Introduction to Mental Disorders related to the Implementation Order in *Franco-Gonzalez v. Holder*

Introduction

The Implementation Order (the Order) in *Franco-Gonzalez v. Holder* defines class membership, in part, as individuals "having a serious mental disorder or defect that may render them incompetent to represent themselves in immigration proceedings." The Order further defines "serious mental disorder or defect" to include individuals with specific mental and medical diagnoses as well as specific symptoms listed in the Order. This guide serves as an introduction to the diagnoses and symptoms listed in the Order. These diagnoses or conditions may be referenced in the mental health materials provided by Department of Homeland Security (DHS) when DHS identifies an individual as meeting the criteria for class membership or in materials received from a Respondent or a Third Party. This guide is not intended to suggest that Immigration Judges should attempt to make medical diagnosis or to discern whether a Respondent is suffering from a particular disorder or defect. Rather, this guide is solely intended to provide general information about the diagnoses and symptoms listed in the Order so that an Immigration Judge may better understand how a diagnosis or symptom may impact a Respondent's ability to represent him- or herself in immigration proceedings.

It is important to note that while the Order provides a discrete list of disorders and symptoms that meet the class criteria, an Immigration Judge is not limited to considering only the listed disorders or defects in deciding whether there is a bona fide doubt as to a respondent's ability to represent him- or herself in immigration proceedings. As such, while there are many diagnoses that are not identified in the Order and that may lead to impairments in cognitive, behavioral or emotional functioning, this guide is limited to describing those disorders and defects specifically articulated in the Order that an Immigration Judge may encounter when ICE identifies a class member.

This guide is organized according to the sections of the Order related to class membership, as follows:

I. Disorders Identified in the Order
II. Descriptions of Symptoms named in the Order
III. Functional limitations identified in the Order
IV. Additional Readings and Resources

I. Mental and Medical Disorders Identified in the Order

A. What is a "Disorder"

There is a great deal of variation in the mental, emotional and behavioral patterns among individuals. When does variation cross the line to "disorder"? A disorder is typically defined as a behavioral, emotional or mental state that causes distress or impaired functioning. In the Order, "mental disorder," including intellectual disability, is defined in Section III.A. of the Order as "a significant impairment of the cognitive, emotional or behavioral functioning of a person."

B. When is a disorder a "serious" mental disorder?

The Diagnostic and Statistical Manual, 5th edition (DSM-5), does not define or categorize mental disorders as "serious." The Order uses "serious mental disorder or condition" to have the same meaning as Class membership criteria identified in Section I.A.3.b. Diagnoses that often overlap with serious mental disorders include the psychotic disorders (Schizophrenia, Schizoaffective Disorder), major mood disorders (Major Depressive Disorder, Bipolar Disorder), some anxiety disorders and eating disorders. Neurological disorders which have significant impact on functioning, such as Neurocognitive Disorder or Traumatic Brain Injury, are referenced as medical disorders in the Order.

C. Diagnosis

A diagnosis is a medical determination that a person meets certain defined criteria for symptoms, duration and severity (distress and dysfunction) for a mental or medical disorder. The criteria are defined in the DSM-5. *See* Section IV below. Most diagnostic criteria require a minimum number of symptoms, a minimum time period for the symptoms and a clinically significant level of distress or dysfunction. While the Order provides a discrete list of disorders and symptoms that meet the class criteria, a diagnosis of a particular disorder or defect is not required for class membership.

1. Basis for Diagnosis

Mental disorder diagnoses are clinical diagnoses. They are based on an individual's reported and documented history of symptoms as well as observations by mental health professionals. In the case of neurocognitive disorders, testing or imaging are often used to facilitate diagnosis. Mental health professionals conduct interviews in which they ask about symptoms and the impact the symptoms have had on the examinee. Screening questions detect symptoms and lead to a more detailed assessment. A diagnosis is made through questioning and record reviews that probe the areas identified on the screening. In the course of an assessment, the mental

health professional often considers a number of diagnoses, an examination of other potential reasons for the symptoms and then determines the diagnosis that best fits all of the available data.

Mental health professionals rely heavily on a person's history, including records, to assist in making a diagnosis. A patient may forget, exaggerate or minimize symptoms of mental disorder. Previous assessments and treatment records are valuable sources of data for accurate diagnoses.

2. Documentation of Diagnoses

Most mental health professionals use the DSM-5 as the standard for diagnostic terminology and criteria. Documentation typically follows the DSM practice of listing both the diagnosis and specifiers that provide additional information about the specific features, severity and pattern of the diagnosis. For example, in the diagnosis of Major Depressive Disorder, a clinician can add specifiers to indicate severity, whether or not the patient has psychotic symptoms as part of the diagnosis and whether this is a first or recurrent episode. For example, a diagnosis may be recorded as Major Depressive Episode, Severe, Recurrent, Without Psychotic Features.

Some individuals have more than one diagnosis. The term "principal diagnosis" indicates the diagnosis that is chiefly responsible for the person's distress or impairment. The principal diagnosis is listed first, followed by other disorders/diagnoses in order of focus of attention and treatments. Medical conditions that lead to mental health symptoms are often listed first.

Sometimes it is not possible to determine a diagnosis at the time of an assessment. Clinicians can indicate a probable diagnosis using the specifier "provisional." Similarly, clinicians can indicate when there is not enough information to determine a specific diagnosis by using the term "unspecified." With a depressive disorder, for example, a clinician may have insufficient information to determine that a patient has met the criteria for Major Depressive Disorder. In this case, the diagnosis may be listed as Unspecified Depressive Disorder.

D. Disorders Specifically Identified in the Order

<u>1. Psychotic Disorders</u> (Order at Section I.A.3.b.ii.1)

Psychotic disorders are characterized by the presence of hallucinations, which are false sensory experiences, and/or delusions, which are fixed false beliefs. These breaks with reality typically result in significant dysfunction in thought, emotion and behavior.

a. Delusional Disorder

Delusional disorder is characterized by the presence of one or more fixed false beliefs lasting one month or longer. People with Delusional Disorder usually do not have hallucinations and do not demonstrate changes in their overall ability to care for themselves. There are a number of subtypes that reflect the main content of the delusions. These are:

> *Paranoid or Persecutory Type*: the central theme is a belief that the individual is being conspired against, harassed, poisoned, spied on, followed or otherwise harmed by an individual or a group of individuals. For example, an individual may believe that others are conspiring to disrespect or harm him. Paranoia often manifests as beliefs that a person is under monitoring.
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> *Grandiose Type***:** the central theme is the conviction of having great talent, powers, wealth, resources, connections or responsibilities, such as the responsibility to save the world from evil.
>
> *Erotomanic Type*: the central theme is that another person is in a love relationship with the individual.
>
> *Somatic Type***:** the central theme is the alteration of bodily functions or sensations, such as a belief that an individual has received a brain transplant or is infested.

b. Brief Psychotic Disorder

This is a disorder of transient psychotic symptoms that last at least one day but less than one month. The psychotic symptoms can be hallucinations, delusions or both. This disorder sometimes occurs during periods of intense stress and resolves completely.

c. Schizophrenia (Order at Section I.A.3.b.ii.3)

Schizophrenia is a chronic psychotic disorder that is usually accompanied with significant functional impairments. The symptoms of schizophrenia may include disorganized speech, such as rambling or incoherence, and disorganized behavior, such as purposeless, repetitive actions. People with schizophrenia sometimes manifest "negative symptoms." These are deficit symptoms such as lack of emotional expression and general lack of motivation.

Although the term "Paranoid schizophrenia" was used to describe a subtype in the past, this is no longer a current diagnosis. Catatonia, is a rare but severe symptom of Schizophrenia that is described in Section III.E.

d. Schizoaffective Disorder (Order at Section I.A.3.b.ii.3)

Schizoaffective Disorder is a psychotic disorder with delusions or hallucinations that includes major mood symptoms occurring for the majority of time of the illness. This disorder can be bipolar or depressive type, depending on whether depression or elevated mood symptoms are present.

e. Substance or Medication-Induced Psychotic Disorder

A person may develop delusions or hallucinations following a period of substance or medication use. For example, stimulants such as cocaine and methamphetamine are associated with development of paranoid delusions as well as hallucinations. Psychotic symptoms can last long after the end of the substance use. It is not always possible to distinguish between a psychotic disorder resulting from substance use and a primary psychotic disorder such as Schizophrenia.

f. Other Specified and Unspecified Psychotic Disorders:

These diagnoses apply when there are symptoms characteristic of a psychotic disorder with clinically significant distress or impairment but not enough data to meet the full criteria for the diagnosis.

2. Bipolar Disorder (Order at Section I.A.3.b.ii.2.)

Bipolar Disorder is a mood disorder with episodes of abnormally high and low mood. During a manic episode, a person may have delusions, typically grandiose delusions that involve religion, special powers, and special importance, hallucinations, decreased need for sleep, increased talking, distractibility, increased sexual behaviors, increased spending and agitation. A manic episode may be caused by drug abuse, medications or another medical condition, in which case the diagnosis is not Bipolar Disorder but is a substance induced mood disorder.

Individuals with Bipolar Disorder typically cycle with alternating manic episodes and depressive episodes. There is a subtype of Bipolar Disorder known as Bipolar II Disorder with less severe mood symptoms.

3. Major Depressive Disorder with Psychotic Features (Order at Section I.A.3.b.ii.4)

If a person with depression describes or demonstrates psychotic symptoms, his or her diagnosis would reflect the subtype Major Depressive Disorder with Psychotic Features. Delusions associated with major depressive disorder often include depressive themes of guilt, nihilism, paranoia and financial ruin. Hallucinations in Major Depressive Disorder may include auditory, visual or other sensory hallucinations and are usually connected to delusional thoughts. For example, if a person with a Major Depressive Disorder has delusions of guilt, he or she may experience voices that are condemning or taunting.

4. Neurocognitive Disorders (Order at Section I.A.3.b.ii.5)

The Neurocognitive Disorders are based on problems with attention, orientation, executive functioning (organization, planning, judgment), learning, memory, language, movement related skills and social behaviors. Some Neurocognitive Disorders are congenital, such as developmental and intellectual disabilities that are recognized early in life. Other Neurocognitive Disorders are acquired later in life as the result of an injury or illness.

Neurocognitive Disorders are usually diagnosed and managed by medical providers such as neurologists. The following disorders are categorized as Neurocognitive:

a. **Delirium:** Delirium is a transient disturbance in awareness, attention, orientation and reality testing due to a medication or medical disorder. Drug and alcohol withdrawal can cause delirium. Some patients experience hallucinations and delusions (including paranoid delusions) during an episode of delirium.

b. **Major and Minor Neurocognitive Disorders:** This group of disorders includes dementias, other degenerative diseases, chronic brain infections and traumatic brain injury. A diagnosis of Minor Neurocognitive Disorder reflects modest cognitive decline and mild impairments. Minor Neurocognitive Disorder is not associated with a need for assistance in everyday activities for someone living in the community. In contrast, a diagnosis of Major Neurocognitive Disorder is based on significant concern of decline and evidence of impairment of cognitive performance. Major Neurocognitive Disorder is associated with need for assistance in everyday activities for someone living in the community.

Neurocognitive disorders are described according to underlying cause or pathological findings. The common disorders are: Alzheimer's disease, Frontotemporal Degeneration, Lewy Body Dementia, Vascular Neurocognitive Disorder, Traumatic Brain Injury, Infections (e.g. HIV, prion), Parkinson's disease and Huntington's disease. Each disorder is associated with patterns of progression, behavioral symptoms, motor symptoms and patterns of cognitive decline. See Section IV. for additional information.

c. **Traumatic Brain Injury:** Neurocognitive Disorder related to Traumatic Brain Injury follows a head injury that is associated with symptoms of loss of consciousness, amnesia, disorientation, confusion or neurological signs. The injury may be associated with long-term deficits in cognition and behavior.

5. Intellectual Developmental Disorder (Order at Section I.A.3.b.ii.6)

Intellectual Developmental Disorder, previously termed intellectual disability or mental retardation, is a diagnosis that includes deficits in intellect and ability to adapt that appear in the developmental period, before age 18. People with Intellectual Developmental Disorder may also have other mental disorders.

Deficits in intellectual development are problems with reasoning, problem solving, planning, abstract thinking, judgment, academic learning and learning from experience. These deficits are quantified through observation, clinical assessment and standardized assessment. Academic learning problems sometimes result in referral to special education or other learning support.

Deficits in adaptive functioning result in failures to meet expectations for personal independence and social responsibility. People with these deficits require supports to compensate for limits in communication, social participation and independent living in the community. For example, a person who is unable to master a public transportation system may require support from a family member.

The DSM specifies four levels of severity for Intellectual Developmental Disorder: mild, moderate, severe and profound. Severity levels are associated with deficits and resulting needs for support in conceptual, social and practical functioning. For example, moderate severity is associated with academic skills development limited to the elementary level, limited social judgment and decision making and dependence on support in work settings. Individuals with moderate severity are able to independently care for their personal needs but may require additional time, teaching and reminders. People with a severe level of intellectual developmental disorder use simple speech and require support for all activities of daily living such as meals, dressing and hygiene. People with profound deficits depend on others for all aspects of daily life.

II. Symptoms Identified in the Order (Order at Section I.A.3.b.i.2)

A. Severe Disorganization

In mental health, the term disorganization is used to describe disturbances in thoughts, speech and behavior that interfere with communication and functioning. Disorganized thoughts are thought patterns that may be illogical, rambling, disjointed or nonsensical. Mild disorganization may take the form of repetitive and digressive statements. More severe disorganization is when logical connections break down and the thought and speech patterns are no longer coherent. Tangential thought processes are reflected in speech or writing that is difficult to follow because it lacks logical connections from one phrase or sentence to the next. Flight of ideas is a type of disorganization that reflects rapid shifts in concepts or topics. At the extreme end of disorganization, thoughts and speech are described as “word salad” because of the extreme fragmentation of logic and language.

Disorganized behavior represents illogical or non-purposeful behavior that can be repetitive or ritualistic movements such as rocking or marching in place. Some disorganized behaviors are trivial; a person may repeatedly open and close a book with no purpose. Examples of severe disorganized behavior are seen in mentally ill people who tear up papers and belongings or fail to care for their hygiene, resulting in a filthy living environment.

Disorganized thoughts and behaviors are often associated with major mental disorders such as Schizophrenia, Schizoaffective Disorder or a manic episode. Significant disorganization may also be observed in Intellectual Developmental Disorder and Neurocognitive Disorder.

Evidence of disorganized thoughts, speech and behavior is found in a person’s appearance, written and spoken communication and in the clinical documentation of their thought processes. A person with severe disorganization may demonstrate bizarre grooming, poor hygiene, repetitive behaviors or documentation of a messy or filthy living environment.

B. Hallucinations

A hallucination is a false sensory experience. A person may perceive a voice or sound, a vision, a smell or a taste that originates internally and not from the environment.

Hallucinations are most often auditory but an individual can experience visual, somatic, olfactory and gustatory hallucinations. Auditory hallucinations typically manifest as voices. Many people experience the voices as derogatory, threatening and harassing. Some auditory hallucinations command actions which may be trivial (such as choosing coffee instead of tea) or very harmful (such as harming oneself or others).

Most people do not talk about hallucinations unless they are asked about them. Auditory hallucinations sometimes discourage people from accurately reporting their presence or nature of the hallucination. Often, hallucinations are tied to delusions. For example, a person may have a paranoid delusion that there are people spying on him and have auditory hallucinations of hearing people talking outside the window.

Hallucinations are associated with a number of mental disorders. People with Schizophrenia and Schizoaffective Disorder may have prominent and persistent hallucinations that cause significant distress and dysfunction, especially if they comply with command hallucinations. Hallucinations may be present in mania, depression with psychotic features, delirium, dementia and mental disorders resulting from substance use.

Evidence that a person is actively experiencing a hallucination may be through disclosure of hearing or seeing things that others cannot see. At times, a person will not disclose that he or she is experiencing hallucinations but there is behavior that suggests they are present. For example, a person may appear distracted or address a person not in the room. In clinical notes, this is often documented as “responding to internal stimuli.”

C. Delusions

A delusion is a fixed false belief. A belief is false when it does not reflect reality, such as a belief of great wealth in a person with no resources or an unsubstantiated belief of harassment by a government conspiracy. A person is delusional when he or she lacks insight into the false nature of a belief and cannot accept alternative explanations, even when logic and evidence are offered. In some cases, clinicians must carefully explore the belief and the underlying facts to determine that the belief is indeed false. Some uncommon religious and political beliefs are shared by a group or culture (e.g. sovereign citizens) and shared by subcultures are not delusions.

Delusions are associated with a number of mental disorders. Persistent delusions are core symptoms in Delusional Disorder and in Schizophrenia and Schizoaffective Disorder. People suffering from mania may experience delusions, often relating to grandiose themes such as fantastic wealth and influence. As noted above, Major Depressive Disorder may include delusions, often with depressive themes. Substance use disorders, delirium and dementias may include delusions, which are typically paranoid. People with stimulant use disorders sometimes experience delusions of infestation or delusions that devices were implanted in their bodies.

The evidence that a person is actively experiencing a delusion may be direct or indirect. Direct evidence comes from the statements a person makes related to a delusional belief. Anxiety, irritability, anger and self-harm may be indirect manifestations of delusional beliefs.

D. Mania

A manic state is an elevated or irritable mood state accompanied by increased energy, abundant speech, abnormal and often grandiose thoughts and behaviors that are outside of the person’s usual interests and patterns. A manic state is almost always accompanied by a decreased need for sleep and high energy levels even after minimal rest. Mania is often accompanied by delusions of grandeur but is sometimes associated with paranoia.

Mania, or a manic state, is usually associated with a diagnosis of Bipolar Disorder but can result from substances, medication or withdrawal. Schizoaffective Disorder often includes manic symptoms.

Observations of rapid speech that may be difficult to interrupt, disorganized thoughts (for example, flight of ideas) and grandiose thoughts about the possession of special qualities are highly suggestive of a manic state.

E. Catatonia

Catatonia is a usually dramatic physical slowing or immobility. The criteria for catatonia are three or more symptoms that may include stupor, mutism, posturing, mannerisms, mimicking and grimacing. People who are in a catatonic state are usually unable to communicate and require psychiatric hospitalization for care and treatment. Catatonia is rare and is most often associated with a major mental disorder such as Schizophrenia or severe depression.

F. Severe Depressive Symptoms

Unlike the periods of sadness that most people experience, severe depressive symptoms are pervasive, recurrent and interfere with functioning. Severe depressive symptoms are associated with Major Depressive Disorder, the depressed phase of Bipolar Disorder, Schizoaffective Disorder and some neurocognitive disorders. Symptoms of depression include depressed or irritable mood, loss of interest in usual activities, decreased energy or activity, decreased appetite with weight loss, fatigue or loss of energy, difficulty concentrating, sleep disturbance, ideas of guilt and unworthiness and thoughts of death and suicide. Severity of depressive symptoms is rated by both the overall of number of symptoms and the degree of distress and functional impairment. Psychotic symptoms or active planning for suicide are examples of severe depressive symptoms.

Evidence that a person is experiencing severe depressive symptoms may be found in the description of symptoms in medical record or self-report of feeling sad, hopeless, guilty or nihilistic. A person may appear sad and fatigued and respond slowly to questions. A severely depressed person may have hopeless or suicidal thoughts and withdraw from interactions with others.

G. Suicidal Ideation and Behavior

Thoughts of suicide and suicidal behavior are associated with many psychiatric diagnoses: depressive disorders, psychotic disorders (particularly in the context of certain hallucinations or delusions), substance use disorders, some personality disorders and severe anxiety disorders. In addition, people with chronic pain and terminal illness may have suicidal thoughts and behaviors.

There is no reliable way for clinicians to know if or when a person is going to attempt suicide. Even minor acts of self-harm, such as superficial cuts, can be followed by serious suicide attempts.

People entering mental health and medical facilities are routinely screened for suicidal thoughts and history of past suicidal attempts. Careful screening questions will still miss some people who do not disclose suicidal thoughts or who, after being detained for a period of time, develop thoughts about killing themselves. Some behaviors, such as saying farewell and disposing of belongings, may

represent suicidal thoughts. Although it is rare, sometimes evidence of past suicide attempts are visible with marks or scars on wrists or on a person's neck.

H. Marked Anxiety

Although transient anxiety is a fairly common experience, severe anxiety symptoms can be pervasive, recurrent and interfere with functioning. There are over 100 symptoms of anxiety, which may include shortness of breath, chest pain, feelings of panic, and avoidance of situations that worsen anxious feelings. A number of disorders feature marked anxiety symptoms such as Phobias, Post-Traumatic Stress Disorder, Panic Disorder and Obsessive Compulsive Disorder. Marked anxiety may also be present with Major Depressive Disorder, psychotic disorders and Neurocognitive Disorders.

Physical manifestations of marked anxiety there may be observable such as tremor, shaky voice, startle response, difficulty speaking and decreased focus. A person may report impaired concentration or respond in vague or negative terms as a result of the cognitive effects of anxiety.

I. Impulsivity

Impulsivity represents a failure to plan or consider consequences before speech or action. Verbal impulsivity may manifest as blurting out or interrupting others. Behavioral impulsivity may be a self-harm act, such as head banging. It may be touching another person, or taking or throwing objects. Decision-making is impulsive when a person does not consider alternatives or consequences.

Impulsivity may lead to distress and dysfunction. Clinically significant impulsivity is associated with a diagnosis of mania, psychotic disorders, attention disorders, Intellectual Developmental Disorder and the Neurocognitive Disorders.

Evidence that a person is impulsive may be indicated by inappropriate speech, bizarre or socially inappropriate behavior or rash decision-making. A medical record may document impulsive self-harm behaviors or rule violations related to impulsive behaviors.

III. Functional Limitations Identified in the Order (Order at Section I.A.3.b.i.1)

The Order identifies functional limitations in four areas as relevant to class membership.

1. Communication: Functional limitations in communication may be impairments using language, expressing opinions, sharing information, understanding information or responding to questions.

2. Reasoning: Reasoning is limited when a person is unable to solve problems, work with abstractions or interpret information.

3. Activities of Daily Living: Often described as "ADLs," these are the everyday activities meet basic needs: eating, dressing and hygiene. A person living independently in the community may be limited in ADLs, but able to meet their needs in a more structured environment.

4. Social Skills: Social skills are a broad set of skills that allow a person to interact with others. These skills require verbal and non-verbal skills to make and negotiate requests, control impulses and cooperate.

IV. Additional Readings and Resources

The following resources, although not specific to the Order, provide additional information on mental and medical disorders:

Books

Diagnostic and Statistical Manual, 5th edition (DSM-5), American Psychiatric Association
Understanding Mental Disorders: Your Guide to DSM-5, American Psychiatric Association
Judges' Guide to Mental Health Jargon, 3rd edition, SAMHSA's GAINS Center https://www.prainc.com/our-work/products/

Websites

Neurocognitive Disorders https://www.psychologytoday.com/conditions/neurocognitive-disorders-mild-and-major
Symptoms & Treatments of Mental Disorders https://psychcentral.com/disorders/
National Alliance on Mental Illness https://www.nami.org/learn-more/mental-health-conditions
American Psychiatric Association https://www.psychiatry.org/patients-families/what-is-mental-illness
Mayo Clinic https://www.mayoclinic.org/diseases-conditions/mental-illness/symptoms-causes/syc-20374968