Central American Victims of Gang Violence as Asylum Seekers: The Role of the Forensic Expert

Gilberto De Jesús-Rentas, MD, James Boehnlein, MD, and Landy Sparr, MD

Individuals fleeing persecution have the right to asylum. This most fundamental right was guaranteed by the 1951 United Nations (UN) Convention Relating to the Status of Refugees and 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). In claiming refugee status, the burden of proof rests with the asylum seeker and is often a daunting task, given language and cultural barriers, lack of knowledge about U.S. legal procedures, and the reality that oppressive states do not document their intentions to persecute dissidents. Forensic psychiatrists may be asked to provide mental health assessment in immigration cases. In this article, an example of a Central American man with a nontraditional but increasingly common request for asylum is presented, the asylum process is described, and the role of the forensic psychiatric expert before the immigration court is explored.

J Am Acad Psychiatry Law 38:490–8, 2010

The horizons of forensic psychiatric practice are ever expanding and have moved beyond criminal and civil courts, disability assessments, custody cases, and evaluations of malpractice. In recent years, mental health practitioners have become involved in the evaluation of asylum seekers who claim to be victims of torture and persecution because of their political points of view, or because of oppression in their country of origin. Recently, individuals in a new wave of asylum seekers from Central America have allegedly been victims of torture and persecution, not by government agencies, but by Central American gangs.

In this report, we present a summary of the evaluation of a Central American man at the Intercultural Psychiatric Program (IPP) at Oregon Health and Science University (OHSU). The requirements for requesting asylum in the United States, the expectations of the immigration court and immigration attorneys, and the purpose and methodology of forensic consultation will be explored. The man described in this case gave informed consent for his history to be used.

Dr. De Jesús-Rentas is a forensic psychiatry fellow, Dr. Boehnlein is Professor, and Dr. Sparr is Associate Professor, Department of Psychiatry, Oregon Health and Science University, Portland, Oregon. Address correspondence to: Landy Sparr, MD, Department of Psychiatry (OP02), Oregon Health and Science University, 3181 SW Sam Jackson Park Road, Portland, OR 97329. E-mail: sparrl@ohsu.edu.

Disclosures of financial or other potential conflicts of interest: None.

Case Example

Mr. G., a young Guatemalan, was referred by his immigration attorney for psychiatric evaluation as part of the process of applying for asylum. His chief complaints were nightmares and symptoms of depression since 2006. He was raised by his grandparents and worked in agriculture until late adolescence when he decided to start a new job as an auto mechanic's assistant in a nearby town. He traveled to work approximately 30 minutes by bus and walked another 15 minutes to the auto shop. He stated that a gang was involved in criminal activity in the town. One day, while walking home, he was approached by gang members who wanted to recruit him. He said that the leader threatened him when he refused to join the gang.

Mr. G. reported that 10 days later he was again confronted by gang members who assaulted him when he continued to refuse to join them. He remembered being punched, thrown on the sidewalk, and kicked. He was held from behind and a second attacker pulled out a knife and inflicted multiple cuts

on his left hand. When he saw the blood and the depth of the wounds, he fainted. He was taken to the hospital and admitted for 15 days of treatment. At the hospital, a doctor performed multiple surgeries to repair damage to nerves, ligaments, and tendons in his hand. He never reported the incident to the police because he was afraid that some of the police officers might have an affiliation with the gang and retaliate against him.

After being released from the hospital, he went to live at his grandmother's house, but did not return to work. His grandmother tried to persuade him to go back, but he refused. Another relative who had had a similar experience with the gangs was ultimately murdered, and Mr. G. believed that he, too, would be murdered. After a few months, he decided to leave the house and help his extended family by working on their farm. His plan was to work at the farm in the early morning and return home no later than 10 a.m., because he believed that the gang members would be sleeping early in the morning and he would be safe.

During the following months, he felt depressed, with an extreme lack of interest in doing things that had formerly been part of his daily routine. Eventually, he isolated himself at home and avoided interaction with strangers. He started experiencing episodes of anxiety, particularly when someone approached him from the back, and he had difficulty sleeping because of nightmares related to the assault. Before the assault he had played soccer, gone to church, and spent time with friends, but he had stopped everything because "life was not the same."

His family was concerned about his emotional condition, and his grandmother proposed that he move to a different town in Guatemala, but he thought that gang members would find him, and so he decided to go to the United States. Once he arrived, however, his symptoms did not resolve. He was able to go out of the house to work, go to church, and spend time at home where he felt safe, but he had no friends and never played soccer. At the initial evaluation he said that he was sleeping only four to five hours per night, and his sleep was interrupted by nightmares at least once a week.

Mr. G. denied any previous psychiatric illness or family psychiatric history. He denied past medical problems other than the hand surgery. During the evaluation, at least three scars were observed on his left hand, and he had difficulty flexing the fourth and fifth fingers. He denied the use of tobacco, alcohol, or illicit drugs. He also denied prior military or paramilitary service, physical or sexual abuse, and legal problems.

During the mental status examination, he maintained fair eye contact and was calm and cooperative. He had mild psychomotor delay, and his speech was soft in tone and low in volume. He was worried about the asylum process, and the resulting anxiety adversely affected his ability to sleep. His affect was sad and his mood was depressed. He was ashamed of feeling depressed. There were no psychotic features or thoughts about hurting himself or others. His thought process was coherent and goal directed. His concentration and attention span were poor to fair, but his remote memory was good.

As a result of the clinical evaluation, post-traumatic stress disorder (PTSD) and major depression were diagnosed. Psychological testing was not performed because there was no bilingual psychologist who could perform measures that were reliable and valid in Spanish. Mr. G. was referred for treatment, and a report of his clinical condition was submitted to his immigration attorney.

The Asylum Process

Asylum is a form of protection that allows individuals who are already in the United States to remain, provided they meet the definition of a refugee and can demonstrate that they have been persecuted or fear that they will be persecuted because of their race, religion, nationality, membership in a particular social group, or political opinion. Refugees outside the country may ask for protection in the United States because of some fear of persecution, but asylum seekers have already entered the country.

The United States is a signatory of the 1967 United Nations Protocol Relating to the Status of Refugees,[1] which incorporates some articles of the 1951 United Nations Convention Relating to the Status of Refugees.[2] As a signatory of the United Nations Protocol, the United States is obligated to protect refugees seeking asylum from persecution.[3] Congress legislated the U.S. obligations under the United Nations Protocol when it 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).[4] The primary goal of the Act was to bring U.S. law into compliance with the requirements of international law. With the

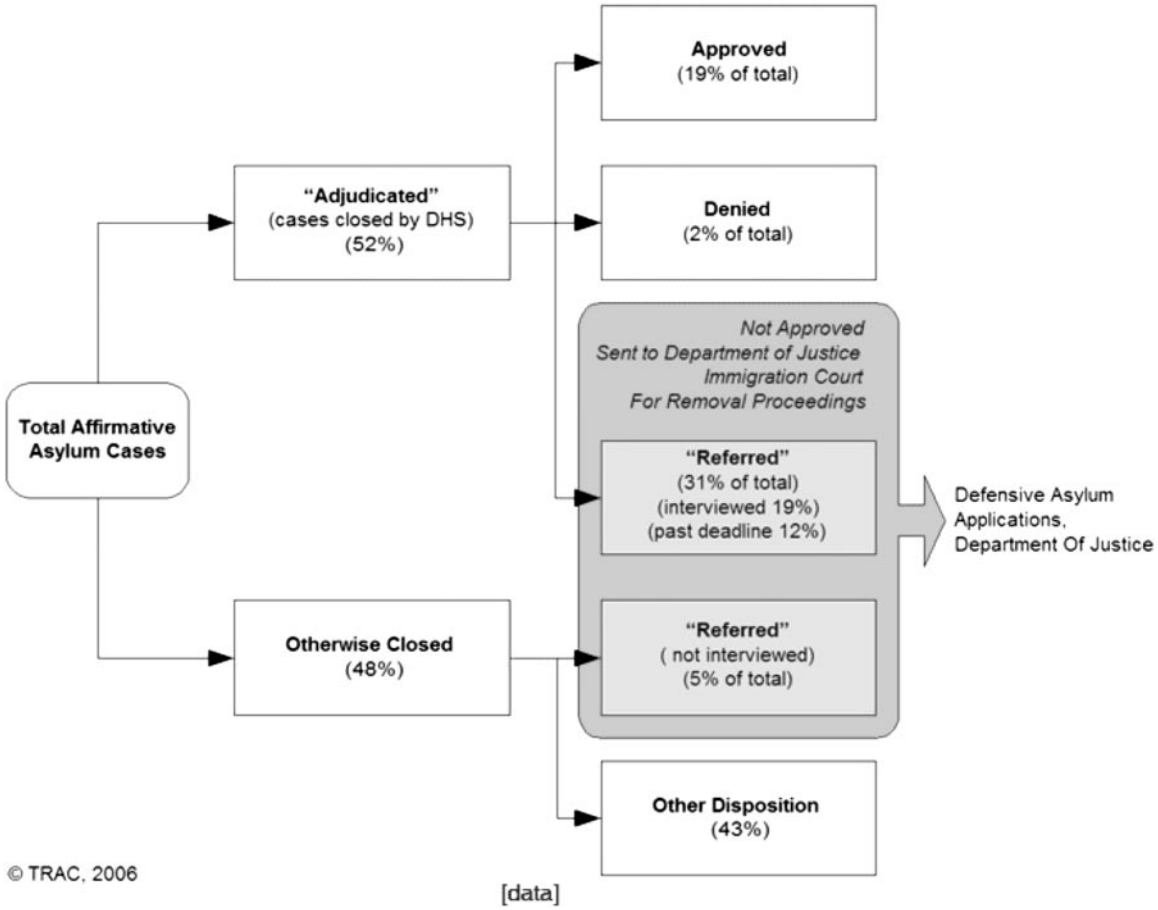

Figure 1. Process flow for affirmative asylum applications. Reprinted with permission from TRAC Reports, Inc., November 2, 2010.

passage of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRAIRA),[5] Congress enacted significant changes in immigration law. In an attempt to address illegal immigration, the IIRAIRA increased, sometimes drastically, the penalties for immigration violations. Included in this legislation was the introduction of expedited removal, which exposes a person seeking entry into the United States to possible lifetime exclusion from admission without right to counsel, administrative hearing, or review.

Responsibility for the implementation and enforcement of most U.S. immigration law, including asylum and refugee law, is shared between the Department of Homeland Security (DHS) and the Department of Justice's Executive Office for Immigration Review (EOIR). The former INS (Immigration and Nationality Service) was dissolved and its duties divided among three agencies under DHS: U.S. Citizenship and Immigration Service (USCIS), Customs and Border Protection (CBP), and Immigration and Customs Enforcement (ICE). USCIS adjudicates applications for immigration benefits, CBP inspects and admits noncitizens into the United States, and ICE investigates violations and detains and removes violators of immigration law. The EOIR primarily conducts removal proceedings and adjudicates appeals. Asylum seekers may hire attorneys and may encounter any or all of these various immigration agencies during the asylum process.[6]

The INA authorizes the DHS officers to remove certain aliens from the United States without giving them an opportunity to seek relief from removal in proceedings before an immigration judge in immigration court. At the same time, Article 33 of the United Nations Convention Relating to the Status of Refugees[2] and Article 3 of the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment[7] still applies in these cases. If an individual expresses fear of returning to the country to which he or she has been ordered removed, the immigration officer must refer

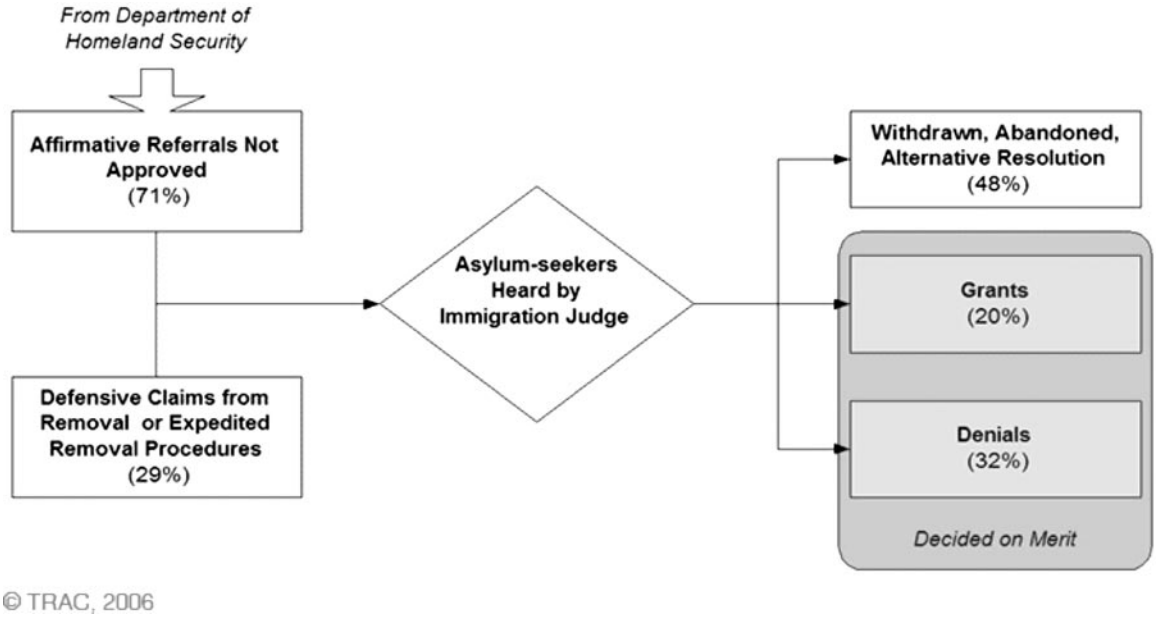

Figure 2. Process flow for defensive asylum applications. Reprinted with permission from TRAC Reports, Inc, November 2, 2010.

the case to an asylum officer, who will conduct an interview to determine whether the individual has a reasonable fear of persecution or torture. Psychiatric evaluation and testimony may be used in this process by an asylum defense attorney.

There are two routes to gaining asylum: affirmatively, through a U.S. Citizenship and Immigration Services (USCIS) asylum officer, or defensively, through an immigration judge as part of a removal proceeding. How an asylum seeker enters the process plays a role in the eventual outcome. Figure 1 presents an overview of the process flow for affirmative applications and Figure 2 presents the flow for defensive applications.[8] The affirmative channel is open to applicants, whether or not they have entered the country legally, as long as they have not been arrested by the DHS and put into removal proceedings before the immigration court. Unlike the defensive process, the affirmative process tends to be nonadversarial. The path to gaining asylum in the United States has become even more difficult to navigate in the wake of the events of September 11, 2001. Congress passed the REAL ID Act of 2005,[9] amending sections of the Immigration and Nationality Act that relate to asylum. Although asylum seekers already had the burden of proving refugee status, they must now prove motive such that "race, religion, nationality, membership in a particular social group was or will be at least one central reason for persecuting the applicant" (Ref. 10, p. 244). Recently, as part of the ongoing immigration reform debate, Congress has deliberated about changing the process so that most people who enter the United States illegally would be barred from seeking affirmative asylum.[11]

Defensive asylum cases are heard in immigration court (the Department of Justice's Executive Office for Immigration Review, EOIR) by an immigration judge. Although the terms court and judge are used, the process is administrative and is presided over by a Department of Justice employee. Neither the court nor the judge is part of the judiciary. The defensive process is triggered automatically for individuals placed in removal proceedings who have expressed a "credible fear" of persecution if they return to their homeland. The hearing is meant to give these individuals an opportunity to defend themselves from removal. Unlike the affirmative process, the hearings are adversarial, with evidence exhibits, cross-examination, and witnesses.[12] In most cases, the immigration judge will allow one to two hours to adjudicate the claim. Evidentiary rules in immigration court are different from those in trial court proceedings, and most evidence is admissible. In typical cases, the testimony of the asylum seeker is the only direct evidence and the standard of proof is a preponderance of the evidence. The burden of proof rests with the asylum seeker and may be a daunting task, given language and cultural barriers, psychiatric symp-

toms, lack of knowledge about U.S. legal procedure, and the tendency of oppressive states not to document their intentions to persecute dissidents.

The credibility of the asylum seeker may be challenged. The immigration judge looks for consistent testimony without contradictions and a history that matches known conditions in the country of origin. Because this interrogatory approach is arduous and attended by many pitfalls, asylum seekers may be hesitant to approach authorities to lodge claims. PTSD may impede memory, lack of trust of officials may lead to evasiveness, and sensitive material, such as a history of rape, may be suppressed. Discrepancies in history are often used as a key reason for rejecting asylum claims. Many factors can be cited as affecting credibility, such as lack of details, facts omitted from previous statements, or even minor discrepancies in dates. The odds of being granted asylum appear to be approximately the same for both the affirmative and the defensive groups in immigration court; asylum is received by about one of every five applicants, although the number varies by region.[8]

Discussion

In the past, most evaluations of asylum seekers have been related to political persecution and torture and have involved individuals who were trying to escape dictatorial regimes. From 2000 to 2005, asylum seekers from China were by far the most prevalent (35,046), followed by those from Haiti (14,607), Columbia (14,323), and Albania (6,351).[13] Asylum seekers from Central America traditionally have been victims of combatants on both sides in civil wars. In recent years, however, as civil war has ended in Central American countries, new social problems have found their way into asylum applications. Former members of the military forces and *la guerrilla* have joined forces in the establishment of gangs that have become new crime organizations in Central America and the United States.[14] Simultaneously, there has been a group of Central American immigrants who have tried to avoid contact with these gangs after deciding not to join them.

In the case example, much of the asylum applicant's fear was related to the intimidation and assault commonly used by Guatemalan gangs as coercion in recruiting new members, in both Guatemala and the United States. The FBI regards a Guatemalan gang as the most dangerous and notorious gang in America, with an estimated eight to ten thousand members in approximately 42 states and the District of Columbia.[15] In December 2004, the FBI decided to launch a multi-agency operation against this gang with a National Gang Task Force focused on dismantling the group.[15,16]

The number of illegal immigrants who face the same circumstance as Mr. G. appears to be rising. As the number of victims of gang violence seeking asylum has increased, some cases have reached the U.S. Court of Appeals. In *Lopez-Soto v. Ashcroft*,[17] Lopez-Soto petitioned for review of a Board of Immigration Appeals (BIA) order denying his asylum request and denying him relief pursuant to the Convention Against Torture. Mr. Lopez-Soto is a native and citizen of Guatemala who entered the United States in 1999, having fled Guatemala with his cousin because they said the gang Mara 18 posed a threat to their lives. Previously, Mara 18 had killed the petitioner's older brother, and gang members threatened to kill Lopez-Soto, his other brother, and cousin if they did not join. When Lopez-Soto and his cousin attempted to flee to the United States, his cousin was apprehended by Mexican authorities and deported to Guatemala. Shortly after the cousin returned to Guatemala, he was murdered by Mara 18.

While it was clear that Lopez-Soto had an objectively reasonable fear for his life if he returned to Guatemala, the BIA determined that the petitioner was not politically persecuted, and the asylum petition was denied. The BIA concluded that the petitioner "failed to establish eligibility for relief under the Convention Against Torture because he has not shown that the government acquiesces in the torturous activities of the gang, the Mara 18" (Ref. 17, p. 240). In a two-to-one ruling, the U.S. Fourth Circuit Court of Appeals held that the BIA had properly rejected the petitioner's Convention Against Torture claim and also denied his petition for review. Judge Michael, who wrote the dissent, said that to be eligible for asylum as a refugee, Rutilio Lopez-Soto had to show that he had a well-founded fear of persecution "on account of" his "membership in a particular social group," in this case his family, and also that he could not have reasonably relocated elsewhere in Guatemala (Ref. 17, p 243). Judge Michael concluded: "There is extensive evidence of Mara 18's persecution of the Lopez-Soto family and the gang's nationwide activities in Guatemala. This compels the conclusion on review that Rutilio was persecuted at least partly on account of his family and that he can-

not safely relocate within Guatemala"(Ref. 17, p 248).

Other cases, such as *Menjivar v. Gonzales*,[18] *Valdiviezo-Galdamez v. Attorney General of the United States*,[19] and *Arteaga v. Mukasey*,[20] have also been met with denials. In the latter case, the Ninth Circuit panel upheld the BIA's rejection of Santos-Lemus's claim that his resistance to gangs or his antigang opinions constituted political opinion, reasoning that expression of a fear of harm resulting from general conditions of violence and civil unrest does not substantiate a well-founded fear of persecution on account of political opinion.

A requesting immigration attorney may chose not to use a forensic psychiatric evaluation, and there are no specific assessment guidelines stipulated by the court, but if offered, the psychiatric report may be part of the evidence used by the court to clarify an applicant's history. The report can help corroborate symptoms of PTSD, anxiety, and depression related to previous trauma or torture in the native country. In asylum cases, a forensic evaluation should report whether the client fears returning to his native country due to a subjective fear of persecution, but authentication of the reason for the fear is the province of the fact finder. The evaluation should document whether the individual has a psychiatric illness such as PTSD or another anxiety or mood disorder. Also, the report should note particular consistencies or, in contrast, the possible reasons for inconsistencies in the claimant's presentation and history.[21] A forensic evaluation that documents a consistent history may bolster the credibility of the applicant and is more likely to be used by the attorney as evidence in immigration court. Although outcome studies regarding the presence or absence of psychiatric evaluations have not been performed, data indicate that an important determining factor in the decision process is the presence or absence of legal representation. While having a lawyer by no means ensures success (64 percent of those requests are denied) the denial rate for those without is far higher (93 percent).[13]

Unfortunately, in practice, adjudicators who hear inconsistent accounts of trauma are more likely to deem an asylum applicant factitious. Applicants or respondents who are found not credible are denied asylum. These denials, however, can be unjust when applicants telling inconsistent accounts of traumatic events are suffering from PTSD. Numerous studies have empirically demonstrated that discrepancies are likely to occur among PTSD victims in repeated interviews. Southwick *et al.*[22] and their research team conducted a set of studies demonstrating that memory of traumatic events is subject to considerable alteration over time. In the first study, Gulf War veterans were interviewed at one month, two years, and six years after returning from the war.[22] When requestioned the first time, combat veterans changed their answers to specific questions about their exposure to trauma. The veterans were more likely to say, when interviewed at the two-year point, that they had seen more trauma than originally described, rather than less. Although there was an alteration in memory in nearly all subjects, the greatest changes were seen in veterans with PTSD, and the more PTSD symptoms subjects had, the more they changed their answers. In the six-year follow-up study, alterations in memory (increase or decrease) were also significantly related to symptoms of PTSD.

All subjects were absolutely convinced that their answers were right, even though they changed their answers each time and were sure that each answer was correct. The answers provided by the subjects were considered inconsistent rather than inaccurate, because the research team had no way of knowing which accounts were true. In separate studies, Roemer *et al.*[23] and North *et al.*[24] have shown that many individuals with PTSD symptoms at the one-year follow-up may deny symptoms that they had previously endorsed. Roemer *et al*. found that the more PTSD-type symptoms endorsed by the subjects, the more the subjects became inconsistent when reporting traumatic events. Foa *et al.*,[25] and van der Kolk and Fisler[26] also showed that female rape victims may change their stories to a significant degree and that memory in people who have highly stressful, life-threatening experiences may be unorganized. Herlihy *et al.*,[27] in a study of 39 Kosovan and Bosnian refugees, concluded that discrepancies cannot be explained on the grounds of intent to deceive. "If discrepancies continue to be used as a criterion for regarding a case as lacking credibility, then asylum seekers who have PTSD at the time of their interviews are systematically more likely to be rejected . . ." (Ref. 27, p 327).

The asylum client should be aware of the purpose of the psychiatric evaluation, and written informed consent should be obtained. The face-to-face evaluation can average two to three hours and

should progress in a way that does not intimidate the client, so as to avoid retraumatization. An expert who can provide psychological testing as part of documentation to support a diagnosis may increase the credibility of the evaluation. Psychological testing, however, should be conducted with a validated instrument that is translated into the language of the claimant.[28] Another important factor is the knowledge of the expert regarding the cultural influences in mental illness.[29] The evaluator should take into consideration cultural expressions of certain symptoms, particularly when asking about suicidal thoughts, avoidance, and numbing. Finally, working through a translator may present difficulties, including lack of equivalent words in a different language and even the cultural prejudices of the interpreters themselves. Durieux-Paillard *et al.*[28] have recently adapted the PTSD and major depressive episode (MDE) sections of a validated psychiatric diagnostic instrument, the Mini International Neuropsychiatric Interview (MINI), for use with asylum seekers.

A good forensic report includes an explanation of the methodology used to collect data and acknowledgment of awareness of the possibility of malingering. As Morgan observed:

> . . . at present all symptoms of PTSD are subjective report-based; there are no current objective measures of PTSD. Thus, the clinician who accepts the story provided at face value and who assumes that the symptoms reported by the applicant are evidence of the exposure to a traumatic event is engaged in a dubious process [Ref. 30, p 33].

The history section of the report should be detailed, but facts or speculation extraneous to the matter at hand should be avoided, because an unintentional minor inconsistency between the facts in the forensic report and the applicant's petition may cloud the judge's perception of the applicant's credibility. The forensic report also should avoid certain accusatory terms that are reserved for the trier of fact, such as persecutor.

If the asylum-seeker presents any physical signs, such as scars, burns, or incisions, it is important to document them.[31] A showing of physical evidence of persecution creates a rebuttable presumption that well-founded fear exists. An individual who demonstrates that he has suffered severe persecution may be granted asylum without proving a well-founded fear of future persecution. If necessary, the client can be referred to another medical specialist such as a neurologist or orthopedic surgeon who can assess and document physical injuries that can, in turn, underlie psychiatric symptoms.

The forensic psychiatrist traditionally has separated the roles of treating physician and forensic expert. Many attorneys, however, believe that in asylum cases the report and testimony of the psychiatrist involved in actual treatment may be more credible, but the treater cannot forget that the evaluation will open the door to being called to provide testimony and subsequent cross-examination. Evans[32] has described the powerful emotions often elicited by asylum evaluations when an examiner, faced with compelling evidence of human courage, has difficulty maintaining neutrality. Nevertheless, the independent forensic examiner should not be an advocate. As Morgan observed: "[E]xtending beyond evidence-based uses of our clinical skills to achieve a legal goal is advocacy, not ethical practice, and it will undermine the credibility of our profession" (Ref. 30, p 33).

In the case of Mr. G., his credibility and the integrity and accuracy of the forensic psychiatric evaluation were reinforced over two years of ongoing treatment. After initial screening by the IPP faculty psychiatrist for the appropriateness of the immigration attorney's case referral, the initial psychiatric evaluation was performed by a forensic psychiatry fellow (G.D.) who speaks Spanish, and then the case was presented to a faculty psychiatrist who is board certified in forensic psychiatry (J.B.) and became the treating psychiatrist. Mr. G.'s initial history and clinical presentation proved to be consistently credible over time, and the general framework of historical events involving gang intimidation and violence paralleled numerous unrelated IPP cases from both Guatemala and El Salvador. Mr. G. continued to fear returning to Guatemala despite his extremely unstable financial status in the United States and the illness and eventual death of his grandmother, his primary caretaker throughout his life. The clinical course of his PTSD symptoms also followed a classic pattern of waxing and waning in response to stressful life events, but showed general improvement in response to both medication for hyperarousal symptoms and supportive psychotherapy.[33] His credibility has been further strengthened by the fact that he has never missed any clinic appointments, even during long stretches of inactivity in his still-open asylum case. Treatment has focused

on reducing PTSD triggers in his daily life, processing long-term grief, and dealing with normal developmental and acculturation challenges.

Dual agency, which can be an unavoidable problem in many asylum cases because of a dearth of both specific cross-cultural forensic psychiatric expertise and access to clinical facilities that evaluate and treat a broad spectrum of refugees, was somewhat minimized in Mr. G.'s case (as in many other IPP cases) by having the initial evaluation conducted by the forensic fellow and the ongoing clinical treatment by the faculty forensic psychiatrist. Of course, the absence of dual agency does not completely eradicate the problems of countertransference that are inherent in ongoing clinical treatment, particularly when those seeking asylum present with psychiatric problems related to intense trauma. In our IPP experience, it has been extremely rare that the forensic psychiatrist (either evaluator or treater) is called to testify in immigration court, and in the great majority of cases, the initial psychiatric report (prepared by the fellow under faculty supervision) has been the sole psychiatric input into the legal process.

Conclusions

Asylum petitions filed on the basis of fear of gang retribution in Central America have just begun to populate immigration courts. Thus far, most of these claims have not been allowed because they do not meet traditional criteria for asylum, but the rising number of cases may ultimately dictate otherwise. Whatever the outcome, the forensic psychiatry expert in immigration court should strive to maintain an objective and impartial stance while following the same guidelines for accuracy and completeness that is germane to any forensic evaluation and report. The forensic expert should keep an open mind and not forget that acculturation factors may have relevance throughout the entire evaluation process. Even if diagnostic categories such as major depression and PTSD possess a universal validity, culture can influence symptomatic presentation, explanatory models, and help-seeking behavior.[28] Finally, the expert should be cognizant of the difference between immigration court and civil and criminal courts. Awareness of these various nuances will allow experts, clients, and legal representatives to work together successfully.

References

1. United Nations: 1967 U.N. Protocol Relating to the Status of Refugees, Jan. 31, 1967, 19 U.S.T. 6223, T.I.A.S. No. 6577, 606 U.N.T.S. 268 (Nov. 1, 1968)
2. United Nations: Convention Relating to the Status of Refugees, July 28, 1951, 19 U.S.T. 6259, 189 U.N.T.S. 137 (April 22, 1954)
3. 8 U.S.C. § 1231(b)(3) (2006)
4. Refugee Act of 1980, Pub. Law No. 97-212
5. Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. Law No. 104-208, 110 Stat. 3009 (1996)
6. The Advocates for Human Rights: Pro Bono Asylum Representation Manual: An Overview of Asylum Law and Procedure. Minneapolis, MN: The Advocates for Human Rights, 2006. Available at www.mnadvocates.org. Accessed July 11, 2008
7. United Nations: Convention Against Torture. Available at www.hrweb.org/legal/cat.html. New York: United Nations, July 16, 1994. Accessed September 20, 2008
8. The Asylum Process. Syracuse, NY: TRAC Reports, Inc., 2006. Available at http://trac.syr.edu/immigration/reports/159/. Accessed December 31, 2008
9. REAL ID Act, 109 Pub. Law No. 13, 119 Stat. 231 (2005)
10. Suzuki CM: Unpacking Pandora's box: innovative techniques for effectively counseling asylum applicants suffering from posttraumatic stress disorder. Rochester, NY: Social Science Electronic Publishing. September 17, 2007. Available at http://ssrn.com/abstract=1011926. Accessed September 15, 2009
11. The immigration reform debate: asylum seekers and others remain at risk. Asylum News 40. New York: Human Rights First, 2006. Available at http://www.humanrightsfirst.org/asylum/torchlight/newsletter/newslet_40.htm. Accessed September 15, 2009
12. Boehnlein JK, Manning SW, Garnett-McKenzie M, *et al*: Psychiatric evaluations for asylum hearings: unique challenges. Presented at the Annual Meeting of the American Academy of Psychiatry and Law, Miami Beach, Florida, October 21, 2007
13. Immigration judges. Trac Immigration. Syracuse, NY: TRAC Reports, Inc., 2006. Available at http://trac.syr.edu/immigration/reports/160/. Accessed July 10, 2008
14. Del Barco M: The International Reach of the Mara Salvatrucha. Washington, DC: National Public Radio, March 17, 2005. Available at http://www.npr.org/templates/story/story.php?storyID=4539688. Accessed September 9, 2008
15. Federal Bureau of Investigation: The MS-13 Threat: A National Assessment. Washington, DC: Federal Bureau of Investigation, January 14, 2008. Available at http://www.fbi.gov/page2/jan08/ms13_011408.html. Accessed December 31, 2008
16. Federal Bureau of Investigation: Going Global on Gangs: New Partnership Targets MS-13. Washington, DC: Federal Bureau of Investigation, October 10, 2007. Available at http://www.fbi.gov/page2/oct07/ms13tag101007.htm. Accessed December 31, 2008
17. Lopez-Soto v. Ashcroft, 383 F.3d 228 (4th Cir. 2004)
18. Menjivar v. Gonzales, 416 F.3d 918 (8th Cir. 2005)
19. Valdiviezo-Galdamez v. Attorney General of the United States, 502 F.3d 285 (3rd Cir. 2007)
20. Arteaga v. Mukasey, 511 F.3d 940, 944 (9th Cir. 2007)
21. Frumkin B, Friedland J: Forensic evaluations in immigration cases: evolving issues. Behav Sci Law 13:477–89, 1995

22. Southwick SM, Morgan CA, Darnell A, *et al*: Trauma-related symptoms in veterans of Operation Desert Storm: a 2-year follow-up. Am J Psychiatry 152:1150–5, 1995
23. Roemer L, Litz B, Orsillo SM, *et al*: Increases in retrospective accounts of war-exposure over time: the role of PTSD symptom severity. J Trauma Stress 11:597–605, 1998
24. North CS, Smith EM, Spitznagel EL: One-year follow-up of survivors of a mass shooting. Am J Psychiatry 154:1696–702, 1997
25. Foa EB, Molnar C, Cashman L: Changes in rape narratives during exposure therapy for posttraumatic stress disorder. J Trauma Stress 8:675–90, 1995
26. van der Kolk BA, Fisler RE: Dissociation and the fragmentary nature of traumatic memories: overview and exploratory study. J Trauma Stress 8:505–25, 1995
27. Herlihy J, Scragg P, Turner S: Discrepancies in autobiographical memories-implications for the assessment of asylum seekers: repeated interviews study. BMJ 324:324–27, 2002
28. Durieux-Paillard S, Whitaker-Clinch B, Bovier PA, *et al*: Screening for major depression and post-traumatic stress disorder among asylum seekers: Adapting a standardized instrument to the social and cultural context. Can J Psychiatry 51: 587–97, 2006
29. Boehnlein JK, Schaefer M, Bloom J: Cultural considerations in the criminal law: the sentencing process. J Am Acad Psychiatry Law 33:335–41, 2005
30. Morgan CA: Psychiatric evaluations of asylum seekers: is it ethical practice or advocacy? Psychiatry 4:26–33, 2007
31. Mygind P, Banner J: Forensic medical examination of refugees who claim to have been tortured. Am J Forensic Med Pathol 26:125–30, 2005
32. Evans FB: Trauma, torture, and transformation in the forensic assessor. J Pers Assess 84:25–8, 2005
33. Boehnlein JK, Kinzie JD: Pharmacologic reduction of CNS noradrenergic activity in PTSD: the case for clonidine and prazosin. J Psychiatr Pract 13:72–8, 2007