Volume 141 Issue 1 April 2018 ISSN 0020-7292

# International Journal of GYNECOLOGY & OBSTETRICS

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WILEY

DOI: 10.1002/ijgo.12042

SYSTEMATIC REVIEW

WILEY International Journal of Gynecology Obstetrics

# Supportive psychotherapy or client education alongside surgical procedures to correct complications of female genital mutilation: A systematic review

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Funding Information
WHO, Department of Reproductive Health and Research

## Abstract

**Background:** Supportive psychotherapy, in individual or group settings, may help improve surgical outcomes for women and girls living with female genital mutilation (FGM).

**Objectives:** To assess whether supportive psychotherapy given alongside surgical procedures to correct complications of FGM improves clinical outcomes.

**Search strategy:** We searched major databases including CENTRAL, Medline, African Index Medicus, SCOPUS, PsycINFO, and others. There were no language restrictions. We checked the reference lists of retrieved studies for additional reports of relevant studies.

**Selection criteria:** We included studies of girls and women living with any type of FGM who received supportive psychotherapy or client education sessions alongside any surgical procedure to correct health complications from FGM.

**Data collection and analysis:** Two team members independently screened studies for eligibility.

**Main results:** There were no eligible studies identified.

**Conclusions:** There is no direct evidence for the benefits or harms of supportive psychotherapy alongside surgical procedures for women and girls living with FGM. Research evidence is urgently needed to guide clinical practice.

**PROSPERO registration:** 42015024639.

KEYWORDS

Counselling; Education; Female genital mutilation; Supportive psychotherapy

## 1 | INTRODUCTION

In many countries, female genital mutilation (FGM) is often performed by untrained individuals under aseptic conditions, resulting in significant physical, social, psychological, and sexual complications.

These complications may be immediate or long term and can include bleeding, shock, genital tissue swelling, severe damage to genital tissue, infections, problems with urination and wound healing, as well as chronic vaginal discharge, urological complications, and dyspareunia.[1,2] Some studies have also reported a decline in sexual functioning among women living with FGM especially in the areas of arousal, lubrication, and orgasm.[3–5]

There are a number of surgical procedures that women living with FGM may undergo. Deinfibulation is often used to correct type

III FGM (infibulation). It involves cutting open the narrowed vaginal opening in a woman who has been infibulated, which is often necessary for improving health and well-being, as well as to allow for sexual intercourse and child birth. It may be partial or total depending on whether the urethral meatus, clitoral tissue, or entire body of the clitoris is involved.[6,7] In clitoral reconstruction/repair, the skin overlying the clitoral stump is resected and suspensor ligaments sectioned to mobilize the stump. Then sclerous tissues are removed and the neo glans is restored.[8] Surgery may also be performed to remove cysts or resolve other complications such as vulvar pain and labial adhesions.[9–11] Reduced pain and improved sexuality have been reported post reconstructive surgery.[12,13]

Women living with FGM may also experience psychological problems including low self-esteem, stigma, guilt, post-traumatic stress disorders, anxiety disorders, depression, and somatic disorders.[14,15] Some girls and women may also report "feelings of incompleteness, fear, inferiority and suppression, chronic irritability and nightmares".[2] These psychological issues, which may be the result of FGM, adversely affect interpersonal relationships resulting in low productivity, isolation, interpersonal losses, and marital disharmony.[6,16]

Supportive psychotherapy is defined as "a dyadic treatment characterized by the use of direct measures to ameliorate symptoms and to maintain, restore or improve self-esteem, adaptive skills and ego function".[17] It is offered in individual or group settings and is aimed at "restoring and strengthening the patient's impaired defenses and integrating capacities. It provides a period of acceptance and dependence for a patient who needs help to deal with guilt, shame, and anxiety and to meet frustrations or external pressures that may be too great to handle".[18] It may involve several methods including help in developing pleasurable activities, rest and diversion, counselling, and advice in resolving current issues. Previous studies suggest that supportive psychotherapy may be effective in a range of mental and physical conditions,[19,20] and has the potential to offer women living with FGM much-needed support. For instance, women with vulvodynia have been reported to experience reduced pain and better sexual functioning after receiving supportive psychotherapy.[21] Surgical patients need to be empowered to acquire the skills and confidence required to become more active participants while undergoing surgical procedures.[22] Supportive psychotherapy potentially facilitates a therapeutic environment for patient empowerment, growth, and independence. It achieves this by strengthening adaptive coping mechanisms, encouraging patient involvement, raising self-esteem, and enabling therapeutic alliance.[23]

Client education for FGM involves sharing culturally appropriate, sensitive, and evidence-based information in a confidential setting. This information may include knowledge of the reproductive system, sexuality, living with persisting complications as well as managing symptoms and adapting to changes in the body after surgery. They may also need to understand how to access appropriate health care for their physical and mental needs.[24] Client education improves clinical outcomes by bridging the gap between patients' expectations and surgical interventions. This may improve client satisfaction and quality of life postoperatively.[25]

The relatively high prevalence of mental health problems before and after surgical interventions for FGM may negatively affect treatment outcomes.[26] This has raised the need for specialized health services that provide psychological care and counselling for girls and women living with FGM.[27] The objective of this review was to assess whether supportive psychotherapy given alongside surgical procedures to correct complications of FGM in women and girls living with any type of FGM will lead to better treatment outcomes. The primary outcomes of interest were reduction in duration of the postoperative recovery period and improved return to full functioning. Secondary outcomes were decreased medico-legal complaints, reduced need for postoperative analgesia, improved postoperative Female Sexual Function Index (FSFI), and improvement of patient satisfaction. We also sought to evaluate the effectiveness of client education alongside clitoral repair surgery for improving treatment outcomes.

## 2 | MATERIALS AND METHODS

We searched major databases including CENTRAL, MEDLINE, African Index Medicus, SCOPUS, PsycINFO, WHOLIS, LILACS, POPLINE, ERICS, NYAM Library, CINAHL, and Web of Science. The reference lists of retrieved studies were checked for additional reports of relevant studies. The keywords were relevant to interventions, i.e. supportive psychotherapy and education, and population of interest. The searches for supportive psychotherapy and client education were run separately. We attempted to identify all relevant studies irrespective of language or publication status (published, unpublished, in press, and in progress), but did not include the grey literature.

Two team members (AO, MC) independently assessed for inclusion all the potential studies identified from the literature search. We resolved any disagreement through discussion or, if required, we consulted a third team member (EO). We linked together multiple reports of the same study. We examined the titles and abstracts to remove obviously irrelevant reports and retrieved the full text of any potentially relevant reports. We examined the potentially relevant full-text reports for compliance of the studies with our eligibility criteria (determined a priori). Eligibility criteria included girls and women living with any type of FGM that had undergone any surgical procedure to manage the condition and/or its complications. Eligible designs included randomized controlled trials and nonrandomized controlled trials comparing supportive psychotherapy, multidisciplinary education, and no treatment. Relevant outcome measures were duration of the postoperative recovery period, functioning, need for postoperative analgesia, postoperative Female Sexual Function Index (FSFI) score and client satisfaction, stigma of having a mental illness and/or seeing a mental health professional, worsening of preoperative complaints (e.g. hyperesthesia of the clitoris, dyspareunia), hospital readmission rates, and medico-legal complaints.

The protocol for this review was registered with the International Prospective Register of Systematic Reviews (PROSPERO) with registration number 42015024639 on July 20, 2015.

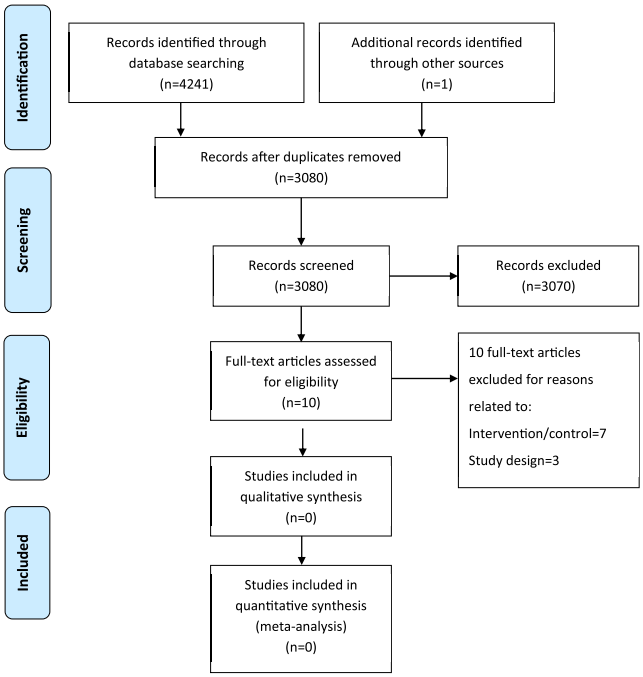


**FIGURE 1** Flow diagram of identified studies.

## 3 | RESULTS

Among 3080 nonduplicate records identified from the electronic database search, and from other sources, 10 articles were identified for full text review (Fig. 1). Of these 10, we excluded three of these studies because they were case reports,[28–30] four because they had no interventions,[31–34] and two studies were excluded because of lack of controls.[35,36] One text provided adequate information for screening but was only available as a conference abstract,[37] and we could not reach the authors for more information. As an abstract, it did not provide sufficient details on methodology or comparison groups, and was therefore excluded from this review. No studies that evaluated the effectiveness of supportive psychotherapy or client education alongside surgical interventions to treat girls and women living with FGM were identified.

## 4 | DISCUSSION

This systematic review was conducted to evaluate the impact of supportive psychotherapy or client education on clinical outcomes among women and girls undergoing surgery to correct complications from FGM. Despite a comprehensive search, we did not find evidence for the effects of these interventions among this population. We did however find two studies that addressed the use of counselling (a tool in supportive psychotherapy) along with other interventions in women and girls with FGM with positive outcomes. One was a case report of a 24-year-old that had surgical excision of a painful, post-FGM clitoral cyst. This was associated with reduced vulvar pain 1 month post intervention.[28] The other was a conference abstract of a retrospective study evaluating the impact of prenatal counselling on postdelivery repair in persons with FGM. The authors reported that respondents who received counselling were more likely to opt for surgical procedures to correct FGM.[37] This study was not included in this review because it lacked sufficient details.

The benefits of supportive psychotherapy have been attributed to the use of therapeutic alliance characterized by concern, empathy, and support. It usually consists of seven components, namely reassurance, explanation, guidance, suggestion, encouragement, effecting change in the environment, and permission for catharsis.[38] This engenders hope and helps clients believe that they can overcome their problems and lead better lives.[39] The therapist's behavior differs from the harsh, threatening approaches that the client may have encountered in the past. This provides a platform for uptake of suggestions and advice that may help the individual feel secure, accepted, and safe.[40] In the context of this warm supportive atmosphere, individuals experience less anxiety, have positive views of self, and are motivated to solve problems or adjust to difficult circumstances. This approach could be valuable in the case of women and girls having surgery for FGM complications because it strengthens an individual's capacity to cope with psychosocial problems associated with the condition and its treatment.

Client education consists of two major components: clinical patient education and health education. Clinical patient education is a planned, systematic, and logical process of teaching. It is tailored to the patient's needs, prognosis, and interventions, while health education focuses on wellness, prevention, and health promotion.[41] Client education empowers the individual to seek appropriate measures to deal with FGM and overcome feelings of discrimination, stigma, and low self-worth in the context of any relationship. Further studies on the role of supportive psychotherapy and client education in managing FGM are needed to guide clinical practice.

This review had limitations and strengths. First, we did not include grey literature in our search. There may have been interventions in the grey literature that could inform our outcomes; however, given the high standard we required for study design, this is unlikely. Second, the dearth of controlled trials significantly limits conclusions that can be drawn. Despite these limitations, the strength of the review lies in its use of a comprehensive and systematic search strategy.

In conclusion, no direct evidence was found on the effects of supportive psychotherapy or client education for girls and women living with FGM seeking surgery. Clinical guidelines issued by professional bodies recommend counselling—an element of supportive psychotherapy—as an essential tool in the care of women and girls with FGM.[42,43] Nevertheless, this systematic review shows that more research is urgently needed to provide evidence for specific guidance on counselling and client education for women undergoing surgical procedures for FGM. Additionally, we would recommend studies to assess the cost-effectiveness of these interventions. This would help inform practice and policy in countries where FGM is prevalent and countries with increasing numbers of immigrant populations from these areas.

## AUTHOR CONTRIBUTIONS

OA was involved in the study design, eligibility screening, drafting the manuscript, and revising it critically for important intellectual content. MC contributed to drafting the protocol, eligibility screening, and drafting the manuscript. BO was involved in drafting the manuscript and revising it critically for important intellectual content. EE extracted data and was involved in drafting the manuscript. EO extracted data and was involved in revising the manuscript. MM made substantial contributions to the conception, design, interpretation of data, and revising it critically for important intellectual content. All authors read and approved the final draft.

## ACKNOWLEDGMENTS

This review was commissioned and funded by WHO, Department of Reproductive Health and Research. Michelle Hindin and Karin Stein provided editorial support.

## CONFLICT OF INTEREST

The authors have no conflicts of interest.

## REFERENCES

1. Berg RC, Underland V, Odgaard-Jensen J, Fretheim A, Vist GE. Effects of female genital cutting on physical health outcomes: A systematic review and meta-analysis. *BMJ Open*. 2014;4:e006316.
2. Utz-Billing I, Kentenich H. Female genital mutilation: An injury, physical and mental harm. *J Psychosom Obstet Gynaecol*. 2008;29: 225–229.
3. Alsibiani SA, Rouzi AA. Sexual function in women with female genital mutilation. *Fertil Steril*. 2010;93:722–724.
4. el-Defrawi MH, Lotfy G, Dandashc KF, Refaat AH, Eyada M. Female genital mutilation and its psychosexual impact. *J Sex Marital Ther*. 2001;27:465–473.
5. Andersson SH, Rymer J, Joyce DW, Momoh C, Gayle CM. Sexual quality of life in women who have undergone female genital mutilation: A case-control study. *BJOG*. 2012;119:1606–1611.
6. Abdulcadir J, Margairaz C, Boulvain M, Irion O. Care of women with female genital mutilation/cutting. *Swiss Med Wkly*. 2011;6:w13137.
7. World Health Organization. Female genital mutilation factsheet. 2016. http://www.who.int/mediacentre/factsheets/fs241/en/. Accessed July 21, 2016.
8. Foldes P, Louis-Sylvestre C. Results of surgical clitoral repair after ritual excision: 453 cases [in French]. *Gynecol Obstet Fertil*. 2006;34:1137–1141.
9. Gudu W. Acute vulvar pain in a lady with post circumcision inclusion cyst of the vulva containing stones: A case report. *BMC Womens Health*. 2014;14:2.
10. Asante A, Omurtag K, Roberts C. Epidermal inclusion cyst of the clitoris 30 years after female genital mutilation. *Fertil Steril*. 2010;94:1097.
11. Adekunle AO, Fakokunde FA, Odukogbe AA, Fawole AO. Female genital mutilation – postcircumcision vulval complications in Nigerians. *J Obstet Gynaecol*. 1999;19:632–635.
12. Foldès P, Cuzin B, Andro A. Reconstructive surgery after female genital mutilation: A prospective cohort study. *Lancet*. 2012;380:134–141.
13. Nour NM, Michels KB, Bryant AE. Defibulation to treat female genital cutting: Effect on symptoms and sexual function. *Obstet Gynecol*. 2006;108:55–60.
14. Mulongo P, Martin CH, McAndrewb S. The psychological impact of Female Genital Mutilation/Cutting (FGM/C) on girls/women's mental health: A narrative literature review. *J Reprod Infant Psychol*. 2014;32:469–485.
15. Jan IK. Impact of psychological disorders after female genital mutilation among Kurdish girls in Northern Iraq. *Eur J Psychiatry*. 2011;25:92–100.
16. Khodabakhshi KA, Pourebrahim T, Mohammadmoradi B, Hameedy MA. The comparison of marital satisfaction and mental health in genital mutilated females and non-genital mutilated females. *Int J High Risk Behav Addict*. 2012;1:115–120.
17. Pinsker H, Rosenthal R, McCullough L. *Dynamic Suzrpportive Therapy. Handbook of Short-term Dynamic Psychotherapy*. New York: Basic Books; 1991.
18. Sadock BJ. *Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences, Clinical Psychiatry*. USA: Lippincott Williams and Wilkins; 2002.
19. Buckley LA, Maayan N, Soares-Weiser K, Adams CE. Supportive therapy for schizophrenia. *Cochrane Database Syst Rev*. 2015;(4):CD004716.
20. Nazari S, Moradi N, Sadeghi Koupaei MT. Evaluation of the effects of psychotherapy on anxiety among mothers of children with leukemia. *Iran J Child Neurol*. 2014;8:52–57.
21. Masheb RM, Kerns RD, Lozano C, Minkin MJ, Richman S. A randomized clinical trial for women with vulvodynia: Cognitive-behavioral therapy vs. supportive psychotherapy. *Pain*. 2009;141:31–40.
22. Jørgensen LB, Fridlund B. Restoring integrity–A grounded theory of coping with a fast track surgery programme. *Int J Qual Stud Health Well-being*. 2016;11:29864.
23. Misch D. Basic strategies of dynamic supportive therapy. *J Psychother Pract Res*. 2000;9:173–189.
24. Perron L, Senikas V, Burnett M, Davis V. Female genital cutting. *J Obstet Gynaecol Can*. 2013;35:1028–1045.
25. Lai VK, Lee A, Leung P, et al. Patient and family satisfaction levels in the intensive care unit after elective cardiac surgery: Study protocol for a randomised controlled trial of a preoperative patient education intervention. *BMJ Open*. 2016;6:e011341.
26. Weinberg DS, Narayanan AS, Boden KA, Breslin MA, Vallier HA. Psychiatric illness is common among patients with orthopaedic polytrauma and is linked with poor outcomes. *J Bone Joint Surg Am*. 2016;98:341–348.
27. Leye E, Powell RA, Nienhuis G, Claeys P, Temmerman M. Health care in Europe for women with genital mutilation. *Health Care Women Int*. 2006;27:362–378.
28. Abdulcadir J, Pusztaszeri M, Vilarino R, Dubuisson JB, Vlastos AT. Clitoral neuroma after female genital mutilation/cutting: A rare but possible event. *J Sex Med*. 2012;9:1220–1225.
29. Abdulcadir J, Rodriguez MI, Petignat P, Say L. Clitoral reconstruction after female genital mutilation/cutting: Case studies. *J Sex Med*. 2015;12:274–281.
30. Okwudili OA, Chukwudi OR. Urinary and genital tract obstruction as a complication of female genital mutilation: Case report and literature review. *J Surg Tech Case Rep*. 2012;4:64–66.
31. Kizilhan JI. Impact of psychological disorders after female genital mutilation among Kurdish girls in Northern Iraq. *Eur J Psychiatry*. 2011;25:92–100.
32. Applebaum J, Cohen H, Matar M, Abu Rabia Y, Kaplan Z. Symptoms of posttraumatic stress disorder after ritual female genital surgery among Bedouin in Israel: Myth or reality? *Prim Care Companion J Clin Psychiatry*. 2008;10:453–456.
33. Behrendt A, Moritz S. Posttraumatic stress disorder and memory problems after female genital mutilation. *Am J Psychiatry*. 2005;162:1000–1002.
34. Strenge DK. Genital mutilation in women – a process model of traumatisation with special reference to migrancy [in German]. *Trauma und Gewalt*. 2013;7:324–337.

35. Krause E, Brandner S, Mueller MD, Kuhn A. Out of Eastern Africa: Defibulation and sexual function in woman with female genital mutilation. *J Sex Med*. 2011;8:1420.
36. Antonetti Ndiaya E, Fall S, Beltran L. Benefits of multidisciplinary care for excised women [in French]. *J Gynecol Obstet Biol Reprod (Paris)*. 2015;44:862–869.
37. Wheeler ME, Burke M, Kramer T, Coddington C. Impact of antenatal counseling on management of patients with female circumcisions. *Obstet Gynecol*. 2005;105:76S.
38. Bloch S. *Introduction to the Psychotherapies*, 3rd edn. UK: Oxford University Press; 1996.
39. Barber JP, Connolly MB, Crits-Christoph P, Gladis L, Siqueland L. Alliance predicts patients' outcome beyond in-treatment change in symptoms. *J Consult Clin Psychol*. 2000;68:1027–1032.
40. Talbott JA, Hales RE, Yudofsky SC, eds. *American Press Textbook of Psychiatry*. Washington, DC: American Psychiatric Press; 1988.
41. Dreeben O. *Significance of Patient Education for Health Care and Rehabilitation. Patient Education In Rehabilitation*. UK: Jones and Barlett; 2010.
42. World Health Organization. Female genital mutilation: Integrating the prevention and management of health complications into the curricula of nursing and midwifery. A Teacher's Guide. WHO/RHR/01.16. Geneva: WHO; 2001. http://www.who.int/reproductivehealth/publications/fgm/RHR_01_16/en/. Accessed June 29, 2015.
43. Royal College of Obstetricians and Gynaecologists. Female Genital mutilation and its management. Green-top Guideline No. 53. July 2015. London: RCOG; 2015. https://www.rcog.org.uk/globalassets/documents/guidelines/gtg-53-fgm.pdf. Accessed August 20, 2015.