

The relationship between female genital mutilation and post-traumatic stress disorder with rural girls: Implications for Trauma-Informed Social Work Practice

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ABSTRACT:

Female genital mutilation (FGM) often referred to as "female circumcision" is still practiced around the world. Since 1997, international efforts to end FGM--which has been in practice since ancient times-- have intensified According to the World Health Organization, FGM practices are common in 30 countries across Africa, Asia, and the Middle East. However, it is also a worldwide health issue as a result of international migration. Importantly, FGM is also widely linked to psychological disorders. The purpose of the study was to identify the relationship between FGM and post-traumatic stress disorder (PTSD) among rural girls in Upper Egypt.

This research is a descriptive cross-sectional study with statistical population includes a sample of 60 rural girls in Upper Egypt, between the ages of 15 and 30 years, who have undergone FGM. The sample size was selected using the Purposive Sampling techniques. Data collecting tools consisted of the scale of the post-traumatic stress disorder. The study finds that there is a significant correlation between FGM and PTSD within this sample of females.

KEYWORDS: Female Genital Mutilation – Post-Traumatic Stress Disorder - Trauma-Informed Practice- Rural Girls- Upper Egypt

INTRODUCTION

In 1997, the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) issued a first Joint Statement on Female Genital Mutilation/Cutting which described the implications of the practice for public health and human rights and declared support for its abandonment. Since then, children's rights organizations have published many reports on female genital mutilation (WHO, UNICEF, UNFPA, 1997).

According to the WHO report, the term Female Genital Mutilation [hereafter, FGM] refers to "all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons" (WHO, 2008, P1).

FGM/C is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes and constitutes an extreme form of discrimination against women (UNFPA & UNICEF, 2017. P1).

In 2012, the United Nations General Assembly adopted the first-ever resolution against FGM (67/146), calling for intensified global efforts to eliminate it (UNFPA,2015, P7)

The degree of cutting varies in different traditional practices across cultures. FGMs often used to replace the traditional term 'female circumcision' in order to emphasize the physical mutilation of Women (Donna Dustin & Liz Davies, 2007, P4).

FGM is practiced in about 30 African countries (Figure1) and several Asian countries. Although concentrated in these areas, it is also practiced in many other countries around the world at low rates within immigrant families from Africa and Asia. The spread of this practice is referred to as the "African belt", which encompasses both sides of the equator. In the Muslim world, this practice is found in Egypt, Somalia, Sudan, Djibouti, and some parts of Yemen and Oman. It is rare to find FGM in practice across other Islamic and North African countries, such as Saudi Arabia, the Gulf States and Iran., Most FGM practitioners are residents of African countries (Abu Srour, J & Ragab, A, 2013; UNICEF, 2016).

According to UNICEF statistics, at least 200 million girls alive today have undergone FGM, across 30 countries. More than half of these females reside in just three countries: Indonesia, Egypt and Ethiopia and 44 million are girls below the age of 15 (UNICEF, 2016).

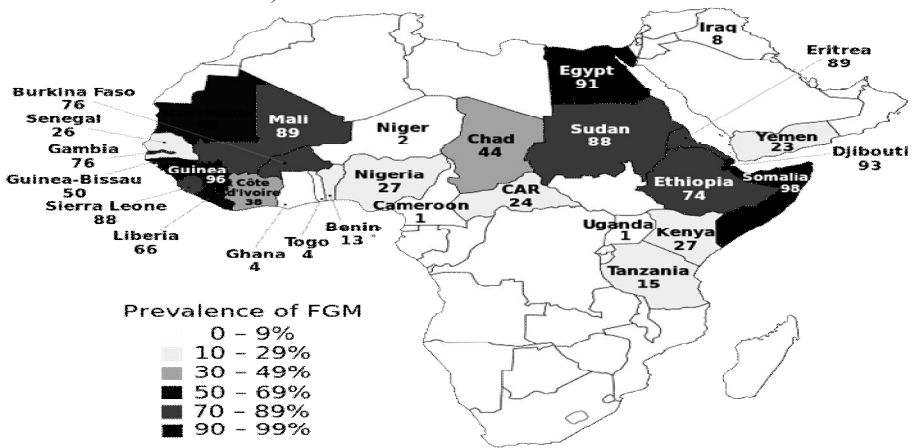
The 2015 Demographic and Health Survey (DHS) in Egypt found that 87%of women ages 15 to 49 have undergone FGM g. The study also revealed that half of these women were between 7 and 10 years old at the time they underwent FGM (DHS, 2015). virtually all of the women were circumcised before the age 15 (DHS, 2015). This reflects the fact that, in Egypt, girls are traditionally circumcised slightly before or at puberty (El-Zanaty F, 2015, P105).

A women's FGM status is determined by direct examination of the external genitalia and in accordance with the WHO's four-category classification of FGM, established in 1995 and again in 2007:

Table 1 Types of female genital mutilation as defined by the World Health Organization

Type (I)	Partial or total removal of the clitoris and/or the prepuce
Type (II)	Excision of the clitoris with partial or total excision of the labia minora.
Type (III)	Total or partial excision of the external genitalia and stitching or narrowing of the vaginal opening (infibulation).
Type (IV)	Unclassified, which includes pricking, piercing or incising the clitoris and/or labia; stretching the clitoris and/or labia; cauterizing the clitoris and surrounding tissue; scraping the tissue surrounding the opening of the vagina (angurya cuts) or cutting the vagina (gishiri cuts); introducing corrosive substances or herbs into the vagina to cause bleeding or to tighten or narrow it; and any other procedure that can be included in the definition of FGM noted above

• (WHO, 1995; 2007; Taghreed Adam et al., 2010)



(Figure 1: Prevalence of female genital mutilation, data from national surveys 2016 UNICEF)

There are various reasons for why FGM is practice across the world. These reasons include beliefs that FGM increases female fertility, promotes chastity increases marriage opportunities, prevents girls from delinquency, and that it reduces females’ sexual desire. It is a necessity that should be conducted for young girls, FGM is often

considered to be a religious duty to which you that must be adhered (Okeke, Anyaehie, & Ezenyeaku, 2012)

According to Dustin & Davies (2010), FGM is more often practiced for cultural and traditional rather than for religious reasons. Nevertheless, religion is often cited as the underlying reason for the practice. FGM is practiced among Christians, Muslims, Jews and other religious groups indigenous to Egypt. However, the practice predates the establishment of Christianity and Islam: either the Bible, the Koran nor the Hadith (collections of the sayings of the Prophet Mohammed) advocate FGM many Muslim groups do not practice FGM (Dustin & Davies, 2010).

Rasheed (2011) explains that, although FGM is criminalized, it is still widely practiced covertly. The real reasons for practicing FGM are unclear, but often the reasons cited are respecting tradition, following a religious precept, and the necessity of ensuring female chastity (Rasheed, 2011).

FGM is mostly carried out by traditional circumcisers, who often play other central roles in communities, such as attending childbirths. In many settings, health care providers perform FGM due to the erroneous belief that the procedure is safer when medicalized (OHCHR, U., & UNDP, U. 2008; United Nations Children's Fund, & Gupta, G. R, 2013).

The social work profession is expected to play a significant role in increasing awareness of the harmful effects of Female Genital Mutilation (FGM) and reducing the prevalence of its practice at both macro and micro levels. With this type of this harmful practice and raise awareness of the harmful effects of female circumcision. This is what Burson 2007 pointed out that although social work's respect for cultural diversity, the profession has a responsibility to work toward the elimination of harmful practices, even when such practices are valued by a given society (Burson, 2007).

LITERATURE REVIEW

There are only a few studies in the field of social work that have looked at FGM specifically. For instance; Dustin & Davies (2010) suggest that FGM is an infringement on child rights. citing the United Kingdom's Children's Rights, the study emphasizes the physical, emotional and cultural impact on girls subjected to FGM and explains that social workers are professionally and ethically responsible for preventing the practice of FGM. The risks of as well as the rationalizations for FGM are explored in this study to further

our understanding of the practice. The authors end by proposing social work interventions that would protect females from FGM.

Another relevant study was conducted by Costello (2013) addresses the prevalence of and harm imposed by FGM, its cultural and social bases, as well as prevention strategies that have proven to be effective. Importantly Costello (2013) also discusses r how practitioners could harness communities' commitment to their children's best interests by abandoning FGM.

Ross-Sheriff and Orwenyo (2014) explores the various reasons cited in favor of FGM. These reasons can be broken down into four main categories: sociocultural Hygienic and aesthetic spiritual and religious, and lastly, psycho-sexual reasons. This study also refers to the risks Brought on by Female Genital Mutilation and the Social Work roles with Communities Practicing Female Genital Mutilation (Ross-Sheriff & Orwenyo, 2014)

Elvin (2014) identifies how social workers can protect girls at risk of FGM. This study found that there is an important role for social workers as well as the medical team in the prevention of FGM, through assessing the level of risk. The author also proposes that social workers work directly with the family to minimize the risk but also to intervene if they believe FGM is likely to occur or has occurred (Elvin, 2014)

Costello (2015) addresses risks of FGM risks among Australian women who migrated from FGM-practicing countries. This article provides some background on FGM/C and its epidemiology outlines its prevalence, types, health risks and complications it imposes for women and girls (Costello, 2015). The study also discusses risk-prevention strategies for health practitioners and welfare and social workers and health care professionals.

FGM has no health benefits and in fact harms girls and women in many ways. It involves removing and damaging healthy and normal female genital tissue, and interferes with the natural functions of girls' and women's bodies. In general, risks increase with the degree of invasiveness of the procedure. In addition, there are many social, familial and psychological problems that occur as a result of FGM FGM is a medically unnecessary procedure that is associated with both physical and mental health consequences among girls and women who undergo the practice (Berg., 2014; Knipscheer , 2015; Ibrahim & Mahmoud, 2016; Adelufosi, 2017)

Several studies --in the areas of in Medicine, Psychiatry, Psychology, Nursing, and Anthropology--have had been carried out to promote the hypothesis that FGM is both medically unnecessary and that it imposes severe physical and mental health consequences. The literature reviews, indicated that there were studies that focused on determining the relationship between FGM, and psychological problems and mental health problems such the study of Kizilhan (2011) which explores the Impact of psychological disorders after FGM among Kurdish girls in Northern Iraq and investigated the mental health status of young girls after genital mutilation in Northern Iraq. In this study the circumcised girls showed a significantly higher prevalence of depression disorder, anxiety disorder and somatic disturbance.

The studies of Mulongo (2014) also identifies the psychological problems that may follow FGM such as Post-Traumatic Stress Disorder (PTSD) and affective disorders. and the study of Knipscheer (2015) which addresses the mental health problems associated with female genital mutilation among 66 genitally mutilated immigrant women originating from Africa.

In addition, there are many studies concerned with determining the relationship between FGM and sexual function such; the study of Salihu (2012) which addresses the association between FGM and intimate partner violence. The study also identifies the risk factors for intimate partner violence and its subtypes (physical, sexual and emotional). Results reveal the many risks associated with FGM (Salihu, H. M et al., 2012)

The study of Biglu (2016) which examines the effects of FGM on female sexual functions in Iranian-Kurdish women, who are living in the Kurdistan province of Iran, compared to Iranian uncircumcised women (Biglu, M. H et al., 2016).

The study of Jungari (2016) addresses the practice of FGM worldwide and its adverse effects on women's reproductive health and the result of this studies found that FGM has no health benefits; is mostly carried out on girls before they reach the age of 15 years; can cause severe bleeding, infections, psychological illness, and infertility; and, most important, can have serious consequences during childbirth (Jungari, S. B, 2016).

PTSD IN SOCIAL WORK

One of the disorders that social work is interested in dealing with is post-traumatic stress disorder (PTSD). Every day Social workers encounter people affected by trauma. Those diagnosed with PTSD are often victims of violent crime, combat veterans, survivors of disasters and accidents, people suffering from chronic and life-threatening illnesses and emergency service personnel, who are recognised to be at high risk for developing PTSD (Joseph & Murphy, 2013, P4)

PTSD, a severe psychological trauma that leads to emotional suffering and a significant deterioration in social relationships, is a reaction to traumatic events. Many people recover from PTSD in the months following the trauma, but some continue to be affected by PTSD each year (Abdel Hafeez, 2017, P37).

American Psychiatric Association (APA) identified the concept of PTSD is a condition characterised by three clusters of symptoms: (i) re-experiencing symptoms (e.g. intrusive imagery, recurrent dreams); (ii) avoidance symptoms (e.g. of thoughts, feelings and reminders of the trauma); and (iii) arousal symptoms (e.g. irritability, poor concentration, hypervigilance) (American Psychiatric Association, 1994).

Shea-Porter, C defined PTSD as “a psychological reaction that occurs after experiencing a highly stressing event that is usually characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of reminders of the event (Shea-Porter, 2009, P235)

Many studies --in the areas of social work have had been carried out to highlighted the PTSD in various social work practice settings such: Freshman, 2012 explained the financial disaster as a Risk Factor for Posttraumatic Stress Disorder: Internet Survey of Trauma in Victims of the Madoff Ponzi Scheme (Freshman, 2012) Archuleta & Lakhwani (2016) indicate that emotional regulation and social integration negatively relate, whereas environmental mastery positively relates, to posttraumatic stress disorder symptoms among Latino youths in an English as a Second Language School (Archuleta, A. J., & Lakhwani, M) and Dana Schmidt, 2014 Addressing PTSD in Low-Income Victims of Intimate Partner Violence (IPV): Moving toward a Comprehensive Intervention, this article presents a model of a comprehensive intervention for disadvantaged minority victims of IPV that can help address issues related to PTSD and empower survivors to access necessary resource (Dana Schmidt, I. 2014)

According to SAMHSA’s the concept of a trauma-informed approach, “A program, organization, or system that is trauma-informed: Realizes the widespread impact of trauma and understands potential paths for recovery; Recognizes the signs and symptoms of trauma in clients, families, staff, and others involved with the system; Responds by fully integrating knowledge about trauma into policies, procedures, and practices; and Seeks to actively resist re-traumatization.” (SAMHSA’s, 2018).

Elliott, D. E., et al., (2005) proposed that trauma-informed practice consists of (a) recognising the impact of traumatic events on the functioning of clients and that their symptoms serve as attempts at coping; (b) viewing recovery from trauma as a primary treatment goal; (c) utilising an empowerment model; (d) maximising client control over their recovery; (e) relying on relational collaboration; (f) creating an atmosphere of safety, respect, and acceptance; (g) focusing on adaptation over symptoms and resilience over pathology; (h) seeking to minimise the potential for re-traumatisation; (i) conceptualising clients’ life experiences in a cultural context; and (j) soliciting client input and involving clients in the design and evaluation of services (Elliott, D. E et al., 2005; Alessi & Kahn, 2017, P3).

In 2013, the American Psychiatric Association revised the PTSD diagnostic criteria in the fifth edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-5) The diagnostic criteria are specified below (APA, 2013, pp 271:274)

Table (2) DSM-5 Criteria for PTSD

Diagnostic Criteria	Description	Required
Criterion (A) Stressor	The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, as follows:	
	1. Direct exposure.	(1) required
	2. Witnessing, in person.	
	3. Indirectly, by learning that a close relative or close friend was exposed to trauma. If the event involved actual or threatened death, it must have been violent or accidental.	
	4. Repeated or extreme indirect exposure to aversive details of the event(s), usually in the course of professional duties (e.g., first	

	responders, collecting body parts; professionals repeatedly exposed to details of child abuse). This does not include indirect non-professional exposure through electronic media, television, movies, or pictures.	
Criterion (B) Intrusion Symptoms	The traumatic event is persistently re-experienced in the following way(s):	
	1. Recurrent, involuntary, and intrusive memories. Note: Children older than 6 may express this symptom in repetitive play.	(1) required
	2. Traumatic nightmares. Note: Children may have frightening dreams without content related to the trauma(s).	
	3. Dissociative reactions (e.g., flashbacks) which may occur on a continuum from brief episodes to complete loss of consciousness. Note: Children may reenact the event in play.	
	4. Intense or prolonged distress after exposure to traumatic reminders	
	5. Marked physiologic reactivity after exposure to trauma-related stimuli.	
Criterion (C) Avoidance	Persistent effortful avoidance of distressing trauma-related stimuli after the event:	
	1. Trauma-related thoughts or feelings.	(1) required
	2. Trauma-related external reminders (e.g., people, places, conversations, activities, objects, or situations).	
Criterion (D) negative alterations in cognitions and mood	Negative alterations in cognitions and mood that began or worsened after the traumatic event	
	1. Inability to recall key features of the traumatic event (usually dissociative amnesia; not due to head injury, alcohol or drugs).	(2) required
	2. Persistent (and often distorted) negative beliefs and expectations about oneself or the world (e.g., "I am bad," "The world is completely dangerous.").	

	3. Persistent distorted blame of self or others for causing the traumatic event or for resulting consequences	
	4. Persistent negative trauma-related emotions (e.g., fear, horror, anger, guilt or shame).	
	5. Markedly diminished interest in (pre-traumatic) significant activities.	
	6. Feeling alienated from others (e.g., detachment or estrangement).	
	7. Constricted affect: persistent inability to experience positive emotions.	
Criterion (E) alterations in arousal and reactivity	Trauma-related alterations in arousal and reactivity that began or worsened after the traumatic event	
	Irritable or aggressive behavior	(2) required
	Self-destructive or reckless behavior	
	Hypervigilance.	
	Exaggerated startle response	
	Problems in concentration	
	Sleep disturbance	
Criterion (F): duration	Persistence of symptoms (in Criteria B, C, D and E) for more than one month	
Criterion (G) functional significance	Significant symptom-related distress or functional impairment (e.g., social, occupational).	
Criterion (H) attribution	Disturbance is not due to medication, substance use, or other illness.	

In 2017, Levenson indicated that Social workers always dealing with clients with a history of trauma. and according to his view the Trauma-informed care is a way of providing services by which social workers practitioners recognize the prevalence of early adversity in the lives of clients, view presenting problems as symptoms of maladaptive coping and understand how early trauma shapes a client’s fundamental beliefs about the world and affects his or her psychosocial functioning across the lifespan (Levenson, 2017, P105)

The previous literature shows that there are many medical and psychological effects associated with FGM. In addition, most of the studies conducted were dealt with in many medical, social and

psychological specialties, but there is a lack of studies related to FGM and its relation with PTSD in the social work.

In this paper, we sought to determine whether FGM is associated with PTSD with rural girls, as well as its subtypes (i.e. intrusive re-experiencing, avoidance and numbness and hyperarousal).

OBJECTIVES OF THE STUDY

Our study aimed to investigate the relationship between FGM and PTSD among rural girls in Upper Egypt

RESEARCH QUESTION:

The primary research question for this study is the following: What is the relationship between FGM and PTSD among rural girls in Upper Egypt? Addressing this question will provide empirical evidence as to what are the relationship between FGM and PTSD among rural girls in Upper Egypt.

RESEARCH HYPOTHESES

- There is no a statistically significant correlation between FGM and PTSD among rural girls in Upper Egypt (study sample).
- There is no a statistically significant correlation between some demographic variables (gender, age, dwelling, academic level, grade) and PTS Dr among rural girls in Upper Egypt (study sample).

METHOD

Study Design:

The current study is part of a cross-sectional study designed to assess the relationship between FGM and PTSD with rural girls in Upper Egypt.

Sample of the study:

The study population included (60) rural girls. The selection of participants was based on the Purposive Sampling techniques. with a sample who had undergone FGM. All participants were currently educated. Data was collected in 2018.

The sample of the current study was selected through the Program of rural girls in the Youth Protection and Empowerment, (15 or above in age). In Manfalut, Abu Tig, and El Ghanayem city. This Program consider as one of the programs of Caritas Egypt in Assiut Governorate, which was funded by the Plan International Egypt Commission in Assiut Governorate.

Data collection procedure:

The present study was conducted to identify the relationship between FGM and PTSD among rural girls in Upper Egypt. The study was conducted between January and March, 2018. Approval of the authority was assured. Ethical consideration and confidentiality of the data were assured. Verbal consent was obtained from every participant after explanation of the objectives of the study.

MEASUREMENT INSTRUMENT:

The current study used an instrument to measure the level of PTSD exhibited by a sample of circumcised girls. This scale was initially developed by Davidson (1997), and later re-standardized and validated with an Arab population by Thabet (2006). This PTSD scale contains 25 items. In order to insure the accuracy of this tool, we rephrased certain statements according to the criteria used in the DSM5. The scale has been translated into Arabic, totaling to 25 Items in its current state.

To measure the level of severity of PTSD symptoms, we included a 5-point frequency and severity scale for each item (1 = never, 2 = scarcely, 3 = sometimes 4 = often 5 = always). The scale also included three key components: intrusive re-experiencing, avoidance and numbness, as well as hyperarousal. The sample of the study has been verified to meet the criteria of PTSD outlined in the DSM5.

The final scale of the post-traumatic stress disorder of female genital mutilation in rural girls was reviewed for content validity by ten social work professors with expertise in this area in order to assure that the survey content asked the appropriate questions of the potential research participants. Additionally, Pearson Correlation Coefficient was used to calculate the validity of the PSTD Scale. It can be concluded that the dimensions of the post-traumatic stress disorder scale of female genital mutilation in rural is statistically significant at (0.01). This indicates high internal consistency coefficients, as well as the high and sufficient indicators of validity that can be trusted in applying the current study. Also, Cronbach's alpha was used to calculate the internal consistency of the measurement scale. From the statistical analysis, it can be concluded that the instrument was reliable as a score of 0.912 was obtained for the items. the result of the tests indicates the internal consistency validity of this scale using a Pearson correlation coefficient. indicates a Cronbach's alpha coefficient (reliability) 0.89 for the original questionnaire and 0.87 for this current study.

ETHICAL CONSIDERATIONS

Prior to data collection, ethical clearance was obtained from the school of social work at Assiut University in Egypt. In addition, Verbal consent from the respondents was obtained prior to the commencement of the study.

DATA ANALYSIS

Data analyses were performed using SPSS for Windows 20.0 (Armonk, NY: IBM Corp.). Descriptive statistical techniques were applied to clarify demographic characteristics of the study sample. The frequencies and percentages (mean, median and standard deviation) were calculated for each Likert-scale item. Lastly, Brown Spearman's split-half equation and Cronbach's alpha were used to assess the reliability of the study tools and measure the degree of their consistency and T-Test. Pearson Correlation Coefficient was used to calculate the validity of the PSTD Scale.

RESULTS Demographic Information

Table 3 displays the demographic information of participants. The participant's average age was 23.22 years old with a range from 14 to 32 years. A majority of participants reported a single 42(70.0 percent) as their social status; 12 (20.0 percent) reported as a married; only 4 (6.7 percent) reported as a Detached; and only 2 (3.3 percent) reported as a Widower. A majority of participants reported an Preparatory School of participants 24(40.0 percent) as their highest level of education; and 17 (28.3 percent) reported having University education level; 11 study participants (18.3 percent) reported having Basic School; only six study participants (10.0 percent) reported having Secondary School; and only two study participants (3.3 percent) reported having Post graduate. A majority of participants reported an Illiterate 24(40.0 percent) as their father highest level of education; 11 (18.3 percent) reported having Preparatory School Their father education level; 8 study participants (13.3 percent) reported their father having Read and write; only six study participants (10.0 percent) reported their father having Basic School and University educational; and only five study participants (8.3 percent) reported their father having Secondary School. A majority of participants reported an Illiterate 46(76.6 percent) as their mother highest level of education; 5 (8.3 percent) reported having Preparatory School their mother education level; and 2 study participants (3.3 percent) reported their mother having Read and write. The great majority of Age at the time of FGM (58.3%) They were circumcised during the period 6-8 e (M 7.82, SD 1.642). according to this table, females with lower levels of education are more likely to have undergone FGM.

**Table (3) Demographic characteristics of the participants
(n = 60)**

Demographic	Frequency	Percentag	SD
Age			5.384
Less than 15 years	2	3.3	
15- 19	15	25.0	
20-24	17	28. 3	
25 - 29	18	30. 0	
30 +	8	13.3	
Social Status			
Single	42	70.0	
Married	12	20.0	
Detached	4	6.7	
Widower	2	3.3	
Educational level			
Basic School	11	18.3	
Preparatory School	24	40.0	
Secondary School	6	10,0	
University	17	28.3	
Post graduate	2	3.3	
Father educational level			
Illiterate	24	40.0	
Read and write	8	13.3	
Basic School	6	10.0	
Preparatory School	11	18.3	
Secondary School	5	8.3	
University	6	10.0	
Mother educational level			
Illiterate	46	76.7	
Read and write	2	3.3	
Basic School	7	11.7	
Preparatory School	5	8.3	
Secondary School	0	0.0	

University	0	0.0	
Age at the time of FGM			1.642
Less than 6 years	4	6.7	
6-	35	58.3	
9-	19	31.7	
12 +	2	3.3	

RESULTS OF STUDY HYPOTHESES

Table (4) Differences between the average scores of the sample on the dimensions of the PTSD scale

Scale dimensions	Mean	SD	T	df	Sig.
intrusive re-experiencing	38.20	16.617	17.807	59	0.000
avoidance and numbness.	42.72	18.030	18.352	59	0.000
Hyperarousal.	23.42	10.761	16.855	59	0.000
Total	104.33	44.347	18.224	59	0.000

The T-Test coefficient was used for one sample in order to answer the three hypotheses. The results were based on differences between the average of the sample as opposed to the hypotheses.

Table 4 displays the differences between the average scores of the sample on the dimensions of the PTSD scale. The result of this table shows that there are differences between the samples of the study in terms of the first dimension, intrusive re-experiencing associated with FGM, where the value of (T) calculated (17807) is greater than the value of (T) Table. The table shows that there are differences between the samples of the study in relation to the second dimension, avoidance and numbness experience caused by FGM, where the value of (T) calculated (18.352) is greater than the value of (T) table.

It was also revealed that there were differences between the samples of the study with respect to the third dimension of Hyperarousal, where the value of (T) calculated (16.855) is greater than the value of (T) table.

As for the total scale dimensions of PTSD, the previous table showed that there were differences between the sample of the study and the value of (T) calculated (18.224), which is greater than the value of (T). Table.

Table (5) The Average scores of the sample on the total of PTSD Scale according to the age variable

Source of contrast	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	10960.14	4	2740.035	1.482	0.220
Within Groups	101704.4	55	1849.172		
Total	112664.6	59			

Table 5 displays the average scores of the sample on the total of PTSD Scale according to the age variable, the One-Way ANOVA coefficient was used to compare the computation of three or more groups to answer the first hypothesis. The age variable contains more than two categories, so the coefficient used (One Way ANOVA) to compare the mean scores of the study sample by age variable. The previous table, proved the validity of the second hypothesis: "There were no statistically significant differences at the 0.05 level between the mean scores of the sample on the PTSD scale for the age variable " because the calculated value of (F) is 1.482, which is smaller than the value of the (F) Table (2.606). This means that all members of the sample have post-traumatic stress disorder with age difference, whether large or small, and there are no differences between them.

Table (6) The Average scores of the sample on the total of PSTD Scale according to the Age at the time of FGM variable

Source of contrast	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	8964.014	3	2988.005	1.614	0.196
Within Groups	103700.569	56	1851.796		
Total	112664.583	59			

Table 6 displays the average scores of the sample on the total of PTSD Scale according to the Age at the time of FGM variable, the One-Way ANOVA coefficient was used to compare the computation of three or more groups to answer the first hypothesis. The Age at the time of FGM variable contains more than two categories, so the coefficient used (One Way ANOVA) to compare the mean scores of the study sample by the Age at the time of FGM variable. The previous table, proved the validity of the second hypothesis: "There were no statistically significant differences at the 0.05 level between the mean scores of the sample on the PTSD scale for the Age at the time of FGM variable" because the calculated value of F is 1.614, which is smaller than the value of F Table (839). This means that all

members of the sample have post-traumatic stress disorder with the age at the time of FGM variable difference, there are no differences between them whatever the age during the FGM.

Table (7) The Average scores of the sample on the total of PTSD Scale according to the Social Status variable

Source of contrast	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	7884.262	3	2628.087	1.405	0.251
Within Groups	104780.321	56	1871.077		
Total	112664.583	59			

Table 7 displays the average scores of the sample on the total of PTSD Scale according to Social Status variable, the One-Way ANOVA coefficient was used to compare the computation of three or more groups to answer the first hypothesis. The Social Status variable contains more than two categories, so the coefficient used (One Way ANOVA) to compare the mean scores of the study sample by the Social Status variable. The previous table, proved the validity of the second hypothesis: "There were no statistically significant differences at the 0.05 level between the mean scores of the sample on the PTSD scale for Social Status variable" because the calculated value of (F) is 1.405 and is smaller than the value of (F) Table (839). This means that all members of the sample have post-traumatic stress disorder with the Social Status variable difference; there are no differences between them whatever their social Status.

DISCUSSION

This paper attempts to advance the empirical study of linking FGM and PTSD to rural girls. FGM on has been reported as correlating with PTSD, intrusive re-experiencing, avoidance and numbness, as well as hyperarousal.

In the present study, we attempted to bridge the gap in social work literature in Egypt, namely with respect to the relationship between FGM and PTSD among rural girls. In pursuing this objective, the PTSD Scale was applied to a population of 60 rural girls in the Assiut Governorate.

Our results reveal differences between the samples of the study in relation to the first dimension, intrusive re-experiencing associated with FGM, where the value of (T) calculated (17807) is greater than the value of (T) Table.

Our results also reveal differences between the samples of the study in relation to the second dimension, avoidance and numbness experience caused by FGM, where the value of (T) calculated (18.352) is greater than the value of (T) table. It was also revealed that there were differences between the samples of the study with respect to the third dimension of Hyperarousal, where the value of (T) calculated (16.855) is greater than the value of (T) table. As for the total measure of PTSD among rural female who had undergone FGM, genital mutilation in rural, the previous table showed that there were differences between the sample of the study and the value of (T) calculated (18.224), which is greater than the value of (T). Table.

The present study also doesn't accept the first hypothesis, assuming there is a no statistically significant positive correlation between FGM and PTSD, including marginal hypotheses (Restore traumatic experience associated with FGM, Avoid traumatic experience caused by FGM, and Excitement), was verified.

These findings are consistent with previous studies (Adelufosi., 2017; Biglu 2016; Ibrahim and Mahmoud 2016; Knipscheer., 2015; Mulongo., 2014; and Salihu ,2012). These studies have demonstrated a statistically significant positive correlation between FGM and many other issues, such as intimate partner violence, sexual dysfunctions, as well as psychological disorders such as Anxiety, Depression PTSD and other affective disorders.

The result of the present study also showed that the second hypothesis, assuming there is a no statistically significant correlation between some demographic variables (gender, age, dwelling, academic level, grade) and PTSD for among rural girls in Upper Egypt, was not verified. Result shows no statistically significant difference at the 0.05 level between the mean scores of the sample on the PTSD scale. For the age variable, since the calculated value of (F) is 1.482, which is smaller than the value of the (F) tabular (2.606). This indicates that the sample of the study confirmed that they were affected by FGM at different ages.

The present study found that there were no statistically significant differences at the 0.05 level between the mean scores of the sample on the PTSD scale according to the age variable during FGM. The calculated value of F is 1.614, which is smaller than the value of F Table (839). This indicates that the sample of the study confirmed that participants were affected by FGM at different their ages at the time of practice FGM with them.

The present study reveals that there were no statistically significant differences at the 0.05 level between the mean scores of the sample on the PTSD. Depending on the variable of the social situation"; the calculated value of (F) is 1.405 and is smaller than the tabular value (F) (839) this indicates that the sample of the study confirmed that they were affected by FGM differently with regards to different their social status.

Implications for Trauma-Informed Social Work Practice:

The results of the study indicate that FGM is closely related to PTSD among rural girls according to different dimensions: restore traumatic experience associated with FGM; avoid traumatic experience caused by FGM; and excitement. For that reason, the findings of this study have useful academic and practical implications for social workers, especially social workers in rural areas

Our findings clearly indicate that there is a statistically significant positive correlation between FGM and PTSD for rural girls. This makes clear the importance that academics and social workers must give to raising awareness with regards to the dangers of these practices, especially in rural areas. As a result, we recommend:

1. Making the topic of FGM part of the curriculum in social work schools and creating well-designed continuous education programs that would include social work practitioners working in rural areas in Upper Egypt
2. Including social work practitioners in planned health education and publicity campaigns by local communities, governments, as well as national and international organizations. This is necessary to raise awareness with regards to the major risks of FGM
3. Encouraging social workers to follow the WHO's guidelines for reducing the prevalence of and risks associated with FGM. The WHO efforts include:: a) Advocacy: developing publications and advocacy tools for international, regional, and local efforts to end FGM within a generation; b) Research: generating knowledge about the causes and consequences of the practice, how to eliminate it, and how to care for those who have experienced FGM; c) Guidance for health systems: developing training materials and guidelines for health professionals to help them treat and counsel women who have undergone procedures. All of these calls are considered as the core of social workers' roles in professional practices.

4. Setting a series of training courses to combat the FGM for social workers in a manner that contributes to the reduction of these harmful practices, specifically in Upper Egypt.
5. Setting a series of training courses targeting social workers on how rehabilitation and treatment of victims, especially young girls.
6. Social workers should be concerned with increasing awareness campaigns about the dangers of FGM, especially in the less educated villages. The results of the present study showed that there is a correlation between the level of education and the practice of FGM. These points to the importance of targeting education when attempting to decrease the prevalence of FGM practice.

IMITATIONS AND STRENGTHS

Research Limitation:

There are several limitations to this study.

- First, this study relied on the perceptions of the purposive sample with rural girls at Assiut governorate. Samples from different geographical regions may provide differing results.
- Second, because surveys are self-reporting measures, participants may have consistently given high or low ratings.
- Third, the sample of this study came from educated rural women only. A sample of uneducated rural women may give other results.

CONCLUSION

FGM is one of the most common forms of violence inflicted on young girls in Upper Egypt. One of the most important effects of FGM is PTSD. Future studies should explore the effectiveness of treatment interventions in social work and explore strategies to reduce the psychological problems associated with FGM among rural girls.

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