Chapter 7
Cultural and Linguistic Issues in Assessing Trauma in a Forensic Context

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Immigration and Its Trauma Contexts

Sociopolitical and socioeconomic instabilities in many countries of the world have created a tremendous influx of immigrants who are forced to flee their countries of origin in search of safer and more economically and politically predictable conditions (United Nations, 2017). We have evidence of this influx of immigrants engaged in desperate and dangerous journeys to seek asylum from many countries of Europe (from Italy, Spain, France, Germany, England, Greece, Turkey, Demark, Rumania, Hungry, Austria, Australia, etc.), the United States, and Latin and South America (like Columbia, Mexico, Brazil, Chile, and Argentina) (United Nations, 2017). In Europe, the influx of immigrants has been fueled by sectarian wars in countries like Afghanistan, Iraq, Libya, Lebanon, Yemen, Nigeria, etc. (Hammer, 2015; O'Malley, 2018), including the emergence of ISIL and Boko Haram in some of these countries. In Latin American, this influx is fueled by political and economic instabilities in Venezuela, Cuba, Haiti, Honduras, Nicaragua, Guatemala, El Salvador, and Mexico (Edwards et al., 2019; Rojas-Flores, Hwang Koo, & Vaughn, 2019). Another additional contributing factor for these latter countries is the threats coming from the proliferation of vicious gang activities which seems to operate with impunity, partly due to the high level of corruptions in the very institutions responsible for securing the safety of their citizens (Guillermoprieto, 2010; Rojas-Flores et al., 2019).

In the end, these individuals have decided that it was better to gamble into conditions with no guarantee of a successful outcome than to remain in places where they and/or their families were not safe and in constant threat of physical and/or psychological harm and even death. There are horrific stories reported by those individuals

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lucky enough to have had a receptive country that have provided at least a temporary refuge (Edwards et al., 2019; Rojas-Flores et al., 2019). Stories of many who have lost their lives in the process have witnessed others who have lost their lives or, at the very least, have been victims of physical and sexual assaults, and psychological manipulation, after leaving everything known to them for a chance to have a better life, a paradoxical and ironic outcome to a reasonable dream (Keygnaert, Vettenburg, & Temmerman, 2012; Haskins, 2017; Pineteh & Muly, 2016).

These are the conditions that have been associated with the development of trauma with the resulting cognitive and emotional sequelae in those affected (American Psychiatric Association, 2013). These are the types of conditions affecting many of the immigrants also coming into the United States and Europe (United Nations, 2017; Zayas, 2015). To add complication to an already traumatic condition for these immigrants, the influx of immigrants has had a variety of responses in the host countries, from a welcoming and humanitarian approach (e.g., securing lodging and safe haven) to an increase of nationalistic and anti-immigrant responses (Scherer, Altman, & Miller, 2017; Walt, 2019), which have resulted in adding additional upheaval and uncertainty in the lives of these immigrants and their families (Buchanan, Abu-Rayya, Kashima, Paxton, & Sam, 2018; Halpern & McKibben, 2014; Sadeghi, 2019).

The success of anti-immigrant political platforms has led to a rise in right-wing nationalist parties in the European Union, countries such as the Philippines, Russia, Italy, Turkey, Hungary, France, and here in the United States, and the success of nationalist initiatives such as Brexit in the United Kingdom (Walt, 2019; Edwards et al., 2019; Scherer, Altman, & Miller, 2017).

There are many challenges created by the immigrant influx, from challenges to housing, education, health and mental health systems, to challenges to the court and justice systems, etc. It requires the host countries to prepare their citizens to absorb and incorporate these individuals by addressing their various needs. The negative anti-immigrant rhetoric currently influencing these services has managed to create a toxic environment for these individuals, many of whom find themselves detained and in deportation centers (Vick, 2018). The fear is that the immigrant influx is threatening the very heart and soul of these countries and how they have defined themselves. To assuage the tremendous anxiety verbalized by the most vocal critics in these countries, many have resorted to demonizing the immigrants as rapists, thieves, terrorists, drug addicts, child predators, and hardened criminals sent to destroy our families and countries. In the process, it has managed to trigger from those willing and ready to entertain such a view, the most primitive fears. Once these fears are unleashed, it makes possible the evolutionarily based responses guided by the need for self-preservation (well described by Solms & Trumbull, 2002) and provides the justification for the inhumane treatments received by the immigrants, including the separation of children from their parents (American Psychological Association [APA], 2018; Ayon, 2018; Ball, 2018; Gibbs, 2018). For many, such decisions have resulted in further compounding the trauma already experienced in the countries of origin. This condition is what has been referred to as "complicated trauma" (Ford & Courtois, 2009) which has been found to result in devastating cognitive and emotional consequences for the individuals affected

(Allen & Fonagy, 2017). These are the complications likely to be encountered by the forensic professional who is now asked to engage in assessing and/or providing services to this population. The fact that these individuals come from different cultural, linguistic, socioeconomic, and sociopolitical conditions presents a particular challenge to mental health and forensic professionals who are called to provide these services. The purpose of this chapter is to highlight and examine some of these challenges and offer some remedies/recommendations to ensure objective and as accurate as possible assessment outcomes. We examine the situation in the United States as an example of the issues to consider when providing services to immigrant population with a trauma history, which may also apply to situations in Europe and other parts of the world (Wells, Wells, & Lawsin, 2015).

Defining the Terms

Before proceeding with our discussion, it is vital to define a few key terms most often used when referring to individuals with different cultural background (e.g., race, ethnicity, and culture). The importance of defining these terms stems from our concern to ensure an agreed-upon reference point regarding terminology in order to avoid confusion. For instance, race has several different definitions, ranging from physical, biologically based appearance (Rowe, 2002), to a social construct used to maintain established sociopolitical hierarchy (Clauss-Ehlers, Chiriboga, Hunter, Roysircar, & Tummala-Narra, 2019). Racial categories are often used to refer to the physical characteristics of an individual, but doing so, often fails to account for the considerable variation these labels encompass (Weiss & Rosenfeld, 2012).

Some scholars suggest focusing instead on the term ethnicity because it emphasizes critical components or commonalities (such as values, customs, and traditions) that allow an individual to experience and organize a sense of identification, meaning, and belonging (Helms, Jerrigan, & Mascher, 2005; Markus, 2008). A number of these commonalities are developed in the context of one's culture, a term that refers to the behavioral and ideological norms that define a group's identity (Alarcon, 2009). Culture includes variables such as language, traditions, values, religious beliefs, moral thoughts and practices, gender and sexual orientation, socioeconomic status, economic philosophies, and realities imposed by technological advances (Alarcon, 2009). These different components have been referred to as the intersectionality of multiple identities (Greene, 2006) that influence the individual's overall psychological makeup and which create a tremendous challenge to the forensic professional when in the process of addressing a forensic question. Part of the challenge is created by the unconscious way the forensic professional negotiates his/her personal feelings or bias (unconsciously derived reaction toward the client) about their clients' multiple cultural and linguistic identities (Morris, Javier, & Herron, 2015). Sue and associates (2007) provide us with ample examples of ways our personal reactions may come into play when face-to-face with individuals whose multiple identities are different from ours (see Table 7.1). In this context, they identified several types of microaggressions (e.g., microassault, microinsult,

Table 7.1 Instances of microaggressions

Extension of the nine categories of microaggression themes Initially identified by Sue and associates (2007)
• *Alien in one's own land*: Relate to culturally/linguistic different clients emphasizing that "you speak with an accent" or being asked "where are you from?"
• *Ascription of intelligence*: Thinking/making statements suggesting that the client's cultural group is intellectually inferior: "You are a credit to your group or race," or "I am impressed, I did not expect that you will know that, considering where you come from." "How is that you have not learned English?"
• *Color blindness*: In an attempt to appear fair, the examiner may think/communicate to the client that "I don't see color/race when I see you."
• *Criminality/assumption of criminal status*: Not recognizing the traumatic effect of being made to feel like a criminal when the client relates stories of going to stores or walking in the street and being followed or stopped by the police as part of the "Stop-and-frisk." "You are too sensitive," "You look different…it is reasonable/not surprising for someone to be suspicious."
• *Denial of individual racism/classism*: Making comments to communicate open-mindedness… "We are all the same in the eyes of God"; "I am not a racist or a bigot, I have good friends who look like you."
• *Myth of meritocracy*: Telling the client that "In the end, anyone who works hard can succeed in this society."
• *Pathologizing cultural values/communication styles*: Saying to the client that what they describe sounds "weird" or "Do all your people tend to be so loud when having a normal conversation?"
• *Second-class status*: A person of color being mistaken for a service worker.
• *Environmental invalidation*: Overabundance of liquor stores/overcrowded schools in community of colors.

and microinvalidation) that can seriously derail the objectivity of the evaluation and reflect negative bias toward the client.

Another critical term to consider is "acculturation," which reflects the extent to which the client is assimilated into a new cultural and linguistic context. It refers to the degree to which the individual adopts the customs and linguistic characteristics of the host society (Dana, 1996). From our perspective, we will use acculturation to include assimilation to the host society, familiarity with cultural norms of the host country, length of time spent in the new culture, and the fluency with the host culture and language (Weiss & Rosenfeld, 2012).

One final interrelated term to consider is the concept of bilingualism. An individual is defined as bilingual when he/she knows and uses more than one language to communicate (Bialystok, Craik, & Luk, 2008; 2012; Grosjean, 2010; Javier, 2007), the nature and quality of which requires different levels of cultural and linguistic proficiencies. This is an important consideration, in view of what forensic psychologists are likely to encounter when examining individuals who are coming from different cultural and linguistic contexts with various degrees of linguistic proficiency in the language of the host country. In many of these situations, the concept of bilingualism may not apply because the client may have little, if any, knowledge of the language of the host country. We will resume this discussion later in the chapter under the section on the "Role of Culture and Language in the Development and Presentation of Emotions."

Challenges in the Assessment of Culturally and Linguistically Diverse Individuals

The ubiquitousness of cultural and linguistic factors in a person's overall functioning has been found to impact on every aspect of the assessment process, beginning during the initial contact with the client (Javier & Herron, 1998; Malgady & Costantino, 1998; Weiss & Rosenfeld, 2012). Concerned with this impact, Richard Dana (1993) put together an important volume dedicated specifically to delineating and identifying those very factors in psychological services that are still relevant today. He explored a series of unique aspects to consider when treating and evaluating clients coming from African-American, Asian, Hispanic, and Native Americans cultures, particularly the different components of worldviews that guide the behavior of individuals from these different cultural and linguistic backgrounds. The 2013 second edition compendium edited by Paniagua and Yamada should also be considered for its comprehensiveness of cultural influences in the development of multisectionality of identities in various cultural groups. West (2018), El-Jamil and Abi-Hashem (2018), and Clauss-Ehlers, Millan, and Zhao (2018) most recently also explored and expanded further many of the general themes identified by Dana and by Paniagua and Yamada, particularly with Arab-Middle Easterners (El-Jamil & Abi-Hashem, 2018). An important consideration to keep in mind that emerges from these explorations is moderator variables in the different cultural and linguistic groups related to "Emic" (culturally indigenous and idiographic) and "Etic" (universal, nomothetic, and cross-culturally comparable) perspectives that are likely to be operating during the assessment (Draguns, 1998, 1999). For example, while in some cultures a handshake may be appropriate for a first greeting, in others it may not. Eye contact may be seen as a typical way to communicate attention to and by a client in some cultures; in others, it may be seen as a threat, sign of untrustworthiness, or lack of respect. This was the case of a client hospitalized in an inpatient unit who in the midst of a psychotic decompensation decided to divest herself of all her clothing and now was standing star naked in the middle of the community room with the rest of the other psychiatric patients. When approached by the unit supervisor, she remained where she was standing but now with her eyes downcast as if embarrassed for being approached by someone in authority. The supervisor attempted to make eye contact with the patient and even asked her to look at him, only to be responded to with further evasive moves to avoid connecting with the eyes of the supervisor while saying "I am not supposed to look you in your eyes… it would be disrespectful." She was referring to her culturally ingrained behavioral expectation of how to deal with a person in authority that was part of her self-definition and was guiding her behavior even in the midst of a psychotic break.

It is clear from this example the importance of considering the pervasiveness of culture throughout the assessment process but particularly to be explored during the initial encounter/interview with the client. We need to consider, in this context, the specific ways the client's cultural identity is interwoven in his/her developmental history (Lu, Lim, & Mezzich, 1995); that includes consideration of the client's

country of origin, family structure, customs, values, beliefs, and attitudes toward medicine and psychology. It also includes consideration of the linguistic and cultural contexts, as well as educational and social developments during the client's crucial developmental history (see Table 7.2). In the end, the forensic evaluation should consider the client's level of acculturation at the time of the examination because it will determine the extent to which the tools (tests) selected for the evaluation are linguistically and culturally appropriate. In the case of a recent immigrant client, there is an additional consideration of how to best assess the possible trauma history related to separation, losses, alienation, displacements, or disappoints, domestic and gang violence exposure, etc. (Lu et al., 1995; Weiss & Rosenfeld, 2012), which may be implicated in the decision to immigrate.

There are specific cultural factors that may make it difficult for the professional to elicit symptoms or understand their cultural significance (Lu et al., 1995). Both culture and society are involved in shaping the meanings and expressions people give to their various emotions and can determine which symptoms or signs are normal or abnormal, help define what comprises illness, and shape the illness behavior and help-seeking behavior (Kirmayer & Ryder, 2016; Lu et al., 1995; Wells et al., 2015). Culture can play a significant role as a trigger of psychopathology (pathogenic role) and/or as a buffer (resilience) against challenging conditions and thus can contribute to higher or lower levels of severity of psychiatric symptoms (Alarcon, 2009). It can represent a unique expression of clinical symptoms,

Table 7.2 Brief assessment guide questions

List of possible areas to inquiry during assessment
Questions regarding basic medical/developmental history:
*When did the assessee reach the basic developmental milestones (*i.e.*, walking, language, toilet training,* etc.*)? This is particularly important in children.*
Was there any history of trauma, illnesses, etc. *that could have affected the subject's cognitive and linguistic development? Is there a history of lead intoxication and other contaminants, prenatal substance abuse, exposure to domestic violence and child abuse, terrorism, bullying,* etc.*? Again, this is particularly important in children.*
General questions:
What level of education, level of cognitive/scholastic achievement proficiency did the subject reach in the native language?
In what language and cultural context did the subject have the early schooling?
What level of professional accomplishment did the subject reach in the country of origin?
At what age did the subject learn the second language?
How long has the subject been in the linguistic/cultural context of the language of the evaluation?
What level of proficiency has the subject reached in the second language in
speaking?
reading?
writing?
thinking?
What language does the subject use now for intellectual/school-related material?
In what language does the subject dream?
What language does the subject prefer when upset or dealing with emotions?

reflecting the general themes of the period in which the illness occurs, as well as culturally idiosyncratic manifestations in these individuals' behavioral repertoire.

Cultural factors may also affect how the client relates to the professional. There is evidence that some cultures may be more open to relying on the professional for help and thus be more forthcoming due to their higher cultural value bestowed in that community to communicating one's psychological anguish and questions to professionals (Langman, 1997; Mojaverian, Hasimoto, & Kim, 2013). This is in contrast to other cultures, such as some western cultures, where independence is valued and reliance on others may be construed as a weakness (Langman, 1997). This sort of contrast is likely to affect and determine the strategies that a professional would need to use in order to complete the assessment successfully.

A culturally competent (or intelligent) forensic professional should be cognizant of how various cultural factors may influence the assessment and describes not just that the identified disorder goes against cultural norms but explains how it does (Lu et al., 1995) and what harm, if any, can be adjudicated in relationship to the specific events (e.g., a physical assault, sexual harassment, employment discrimination, etc.) being examined. The challenge in forensic cases is how best to assess the extent of a psychological harm (e.g., trauma) following these events when there are so many factors to consider (including cultural and linguistic factors, as well as those related to intersectionality, etc.) that can shape the way those being evaluated process and communicate their personal response to these events. Wells et al. (2015) suggested, in this regard, that we should be careful in how we go about gathering our evidence of the presence or absence of psychological disorders from someone coming from a diverse cultural and linguistic context. According to these authors, these individuals may or may not endorse the relevant items of the PTSD scales or the Beck Depression Inventory (BDI) but may still be suffering from a trauma or depression. Another possibility is that individuals may be diagnosed with PTSD and/or depressive disorder based on the endorsement of these items, whose meanings and relevance have been taken out of their cultural/linguistic contexts. They reported evidence, in this regard, from a study by Nicolas and Whitt (2012) of Haitian women not identifying items in the BDI as expressions of distress, something that can be avoided by contextualizing the items (criterion validity), and taking into consideration the specific ways the impact of distress becomes evident in these individuals' cultural contexts (e.g., by emphasizing somatic symptoms).

Role of Culture and Language in the Development and Presentation of Emotions

It is, therefore, vital for the professional to recognize common cultural-specific ways that individuals may experience, express, and cope with their feelings of distress (Desai & Chaturvedi, 2017; Durà-Vilà & Hodes, 2012; Kleinman, 1987, 1988; Nichter, 1981). To that point, it is important to identify the primary idioms of distress that the symptoms reflect, as well as the meaning and perceived severity of these symptoms in relation to the norms of the original culture of the client being assessed. In this context, it is also important to obtain information about the

different local illness categories used by the individual's community to identify illness and distress, the perceived causes or explanatory models that the individual and members of the original culture use to explain illnesses in general, and their view and nature of past experiences with mental health professionals (Kleinman, 1987/1988; Maeda & Nathan, 1999; Rogler & Cortes, 1993; Schwartz, 2002; Singh, et al. 2016).

When trying to conceptualize culture-bound assessment, Lu and associates (1995) proposed two methods: The first is through the use of an "interpersonal grid," which assesses the client's worldview through a system variable. According to these authors, this can only be accomplished by including in the assessment information about demographics, status, affiliations, and the behaviors, expectations, and values associated with these factors. Such a consideration allows the professional to understand, contextualize, and interpret specific behavior within the individual's cultural meaning.

The second method is through the use of what they referred to as "a multicultural cube." The multicultural cube allows for the addition of multiple dimensions of "cultural identity development" process and how the culturally diverse individual sees himself/herself in respect to the host culture. According to Lu and associates, the least advanced level of cultural identity development is found in individuals engaged in blind acceptance or conformity or what they describe as a "compliant position." A more developed "dissonance position" is found in individuals who are in conflict with their cultural identity and that of society as a whole. When the individual is engaged in rejecting all of the new culture, a "resistance position" is thought to be at play. An individual can also progress into a "introspection position," where he/she comes to accept that both cultures, the original and new, can coexist but that the new culture is irrelevant. The final level is "integrative awareness," which finds the individual accepting both the best and worst parts of both cultures. Other scholars have described similar processes in reference to an individual's identity development when multidimensional aspects of one's experiences (multiple and overlapping components of identities) are involved and required to negotiate the resulting multisectionality of their identities (Baden & Steward, 2007; Greene, 2006; Grotevant, Dunbar, Kohler, & Esau, 2007).

Hinton and Kleinman (1990) offer a practical method with three basic rules that they found useful (and still relevant today) to develop a culturally appropriate approach in assessment of individuals from diverse populations. The first rule is to show empathy throughout the interview and then elicit the client's perspective on the illness. The second rule is to assess the client's experience in the context of the client's family, workplace, health-care systems, and community. The final rule is to diagnose the illness through both DSM categories and the client's cultural idioms of distress, such as *susto* or *ataque de nervios*. These authors seem to be following and emphasizing the gold standards for the most effective ways to conduct a clinical interview amply discussed by McWilliams (2004), Safran (2012), and Weiner and Bornstein (2009).

Alarcon (2009) makes similar recommendations to ensure adequate assessment of clients from culturally and linguistically diverse communities: The first is to

make sure to include cultural variables, which contain specific information about language, religion and spirituality, migration history, level of acculturation, and other family dynamics, child-rearing practices, rituals, etc. The gathering of all these data is meant to provide information about modalities used in child-rearing practices, familial roles or hierarchies, the types of activities that instilled their values, eating habits, social interactions, and help-seeking behaviors. Professionals are then encouraged to direct their focus onto what Alarcon refers to as "pathoplastic factors" or the uniqueness of the symptom's expression. This is accomplished by comparing the different descriptions of symptoms provided by clients and relatives, the words and terms used, and the context in which these symptoms tend to emerge. Of particular importance to consider is how the environment affects the form of the symptoms. In the end, the cultural identity of the person, their ethnic and cultural reference groups, should take front and center in these assessments (Center for Substance Abuse Treatment, 2014). These elements should also include the differences in culture and social status between client and professional, as well as how these differences may affect the diagnosis and treatment process.

This information becomes particularly important when deciding the appropriateness of testing norms in the host country to be applied to clients from diverse communities. It requires determining the level of competency in the host language and in how they navigate the tasks of learning to live in the culture of the host country. According to Lu and associates (1995), this can be assessed by examining not only how many years the client has spent in the host culture, the age at immigration, and exposure to the host culture in their original culture but also how successful the client is in securing housing, employment, childcare, and mastery of the public transportation system, etc.

Another way to measure level of acculturation is to examine how the family relates in the new culture. Lee (1990) suggests several family patterns whose specific family dynamics tend to complicate the interaction among their members once immigrated to a different cultural and linguistic context. Lee suggests, in this context, that "traditional families" that were born and raised in their country of origin and only speak their native language at home, live in ethnic enclaves, or have a rural background may tend to approach their problems in a concrete and functional fashion. In the case of traditional families in which the children are better acculturated than their parents (Lee, 1990), an interesting phenomenon tends to develop; the parents are forced to remain dependent on their children to navigate the linguistic and cultural demands of the new environment. According to some findings, these sorts of families tend to present more parent-child conflicts, role confusion, and marital difficulties (Lee, 1990) as compared to more integrated families. Some findings have also highlighted that these types of families tend to suffer from conflict resulting from the dislodging of the parents' position of authority by their dependency on their children for linguistic and cultural translation (Lee, 1990). In the case of a "bicultural family" where parents are professionals or business owners and speak primarily English (Lee, 1990), parental authority tends to be more egalitarian as opposed to patriarchal; these families tend to live in suburban areas and are more stable than the previous family types.

Issues in the Assessment of Trauma in Cultural Contexts

We will now discuss some of the culturally specific organizations to express distress that have been identified in various publications, with the understanding that our presentation is only meant to highlight this important phenomenon and not intended to compile and offer an extensive and complete list. We want to encourage those engaged in assessing the impact of traumatic experience in culturally and linguistically diverse populations to explore with their clients the specific and unique ways that are relevant to the client being assessed. This is guided by the fact that cultural factors are shown to influence the presentation of psychiatric disorders (Balhara, 2011; Fabrega, 1987), which then may complicate the forensic picture to be examined. These culture-specific conditions are better known as a "culture-bound syndrome" (CBS) and are a broad range of behavioral, affective, and cognitive manifestations that are seen in specific cultures (Balhara, 2011; Mehta, De, & Balachandran, 2009) (see Paniagua & Yamada, 2013 for other examples). They are recurrent and specific patterns of aberrant behavior and troubling experiences that may not be linked to any specific disorder. These sorts of behavior manifestations are atypical of others in their original culture and are seen both as a reflection and as a source of distress (Balhara, 2011).

Paniagua and Yamada (2013)'s recent book provides an extensive and thoughtful analysis of the multiple challenges likely to face the professional when assessing the linguistically and culturally diverse populations. These authors make particular reference to cultural-bound syndromes used to communicate personal reactions to difficult events in their environments. These are unique syndromes whose descriptions suggest strong reactions and discomfort that the individuals had difficulty handling and that these scripts or schemas provide a way to organize that reaction. Let's take a look at some of the most relevant syndromes related to trauma expression: "*Amok*" is a violent and aggressive outburst normally directed at people and/or object. It is found to be associated with syndromes such as amnesia, exhaustion, and persecutory ideas. It is normally found in Malaysians, Laotians, Filipinos, Polynesians, Padua, New Guineans, and Puerto Ricans. "*Boufée Délirante*," usually found in Haitians and people from West Africa, is described as "sudden outburst of aggression, or agitation associated with cognitive confusion, psychomotor excitement, and symptoms resembling a Brief Psychotic Disorder" (also including visual and auditory hallucinations and paranoid ideations) (p. 26). "*Pibloktoq*," normally found among Arctic and Subarctic Eskimos, is described as an emotional reaction characterized by excitement, coma, and convulsive seizures resembling a dissociative episode. While in the midst of that reaction, the individual may show the presence of "withdrawal, amnesia, irritability, irrational behaviors" (e.g., breaking furniture, eating feces, obscenities, etc.) (p. 27). "*Susto*" (also referred to as Pasmo, Espanto, and Miedo) is found among the Hispanic populations and is described as "general weaknesses resulting from frightening and startling experiences" (p. 28). A related reaction also found among the Hispanic populations is "*Ataque de Nervios,*" also referred to as the "*Puerto Rican Syndrome*" (Ghali, 1982; Godoy, 1995; Moitra, Duarte-Velez, Lewis-Fernandez, Weisber & Keller, 2018). This condition is characterized

by epileptic-like reactions, including attacks of crying, trembling, uncontrollable shouting, physical and verbal agitation, normally followed by a temporary loss of consciousness, particularly in situations of high emotional intensity. Two conditions found among African Americans are "*Falling-out*" and "*Brain Fag*." The first one is characterized by "seizure-like symptoms resulting from traumatic events" (p. 26) and hence bearing some resembling to the "*Ataque de Nervio.*" The latter one is normally found among high school and university students struggling with school demands. It is characterized by concentration and thinking problems, head and neck pain, blurred vision, burning, and general somatic, somatoform, depressive, and anxiety disorders.

Language

Language identifies and codifies an individual's experience, which cannot be translated from one language to another without some distortion (Lu et al., 1995). Due to the nature of culturally diverse patients sometimes speaking more than one language, it is important to determine the individual's primary language prior to the evaluation. That is because a bilingual individual may vary on aspects of second language (L2) proficiency, age of L2 acquisition and processing emotional words (Baum & Titone, 2014; Bialystok, Craik, & Luk, 2008; Chen, Lin, Chen, Lu, & Guo, 2015), degree of L2 proficiency and fluency (Francis, Tokowicz, & Kroll, 2014; Gollan, Starr, & Ferreira, 2015), and the context of L2 learning (de Bruin, Bak, & Della Sala, 2015; Green, 2011). In that context, the forensic professional is likely to encounter clients who are considered beginners of the language or what we refer to as "subordinate bilingual" (Diller, 1974). These types of clients are quite deficient in the second language and tend to process whatever is going on with them through the lens of their first language, although they may be using words and phrases in the second language in ways that appear that they understand more than it is actually the case. There is enough evidence of the possibility for serious inaccuracies in the assessment of these individuals, giving rise to different conclusions of the nature of the psychological difficulties, depending on the language of the assessment. For instance, psychiatric assessments in the second language resulted in much more severe diagnosis of psychopathology, as compared with the assessment in the first/native language, in a sample of subordinate bilinguals (Javier, 2007; Marcos, Urcuyo, Kesselman, & Alpert, 1973).

We may also encounter another type of client that seems to have more knowledge and proficiency in the second language, having learned the second language either while in their country of origin or during their years in the host country, but in a different context from the first language. These individuals may have developed a coordinate linguistic organization and, as such, could be considered "coordinate bilinguals" (Lambert, 1972; Javier, 2007). Depending on the level of proficiency, there are challenges likely to emerge in the assessment of these individuals as well. Some of these challenges have been amply discussed by Javier, Barroso, and Munoz

(1993); Javier (2007); and most recently by Itzhak, Vingron, Baum, and Titone (2017). It has also been highlighted in a series of research findings in our lab (Acevedo et al., 2017; Amrami, Lamela, Maskit, Bucci, & Javier, 2019) that assessed qualitative and quantitative differences in the communication of events, memory of events, emotional reactions, etc. in a sample of coordinate bilinguals. Our concern for this group is the assumption of accuracy in communication, particularly with regard to communicating emotionally laden material. There is some evidence that with material related to too strong emotions (likely to be the case with individuals with a history of early trauma related to experience prior to immigration), important details of the event may not be that clearly available in the language of the assessment (Javier, 1996/2007).

More concretely, if a client uses the more limited secondary language, he/she may not be able to present their history accurately. The client may lose the more vibrant aspects of communication such as humor, assertiveness, expressions of displeasure, frustration, love, and trauma. Lacking this richness may lead to misdiagnosis or misconceptualization of the case (Lu et al., 1995). This issue was eloquently examined most recently by Itzhak et al. (2017) in their examination of how proficiency, emotion, and personality in L2 can impact communication. According to these authors, the higher a bilingual individual's L2 proficiency, the more likely that he/she is able to get by on L2 (Itzhak et al., 2017), because higher L2 proficiency may mean that the individual may have a greater L2 vocabulary (Hellman, 2011) when compared with L1 (the person's first language). However, this bilingual may still lack the specific vocabulary needed to fully express himself/herself in different contexts. This may result in the individual attempting to communicate his/her message via gestures or through the swapping of words (Itzhak et al., 2017). High L2 can also mislead an assessor into thinking the individual has a greater understanding of what is being communicated to him/her than is actually the case. In this context, the authors reported the difficulty of Low L2 proficiency (subordinate) bilinguals to convey important details of their personal history or presenting problem; their overall demeanor was found to be guarded and deferent with the evaluator that added to the perception or misperception of these individuals' level of difficulties (Itzhak et al., 2017).

These authors also provided confirmation that processing and communication of emotional content are dependent on language as emotion is not always processed the same way across all languages (Itzhak et al., 2017). This is particularly the case with emotionally laden communication. For example, some studies have found that phrases such as "I love you," "shame on you," or swear words have a greater emotional response based on their L1 as compared to their L2 (Dewaele, 2004, 2008), a finding supported by a study using an objective measure (e.g., skin conductance) (Harris, Aycicegi, & Gleason, 2003). These findings suggest that L2 has a weaker link to basic emotions than does L1. However, these findings become complicated when the factors of L2 proficiency and age of L2 acquisition are considered. Some studies have found that weaker emotionality is related to L2 proficiency factors and showed a weaker effect of emotion in L2 compared to L1 (Harris et al., 2003; Segalowitz, Trofimovich, Gatbonton, & Sokolovskaya, 2008) when subjects showed

less proficiency in L2. However, there are some studies that found similar levels of emotion processing in L1 and L2 when there is a higher L2 proficiency or earlier acquisition (Conrad, Reccio, & Jacobs, 2011; Eilola, Havelka, & Sharma, 2007; Ferre, Garcia, Fraga, Sanchez-Casas, & Molero, 2010; Sutton, Altarriba, Gianico, & Basnight-Brown, 2007). One explanation for these findings may stem from how different language patterns are used across emotionally charged social contexts (Altarriba, 2003, 2008; Caldwell-Harris, 2015; Harris, Gleasson, & Aycicegi, 2006). That means that a word needs to be experienced during a real-life emotionally charged situation (Segalowitz et al., 2008) to be bound to the language used in the experience; this finding was supported by an emotional processing advantage with positive words in L2 but not negative ones (Sheikh & Titone, 2016). Based on these findings, it is possible for two equally proficient L2 speakers to express and understand emotion in L2 differently based on the experiences they have had (Caldwell-Harris, 2015).

Presentation of personality may also be affected by the language that is used, with bilinguals appearing to switch personalities based on the language they use (Itzhak et al., 2017). In a 2006 study of this phenomenon, Pavlenko found that two main themes arose when bilinguals were asked open-ended questions about how they felt like when speaking different languages. The first theme that emerged in almost two thirds of bilinguals was a feeling of change in self-image. The second theme was of a feeling that the L1 reflected their true and natural personality, whereas L2 reflected an "artificial self." These findings were supported by a second study that found a consistent shift in the way bilinguals perceived aspects of their own personality across their languages (Dewaele & Nakano, 2013). Dewaele and Nakano (2013) found that bilinguals expressed being less logical, serious, and emotional while being more unauthentic when not using their L1. This finding can only be understood if we also consider the close interconnection of language and culture. Some studies have found that psychological personality tests have had different results based on modifications to test administration that reflected the assessee's respective culture and language (Chen & Bond, 2010; Ramirez-Esparza, Gosling, Benet-Martinez, Potter, & Pennebaker, 2006; Veltkamp, Recio, Jacobs, & Conrad, 2013).

A related issue is that bilinguals may alternate between both known languages throughout the day in different aspects of their lives depending on context (Itzhak et al., 2017), a phenomenon we refer to as "code switching" (Javier & Marcos, 1989). One example may be when the bilinguals use their learned language at work while using their native language (L1) at home. There are many factors involved in language switching that could be at play in a forensic evaluation, and hence, the reader is encouraged to keep in mind and explore the possible factors that may be involved when present in the assessment process. Code switching has been found to be triggered by uncomfortable and trauma-related emotions (Javier, 1996, 2007; Perez-Foster, 1996) and as expression of social status (Itzhak et al., 2017). Ultimately, our concern is the implications for the forensic practice.

These findings highlight the difficult challenge a forensic psychologist may face when evaluating these types of individuals using psychological tests considered the

gold standards of the discipline. This is true even if the test is in the language of the person being evaluated and with test tools that have been supposedly normed with a culturally relevant sample. According to these findings, we are left with what we actually get in terms of assessing the nature and extent of trauma that may have been processed in one or both languages. The fact that there are different contents of experience between which code-switching operates reflects not only that these individuals have developed different context-specific registers that are now encapsulated in their languages but that relevant information needed for the full forensic assessment of the condition under consideration may not be easily accessible in the language of the assessment.

Nonverbal

Another complication is related to the issue that communication is not just limited to verbal methods of communication, as it also includes nonverbal communication (Lu et al., 1995). Culturally influenced eye contact, touch, and forms of gesticulation as well as body language, facial expressivity, and grooming are all aspects that may provide important information to be considered in the forensic evaluation.

Some Remarks on the Use of Tests/Questionnaires in Forensic Contexts

The nature of linguistic and cultural issues delineated earlier make clear the serious challenge faced by the forensic psychologists in using standardized test material. Even translating a construct, however faithfully, may interfere with its reliability or validity (Camino & Bravo, 1994; Javier, 2007; Javier, Vasquez, & Marcos, 1998). For an assessment to follow proper standards, all measures must be reliable and valid, and the interpretation should consider the individual and group differences (Haas, Boyes, Cheng, MacNeil, & Wirove, 2016). While APA standards for forensic assessment (January 2013) make it clear that we have an ethical responsibility to ensure that measures are used relatively unbiasedly and in a culturally sensitive manner (Haas et al., 2016), this continues to be a difficult challenge for the discipline when dealing with culturally and linguistically diverse populations and where there are no sufficient and adequately standardized measures available.

A significant concern in these types of assessments is that of test equivalence, as tests may vary between cultural groups, particularly the case with migrant and refugee populations (Davidson, Murray, & Schweitzer, 2010). Equivalence (or degree of comparability between measurement outcomes) is a function of test validity across different cultural groups. The validity of a test refers to the soundness and defensibility of the interpretation, projections, and application of test results and that the extent to which the same construct is being assessed (Haas et al., 2016). It requires a structural equivalence, the similarity of meaning, and dimensional

organization of the psychological construct across different cultural groups. It is a measurement of equivalence or the similarity of both the item content and formal psychometric properties across cultural groups.

Test bias is another concern because it involves the existence of external sources of variance unrelated to the valid variance held by the construct of interest (Byrne et al., 2009). Test bias can exist in two forms, namely construct bias and item bias. Construct bias occurs when a test does not accurately measure an identical construct among different groups; when an issue with item content or formatting influences the individual's responses in unexpected or unintended ways, item bias is suspected to be at play (Geisinger, 2003; Matsumoto & van de Vijver, 2011).

Finally, Byrne et al. (2009) raised a serious concern with the issue of data interpretation, particularly when the individual findings are found to be nested within a culture. According to these authors, by ignoring the nested structure of cross-cultural data, a single-level focus occurs that creates interpretive errors at both the individual and group levels. This can create an unfortunate condition resulting in a failure to detect the cross-cultural validity of the data. Different constructs may be required to test individual- and group-level differences because there are not many constructs that are statistically level-invariant. Van de Vijver and Poortinga described this in their 2002 paper which found that the multitude of outcomes can be reduced into three possibilities in terms of suitability and unsuitability of individual- and country-level differences. The first occurs when items show a different, but meaningful clustering on the individual and country levels (van de Vijver & Poortinga, 2002). Some tests may find correlated factors within country but may show differences between countries. In these cases, different constructs would be needed to describe these sort of differences. The second possibility occurs when a meaningful structure only occurs on one level (van de Vijver & Poortinga, 2002). This can occur when either within-country or between-country data yield a theoretically expected structure, but the converse within-country or between-country data structure cannot be interpreted. This shows the unsuitability of such an instrument for cross-cultural comparison. The third is a full agreement of individual- and country-level solutions, which may occur after a few items have been omitted from the comparison (van de Vijver & Poortinga, 2002).

Several scholars have attempted to provide recommendations for the selection of test material that consider the client's level of acculturation and linguistic proficiency in the context of the specific cultural and linguistic demands of these tests. The "Bio-Ecological Assessment System or Bio-Cultural Model of Cognitive Functioning" suggested by Armour-Thomas and Gopaul-McNicol (1997) attempts to address that issue head on with the recommendation that all relevant information emerging from all sources about the individual's cognitive and emotional ability be meaningfully included in the assessment. Richard Dana's work (1993) on "Multicultural Assessment Perspectives for Professional Psychology" is worth mentioning in this regard as his work represents one of the earliest and most serious attempts to include concerns of the role of culture and language in psychological assessments. The work of Giuseppe Costantino and his colleagues (Costantino, Dana, & Malgady, 2007; Costantino, Malgady, & Rogler, 1985) is also worth

mentioning because of the unique culturally specific approach to capture and assess emotional difficulties in culturally diverse populations. These authors contributed to the creation of Tell-Me-A-Story (TEMAS) test and CUENTO (Story Telling) therapy that allow the evaluator to examine the nature and quality of the psychological problems presented by individuals from culturally, ethnic, and racially diverse communities. In the case of TEMAS, they developed a series of cultural/ethnically and racially sensitive scenarios guided by the Murray's Thematic Apperception Test (1938) but now populated by cultural-racial-ethnic characters and the scenarios reflecting relevant real-life situations for these individuals. It has a more carefully designed scoring system that has been adopted with several cultural, ethnic, and linguistic groups in various parts of the world (Costantino et al., 2007). CUENTO therapy is a method of using culturally relevant material and heroes and/or important characters in the folklore of the target group to address different psychological difficulties the person may be suffering from. It allows the person to anchor his/her personal processing of the nature of the psychological problems within his/her culturally relevant contexts. It has been found to be effective in working with juvenile delinquent populations and trauma victims (Costantino et al., 1985).

The contribution by Flannigan, McGrew, and Ortiz (2000) is also worth consideration. Their extensive work offers very specific analysis/recommendations of the cultural and linguistic loadings in these tests. We have discussed this issue more fully in an earlier publication (Javier, 2007) and hence will only summarize it here. The most important point for our purpose is the need to consider a cross-battery approach to assessment where specific tests are selected based on the client's expected linguistic and cultural demands and ability to respond to them. They predict that clients who are deficient in the second language and are very low in acculturation are likely to do poorly in tests assessing verbal knowledge. Thus, they are likely to fail any test that requires the subject to have a high-to-moderate linguistic and cultural knowledge to do relatively well. From that perspective, they suggest that the following subtests should be selected based on these demands and the best conditions likely to offer the most accurate information about the individual's true cognitive ability:

- *High in linguistic and cultural demands*
  - Similarities
  - Vocabulary
  - Information
  - Comprehension (Listening/Oral/Verbal comprehension)
- *High in linguistic and moderate in cultural demands*
  - Incomplete words
  - Sound blending
  - Memory for words
  - Auditory attention
  - Decision speed

- *High in linguistic and low in cultural demands*
  - Concept formation
  - Analysis synthesis
  - Auditory working memory
  - Pair cancellation
- *Moderate in linguistic and high in cultural demands*
  - Oral vocabulary
  - Picture vocabulary
- *Moderate in linguistic and cultural demands*
  - Visual auditory learning
  - Delayed recall-visual auditory learning
  - Retrieval fluency
  - Rapid picture naming
  - Arithmetic
- *Moderate in linguistic and low in cultural demands*
  - Digit span
- *Low linguistic and moderate cultural demands*
  - Object assembly
  - Picture recognition
  - Visual closure
- *Low linguistic and cultural demands*
  - Geometric design

In the case of a recently emigrated individual or someone who has limited knowledge of the language/culture of the assessment tool used (e.g., subordinate bilingual), subtests that have low linguistic and cultural loadings will likely offer the best condition for the purpose of the evaluation.

The Bender Gestalt has also been suggested as a nonverbal cognitive functioning screener to assess visual maturity, visual motor and spatial-motor integration skills, visual memory, response style and reaction to frustration, ability to correct mistakes, planning and organizational skills, and motivation (Kaufman & Lichtenberger, 2001; Koppitz, 1975). The newly re-normed Bender Gestalt II has been found to have good psychometric properties (e.g., reliability, concurrent validity, criterion-group validity, and construct validity) (Campbell, Brown, Cavanagh, Vess, & Segall, 2008).

There are specific tests that have been suggested for the assessment of trauma in diverse populations. Although these tests have not necessarily being validated in forensic samples, most have been found to retain good statistical properties when translated and used in languages other than English with other linguistically and culturally different populations. Listed under this category are the Clinically Administered PTSD Scale for DSM-5 (CAPS-5), the PTSD Checklist for DSM-5

(PCL-5), the Life Event Check List, 5th edition (LEC-5), and Minnesota Multiphasic Personality Inventory-2 (MMPI-2).

Typically considered the gold standard of PTSD interviews, the CAPS-5 is a 30-item structured interview that can be used to make a current and lifetime diagnosis of PTSD and assess PTSD symptoms over the past week (Weathers et al., 2013a). The CAPS-5 examines the onset and duration of symptoms, subjective distress, impact of symptoms on social and occupational functioning, improvement in symptoms since past CAPS assessment, PTSD severity, and PTSD subtype along with the 20 DSM-5 PTSD symptoms. Previous versions of the CAPS had been translated into other languages such as Chinese, German, Swedish, and Bosnian with high levels of validity, reliability, and correlation to the original English version (Charney & Keane, 2007; Chu, 2004; Paunovic & Ost, 2005; Schnyder & Moergeli, 2002; Wu & Chan, 2004; Wu, Chan, & Yiu, 2008). Research is ongoing on the validity of the translated versions of the CAPS-5 with versions translated into Turkish and German showing high levels of validity (Boysan et al., 2017; Müller-Engelmann et al., 2018).

The PCL-5 is a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD (Weathers et al., 2013). The PCL-5 can be used as a way to monitor symptoms change during and after treatment, screening for PTSD, and making a tentative PTSD diagnosis. Previous versions of the PCL have been translated into other languages such as Chinese and Spanish and with high levels of validity, reliability, and correlation to the original English version (Marshall, 2004; Miles, Marshall, & Schell, 2008; Orlando & Marshall; Wu et al., 2008). Since the development of the latest version, research into the validity of translated versions are ongoing. Currently, studies show high levels of validity for versions in Arabic, certain Kurdish dialects, Brazilian Portuguese, and French (Ashbaugh, Houle-Johnson, Herbert, El-Hage, & Brunet, 2016; de Paulo Lima et al., 2016; Ibrahim, Ertl, Catani, Ismail, & Neuner, 2018).

The LEC-5 is a self-report measure designed to screen for potentially traumatic events in the assessee's lifetime (Weathers et al., 2013b). The LEC-5 accomplishes this by assessing exposure to 16 known life events that potentially result in PTSD or distress. Current studies have found that other languages, such as Korean or Brazilian Portuguese, have found high levels of reliability and validity of the LEC when translated (Bae, Kim, Koh, Kim, & Park, 2008; de Paulo Lima et al., 2016).

Finally, the MMPI-2 is a personality and psychopathology measure that consists of 567 self-report items that reflect 8 Validity Scales, 10 Clinical Scales, and 15 Content Scales (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989). These scales include measures that may relate to aspects of trauma such as depression, paranoia, anxiety, fears, obsessions, depression, demoralization, low positive, emotions, and more.

An issue to keep in mind with regard to framing the diagnosis of PTSD following a DSM-5 is that serious questions have been raised with regard to the possible accuracy of the diagnosis using the criteria delineated in the DSM-5 nomenclature. According to Allen and Fonagy (2017), a traumatic reaction may still be present in an individual even when PTSD, as defined by the DSM-5, may not totally apply.

We also should keep in mind that although several of these scales showed good validity and reliability properties with their English version, it is not clear if construct validity was also assessed. In order to assess for construct validity, an assessment of the structural equivalence across different cultural groups is required.

Conclusion

The primary goal of this chapter was to provide the reader with the necessary context to determine the extent to which assessment and intervention for individuals coming from diverse cultural and linguistic communities have followed the standard of practice of the profession. By that we mean that all efforts are made to ensure accuracy of information within that context when deciding on the presence of trauma in these individuals and the extent to which their overall functions are compromised. Although we discussed areas to keep in mind and types of test material to consider for this group based on the linguistic ability of these individuals and their understanding of cultural expectations (acculturation), this has to be preceded by a careful history taking of the individual history from the country of origin to the present. This is particularly important in assessing the presence of early trauma and the implication for the developmental trajectory with regard to the cognitive and emotional functioning that is the subject of the evaluation. In that context, gathering careful and relevant information about developmental history and kinds of early attachment, medical complications, school functioning, work history, family history, legal history, trauma exposure, etc., both in the country of origin and currently, are important; they provide the necessary context to understand the nature of the condition under assessment. The reader is encouraged to develop this mental set and approach to ensure the most ethical approach to the forensic assessment of this population.

Questions/Activities for Further Exploration

1. Select an individual from a diverse cultural group and identify as many different ways stress is experienced and strategies utilized to address it.
2. Discuss how standard assessment tools can provide inaccurate information about the person being assessed in terms of cognitive abilities and emotional difficulties when cultural and linguistic factors are not considered.
3. List five important components to include in an assessment of culturally and linguistically diverse clients to ensure the most appropriate and ethical practice.
4. Identify the most important components to include in best practice curriculum to train future forensic professionals to address culturally and linguistically relevant issues in their clients.

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