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Evaluating Asylum Claims Based on Female Genital Mutilation/Cutting for Immigration Court—Opportunities and Challenges for Licensed Mental Health Professionals

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Although female genital mutilation/cutting (FGM/C) is illegal in many countries, over 200 million women and girls have been subjected to the practice worldwide. FGM/C has been declared a violation of human rights and constitutes grounds for asylum in many nations. Despite the reported physical and psychological sequelae of the practice, typically only medical professionals are sought to provide expert testimony in immigration court (IC). However, with growing recognition that licensed mental health professionals (LMHPs) can offer significant contributions to immigration proceedings, increasingly LMHPs have become involved in conducting psychological evaluations for such cases. This article highlights the key contributions that LMHPs with specialized knowledge and clinical skills can provide during immigration proceedings when evaluating females who have experienced or are at risk for FGM/C, including working with the asylum seeker and her attorney, conducting the evaluation, writing the affidavit, and testifying in IC.

Public Significance Statement
This article discusses the critical contributions licensed mental health professionals can make to immigration proceedings in cases pertaining to females who have experienced or are at risk for female genital mutilation/cutting.

Keywords: female genital mutilation/cutting, asylum seekers, immigration court

The practice of female genital mutilation/cutting (FGM/C) is a human rights violation and illegal in several countries, including the United States (U.S.). Since the precedent-setting Kassindja case in 1996 (Center for Gender and Refugee Studies [CGRS], 1996), FGM/C has been used as grounds for asylum in the United States (CGRS, 1996; Mishori et al., 2021). This type of asylum case requires a woman or girl to prove that she has undergone FGM/C or is at risk if she returns to her homeland. Medical assessments can play an integral role in these cases, but so can psychological evaluations, because FGM/C causes bodily and emotional harm (Knipscheer et al., 2015; World Health Organization [WHO], 2020a).

Even though both medical and psychological assessments can be critical in FGM/C asylum cases, a literature search using multiple databases (e.g., EBSCO, MEDLINE, PsychArticles, PsychINFO, Pubmed, SocINDEX) demonstrates that the only guidelines available for conducting such evaluations are centered on medical professionals (Muñoz et al., 2020; Wikholm et al., 2020). There are no formal written guidelines for licensed mental health professionals (LMHPs), who are increasingly conducting these forensic

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evaluations, authoring affidavits, and testifying in immigration court (IC) as expert witnesses (Barber-Rioja & Garcia-Mansilla, 2019; Evans & Hass, 2018; Frumkin & Friedland, 1995).

This article recognizes the unique contributions LMHPs can and do make to asylum claims based on FGM/C. It also highlights the ways in which LMHPs can expand their clinical and cultural knowledge and skills, beyond a solid understanding of trauma, so they can competently assist individuals who have undergone FGM/C or have fled the practice and seek relief in the context of immigration proceedings.

The authors' interest and expertise on this topic are derived from their combined histories of clinical work and research in public and private hospitals, social service agencies, and private practice in New York City with immigrant females who endured FGM/C or were at risk. In addition, they have trained legal, law enforcement, medical, mental health, and social service professionals on this subject and have conducted and written forensic reports as well as testified in numerous immigration proceedings.

Background

FGM/C is the practice of altering or removing part of the external genitalia of girls and women (WHO, 2016, 2020a), and it is usually performed on girls between the ages of 2 and 15 (United Nations International Children's Emergency Fund [UNICEF], 2020). There are no reported health benefits to FGM/C, and individuals have died from the procedure (WHO, 2020b). Additionally, there can be severe short- and long-term consequences to one's physical health (e.g., blood loss, urinary infections, painful menstruation or sexual intercourse, HIV/AIDS infection) and mental health (e.g., posttraumatic stress distress [PTSD], anxiety, depression; Behrendt & Moritz, 2005; Knipscheer et al., 2015). Domestic violence, rape, and child marriage along with other gender-based abuses also have been associated with FGM/C (Wikholm et al., 2020).

According to the WHO, there are estimated to be over 200 million females globally who have undergone a form of FGM/C (UNICEF, 2016). The practice is concentrated in 30 countries in Africa, Asia, the Middle East, and parts of Central and South America (WHO, 2016) and prevalent in many cultures and ethnic groups. In recent years, with increased global mobility resulting from economic, political, and climate conditions, immigrants from FGM/C-practicing countries have moved to Western countries. In the United States, there are estimated to be more than 513,000 females who have undergone or are at risk of FGM/C (Goldberg et al., 2016).

The WHO has classified FGM/C into four major types. Type I is the partial or total removal of the clitoral glans and the fold of skin surrounding the glans. This is also called clitoridectomy. Type II is the partial or total removal of the clitoris and the labia minora with or without the removal of the labia majora. Type III is the narrowing of the vaginal opening by creating a covering seal from cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoral prepuce/clitoral hood and glans. This is also known as infibulation (WHO, 2020a). Finally, Type IV consists of "all other harmful procedures to the female genitalia for nonmedical purposes (e.g., pricking, piercing, incising, scraping, and cauterizing the genital area)" (WHO, 2020a, p. 2). Types I and II are the most predominant forms of FGM/C, with Type II being the most common among women who applied for asylum in the United States (Lever et al., 2019; Wikholm et al., 2020).

FGM/C as a Basis for Asylum in the United States

U.S. laws relating to asylum and FGM/C are derived from international laws and conventions. Internationally, FGM/C is a human rights abuse based on the International Covenant on Civil and Political Rights, the Universal Declaration of Human Rights, and the Convention on the Elimination of All Forms of Discrimination against Women. In addition, FGM/C violates the International Covenant on Economic, Social, and Cultural Rights (1966), which demands the "highest attainable standard of physical and mental health" (p. 4), and the Convention on the Rights of the Child (United Nations General Assembly, 1989), which states that children have the right to be protected from "all forms of physical or mental violence, injury or abuse" (p. 5). In the United States, the 1952 Immigration and Nationality Act describes the criteria related to the status of refugees or those who face an actual risk of being subjected to serious harm. Asylum officers and immigration judges, also referred to as adjudicators as they decide whether a person's claim is granted or denied, are primarily responsible for implementing asylum laws.

In the United States, the asylum process evaluates the claims of individuals who report leaving their homelands because of past persecution or well-founded fear of future persecution based on race, religion, national origin, political opinion, or membership in a particular social group. An asylum claim based on FGM/C may be supported on various grounds, including gender-based violence and a child-specific type of persecution. It violates the principle of nondiscrimination, as it affects only girls and women, and the rights of girls to be protected against harmful health practices. In addition, due to its short- and long-term health consequences, FGM/C is viewed as a type of torture and a continuous form of persecution (Khosla et al., 2017; WHO, 2016).

Overview of Immigration Proceedings

In the United States, individuals may apply for asylum using one of two primary methods: the affirmative process and the defensive process. Both processes require applicants to be physically present in the United States, and the affirmative process does not apply to people in removal proceedings. The U.S. Citizenship and Immigration Services (USCIS), a part of the Department of Homeland Security, conducts the affirmative process that involves a USCIS adjudication officer reviewing the application and accompanying documents (e.g., medical and psychological affidavits), interviewing the claimant, and deciding whether to grant the asylum application. If an adjudication officer denies an applicant's claim, then an asylum seeker is referred to IC for removal proceedings (United States Citizenship and Immigration Services, 2021). In IC, an asylum seeker may fight the removal proceeding and request asylum using the defensive process. Through this process, an individual files an application with an immigration judge at the Executive Office of Immigration Review in the Department of Justice (Baker et al., 2018). Asylum seekers who arrive in the United States through a port of entry or without inspection usually apply through the defensive asylum process (American Immigration Council, 2020).

Categories of Witnesses

In immigration cases, there are two distinct categories of witnesses: material (or fact) and expert, and both are required to be in the United States legally, although exceptions can be made for certain types of expert witnesses. Material witnesses are individuals who can corroborate the asylum seeker's claim of past persecution or well-founded fear of future persecution. Additionally, this type of witness can often link the applicant's persecution with their membership to a particular gender, racial, religious, social, or political group. These witnesses cannot offer their judgments (Baker et al., 2018; Malphrus, 2010). Expert witnesses with their "scientific, technical, or specialized knowledge" (Malphrus, 2010, p. 1) can give a full range of opinions, including hypothetical ones, and are hired specifically for forensic situations, such as asylum cases. Adjudicators decide whether to admit expert evidence based on three factors: relevancy, qualifications, and reliability (Malphrus, 2010). The central issue about expert evidence is whether it is admitted and how much weight an adjudicator places on the evaluation and testimony when deciding a case. Furthermore, a claimant's lawyer only can call an expert witness to testify in immigration proceedings using the defensive process, not the affirmative process.

Expert witnesses can offer useful guidance to asylum officers and immigration judges. Country experts can provide adjudicators with information about conditions in the claimant's homeland and the likelihood of those conditions changing, as well as the history and treatment of the persecuted group(s) to which the claimant belongs. On rare occasions, the court grants exemptions allowing country experts who are in the applicant's home country to participate in immigration cases; however, this usually lengthens the process and makes it more difficult than using country experts who are in the United States. In FGM/C cases, a country expert can attest to the prevalence of the practice in that country, the most common types of FGM/C, and when it occurs, as well as provide further details about the cultural aspects of the practice. Medical experts can confirm that the claimant underwent FGM/C and describe the physical consequences of the procedure. Mental health experts can help explain an asylum seeker's physical behaviors (e.g., poor eye contact), cognitive issues (e.g., gaps and inconsistencies in testimony), and emotional functioning (e.g., anxiety, depression, relational issues), resulting from undergoing or being at risk of FGM/C. These experts and their reports can play a critical role in asylum cases because they can personalize and strengthen claimants' cases and help adjudicators distinguish one person's claim from another's (Malphrus, 2010).

The Psychological Evaluation

Research suggests that asylum cases tend to be more successful when they include a psychological evaluation (McLawsen et al., 2011). Given the increasing number of asylum seekers, there is a growing body of literature highlighting the factors LMHPs must consider when conducting forensic psychological evaluations for the immigration process (Barber-Rioja & Garcia-Mansilla, 2019; Evans & Hass, 2018; Filone & King, 2015; Huminuik, 2017; Prabhu & Baranoski, 2012). Ultimately, the goal of conducting these evaluations is to document evidence of emotional trauma(s), to record the impact of the traumatic event(s) on an asylum seeker's psychosocial functioning, and to organize the data gathered in order to provide "an independent, neutral, objective evaluation of the relevant psycholegal question at hand and to share that information with the attorney" (Evans & Hass, 2018, p. 13).

While the emphasis of the encounter is rightly focused on the actual evaluation and the resulting affidavit, the LMPH must be cognizant of the processes that can contribute to or hinder the assessment. Bearing this in mind, such factors are described within the following phases: (a) preparation, (b) clinical interview, (c) affidavit, and (d) testimony in IC. This phased approach is informed by the combined experiences of the authors and their work on conducting this type of forensic assessment for FGM/C asylum seekers. In the next section, the steps involved in each of these four phases are outlined.

Phase 1: Preparation

Referrals for this type of forensic evaluation come from various sources, including immigration attorneys, immigration judges/adjudicators, and community members. Prior to the first contact with the client, it is recommended that LMHPs gather information from the referring source about the client, including basic demographic data (e.g., age, country of origin); availability of any existing documents, such as previous medical reports confirming the claimant underwent FGM/C and past psychological evaluations; deadlines by which the affidavit is needed; the next court date, if available; and whether the LMHP is required to testify (in person, telephonically, or online). In addition, the LMHP needs to know the asylum seeker's primary language and proficiency in other languages to determine whether a professional interpreter is required to conduct the assessment, or the referring attorney needs to find an LMPH proficient in the same language(s) as the claimant. In sum, during this phase, the LMHP's goals are to gather specific information about the claimant and to clarify their role and the format of the evaluation to the referral source as well as to the client.

With ongoing health and safety concerns brought about by the COVID-19 pandemic, there has been a significant shift from in-person, face-to-face sessions to telemental health (Bayne et al., 2019; Zhou et al., 2020). To reduce the burden of service delivery and to ensure the safety of all parties, many LMHPs now utilize the telephone and/or secure online platforms to conduct these evaluations. A 2013 comparison of face-to-face and internet evaluations concluded, "Telemental health is effective for diagnosis and assessment across many populations (adult, child, geriatric, and ethnic) and for disorders in many settings (emergency, home health) and appears to be comparable to in-person care" (Hilty et al., 2013, p. 444). The decision to incorporate telemental health into an evaluation for IC must take into consideration several factors, including whether the client has access to the necessary technology to ensure a secure online platform and to a private, secure space in which she can sit for a remote interview.

Phase 2: Clinical Interview

Unlike medical professionals, who perform physical examinations to assess FGM/C claims (Mishori et al., 2021), psychological evaluations conducted by LMHPs rely on detailed clinical interviews. By adopting a trauma-informed approach, the LMHP creates a therapeutic alliance, establishes a sense of security, and builds trust, to avoid retraumatization and the potential ensuing sense of shame. The LMHP functioning in this role seeks to gather life history, including past and present stressors, comorbid factors,

and changes in levels of functioning because of the FGM/C experience. When conducting an evaluation, the LMHP must also consider the influence of developmental factors (e.g., age at which the procedure occurred) and cultural factors (e.g., the rationale for the procedure, circumstances under which the procedure took place). Furthermore, a significant portion of the interview must be specifically directed to the reported experience of FGM/C (or efforts to flee from the practice) and the consequences of FGM/C on the individual's psychological, emotional, and behavioral functioning. Thus, the LMHP's knowledge of FGM/C and comfort with talking and hearing about the procedure can facilitate building a strong working alliance with the asylum seeker. This alliance is pivotal to obtaining and interpreting the often emotionally charged data required for an accurate and comprehensive assessment.

The types of referrals for psychological evaluation of FGM/C cases in IC fall within one of three categories: (a) females who have experienced FGM/C; (b) those who underwent FGM/C at such a young age (2 weeks–4 years) that they may have minimal to no memory of the actual experience; and (c) individuals seeking asylum because they are being forced to undergo the procedure by their family or community, or parents who fear that their female child(ren) will be cut. LMHPs who conduct these assessments should have a clear understanding about which category their client falls into during the preparation phase, and based on that information, they should incorporate the following area of exploration into their clinical interviews:

1. crucial inquiries to be included in the clinical interview of an FGM/C client who reports experiencing FGM/C, has recollection of the procedure, and is struggling with physical and psychosocial consequences (see Table 1);
2. key questions to consider when interviewing an individual who underwent FGM/C at an early age and has little to no memory of the procedure (see Table 1); and
3. areas of exploration when evaluating asylum seekers who are forced to undergo the procedure by their family or community or parents who fear that their female child(ren) will be cut (see Table 2).

Table 1
Clinical Interview Recommendations for Asylum Seekers Reporting FGM/C

Topic	Recommended interview questions
Recollections of the procedure	– What was the procedure called in your country or among your ethnic group? This is important to know as many do not use the term "FGM/C." – At what age were you cut? Do you recall being cut? Did you learn about it from others? – Where did the procedure occur (e.g., urban vs rural, home vs hospital)? – Who was the decision maker? Even though research indicates the decision makers are usually family matriarchs, it is important to gather as much information about who took her to undergo the procedure. Questions assessing whether key family members were reluctant or insistent about the procedure can provide invaluable information about the pressure the female or her family was under to have the procedure. In some cases, a potential suitor or his family may have been the decision maker. – Who was directly involved in the procedure? Was it a surprise? Did you feel betrayed by close family members (e.g., mother, respected elder, family matriarch)? – Who conducted the cutting (e.g., community member, member of a traditional women's society [TWS], medical professional)? – How was the procedure conducted? Was it part of a rite of passage ceremony? – Who else was present? If the female is from a culture in which TWS play a role in the practice of FGM/C, such information can be critical. Among members of a TWS, FGM/C is part of an initiation process and there is much secrecy surrounding the issue. In such cases, the procedure is usually performed for a cohort of girls, creating the bonds of a sisterhood. – Did you go through the process alone or in a group? If you were part of a group, did you or anyone else in the group develop complications? If so, what were they and how were they handled? If the procedure was part of a TWS, was there any related traditional scarification? If so, where on the body? – Any recollections of what tools were used? – How many times were you cut? If you were cut more than once, when and what explanation was provided? – Were you forewarned? Had the procedure been discussed? Often there is a surprise element which can create a sense of betrayal. – What was your experience of the procedure? Were there any complications? If so, how were they handled? – What social, medical, or psychological resources were available to you for healing after FGM/C (e.g., traditional herbs to stem blood flow)? – Were there any celebrations or gifts after the procedure? – Have other family members undergone FGM/C? – Have any family members or friends had any severe reactions (e.g., excessive bleeding, infections, or death) to the procedure in the past? – Were there any additional events (e.g., getting married immediately after the procedure) during the procedure that made your circumstances unique? – Have you experienced any significant traumatic events in your life?
Cultural components related to FGM/C	– How common is the practice within your cultural or religious group? – What explanations were provided for FGM/C within your culture (e.g., celebrating entrance into womanhood, hygiene, maintenance of purity, religious beliefs)? – Has anyone in your family or community ever rejected the practice? What has happened to females or their families who have rejected the practice? How does your family, community, or society look upon women and girls who have not been through FGM/C? What type of backlash (e.g., being called names (i.e., "blakoro"), being ostracized) have you witnessed or heard about?

(*table continues*)

Table 1 (*continued*)

Topic	Recommended interview questions
Impact on Physical/ Reproductive Health	– Have you ever had an OB-GYN exam? – Did your OB-GYN discuss any health issues related to the practice, including infections, difficulty urinating, genital ulcers, urinary tract infections, or the accumulation of menstrual blood? – Did your OB-GYN share concerns about the impact of this procedure on your reproductive health?
Reproductive health concerns	– Do you have a history of reproductive health concerns? If so, what was the explanation given and how have they been addressed in the past? – Do you remember having any medical complications after the procedure? – Did you need medical attention after the procedure? If yes, who provided the treatment? Were you taken to a medical facility or back to the circumciser for the care? – Do you have children? Tell me about your experience(s) of childbirth. – If you want children and have been unable to have them, has your OB-GYN discussed any possible correlations between your difficulty having children and having undergone FGM/C?
Sexual functioning and sexual relationships	– Have you ever had any difficulties with sexual intimacy? – When did you first become aware of these difficulties? – How would you describe your sexual desire/satisfaction? – Have you and your partner ever discussed any issues related to sexual intimacy? – How has your partner responded to you having had the procedure and to discussing sexual consequences from it?
Mental health functioning	– How has the procedure affected you? How often do you think about the experience? – Can you describe any additional factors related to the practice that are causing you distress? – If you had been given a choice to have the procedure or not, what would you have wanted? – Do you have daughters? Would you consider having them undergo FGM/C?

Note. FGM/C = female genital mutilation/cutting; TWS = traditional women's society; OB-GYN = Obstetrician/Gynecologist.

The questions provided in Tables 1 and 2 are not exhaustive and are meant to serve as guides. LMHPs should use their clinical judgment, ask questions in a flexible way that is suited to their own style, and add questions as they see fit.

Active listening and observing are essential when conducting a clinical interview. It is important to listen to what an asylum seeker says and how she says things, especially related to undergoing or being at risk of FGM/C. An LMHP must be an active and critical listener, particularly when assessing individuals who have experienced traumatic event(s), because trauma narratives are often difficult to follow, incomplete, and might appear to be illogical or incomprehensible. An LMHP's observational skills are also important, as attention needs to be focused on an individual's nonverbal behaviors throughout the forensic evaluation. A clinician's observations of a client's eye movement, such as averting her eyes when talking about difficult material and noticing signs of dissociation. A client's physical activity may indicate when she becomes anxious (e.g., shaking leg, fidgeting, placing something on her lap).

Gaining insight into the client's perspective is also a key component during the evaluation. For example, what terms does this client use to describe the procedure? Does she consider herself to be mutilated or does she take pride in having undergone the procedure? What are her thoughts about the procedure for her daughters if she has any? If she is in a sexual relationship, how has her partner reacted to this experience? What is her perception of how the procedure has impacted sexual functioning and intimacy?

Table 2

Clinical Interview Recommendations for Asylum Seekers Reporting Fear of Being Forced to Undergo FGM/C Against Their Will or Are Fearful for Their Female Child(ren)

Topic	Recommended interview questions
Personal experiences	– Was the individual forced to undergo the procedure (if so, go to Table 1)? – Have their other female children experienced FGM/C? – Have other family members undergone FGM/C? – Have any family members or friends had any severe reactions to the procedure in the past (e.g., excessive bleeding, infections, or death)? – Has anyone in their family or community every rejected the practice? What happens to females (or their families) who have rejected the practice? How does their family, community, or society regard women and girls who have not been through FGM/C? What type of backlash have they witnessed (e.g., called names (*blakoro*), being ostracized)?
Cultural components related to FGM/C	– Rationale proffered for the procedure (e.g., religious, cultural, TWS) within the individual's culture? – How common is the practice within the female's cultural or religious group? – What explanations are provided for FGM/C within their culture (e.g., celebrating entrance into womanhood, hygiene, maintenance of purity, religious beliefs)?
Protections	– Are there any laws in that country regarding FGM/C? – If so, is there any real enforcement of the laws?

Note. FGM/C = female genital mutilation/cutting; TWS = traditional women's society.

Use of Standardized Measures During the Clinical Interview

There are numerous reliable and valid measures designed to capture trauma-related symptoms, such as PTSD, anxiety, or depression, which can be used with caution to assess the mental health of asylum seekers (Baranowski, 2020; Evans & Hass, 2018). Many females seeking asylum based on FGM/C may not be native English speakers and/or may have low levels of education or lack formal education. Furthermore, many standardized measures have been developed for and validated on Western populations (Reynolds & Suzuki, 2013) and may be inappropriate for this population. Thus, in determining whether to include structured, standardized psychological measures, LMHPs should consider the "linguistic, cultural, socioeconomic, and educational diversity" (Smith et al., 2015, p. 249) of this population. If the decision is made to incorporate such measures, LMHPs should include the test results as supplements, to complement the clinical interview rather than providing definitive contributions.

Phase 3: Affidavit/Written Report

Upon completion of the clinical interview, LMHPs summarize their encounter in the form of an affidavit, a sworn written document of their findings that may be used at the discretion of a client's attorney (Scruggs et al., 2016). Thus, the next steps involve providing a written report in the form of a legal affidavit to the client's legal team and making oneself available to review the findings with them and the client (see Table 3).

The current psychological research typically focuses on a narrow set of consequences related to FGM/C, such as PTSD, anxiety, depression, sleep disturbances, chronic pain, and memory difficulties (Behrendt & Moritz, 2005; Burrage, 2016; Knipscheer et al., 2015; Lever et al., 2019; Mulongo et al., 2014; WHO, 2008). LMHPs are encouraged to look beyond this constellation of symptoms and bear in mind that psychological symptoms, such as anger, shame, social withdrawal, and problems with self-esteem, have also been observed (Burrage, 2016; Knipscheer et al., 2015; Lever et al., 2019; Mulongo et al., 2014). Furthermore, as mentioned earlier, research findings have noted that some females seeking asylum on the

Table 3
Key Elements to Include in an Affidavit (Psychological Report) for an FGM/C Asylum Seeker

Section	Suggested content
Clinician's qualifications	– Provide LMHP's relevant work experiences, training, and license held. – Evidence of expertise to conduct the evaluation and provide expert opinions regarding FGM/C and its impact.
Identifying information/reason for referral	– Basic demographic information about the client (e.g., age, marital status, country of origin, ethnic group, religion), referral source and reason for the evaluation.
Conditions of evaluation	– Circumstances of the evaluation, where conducted (e.g., location, who was present, was an interpreter used, in person or via video platform) and all disclosures made to the client about the purpose of the evaluation and who will have access to the information gathered.
Sources of information	– Discuss additional sources of information (e.g., standard measures of trauma, medical reports or country reports regarding FGM/C practices or prevalence rates from reliable sources such as WHO or UNICEF reviewed to supplement client's account).
Background information	– Background information to address key aspects of the individual's history including those listed below: Personal/Developmental history Educational history Employment history FGM/C experiences and impact Mental health history Medical history Relational history Substance use history
Current clinical functioning/Behavioral observations	– Mental status evaluation (e.g., general appearance, rapport, eye contact, motor activity, speech, mood and affect, thought content, suicidal and homicidal ideation, cognitive exam).
Psychological test results (if measurements administered)	– Description of measures and findings. – Discuss validity and reliability issues, language and reading issues.
Summary/Opinion	– Summarize and provide an opinion on the consistency among the various sources of data gathered in the evaluation process (e.g., clinical observations, psychological functioning. medical and/or country report, results of diagnostic tests, stressors, such as loss of family). – Provide opinion on individual's claim of having experienced FGM/C and/or being at risk of the procedure if she returns to her country of origin based on the data collected and on the clinician's past experience with such cases. – Include recommendations for further assessments and/or care for the individual.
Diagnostic impression (*Diagnostic and Statistical Manual of Mental Disorders, fifth edition, Test Revision*)	– Provide diagnostic impressions of the individual in a manner that is accessible to non-mental health professionals. – Include and support the individual's diagnosis or diagnoses.

Note. FGM/C = female genital mutilation/cutting; LMHP = licensed mental health professional; WHO = World Health Organization; UNICEF = United Nations International Children's Emergency Fund.

grounds of FGM/C have experienced cooccurring gender-based violence, including forced marriage, torture, child marriage, rape, and intimate partner violence (Akinsulure-Smith & Chu, 2017; Center, 2016; Wikholm et al., 2020). It is also important to recognize that for others, FGM/C has affected sexual and spousal relationships, created sexual issues (e.g., diminished satisfaction and desire, painful intercourse), caused shame around sexual intimacy, and produced reproductive and childbirth difficulties (Berg & Denison, 2012; Burrage, 2016; Elnashar & Abdelhady, 2007).

Integration of Relevant Supporting Documents

For a variety of reasons, it may not always be possible to access corroborating information, but given that there are physical consequences to FGM/C, it may be useful to review a medical report that provides conclusive evidence of FGM/C and documents the type of cutting. These reports can also offer additional support to the psychological evaluation. In some instances, such information would be helpful to understand the individual's level of distress.

Phase 4: Testimony

The LMHP should clarify with the attorney as early in the process as possible whether they are expected to testify in IC. Beyond knowing the date and time of the hearing, LMHPs should find out whether they are expected to testify in person, telephonically, or via a video online platform. Whenever possible, it is always useful to meet with the attorney to review their intended questions. It is important to remember that when testifying, the focus should be on the client's presentation and symptoms (e.g., Are they consistent with others the LMHP has evaluated with similar history?). In addition, for LMHPs who have never testified before, talking with other professionals who have about their experiences can help allay fears and concerns.

Usually, the LMHP has no further communication with their client after testifying and will not know the outcome of the case unless the claimant or her attorney contacts the evaluator with this information. There are a few instances, however, when the LMHP may have contact with the asylum seeker after testifying. In rare instances, the FGM/C asylum seeker's case may continue for several years, and her attorney may ask the LMHP to conduct another assessment. After asylum cases are decided, some LMHPs may start to treat former claimants in therapy. This situation can arise when the LMHP, who conducted the evaluation and testified, works for an organization (e.g., social services, hospital) that can offer therapy to the former claimant.

Factors That Might Impede the Evaluation Process

As noted by Dignam (1992), there are many factors that might inhibit the asylum seeker's ability to provide information to the professional conducting their evaluation, to their attorney, and to the court during their testimony. An understanding of such factors is particularly key with this population. Researchers and practitioners in the field have argued that given the increasingly taboo view of FGM/C, particularly in the West, issues related to sexuality, and membership in a Traditional Women's Society (TWS; 28TOOMANY, 2014; Williams, 2020), can make it difficult for women who are seeking asylum on the grounds of FGM/C to openly share or discuss their experiences. A myriad of factors that may influence an individual's willingness to disclose her experience have been identified. Often, asylum seekers are hesitant to share their experiences because they fear negative consequences for breaking the secrecy oath taken during their initiation into TWSs and undergoing FGM/C. They may also be concerned about bringing shame to their community for talking about FGM/C and possibly be ostracized for their actions. The women may experience shame for being "different" and expect LMHPs and immigration adjudicators to negatively judge them. The clients may have had unpleasant experiences with service providers (e.g., medical doctors, LMHPs), who treated them as curiosity objects rather than human beings and do not want to reexperience the feelings associated with those encounters. Finally, females who have undergone FGM/C after arriving in a country where FGM/C is illegal may be reluctant to speak about their experiences for fear of creating legal issues for their parents or guardians (Akinsulure-Smith et al., 2018, 2021; Käkelä, 2021).

In addition, those who experienced FGM/C during infancy may be unable to retrieve specific memories. Further challenges, such as a deep sense of shame due to widely held negative and punitive attitudes in the West about the practice, may serve as an additional deterrent to discussing their experiences for others (Johnsdotter, 2018; Johnson-Agbakwu & Manin, 2021; Kaplan et al., 2019; Lien & Schultz, 2014). Finally, it is important for LMHPs to remember that as with any traumatic event, the response to the experience of FGM/C is varied and the willingness to discuss the experience can also be so, and avoidance is a common coping mechanism among survivors of trauma. This variability has been noted and discussed by Vloeberghs et al. (2012) who classified survivors of FGM/C into three categories: (a) adaptives (women overcoming their FGM/C experience and were able to discuss); (b) disempowered (those feeling angry and defeated, refused to discuss their experiences and left feeling ashamed, alone and disempowered); and (c) traumatized (women experiencing pain, sadness, chronic stress, traumatic symptoms). A survivor of FGM/C may exhibit the characteristics of one or more of these groups.

As discussed earlier, other factors that can hinder the evaluation process include marital status and marital expectations. Some justifications of the practice revolve around reducing the women's sexual sensitivity and making them marriageable. Previous research has suggested that females who have been subject to the practice tend to experience less sexual orgasm, less satisfaction, and less sexual arousal and desire (Berg & Denison, 2012). These consequences can lead to an extreme fear/refusal of intimacy for woman who experienced FGM/C. Consequently, such issues can result in other types of abuse (e.g., severe physical and sexual abuse) perpetrated by intimate partners and/or family members who expect women to meet their marital obligations, including sexual obligations, to satisfy their intimate partners (Sanctuary for Families, 2013).

The LMHP Experience During This Process

FGM/C is a highly controversial topic and can give rise to many emotions. Given the ongoing debate surrounding the practice, including the opinions supporting the practice (Ahmadu, 2000; Oba, 2008) and against it (Nour, 2015; WHO, 2016), along with

the view of the practice as a human rights violation (Khosla et al., 2017; WHO, 2020b), a neutral and objective stance by LMHPs performing such evaluations is paramount. At the same time, because of the profound cultural component of this practice, LMHPs must work hard to understand and locate the individual within "the context of family, community, and culture" (Frumkin & Friedland, 1995, p. 477), as these are key components that have maintained the practice of FGM/C (UNICEF, 2016; WHO, 2020b).

Despite the effort to maintain this neutral and objective stance, conducting asylum evaluations can and does elicit a myriad of powerful emotions, with professionals variously calling the experience rewarding, gratifying, difficult, and harrowing, as well as acknowledging that it can elicit vicarious trauma/compassion fatigue reactions (Baranowski et al., 2018; Mishori et al., 2018). Given the contentious nature of FGM/C, it is particularly important that LMHPs pay close attention to their own reactions while conducting such evaluations. While some might think "never in my country," it might surprise LMHPs to learn there is an unsavory history of this practice in the West. Medicalized FGM/C was first reported in *The Lancet* in 1826, in an article entitled, "Case of idiocy in a female, accompanied with nymphomania, cured by the excision of the clitoris." As highlighted in the article, "the excision of the clitoris has been recommended by Professor Dubois as a remedy in nymphomania; this operation was resorted to with success by Dr. Graefe of Berlin" (The Lancet, 1826, p. 420). In fact, between 1890 and the 1930s, the clitoris was removed in the treatment of some cases of psychoses and neuroses in the United States (Rodriguez, 2014). In the United States, the practice of FGM/C gradually died out in the 1950s, but articles continued to be published in medical journals and popular magazine even into the 1970s. Medicalized FGM/C continued into the 1970s, as evidenced by the insurer Blue Cross Blue Shield covering clitoridectomies (Robinett, 2006).

It is imperative that LMHPs can recognize and reflect on their own stereotypes surrounding FGM/C. For example, often there is an assumption that the practice happens primarily within the sub-Saharan African cultural context. However, the reality is that FGM/C is a global issue practiced in the Middle East, Asia, and parts of Central and South America (UNICEF, 2016). This article has focused on the assumption that the individual seeking asylum based on FGM/C is female because this practice is linked to gender. There are, however, cases in which parents sought asylum on these grounds after fleeing their country because they refused to allow their daughters to undergo the procedure. The authors have never encountered nonbinary or transgender men who experienced FGM/C and were seeking asylum. However, it is possible that a nonbinary or transgender man underwent the procedure when they were children. These individuals can apply for asylum based on various grounds.

While the use of language is a critical element for those who might not speak the language of their client, it is beyond the scope of this article to provide details about using interpreters in such cases. However, there is significant literature about the appropriate and sensitive use of interpreters when working with forced migrants. Most importantly, in such cases, a professionally trained interpreter should always be used (O'Hara & Akinsulure-Smith, 2011; Paone & Malott, 2008). Ideally, a female interpreter should be used when conducting a psychological evaluation of an individual who has experienced or is at risk for FGM/C, and this interpreter should be debriefed afterward.

Finally, although there are no guidelines for LMHPs specific to FGM/C, whether the individual is licensed in social work, counseling, psychology, or psychiatry, it is the professional responsibility of all LMHPs who seek to contribute to immigration proceedings to ensure that they fully comprehend all related specialty guidelines and ethical codes of conduct in their respective fields. Specifically, the National Association of Forensic Counselors has maintained guidelines of Ethical Standards and Code of Conduct (AFFILIATES, A. B.), the American Academy of Psychiatry and the Law also provides Ethical Guidelines for the Practice of Forensic Psychiatry (American Academy of Psychiatry and the Law, 1991). Psychologists providing services in IC should become familiar with the American Psychological Association's (APA) Specialty Guidelines for Forensic Psychology (American Psychological Association [APA], 2013); the APA's Guidelines on Multicultural Education, Training, Practice, and Organizational Change for Psychologists (APA, 2003); and APA's Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations (APA, 2008). Finally, in the field of Social Work, the National Organization of Forensic Social Workers has maintained a Code of Ethics for its members since 1987 (Butters & Vaughan-Eden, 2011).

Conclusion

By mid-2022, it was estimated that 103 million people across the globe had been forced to flee their countries due to persecution, conflict, violence, and human rights violations. Of this number, 4.9 million were asylum seekers (United Nations High Commission on Refugees, 2022). Among the reasons for fleeing and seeking asylum are gender-specific issues such as FGM/C (Akinsulure-Smith & Chu, 2017; Wikholm et al., 2020). Increasingly, women and girls who have been forced to undergo FGM/C or are at risk for the procedure are seeking asylum in Western countries (Käkelä, 2021; Lever et al., 2019; Middelburg & Balta, 2016; Wikholm et al., 2020). Even though studies have repeatedly documented the psychological impact of FGM/C (Knipscheer et al., 2015; Mulongo et al., 2014), much of the literature focuses on the physical impact and the key contributions by medical professionals to immigration proceedings. Increasingly, there has been recognition of the critical contributions LMHPs make, not only in providing service and treatment but also in immigration proceedings when FGM/C is a ground for asylum. While research priorities for addressing FGM/C have been outlined (Atkinson et al., 2019), and there have been efforts to raise awareness among mental health service providers (Akinsulure-Smith & Sicalides, 2016), to date, there have been no efforts to prepare LMHPs to contribute to immigration proceedings. As the number of cases of FGM/C seeking asylum in the United States continues to rise, more LMHPs must be able to provide competent and culturally informed evaluations. Ultimately, the aim of this article is to provide a foundation for this work. Our hope is that these interim guidelines will continue to develop as the research in this field evolves.

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