

Mental Health Assessments for Immigration Cases: A Practical Guide

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### Abstract

Undocumented immigrants comprise a sizable portion of the population in the United States. Due to their illegal status, they face a host of challenges that ranges from discrimination to lack of access to health care. Fortunately some recent changes to immigration law have come about, that provide immigrants the opportunity to apply for citizenship and to receive health benefits. These statutes require that petitioners undergo mental health assessments as a part of the formal evaluation process, and affidavits prepared by mental health professionals must be presented to support these petitions. Unfortunately, for those mental health professionals seeking a holistic understanding of laws and ethical practices involved in these types of assessments, there isn't a comprehensive source of information readily available. This document proposes a guide for mental health practitioners to conduct ethical and effective mental health assessments for undocumented immigrants seeking legal status. Information is provided on the types of Visas available for this immigrant population. Important ethical issues that are unique to the elaboration of these assessments are discussed. Furthermore, the best practices for conducting interviews, supporting diagnosis, as well as drafting the narrative of these assessments are provided.

The findings in this document reflect the author's training and experience, existing research available regarding assessing undocumented immigrants, as well as reported best practices developed by specialists in the field of immigration mental health assessments.

## Mental Health Assessments for Immigration Cases

### **Access to Health Care for Immigrants**

The topic of universal health care is both divisive and controversial. It has received an inordinate amount of attention in the media and is a major source of political dissent in the United States today. According to the UCLA Center for Health Policy Research (Wallace, Torres, Sadegh-Nobari, Pourash & Brown, 2012), despite the far-reaching expansion of health care coverage for the large number of uninsured individuals in the US brought forth by the Affordable Care Act (ACA), also known as “Obamacare,” undocumented immigrants continue to experience explicit exclusion. The ACA prohibits these populations from purchasing health insurance coverage through the health exchanges. The undocumented immigrant population is already suffering hardships due to factors such as difficult acculturation, lack of steady employment and discrimination. In addition, undocumented immigrants continue to be ineligible for most public forms of health insurance coverage and would not benefit from any Medicaid expansions carried out by the states. Excluding undocumented immigrants from receiving government-funded health care services is unlikely to reduce the level of immigration and likely to affect the well-being of children who are U.S. citizens living in immigrant households (Berk, Schur, Chavez & Frankl, (2000).

### **Undocumented Immigrant Statistics**

Recent estimates of the undocumented immigrant population in the United States are astounding. Wallace et al. (2012) state that 11.2 million undocumented immigrants resided in the United States in 2010, of which, one million are children. The same study indicates that an additional four and one half million United States residents are the US-born children of undocumented immigrants. It is estimated that 8.5 million undocumented immigrants in the

United States are from the North American region (Mexico, Canada, Central America, and the Caribbean), followed by 980,000 from Asia and 740,000 from South America (Hofer et al., 2009). Approximately 1.1 million undocumented immigrants arrived in the United States as young children, were raised and educated in this country, and are aging into adulthood as undocumented persons. All told, undocumented immigrant adults and children make up approximately 4% of the total U.S. population (Passel & Taylor, 2010).

Estimations imply that undocumented immigrants appear to settle in states that border the Atlantic Ocean, Pacific Ocean, or the Gulf of Mexico, and states where median family income is higher, average January temperatures are higher, the percent of the state population that is Hispanic is higher, and where economic freedom is higher. On the other hand, undocumented immigrants are less likely to settle in states with a higher cost of living (Cebula, Duquette & Mixon, 2013). While historically concentrated in a few destination states, including California, Florida, New York and Texas, about one-third of undocumented immigrants are now living in so-called “new destinations” states such as Illinois and Georgia and Minnesota, and their plight has become much more visible and present around the country.

### **Legal Reprieve**

Historically, immigrant populations have been the target of close scrutiny and discrimination in the United States. Several laws such as the Chinese Exclusion Act of 1882, as well as the Immigration Act of 1924, acted as barriers in the path to citizenship for millions of aliens, due to ethnicity and physical or emotional health conditions ([www.ourdocuments.gov](http://www.ourdocuments.gov)). Throughout the 20<sup>th</sup> century these types of laws were abolished, and substituted by others that sought to keep out malicious political forces from entering the country. Individuals fleeing persecution were granted the right to asylum by the 1951 United Nations (UN) Convention

Relating to the Status of Refugees, which was implemented in the 1967 UN protocol regarding refugee status. The United States codified refugee protection and the procedures for asylum in the Refugee Act of 1980, which was made part of the Immigration and Nationality Act (INA) (De Jesus-Rentas, Boehnlein & Sparr, 2010). The elimination of immigration barriers based on ethnicity are now part of history, yet, in many ways, the anti-immigrant sentiment is still very much a part of everyday life in America and still permeates legislation in very direct ways, as in the Affordable Care Act.

Historically and today, the psychological community has given very little attention to forensic evaluations of immigration cases (Frumken & Friedland, 1995). Fortunately, in the last ten years, legislation that allows undocumented immigrants, who are not refugees or asylees, to petition for legal status has become available. These laws are aimed to protect individuals who have been victims of certain types of crimes, and legal family members of undocumented immigrants enduring hardships. The attainment of these special Visas requires, among several preconditions, that the petitioner be examined by a mental health professional, to ascertain the degree of emotional impact that they have suffered as a result of the crimes committed against them as well as the effects that deportation of a family member would have on a United States citizen or legal resident. Unfortunately these immigrants have a difficult time finding mental health professionals who have either the language ability or the training to conduct these mental health assessments. Not surprisingly, there is very little research available regarding the preparation of mental health assessments for immigration cases.

It is imperative that those completing immigration assessments be educated and trained in the process and ramifications of these assessments. This paper will focus on four specific legal recourses that are available. The process of conducting these immigration assessments will be

described, as well as ethical issues that must be considered for these types of assessments. A step-by-step guide to interviewing the subjects of these assessments will be provided, as well as guidelines to draft the assessment letters that individuals must obtain as a result of these assessments. Cultural considerations in serving these populations, as well as psychological theory that will help practitioners understand these populations and provide a professional and effective services will be discussed.

### **Recourses in Immigration Law**

There are several legal recourses available to undocumented immigrants to petition for special visas. The legal recourses that will be discussed in this document are the petition for cancelation of removal, the U-Visa, the T-Visa and the Violence Against Women act self-petition (VAWA). The information below regarding the four types of legal recourses discussed in this document was obtained from the website of the Department of Homeland Security, on the U.S. Citizenship and Immigration web page (<http://www.uscis.gov>).

#### **Cancelation of Removal**

One of the forms of relief available to foreign nationals who find themselves in the process of deportation, is the cancellation of removal. There are two types of instances when a cancelation of removal can be requested., One is when persons who have a green card, a permit allowing a foreign national to live and work permanently in the United States, stand to lose their legal standing due to some criminal violation. The other type refers to undocumented immigrants who never had a green card and are in the same predicament. Each one has its own requirements, but the lynchpin is usually the establishment of unusual hardship to family members who are United States citizens or green card holders.

The mental health assessment for these types of cases must highlight the hardship that the

removal of the individual will to the entire family. The methodology involves identifying the quality of the relationships between children and parents, the parenting aptitude of the person being deported, as well as the resiliency of the child in question. In order for a cancellation of removal to be granted, the assessment must demonstrate that it is unconscionable to remove the parent from the family, or to have family follow the parent in question back to their country of origin.. A specific process of testing will be discussed regarding these types of cases in the psychometric instrument section of this document.

### **U Visa**

The U visa exemption was enacted by the Victims of Trafficking and Violence Protection Act of 2000, to protect certain noncitizen crime victims, who assist or are willing to assist in the investigation or prosecution of a criminal offense. A U visa candidate must have been the victim of a crime, and must be presenting with pathological aftereffects of these events in order to be considered. The assessor must provide a compelling argument based on an account of the event, the changes that happened in the life of the candidate as a result of the event, as well as corroboration of their statements with evidence from psychometric instruments. A U visa grants the victim permission to live and work in the United States and may result in the dismissal of any case in immigration court filed against the immigrant.

### **T Visa**

The T visa was created to provide immigration relief to victims of severe forms of human trafficking. A noncitizen may be eligible for a T visa if she is physically present in the United States on account of trafficking, if she assists law-enforcement officials in the investigation or prosecution of the traffickers (victims under 18 years of age are exempted from this requirement), and if she can demonstrate that she will suffer extreme hardship involving unusual

and severe harm if removed from the United States. Much like the U-Visa, there is a burden of proof necessary to establish the psychological and physical effects of the traumatic experience.

A T visa protects recipients from removal and gives them permission to work in the United States. Bona fide T-visa applicants also have access to the same benefits as refugees, including cash assistance, food stamps, and job training.

### **VAWA Self Petition**

Under The Violence Against Women Act (VAWA), immigrant victims of domestic violence, child abuse, or elder abuse may “self-petition” for lawful permanent resident status without the cooperation of an abusive spouse, parent, or adult child. VAWA allows the victim to confidentially file the self-petition and attain lawful permanent resident status without separating from the abuser. This allows the victim to leave the abuser after a lawful permanent resident status has been obtained. Once again, the assessor must be able to identify the traumatic aftereffects of the abuse that the individual suffered by providing a historical account of the pattern of abuse, the presence of symptoms for a diagnosis, as well as corroboration of those symptoms through psychometric instruments.

An approved VAWA self-petition provides the applicant with work authorization, deferred action, and an approved immigrant petition, which allows her to apply for lawful permanent residency. VAWA self-petitions are available to spouses and former spouses of abusive United States citizens or lawful permanent residents. They are also available to divorced spouses whose termination of the marriage was related to the abuse, if the application is filed within two years of the termination of the marriage. VAWA also benefits children of abusive citizens or lawful permanent residents who file before turning 25. An immigrant parent of an abused immigrant child, is also covered, even if the immigrant parent is not herself abused. Non-

citizen spouses whose children are abused by the child's other United States citizen or lawful permanent resident parent are also eligible.

### **Ethical Considerations**

The provision of Immigration mental health assessments is an intricate matter that warrants close adherence to ethical standards. The implications relative to the provision of mental health assessments to mainstream populations, differ in significant ways from the those germane to immigrant populations. The main issues that differ from usual practices in assessments, and require close attention, are informed consent, confidentiality, scope of practice, development of new skills, and the administration of psychometric instruments.

### **Informed Consent**

Informed consent is a legal procedure to ensure that a patient, client or research participant is aware of all the potential risks and costs involved in a treatment or procedure. The elements of informed consent include informing the client of the nature of the treatment, possible alternative treatments, and the potential risks and benefits of the treatment (Woody & Woody, 2001).

As it pertains to the administration of immigration assessments, a few issues warrant clarification. The assessor must inform the client that there is no guarantee that the assessment procedure will yield a favorable decision in a court of law. Assessors must also explicitly inform the individual if their presentation was insufficient for a diagnosis, and that an assessment letter would reflect those findings. Individuals being assessed, in many cases, do not understand the aforementioned distinctions, and perceive the assessment as having a definitive effect on their immigrations case.

Assessors must also obtain informed consent to assess the client, due to the risks involved

in the client participation. There is a risk that the act of narrating a traumatic event, can re-traumatize the client. Early models of treating trauma, typically involved talking about the traumatic event as a central component of treatment. Retelling the trauma was viewed as curative and necessary. Often the goal was to retrieve traumatic memories and review them in counseling session. However, more recent research suggests that while some individuals do experience symptom relief after talking about trauma, others respond with an exacerbation of symptoms (van der Kolk & McFarlane, 1996). In fact, exploring traumatic memories can even be damaging to some clients. “A client is most at risk for becoming overwhelmed, possibly re-traumatized, as a result of treatment when the therapy process accelerates faster than the clinician can contain it” (Rothschild, 2000, p. 78). As a result, counselors are responsible for managing the intensity of exposure to traumatic materials during the assessment interviews. They must pay close attention for signs of overstimulation, regression, and dissociation in the session and take action to diminish or avoid the re-traumatization experience (Bicknell-Hentges & Lynch, 2009). The assessor must have a plan, and make that plan known to the client, in case the individual begins to re-experience trauma. This usually involves an intervention that centers the client, and brings them to the “here and now”.

Invariably, the assessor will have to document some level of detail regarding the traumatic experience in order to formulate a report. The caveat is to inform the client of the risk of re-traumatization, and to inform them that if they are not obligated to provide detailed accounts of traumatic events. In the most severe cases, an assessor might use the information contained in the police report to describe an event, and will correlate the results of psychometric testing as a means to provide a diagnosis.

**Confidentiality**

Confidentiality is an important ethical issue, which must be discussed with clients prior to having them report any information surrounding their emotional state. The AAMFT code of ethics dictates that practitioners disclose to clients and other interested parties, as early as feasible in their professional contacts, the nature of confidentiality and possible limitations of the clients' right to confidentiality (Woody & Woody, 2001). Therapists must review with clients, the circumstances where confidential information may be requested and where disclosure of confidential information may be legally required. For this particular type of assessment, the degree of confidentiality is very limited when compared to more common therapeutic circumstances. The assessor is obligated to make that distinction, and disclose to the client that their assessment will become a public record, and that if they wish to withhold any information that they do not wish to become public, they have the right to do so.

The customary therapeutic alliance and typical assurances of confidentiality do not exist in a forensic context (Kalmbach & Lyon, 2006). Pressure to assume an advocacy position, however subtle, may pose an ethical dilemma for the assessor. Unlike a therapeutic relationship, the forensic evaluation involves limited contact, an impartial stance, and a critical, evaluative style.

**Scope of Competence and New Skills**

According to the AAMFT code of ethics, therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies. This provides a grave challenge to many practitioners that are engaging in mental health assessments of foreign nationals. The excessive reliance on the delivery of mental health services rooted within Western assumptions, knowledge, and practices can have deleterious consequences to persons of other

cultures. It is essential that mental health services be responsive to ethno-cultural differences in etiological and causal models of health and disorder, patterns of disorder, standards of normality, and treatment alternatives (Marsella, 2011). This involves understanding the cultural specific aspects of the client's presentation, as well as the client's perspective and subjective experience of psychosocial stressors, among other factors.

The AAMFT code of ethics states that while developing new skills in specialty areas, therapists must take steps to ensure the competence of their work and to protect clients from possible harm. Therapists must practice in specialty areas new to them only after attaining appropriate education, training, or supervised experience (Woody & Woody, 2001).

Assessing individuals who are not proficient in English can prove to be a challenging endeavor. Monolingual assessors often face cultural and linguistic challenges when working with immigrant populations. Assessors need to communicate accurately and effectively with their clients throughout the entire assessment process (Acevedo et al., 2003). There is evidence that language discrepancy negatively affects assessment accuracy, the type of information reported by clients, and the ability of assessors to extract meaningful information from clients (Acevedo et al., 2003; Bamford, 1991). Fortunately, there is also evidence that using well-trained interpreters greatly improves psychologists-clients/participants communication (Acevedo et al., 2003). Professional interpreters should be hired when necessary and appropriate referrals should be made when assessors do not possess the needed competency to ethically and effectively conduct assessments with particular ethnic groups (APA, 2002; Canter, Bennett, Jones, & Nagy, 1994).

### **The Use of Psychometric Instruments**

Perhaps, the most sensitive ethical issue surrounding the administration of mental health

assessments for undocumented immigrants is the use of appropriate psychometric instruments. There is ongoing debate about whether standardized assessment instruments can "be effectively used with racial and ethnic minorities" (Padilla, 2001, p.113). The majority of the standardized psychological assessments are normed on mainstream, white, middle-class populations or developed using Western approaches to assessment (Padilla, 2001). Many of these standardized assessments are emic, or cultural specific measures designed for European Americans. Yet, without empirical and research support for the equivalence of measurement use with different cultural groups, these standardized assessments are often assumed to be etic, or cultural-general assessment instruments (Dana, 1996). Using a pseudo-etic instrument with multicultural populations may lead to unethical and inaccurate evaluation, treatment or discrimination against the ethnic minorities (Dana, 1996; Padilla, 2001).

Richard Dana (2005), a scholar of Multi-Cultural assessment practices, defines a Multi-Cultural Assessment as the use of assessment applications of all standard instruments in concert with interviews and other test methods providing additional information necessary for multicultural competence. Dana also states that the application of standard instruments with ethnic minority populations for which these instruments were inadequately constructed and normed requires not only knowledge about these populations derived from research and clinical experience, but an explicit recognition of the strengths and weaknesses of the instrument vis-à-vis assessment bias (Dana, 2005). This means that when considering screening immigrants and refugees, the line between efficacy and effectiveness may be blurred, since it is unlikely that a screening instrument developed in one cultural context will be valid, reliable and accurate in another (Birman & Chan, 2008).

To be culturally competent in assessments, practitioners need to demonstrate the use of

instruments with metric equivalence and cross-cultural construct validity (Dana, 1996; Gil & Bob, 1999; Prediger, 1994). Unfortunately, due to the lack of research regarding equivalence, it is somewhat customary for assessors to utilize what is available to them, while employing a multi-cultural approach. In a later portion of this document, the author will provide a list of structured assessment tools that have been normed for specific immigrant populations, and can therefore be used to corroborate an individual's diagnosis. The author will also discuss other tools which were not normed for individual immigrant populations, but that, according to experienced forensic assessors, have provided a next best approach to utilizing testing through the employment of multi-cultural practices.

### **Conducting the Assessment Interview**

Assessment interviews provide an opportunity for clinicians to acquire much needed information from their clients in order to reach a diagnosis. It is of the utmost importance to both the clinician and the client, that the limited time available for assessments be utilized in the most effective way possible. The following paragraphs will provide the reader with a road map for conducting effective interviews, and with the necessary theoretical and experiential acumen to obtain accurate and meaningful results.

### **Confidentiality and Informed Consent**

The first portion of the interview concerns the discussion of confidentiality, informed consent and the signing of forms. The issues of confidentiality and informed consent have been discussed in the previous section of this document regarding ethical practices.

### **Client Mental State**

During the interview, the assessor should make note of the interviewee's mental state, by recording information regarding the individual's appearance, behavior, thought form, thought

content, mood, affect perceptions, cognitions, insight and neuro-vegetative state. The therapist should use an in-depth checklist during the interview to record these findings.

### **Client History and Presenting Problem**

The assessor must perform a thorough examination of the interviewee's background and present functioning. The assessor must elicit a description of the presenting problem from the client, as well as any information regarding any events that preceded or precipitated the client's presentation. Ackerman (2013) documents the importance of a thorough clinical interview, as some psychometric measures are simply not appropriate for all examinees. In those cases, the assessor must rely on a free-response autobiographical narrative in which examinees simply report their life-story, in order to assess the client.

### **Ruling Out Diagnoses**

Once the therapist has an indication of what the presenting problem or problems might be, a direct line of inquiry must be made to rule in or out any possible diagnoses. In order to do so, the assessor must employ decision tree models, found in the Diagnostic and Statistical Manual. The purpose of using these decision trees is to collect of pertinent data points, and to rule out diagnoses. Assessors should anticipate the most common presentations and have symptoms checklists and decision trees available for the most common disorders, such as mood disorders, anxiety disorders, trauma and stress related disorders, dissociative disorders, substance abuse disorders, among others.

### **Transcending The DSM**

It is very important to explore the entire life span of the individual, in order to rule in or out the compounding effects of previous traumatic experiences. Illegal immigrants are very prone to have had repeated traumatic experiences due to abject poverty and other hostile living

conditions in their countries of origin. The undocumented, in many instances, have also been traumatized as a result of the immigration experience. Many times, they undergo unspeakable hardships as a result of sub-par living conditions after entering the United States, due to lack of access to community resources. The assessor must take an inventory of psychosocial stressors that have challenged the individual before, during and after their immigration journey, such as risky border crossings, victimization by smugglers or authorities, separation from home and family, victimization by the criminal elements in the United States, poverty, acculturation stress and discrimination, to provide a clearer picture (Lydersen, 2013).

In order for the assessor to appropriately parlay a detailed explanation of the effects that the traumatic events have had on the individual or family being interviewed, they must transcend the perspective and understanding provided by the Diagnostic and Statistical Manual of Mental Health Disorders. The assessor must embrace the complexity of issues endemic to that population as an ethos for provision of ethical treatment. To this end, the assessor must become knowledgeable about a number of theories that are highly relevant to understanding the presentations of undocumented immigrants in America.

### **The Cycle of Abuse**

The challenges that immigrant women face in the United States, are very different from those of most United States citizens. Immigrant women are at high risk for domestic violence, yet, due to their immigration status, they may face a more difficult time escaping abuse. Immigrant women often feel trapped in abusive relationships because of immigration laws, language barriers, social isolation, and lack of financial resources. Despite recent federal legislation that has opened new and safe routes to immigration status for some immigrant women who are victims of domestic violence, such as the previously discussed Violence Against

Women Act, these women continue to be severely impacted.

Studies on spousal abuse among immigrant women clarify the disparity of incidence of abuse among immigrant women and provide a clear picture of the challenges they face due to their legal status. Immigrant women often suffer higher rates of battering than United States citizens, because they may come from cultures that accept domestic violence or because they have less access to legal and social services than U.S. citizens. Additionally, immigrant batterers and victims may believe that the penalties and protections of the United States legal system do not apply to them (Orloff et al., 1995).

Abusers often use their partners' immigration status as a tool of control (Dutton, Orloff & Haas (2000). In such situations, it is common for a batterer to exert control over his partner's immigration status in order to force her to remain in the relationship (Orloff et al, 1995). Married immigrant women experience higher levels of physical and sexual abuse than unmarried immigrant women, 59.5 percent compared to 49.8 percent, respectively (Dutton, Orloff & Haas, 2000).

The assessor who is working with an undocumented immigrant victim of abuse, must have a clear understanding of how to identify and correlate the maladaptive relational behaviors described by clients to accepted theoretical constructs. One such construct is the Cycle of Abuse. This theory was developed by Dr. Leonor Walker, a clinical psychologist considered to be amongst the pioneers of psychology with regard to studies of domestic violence and abused women.

The Cycle of Abuse serves to illustrate the methodology, process, and systematic manifestation of abusive relationships. It not only outlines the events leading up to domestic violence, but also the itemization of the gradual unfolding of events resulting in domestic

violence. Assessors can compare anecdotal statements from petitioners with this accepted theoretical construct in order to validate the assumption that individuals were victims of domestic abuse.

### **Complex Trauma**

Another theoretical construct that is vital to understanding and working with immigrant populations is complex trauma. Complex trauma is described by psychologist and trauma expert Dr. Christine Courtois ([www.drchriscourtois.com](http://www.drchriscourtois.com)) as “a type of trauma that occurs repeatedly and cumulatively, usually over a period of time and within specific relationships and contexts.” involves repeated incidence of maltreatment over extended periods of time, including emotional abuse, physical abuse, sexual abuse, neglect, and witnessing family violence. Although CT experiences can occur at any age in highly oppressive contexts (e.g., partner violence, political and religious settings, acts of terrorism, refugee status, and war), it has its greatest impact in childhood (Lawson, Davis & Brandon, 2013). Examples include severe child abuse, domestic abuse, or multiple military deployments into dangerous locales.

Courtois states that interpersonal traumatization causes more severe reaction in the victim than does traumatization that is impersonal, the result of a random event or an act of God. Interpersonal violence can be a one-time occurrence that takes place without warning and "out of the blue" usually perpetrated by a stranger (i.e., a robbery, a physical assault). When it occurs within the family, between family members or in other closed contexts that involve significant roles and relationships, it is usually repeated and can become chronic over time ([www.drchriscourtois.com](http://www.drchriscourtois.com)).

Cumulative adversities faced by many persons, communities, ethno-cultural, religious, political, and sexual minority groups, and societies around the globe can also constitute forms of

complex trauma. Some occur over the life course beginning in childhood and have some of the same developmental impacts described above. Others, occurring later in life, are often traumatic or potentially traumatic, and can worsen the impact of early life complex trauma. These adversities can cause the development of complex traumatic stress reactions ([www.drchriscourtois.com](http://www.drchriscourtois.com)).

Courtois ([www.drchriscourtois.com](http://www.drchriscourtois.com)) explains that although some individuals who were traumatized as children manage to escape relatively unscathed at the time or later (often due to personal resilience or to having had a restorative and secure attachment relationship with a primary caregiver that countered the abuse effects). The majority develop a host of aftereffects, some of which were posttraumatic and met criteria for Posttraumatic Stress Disorder (PTSD).

The assessor must be able to identify the indicators of complex trauma in client presentations and highlight, in the assessment, the chronic nature of the abuse suffered, as well as the gravity of aftereffects experienced. These distinctions regarding complex trauma are pivotal in providing a clear picture to the adjudicators of an immigration case, of the degree of hardship and suffering that a petitioner is experiencing.

Complex trauma, a construct that has been the subject of debate among psychologists and mental health practitioners, has now been included for diagnosis as a sub-type within the PTSD diagnosis (American Psychological Association, 2012).

### **Fiscal Trauma**

Fiscal trauma is also another developing theory relevant to immigrant populations. Vanessa Jackson (2008) coined the term fiscal trauma, to describe the life threatening and shame inducing experiences that result from inadequate income and resources. Jackson defined it as an intense emotional reaction, characterized by depression, anxiety, a profound sense of shame and

a fear for survival in response to inadequate financial resources (recovery.rfmh.org). Fiscal trauma may also manifest as anger when individuals feel like their experiences are ignored and minimized.

It is critical for clinicians to explore what impact economic lack has on an individual's sense of self, their relationships with family and friends, their views about economic and career possibilities and their relationship with their community (recovery.rfmh.org). During assessments for immigration cases, clinical conversations should include a discussion of external factors (social, economic, political, and geographical) that impact the individual's access to necessary resources and the effects of those deficits. The assessor must do so, due to the financial and emotional hardships experienced by immigrants before, during and after their immigration journeys. These hardships and the concept of fiscal trauma will further elucidate the psychological state of an individual to an adjudicator in an immigration case.

### **The Use of Assessment Tools**

Once the assessor has found a plausible diagnosis or diagnoses, and has obtained an understanding of the stressors with which the client has been faced, this is the opportunity to corroborate their findings with the use of assessment tools. Different tools necessitate different levels of assessor skill, experience and education. Assessors must behave ethically during the administration of these assessment tools, and not employ instruments that are beyond the scope and skill base of their practice.

### **The Use of Culturally Specific Measures**

The appropriate use of psychological tests can be defined as a function of the assessor's competence and the validity of the test itself. This denotes that before an assessor chooses to apply a particular test, they must make an ethical judgment of their capabilities, experience, training

and education. They must also consider the limitations of the test and must be able to select the test that best suits the client, from the standpoint of ethical multicultural practice.

In order to clarify the first distinction regarding competence, the author will utilize the tenets laid out by Susan Winston in her book, *Principles and Applications of Assessments in Counseling* (Winston, 2009). Winston states that in selecting an instrument, practitioners should consider their own competencies and training. They must select instruments from a pool that they can use ethically. Furthermore, they must become competent with an instrument before they can use it with a client. Instruments vary in the amount of training and experience that is necessary. Some instruments can be used with the knowledge gained from studying a manual, while others require specific training. Winston (2009) provides a hierarchy of instrument classes that distinguishes between three types of instruments classified by the aforementioned tenets.

The first tier of instruments, can be used after reading the manual. Some examples are achievement tests and the Self Directed Search (SDS). The second tier of instruments requires technical knowledge in instrument development, psychometric characteristics and appropriate test use. The practitioner must have a master's degree in education or psychology or the equivalent with relative training in assessments. Examples of such tests are the Myers Briggs Type indicator, The Strong Interest Inventory, The Suicidal Ideation Questionnaire and the NEO Personality Inventory 3 (NEO-Pi-3).

The third tier consists of tests that require the administrator to have a doctorate in psychology or education, with specific coursework related to the test. These instruments require substantial knowledge about the constructs being measured and about the specific instrument being used. Some of these instruments are the Stanford-Binet, The Minnesota Multi-Phasic Personality Inventory II (MMPI II), the Rorschach test and the Wechsler Intelligence Scale for

Children IV (WISC IV).

The use of validated and reliable testing measures is preferred, but not always a sine-qua-non, or indispensable condition. Earlier in this document, the practice of multi-cultural assessment proposed by Richard Dana (2005) was mentioned. Dana's approach involves an in-depth analysis of several elements of an assessment. Dana considers the client's level of acculturation and the type of assessment (emic or etic), and provides a case specific formulation, assessment approach as well as treatment approach depending on those two variables. Dana suggests that the assessor use this analytical model, or decision tree, that he calls the Multicultural Assessment and Intervention Process (MAIP). The MAIP is used to evaluate the multicultural validity of the instrument used in reference to the person being assessed, and to provide a list of potential issues with bias in their report. In his book, *Multicultural Assessments, Principles, Applications and Examples* (2005), Dana explains the process of implementing the MAIP, in concert with the Rorschach test and the Minnesota Multi-Phasic Personality Inventory II, to demonstrate the ethical use of emic and etic tests on persons from any cultural background. Dana also defends the ethical practice of discussing the shortcomings of the test (lack of cultural validity) in the assessment report, in order to provide an ethical multi-cultural interpretation.

Levitt et al. (2007), who are fervent believers in applying etic psychometric tools normed for specific populations, apply concepts from the treatment outcomes literature of efficacy and effectiveness to evaluate the quality of existing screening and problem identification instruments. Efficacy is concerned with whether instruments are reliable, valid, and accurate in detecting symptoms of mental disorders. Effectiveness refers to whether it is feasible to use these instruments in real world settings. It also refers to the feasibility of using these instruments with immigrants who speak a variety of languages, and whether the instruments can be used with

persons who may not have literacy skills in any language.

Levitt et al. (2007) also suggest the use of a number of tests which they subdivide into three discrete categories, to be used with immigrant populations. They classify these instruments as broad, selective, and targeted measures.

Broad measures are designed to identify emotional and behavioral problems that are not necessarily symptoms of mental disorder. One such broad measure instrument is the Strengths and Difficulties Questionnaire (SDQ). The SDQ is particularly advantageous as a broad screening tool, because it is brief and includes both strengths and problematic behaviors. It is also published in a large number of languages. Researchers have used the SDQ with Pakistani, Turkish, and Somali adolescent refugees (Oppedal et al., 2005) and Asian and South American adolescent refugees (Rousseau et al., 2007). In both studies, researchers reported satisfactory reliability. However, more research is needed to determine the cross-cultural validity of SDQ (Woerner et al., 2004).

Selective measures aim to detect a broad spectrum of symptoms of a disorder. The best example of a selective measure is the Behavioral Assessment System for Children, or BASC. It measures behaviors, thoughts, and emotions of children and adolescents. A 1996 study showed that the BASC is valid for Latino kindergarten children (Flanagan et al.). However, Wilder and Sudweeks (2003) cautioned about the use of BASC with minority populations in the United States, because studies have not reported complete findings of reliabilities of the measure for these populations.

Targeted measures are basically symptom checklists for specific pathologies. Given the prevalence of traumatic experiences among undocumented immigrants, it may be appropriate to screen for exposure to traumatic events. One advantage of using screeners for exposure to

traumatic events is that it prevents issues of cross-cultural equivalence, since the scales are factual. The Harvard Trauma Questionnaire is a measure that assesses exposure to traumatic events and presence of PTSD. It was developed for adults from Southeast Asia who were former political prisoners (Mollica et al., 1992). Levitt et al. (2007) also suggest the use of some other targeted measures that have been normed for immigrant populations. One of them is the University of California at Los Angeles Posttraumatic Stress Disorder Reaction Index (UCLA-RI) which is designed to assess symptoms of PTSD during the past month, consistent with the diagnostic criteria in the DSM IV (Steinberg et al., 2004). Levitt et al. (2007) also suggest the use of the Hopkins Symptom Checklist (HSCL)-25.

### **The Use of Culturally Generalized Measures**

Mark Ackerman, a recognized forensic psychologist with many years of experience in conducting immigration mental health assessments, reports using simple self-report measures that are well-validated (though not for immigrant populations) and easily interpreted, including the Beck Depression Inventory-II, Post Traumatic Stress Disorder Symptom Scale-Interview, Children's Depression Inventory-II, Revised Children's Manifest Anxiety Scale-2, Prime MD Evaluation of Mental Disorders, the Trail Making Tests and Montreal Cognitive Assessment Scale, for culture fair cognitive screening (Ackerman, 2013).

Vaisman-Tzachor (2003) of the Association of Social Work Boards (ASWB), detailed a highly involved approach used in the more complex cases of hardship letters for cancellation of removal proceedings. Vaisman-Tzachor (2003) reports the use of the Minnesota Multiphasic Personality Inventory-II (MMPI-II) as a viable tool for this purpose even though it is not normed on minority populations. The Minnesota Multiphasic Personality Inventory is considered a protected psychological instrument, meaning it can only be given and interpreted by a

psychologist trained to do so. While it is commonly administered by computer, and requires no direct professional involvement during its administration, psychological testing is nearly always preceded by a clinical interview by the psychologist who is doing the testing. It is through the interview that Vaisman-Tzachor (2003) reports to adjust for validity, though he does not explain how. After the computer scores the test results, the psychologist writes up a report interpreting the test results in the context of the person's history and current psychological concerns (Framingham, 2011).

The MMPI II provides scores and measurements of a wide variety of aspects of personality, and it is a measure of both personality and psychopathology. Highly elevated scores in the profile indicate major psychiatric disorders, whereas scores in the normal range reveal the personality patterns of essentially "normal" adults. As a measure of a person's emotional state and behavioral tendencies at a point in time, the MMPI-II indicates the person's current clinical status, as well as the influences of the person's long-term personality makeup and emotional history on present functioning. The pattern and severity of a test profile reflect both the effects of past experiences (traumatic or beneficial) on the personality makeup, as well as their activation by ongoing contextual threats and pressures that are crucial to measuring the degree of hardship.

Vaisman- Tzachor (2003) also advocates the use of the Parent Awareness Skills Survey (PASS). The PASS is a clinical tool designed primarily to reflect strengths and weaknesses in a parents' ability to recognize critical intervention opportunities in childcare situations, and subsequently to communicate clearly and effectively at these points of opportunity. PASS scores can be used for comparative purposes in a custody evaluation case to establish minimal adequacy in parenting skills (Bricklin, 1990). The PASS reflects, the kinds of skills a parent must have in order to be effective, regardless of the age of his or her children, and regardless of the situation

presented. This can be used to demonstrate the advantage of awarding a cancellation of removal Visa to the parents of a child who is experiencing undue hardship. The PASS is also not normed on minority populations.

Vaisman- Tzachor (2003) also advocates the use of the Perception of Relationship Test (PORT), another test that is not normed on minorities. It measures the degree to which a child seeks psychological closeness and positive interactions with each parent. It also measures the child's particular action tendencies and dispositions to behave in certain ways (e.g., assertively, passively, aggressively, fearfully, etc.). Adaptive as well as maladaptive behaviors that the child has had to develop to permit or accommodate interaction with each parent are predicted in the outcome scores.

The PORT is particularly useful in forensic decision-making, because it sheds light on the degree to which a child actually seeks interaction with a given parent, and reflects the degree to which he or she has been able to work out a comfortable, conflict-free style of relating to each parent (Bricklin, 1989). The utility of the PORT is in that it taps into largely unconscious sources. These sources reflect more of the child's actual interactions with a given parent and less of what he or she has been told. Hence, the verbal bribery that children in forensic settings are often exposed to is bypassed and loyalty conflicts are avoided.

Vaisman-Tzachor (2003), much like Ackerman (2013), defends the use of psychometric instruments that were not normed for immigrant populations. This reflects the commonality of the practice of using etic assessment instruments among a great number of assessment professionals, in the absence of those specifically normed for minority populations. This implies that a very important element of providing mental health assessments to immigrants is based on best practices and is not necessarily an evidence-based practice.

After having researched the ethical practices that are necessary to select appropriate tests for immigration assessments, I have concluded that even though all tests should be normed with discrete populations, most are not, and the ones that are, could still benefit from further validation. Secondly, the research on the area of ethical use of instruments suggests that the more elementary instruments are easier to use and can be used by a wider array of practitioners. The research also points out that training, education and supervision are hallmarks of the ethical use of instruments, and that depending on an assessors background some instruments should not be used. Otherwise the research indicates that the use of instruments that are not normed for specific populations does not necessarily have to be avoided. Assessors must engage in a multi-cultural approach for the use of the instruments. They are ethically obligated to report on the shortcomings and implications of instruments, and to apply a multi-cultural approach to support the validity of those instruments in their reports.

### **Assessing Client Strengths**

The field of mental health and social services has a long history of focusing on clients' deficits, problem behaviors, and pathologies. Within the last decade, researchers and practitioners within the fields of education, mental health, psychology, social work, and child welfare have begun to question the deficit-based approach and move toward a more holistic model of development (Trout, Ryan, La Vigne, & Epstein, 2003). Rather than focusing on individual and family weaknesses or deficits, strength-based practitioners collaborate with families and children to discover individual and family functioning and strengths (Laursen, 2000). At the foundation of the strength-based approach is the belief that children and families have unique talents, skills, and life events, in addition to specific unmet needs (Epstein, 1999).

The importance and credence in a strengths based approach is also evident in the practice

of conducting mental health assessments for undocumented immigrants. This is not only because of the aforementioned benefits, but for reasons specific to the types of assessments discussed in this document. The assessor must communicate the positive behaviors of the client in order to balance the perspective of the adjudicator who is browsing the assessment letter to make their decision. The list of strengths juxtaposes the somber accounts of the client's vulnerabilities and symptoms. This humanizes the individual in the eyes of the adjudicator and highlights the positive qualities of the petitioner. It is important to highlight how the individual has been a productive member of society, how they have positively influenced the lives of family members, as well as the community at large, even though they are, in many cases, seriously compromised. Personal statements from the client regarding their hopes for a better life through the attainment of legal status and subsequent access to much needed healthcare are common in assessment interviews, but should not permeate the content of the assessment letter.

### **Drafting The Assessment Letter**

Armed with pertinent accounts of a client's presenting problems, the subjective observations regarding the client's emotional state, the contextual theoretical understanding of the events that have brought the client to the evaluation, the corroborating data offered by psychometric assessment tools, and a list of client's strengths, the assessor is prepared to put pen to paper and prepare the client's assessment letter. The elements described bellow are a compendium of best practices, derived from trainings and individual supervision, as well as statements from experienced practitioners, extracted from narratives in their websites and presentations. They are specific to assessment letters for immigration cases, and are not derived from any specific generally accepted method of writing assessment letters.

**Statement of Purpose**

The first few lines of the letter should be a statement of purpose. The assessor must convey the reason that the client underwent the assessment. An example might be, for the purpose of understanding the effects that a traumatic event has had on an individual's functioning. Another, in the case of a cancellation of removal, could be the effects that removing a parent from the family might have on the degree of functioning of another individual.

**Assessor Credentials**

Once the purpose of the letter is stated, it is common practice to elaborate on the credentials of the assessor, and why they are qualified to make assertions regarding the individual. The assessor must list their qualifications, experience, skills and any kind of specific training they might have had in order to provide a valid assessment.

**Client Mental State**

The next portion of the letter is a declaration of the client's mental state during the interview. The assessor must provide an explanation of the presenting problem and any relevant history associated to the presenting problem. , The assessor must expound upon the client's current level of functioning vis-à-vis the client's condition and any traumatic event that precipitated and/or exacerbated the client's condition.

**Assessment**

The following portion of the letter is the clinician's assessment of the client. The assessment will be based on the explanation of the individual's DSM diagnosis, as well as the confirmation of the diagnosis via psychometric tests. The assessor can complement the elaboration of the client's diagnosis by correlating the stated stressors and the client's life-span narrative to some of the aforementioned theories, such as fiscal trauma, complex trauma, the

cycle of abuse, as well as any other theory that might be relevant to the client's presentation. This information serves to corroborate assertions regarding the degree of trauma and psychosocial stressors that have caused the manifestation of the client's particular presentation, and also to add the dimensions of intensity, frequency and duration of the psychosocial stressors.

### **Client Strengths**

After the assessment section is concluded, it is customary to include the list of client strengths, or, examples of their adaptive social behaviors. The purpose of this section is to balance the pathological and maladaptive accounts regarding the client, with positive aspects about the client's personality. This particular section of the assessment is indicative of the perspective that an individual uses their thinking, feeling, and actions to achieve a social end in a positive way. It is a testament that the individual does not merely inherit or possess certain qualities, traits, or attitudes, but adopts only those characteristics that serve their goal, and rejects those that do not fit their intentions (Degree & Snyder, 1988). This assumption emphasizes personal responsibility for one's character, and can evoke empathy from the adjudicator depending on the individual's list of strengths. It is also an account of the client's resiliency vis-à-vis their psychosocial stressors.

### **Prognosis**

Once the explanation of the rationale behind the diagnosis is completed, it is customary for the assessor to provide a prognosis for the individual. This will shed light on what the client is expected to experience if their current mental health status, immigration status, level of psychosocial stressors and current level of treatment is maintained.

### **Recommendations**

After the prognosis is stated, the assessor must state their recommendations for the client.

These recommendations can include treatment modalities, ancillary services and what course of action should be taken in order for the individual to diminish their social stressors, so that they can begin the process of treatment. The letter must contain the signature of the assessor, as well as that of any supervisor that the assessor might have worked with in order to corroborate the validity of their assertions. In that case, the supervisor's credentials must also be present in the beginning of the letter.

### **Other Relevant Details**

After the assessor has finished drafting the assessment letter, it is a best practice to review the letter with the client's legal council. This is important, because the assessor might have overlooked details important to the client's case. It is also important to do a thorough review with legal council because, it is very common for victims of traumatic events to recollect the accounts of those events in a manner inconsistent with what they have previously stated in a police report or other affidavit. Otherwise, the assessment letter must be typewritten on stationary, and must include a list of academic references to any quotations used in the narrative. There is no required format to writing these assessments, such as APA, that the author has encountered in practice or research, yet, there is a general consensus that these letters must be direct and to the point, and preferably, depending on the case, that they not be overly lengthy or verbose.

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