Reflections on research with survivors of female genital mutilation

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This article offers a reflexive account of conducting research with survivors of female genital mutilation (FGM). It explores the challenges encountered throughout the research process including recruitment, researcher position, and power dynamics. The article also reflects on issues of countertransference between the researcher and the participants, their impact, and their management. The considerations are important for those engaging in clinical work with survivors of FGM.

Introduction

Female genital mutilation (FGM) is recognised widely as a human rights abuse and represents sexual-gender based violence against women and girls (WHO, 2008). Despite the United Nations Sustainable Development Goals (2015) making FGM a priority to achieve gender equality and empower all women and girls by 2030, FGM is under-researched. This article presents a reflective account of the ethical and methodological challenges I faced as a Trainee Clinical Psychologist when carrying out qualitative research on the psychological impact of FGM. The research, which formed the thesis component of my doctorate, implemented a Grounded Theory (Strauss & Corbin, 1998) approach whereby 20 interviews with survivors of FGM originally from African countries were recorded, transcribed verbatim, and analysed; leading to the development of a theoretical model from the resultant data (Glover et al., unpublished). The model developed revealed that participating survivors of FGM related culture, religion, role of men, lack of education, female identity and deception as the major factors influencing their understanding and the impact of FGM. Their experiences of FGM, as well as their conceptualisation of the practice, led to effects on their emotional life, relationships, identity, and physical body. Many of the women interviewed described difficulty with trusting others, particularly women, as well as difficulties with intimacy due to the physical pain of FGM. The fear resulting from their experiences of FGM also negatively affected survivors’ resilience. It is noted that within the context of this research, resilience referred to ‘the ability to bounce back from negative emotional experiences and flexible adaption to the changing demands of stressful experiences (Tugade & Frederickson, 2004, p.320).

All the core categories of emotional, relational, identity, and physical impact, as well as resilience, were further influenced by important transitions of womanhood; including menstruation, marriage and childbirth. Women voiced their views that all the above issues were compounded by their needs not being met and by the lack of meaningful and effective service responses. The research held important implications for improving services to address the psychological needs of survivors, as well as providing a structure for understanding the needs of women who have experienced FGM.
When carrying out this research, qualitative and feminist approaches were utilised as these prioritise the use of reflexivity in research (Bryant & Charmaz, 2007). Reflexivity refers to the ability to attend, acknowledge and mediate the impact of a researcher’s position and background on ‘their choice of research topic, the angle of investigation, the methods judged most adequate for the research purpose, the findings considered most appropriate, and the framing and communication of conclusions’ (Malterud, 2001, p.483). Within a reflexive framework, researchers are advised to consider their ‘presuppositions, choices, experiences, and actions during the research process’, as well as their personal experiences, values, and positions of privilege in various hierarchies that have influenced their research interests (Harrison et al., 2001, p.325). Considering this, I acknowledged my position as a middle class, white female who was born and brought up in the United Kingdom. I further acknowledged my pre-existing knowledge on some elements of African culture having spent considerable time in South Africa for a period earlier in my life.

A reflective diary was kept by myself, the Lead Researcher, throughout the research process documenting my experiences of this journey. This narrative revealed several core themes of reflection including ethical difficulties, counter-transferences, researcher positionality, recruitment, and empowerment of survivors. Each of these central themes is addressed separately in this article. It was also noted that many of the themes mirrored components of the theoretical model described above which was developed from the empirical data (Glover et al., unpublished). Alongside discussion of the aforementioned themes extracted, some of these parallels are considered in the following reflection thereby providing areas of consideration for practitioners engaging in clinical work with survivors of FGM.

Ethics, counter-transference and mirrored processes
As previously emphasised, reflexivity is an important underpinning to qualitative research. It is further essential to the clinical practise which my research into FGM aimed to inform. In the context of the latter, reflexive consideration allows therapists to consider the emotions that both they and the client experience during the therapy process, thereby allowing for a potentially deeper and more meaningful therapeutic relationship and process. In relation to the former, Holloway (2016) argues that psychoanalytic concepts of transference and counter-transference can enhance qualitative research methods and ‘expand the practice of research reflexivity’. Transferences refer to emotions and attitudes which unconsciously transfer from situations of the past, to situations in the present. When carrying out research, transferences will be evidenced both in the direction of the participant towards the researcher, and of the researcher towards the participant. Countertransference, a concept intertwined with transference, is the emotion which is elicited in an individual in response to another’s unconscious transference communications. As noted by Holloway (2016), within the context of research reflexivity, it has been questioned whether analysis of researchers’ countertransferences could result in the misinterpretation or misuse of feelings evoked during the interview process resulting in biased or inaccurate analysis (Jervis, 2009). It can further be argued that researchers can never be entirely certain whether feelings elicited during the interview process are due to transference (feelings the participant is experiencing are also experienced by the researcher) or researchers’ own feelings bound within the context of their own personal histories. Thus, interpretation must be done with caution.

The transferences experienced when carrying out this research were considered both separately and in conjunction with the
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raw data analysis. Furthermore, the model developed from the data was validated by other members of the research team who had not partaken in the interviews and could read interview transcripts with more emotional distance. This section considers some of my experiences of transference when conducting this research.

Despite being carried out ethically and sensitively with fully informed consent and a debriefing ensured for all participants, the study faced several ethical dilemmas. One of the main ethical issues was the potential for women to feel distressed by the interview. In preparing for interviews, I attempted to enhance women’s comfort in taking part as much as possible. I allowed the women to choose where the interview took place, and whether they would like a friend or someone to support them present. Participants were also provided with a copy of the interview schedule prior to taking part, however in common with the sentiments of Fontes (2004), I could not always predict the impact recalling a potentially traumatic event might have on each of the women. During the interviews, women often became upset at recalling their experience of FGM. Seeing the women distressed and tearful, I often felt a desire to circumvent asking further questions. For instance, some of the women spoke of choosing to ignore the emotional impact of FGM in order to avoid having to re-experience difficult feelings. At these points, I felt particularly guilty in asking these women to share such an intimate narrative with me as I felt like I was in some way diminishing the mechanisms they had built up in order to cope. The guilt I felt often made me feel disempowered and inadequate in supporting the survivors. Whilst time was given in the interview to help manage women’s distress and allow the interview to be stopped if needed, at these times, I now wonder if the disempowerment I felt reflected women’s feelings following experiencing FGM. However, I also noted at this point that my feelings of disempower-

There were also times during the interviews that I experienced strong feelings of anger and sadness. While readily admitting that I regularly felt my own anger towards perpetrators of FGM, I also considered that some of the anger may have been counter-transference from the anger the participants expressed. This initially frightened me, as such intense anger was not something I had experienced within my therapeutic role, and I was fearful that my emotional responses could seem problematic to the women. However, containing my own emotions and showing how touched I was by their experience, appeared to assist them to talk openly and to validate their narratives.

Reflective consideration of the fluctuation in my emotions during the interview process showed how my emotional state appeared to mirror those of the women due to the impact of FGM. The results of the study indicated that the fear women expressed influenced both the emotional impact of FGM, as well as women’s ability to show resilience. For instance, some of the women interviewed reported that FGM had left them with a fear of trusting others. For some women, this fear led them to avoid returning to their country of origin for concern that their children would be taken without consent and ‘cut’. For others the fear of trusting people inspired them to campaign against FGM to ensure that girls and women were protected from the experience and subsequent difficult emotions. I feel this was emulated in my sometimes-reduced ability to ask difficult questions when carrying out interviews, for fear that certain questions may cause distress in women. As the interviews progressed I could manage this more easily using regular research supervision and discussion in trainee peer research groups, however I felt it mirrored the way many of the women described using avoidance to cope with the emotional impact of FGM. Conversely, at
other times the same fear led me to show resilience, creating an increased sense of duty to complete the interview as I had originally intended. Many of the women described developmental stages in their lives as causing them to struggle emotionally, however they all described how those same experiences often also led them to build their resilience. For instance, women described childbirth as being particularly traumatic as for many women it elicited flashbacks of FGM. Due to the physical complications FGM can cause during childbirth, this was often also a time of extenuated distress, with women describing infections and pain which made caring for a new born particularly difficult. Childbirth is a key stage in many women’s lives, and one which was made physically and emotionally harder due to FGM for all of the women interviewed. However, despite this, the power of becoming a mother enhanced women’s ability to fight to ensure their daughters and other young girls were never subjected to FGM. On reflection, I wonder if the fluctuation I experienced between avoidance and resilience was reflective of the everyday experiences of women I interviewed.

Researcher positionality
As has been referred to earlier, reflexive consideration of the researcher’s position in comparison to their participants is an important component of the qualitative research process (Koch & Harrington, 1998). Within this context, reflexivity involves researcher self-scrutiny of the ever-changing relationship between the researcher and the participant (Chiseri-Stater, 1996; Pillow, 2003). Berger (2015) discusses two differing positions that the researcher can assume; ‘insider’ or ‘outsider’. When taking the ‘outsider’ position, the researcher has no prior connection with the study population while when in an ‘insider’ position, the researcher holds prior experience and connections with the research participants.

When commencing the research, I was aware of my position as an outsider. While I had some experience, and understanding of a small component of African culture having spent considerable time in South Africa, as well as working with women survivors of FGM, I was an outsider to the research participants. Being a British, middle class, white woman, I was very mindful of feminist narratives that criticise Western research with women from ethnic minorities which assert that outsiders often fail to accurately represent minority experiences (Barrett & McIntosh, 1985; Carby, 1982; Shah, 2004; Devault, 1999). When considering my position as ‘an outsider’, I was concerned that I would come across to the participants as ignorant or naive. I was also aware of literature that argued white Western women can be perceived by non-Western women as ditsy, shallow, privileged, sexually available, and appearance focused (Conley, 2013). Prior to interviews with the women, I regularly felt anxious about how I came across to them, already positioning myself as being different in some way to the women I was interviewing. I was concerned of becoming positioned as ‘other’ to my participants, resulting in me often failing to consider similarities (see, also Busso, 2007). I now wonder if my fear of judgement and positioning as ‘other’ matched women’s own fears of being stigmatised and judged due to being an FGM survivor, as reflected in the model developed from my empirical research.

I also considered my ‘outsider’ or ‘other’ position to have been advantageous. Openly sharing with participants that I knew little about the practice of FGM, or about the differing cultural contexts and backgrounds of the women, enabled them to adopt an ‘expert’ position, thereby placing them in a more empowered standpoint. Acknowledging my outsider position allowed participants to consider which elements of difference they felt were most important thereby leading to more detailed and comprehensive explanations of their experiences. For example, the participants spent time ensuring I understood what various
terminology meant and that I appreciated their experiences within their own cultural and religious framework. This approach enabled women’s underlying belief systems to emerge.

**Navigating researcher-clinician roles**

When carrying out interviews with survivors, I found myself experiencing some conflict between my clinical role at that time as a Trainee Clinical Psychologist and the role of a researcher. This conflict has been widely acknowledged by scholars (Yanos & Ziedonis, 2006; Haverkamp, 2005) who emphasise the internal clash between a therapists’ clinical obligation to act in the participants’ best interests, and the researcher’s mandate to pursue answers to research questions with appropriate rigor.

When carrying out the research, I immediately felt a sense of guilt that I was asking women to share their stories. Unlike a therapeutic relationship where I feel I am aiding individuals to make sense of their experiences and make progress, the dynamic of the research interviews often left me feeling guilt ridden. The nature of the research was very personal and intimate and the power imbalance between myself and the participants was difficult at times to manage both emotionally and practically. Although I was allowing the women time to describe the impact of their experiences, it was a one-off research interview, very different from a therapy session where there is sufficient time to process experiences. To help manage this, I utilised peer support from fellow trainee clinical psychologists, processing feelings in a reflective diary, as well as research supervision.

There were points throughout the research where I wondered if I was being unfair by putting the women I spoke with in this position. I was also aware at times that I was tempted to blur boundaries between researcher and therapist, often having to consciously prevent myself from moving into a therapeutic stance in which I would have usually facilitated understanding and guidance of ways to process, make sense of, and move forward from difficult experiences. However, at the same time I utilised my therapeutic skills to enable women to talk in a way that they told me was empowering. This was one of the most powerful aspects of my research with survivors of FGM. When speaking to the women about what they felt would help them manage the emotional impact of FGM, three women stated that until the research interview they had not considered talking about their experiences to be beneficial in any way. The process of taking part in the research appeared to have provided a safe space for allowing women to experience sharing their story in a way they felt was empowering and helpful. This is consistent with feminist research methods in which the role of taking part in research can also serve to empower women participants.

Some women had never shared their experiences before, and I felt truly moved that they felt able to do so with me. Other women I spoke to told me they had shared parts of their story, but had not considered in detail the impact of their experience of FGM. To illustrate the participant’s views of the impact of taking part in the research, I will draw on powerful verbatim quotations made by three of the participants. Faridah (lines 457–459) expressed that even though she had received psychological support:

> In one session with you [myself as the researcher], you have taken me to a place I didn’t cover in six years of therapy, so every woman who has gone through FGM should have this chance to really talk about what happened to them.

Keisha (lines 64–65) voiced that she:

> Would love someone to talk to me like you [Myself as the researcher] are, to listen and respond and really care... I don’t know what it is, but the way you listen... we need more people like you, to talk and show that people can be trusting.
Finally, Saskia (lines 98–100) stated:

It sounds strange but I don’t think I realised how much talking helped until we did this today. You seem so much to care and I can see your face that you care and are impacted by what I say. If it hadn’t been today I would say no-one can help me. But you... no you, talking may be an answer I had not yet considered.

Although I found all the interviews moving, my clinical experience allowed me to attend and be sensitive to the emotional needs of the participants, whilst the researcher part of my role allowed me to progress the interview forward and gain the information I needed relevant to the study questions. However, when I was told by the women that I had changed their view on the value of talking therapies, partly due to the empowering impact the research interview had, I was visibly lost for words. The empowerment women described was a key theme emerging from the data, and one that I felt paralleled my own experience of carrying out the research. Similar to the women just after having FGM, at the start of the research journey, I felt very anxious and powerless. However, also mirroring the participants’ shift in feelings throughout their lives, having conducted interviews, I felt empowered due to the impact of women’s views suggesting I had aided them to see the positive side to talking through their experiences. Furthermore, their words forced me to appreciate the powerful roles a qualitative researcher has as well as the potential to empower individuals through this process (Lather, 1988).

**Sense of duty**

Regularly throughout the research process, I felt a strong sense of moral and ethical duty towards women I was interviewing, the subject area, and my integrity as a researcher. Feelings of duty were the most pronounced during the data collection and analysis phases of the research. As previously discussed, many of the women participants experienced an emotional response during the interview. Although all the women were fully debriefed and received information about support services, I regularly found myself feeling a sense of duty to contact the participants at a later point to check that they were OK. Whilst for some women I had pre-arranged that I would do this, due to the level of distress they exhibited during the interview, for others I made the decision that it would not have been appropriate to contact them outside of pre-arranged times. I found being unsure about how they were very unsettling and spent considerable time wondering why I was struggling to maintain clear boundaries between my professional and personal life. I wondered again if this pull to offer support to the women was a result of countertransference. Many of the women I spoke to described feeling let down and unprotected by their mothers and I believe this led to my taking on a protector role. Effective supervision with my research team helped me to make sense of and manage this.

Analysis of the interview data also led me to feel a sense of duty towards the participants. The women who spoke to me had shared so much information relating to their experience of having FGM, it felt overwhelming trying to formulate their narratives into a model that did justice to all their voices. I noted the duty I felt to accurately represent participants’ experiences further echoed in the theoretical model developed from the interviews. Women described becoming more resilient following FGM by developing a sense of duty to advocate against and resist its practice. The sense of duty I felt towards the women I interviewed led me to carry out the research in the first instance, as well as my future desire to utilise my research to promote the needs of FGM survivors to services.

Fuelling my sense of duty was my admiration and respect for women who took part in the study. Had the tables been turned, I
wondered if I would have been able to speak with their openness and honesty about such an intimate and traumatic experience. With this admiration also came a personal desire, in addition to the theoretical need, to accurately represent the women’s narratives.

A crucial part of the research process involved obtaining feedback from women participants regarding the results and analysis of the data (Mays & Pope, 2000). From the outset of the study, I was aware of participant comments that they had regularly experienced feeling judged and stigmatised by health care professionals in the United Kingdom. I distinctly recall Saskia (line 75) stating that when giving birth to her child, the medical doctors had been unfamiliar with the practice of FGM. She related her experience: ‘They just laughed and said some cultures are silly. I felt this big… I wished I was dead’. These words echoed in my head whilst analysing the data and I felt it essential to provide women with a positive experience of health care professionals through the research process. Whilst not all participants could be contacted due to language limitations, respondent feedback demonstrated women agreed with the conclusions drawn from the data and were positive about the model generated.

The experience of having my analysis validated by participants was new to me, and showed me how valuable this is within qualitative research.

**Recruitment**

A further challenge I faced when carrying out this research related to the recruitment of women who had experienced FGM to take part in face to face interviews. In line with the importance to grounded theory of recruiting a homogeneous sample, participants were sought from UK residents who originated from Africa. This recruitment strategy was informed by existing literature that suggests that FGM predominantly occurs in African contexts. The recruitment of minority ethnic groups for research participation can prove challenging (Knight et al., 2004; Yancey et al., 2006) due, in part, to a lack of trust towards researchers’ intentions (Fisher & Ragsdale, 2005). This issue is often compounded by unsuitable recruitment methods that fail to consider both the context of the research population, and potential barriers to their participation (Yu, 2009). Upon reflection, several factors were considered to have contributed to these difficulties including the role of legislation and the media, and my self-perceptions as the lead researcher.

Since the submission of my initial research proposal, some 6 months prior to recruitment of participants, the subject of FGM had been widely discussed in several forums including in the media, and the legalities surrounding its practice had been considerably tightened (Serious Crime Act, 2015; Female Genital Mutilation Act, 2003). The wide attention FGM received initially felt positive as it made the prospect of broaching recruitment appear easier. Thus, upon commencement of the recruitment process I believed that survivors might be grateful to hear from me. The reality of the situation was very different. Upon approaching gatekeepers of non-government organisations accessed by FGM survivors in London and the Midlands, I was regularly met with resistance, suspicion, or in many cases simply ignored. When given the opportunity, I discussed my research with members of the FGM practising community. They expressed that since FGM had gained an increased media presence; they had received an abundance of student requests to interview survivors. Some women reported negative experiences of being interviewed, when they were unclear where and how their information was being used and without question of the utility of the interview for them. Women also reported that the increased attention had led them to feel stigmatised, with the tightened legislation around the practice increasing women’s fear of being prosecuted for being part of a FGM practising community.

I also found that some gatekeepers were
understandably quite protective over survivors and hesitant to allow direct contact with them. However in doing so, these gatekeepers also exercised power in terms of restricting FGM survivors informed choice about participation in my research. The dominance of the gatekeeper has been observed in other sensitive research within the sexual and gender-based violence literature, with Hanley (2005) and Davison (2005) asserting that some gatekeepers overpowered and drowned the voices of others, thereby placing survivors in a disempowered position by not allowing them to make their own informed decisions and reducing opportunities for active consent or non-consent. Additionally, perhaps as a representation of the limited current services available to survivors of FGM, some organisations were only willing to allow contact with potential participants if I could utilise my position as an NHS employed Trainee Clinical Psychologist. The organisations’ motive in this situation was their wish that I might be able to help provide women with a means of attaining a ‘diagnosis’ of depression or post-traumatic stress disorder (PTSD), as this would provide the services with a means to increase their funding. This raised very important awareness of the enormous political and financial influences that emerged as an influence on the research process.

At this point during the recruitment I noted my own feelings of helplessness due to the reluctance of some gatekeepers to permit access to potential participants. I reflected during the research process that my feelings of powerlessness mirrored the feelings of my participants towards services, enhanced further by the frustration survivors have towards the lack of knowledge of health care providers in the United Kingdom.

It became clear at this stage that something would need to shift in the research team’s approach to recruitment; however, I felt out of my depth and unsure how to progress the research forward. Due to the inherent distrust the practising community appeared to hold towards researchers, it became evident that building trust and rapport with gatekeepers was essential. When initially considering the complexities of this, I felt stuck as to how I might proceed and therefore sought support from my research team. Upon reflection, I believe my anxiety and desire to prioritise the experiences and perspectives of marginalised women who had been tortured led me to over-complicate how I, like other researchers within the field, could demonstrate the value of my research. Reflexive consideration of this allowed me to consider that my interest in the research area may not be perceived as genuine or of value which in turn stemmed from my own self positioning as different. I assumed, often wrongly, that survivors and gatekeepers would see me as different based on the literature suggesting negative views on Western researchers. Attending meetings with gatekeepers appeared to serve as an assurance of my character (Eide & Allan, 2005), and it was therefore crucial to the recruitment process as it helped services develop trust and feelings of alignment. I was also concerned and motivated to carry out my research given the lack of justice for women who had survived FGM in terms of state recognition and action as well as the dearth of services provided for survivors. It was important to me to carry out the study in a way that ‘gave back’ to participants through disseminating the research findings and providing a summary document that could be used by stakeholders to action my recommendations.

The difficulties I experienced during recruitment emphasised the importance of considering my identity not only as a researcher, but as a professional trying to use research to promote and analyse women’s own experiences of FGM, and to utilise this information to try to effect positive changes. This also helped me to be mindful that aligning trust and building relationships between participants and myself, and showing genuine personal interest in a research area, is essential for the effective completion of good research.
Conclusion
The process of reflecting on my research journey enabled a more detailed understanding of some of the complex reflective, methodological and ethical issues that occur when carrying out ethnographic, sensitive research including challenges with recruitment, negotiation of my position as a researcher, and working with interpreters. Considering participants’ and my own responses to the interviews allowed a deeper understanding of the reciprocal impact that participants and researcher have on one another. Reflecting on the research process has highlighted the importance of a reflexive approach when carrying out qualitative research, as well as allowing for personal and professional development. It has further highlighted the value of both researcher and psychological skills when carrying out sensitive research in a way that aims to facilitate further empowerment of participants.

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References


