Changing attitudes towards female genital mutilation. From conflicts of loyalty to reconciliation with self and the community: The role of emotion regulation

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Background

Female Genital Mutilation (FGM) is a public health concern with harmful consequences on women's health (1,2). FGM is a gender-based violence which violates the bodily integrity of the women and girls. The practice which is an intentional partial or total removal of female external genitals (1,3,4), contributes to the cultural identity of the woman who receives a mark in her body. This mark is a perfection of physical appearance within the culture (5). Elderly women, guardians of the tradition, always strive to ensure that the practice is passed on from generation to generation. Consequently, the fear of seeing other members of the community performing the practice on their daughters results in women fleeing and migrating to western countries, at times in very difficult conditions, in order to protect their daughters.

The health consequences that are reported to result from FGM vary according to the type of the practice undertaken. The physical consequences include pain, urine retention, infection, pain during sexual intercourse, haemorrhage, shock, and sometimes even death (3,6). Psychological consequences include feelings of incompleteness, anxiety, depression, loss of trust, chronic irritability and frigidity. FGM creates psychological trauma and is a potential cause of Post-Traumatic Stress Disorder for the women (7–9). From Toubia's work, infibulated women suffered from chronic anxiety and depression, arising from worry over the state of their genitals, as well as intractable dysmenorrhea, and the fear of infertility (10). The shocking experience of FGM comes from the girls being unprepared for the excruciating physical and emotional

experience that the practice entails. Evidence shows that the severe pain experienced during the procedure can result in deep psychological wounds, leaving painful memories and emotional scars (3,11,12). Women who have undergone the practice have had various emotional struggles and psychosocial problems, such as a loss of trust in the mother-daughter relationships (13). Thus, it results in social consequences too; and besides the psychological impact of FGM, women and girls also suffer emotionally. Girls and women, traumatised by their experience but with no acceptable means of expressing their fears, suffer in silence. Feelings of fear, helplessness, and anger were also related to FGM as well as anxiety, bad memories, and stress (8). Fear and helplessness are associated with having experienced the procedure (14). Even years after the procedure, girls and women experience feelings of loss and incompleteness, anger, shame, and depression, as well as a sense of betrayal (14). However, through socialisation, women have been taught to remain silent about the procedure and their feelings. Despite the practice of FGM remaining a social norm that is difficult to change because of its deep roots in the tradition of the communities and how it is embedded in the patriarchal system, some migrant women succeed in changing their attitudes towards it and do not perpetuate the practice on their daughters.

In a previous study (15), we identified and described specific significant events (*turning points*) which played a role in the lives of the women that were interviewed. *Turning points* were defined as significant events including social interactions that challenged their norms and any other expectations associated with the practice of FGM, leading to women changing their attitudes towards it, and to take action to quit their community in order to protect themselves and their daughters from the practice. In relation to these *turning points*, we had hypothesised that emotion regulation and the resolution of conflicts of loyalty might be two common mechanisms involved in the empowerment of the women as they decided to take action against FGM for themselves and their daughters. This paper seeks to further explore how these two processes may interact to explain the change in their attitudes towards traditional norms.

Methods

A qualitative methodology informed by the grounded theory approach was used and it allowed us to generate the hypotheses mentioned above (15). The approach inductively helped to consolidate these hypotheses through constant comparison (16), taking into account the narratives of the women who had participated in the first study (n=15) and comparing them with published testimonies (n=10) , while further exploring the literature and consulting experts

including one expert with lived experience to discuss and consolidate our emerging theorisation.

Data sources

In addition to the continuous exploration of the literature, three sources of data were used to help us theorise the process of change experienced by women as they turned their backs on the practice of FGM and took action to protect future generations from it: (a) The 30 transcripts from the interviews conducted with the 15 women of our previous study (15). The 15 participants in this study had all undergone FGM in their countries of origin during childhood, originated from Sub-Saharan African countries and were living in Belgium at the time of the interview. Full details of the sample can be found in our publication. (b) In addition to the 30 original interview transcripts, we included the life stories and public testimonies of 10 women referred to as 'norm leaders' (Table 1).

(c) The third source of our data comes from interviews we conducted with six experts, including one expert with lived experience) who were chosen for their complementary fields of expertise to discuss the emerging concepts and theory, generated by our study: lived experience (Kadhiatou Diallo), philosophy, bioethics, norms and capabilities approach (Mylene Botbol-Baum); sexual health and identity issues (Elise Ricadat); psychology and traumatic memory (Annalisa D'Aguanno); transcultural clinical psychology and anthropology (Jean-Luc Brackelaire); and emotional competence and regulation (Moïra Mikolajczak). Due to COVID-related restrictions, regarding all but one, the experts were met individually through videoconference by the first and last authors. The consultation with the lived experience was done face-to-face by the first author alone.

These discussions and exchanges ranged from 45 minutes to one hour with an average of 50 minutes. The duration of the face-to-face interview was 45 minutes. Notes were taken during the discussions. Prior to the meeting, they had had the opportunity to read and comment on a document which presented the draft results on the applicability of the concepts of emotion regulation and the resolution of conflicts of loyalty to understand the process of changes in attitudes towards the norms associated with FGM. During the process of generating and enriched theory, based on their complementary initial comments, all experts had the opportunity to further contribute by commenting on draft versions of this article. Eventually, all were invited to choose to co-author the article or to be thanked in the acknowledgement section for their contribution.

Ethical considerations

The study received approval from the Ethics Committee (Comité d'Ethique Hospitalo-facultaire) of Saint Luc University Hospital Brussels with reference number: 2013/21NOV/522 dated10th July 2017.

Data analysis

The data analysis occurred in three steps following a sequential design and through constant comparison.

Secondary analysis of the 30 transcripts from the first study

The objective for this first step was to systematically screen the 30 transcripts from the first study again, which had initially been inductively analysed to reveal specific turning points in the lives of the participants. In this secondary analysis, we aimed to examine how the emerging categories of emotion regulation and conflict of loyalty resolution were represented in the data. The *turning points* revealed in the first study constituted the starting points for the secondary analysis of the transcripts. More precisely, we verified that the *turning points* were indeed associated with experiences and the expression of emotions as well as conflicts of loyalty, as we had hypothesised at the end of our first study. The data were synthesised using a framework analysis approach, a process which involves a systematic indexing of responses in line with a given framework (17). This was based on the dimensions of Gross' model of emotion regulation (18) on the one hand, and on the model of the processes of informing loyalty on the other (19). The two theories referred to for this framework analysis may be approximately presented as follows:

Emotional regulation

Emotion regulation is a key contributor to social functioning and refers to the processes by which individuals influence what emotions they have, when they have them, and how they experience and express them (18). Such control processes may be conscious or automatic (18,20) when responding to environmental demands and may take effect at one or more points in the emotion generative process. Gross (18) developed a process model of emotion regulation which allows for the identification of when regulation may be understood to have occurred. The model has five major points of focus (*situation selection, situation modification, attention deployment, appraisal and response modulation*). Emotion regulation is goal-oriented. Goal-oriented emotion regulation strategies related to bodily expression include emotion suppression,

in which people actively try to inhibit their emotional expression (18). Expressive suppression is defined as the inhibition of emotional expression, such that an outside observer would be unaware of an individual's internal emotional experience (18). The suppression does not always lead to the desired changes in emotional experience but can lead to a negative emotional experience instead.

Conflicts of loyalty

Loyalty is a feeling or an attitude of devoted attachment, even where it may not be deserved (19). Loyalty conflicts occur when a person feels trapped in a disagreement between two people, and they expect the trapped person to support them over the other. The literature describes mainly children's perceptions of one parent's pressure to side against the other and the conflict is expressed by the feeling of being trapped, torn, or 'caught between parents' (19,21). Research on children in foster care presents a model of processes informing loyalty to help to understand the experience of children in foster care and how they negotiate living with a new family while retaining their place in their birth family (19). The model which emerged from their results encompassed seven theoretical categories that enable different relationships children have with their parents' loyalty to be distinguished: *new realities; considering position; making sense; relating emotionally; working out loyalties; considering others' perspectives; and self-determination.*

Loyalty conflicts have generally been the focus of attention in the literature on children of divorced parents (21,22), as well as in foster care literature (19). It has not been applied to adults much; however, the concept seems essential in our study because the women felt trapped between what the community expects from them and what they want for their daughters.

Original analysis of the books (n=10)

All 10 books were read by the first and second author to identify the turning points in the women's lives that had prompted them to change their views and attitudes toward the practice of FGM, and other related norms. Then the two theoretical frameworks mentioned above were applied by the first author to systematically screen for expressions of emotions and conflicts of loyalty resolutions in relation to those *turning points*.

Table 1: Table of the books of norm leaders

Names of NL	**Title of the book**	**Year of publication**	**Country of origin**	**Host country**
Thiam, A	La parole aux négresses [The voice belongs to the negress]	1978	Senegal	France

Diallo, K	Mon jardin dévasté [my devastated garden]	1991	Senegal	Belgium
Dirie, W. & Miller C.	The desert flower	1999	Somalia	Austria
Barry, M	La petite peule [The little polar]	2000	Senegal	France
Abdi, N	Larmes de sable [Tears of sand]	2003	Somalia	Germany
Koita, K	Mutilée [Mutilated]	2005	Senegal	France
Bah, D	On m'a volé mon enfance [My childhood has been stolen]	2009	Guinea Conakry	France
Miré, S	The girl with three legs	2011	Somalia	USA
Kanko, A	Parce que je suis une fille [Because you are a girl]	2014	Burkina Faso	Belgium
Bowin, L	Swimming in the red sea	2018	Guinea Conakry	Canada

Consultations with experts

In the third stage, after having confirmed that aspects of emotion regulation and conflicts of loyalty resolution were indeed present in the women's narratives as they reported turning points in their lives, we submitted our results to several experts from different disciplines in order to discuss our emerging theorisation, and to help us refine it, by collaboratively working out the interrelations between the two hypothesised mechanisms of change, i.e. emotion regulation and conflicts of loyalty resolution.

The notes taken during the different discussions were compared and analysed by the first and last authors to further clarify our emerging theorisation, which was also discussed with co-author FR on several occasions and enriched through review of some published material suggested by the experts. For instance, in order to understand trauma and its impacts on the body, we read the literature of Van der Kolk (23); Rothschild (24); Salmona (25) and Hoschild (26). To become more familiar with narratives and the capabilities approach, we read the books of Botbol Baum (27) on '*Bioethics dans les pays du Sud'* [Bioethics in the southern countries] and Nussbaum (28) on women and human development, the capabilities approach. We iteratively pursued this theorising and integrative process, until we came up with a model with five stages (*the suppression, the awakening, the clash, the reappropriation of self and the reconciliation*), which we present hereafter in our results section, to explain the process of the change of attitudes in women with FGM as they move from being full members of their community at the cost of suppressing their emotions and denying their selves to becoming their whole selves while symbolically remaining members of their communities of origin. The results hereafter are presented according to the five stages of our proposed model, and integrate the findings from all three steps of our analysis.

Results

From suppression of emotions to reconciliation with self and community

The model that emerged from our findings consists of the five stages mentioned above. Each stage refers to the processes that were found to explain the women's attitudes towards change. The theorisation that emerged from our work is summarised in the model we propose. In the diagram below (Figure 1), the five stages are depicted as parts of a linear process, but we are aware that these stages might not always be linear, as there may be overlap and a woman may move through and between stages of the model numerous times or simultaneously.

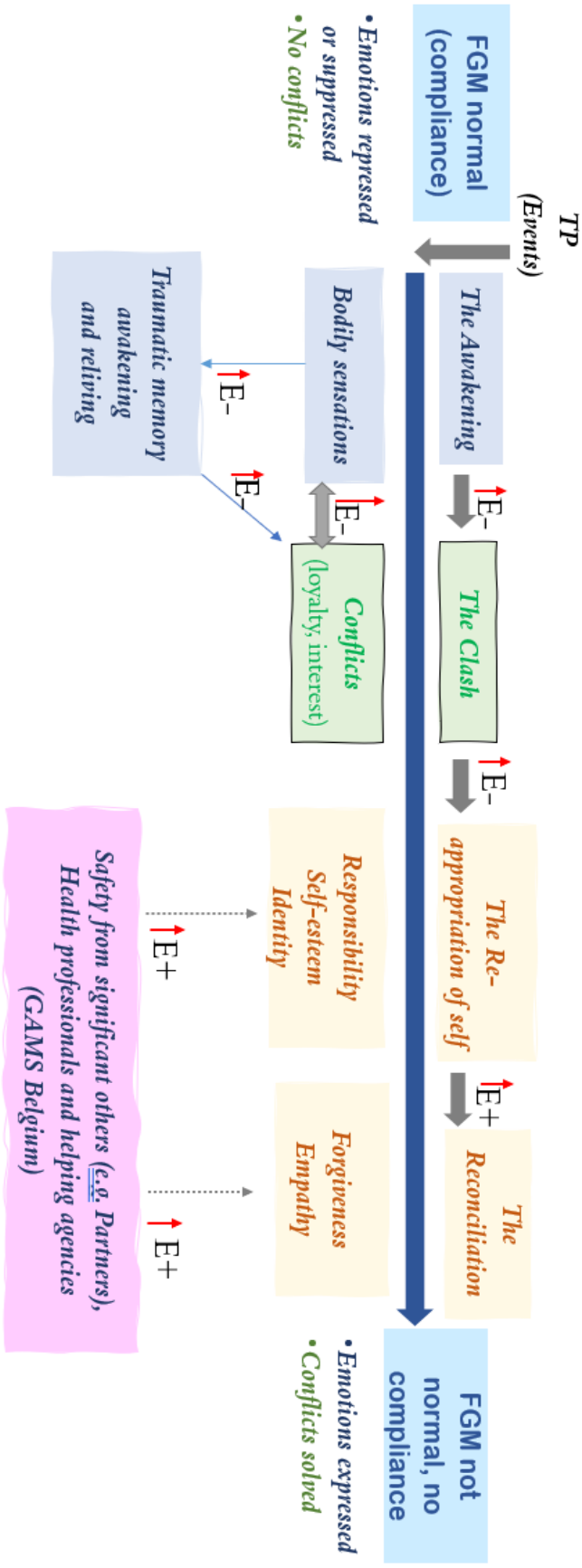

Figure 1: the emerging model. A woman's journey: from compliance to FGM and community norm to non-compliance.

Emotion suppressed or repressed

Our results show that women's emotions were often repressed and suppressed before the *turning points*. Emotions are socially constructed so culture has an impact on the expression of emotions. Girls are taught to be brave and not to cry during the procedure to prevent bringing shame upon their family.

> *"Afterwards, we are told: you must remain courageous, never complain, you have passed the first stage, there will be others that will come with pain too, but do not forget that a good woman must always bear the pain, and must suffer." Interv_2*

> *"... I got used to being in pain; not crying anymore but clenching my teeth...later on, I continued clenching my teeth as I was always told…" (Kanko, 2014: pp 27)*

Before the occurrence of the *turning points*, the suppression of emotions was associated with the acceptance and internalisation of the practice of FGM. The women used to comply with the social norm as prescribed by the patriarchy. The patriarchy system determines and prescribes how individuals ought to behave in regard to certain feelings (affects) and emotions. The cultural grounding of emotional expression is reflected in the whole procedure when at times, women are instructed to be brave and endure pain and sufferings without complain. This is a norm in the patriarchal system. Even though, the women were not allowed to express any emotion, they felt them, and they were affected by them. Some women described their initiation stage as being taught about their gender roles by the older women who are the guardians of the tradition. They were guided by the instructions from the older women to endure pain and sufferings as their accepted fate. Fear was what generally drove women to comply with the social norm to avoid being ostracised and isolated from the community and have their daughters unmarried.

> *"I was constantly in fear and felt the anger, but I did not know where they were coming from. Because something tells you why 'you'? And during all the initiation phase, they talked about your recognition as part of the community, you are going to become a woman, you are going to serve the cakes, you are going to be pure and say good prayers but they will never tell you the intensity of the pain, just to bear it and not talk about it. It's like you are being plunged in the unknown which is unbearable and that's the problem." Expert with lived experience.*

The suppression of emotions which results in the inhibition of the emotional expression, is one of the response components according to Gross' model (18). It represents the last stage on Gross' model while it is the starting point on our model. Suppressing emotions ensures community membership and the women usually do as they are instructed from respect to the

elders. Silence is also imposed by the patriarchy and the women are trained socially to bear pain at important moments of their lives (for instance, first sexual intercourse on the wedding night, as well as at childbirth and not screaming during labour).

> *"The patriarchy uses violence to assign identity and thus, construction of cultural identity is through the bearing of pain without complaint, so involving suppression of emotions" Expert in psychology and traumatic memory.*

The awakening

At the second stage of our model, which we call *the awakening*, emotions are expressed in relation to the *turning points* described in the narratives of the women who participated in our previous study, as well as those from the norm leaders whose testimonies we analysed.

> *"The emotions that were expressed evolved with the process of emancipation and questioning of norms. Turning points are as a normative conversion, allowing the capability to act against one's s community beliefs, which is also a definition of emancipation. This conversion of self is indeed a turning point for it allows to go beyond the conflicting emotions between community and self" Expert in Philosophy and Bioethics*

At this stage, the emotions are felt and acknowledged. In Gross' model, the acknowledgement refers to the *attention deployment* stage, and to the events and emotions it generates. As they recalled the *turning points* in their lives, most women described sensations in their bodies in the form of pain in the womb and goose bumps. These prompted them to reflect on their own experiences of the procedure of FGM, which in turn awakened their traumatic memories. They described these *turning points* as events causing them to relive the procedure of FGM, thus experiencing emotions of fear, helplessness, and betrayal.

> *"…then on the skype, my mother-in-law had called me...soon you will be with us, I have prepared everything, and the circumciser is ready to purify the little one like this, she will be clean and everything. Baf! It was like a slap! I felt something in my belly". Interv_1*

> *"My stomach sank as I recalled the sound of scissors, the horror and the fear that overwhelmed me when I faced the men in white coat…" (Miré* (29)*: pp 368)*

We know from our previous study (15) that there might be different types of events leading to *turning points* and thus the awakening of emotions. In some narratives, an encounter with a health professional (a gynaecologist or psychologist) was key in provoking the awakening. The role of others when old memories are stirred up and emotions relived and expressed by the women, sometimes for the first time is crucial. Indeed, the women need to experience a sort of

'safety net' while their negative emotions are relived as they reconsider their own experiences of the procedure of FGM.

At that stage, most of the women reported vivid emotions such as anger, fear, despair, and suffering, which they had been used to conceal not only from others but also from themselves. With external help, the traumatic nature of their experience would be acknowledged, thus allowing their emotions to be integrated as part of their experiences and selves, rather than suppressed again.

> *"The dimension of trauma should be considered here as there is violence against women's bodily integrity. Also, in their traumatic experience, the women's sense of identity may have split due to their emotions and stress (traumatic cleavage). Being supported by a professional who is used to dealing with trauma when they relive it, could therefore be considered the starting point to building their new identity and a way to foster it in a personal and subjective way" Expert in psychology and identity issues*

An expert considered how the acknowledgement and expression of negative emotions was crucial at that stage to help the women move forward in changing their attitudes towards the practice of FGM as they enabled the up regulation of these negative emotions. Contrary to what Gross' model suggests, such negative emotions are not to be down-regulated at this stage but up-regulated instead.

> *"The rising up of negative emotions is important for women to acknowledge and accept them, and thus, the up-regulation of these negative emotions will push the women to do something and act" Expert in Emotion Competence*

The negative emotions relived by the women interviewed in our study as well as those whose published testimonies were analysed. These emotions were derived from the consequences of FGM and brought a lot of trauma into the women's lives. For example, trauma made one woman bleed in any painful circumstances, even when unrelated to FGM.

> *"Anything that upset me makes me to bleed…I can't believe I am bleeding again, at hearing about the Brussels' attack."(Bowin* (30)*:pp 202)*

The clash: the conflicts of loyalty experienced

In the third step of our model, which we refer to as *the clash*, we looked at how the awakening and up-regulation of negative emotions, that were associated with the acknowledgement of trauma led to inner conflicts of loyalty. Women experienced conflicts of loyalty when they

wanted to protect their daughters as they did not want them to go through the same experiences. This gave them to have some mixed feelings as they became aware of different norms and values that would define them in different ways, in their own eyes and that of their community of origin. The feeling of being trapped between the two constituted a conflict of loyalty. As they experienced such conflicts of loyalty, the women became further aware of their bodily sensations and emotions such as embarrassment, shock, fear etc.

> *"I was constantly in fear and felt the anger, but I did not know where they were coming from... your own community has fooled you...you feel bad because you want to be a good Muslim woman…"Expert with lived experience*

At this stage, the negative emotions are still present. This makes the women try to come out of that state. However, the conflict of loyalty generates in turn new sufferings and negative emotions and needs to be solved to gain peace. According to the model's informing loyalty (Dansey *et al.,* 2018), *considering one's own position* is a key stage to moving past this when trapped in a conflict of loyalty. In our study, the women at this stage would consider their positions as mothers and the devoted attachment to both their daughters and their communities would conflict, thus prompting them to work out how to prioritise those loyalties. This was the stage where a need was perceived to weigh up and choose, in order to emerge from the conflicts they were experiencing. Indeed, choosing to protect their daughters by not perpetuating the practice would isolate and even ostracise them from their communities of origin. The women therefore reported experiencing conflicting representations of motherhood: what made them believe they were a good mother in their own eyes and that of the society in their host country by protecting their daughters from the practice of FGM, would make them bad and irresponsible mothers instead in the eyes of their own mothers and their communities of origin. Deciding to protect their daughters, meant the death of their affiliation with their original communities because they were defying the prescribed norms established by the patriarchal system.

> *"I think of my daughter…but I want to be a good mother in my community also » Interv_15*

> *"…I was convinced that I was born free, not with a pot in one hand and a broom in the other...I couldn't understand how a hand that caressed you, wiped your tears, reassured you, comforted you, could hurt you...I was confused…but I had a commitment to my sister and brothers, not to abandon them." (Barry* (31)*: pp 142, 163)*

Along with conflicts of loyalty, conflict of interest might be experienced, as women may be trapped in the feeling of losing the status that they gained through the procedure of FGM. Moreover, when women oppose a norm, their opposition becomes an element that disturbs and endangers the patriarchal system as a whole.

The re-appropriation of self

The next step in our model that we named *the re-appropriation of self* suggests that as they move forward, the women need to actively engage in processes of self-re-appropriation whereby they accept the need to reconsider their positions and see and value themselves for what they are. This is different then, from what is valued in their communities of origin. This is what Dansey *et al.* (19) call the recognition of new position and re-conceptualisation of sense of value.

The re-appropriation of self is an important stage in the women's journey. It entails their own identity re-appropriation as well that of their bodies and sexuality. The women explored their responsibility to themselves and sought to re-appropriate their identity and rebuild their self-esteem and self-confidence. Some women became aware of their inner internal agency and were able to identify and express personal qualities by being curious and stubborn in response to the patriarchal system that see women as subordinates. Developing such personal characteristics enabled them to preserve their sense of self. One woman reported:

> *"I'm a bit stubborn, there are things I didn't accept. For example, I couldn't stand the veil before the wedding and after the wedding, I wore it in my own way, that's me." (Interv_4)*

This stage also entails women starting to think by and for themselves so as to discern their identity as distinct from the one imposed by the community. At this stage, the participants in our study as well as the women who shared their testimonies through published material started to value what they wanted for themselves instead of what the community wanted for and from them. There was an awareness of their internal drive to claim back what they had lost and therefore, their bodies could be reclaimed. The women recognised that some aspects of their future were within their control by wanting to undergo the reconstruction with regards to the lost physical part of themselves (the clitoris) and so to regain their sexuality. The control over their own lives placed more responsibilities on them to make changes to improve their lives. This was a shift from the powerlessness they felt before the *turning points* and as while they were dealing with conflicts of loyalty. As a woman participant reported:

"I wanted to gain something but rather I lost something and that they never told me I felt betrayed; so, I want it back, I want to do reconstruction of the clitoris" Interv_3

The issue of responsibility is an important part of the journey at this stage. Accepting responsibility for themselves and making their own decisions for their wellbeing and that of their daughters gave them control over their own lives. The women's sense of self-worth increased as the positive emotions were released in this resolution of the conflict of loyalty.

An expert asserts that:

"The re-appropriation of the body and sexuality implies the responsibility towards oneself and others; responsibility and identity are articulated. This re-appropriation seeks to (re)define and (re)delimit not only identity but also the roles between oneself and others; that is to say the power and the competencies belonging to each, entering into the transaction by allocating responsibilities in relation to their duties with respect to others" Expert in transcultural, clinical psychology and anthropology.

In addition to the help or advice received from professionals, those women who had a partner from a different cultural background stated how they had been helped by their partner to understand that sexual intercourse ought not to be painful and that they had a right to be satisfied with their sexual lives. This is an important role played by the others in the women's change of attitudes.

"The fact that my partner supports me, encourages me, and has offered to help me with the reconstruction, and that he will pay the costs has also given me strength to move forward and I feel valued… » Interv_12

The women acknowledged the viewpoints of the professionals and partners but made their own decisions, which signals out the phase of *considering others' perspectives* in Dansey *et al.*'s model as important for influencing individuals' position and loyalties. In Gross' model, this stage refers to the *situation modification* which in our study was materialised by actions such as fleeing with their daughter, going forward with clitoris reconstruction or defibulation or writing of a book (becoming an activist). They made sense of their situation by realising that they did not have to suffer without saying anything. Women also reckoned that the assistance from the safety net of helping agencies (for example the non-profit organisations and some health professionals such as psychologists), was important in this phase of dealing with their emotions of fear, anger and the accompanying traumas. This is an empowerment experience for the women, and they saw these relationships as positive contribution to their wellbeing. Some positive emotions were brought up when the women felt supported by significant others.

At this stage of their journey, *self-determination* was established by the choice the women made in another context which enabled them to prevent further FGM. The women reported their ability to be assertive and make plans for themselves for the future, for their comfort and independent lives. This encouraged them to have positive feelings about themselves and think positively for their future. They also made plans for their relationships with their children, families, and new romantic partners.

> *"You see, I have plans, a lot of plans for the future, first of all I tell myself that after my nationality I'm going to move to France so that I'll be close to my parents and then do something else, like going back to school and furthering my education" Interv_4*

The reconciliation: with mother and community

In the last stage of our model, women have managed to not only reappropriate themselves and their bodies, but also to reconcile themselves, even if sometimes just symbolically, with their mothers and communities. At this stage, the women expressed being able to identify with their mothers, understood that they could not have acted differently, and ultimately forgave them for what they were once subjected to. They did not apportion any blame to their mothers.

> *"And when I think that my grandmother certainly underwent this in a more archaic way ... I say to myself that we need to understand them…" Interv_9.*

At this stage, the empathy the women feel towards their mothers enabled them to overcome their sense of blame towards them. They become able to *relate emotionally* again to their mothers. Many participants reported of their struggle to understand why their mothers made them undergo FGM. But they also thought of the fact that their mothers went through the procedure in a more violent way than they did. Some women reported anger towards their mothers but later did not want to blame them.

At last, the women at this stage report to be able to forgive since their mothers for what they have once been subjected to, as they acknowledge their mothers did probably not have a choice to act differently because of the social pressure inherent to the context and time at the moment. By contrast, they see themselves as having a choice, especially in the context of their Western host countries where the practice of FGM is prohibited by law.

Forgiveness towards their mothers led to a symbolic reconciliation with the community. Some women participants depicted a transformation in their perspective through their acceptance and forgiveness of themselves and their mothers. By forgiving their mother, the women did not

condone their mothers' actions but rather they freed themselves from the anger and the negative feelings that threatened their own wellbeing. As one woman put it: "*I love my mother and my people" Interv_13.* They understood that, forgiving their mothers was part of the process that would enable them to move forward and be part of the community again, even if just symbolically. They let go of both anger and blame towards their mothers.

> *"Letting go allowed me to live my life so that I don't live other people's lives. Then, I gradually learned to regain confidence in my parents. I undertook not to judge my mother anymore...But I wouldn't want her story to be really mine, nor that of my children" (Kanko* (32)*:pp.30)*

> *"Our mothers, my grandmother, they are the bearers of this tradition to please the men but in fact it is ignorance. And when you realise that, your anger fades away, you just know that you can't be like them...I have to protect my daughter and other little girls who undergo the practice during the school holidays. I am less angry today" (Bah* (33)*:pp. 341)*

At this stage, by seeing themselves as different from their mothers yet being able to identify with them and forgive them, the women may be seen as having *self-determination* management despite their powerless position and successfully *work out their conflicting loyalties* as Dansey *et al.*'s model (19) suggests.

> *"I first began to reconcile myself with the part of my body that was ignored, and then with my community so as not to blame anyone" (Koita* (34) *pp.105)*

Discussion

The main aim of this study was to generate a better understanding of the mechanisms and factors that might explain the change of attitudes towards the practice of FGM in the context of migration in relation to *turning points* that occur in the life trajectories of the women who challenge the practice of FGM. Emotions such as fear and helplessness were reported in our study as relating to the patriarchal ideals of what a normal and good mother should be. Negative emotions tend to be suppressed before *turning points,* as according to patriarchal ideals, women should endure pain and suffering without complaining. Therefore, anything that the women felt but were not able to express because there was nobody to hear them, tended to transform into fear that would hinder their emancipation and freedom. Conflicts of loyalty inevitably arise when the women question the legitimacy of the rules and norms of their own communities. In our study, the women reported to have felt torn apart by conflicts of loyalty as they sought to be themselves while being part of the communities. They challenged the prescribed norm when

the lives of their daughters were at stake, which made them think back on their own experiences and feel the urge to protect them.

Our findings illustrate that as they were socialised in a patriarchal system, the women were not permitted to express their emotions especially pain in three crucial moments of their lives i.e. at the procedure, on the wedding night and during childbirth. These findings confirm other research findings for example Abdalla (35); Malstrom (36); Fisaha (37); and Morgan (38); in that women were not allowed to express their suffering verbally during the procedure and in the social interaction of their everyday lives. Suffering and pain were understood as '*normal*' and as expected parts of a woman's life. This socialisation-based learning includes acts that demand silence without complaint. Verbal complaints were understood as a failure and also as shameful, since these acts were connected to sexuality and reproduction. Silence and secrecy guard against the making of the feminine self (39), while the painful experiences are continuously engraved on the inside of the body. For them, being silent or silenced about one's trauma signifies the loss of power and self (40).

The women acknowledged that the FGM experience creates psychological trauma and is a potential cause of Post-Traumatic Stress Disorder (PTSD) for the women (7). The trauma is considered a psychophysical experience where the traumatic event has a damaging impact on the mind and the body, and the bodily injury can result in fear of annihilation (24). The results of this trauma invade the consciousness (flashbacks, sensory illusions, nightmares) and means all or part of the trauma is relived identically, with the same distress, the same terror and the same physiological, psychosomatic and psychological reactions as those experienced during the violent event itself (25). Van der Kolk (23) asserts that the re-experiencing in the present moment of the physical sensations of past traumatic events triggers the experience of uncontrollable intense feelings. The impact of PTSD on the mind and body has been discussed by Rothschild (24). She examines a normal response to that of a PTSD response and concludes that the most severe consequences of PTSD result from *dissociation*. Women who have undergone FGM manifest PTSD as well as trauma-related complications, shutdown dissociation, depression, and anxiety (7,11,12).

In the literature, suppression of negative emotions is thought to lead to poor long-term health outcomes (41,42). In our results, the rising of the negative emotions in women triggered sensations in their bodies, causing them to relive their own personal experience of the procedure of FGM. These personal experiences brought some negative emotions to surface which led to feelings of vulnerability in the women and the awakening of the traumatic memory. In theory, the negative emotions are to be down regulated by positive emotions in order to minimise the

consequences of emotional experiences (43,44). However, the up regulation of the negative emotions was key in prompting the women to move forward, as they started to question the norm in the process of becoming aware of the responsibility they have towards their daughters' safety as well as to their own personal lives. As the traumatic memory was awakened, the women in our study became more aware of their negative emotions (fear, betrayal, helplessness, pain, and a sense of being overwhelmed) and this triggered sensations in their bodies. The acknowledgement and acceptance of these emotions, called *the attention deployment* in Gross' model (18), represents the explanatory mechanism of up regulation of negative emotions in *the awakening* stage of our proposed model. It also led the women to move through and reach the next stage, *the clash* (conflict) stage even though this was uncomfortable for them. That is the stage when most of them took action and fled from their countries of origin meaning that they were able to step out of the normativity of the social community. In the context of migration, these women had the advantage of the new context offering them a choice which their mothers and grandmothers did not have because they were only participating in the patriarchal model which was the only narrative available. However, making the choice and act on it implies the concrete realisation of freedom as a transgression of their own norms while they respect the law of the host country (45). The choice was also an important part in *working out their loyalties* (19), which enable the women in our study to be able and determined to choose their daughters and take control as Dansey *et al.* (19) stress this *self-determination* is understood as being underpinned by empowerment. They created their own sense of meaning and acted to make their own decisions for themselves and their daughters.

The body as a vehicle for empowerment and capability

The changes in their sense of self the women described in our study while they re-appropriated their bodies and sense of identity and responsibility towards themselves and their daughters, constitutes a gain of empowerment. This is consistent with other studies on violence against women where women experienced changes in themselves through a change in their power and their concrete actions to take control over their own lives (46,47). This process includes recognition of their power to make choices about their own lives and take steps to embracing that power. Fahs and Swanks (48) suggest that embodied resistance is when the body is used to contradicting cultural norms; as for example, the women resisted and decided to go ahead with the reconstruction of the clitoris or de-infibulation. Their bodies gave them the means to act on their decisions about themselves. This is a *capability* according to Nusbaum (28). These parts of their bodies appeared meaningful to them and they thought of protecting their daughters'

bodies as well. Before the *turning points*, what the norm imposed was contrary to what they felt. After the turning points, they were able to disclose their feelings and express their emotions. This was consistent with previous studies (15). Under the practice of FGM, there was a sense of communal body. However, after the *turning points*, the women have a sense of a more individualistic body, where their rights are promoted in terms of their decisions concerning their bodies. Their emancipation or empowerment is therefore seen as from the bottom-up, from an individual body towards a community. The narratives of the women enable them to gain the strength of internal resistance that comes from self-confidence by becoming responsible for the sequence of events experienced (27). Furthermore, the capability to preserve one's self as a person within the community represent the definition of concrete freedom (27). A sense of agency and responsibility to take their own decision and to protect their daughters was a source of relief that acted as a counterpoint to their own memories and pain. This is consistent with the findings of Koukoui *et al.* (49) that mothers were appreciative of the opportunity to raise their daughters in an environment that offered protection against FGM and took comfort in knowing that their daughters would know another destiny.

The role of significant others in this process

The significant others played an important role in the change of attitudes of the women. Migration in the host country contributed to raising the awareness of differences between cultures and not being defined exclusively by FGM. The safety net of helping agencies and the assistance of significant others and health professionals were determining factors in the stage of resolution of conflicts of loyalty. They can help to identify women in all stages of the process in order to provide assistance to their needs at that stage.

When they had partners from another culture, this was also significant because the women understood that one could be a member of a community without being cut. They no longer believed that women must endure pain and sufferings when their partners made them aware of the possibility of living their sexual life openly without pain during sexual intercourse which was a clear difference to the expectations of their own culture. In the host country, the different interactions with others also helped in the construction of their identities. Identities are relational socially constructed (50,51).

Women were able to shift and exercise their internal agency as an empowering means to achieve the stages of re-appropriation and reconciliation. This demonstrates their direction in moving forwards which reinforces the women's self-esteem, security and freedom.

It also appears to enhance their determination to move through all the stages and to advocate against the practice.

Forgiveness and empathy in the process of changing attitudes towards FGM

The women represent themselves within their communities by identifying themselves with their mothers. They can be themselves and, also, they can be part of the community. The identification is a form of empathy they felt for their mothers which enabled them to reconcile with their mothers and see themselves as being part of the community again through the process of forgiveness. This correlates with other findings on the study of childhood abuse where forgiveness of parents was found to have good impact on emotional health (Freedman, 1998). Forgiveness refers to the process of the voluntary waiving of resentment, hatred and blame towards others so that not only the person not only forgets the hostility and hatred but also wishes the best for the transgressor (52). This forgiveness requires a deliberate act of giving up anger and resentment toward the offender while also not requiring a response from the offender (53). The offenders in this case are the mothers in the communities, and the women succeeded in seeing them as not having a choice in a pressurised community. This is empathy they demonstrated when they put themselves in the shoes of their mothers.

Strengths and limits of the study

The study was strong in various areas. An important one was the use of the inductive approach in analysing the data and the triangulation of different sources of data, as we did a secondary analysis of interviews conducted with 15 women (15), which we compare with the experience of 10 further women with publicly available narratives (see list of books in methods section). The rich dialogues with experts from different fields including an expert with lived experience, also contributed to bringing out concepts that were relevant in enriching the interpretation of the results. The contribution of the expert with lived experience was valuable to enriching the trustworthiness of our results.

The study also presents some limits. First, our emerging theorisation was not tested through further interviews with a theoretical sampling methodology. Therefore, we cannot be certain that we have reached saturation. Moreover, our proposed theorisation might have been enriched through interactions with experts in presential seminars, as we had initially intended. Such seminars could unfortunately not be organised due to the sanitary situation in 2020-2021 in context of the COVIS-19 pandemic.

Conclusion

Building on hypotheses generated from an earlier study (15), this study examined possible mechanisms which might explain the change of attitudes towards the practice of FGM in migrant women. The model of change which emerged from our analysis gives us an insight into the journey of the women towards changing their attitudes after some self-reported *turning points* in their lives drove them to change. Re-appropriating their own self and identity as well as reconciling themselves with their communities of origin were both valuable in the women's perspectives in order to move forward with their lives. Trying to protect their daughters from going through the same experience led them to identify FGM as a violation of a woman's right to bodily integrity. The importance of acknowledging the emotional work and painful traumatic memories awakened during the journey has significant implications for the assisting agencies and health professionals who are in contact with migrant women who originate from countries where FGM is practised. Our model describes several stages including the stage of *the clash,* where the women find themselves trapped in the conflicts of loyalty and which in turn generates very uncomfortable and painful feelings. Thus, our study contributes to the body of knowledge and provides avenues to be explored by health professionals working with migrant women subjected to FGM, in order to support their processes of reconciliation with themselves and their communities.

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