No. 1:09-cv-00745-RCL

In the United States District Court for the District Of Columbia

TOFIQ NASSER AWAD AL BIHANI (ISN 893),	Case Nos.
ABDUL LATIF NASSER (ISN 244),	04-cv-1194 (TFH) (ISN 569)
SHARQAWI AL HAJJ (ISN 1457),	05-cv-23 (UNA) (ISN 841)
SANAD AL KAZIMI (ISN 1453),	05-cv-764 (CKK) (ISN 244)
SUHAIL SHARABI (ISN 569),	05-cv-1607 (RCL) (ISNs 1460, 1461)
HANI SALEH RASHID ABDULLAH (ISN 841),	05-cv-2386 (RBW) (ISNs 893, 1453)
ABDUL RABBANI (ISN 1460),	08-cv-1360 (EGS) (ISN 10016)
AHMED RABBANI (ISN 1461),	08-cv-1440 (CKK) (ISN 10025)
ABDUL RAZAK (ISN 685),	09-cv-745 (RCL) (ISN 1457)
ABDUL MALIK (ISN 10025),	10-cv-1020 (RJL) (ISN 685)
ABU ZUBAYDAH (ISN 10016),	
Petitioners,	
v.	
DONALD J. TRUMP ET AL.,	
Respondents.	

BRIEF OF *AMICUS CURIAE* CENTER FOR VICTIMS OF TORTURE IN SUPPORT OF PETITIONERS' HABEAS CORPUS MOTION

Laura A. Wilkinson
D.C. Bar No. 413497
Weil, Gotshal & Manges LLP
2001 M Street NW, Suite 600
Washington, DC 20036
(202) 682-7000
laura.wilkinson@weil.com

Stephen Scott Roehm*
**Pro Hac Vice Admission Pending*
Center for Victims of Torture
1015 15th St NW, Suite 600
Washington DC 20005
(646) 522-6110
SRoehm@CVT.org

Counsel for Proposed Amici Curiae Center for Victims of Torture

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Founded in 1985, the Center for Victims of Torture (CVT) is the oldest and largest torture survivor rehabilitation center in the United States and one of the two largest in the world. Through programs operating in the U.S., the Middle East, and Africa—involving psychologists, social workers, physical therapists, physicians, psychiatrists, and nurses—CVT annually rebuilds the lives of nearly 25,000 primary and secondary survivors. CVT also provides training and technical assistance to torture treatment centers both inside and outside the United States.

This brief is intended to help the Court better appreciate the substantial human cost of ongoing indefinite detention at Guantánamo Bay, given the histories of both the facility and the men who remain there.[1]

Introduction

Guantánamo's detention operation has now entered its seventeenth year. Forty-one Muslim men still languish there, five of whom have long been cleared for transfer by the Executive Branch's national security apparatus. Many of the men, including participants in the joint motion now before the Court, are torture survivors. They are confined to a place where torture was practiced (for some, on them) but where effective treatment is not, and can never be, available. All of the men face serious medical consequences—independent of the effects of any past torture and cumulative of those effects for survivors—associated with the agonizing uncertainty of indefinite detention.[2]

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[1] This brief is not based on individual evaluations of Guantanamo detainees by CVT clinicians. However, given its expertise regarding the effects of torture and ill-treatment, CVT believes it is reasonable to presume that many Guantanamo detainees currently suffer profound physical and psychological symptoms and disabilities.

[2] As explained more fully in Section II *infra*, CVT defines "indefinite detention" as detention without charge or trial for an undefined duration throughout which the individual does not know when or whether he will be released.

Put more simply, the status quo at Guantánamo is human suffering. The United States should not be in the business of prolonged noncriminal detention to that end, and as such the court should grant the Petitioners' motion.

Argument

I. Guantánamo Will Forever Be Synonymous With Torture

A. What Happened In America's "Battle Lab"

"If the detainee dies you're doing it wrong."[3]

- Jonathan Fredman, then Chief Counsel for the CIA's Counterterrorism Center, advising Guantánamo staff at a 2002 meeting to discuss ways to "get 'tougher'" with interrogations

More than a decade and a half after its founding, and in light of much more recent disclosures about the CIA's ruthless "enhanced interrogation" program, it is easy to forget how central a role Guantánamo played in the birth of government-sanctioned torture. Throughout its early years, several Defense Department officials, including senior Guantánamo commanders, referred to the detention facility as a "Battle Lab."[4] The label proved accurate: the military's torture first tested at Guantánamo would soon spread to Afghanistan, and then to Iraq, culminating in the horrors of Abu Ghraib.[5] This history is important, not in the least because it bears directly on Guantánamo's ongoing human costs.

By executive order in 2002, President Bush gave Guantánamo's Joint Task Force-170 responsibility "for the worldwide management of interrogation of suspected terrorists detained in

[3] Senate Armed Services Committee, *Inquiry into the Treatment of Detainees in U.S. Custody*, at xvii (2008), available at https://www.armed-services.senate.gov/imo/media/doc/Detainee-Report-Final_April-22-2009.pdf ("SASC Report").
[4] SASC Report at 43.
[5] *Id.* at xxii, xxiii.

support of us [*sic*] military operations . . . ."[6] As a 2008 Senate Armed Services Committee report explains in detail, Guantánamo staff discharged that responsibility by researching, developing, and implementing strategies to "break" detainees.[7] They solicited and received advice and training from instructors for the military's Survival, Evasion, Resistance and Escape (SERE) program, which is designed to teach American soldiers to resist (largely Communist-era) torture tactics that historically were aimed at producing false confessions.[8] Never mind that SERE "interrogators" are typically just "role players" who are "not trained to obtain reliable intelligence information from detainees" or qualified to do so.[9] Perhaps more troubling, medical personnel—psychologists and psychiatrists in particular—were deeply involved, both in designing abusive interrogation plans and, at times, monitoring their implementation.[10] "In a sense," explains Mark Fallon, Deputy Commander of the Criminal Investigation Task Force then operating at Guantánamo (as well as in Afghanistan and Iraq), "they were serving a similar role as [James] Mitchell and [Bruce] Jessen, but instead of providing medical cover for torture in the CIA, they were doing so in the DOD."[11]

The results of trying to "get 'tougher'" with interrogations were disastrous. Guantánamo interrogators brutalized detainees in a wide variety of ways. Some men were literally treated like animals: strapped in dog collars, led around on leashes, and forced to perform tricks. One female interrogator wiped what she told a detainee was menstrual blood on his face. Men were stripped

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[6] E-mail from Linda Watt to Gregory M. Suchan (Feb. 19, 2002, 16:00), available at https://www.thetorturedatabase.org/document/email-gregory-suchan-linda-watt-foreign-policy-advisor-southcom-re-establishment-jtf-170-gu?pdf_page=1.
[7] SASC Report at xx.
[8] *Id.* at xiii, 103-104.
[9] *Id.* at xiii.
[10] *Id.* at 38, 39; Mark Fallon, *Unjustifiable Means* 66 (2017); Sheri Fink, *Where Even Nightmares Are Classified: Psychiatric Care at Guantanamo*, N.Y. Times, Nov. 12, 1016, available at https://www.nytimes.com/2016/11/13/world/guantanamo-bay-doctors-abuse.html.
[11] Fallon, *Unjustifiable Means* at 65.

naked and otherwise sexually humiliated. They were forcibly groomed, shackled in stress positions, and subjected to extreme temperatures. They were sensory and sleep deprived. They were threatened with death.[12]

Several of these abuses were clearly designed to exploit the men's faith. Others were simply gratuitous. None of them improved intelligence gathering, experts say,[13] but all of them ensured that Guantánamo would forever be synonymous with torture.

B. The Torture Survivors Who Remain At Guantánamo

Guantánamo was built to house "the worst of the worst;" a "limited number of detainees [who] . . . would all be targets for prosecution or high-value intel exploitation."[14] That result, of course, was never achieved—"most of the people who ended up at [Guantánamo] were picked up by the Northern Alliance or other groups that didn't necessarily have any interest in the global war on terror, aside from picking up a $5,000 per head bounty."[15] Instead, Guantánamo has become a figurative graveyard for torture survivors.

Some detainees—including at least seven of the eleven men who joined the habeas petition now before the court—were held at secret CIA black sites before being taken to Guantánamo.[16] In late 2014, the Senate Select Committee on Intelligence more fully exposed the scope and gravity of the CIA's "enhanced interrogation" program. The abuses the CIA inflicted

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[12] *E.g.*, SASC Report at 132-145.
[13] Fallon, *Unjustifiable Means* at 204, 207.
[14] *Id.* at 50.
[15] *Id.* at 49.
[16] *See* Senate Select Committee on Intelligence, *Committee Study of the CIA's Detention & Interrogation Program* 458-461 (2014), available at https://www.intelligence.senate.gov/sites/default/files/documents/CRPT-113srpt288.pdf ("SSCI CIA Report") (Table listing detainees held in the CIA's detention and interrogation program). Note that detainee #93, "Riyadh the Facilitator," is an alias for petitioner Mr. Al Hajj. *See* The Rendition Project, *Profile of Ali Al-Hajj Al Sharqawi*, available at https://www.therenditionproject.org.uk/prisoners/sharqawi.html.

ranged from confinement in boxes the size of small dog crates (sometimes with insects), to simulated drowning, to prolonged sleep deprivation (often while shackled to the ceiling and wearing only a diaper), to "rectal rehydration"—a euphemism for rape.[17] Petitioner Abu Zubaydah was among the CIA captives. He lost his left eye while in CIA custody, and has reported suffering excruciating sound sensitivity, partial amnesia, and loss of bladder control—urinating uncontrollably when stressed.[18] Just in the period between 2008 and 2011, he experienced more than 300 seizures.[19]

Other detainees were tortured and abused at the hands of allied governments or third parties prior to their transfer to Guantánamo. For example, American and Pakistani authorities arrested Sharqawi Al-Hajj in February 2002 in Pakistan.[20] They kept him in solitary confinement for three weeks before transferring him to Jordan.[21] There, Jordanian authorities regularly beat Mr. Al-Hajj with rods, threatened electrocution and sexual abuse, and interrogated him while a guard stepped on his face.[22] His interrogators threatened to permanently disable him both physically and mentally.[23] After two years, he signed a false confession and was taken to the CIA's "Dark Prison" in Kabul, Afghanistan, where his torture continued.[24] Mr. Al-Hajj would eventually be sent to Guantánamo in August 2004.

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[17] SSCI CIA Report at xxiii.
[18] *Zubaydah v. Poland*, Eur. Ct. H.R. at 36, 44 (2015).
[19] *Id.* at 44.
[20] Decl. of Pet'r Sharqawi Abdu Ali Al-Haag (ISN 1457) at 2.
[21] *Id.* at 3.
[22] *Id.* at 4; Joanne Mariner, *Double Jeopardy – CIA Renditions to Jordan*, Human Rights Watch Report at 24 (2008) ("HRW Report").
[23] HRW Report at 24.
[24] Decl. of Pet'r Sharqawi Abdu Ali Al-Haag (ISN 1457) at 7-8; SSCI CIA Report at 386, n. 18265.

Still other detainees were brutalized at Guantánamo itself. For example, Abdel Razak Ali was brought there after being abused in both Pakistan and Afghanistan.[25] Guantánamo personnel forcibly groomed him and taunted him sexually. Mr. Ali was subjected to dietary and temperature manipulation. He was sleep deprived. He was repeatedly denied access to a bathroom, and refused clean clothes when he could no longer avoid relieving himself on himself. One interrogator threatened to send Mr. Ali to another country where he would be tortured or killed.[26]

To be sure, Guantánamo is different now than it was in the early to mid-2000s. But for torture survivors in particular, Guantánamo's essence will never change, and as long as the men remain confined there, they will never escape it.

II. It Is Reasonable To Presume That The Men Remaining At Guantánamo Are Suffering, Torture Survivors Especially

A. Prolonged Indefinite Detention Causes Physical And Psychiatric Trauma

CVT considers detention "indefinite" when it is without charge or trial for an undefined duration throughout which the individual does not know when or whether he will be released. This clearly describes the eleven men now petitioning the court; all of them have been at Guantánamo for more than a decade, none has been charged, and—since President Trump took office—there appears to be no meaningful process even for evaluating any threat they purportedly pose, much less a path to eventual release.[27]

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[25] Bakhouch Aff. at 7, *Ali v. Obama*, No. 11-5102 (D.C. Cir. June 11, 2013), Doc. 1440698. As explained in his sworn affidavit, Mr. Ali's true name is Saeed Bakhouch. He is referred to above as Mr. Ali for ease of reference given the caption of his case and that his ISN number is assigned to that name.

[26] *Id.*

[27] Mot. for Order Granting Writ of Habeas Corpus at 11-15, *Al Bihani (ISN 893) et al. v. Trump, et al.*, No. 09-cv-00745-RCL (D.D.C. Jan. 11, 2018), Doc. 1885.

From thirty-three years of experience healing torture survivors, CVT knows that indefinite detention causes such severe and prolonged health and mental health problems that it can constitute cruel, inhuman, and degrading treatment.[28] The very indeterminacy of indefinite detention creates so much uncertainty, unpredictability, and loss of control over the elemental aspects of one's life, that it seriously harms healthy individuals, independent of other aspects or conditions of detention. More specifically, as CVT's executive director explained in testimony to the Senate Judiciary Committee,[29] medical examinations have documented indefinite detention leading to profound depression and vegetative symptoms, with all the attendant degradation of multiple aspects of health. Indefinite detention's harmful psychological and physical effects include:

- Severe and chronic anxiety and dread;
- Pathological levels of stress that have damaging effects on the core physiologic functions of the immune and cardiovascular systems, as well as on the central nervous system;
- Depression and suicide;

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[28] *Curt Goering, The Center for Victims of Torture, Testimony to the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights: Closing Guantanamo: The National Security, Fiscal, and Human Rights Implications* 1 (2013), available at http://www.cvt.org/sites/default/files/attachments/u10/downloads/CVT-Testimony-Senate-ClosingGuantanamo-2013July.pdf ("CVT Testimony"). The former United Nations Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan Mendez, agrees: "at Guantánamo, the indefinite detention of individuals, most of whom have not been charged, goes far beyond a minimally reasonable period of time and causes a state of suffering, stress, fear and anxiety, which in itself constitutes a form of cruel, inhuman, and degrading treatment." Juan E. Mendez, Inter-American Commission on Human Rights, Statement of the United Nations Special Rapporteur on Torture at the Expert Meeting on the Situation of Detainees Held at the U.S. Naval Base at Guantanamo Bay, October 3, 2013, available at http://newsarchive.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=13859&LangID=E.

[29] CVT Testimony.

- Post-traumatic stress disorder (PTSD); and
- Enduring personality changes and permanent estrangement from family and community that compromises any hope of the detainee regaining a normal life following release.[30]

These severe disorders arise because the indefinitely-detained person realizes nothing he does matters; that there is no way to end, foreshorten, or even know the duration of his captivity. As detailed medical and mental health evaluations of former detainees from Abu Ghraib and Guantánamo have shown, uncertainty about the future, including lack of information about when or whether they would be released, was one of the factors that produced the greatest ongoing stress.[31] This uncertainty resulted in tremendous anxiety, numbing, and disconnection from feelings of hope. The Inter-American Commission on Human Rights has confirmed these findings, noting its receipt of "specific information regarding the severe and prolonged physiological and psychological damage caused by the detainees' high degree of uncertainty over basic aspects of their lives, such as not knowing whether they will be tried or whether they will be released and when; or whether they will see their family members again."[32]

Many of CVT's clients who were imprisoned without charge or trial speak of the absolute despair they felt, never knowing if their detention would come to an end. This creates severe, chronic emotional distress: hopelessness, debilitation, uncertainty, and powerlessness. These

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[30] *Id.* at 2 (citing Physicians for Human Rights, *Punishment Before Justice: Indefinite Detention in the U.S.* 2 (2011), available at https://s3.amazonaws.com/PHR_Reports/indefinite-detention-june2011.pdf.).

[31] Physicians for Human Rights, *Broken Laws, Broken Lives: Medical Evidence of Torture by U.S. Personnel and Its Impact* 75 (2008), available at http://physiciansforhumanrights.org/library/reports/broken-laws-torture-report-2008.html.

[32] U.N. News Tracker, *Amid Hunger Strike, UN Rights Experts Urge US to Close down Guantánamo Detention Facility* (May 1, 2013), available at http://www.un.org/apps/news/story.asp?NewsID=44801#.WmJRxq6nHIW.

effects are exacerbated in detainees who have been traumatized or tortured prior to commencement of indefinite detention. Lacking any control, and having no sense of what will happen next, re-stimulates the kinds of experiences detainees suffered while being tortured.

Moreover, indefinite detention affects individuals beyond the detainee himself. When a loved one is indefinitely detained, families are separated; parents, spouses, and children can suffer—and have suffered—similar feelings of uncertainty, unpredictability, and uncontrollability, leading to the physical and psychological effects described above.

B. Torture Deliberately And Systematically Dismantles A Person's Identity And Humanity

The effects of torture are profound. As CVT explained in a 2013 report:

> Torture induces long-term suffering that leaves bodies and minds broken. Many of torture's survivors remain captive to their traumatic past, suffering from deep feelings of shame, self-blame, guilt, humiliation and loss of control. They describe being haunted by intrusive memories, excessive rumination and nightmares, with repeated episodes of actively re-experiencing past traumas. Survivors have often lost their sense of safety, feel unable to attach to meaningful relationships, question their sense of justice in the world, feel that their identity and role in society is erased, and grapple with existential questions about life. They struggle with sleep disorders, anxiety, chronic pain, irritability, startle responses, suicidal ideation, and depression. Many report feeling "dead" inside and may describe themselves as if they are living outside their body, physically and emotionally numb, socially estranged and profoundly alone.[33]

Specific types of torture tend to produce particular kinds of harms.[34] For example, survivors threatened with death or injury relive these experiences in nightmares or flashbacks. Some report having pleaded with their torturers to kill them, preferring real death over the intolerable pain associated with constant threat. Survivors of sexual humiliation often suffer symptoms of post-traumatic stress disorder (PTSD) and major depression. They, too, have

[33] The Center for Victims of Torture & The Torture Abolition and Survivor Support Coalition, *Tortured & Detained – Survivor Stories of U.S. Immigration Detention* 5 (2013), available at http://www.cvt.org/sites/default/files/Report_TorturedAndDetained_Nov2013.pdf.

[34] The Center for Victims of Torture, *Effects of Torture* (2015), available at https://www.cvt.org/sites/default/files/downloads/CVT%20Effects%20Torture%20April%202015.pdf.

flashbacks or nightmares. Forced nakedness creates a power differential, stripping victims of their identities, inducing immediate shame, and creating an environment where the threat of sexual and physical assault is always present. Survivors of sensory deprivation can exhibit a variety of harmful effects, including depression, anxiety, difficulty with concentration and memory, hypersensitivity to external stimuli, hallucinations, perception distortions, paranoia, and problems with impulse control. Other forms of torture have similarly debilitating consequences.[35]

It is well established that the damage torture inflicts will not simply repair with time. According to Bessel van der Kolk, one of the lead experts on the effects of trauma on the brain and body:

> We have learned that trauma is not just an event that took place sometime in the past; it is also the imprint left by the experience on mind, brain and body. This imprint has ongoing consequences for how the human organism manages to survive in the present. Trauma results in a fundamental reorganization of the way mind and brain manage perceptions. It changes not only how we think and what we think about, but also our very capacity to think . . . . Under normal conditions people react to a threat with a temporary increase in their stress hormones. As soon as the threat is over, the hormones dissipate and the body returns to normal. The stress hormones of traumatized people, in contrast, take much longer to return to baseline and spike quickly and disproportionately in response to mildly stressful stimuli.[36]

Effective rehabilitation is, of course, possible, but only under the right conditions.

III. Torture Survivors Will Continue To Suffer Absent Effective Rehabilitation, Which Guantánamo Cannot Provide

In a sworn affidavit provided to a defense team in an unrelated Guantánamo military commissions litigation, CVT's Director of Client Services, Dr. Andrea Northwood, explained the minimum requirements necessary for effective rehabilitation for torture survivors. These requirements can be summarized in four domains, each of which is further described below: a)

[35] *Id.*
[36] Bessel van der Kolk, The Body Keeps the Score 21, 46, (2014).

providing a sense of control to the victim over key features of the rehabilitation context, content, and process; b) restoring a felt-sense of safety as it pertains to the internal physiological state and external habitat of the victim, including adequate management of pain; c) providing the victim with trusted human connections that are consistently available, including regular, predictable access to the treatment provider(s) and regular, meaningful access to other trustworthy sources of social support; and d) the treating provider(s) must be sufficiently skilled and experienced in treating severe trauma explicitly designed and perpetrated by other human beings. This involves knowledge of a variety of tools such that one can calibrate an individual treatment plan according to the specific effects of particular torture methods on a particular individual from a particular culture, as well as tools the victim can accept and practice to gradually restore proper functioning to his or her nervous system.

It is perhaps axiomatic that these requirements cannot be met at Guantánamo, at least not in any meaningful sense that would allow for effective rehabilitation.

A. Minimum Requirements For Effective Treatment For Torture Survivors

1. Control

Control, even over one's most basic bodily functions, is the first casualty of torture. Loss of control or choice by the victim is a fundamental dynamic that is consistently reinforced, maximized, and mined for its coercive value in the torturer-victim relationship. At CVT's outpatient rehabilitation programs in the U.S., providers are taught to offer choice and control to torture victims at every juncture, from the very first phone call through the duration of treatment and closure. For example, survivors choose how often they come for treatment, what they are working on in treatment, which treatment methods are utilized among an array of recommended options, how long their treatment course lasts, where and when sessions take place within basic outpatient parameters, what they talk about and do not talk about, when they can take a break

during a session, and (sometimes) the gender or other characteristics of their provider and their interpreter. CVT clinicians have conducted many torture treatment sessions outdoors and in various adaptations of an indoor environment that gave the victim control as to when and how to quickly "escape" if he or she perceived this need. This has included meeting in a very large room, and so on. The variations are many, but the important condition is that the victim has control over basic elements of the setting and the provider is able to accommodate working within the victim's range of tolerance.

2. Safety

Safety is a second fundamental challenge and necessary condition for rehabilitation after persons have adapted to conditions of captivity in which intolerable pain was deliberately applied, typically via multiple methods and over many interrogation sessions. It is now well established that traumatized persons exhibit compromised neurological and hormonal functioning that does not reset itself with time.[37] In essence, torture victims are unable to achieve the subjective sense of safety and calm that healthy people take for granted due to the dysregulation of their nervous system under chronic threat. At CVT, the feeling of safety is first cultivated by having an environment as dissimilar to institutions of detention as possible. CVT's clinic in St. Paul, for example, is located in a large, old Victorian home that was specifically renovated to install soft accent lighting and natural light (in contrast to bright overhead interrogation lights and windowless rooms), to break up long hallways (in contrast to the straight unbroken corridors of prisons), and to avoid rectangular or square rooms (which interrogation cells often are). The home is decorated with art from patients' countries of origin and painted in warm colors. It is devoid of uniformed personnel, guns or weapons, and other common triggers of PTSD symptoms in torture survivors.

[37] *Id.*

Another important aspect of safety for torture victims is to be safe from encounters with their torturers or representatives of the agencies/governments that tortured them. At CVT's domestic service sites, all potential patients are screened as to whether they participated in the torture of others, and those patients who might pose a subjective safety risk to others—due to their positions in the military, police, government, or other institutions associated with torture in their country—are referred to other service providers in the community.

Many survivors of torture experience significant ongoing physical pain in areas of the body that were targeted for their torture. Sometimes, there are physical findings when tests are done to determine the source of the pain, but often there are no physical findings despite significant subjective experience of physical pain. Reducing and managing physical pain is an essential component of safety for torture survivors for several reasons. First, pain is a core feature of the torture experience itself and thus a constant internal trigger for re-living other aspects of the torture methods associated with it. Second, chronic pain is physically and emotionally exhausting, which takes resources away from the rehabilitation process. Third, chronic, unmanaged physical pain is associated with thought processes (such as powerlessness, helplessness, no sense of future without pain, etc.) that are counterproductive to rehabilitation goals.

Restoring a felt-sense of safety is an almost universal early goal of treatment: patients are prescribed medications to help them sleep, reduce their pain, and reduce the pervasive anxiety resulting from damaged neurological systems so that they can actively and safely participate in their treatment. Finding the right dosage or combination of medications to achieve internal safety is often a trial-and-error process that requires some trust in the prescribing physician. Early in treatment, CVT patients also are taught various exercises and strategies to help them manage and

reduce their PTSD and depression symptoms. The length of time this takes for any given individual varies greatly; sometimes it constitutes the bulk of treatment. Often, it is not easy to reset the human nervous system to feel safe and comfortable again, even under optimal conditions.

3. Trusted Human Connections

Torture is an intimate violation of trust and social bonds that occurs within a human-to-human relationship, usually under conditions of secrecy or seclusion, as well as presumed impunity for the torturers. A corrective experience to this trauma must therefore also occur in human relationships, with as much transparency, emotional support, reliability, respect for human dignity, and accountability as possible. Regular, predictive access to one's treatment provider(s) is a minimal condition of rehabilitation at CVT. Re-establishing trust in human beings and human institutions, such as government and law enforcement, occurs over time through survivors' experience of safe, stable, and caring relationships. Addressing the intimacy and calculated cruelty of the violations that occur between two or more human beings under torture is an important component of interventions designed to help torture survivors heal. For some torture survivors, trust must first be rebuilt in one-to-one relationships that afford great privacy and protection before being generalized slowly outward to wider and wider circles. At CVT, the interpreter is an important member of the healing team for patients who do not share a language with the provider. CVT screens, trains, and supervises its own interpreters on the unique needs of torture survivors; patients use the same interpreter throughout treatment, and their particular relationship often serves a powerful role in rebuilding trust.

In addition to a good therapeutic alliance, survivors also need regular predictable access to other forms of social support besides their treatment provider(s) in order to learn to generate trust beyond the therapeutic relationship, to practice interpersonal skills and coping strategies

with peers and loved ones, and to buffer the emotional pain that rehabilitation often involves with support from outside the therapeutic relationship. The power differential between the treatment provider and the patient, as well as common emotions linked to the torture experience (shame, fear, anger, sadness, disgust, etc.), typically result in a very intense counseling experience in which it may be necessary for the patient to experience highly conflictual and painful emotions toward the provider(s) and interpreter in order to come to terms with what happened under torture. It is important for the patient's psychological health that this does not occur in isolation, without other trusted sources of social support to confide in and use as a check on the validity and reality of one's experiences and thoughts.

4. Need For Highly Specialized Treatment Providers

The literature on torture rehabilitation contains many discussions of the need for a tailored, individualized approach using a multidimensional range of interventions. One reason for this is the profound impact of torture on the body, mind, and spirit of a person; when multiple interdependent areas of a person's functioning are wounded, the treatment must address these areas in a coordinated, integrated manner to be successful. The wide range of cultures, religions, presenting issues, symptom severity, sociopolitical histories, developmental age when tortured, and individual proclivities require a correspondingly wide range of treatment methods and creative approaches. Most providers at CVT employ multiple methods in a single treatment, and torture survivors at CVT report that different approaches are helpful at different stages of their recovery. The average length of treatment at CVT is eighteen months, but again there is a very wide range and some persons require psychological treatment for much longer. Indeed, some torture survivors never recover the emotional regulation, sense of self, and interpersonal confidence they enjoyed before torture.

B. Effective Rehabilitation Is Not, And Cannot Be Made, Available At Guantánamo

In many ways, Guantánamo is the antithesis of what Dr. Northwood explains is required to rehabilitate torture survivors effectively. The military is in complete control over all aspects of detainees' lives. The men remain held captive—indefinitely, with all the attendant health consequences—by the government responsible (directly or indirectly) for their torture, and in a setting both replete with common triggers of PTSD symptoms and one that will forever be synonymous with torture.

According to former Guantánamo medical personnel, trust is essentially nonexistent.[38] That is not surprising given the role that some psychologists and psychiatrists played in the design and implementation of abuses detainees suffered. For example, Major Paul Burney, an Army psychiatrist, recently explained that he and Major John Leso, an Army psychologist—both of whom deployed to Guantánamo in 2002—"took turns observing the questioning … of Mohammad al-Qahtani."[39] As part of that "questioning," multiple government investigators later found, al-Qahtani "was menaced with military dogs, draped in women's underwear, injected with intravenous fluids to make him urinate on himself, put on a leash and forced to bark like a dog, and interrogated for 18 to 20 hours at least 48 times."[40]

Guantánamo interpreters at times worked for both mental health teams and interrogators. That obvious conflict of interest produced precisely the fear one would expect: "If you complain

[38] Sheri Fink, *Where Even Nightmares Are Classified: Psychiatric Care at Guantanamo*, N.Y. Times, Nov. 12, 1016, available at https://www.nytimes.com/2016/11/13/world/guantanamo-bay-doctors-abuse.html.
[39] *Id.*
[40] *Id.*

about your weak point to a doctor," one former detainee explained, "they told that to the interrogators."[41]

Some medical personnel arrived at Guantánamo with a mindset and instructions that would make effective care impossible:

> "You heard all these things about how terrible [detainees] are: Not only will they gouge your eyes out, but they'll somehow tell their cohorts to go after your family," said Daniel Lakemacher, who served as a Navy psychiatric technician [in 2007 and 2008]. "I became extremely hateful and spiteful."[42]

According to Dr. Michael Fahey Traver, an Army psychiatrist at Guantánamo in 2013 and 2014, mental health professionals understood that they were not to ask about a detainee's interrogation experiences, either at Guantánamo or with the CIA.[43] "'You just weren't allowed to talk about those things, even with them,' he said." If a detainee raised the subject of his prior treatment, Dr. Traver said his predecessor had told him "to redirect the conversation."[44] And even if health professionals were to broach that subject, Guantánamo medical personnel apparently rotate off the island every three to nine months, so there can be no real continuity of care in any event.[45]

Finally, even theoretically putting aside these fundamental deficiencies and Guantánamo's (inescapable) history, then-Commander of U.S. Southern Command and now-White House Chief of Staff John Kelly told Congress almost four years ago that Guantánamo simply is not set up to provide complex, specialized medical care—of any kind: "Although Naval Station Guantánamo and detainee hospitals are capable of providing adequate care for most detainee conditions, we lack certain specialty medical capabilities necessary to treat

[41] *Id.*
[42] *Id.*
[43] *Id.*
[44] *Id.*
[45] *Id.*

potentially complex emergencies and various chronic diseases."[46] Recent reporting suggests that is still the case, in a rather basic sense: in 2015, a military commissions judge ordered a brain scan of Abd al Rahim al Nashiri—a former black site prisoner who was tortured brutally and repeatedly over four years in CIA custody—to help determine if he is competent to stand trial. But Guantánamo had no MRI machine, so the Pentagon had to procure one. It showed up *more than two years later*,[47] and according to the government, does not even work.[48]

Conclusion

President Trump has made his intentions toward Guantánamo clear, and the result is ongoing human suffering. The Court can and should put a stop to it by granting the Petitioners' motion.

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[46] General John F. Kelly, U.S. Marine Corps Commander, *Posture Statement before the 113th Congress, Senate Armed Services Committee* 14 (2014), available at https://www.armed-services.senate.gov/imo/media/doc/Kelly_03-13-14.pdf.

[47] Carol Rosenberg, *Guantánamo Gets MRI on Four-Month Deployment, for one Detainee?*, Miami Herald, Oct. 2, 2017, available at http://www.miamiherald.com/news/nation-world/world/americas/guantanamo/article176631141.html.

[48] Carol Rosenberg, *The Pentagon Paid $370,000 to Rent an MRI for Guantánamo. It Doesn't Work*, Miami Herald, Nov. 14, 2017, available at http://www.miamiherald.com/news/nation-world/world/americas/guantanamo/article184624408.html.

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Respectfully submitted,

/s/ Laura Wilkinson
Laura A. Wilkinson
D.C. Bar No. 413497
Weil, Gotshal & Manges LLP
2001 M Street NW, Suite 600
Washington, DC 20036
(202) 682-7000
laura.wilkinson@weil.com

/s/Stephen Scott Roehm
Stephen Scott Roehm*
**Pro Hac Vice Admission Pending*
Center for Victims of Torture
1015 15th St NW STE 600
Washington, DC 20005
(646) 522-6110
SRoehm@CVT.org

Counsel for Proposed Amici Curiae
Center for Victims of Torture