Challenges and Opportunities for Forensic Mental Health in Immigration Courts

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Persons residing in the United States face a daily barrage of polarizing political messages about the increasing influx of refugees and other immigrants. Political wrangling aside, forced immigration constitutes a nearly world-wide pattern with global estimates of forcibly displaced persons set to exceed 120 million by the end of 2024.[2] The number of international migrants in the United States surpassed the combined counts for the next four countries by mid-2020 (i.e., Germany, Saudi Arabia, Russia, and United Kingdom[3]). Resultingly, the southern U.S. border has received a dramatic increase in migrant encounters (i.e., apprehensions and expulsions), reaching an all-time high during December 2023 at nearly 250,000.[4] The influx of foreign-born persons within the broader sociopolitical context of U.S. immigration policy and rhetoric threatens to overwhelm justice and social systems.

Rhetoric aside, the faces of America are literally, as well as figuratively, changing. In the 1970s, America was focused inwardly, with fewer than five percent of its population being foreign born.[5] Within five decades, those born in another country more than tripled (15.6% or 51.6 million persons[6]), with undocumented immigrants exceeding 10 million.[7] Beyond the literal changes, the seemingly homogenous American society of the 1970s has undergone profound changes in response to globalization[8] and been fueled by exponential increases in forced migration under ongoing threats of violence.[9]

As expressed in its title, this editorial is organized into challenges and opportunities that often represent contrasting facets of the same complex set of concerns. Of its four sections, the first provides a brief overview of the legal questions and processes commonly encountered in immigration courts. The second summarizes three formidable challenges facing forensic psychiatrists and psychologists, specifically the development of evaluation-related legal and empirical knowledge, the adaptation of traditional evaluative methods for immigration referrals (e.g., addressing culture and individual factors), and the risk of retraumatization and vicarious traumatization during evaluations. The third section centers on two major strengths of forensic practitioners, including their expertise with complex traumas as well as their specialized knowledge of response styles, such as malingering. The fourth and final section summarizes concluding thoughts and ongoing opportunities for forensic practitioners.

Legal Questions and Processes

Mercado and colleagues[10] assembled a total of 16 psycholegal questions that can be raised in

The authors note that parts of this editorial were adapted from a much larger review of immigration courts.[1]

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immigration courts. Most commonly, asylum evaluations determine whether asylees have a well-founded fear of past or future prosecution based on one or more categories: "race, religion, nationality, membership in a particular social group, or political orientation" (Ref. 10, p 256). Assessments of trauma and torture also figure prominently among the common psycholegal questions, along with human trafficking (T visa); violent victimization, such as sexual assault (U visa); and extreme battering after a marriage to a U.S. citizen or permanent resident (Violence Against Women Act or VAWA).[11] Additionally, immigrants convicted of U.S. crimes may file for relief under Article 3 of the United Nations Convention against Torture to withhold or delay their removal.[12]

Assessments of dangerousness and recidivism can include evaluations of moral turpitude, need for detention or parole because of heightened risks, or safety for being removed from detention or parole because of effective rehabilitation. In addition, civil competency typically involves the ability to proceed without legal representation (i.e., *pro se*) in immigration proceedings. Regarding disability, Medical Certification for Disability Exceptions (N-648) may exempt immigrants from certain naturalization requirements in applying for citizenship.[13]

Adolescents have additional protections that may require evaluation,[14] such as whether deportation serves the best interests of the youthful immigrant (Special Immigrant Juvenile Status or SIJS). Additionally, the psychological welfare of unaccompanied minors being held in custody may also be evaluated.

Major Challenges for Forensic Practitioners

Conducting immigration court evaluations presents at least three challenges. First, forensic practitioners must understand and respond accordingly to the legal criteria stipulated in immigration court referrals. Second, they must adapt assessment methods to consider salient cultural factors (e.g., language differences and acculturation). Third, trauma-related needs of examinees (e.g., minimize retraumatization) and evaluators (e.g., minimize vicarious traumatization) should be prioritized. Each challenge is explored, including recommendations for forensic practitioners.

Legal and Empirical Knowledge

As noted, diverse referral questions may be evaluated during immigration proceedings. In criminal contexts, forensic practitioners are likely familiar with most referral questions and their associated case law, and have successfully completed specialized training. Contrastingly, practitioners often lack familiarity with the legal standards for immigration-related referral questions and have limited empirical resources to guide evaluations.[1] In criminal courts, competency to stand trial (CST) represents the most common referral. It has been heralded as "the single most important issue in the criminal mental health field" (Ref. 15, p 168), with yearly estimates as high as 94,000 evaluations.[16] Among the empirical advances, specialized forensic assessment instruments (FAIs) have been validated to address the CST legal criteria: Evaluation of Competency to Stand Trial-Revised (ECST-R)[17] and the MacArthur Competence Assessment Tool-Criminal Adjudication (MacCAT-CA).[18]

For immigration courts, no estimates for competency evaluations are known. Regarding empirical advancements, the development of FAIs is in its infancy with a single dissertation.[19] The existing body of research for asylum evaluations, the most researched for immigration courts, remains very small with 36 published studies.[1]

Forensic practitioners conducting immigration evaluations should thoroughly review relevant case law. As a primary resource, appellate decisions by the Board of Immigration Appeals (BIA; see https://www.justice.gov/eoir/ag-bia-decisions) may be consulted directly. For the empirical literature, several scholarly reviews are readily available.[20,21] These reviews orient forensic practitioners to immigration-related legal standards and associated clinical methods. Relevant editorials include the professional roles of forensic psychiatrists[22] and the importance of mental health evidence in immigration courts.[23]

Franco Class

Evaluators for immigration courts should develop an understanding of its legal landscape and recent developments. Importantly, the 2013 *Franco-Gonzalez v. Holder* lawsuit[24] changed immigrants' protections in California, Arizona, and Washington with potential plans to apply the protections nationally.[25] Given the civil nature of immigration proceedings, respondents are not necessarily entitled to representation. Understandably, this raises concerns regarding *pro se* (i.e., self-representation) competencies for persons with severe mental illness and cognitive impairments. Eligible members, known as the "*Franco* class," are now entitled to representation by a qualified

representative in these three U.S. states. The legal basis for this decision was drawn from Section 504 of the Rehabilitation Act, which prohibits discrimination against qualified persons with a disability and ensures the implementation of reasonable accommodations. Here, "qualified individuals with disabilities" are persons with a "physical or mental impairment which substantially limits one or more major life activities" (Ref. 26, p 1). Notably, this lawsuit was the first to rely on the Rehabilitation Act concerning the right to counsel.[25]

The diagnostic basis for membership in the *Franco* class is relevant to forensic evaluators. Examinees with cognitive or intellectual impairments or active psychiatric symptoms may be eligible. In addition, six diagnoses may result in eligibility for *Franco* class membership: psychosis or a psychotic disorder, bipolar disorder, schizophrenia or schizoaffective disorder, major depressive disorder with psychotic features, dementia or a neurocognitive disorder, or moderate, severe, or profound intellectual developmental disorder. Finally, if the presiding immigration judge finds a *bona fide* doubt of competency, main class membership may be granted.

Evaluations Integrating Cultural Factors

Cultural humility and cultural competence are essential for working with diverse clinical and forensic populations.[27] Cultural humility is theorized as an ongoing learning process whereby practitioners approach examinees with clear intentions to value their culture and associated beliefs, customs, and norms. Cultural competence is based more on training experiences focused on cultural awareness (i.e., navigating the effects of one's own culture for clinical work) and cultural knowledge (i.e., learning to identify distinguishing cultural factors). These combine to enhance cultural skills, including the ability to gather clinical data using culturally validated methods.[27] Forensic practitioners must deepen their knowledge of culture-specific impacts on clinical presentations as part of "an ongoing process of learning, not only with the goal of developing a better understand of others' cultures, but also with the goal of understanding the limitations of one's expertise" (Ref. 21, p 258).

Adaptations

Forensic practitioners need to implement adaptations, often with translations, to address many evaluations conducted for immigration courts. Importantly, practitioners must be mindful of the challenges associated with using interpreters.[28] An evaluator's use of legalese and specialized terminology may present challenges to translations and cross-cultural understandings. Clear and parsimonious communication becomes a clear priority.[29,30] Interpersonal dynamics between the interpreter and examinee may include difficulties developing rapport or, at the other end, an overidentification with the examinee resulting in biased interpretations.[31,32] A practical step toward improved outcomes includes the use of certified court interpreters (see National Center for State Courts Interpreter Database; https://www.ncsc.org/consulting-and-research/areas-of-expertise/language-access/vri/national-interpreter-database) whose training is geared toward the reduction of interpreter-caused communication errors.

Empirical efforts have been devoted to the integration of cultural variables in clinical and forensic evaluations.[33–36] Evaluators must make pivotal decisions regarding if or how to utilize standardized methods in immigration evaluations. Assessment research is overly reliant on Western, Educated, Industrialized, Rich, and Democratic (WEIRD) samples, threatening the generalizability, among other metrics, to immigration evaluations.[37]

One option is to reduce the linguistic load by utilizing nonverbal measures,[21] such as for intelligence (the Comprehensive Test of Nonverbal Intelligence-Second Edition; CTONI-2[38]). Importantly, the elimination of language barriers in psychological testing is, at best, a minimal solution. Other cultural considerations become essential during the administration and interpretation of nonverbal testing to reduce detrimental inaccuracies.[30] For instance, malingering measures include several nonverbal tests with highly consequential classifications. In summary, evaluators should be wary of inflated confidence in nonverbal testing results simply because verbal communication was not the primary mode of administration.

Trauma and Vicarious Trauma

Immigration evaluations hold multiple risks of trauma, including both the perils of retraumatizing immigrant examinees and the accumulated risks of vicarious trauma to evaluators. Trauma-informed care describes tailored treatment that accounts for the individual circumstances of trauma experiences and the resulting behavioral, cognitive, and affective

dysfunction. As subsequently addressed in more detail, immigration stressors occur at premigration, migration, and postmigration stages.[39] Professional care during the forensic evaluation should minimize the risks of overwhelming distress resulting from recounting and possibly reliving past traumatic experiences. A "trauma-informed lens" including adequate compassion "is not only ethical, but also likely to enhance data quality" (Ref. 40, p 226). Guidelines for screening and evaluating trauma are readily accessible to practitioners via the Center for Substance Abuse Treatment.[41] Recommendations include clearly explaining the purposes of trauma-related questioning before it begins and allowing examinees sufficient time to process the questioning, both cognitively and emotionally. To limit intrusions of privacy, the scope of questions should be focused on diagnoses and clinical formulation.

From a trauma-informed approach, forensic assessments can implement several precautions. For example, they can address the power imbalances inherent to evaluations.[40] On this point, forensic practitioners can use the informed consent process to communicate respect for examinees and outline the safeguards (e.g., noncoercion) afforded to them. Further precautions include demonstrating empathy without sacrificing the objectivity of the evaluation. Even in unambiguous cases of malingering, many examinees have endured severe and repetitive traumas.

Forensic practitioners are at risk for vicarious traumas when evaluating immigrants who have experienced severe trauma that may involve entire multigenerational families. For example, asylee and refugee populations may have encountered the ongoing ravages of war or the continued threats of torture and violence without any viable means of escape. Forensic practitioners who work with severely traumatized populations have increased vulnerability to vicarious trauma, compassion fatigue, and professional burnout, all of which negatively affect evaluators and the quality of their work. Vicarious trauma, also referred to as secondary trauma,[42] describes the "negative psychological, emotional, and cognitive effects that result from hearing about the traumatic experiences of others" (Ref. 42, p 371) with symptoms that may mirror direct trauma exposure (e.g., posttraumatic stress disorder symptoms[43,44]). The effects of vicarious trauma may be particularly serious among evaluators working with children facing severe and inescapable suffering.[45] Compassion fatigue debilitates well-being as a result of empathizing with examinee's hardships and traumatic experiences[43] and has been called "the cost of caring" (Ref. 46, p 558). For professionals, vicarious trauma and compassion fatigue may culminate in burnout primarily evidenced by decreased engagement in work because of ongoing stressors. Early-career professionals and trainees are deeply engaged in the development of their professional identities. During this crucial period, risks of secondary trauma-related dysfunction become even greater as early self-concepts of professional competence are directly linked to emotional well-being.[47]

Obviously, chronic professional exposures to examinees' traumatic experiences should not be neglected. Pirelli *et al.*[43] offered three recommendations for reducing vicarious trauma, compassion fatigue, and burnout. First, relevant risk factors must be identified within the work settings, such as large and emotionally challenging caseloads. Second, the bolstering of protective factors, such as self-care, may mitigate risks. Third, forensic practitioners should proactively seek clinical interventions, including those specific to vicarious trauma, such as Components for Enhancing Clinician Engagement and Reducing Trauma or (CE-CERT).[48] Briefly, the CE-CERT model offers a practical framework for practitioners continuing to work with trauma-exposed clients using five broad components. They include experiential engagement, reducing rumination, creating intentional narratives, reducing emotional labor, and parasympathetic recovery. Clear descriptions of these components are readily available (see Ref. 48, p 154, Table 1 for all components and subcomponents). Addressing vicarious trauma must be a personal as well as professional priority. Forensic reports and their conclusions about immigrant examinees could be directly affected by these concerns if left unresolved.

Expertise of Forensic Practitioners

Trauma

The assessment and treatment of trauma-related psychiatric conditions is likely a strength of many practitioners, particularly those engaged with forensic populations known for substantial trauma rates.[49,50] Still, understanding trauma among immigrant populations requires a holistic conceptualization. Specifically, trauma sources and symptom presentations may differ for those with lived experiences of forced immigration.

Immigrant populations may experience accumulated trauma during premigration, migration, and postmigration stages,[39] resulting in "immigrant trauma."[50] Immigrant trauma is often complicated by co-occurring symptoms of trauma, anxiety, depression, and somatic complaints[51] with increased risk of posttraumatic stress disorder (PTSD). Practitioners must carefully consider stressors that are specific to forced immigration and traumatic stressors that precipitate clinical levels of trauma-related dysfunction.[52]

During the postmigration stage, continued deprivations and prolonged detainments may contribute to severe emotional distress on both authorized and unauthorized immigrants. Notably, immigrant populations have been subject to "anti-immigrant federal and state policies" that impose restrictions on civil and personal freedoms (Ref. 53, p 1). Status-related restrictions include limitations to public services (e.g., health care and education), employment, and associated aspects of daily life. Being housed in U.S. immigration detention centers has also exacerbated negative health outcomes, particularly among detained children.[54,55]

Nosological differences for PTSD should be considered between DSM-5-TR[56] and International Classification of Diseases (ICD)-11.[57] One global survey[58] reported about three-fourths of mental health professionals rely primarily on the ICD system. ICD-11 includes Complex PTSD (C-PTSD), whereas DSM-5-TR does not. Therefore, C-PTSD might be a more precise diagnosis for severely traumatized immigration populations with extensive functional impairments.[59] Both diagnoses share similar PTSD symptoms, but C-PTSD adds three components referred to as "disturbances in self-organization" (DSO).[60] These include difficulties in emotion regulation, negative self-concept, and relationship difficulties. DSO symptom clusters were first described to capture the "pervasive psychological disturbances" that extend beyond PTSD among those with severe and chronic trauma exposures (Ref. 60, p 2). An expert consensus survey from the Complex Trauma Task Force of the International Society for Traumatic Stress Studies (ISTSS)[61] provided valuable clinical data. Beyond traditional PTSD symptoms, trauma experts agreed that affect dysregulation (93%), relationship disturbances (87%), and disturbances in belief systems (e.g., negatively altered self-concept, 76%) were usually or always present among complex trauma survivors with varying degrees of associated impairment.[61] Subsequently, Brewin and colleagues explored the factor structures for PTSD and C-PTSD in ICD-11.[59] They noted that the best-fitting model found PTSD composed of reexperiencing (dreams and flashbacks), avoidance (thoughts and concomitant behaviors), and sense of threat (hyperarousal and startle). DSO factors combine with PTSD to make up C-PTSD. DSO factors included affect dysregulation (hyper- and hypoactivation), negative self-concept (feelings of failure and worthlessness), and interpersonal disturbances (cutting off and avoiding others). Understandably, additional validation is needed for trauma-exposed immigrants.

Assessing Trauma and Related Symptoms

Trauma-related dysfunctions impair psychiatric functioning and may compromise cognitive resources relevant to legal competencies, such as rational deliberation.[62] Furthermore, clinical presentations of trauma and associated symptoms among immigrant populations likely reflect cross-cultural differences. As a well-documented example, expressions of emotional distress among Latinx immigrant populations consistently include somatic and physical symptoms.[63–65] This trend may be more prevalent among women than men.[66,67]

Trauma-related measures lack diagnostic research for immigration evaluations. One major exception involves the Trauma Symptom Inventory-2 (TSI-2).[68] Regarding its reliability and validity, TSI-2 profiles from immigrant examinees were similar to U.S.-born trauma survivors.[69] In addition, some initial data support the use of the TSI-2 in assessing C-PTSD.[70] Clearly, much more research is needed, but this is a promising beginning.

Malingering and Other Response Styles

Cultural unfamiliarity may raise questions about the authenticity of the clinical presentation, leading to negative inferences about presumed motivation. In Sweden, as a stark example, some refugee children experienced severe depression-withdrawal reactions to trauma. Instead of utilizing standard diagnoses, practitioners posited a culture-bound syndrome with malingering to directly benefit their refugee families as the presumed motivation.[71] Even its more recent conceptualization as "Pervasive Refusal Syndrome" suggested willful noncompliance.[72]

The adaptation of feigning measures for transcultural applications, such as immigration evaluations, faces formidable conceptual as well as psychometric challenges. In a seminal paper, Weiss and Rosenfeld[30] carefully distinguished two general types of malingering: feigned mental disorders and feigned cognitive impairment. Regarding the latter, a major portion of transcultural feigning studies are devoted to the Test of Memory Malingering (TOMM)[73] and the Dot Counting Test (DCT).[74] According to Weiss and Rosenfeld, these measures are "potentially appealing in cross-cultural assessments because they are based on visual memory and counting (respectively) and do not require English language fluency" (Ref. 30, p 238). As a fundamental complication, however, these measures of cognitive effort are misaligned with feigned mental disorders, such as simulated PTSD, a core consideration for immigration evaluations. At least in a U.S. disability context, most examinees feign either mental disorders or cognitive impairment but rarely both.[75] Thus, extrapolations from feigned cognitive effort to feigned mental disorders may be ill advised in any clinical context, including immigration courts, where it can be further exacerbated by translations and test adaptations.[76]

An important advance involved studies of immigrant populations, with many having limited English fluency. Research has demonstrated the usefulness of the TOMM and DCT for Chinese[77,78] and Iranian[79] immigrants. Although laudable, these efforts have limited generalizability to recent survivors of forced immigration. For example, feigning research in New York City[78] involved a sample of genuinely responding community members who had lived in the United States for more than a decade with presumably no trauma histories. Although valuable, generalizations of data drawn from this sample to populations undergoing forced immigration are limited.

Weiss and Rosenfeld[80] conducted noteworthy research on African asylees being served by the Program for Survivors of Torture (PSOT). Genuine responders with high and low PTSD were compared with feigners. The TOMM performed very well with low false-positive rates but also failed to identify the majority (57%) of PTSD feigners. Contrastingly, the DCT and Miller Forensic Assessment of Symptoms (M-FAST)[81] had concerning high false-positive rates ranging from 33 to 63 percent. A combination of the TOMM and M-FAST performed the best, identifying nearly two-thirds of feigners with a moderate false-positive rate of 17 percent.

The Structured Interview of Reported Symptoms-2nd Edition (SIRS-2)[82] is widely used in forensic settings for the assessment of feigned mental disorders. The Spanish SIRS-2 has comparable validity to the revised English version. With a specificity of .92 and a base rate .50,[83] the false-positive rate was still low (8%) but incrementally larger than the English SIRS-2. Besides the Spanish SIRS-2, only the Chinese SIRS-2 has a substantial level of validation.[84–86] Importantly, examinees' experiences with Western cultures appear to play a valuable role in the effectiveness of the Chinese SIRS-2. Lack of Western exposure (e.g., the fully structured interview format of the SIRS-2) plus Confucian values may be barriers, especially in simulation research on feigned mental disorders.[87]

Cross-cultural feigning research represents a clear priority for forensic practitioners, as summarized in a systematic review.[88] Many notable advances involve adaptations and translations of feigning measures to diverse cultures. Still, much more research is needed to address malingering and other response styles with language-specific and culture-specific investigations.

Concluding Thoughts

Forensic psychiatrists[22,89] and practicing psychologists[53] are increasingly invested in advocating for social and legal actions to further protect authorized and unauthorized immigrants. For example, one such model involves Collaborative Immigration Advocacy created by the American Psychological Association (APA) and National Latinx Psychological Association (NLPA) Interdivisional Immigration Project.[53] The model features avenues for advocacy for psychologists and their allied professionals with a focus on immigrant populations served.

This editorial is focused squarely, however, on the services and expertise immediately needed by immigration courts. As forensic practitioners and educators, we have a professional responsibility to improve the quality of services provided to underserved populations, such as persons facing forced immigrations, who often have been subjected to successive traumas extending from preimmigration through postimmigration. The call for forensic psychiatrists and related professionals to conduct immigration evaluations is longstanding,[90] as referrals continue to vastly outnumber available providers.[91] Responding to this clear need, the American Academy of Psychiatry

and the Law (AAPL), a prestigious organization of forensic psychiatrists, may wish to systematize these efforts by creating practice guidelines for the evaluation and treatment of immigrant populations.

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