there are things that overlap and then there are things that at least we can tell if they maintain or if they don't maintain or if they maintain in other ways, a hypothesis is maintaining them in other ways. But I still think that I'm of the opinion that it should be eliminated, in essence, or at least in another way. Now it is a risky thing, to be done without being done by health professionals, to be against the will of the people, and things like that. I believe that my opinion is very direct in this case, I mean, I'm against it, maybe.

E3F: Hm, it's horrible, and I'm against it. What is my opinion? Contextualizing from a cultural point of view, I can even understand that there are practices here, and this practice is not something recent, it is an ancient practice that corresponds to a certain time in this society and in some communities, that doesn't mean that it can be perpetuated from the moment there is more information and from the moment we realize that they have a very significant damage in people's lives, isn't it? And so, now as a practice, as a tradition, there are always people who feel that it has to be done this way. I think it should be abolished in countries, at least, that are considered more informed and more developed.

4. Discussion

The aim of this research was to study the knowledge, experience, and attitude of Portuguese psychotherapists on FGM/C, to understand how women who have undergone this procedure are, or will be, counseled psychologically in Portugal. Thus, it was possible to find that these professionals are insecure whenever confronted with FGM/C, they know

the general gist of what Female Genital Mutilation is, but they don't know everything that entails this procedure. They have mostly negative attitudes and opinions and are against FGM/C, yet they have a strong belief that they can intervene with these women.

The results of this study are relevant because they deal with the deepening of Portuguese psychotherapists' perspectives and insecurities towards FGM/C, and although it is an issue that isn't much talked about in the country, it is already happening in Portugal and among the people who live in the national territory, with a 24% increase in cases of FGM/C in 2022 compared to the previous year (Diário de Notícias, 2023). Portugal is considered a country at risk, indicating the need for health professionals to be alarmed by this phenomenon (Barreto et al. 2013). As mentioned previously, this practice has consequences attached to it, namely psychological consequences. One hundred and twenty women had psychological complications regarding the data from 2018 and 2021, and 75 women suffered psychological complications just last year, in 2022 (Sábado, 2022; Diário de Notícias, 2022, 2023). Hence, it is important to study what mental healthcare professionals know about FGM/C and how they intervene with this population to help them heal. According to Vicente (2007), it's essential that health professionals know what Female Genital Mutilation is, without this knowledge, it's not possible to establish structured and successful interventions with these women (as cited in Frias & Gomes da Costa, 2014).

In this research, most mental healthcare professionals were able to identify what FGM/C is, in a short and generalized definition, but lacked theoretical knowledge. The majority were unaware of the existence of different types of FGM/C or didn't know how to identify which type it was. In addition, they were able to determine that this procedure tends to occur when girls are younger and that there is a prevalence of this procedure in Africa, although they didn't know at what age it most commonly occurs and could barely identify other countries where it is also frequently performed, such as the Middle East and some parts of Asia (Little, 2015; Cerejo et al., 2017).

Hence, this begs the question, is this general knowledge sufficient to determine that these professionals have a deep understanding of what FGM/C is? Are they able to recognize that a woman has undergone this procedure? This is a major concern, especially because these women tend to hide the fact that they've undergone FGM/C. Working in the mental health field can make it challenging to point out these cases, since this mutilation is more physical and visual, reinforcing the need for these professionals to have an in-depth

knowledge of the practice, as well as know what risk indicators to look out for, such as awareness that this phenomenon is intergenerational, a knowledge that this mutilation tends to take place in the country of origin, and it is important to check when and if these young girls have planned trips, usually during school holidays, to their country of origin, and knowledge of which communities or countries FGM/C is known and practiced (Jamal, 2022). Limited knowledge can contribute to the underreporting of cases and poor collection of evidence (Simpson et al., 2012), therefore, common knowledge may not be sufficient to identify these women, making it difficult to establish a therapeutic relationship and furthermore, intervene.

The following findings by Mulongo et al. (2014), Smith and Stein (2017), and Libretti et al. (2023) confirm the need for in-depth knowledge of this practice and all that it embodies, such as what differentiates each type of FGM/C, where and when it's more common, what health complications can occur and from which types, as well as knowing the reasons behind this practice. For Portuguese psychotherapists, it may also be important to know which countries of origin are most represented in Portugal, namely Guinea-Bissau, Senegal, Guinea, Nigeria, and Ghana (Jamal, 2022).

Healthcare professionals detain an important role in identifying and intervening with these women, as well as establishing therapeutic communication and relationship, to help women that have undergone FGM/C speak about their feelings, doubts, and complaints (Frade, 2009; Campos, 2010 as cited in Frias & Gomes da Costa, 2014). However, there are no official guidelines on how mental healthcare professionals should identify and intervene, as well as there is no knowledge of what type of therapy is more appropriate to do so. And as mentioned above, psychological symptoms and psychiatric disorders are frequently reported among these women, as it is also common for immigrant families to have post-traumatic stress reactions due to acculturation processes (Adelufosi et al., 2017). Midwives need to learn about the origins and customs behind FGM/C in order to help these women with their psychological pain (Mulongo et al., 2014). Therefore, this should also be an important step for all mental healthcare professionals, to better understand these women and intervene with them. Through counseling, in an FGM/C support center in Somaliland, these women learned that their health problems and pain were due to the FGM/C procedure (Smith & Stein, 2017), and it's been proven that women with more education are more likely not to submit their daughters to this procedure (Libretti et al., 2023), which can translate the need for psychologists to intervene with these women through psychoeducation, as well as

psychiatrists, informing them about the consequences that this practice can have on their bodies and psychological state.

These mental healthcare professionals have strong negative attitudes and opinions about FGM/C and are against this practice, yet this doesn't mean that they wouldn't respect these women or try to help them. However, negative attitudes of healthcare professionals can affect the way they intervene with their clients (Simpson et al., 2012) and can increase negative feelings of insecurity and shame that a woman who has undergone FGM/C may experience. This negative attitude can discourage mutilated women from seeking help and increase feelings of mistrust in the health sector. As well as, in immigration situations, the stigma associated with FGM/C can be perpetuated and may increase the fear of seeking help (Marea et al., 2023), which can be a possible explanation for why these professionals have never had contact with a woman who has undergone FGM/C in Portugal. It is therefore important for these professionals to maintain a neutral and respectful attitude towards these women, in order to protect them and gain their trust, as well as to invest in a deeper understanding of the reasons why FGM/C continues to be practiced, namely the cultural and religious values, social pressures, tradition, and gender stratification that underlie the practice.

Omigbodun et al. (2020) affirmed that ''understanding the sociocultural determinants of this practice is central to identifying the factors that continue to drive it''. In this regard, it's important for these professionals to keep in mind that this practice is intertwined with a sociocultural view as well as a gender stratification characterized by men's need to control women's sexuality. Families follow these sociocultural norms to protect their children, in order to ensure a better future for their daughters and to give status to their family (Akweongo et al., 2021; Agboli et al., 2019). However, in a country where this practice is not prevalent, this status is not viewed in the same way, so what was normal in the country of origin may be prohibited and viewed negatively in the host country (Adelufosi et al., 2017). This highlights the need for health professionals to change their attitudes and speeches, respecting the cultural aspect behind this practice so that these women feel safe to seek help for the psychological consequences resulting from this act.

The results of the present research are in line with what was expected, namely that health professionals need to be better educated on the subject. There should be a dissemination effort among these professionals, as well as better preparation in educational

institutions, such as psychology and medicine, but also in institutions and organizations dealing with FGM/C. Marea et al. (2023) affirmed that adequate knowledge, a non-judgmental attitude, and a respectful intervention focused on the client and their culture are they to intervening with these women. Therefore, knowledge is crucial to intervene with women who have undergone this procedure, as it is to combat the lack of information that these women have regarding this procedure and its consequences. Awareness of the complications and awareness of their rights have been proven to make these women reject this practice (Libretti et al., 2023). Therefore, mental healthcare professionals have an important role to play in identifying these women, providing psychological assistance, and helping to end this phenomenon. In addition, it's important that mental healthcare professionals keep an impartial attitude toward these women in order to gain their trust and help them deal with the psychological pain brought by FGM/C.

Overall, through this study, we can understand that Portuguese psychotherapists aren't ready to help these women. They need to learn more about this worldwide phenomenon and change their attitudes in order to help these women. In Portugal, there is a need for greater national investment on the part of the Government and the Ministry of Health, investment aimed at providing knowledge and skills to professionals in public and private health institutions, as well as skills to know how to deal with these situations, and it is fundamental to invest in the NGOs that work with this phenomenon, as there is also a need for global investment in the intervention with these women.

Limitations and Strengths

There were some limitations associated with this study. It was difficult to get in touch with these professionals since this study was carried out in the north of Portugal, whilst the interviewees live in Lisbon's metropolitan area, and there's little information about these professionals available online, making it difficult to get in touch with them. There was also a low adhesion of Portuguese psychologists and psychiatrists, mainly because most of them claimed not to have much knowledge about what Female Genital Mutilation is, even if it was fundamental to analyze in this study. Nevertheless, the number of participants was sufficient to provide an overall picture of the research objectives.

Since the data was collected through self-reporting it is possible for social desirability to occur, to combat this bias, anonymity and a trusting environment were used during the interviews.

There isn't much literature on the role of mental health professionals and their intervention, which reinforces the need for studies like this, that invest in the mental health of women who have undergone FGM/C.

It is also worth mentioning, considering the potential strengths, that this study was innovative since it sought to investigate the knowledge, experience, and perspectives of Portuguese professionals on this practice, as well as to explore the intervention of these professionals with these women, something that has not been much researched worldwide.

5. Conclusion

Portuguese psychotherapists are aware of what FGM/C is, each of them having different and inconsistent definitions within them, what they know about this procedure is limited, reinforcing the need to invest in training mental health professionals to help these women heal from the psychological effects brought by FGM/C procedures. In addition, these professionals have negative opinions and attitudes toward this practice, which can strongly affect their intervention, hence the need to maintain an unbiased attitude and opinion. Meaning that knowledge and a change of attitudes are fundamental to intervene with women who have undergone FGM/C. Furthermore, mental healthcare professionals have an important role to play in identifying and helping these women, although this will only be possible with knowledge of everything that FGM/C entails, as well as a deeper understanding of the reasons behind it, e.g., men's need to have control and power on women's bodies, and a change of attitudes towards the woman who have undergone FGM/C. And in general, Portuguese psychotherapists believe that they are ready to intervene with these women, but the reality is that they are insecure when confronted with this reality. So, in the future, it would be important to interview women who have undergone FGM/C and who are currently living in Portugal, in order to understand if the results previously discussed are within expected. It would also be important to verify whether these women have sought psychological help in Portugal or why they have not, how was the professionals'

intervention, and suggestions for a better intervention, as well as understand how this intervention affected their mental state.

Therefore, this study is expected to contribute to greater clarification of what FGM/C is in Portugal, raising awareness of the importance of preparing mental healthcare professionals for the eventuality of having to intervene or deal with the psychological and emotional consequences of this practice. It also allows us to draw attention to the lack of investment in this phenomenon in the national territory, as well as the need for investment in the knowledge and skills of health professionals and NGOs that work directly with this practice by the Ministry of Health and the Government.

6. References

Adelufosi, A., Edet, B., Arikpo, D., Aquaisua, E., & Meremikwu, M. (2017). Cognitive behavioral therapy for post-traumatic stress disorder, depression, or anxiety disorders in women and girls living with female genital mutilation: A systematic review. *International Journal of Gynecology & Obstetrics*, *136*, 56–59. https://doi.org/10.1002/ijgo.12043

Agboli, A., Botbol, M., O'Neill, S., Richard, F., & Aujoulat, I. (2020). Transforming vulnerability into power: exploring empowerment among women with female genital mutilation/cutting (FGM/C) in the context of migration in Belgium. *Journal of Human Development and Capabilities*, *21*(1), 49–62. https://doi.org/10.1080/19452829.2019.1661981

Ahmed, M., Shaaban, M., Meky, H., Amin Arafa, M., Mohamed, T., Gharib, W., & Ahmed, A. (2017). Psychological impact of female genital mutilation among adolescent Egyptian girls: a cross-sectional study. *The European Journal of Contraception Reproductive Health Care*, *22*(4), ve280-285. https://doi.org/10.1080/13625187.2017.1355454

Akweongo, P., Jackson, E., Appiah-Yeboah, S., Sakeah, E., & Phillips, J. (2021). It's a woman's thing: gender roles sustaining the practice of female genital mutilation among the Kassena-Nankana of northern Ghana. *Reproductive Health*, *18*(1). https://doi.org/10.1186/s12978-021-01085-z

Alhassan, Y., Barrett, H., Brown, K., & Kwah, K. (2016). Belief systems enforcing female genital mutilation in Europe. *International Journal of Human Rights in Healthcare*, *9*(1), 29–40. https://doi.org/10.1108/ijhrh-05-2015-0015

Associação Portuguesa de Apoio à Vítima [APAV]. (n.d.). *Mutilação genital feminina*. https://apav.pt/uavmd/index.php/pt/intervencao/mutilacao-genital-feminina

Barreto, S., Cunha, V., Vicente, L., Campos, A., & Costa, A. (2013). Female genital mutilation: Knowledge from health professionals mutilação genital feminina: O que

sabem os profissionais de saúde? *Acta Obstétrica e Ginecológica Portuguesa*, *7*, 89-94.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Buggio, L., Facchin, F., Chiappa, L., Barbara, G., Brambilla, M., & Vercellini, P. (2019). Psychosexual consequences of female genital mutilation and the impact of reconstructive surgery: A narrative review. *Health Equity*, *3*(1), 36–46. https://doi.org/10.1089/heq.2018.0036

Campos, A. C. (2010). Mutilação genital feminina - a importância de reconhecer e de saber como agir. *Acta Obstétrica e Ginecológica Portuguesa*, *4*(3), 152-156.

Cerejo, D., Teixeira, A., & Lisboa, M. (2017). Contextos socioculturais, discursos e percepções sobre a mutilação genital feminina. *Faces de Eva*. *Estudos sobre a Mulher*, *37*, 83-103. http://scielo.pt/scielo.php?script=sci_arttext&pid=S0874-68852017000100007&nrm=iso

Creighton, S., & Hodes, D. (2016). Female genital mutilation: what every paediatrician should know. *Archives of Disease in Childhood*, *101*(3), 267–271. https://doi.org/10.1136/archdischild-2014-307234

Momoh, C. (2005). *Female genital mutilation* (1st ed.). Radcliffe Publishing.

433 casos de mutilação genital feminina detetados em Portugal entre 2018 e 2021. (2022). *Diário de Notícias*. https://www.dn.pt/sociedade/433-casos-de-mutilacao-genital-feminina-em-portugal-entre-2018-e-2021-15388911.html#media-1

Registados 190 casos de mutilação genital feminina em 2022. (2023). *Diário de Notícias.* https://www.dn.pt/sociedade/registados-190-casos-de-mutilacao-genital-feminina-em-2022-15788548.html#media-1

European Commission. *Gender-based violence (GBV) by definition.* (n.d.) https://ec.europa.eu/info/policies/justice-and-fundamental-rights/gender-

equality/gender-based-violence/what-gender-based-violence_en#gender-based-violence-gbv-by-definition

Frias, A., & Gomes da Costa, F. (2014). *Mutilação genital feminina: Segredos para revelar.*

Heise, L., Ellsberg, M., & Gottmoeller, M. (2002). A global overview of gender-based violence. *International Journal of Gynecology & Obstetrics*, *78*(1), S5-S14.

Jamal, S. (2022). *Mutilação genital feminina. projeto protege +: Capacitação para a identificação e prevenção da Mutilação Genital Feminina (2ªedição)* [Powerpoint].

Jiménez-Ruiz, I., Martínez, P., & Carpenito, L. (2016). Proposal for nursing diagnosis: Post female genital mutilation syndrome. *Enfermería Global*, *16*(1), 51. https://doi.org/10.6018/eglobal.16.1.263331

Libretti, A., Bianco, G., Corsini, C., & Remorgida, V. (2023). Female genital mutilation/cutting: going beyond urogynecologic complications and obstetric outcomes. *Archives of Gynecology and Obstetrics*. https://doi.org/10.1007/s00404-023-06929-6

Little, C. M. (2015). Caring for women who have experienced female genital cutting. *MCN: The American Journal of Maternal/Child Nursing*, *40*(5), 291-297.

Marea, C., Warren, N., Glass, N., Ahmed, W., & Pallitto, C. (2023). Advancing the measurement of knowledge, attitudes and practices of health workers who care for women and girls who have undergone female genital mutilation/ cutting (FGM/C): A qualitative exploration of expert opinion. *PLOS ONE*, *18*(4), e0284900. https://doi.org/10.1371/journal.pone.0284900

Mishori, R., Warren, N., & Reingold, R. (2018). Female genital mutilation or cutting. *American Family Physician*, *97*(1), 49-52.

Mulongo, P., Martin, C., & McAndrew, S. (2014). The psychological impact of female genital mutilation/cutting (FGM/C) on girls/women's mental health: A narrative literature review. *Journal of Reproductive and Infant Psychology*, 32(5), 469-485.

Obaid, Z., Amer, A., El Mahdy, M., & Mohammed, A. (2019). Evaluation of psychological and sexual effects of female genital mutilation (Circumcision). *The Egyptian Journal of Hospital Medicine*, *74*(4), 726-734. https://doi.org/10.21608/ejhm.2019.24073

Olofinbiyi, B. (2021). A review of gender-based violence and the emerging combating policies. *Nigerian Stethoscope*, *3*(2), 1-11.

Omigbodun, O., Bella-Awusah, T., Groleau, D., Abdulmalik, J., Emma-Echiegu, N., Adedokun, B., & Omigbodun, A. (2020). Perceptions of the psychological experiences surrounding female genital mutilation/cutting (FGM/C) among the Izzi in Southeast Nigeria. *Transcultural psychiatry*, *57*(1), 212-227. https://doi.org/10.1177/1363461519893141

Paixão, M., Valente, J., & Leite, A. (2021). Para lá do fenómeno cultural: A mutilação genital feminina como um problema de saúde pública em Portugal. *Acta Médica Portuguesa*, *34*(6), 410–412. https://doi.org/10.20344/amp.15536

Piedade, S., & Moleiro, C. (2012). Mutilação genital feminina em Portugal: atitudes, formação e experiências de profissionais de saúde: Atitudes, formação e experiências de profissionais de saúde. *Transcultural*, *4*(1), 57-75.

Mutilação genital feminina. Em nove anos, foram detectados 835 casos de mutilação genital feminina em Portugal. (2023). *Público*. https://www.publico.pt/2023/02/06/sociedade/noticia/nove-anos-detectados-835-casos-mutilacao-genital-feminina-portugal-2037710

Reig-Alcaraz, M., Siles-González, J., & Solano-Ruiz, C. (2016). A mixed-method synthesis of knowledge, experiences and attitudes of health professionals to female genital mutilation. *Journal of Advanced Nursing*, *72*(2), 245–260. https://doi.org/10.1111/jan.12823

Relph, S., Inamdar, R., Singh, H., & Yoong, W. (2013). Female genital mutilation/cutting: knowledge, attitude and training of health professionals in inner city London. *European Journal of Obstetrics & Gynecology and Reproductive Biology*, *168*(2), 195-198. https://doi.org/10.1016/j.ejogrb.2013.01.004

Rouzi, A., & Alturki, F. (2015). Female genital mutilation/cutting: an update. *Clinical and Experimental Obstetrics & Gynecology*, *42*(3), 300-303. https://doi.org/10.12891/ceog1823.2015

Portugal registou 433 casos de Mutilação Genital Feminina entre 2018 e 2021. (2022). *Sábado.* https://www.sabado.pt/portugal/detalhe/20221125-2131-portugal-registou-433-casos-de-mutilacao-genital-feminina-entre-2018-e-2021

Mutilação genital feminina: em nove anos, registados em Portugal 853 casos. (2023). SIC Notícias. https://sicnoticias.pt/saude-e-bem-estar/2023-02-06-Mutilacao-genital-feminina-em-nove-anos-registados-em-Portugal-853-casos-1fe4f4f4

Simpson, J., Robinson, K., Creighton, S. M., & Hodes, D. (2012). Female genital mutilation: the role of health professionals in prevention, assessment, and management. *BMJ*, *344*, e1361. https://doi.org/10.1136/bmj.e1361

Smith, H., & Stein, K. (2017). Psychological and counselling interventions for female genital mutilation. *International Journal of Gynecology & Obstetrics*, *136*, 60–64. https://doi.org/10.1002/ijgo.12051

Teixeira, A., & Lisboa, M. (2016). Estimating the prevalence of female genital mutilation in Portugal. *Public Health*, *139*, 53–60. https://doi.org/10.1016/j.puhe.2016.05.002

Toubia, N., & Sharief, E. (2003). Female genital mutilation: have we made progress?. *International Journal of Gynecology & Obstetrics*, *82*(3), 251–261. https://doi.org/10.1016/s0020-7292(03)00229-7

World Health Organization. (2001). *Female genital mutilation: integrating the prevention and the management of the health complications into the curricula of nursing and midwifery: A student's manual.* World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/66857/WHO_FCH_GWH_01.4.pdf?sequence=2

Zaidi, N., Khalil, A., Roberts, C., & Browne, M. (2007). Knowledge of female genital mutilation among healthcare professionals. *Journal of Obstetrics & Gynaecology*, *27*(2), 161–164. https://doi.org/10.1080/01443610601124257

Zurynski, Y., Sureshkumar, P., Phu, A., & Elliott, E. (2015). Female genital mutilation and cutting: a systematic literature review of health professionals' knowledge, attitudes and clinical practice. *BMC International Health and Human Rights*, *15*(1). https://doi.org/10.1186/s12914-015-0070-y

7. Attachments

Attachment 1:

Interview Script

INTERVIEW SCRIPT

KNOWLEDGE OF PSYCHOLOGISTS REGARDING FEMALE GENITAL MUTILATION

DIMENSION	QUESTIONS
Warn-up Questions	As you know, the topic of today's interview will be about Female Genital Mutilation, but before we proceed, I would like to get some information about you. What is your educational background and how old are you? How long have you been a psychologist? Where do you work? And the clinic where you work is located in what part of Lisbon?
Thematic Knowledge	In your years as a professional, have you ever come across the concept of Female Genital Mutilation? Do you have any idea of how many women are estimated to have undergone this procedure, who are residents in Portugal?
Perception	What is your opinion about this procedure?
Psychological Intervention	Have you ever had, in a professional context or even in your daily life, with a woman who has undergone this procedure? Have you ever given psychological counseling to a woman? If you did, did you know how to attend to their needs? Have you had any training on this subject? If you didn't know how to attend to the woman's needs, did you need to direct her to another colleague?
Diagnostic and Treatment	Do you know what different psychopathologies are common to present in these women? Were any psychopathologies identified in the woman you intervened with?

	What type of therapy did you use for the patient's clinical picture? Or what type of therapy do you think would be appropriate to intervene in a clinical picture of a woman who has been mutilated?
Closing Question	Gostaria de acrescentar mais alguma informação que não tenha sido considerada e que ache importante referir?

Attachment 2

Consent Agreement

INFORMED CONSENT AGREEMENT OF PARTICIPATION

We request your participation in a research project whose main objective is to deepen the level of knowledge that Portugal, more specifically, the metropolitan area of Lisbon, has about the phenomenon of Female Genital Mutilation, and we ask for your participation in a semi-structured interview.

We also request your permission to record the study so that a later transcription and analysis of the data will be possible. Given the scientific nature of the study, we guarantee that the data collected will be used exclusively for research purposes. We also guarantee that the recordings will be destroyed after the transcription of the interviews as well as the anonymization of your participation.

I thus safeguard the total confidentiality of participation and your anonymity, and remind you that your participation is completely voluntary and that you may withdraw at any time, without any repercussions.

You may, at any time, contact me via email (joycegoulart_@hotmail.com or up201706958@fpce.up.pt), if you wish to withdraw your consent and request that your answers not be included in the study. You may also use the same contact if you wish to have access to the research outputs at the end of the research.

Thank you for your availability and collaboration.

Joyce Terra Goulart

After the above-mentioned information, I declare that I agree to participate in the presented research and that I consent to the audio recording of the research.

Signature of participant: _____

Date ___/___/____

Attachment 3

Approval of this study by Comissão de Ética (Ref.ª2023/02-05b)

U.PORTO
FACULDADE DE PSICOLOGIA E DE CIÊNCIAS DA EDUCAÇÃO UNIVERSIDADE DO PORTO

COMISSÃO DE ÉTICA

PARECER (Ref.ª 2023/02-05b)

A Comissão de Ética (CE) da Faculdade de Psicologia e de Ciências da Educação da Universidade do Porto, tendo reapreciado os documentos do projeto de investigação denominado «**Knowledge of Portuguese Psychologists regarding Female Genital Mutilation**», apresentado pela mestranda **Joyce Terra Goulart**, com orientação da **Prof.ª Doutora Conceição Nogueira** e da **Doutora Ana Luísa Patrão Martins**, emite um **Parecer Favorável** à realização da pesquisa.

Parecer favorável

A CE é favorável à realização do projeto tal como apresentado.

FPCEUP, 29 de março de 2023

A Presidente da CE,

Prof.ª Doutora Carlinda Leite

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