[The R.M.C. 803 session was called to order at 0900, 07 May 2024.]

MJ [Col McCALL]: The commission is called to order.

Good morning, Mr. Trivett. Could you please identify who's here on behalf of the United States both here in the courtroom and at the Remote Hearing Room?

MTC [MR. TRIVETT]: Yes, sir. Good morning.

Representing the United States today in the courtroom is myself, Mr. Clay Trivett; Lieutenant Commander Robert Baxter; Mr. Christopher Dykstra. Also present is paralegal Rudolph Gibbs.

Present from the FBI is Supervisory Special Agent Joseph Hokanson, Staff Operations Specialist Jeremy Ucciardi.

Representing the United States today in the courtroom in the Remote Hearing Room is Mr. Jeffrey Groharing. He's joined by paralegal Ms. Karissa Grippando. We do anticipate Colonel Josh Bearden and Major Dastoor arriving sometime during the morning session.

Your Honor, these proceedings are being broadcast to closed-circuit television sites in the continental United States pursuant to the military commission's orders.

MJ [Col McCALL]: All right. Thank you.

Good morning, Mr. Sowards.

LDC [MR. SOWARDS]: Good morning, Your Honor.

Appearing on behalf of Mr. Mohammad, who is not present, are

Gary Sowards; Kathleen Potter, Lieutenant Colonel, United States Air Force; Gabriela McQuade; Michael Leahy, Captain, United States Air Force; and Elspeth Theis, Major, United States Air Force.

And Lieutenant Xu, at my request, is attending to another matter and may join us a bit later.

We have no one in the Remote Hearing Room.

MJ [Col McCALL]: All right. Thank you.

LDC [MR. SOWARDS]: Thank you, sir.

MJ [Col McCALL]: All right.

Good morning, Mr. Engle.

LDC [MR. ENGLE]: Good morning, Your Honor.

We have for Mr. Bin'Attash: Lieutenant Austin Ridgeway in the courtroom, and I am in the RHR with Prax Kennedy, Captain Marian Messing, and Tasnim Motala.

We expect Mr. Montross to join us a little later this morning.

MJ [Col McCALL]: All right. Thank you.

Good morning, Mr. Connell.

LDC [MR. CONNELL]: Good morning, sir.

James Connell, Alka Pradhan, Rita Radostitz, and Lieutenant Jennifer Joseph on behalf of Mr. al Baluchi.

Lieutenant Joseph is in the RHR.

MJ [Col McCALL]: All right.

Good morning, Mr. Ruiz.

LDC [MR. RUIZ]: Good morning, Judge. I'm here on behalf of Mr. al Hawsawi, along with Captain Patrick Tipton, Kerry Mawn, and Mr. Sean Gleason.

MJ [Col McCALL]: All right. Thank you.

I note that the four accused are not present this morning.

Mr. Dykstra, do you have a witness to account for these absences?

DMTC [MR. DYKSTRA]: Yes, Your Honor.

CAPTAIN, U.S. Air Force, was called as a witness for the prosecution, was previously sworn, and testified as follows:

DIRECT EXAMINATION

Questions by the Deputy Managing Trial Counsel [MR. DYKSTRA]:

Q. Good morning, Captain.

A. Good morning, sir.

Q. For purposes of the record, could you please identify the pseudonym or call sign that you go by?

A. Doc.

Q. Thank you. Now -- and you previously testified before in these proceedings, correct?

A. Yes, sir. I have.

Q. I'd just remind you that you remain under oath.

A. Yes, sir.

Q. Now, did you have the opportunity to advise the accused of their right to be present this morning?

A. Yes, sir. Between approximately 0635 and 0655 hours this morning, I advised each of the accused of their respective right to be present at today's session, using the English version of the Statement of Understanding, Right to Be Present for Commission Proceedings. I also had a translated version and a linguist present with me when I did so.

DMTC [MR. DYKSTRA]: Your Honor, if I may approach the witness, I'm going to hand him what has previously been marked as Appellate Exhibit 943QQ (KSM), 943RR (WBA), 943SS (AAA), and 943TT (MAH).

MJ [Col McCALL]: All right. Go ahead.

Q. So, Doc, are these the forms that you used to advise the accused of their right to be present this morning?

A. Yes, sir. They are.

Q. And when you advised the accused this morning, what was their choice whether to come or not to come?

A. Each of the accused declined to be present for the sessions today but accepted other meetings throughout the day.

Q. And did you have any concerns regarding the voluntariness of their choices this morning?

A. No, sir. I did not.

DMTC [MR. DYKSTRA]: Thank you, Your Honor. No further questions for this witness.

MJ [Col McCALL]: All right. Thank you.

Mr. Connell?

CROSS-EXAMINATION

Questions by the Learned Defense Counsel [MR. CONNELL]:

Q. Good morning, sir.

A. Good morning, sir.

Q. Mr. al Baluchi actually is present in the ELC; isn't that right?

A. I believe he wished to be transported to one of the holding cells but not be present in the session today.

Q. All right. And that holding cell is in the ELC?

A. Yes, sir.

Q. Okay.

LDC [MR. CONNELL]: Thank you.

MJ [Col McCALL]: Do any other defense counsel have questions for this witness?

Apparently not.

All right. Thank you for your testimony. You're excused.

WIT: Thank you, sir.

[The witness was excused and withdrew from the courtroom.]

MJ [Col McCALL]: The commission finds that Mr. Mohammad,

Mr. Bin'Attash, Mr. Ali, and Mr. al Hawsawi have knowingly and voluntarily waived their right to be present at today's session, although it sounds like Mr. Ali is in one of the adjacent facilities where he can listen in to the proceedings and may join us at some point during the day.

All right. I don't have any administrative matters this morning before -- are there any matters to -- the parties want to bring to my attention before we call Dr. Morgan back in?

Mr. Sowards?

LDC [MR. SOWARDS]: Yes. And I'm sorry, Your Honor, this is fairly minor, trivial matter, but I just want you to put a pin in it.

It turns out I'm the proud possessor of an expired common access card. And the paralegals have determined that there are appointments available to get that renewed while I'm on island so I can go home.

And just for your scheduling purposes, the office is open at 0830 any morning. And so if some morning, other than this Friday, either this or next week the commission has some time to maybe allow for a 0915 start, just let us know and I will make an appointment accordingly. And if not, I'll go in someone's carry-on.

MJ [Col McCALL]: That's fine. The making of the appointment, not the carry-on.

So is it possible to make appointments, is that what you're

saying? Or is it just walk-in?

LDC [MR. SOWARDS]: Well, the way it works -- I'm sorry, I'm not pushing -- the way it works is the appointment -- official appointments start as early as 0830, so I can have that one confirmed. I don't know how limited they are, but -- so obviously the sooner we do it, the better.

But then what I had proposed to do is sometimes they will mercifully open the door if you knock around 0800, so I would save us time as well that way.

MJ [Col McCALL]: All right. So go ahead and try to make an appointment for next week.

LDC [MR. SOWARDS]: Okay.

MJ [Col McCALL]: And just let me know, and we'll adjust the court hours accordingly.

LDC [MR. SOWARDS]: Very good, sir. Thank you.

MJ [Col McCALL]: All right. Any other matters?

Mr. Connell?

LDC [MR. CONNELL]: Sir, for planning purposes, we think it would be most efficient to complete the direct of Dr. Morgan, then do the open cross and the open redirect and then do the closed tomorrow, unless the military commission tells us to do it a different way.

MJ [Col McCALL]: No, that makes sense to me.

Mr. Ruiz.

LDC [MR. RUIZ]: Judge, just while we're on some scheduling matters, I just wanted to give the commission a heads-up. I have a phone conference this Friday from 6:00 to 7:00 p.m. That tends to be a safe hour, but I just wanted to let you know ahead of time. If we can accommodate that, that'd be great.

MJ [Col McCALL]: Sure. And I appreciate you bringing that to my attention, because the short time that we do that witness -- again, hard for me to predict. I don't know how extensive the questioning is going to be, but I could see us having to go late on Friday. So -- but I'll try to front-load it, and we'll go a little bit later on Thursday if we feel like we need to.

LDC [MR. RUIZ]: Great. Thank you.

MJ [Col McCALL]: Mr. Connell?

LDC [MR. CONNELL]: Sir, I'm -- usually we do this in an 802, and I'm sorry. I'm teaching a class at 1730 on Thursday.

MJ [Col McCALL]: Okay. That's fine. And, again, I think the parties know that I try to be flexible as long as we are accomplishing what we had wanted to accomplish when we came down, and we are.

So that's fine. So what time did you say? 1730?

LDC [MR. CONNELL]: Yes, sir.

MJ [Col McCALL]: All right. I'll make sure that we're recessed in time for that.

LDC [MR. CONNELL]: Thank you, sir.

MJ [Col McCALL]: All right. Let's go ahead and bring the witness in.

LDC [MR. SOWARDS]: And, Your Honor, may the record reflect that Lieutenant Xu has arrived.

MJ [Col McCALL]: I see him.

LDC [MR. SOWARDS]: Thank you, sir.

MJ [Col McCALL]: Welcome back, Dr. Morgan. Please have a seat. I'd just remind you again that you're still under oath.

Dr. Charles Alexander Morgan III, civilian, was called as a witness for the defense, was previously sworn, and testified as follows:

MJ [Col McCALL]: All right, Ms. Pradhan. Your witness.

ADC [MS. PRADHAN]: Thank you, Your Honor.

DIRECT EXAMINATION CONTINUED

Questions by the Assistant Defense Counsel [MS. PRADHAN]:

Q. Good morning, Dr. Morgan.

ADC [MS. PRADHAN]: Good morning, Your Honor.

All right. I'd like to put back on the document camera the document that was on there when we broke yesterday, which is in the record at AE 628MMMMMMMM. And this is cleared for display to the gallery.

MJ [Col McCALL]: All right. It can be displayed to the public.

Q. Dr. Morgan, you recall when we broke yesterday that you were looking at this chart?

A. I do, yes.

Q. All right. And when we ended, you just testified that, in fact, the classical conditioning line that you see right here, in your opinion, would not have gone down as pictured by Dr. Mitchell; is that correct?

A. That's correct.

Q. I want to call your attention to a note that's -- it's a little bit hard to read. It starts here, and it appears to say: What would trigger spontaneous recovery years after extinction?

Underneath, it says: Pairing CS -- condition stimulus -- and EITs. And second, it says: Context similar to original conditioning environment.

Do you see that?

A. I do.

Q. All right. And what is your understanding of what Dr. Mitchell is indicating here?

A. My understanding is that he is saying the conditioned responses would reemerge and be visible or be measurable in some way if a person was re-exposed to the -- the thing that made them afraid in the first place -- in this case, EITs. Or the conditioned reflexes, which include thoughts and feelings, would reemerge if the

person was placed in a context that was similar to the context in which or the environment in which they had experienced the initial classical conditioning with the EITs.

And we know that from nonhuman experiments and with human experiments, we know for a fact we can review conditioned responding or thoughts and feelings if we give people reminders of their traumatic event. I've done those experiments myself and many of my colleagues have and we have published on those. But there's a good 40- to 50-year history in the scientific literature on this phenomenon.

Q. And could you describe what happens physiologically when spontaneous recovery occurs?

A. When spontaneous recovery occurs, it -- what we observe may depend on the measures we're using.

So in the experiments that I, myself, have done, we were able to reproduce flashbacks, nightmares, feelings of helplessness, hopelessness, anxiety, panic attacks, increased startle, increased hypervigilance. And the reminder that we were using for our veterans with combat-related PTSD was playing sounds and imagery from a war zone experience.

With victims of sexual assault, it was the text of the assault being read to them. And that would elicit profound changes in blood pressure, heart rate, psychosomatic symptoms, anxiety, an

increase in respiration rate, and then a report by the subject that their mind was filled with competing thoughts about the -- their worries and the traumatic event.

So it depends in a laboratory setting on the strength of the cue. When we did it with veterans but didn't give them any explicit cues and simply placed them in the startle chamber, in addition to the experiment I described yesterday, we found that just after sitting in there and hearing the white noise, just hearing a background noise, they could return to the unit and complain of increased difficulty sleeping that night, increased irritability, a reemergence, thoughts, worries, and feelings that they'd had early on in their symptomatology.

So it -- depending on how the -- who the person is and the strength of the exposure, how explicit it is, that can cause a variation in the observable -- observable symptoms.

What's really important to understand in people with post-traumatic stress or have been traumatized is many of their symptoms are not observable to an onlooker. We -- we can't tell when someone is experiencing a panic attack if we don't have physiology on them because people can mask it.

It's an internal event in the central nervous system, and they can feel like they're going to die and the intense feeling of dread. There are many symptoms of panic but we don't see that.

I think many people, their view of it is kind of colored by what they've seen in a movie or on television where people may look more hysterical and act something out. But even with symptoms, if you -- if we give them a reminder and the conditioned response is a flashback, you can't see that when you're watching someone.

Cinematographically in the movies, they show that all the time. But in real life, that's not what the majority of flashbacks look like. They're internal events, and you have to ask the person what their experience is, and they may choose or not choose to tell you, but -- so there's a range.

That's -- so I would agree in general with how that's being described. Whether it's a cue or a context, it will cause a reemergence of the conditioned memory and reactions.

Q. And have you been able to measure how long those symptoms would last for? At once reemerged, to be clear.

A. Oh, once reemerged? That depends. I've worked with people who they've apparently been able to keep their symptoms under control and stay at work, say, if it's a Vietnam veteran, until something about war appeared in the news and then they would end up at the VA Hospital and require admission because they were now unable to manage and control their symptoms, and they might be in the hospital for a week or up to a month.

There's individual variability in the degree to which people

can get symptoms back under control to leave the hospital. And like I say, an analogy can be made with high blood pressure or diabetes. People can manage their symptoms over time in an everyday life way -- where they're not really noticed by other people.

And if there's an exacerbation, something that triggers it, could be a stressor for both diabetes and hypertension, that makes it unable for the person to regulate it with the -- the normal regime of medications that they're using and they may be in a hospital setting for a certain period of time, but it -- it is based on the individual.

Q. All right. I'll come back to this chart a little bit later. I wanted to ask you -- I'd like to ask you to take a look at a paragraph from the OIG report that's in the record at 628RRRRR Attachment C.

ADC [MS. PRADHAN]: This is cleared for display to the gallery, sir, and I'm going to page MEA-2C-00000460.

MJ [Col McCALL]: All right. It can be displayed to the public.

Q. I'll zoom in a little. We have the -- the OIG report is notoriously bad print. So starting with paragraph 97, Dr. Morgan, if you can review that and let me know when you're done.

[The witness reviewed the evidence.]

A. I have.

Q. Moving to 2C-00000461, the top of the page and the rest of that paragraph.

[The witness reviewed the evidence.]

A. I have.

Q. All right. And on that first page, and I'll show that to you again, it states very sort of lightly that that's a mid-2005 interrogator assessment. Do you see that?

A. I do.

Q. All right. The part of the sentence saying, "He described multiple instances of attributing fears to unrelated events" -- for example, hearing the noise of a cell door, strange sounds or other unrelated activities would also make him think he might be harmed and these are the CIA interrogators reporting this -- would this be an example of what you were just describing in terms of spontaneous recovery?

TC [MR. GROHARING]: Objection. Speculation.

MJ [Col McCALL]: Objection overruled.

A. These are the kinds of things we observe in patients all the time. They will report that although they know the -- the element that has driven an increase in heart rate or increase in worry is not related to their original traumatic event and they don't understand why it's making them feel uncomfortable.

This is what we refer to as the generalization of

fear-conditioned responding. And as I mentioned yesterday, it could be cue-specific, like the jingling of keys, or it can be more contextual, whether it's the slamming of doors and the ambient sound.

We've used all those and tested those in an experimental setting over the years to try and understand how to treat people with PTSD.

So his descriptions -- this description is quite a naturalistic one of what we actually observe and know very well in the literature on trauma and conditioned responding.

It's likely a mix of cue-specific and contextual fear conditioning that's reemerging -- that's being triggered. But in layman's terminology, I'd say it's -- fear has been generalized. And they're responding to more than one thing, and those things aren't directly tied to their -- their personal traumatic experience.

Q. Thank you. And one more sentence I wanted to call your attention to -- excuse me -- in that paragraph on the -- on that page is: The interrogators said Ammar explained to them that, quote, he knew this was irrational and would remind himself that he was safe in our agency, custody, and well taken care of in order to make those fears pass.

Now, previously you testified about the use of the prefrontal cortex in providing safety signals for the -- for the subjects or for your patients. Could you describe how that might

apply to this situation where you -- to the description you see here?

A. This is a nice clinical example of what I was talking about yesterday, that there's a difference between people saying what they factually know to be true and what the rest of their brain is not accepting as true.

So in our experiments with the shock and the lights, people were able to say I know the relationship between them, but their body was never responding to the safety signaling as if that was true.

This is what we see in people who have an anxiety disorder like PTSD. They know certain facts to be the case, but that knowledge does not translate into an influence on their body's physiology and the rest of their thinking and their decision-making.

Q. Dr. Morgan, are you familiar with what's called neurotoxicity hypothesis?

A. In part. I have to -- I'd have to see what the reference is, but yes. In general, there is a hypothesis, but things that are neurotoxic, things that are damaging to neurons.

Q. All right. I'd like to show you a document.

ADC [MS. PRADHAN]: The court's indulgence?

MJ [Col McCALL]: Take your time.

[Pause.]

ADC [MS. PRADHAN]: All right. This is a document that's in the record at AE 425OO, the declaration of Shane O'Mara. And this is

for display only to the parties and the commission.

MJ [Col McCALL]: All right.

Q. Dr. Morgan, I'd like to call your attention to paragraph 8. If you could let me know when you've reviewed that when it's up.

[The witness reviewed the evidence.]

A. I have.

Q. All right. My first question is: Would you agree with Dr. O'Mara's assessment of the neurotoxicity hypothesis here?

A. As it's displayed here, yes, I would.

Q. Okay. And -- Okay. And how would you -- what would your interpretation be of the neurotoxicity hypothesis as applied to the RDI program, your understanding of the RDI program?

A. First, I'd like to clarify. When we say something is a hypothesis, that means we're trying to test a theory to see if the idea is borne out. We know very well over the last 40 years of neurobiological investigations in traumatized people that neurons truly are damaged. There really is neurologic injury. So it's not just a hypothetical idea. It's been empirically verified.

So that's why when you said neurotoxicity hypothesis, I kind of hesitated because it's not really a hypothesis anymore in our field. It's just generally accepted that stress damages your brain in very real ways and those ways are measurable.

So in -- I would agree with what he's saying. And we do know that uncontrollable stress produces observable damage in neurons in areas like the hippocampus and around the bed nucleus of the stria terminalis. We know that it causes explicit dysfunction in frontal lobes, and we know that those changes endure in most people for the rest of their life. They're very difficult to treat, but they endure for great periods of time.

There -- in most of our treatments, we're hoping to find a way to counter the damage that's been done when people have been traumatized, but the physical damage in the brain is very real.

ADC [MS. PRADHAN]: I'm done with the document camera for now, sir.

Q. Dr. Morgan, you just -- you just mentioned trying to treat patients with trauma. How does one -- in your experience, how does one go about extinguishing fear in trauma patients?

A. It's -- it's a difficult process and there are numerous kinds of therapies, none of which have been the successful treatment of people with PTSD.

In the field at large, some kinds of treatments produce an improvement in some of the symptoms of PTSD that help people at least function in their daily lives, but we don't have any treatment that -- that cures it.

The treatments generally fall into three formal types. One

would be a psychopharmacology or a medication approach where different classifications of drugs have been used to try and target symptoms of PTSD, for example, the kinds of drugs that might lower one's adrenalin system.

And so some people have put people on drugs that try and cut down the adrenalin response because people are being triggered throughout the day by reminders of their trauma. And if they can't have that surge of adrenalin, the idea is that then that would limit the -- oh, the -- sort of the emergence of panic attacks or of unpleasant thoughts, unwanted or intrusive memories, and then more avoidance.

Other kinds of drugs, like -- like Prozac, I -- our team was one of the first to actually experiment with Prozac in the treatment of PTSD. And that drug was the first that showed an impact not only in the symptoms of irritability, hyperarousal, the sympathetic symptoms that are seen in PTSD, it was also showing an impact on the avoidance/depression-like symptoms and hopelessness-type symptoms in post-traumatic stress disorder.

And so today, patients who are suffering from trauma are likely, if they're on a medication, to be on an antidepressant or an antisympathetic agent drug or a combination, the purpose of which is to try and lower the general state of anxiety, fear, and alarm that they live with on a day-to-day basis.

Some other drugs are attempts to promote sleep, which is a chronic problem in people with PTSD. They generally average two to three hours of sleep a night on sleep-monitoring studies.

And so there's -- there are many different kinds of experiments going on now, because in medicine we really don't have specific drugs that will make you sleep, like slow-wave sleep and -- which is the deep, restful kind of sleep that people are missing out on with only two to three hours of sleep.

Right now there's -- the drugs mainly knock people out. They lower the threshold of consciousness and a person falls asleep, but they're not restorative. So that's an active area of -- of research in PTSD.

The other kinds of therapies, if people aren't using medications -- and sometimes it's paired -- is with psychotherapy or talking therapies. And those fall into generally two broad kinds.

The kind of therapy that is more behavioral, like when -- the most, I would say, en vogue form of therapy right now over the last 20 years has been cognitive behavioral therapy, which involves training a person to go through behavioral exercises of bringing up distressing information in their mind and learning to counter the negative thoughts they go through.

So it requires thinking in a different way about us as humans. It requires refusing to think about a difference between our

thinking and our behavior. Our thoughts are behaviors, and they are triggered by things just as physiologic reactions are, and they can be modulated in a behavioral-therapy context as well.

Some -- some patients can't tolerate that kind of therapy because it -- it requires extensive reading and homework and practice, and it is quite uncomfortable to do. So depending on whether a patient can or not participate in it, that -- that lane would be sort of the lane of therapy.

And then there are other kinds of talking therapies that really focus on the most enduring symptoms that we see in trauma victims, which are the changes in the way they have viewed themself, the world, and other people.

One of the -- one of the core disruptions in who a person is when they've been significantly traumatized is their belief systems about themself and the world. And we almost think of it as what we'd call conditioned defeat. In other words, they no longer truly believe that the effort they will make to get -- to be able to trust someone else, to be able to rely on someone else, will ever happen. Hope is eternal, so they try it, but it usually reinforces their belief that they're going to be retraumatized.

The reason why those symptoms are important to focus on in therapy is because it's a person's belief and their expectation and their reasoning that drives most of their behavior. And the

observation clinically has been that traumatized -- victims of trauma, whether it's sexual assault or torture or other severe forms of injury, seem to behave in ways that become self-defeating over time. And therapists have decided, well, we'll try and focus on those ideas to see if we can change them so there can be a better outcome for that person.

So those are the three main arenas of therapy, and none of them are rapid. They all take years of therapy to show an effect.

Q. Do the two types of psychological therapy that you -- or psychotherapy that you mentioned require trust relationships with their providers?

A. I'm sorry. I didn't hear the last part.

Q. Do the two types of psychotherapies that you were describing require trust relationships with their providers?

A. Absolutely. Most victims of trauma are -- they're very slow to trust. They don't feel safe.

I've worked with people for two to three years before they have finally actually divulged something that they've been hiding for years about their traumatic event. And then they may skip therapy for weeks because now they're not sure what's going to happen. But it's the norm rather than the exception.

Most people after trauma never go to therapy for at least two or three years. They get into self-medicating or they avoid it

and they just try and stay busy, so they don't want to deal with it.

Once they do come to therapy, if they have moderate to severe PTSD -- that's my understanding in this case from looking at the other evaluations -- they're in therapy on and off for -- for years. And they routinely report that trust is essential.

When we work with people who are in, like, the Department of Corrections, that's one of the main efforts, to try and provide consistency in therapy for someone that they can have the chance to develop trust with.

But that's not always possible in the normal clinic or in a -- in a custodial situation. But that's a major issue that's discussed widely in the field on trust, consistency in therapy.

Q. And in your experience, would you recommend medication without psychotherapy for any patients?

A. No.

Q. Okay.

A. We know that actually from a number of studies. It's not just my own personal opinion. That is based on scientific evidence.

Pharmacology alone may help someone get sleep, get rest, make them feel calmer. But it doesn't resolve the core issues that are driving their thinking and their behavior.

Some patients prefer that because they still don't want to talk about trauma and they can go back to work. And so clinically

we'll refer to that as it was a response to medication. But the -- the standard of care recommendation right now is to do cognitive behavioral therapy, or talking therapy, with or without pharmacology.

But we do not teach our residents, our doctors who are training to be psychiatrists and -- to do that, to think of medication as the sole focus of what we do.

Q. Dr. Morgan, just switching tacks a little bit. We've heard testimony previously from Dr. Mitchell ----

ADC [MS. PRADHAN]: And I can provide a record site if Your Honor wants it.

Q. ---- but we've heard testimony previously that the similarity in conditions of confinement among various black sites may have functioned as exposure therapy.

First of all, could you explain what exposure therapy is?

A. Yes. Exposure therapy is based on the idea -- so if you think of it colloquially, people say get back on the horse after you fell off the horse. And you put somebody back on the horse and they'd slowly become comfortable with riding a horse.

For people who have a fear of spiders or a fear of snakes or a fear of blood, the traditional behavioral therapy would be to expose them in repeated doses to the thing they're afraid of.

So, for example, if a person has a blood phobia, that's one

of the specific kinds of anxiety disorders where the heart rate drops rather than elevates. So at the sight of blood or a needle, the person passes out.

So the way we would treat it is a mini form of exposure therapy. They would lay on the gurney with a heart rate monitor on and you place the needle on their arm and watch the heart rate come down. You don't remove the needle until the heart rate begins to go back up.

And you do this repeatedly over and over and over until finally when you touch their arm with the needle, the heart rate does not drop. So the body is learning, their brain is learning, they're learning.

But with that kind of a phobia, it's not just a conscious decision "I will not let my heart rate go down." This is learning at the level with the amygdala. And that's the repeated exposure to the aversive cue.

The same thing is for phobias about spiders and snakes or with people with obsessive-compulsive disorder who feel that everything they touch is dirty and they do lots of handwashing. Part of the exposure therapy is placing -- having them hold on to something dirty. It might be a dirty diaper, it might be something, and they hold it for a particular period of time while the anxiety is up and we don't remove the aversive cue until the anxiety goes down.

So the idea is that by presenting the threat cue and making the person hold -- tolerate the stress, it slowly helps reduce the fear -- the expression of the fear-conditioned response over time.

Why -- but when it's not done appropriately, it just makes the condition worse. So it's like people who fly, have a fear of flying, or that go to the dentist. You go once or you fly once or twice and you say that was a bad experience and you wait a long time before you fly again. All that does is usually reinforce the anxiety and the fear.

Exposure therapy in concept is the principle at survival school. They're taught about something and one version is they're thrown in the deep end of the pool by going to the -- the resistance training lab. They're just plunged into it.

The Air Force model was sort of the idea about getting mini exposure, sort of wading into the pool before you go swimming. So if a child is afraid of swimming, you can throw them in the deep end or you can have them wade in. Both techniques work for regular people. It just depends on how anxious a person naturally is. So that's the principle of exposure.

In PTSD, some colleagues of mine started research years ago looking at whether or not this could be used therapeutically with patients. And the short story is exposure therapy is effective in some people with PTSD.

It is painful for them to do. Sometimes they will vomit on the floor of your office if they have an intense gastrointestinal response, but the -- the practice is preparing them, teaching them breathing and relaxation techniques. And then the principle is when you're in the therapy session with them, they are exposed to specific cues that are directly linked to the previous trauma. And their task is to hold the intensity of those emotions and feelings and physical reactions as long as they can until they begin to subside and then the cue is removed.

So it is a -- it's a -- it's a complicated kind of therapy to do. The scientific data about it said it was the most effective at reducing a specific kind of symptom of PTSD. It was very effective at reducing the intrusive thoughts and reducing some of the hyperarousal symptoms. Exposure therapy has not been effective at treating the other symptoms of PTSD, but there are some people for whom it is effective.

Now, with respect to repeated placement in a room where something has happened, I think that that is a misguided view, and I'll say why. The person's still being detained. They're still not free.

People who -- who do exposure therapy are no longer truly, and they know they are no longer truly, at risk for this happening to them again and they choose to do the exposure. It's a -- they go in

knowing this is to remind me of this and I'm now actively working on it. It -- it -- it's not a passive thing in humans. A human being can decide now I want to trigger the feelings.

So just placing a person back in the context where they received their trauma doesn't naturally desensitize or produce an extinction of the fear. It requires actually a conscious and voluntary effort to -- to reduce the intensity of the fear conditioning. It's not a passive thing.

Q. Would that be true even if they were not presented with explicit threats in those contexts?

A. Oh, I'm -- what would not be true?

Q. Would -- so would it -- would it be true that fear would not extinguish -- and perhaps I'm -- perhaps I need to phrase this differently. Strike that.

Would the fear extinguish -- and this is just to clarify what you just said, I think, and make sure that we understand it. Would the fear extinguish over time if people were placed in similar contexts and the explicit threat cues were not presented to them? So they're in similar contexts ----

A. Right.

Q. ---- but they're not being explicitly threatened.

A. With a victim of trauma? No.

Q. And why do you say that?

A. Because we know from exposure therapies, they are in charge of the degree of -- they are learning to be -- to come into control of sustaining the distress, bringing the imagery up, and then letting the images go, and then rating it on scales. So they're an active -- they're -- they're mentally and actively involved in the process of knowing what they're doing for that -- for -- for traumatized victims.

Even in -- even in behavioral exposure therapy for other kinds of phobias, the person knows what they're doing. They're working on a fear. They're working on the anxiety. So they're an active participant in that process.

But if it's -- if it is not, then it is really unlikely that that would occur. Yeah. I'm not aware of any -- any data in people who have been traumatized or with PTSD where passive exposure to something resulted in anything beneficial. Passive exposure to a reminder of their trauma doesn't result in anything beneficial to them.

ADC [MS. PRADHAN]: Your Honor, my understanding is that Mr. al Baluchi is, in fact, watching from the holding cell, and this is the quickest way I have of doing this. I told him I would give him a heads-up when we turn to his specific experiences, and so we are about to turn to his renditions and his -- the application of EITs.

MJ [Col McCALL]: All right.

ADC [MS. PRADHAN]: So he can choose to listen or not.

MJ [Col McCALL]: All right.

Q. Dr. Morgan, I'd like to briefly talk about the rendition process, and we can talk about this more in closed session? But I have a paragraph here from -- again, it's the OIG report, 628RRRRR Attachment C, page MEA-2C-00000449, paragraph 76.

ADC [MS. PRADHAN]: And this is cleared for display to the gallery.

MJ [Col McCALL]: All right. It can be displayed to the public.

Q. Dr. Morgan, do you see there that this description by the CIA of Ammar's renditions describes him as being hooded while moved -- excuse me.

Let me actually refer you to the previous paragraph for a better description, which is the transfer of Ammar from Location Number 2 to Location Number 7 included a body cavity check, blindfold, covering his mouth to prevent him from communicating, the placement of noise suppressers over his ears to prevent him from hearing, hearing ambient sounds, reclothing in a jumpsuit, and shackles on his hands and ankles.

Do you see that?

A. I do.

Q. Okay. My first question is: Could you identify the different types of stressors, of psychological stressors that you see there?

A. Yes. With -- both with humans and nonhumans when we look at stress, with nonhuman animals in the lab, we can stress them in different ways. One is by depriving them of sensory input, like what they can see, what they can hear, and whether they can move.

So the -- if an animal is reliant on its vision -- humans, we largely rely on vision -- that has a greater impact than if we were relying on acoustic stimuli. So when people are deprived of sight, like this could be -- you can be in solitary confinement without any light, that's considered stressful. It's depriving the person of a way to orient to where they are, what's going on.

So for humans, it's also quite distressing not to be able to see. So there's a -- there's the deprivation of a vital sensory input source, which is our vision, hearing.

And then when you're not allowed to communicate, that can be stressful for people, too. I think most people would think of losing their sight and hearing as more distressing with respect to comparing things to uncontrollable stress.

But restraint stress is stressful for nearly every animal that's evaluated. The inability to move freely causes stress. It might be necessary from a custodial perspective, but that's a

separate issue than how it affects the physiology and mood and affect of a person or of a nonhuman animal.

So there's restraint stress, there's sensory input stress, and it's meant to be disorienting.

People's clothes are changed, that may or may not be stressing to a person. You'd have to ask them. For some people, if their -- if what they were wearing was personally very significant or of a religious nature, we'd say then there was more meaning to someone taking away their clothing or taking away their beard or their hair or something. For -- depending on somebody's culture, that may be very stressful or it may not. It would -- it would really depend on the situation.

So in here, I think -- when I think of it from a -- what we know from research and stress and anxiety, it's the loss of sight and sound and freedom of movement. You're really dependent on someone else to manage everything you're doing, but you can't even anticipate it because you can't hear them, you can't see them. So it's a very -- it's in a very passive state, which would be experienced as uncontrollable.

Q. Okay. And do you recall reviewing photographs of renditions, including Mr. al Baluchi's?

A. I do.

Q. Okay. And is this description of Mr. al Baluchi's

rendition consistent with what you saw in those photographs without -- without expanding further?

A. I believe it is, yes.

Q. Thank you. All right. I'd like to talk about the application of what were called EITs on Mr. al Baluchi.

And my first question for you, Dr. Morgan, is: In your experience with SERE training, do you know if assessments were performed on the servicemembers before they underwent the training?

A. At -- for -- to be clear, to go to survival school, there is a form of assessment. I think the greatest part of the assessment is on someone's physical capabilities at the time. Are they going to be physically capable of navigating obstacles during the evasion phase where they're on the move at night? Are they going to be physically capable of doing those things?

There is a screening for psychological vulnerability. What that means is primarily asking a person if there's anything stressful going on at home or if they've had a previous highly emotional experience or a loss that might either distract them from being able to focus during the course or that might be exacerbated.

So what they're often told is if you have something else going on, this is an intense experience, and that might flare up. So -- and we know that people have said no to that. And then when I've had to debrief them when I was covering as the doc on the site,

that they did have something going on. And the stress -- the exposure of the stress during the RTL caused another issue to resurface that was unrelated to SERE school and that was contributing to their failure to perform well being in mock captivity.

So it's a -- it's a limited screening. It's not an extensive psych eval, but it -- but it is done with the intent of examining that particular issue. Is there something negative and stressful or demanding in their home life, or have they got a personal psychological issue related to either trauma or phobias before, so...

Q. All right. I'd like to call your attention to a couple of paragraphs in the OIG report, and this is at ---

ADC [MS. PRADHAN]: Do you need the record cite again, sir?

MJ [Col McCALL]: No, that's fine.

ADC [MS. PRADHAN]: All right. This is at MEA-2C-00000432, the paragraph -- paragraph 43, and then I'm going to turn the page. And this is for display to the gallery.

MJ [Col McCALL]: All right.

[The witness reviewed the evidence.]

A. Yes, I've read it. Thank you.

Q. And then I'd like to call your attention to paragraph 46 on the next page as well, involving the same individual, JP2.

[The witness reviewed the evidence.]

A. All right.

Q. All right. So actually a little further up in paragraph 45, we see in the last line, it says: JP2 for the second time noted that, based on this interview, there are no indications that enhanced methods, if used, would cause profound and permanent psychological or emotional harm.

And I have a couple of questions for you related to that. The first question I have is that you see there JP2 describing this as an interview, and you see in the previous paragraph, in 40 -- paragraph 43, the description as a psychological assessment.

Do you see any meaningful distinction between the two?

A. I don't.

Q. Okay. And in -- at the end of -- in that statement that based on the interview, there are no indications that enhanced methods would cause profound, permanent harm, I guess my first question is: Have you treated individuals accused of or convicted of crimes?

A. I have.

Q. Okay. And in paragraph 46 when JP2 says he did not see any of these guys as weak and described Ammar as, quote, too robust to require his intervention, my question is: In your experience, does an allegation of criminality have any impact on a person's ability to withstand stressors?

A. In -- in the literature on PTSD, vulnerability to anxiety disorders or stress disorders, there's no relationship between sort of someone's decision to participate or not participate in a crime or being charged with a crime.

In fact, in prison studies we know full well the rates of PTSD can be quite high. So in -- in our field, we do not see a connection between just whether or not a person may participate in something illegal as related directly to their vulnerability to a traumatic stress disorder.

I have actually treated individuals who were the perpetrators of violent crime and who suffered symptoms of post-traumatic stress disorder from that crime. When people don't understand mental health issues, they just say, oh, the person feels guilty. But they have actually specific re-experiencing avoidance and numbing and symptoms of hyperarousal and irritability that make it a real mental disorder, but they were the perpetrator of the crime. They just had not anticipated the impact that that would have on them.

So sort of trauma is, as you would say -- it's sort of any -- trauma can affect anyone. And the degrees to which it's damaging on people may vary, but whether or not they're involved in an illegal enterprise is not one of the factors that we know to be related to that.

Q. Thank you. And I'd like to now call your attention to paragraph 107.

ADC [MS. PRADHAN]: And that's 2C-00000465 in the same document.

MJ [Col McCALL]: All right.

Q. Here you see Y5X, who's a different medical provider, stating that -- and there are a number of redactions that make this a little bit difficult, but I think the overall point is there that: Stating that lasting harm is difficult for -- redacted -- to predict and he's not sure such an assessment is possible. And that uniforms -- no uniform set of criteria exists for determining whether lasting harm can accrue from EITs. The medical provider makes the call subjectively and based primarily on gross behaviors or lack of them.

So my first question for you, Dr. Morgan, is: Do you agree with Y5X's assessment of whether or not there are a uniform set of criteria for determining lasting harm resulting from stressors?

A. I agree, there are no -- there were no guidelines, in fact, at that time in our profession. And I was part of OMS. This is -- we were reminding colleagues there's no way to predict that this will not be damaging and traumatizing to people.

There were individuals who, for whatever reason, it wasn't scientific, believed that they could predict who would and who

wouldn't have a negative outcome from being traumatized.

But it was very clear, even by 2002, there's no beneficial effect to doing what was done in EITs to people. And we were very clear about it. We had a meeting at the National Science Foundation, and Drs. Jessen and Mitchell were there.

But while I was at the CIA, this was a very active point of discussion where many physicians, myself included, said you're saying you can do things that we don't have any data to support that. So this is just a personal, subjective guess on the part of the people who had said I can tell you this person will be fine. That's impossible.

We know that from working with trauma victims, you -- things happen. And then we look at -- we have to ask them, how did -- what impact did this have on you and then what do we observe?

The only factors we know that are predictive of an enhanced vulnerability to get PTSD are if someone has had previous trauma, previous psychiatric illness. And we know that those factors make the person even more vulnerable than the -- than a regular person.

But things like they experienced in the EITs, when people have experienced intense stress like that, uncontrollable stress in repeated occasions, the rates of PTSD are upwards of 67 percent.

So it's one of the most effective ways of damaging people. When we look at the risk ratio for who will get PTSD, sexual assault

is the other one. So things that are done up close and personal by another human being, the person believes they could have chosen not to do this to me, seem to be the kinds of events that are the most damaging to human beings.

But I have -- based on my knowledge of the field and the work that I've done, I would say I would agree with the opinion being expressed that they don't know. They -- they would not know how -- what the outcome would be, at least to say that they would be well.

Most common sense applied at that time, based on what we knew in scientific literature, would be it -- it can't be good. We -- the person might not develop a full-blown case of PTSD, but the prediction would be that it is highly unlikely to be beneficial to the person.

And given the principles outlined in the EIT program, the purpose was to create intense fear-conditioned responses that -- to include conditioned attitudes and beliefs so that subsequently those could be manipulated or exploited to get the person to do things that weren't even in their own interest.

So I think, given the purpose of the program and knowing what we know in the scientific literature about trauma, the -- the doctor at the time could have said I can't tell you they're going to be healthy after this, I can't tell you they will definitely have a

specific disorder, but the odds are the outcome won't be good.

Q. Okay. And you appeared to be making a distinction a minute ago between stressors imposed by humans and perhaps other types of stressors. Could you explain that distinction?

A. Yes. In the field of PTSD, so there's a lot of literature on the risk ratio between certain kinds of things and how likely are they to cause post-traumatic stress disorder. And so it can run the range from fires, floods, tornados, landslides, to a person being in a car accident or witnessing a car accident where your family members were or were not involved, to loss of house and property and then sudden death of a loved one, all the way over to sexual assault or physical assault, combat exposure to death and destruction of other people or personal injury, and then to torture.

And we know that the rates of PTSD are lowest, even if it's a natural disaster, like a tornado or a landslide or something, if people believe it's probably an act of God or something that couldn't have been foreseen.

The -- as people believe more and more that the event could have been prevented, the risk of getting post-traumatic stress disorder increases. So if they're able to attribute it to something impersonal from the universe or to a deity, the rates of PTSD, they're still there but they may not be that high. But the more up-front and close and personal it is, the higher the rates of PTSD.

So, for example, in the general population, the rates of PTSD are about 8 percent. About 50 percent of the population has been exposed to something we'd call a traumatic event, like sudden death of a loved one. Someone might die of a heart attack or something.

And when we break that down in a little bit more of a refined way within, like, military populations, we find the rates of PTSD are higher in some of the reservists than the general population who haven't been exposed to trauma or are more -- have been exposed to trauma but they weren't at the front lines, all the way over to in our special mission units where the rates of PTSD are low but they're involved in much more trauma.

So we have been able to examine the issue about, is it the number of traumas? Is it the personal nature of the trauma? And -- or is it that it's a random act? And the general consensus in the scientific community is that the more -- the more personal and up-front, like a sexual assault or torture, in those -- in those situations it's at least 50 percent of the people who get PTSD.

With rape, the rates vary. Sometimes it's between 48 percent and above. But you don't -- PTSD isn't the only thing that -- that can be the result of a rape. So many women suffer from depression, anxiety, other kinds of disorders and have partial symptoms of PTSD, if not full PTSD. So it's quite devastating.

With torture, the -- the rates are generally accepted as somewhere around 67 percent. Some studies will say it's as high as 90 percent. It will depend on the population that's being studied.

But in my field, everybody agrees that in this category, the odds are really high. If you were going to gamble and bet on it, you'd say they're going to have PTSD from this kind of an event.

Q. I see. I'd like to show you -- and this is at -- same document, 2C-00000430 to 00000431, paragraphs 38 and 39 of the OIG report. And I'm going to show you a list of the techniques that were used on Mr. al Baluchi.

ADC [MS. PRADHAN]: And this is for display to the gallery, sir.

MJ [Col McCALL]: All right. It can be displayed to the gallery.

ADC [MS. PRADHAN]: Thank you.

Q. Okay. I'm going to ask you to review it, and then I have a few specific questions for you.

[The witness reviewed the evidence.]

A. I have reviewed it.

Q. Thank you. And switching to the next paragraph, paragraph 39.

[The witness reviewed the evidence.]

A. All right.

Q. All right. And one more page.

[The witness reviewed the evidence.]

Q. Paragraph 143.

[The witness reviewed the evidence.]

A. All right.

Q. All right. So in what you reviewed, there are 16 -- I guess 15, with a modification, different techniques that were used on Mr. al Baluchi. Number one, the facial attention grasp, the facial slap, the abdominal slap, walling, standing with his forehead against a wall as a stress position, kneeling with his back inclined towards his feet, water dousing, cramped confinement, and sleep deprivation in excess of 72 hours.

And then you saw the use of isolation, reduced caloric intake, deprivation of reading material, use of loud music or white noise, use of diapers for limited periods. That brings us to 14.

A. Yeah.

Q. And then in that last paragraph you see modification of the use of iced water during water dousing; and number 15, I suppose, the use of the stick behind the knees.

A. Yes.

Q. Okay. So my first question is: Are there techniques here that you are not familiar with from your experience in SERE training?

A. There are. I -- at SERE training, I -- over 10, 12 years,

I have never seen the use of the stick behind the knees or the use of diapers.

Q. Okay.

A. But the other techniques are all techniques that students get exposed to in their experience in the mock POW camp.

Q. Okay. What was the longest period that sleep deprivation was authorized in SERE in your experience?

A. Well, the rule from JPRA was students had to get -- they need at least four hours of sleep. That -- that time frame has shrunk and expanded over the years, but it was -- it's practical during -- during the times I was monitoring that. Dr. Hazlett and I did measure cognitive function in the students to try and assess: Are they remembering anything they're being taught?

And so when sleep deprivation -- when they weren't getting at least up to four hours of sleep during that 72, it wasn't clear they were learning anything. But most of the time that was about the amount of sleep they got in 72 hours, was about four hours.

Q. And when you say it wasn't clear they were learning anything during sleep deprivation, what do you mean by that?

A. Well, I was actually asking them about things they'd been taught in the classroom, specific skill sets that they'd been taught that should help them and their survivability if this was a real-world event.

And I thought, well, let me find out if they actually remember. Because they're not displaying the techniques, maybe they can tell me them, sort of like a semantic memory assessment.

And they were just confused. People were hallucinating. They're talking to people they can't see. As the sleep deprivation would increase, often the students will joke about it. They'd say, "I don't know who you were talking to, but you were talking to the tree or talking to the cement wall."

And since it's a school, the idea was, well, you have to give them some sleep because they're here to learn. This is not a real POW camp.

But -- but most of the time I was directly involved with SERE, it was roughly four hours of sleep. If people -- if students were enterprising, they could find a way to sleep when they were in cramped confinement, when no one was looking.

That's often what POWs have said is really helpful, get sleep whenever you can. But at least for the official period of time, it was roughly four hours.

Q. And that would be four hours over how many days?

A. Over 72 hours ----

Q. Over 72 ----

A. ---- or three days, yeah.

Q. Okay. So four hours -- a minimum of four hours of sleep

per night for ----

A. No.

Q. ---- the three days?

A. No. Four hours.

Q. Total?

A. Total.

Q. Got it.

A. Yes.

Q. All right. After which you were observing hallucinations and the other symptoms that you mentioned?

A. Yes. That was common in -- in a number of students. They realized that they were hallucinating from lack -- lack -- lack of sleep.

Q. Did you ever -- at any point during your SERE -- during your SERE studies, were the subjects authorized for sleep deprivation in excess of 82 hours?

A. No.

Q. Okay. I'm going to ask you about waterboarding.

You had mentioned earlier that you, yourself, had been waterboarded at one point.

A. I had a small taste and flavor of the experience, yes, as students would get it, which is different than real-world waterboarding experience. But I had a small experience of that, for

what the students would experience, yes.

Q. Have you heard before of water dousing as a technique?

A. I hadn't heard it referred to in -- with that phrasing. As I read about what people were referring to, I've seen a form of that done at SERE school where people are doused in very cold water from a hose while standing.

And it's -- although it is aversive to the students, it was usually the medic who had asked that it be done because it was very hot in the summers at Camp Mackall. And it was to make sure that they were not going to have any heat stroke or heat exhaustion. But it was very cold spring water and they would douse them with that.

I have -- I've never seen it used at survival school as a form of interrogation.

Q. I'd like to show you a paragraph at 2C-00000445.

ADC [MS. PRADHAN]: And this continues to be for display to the gallery, sir.

MJ [Col McCALL]: All right. It can be displayed to the public.

Q. Do you see paragraph 68, Dr. Morgan?

A. I do.

Q. All right. And here's the description of water dousing, as applied on Mr. al Baluchi, wherein the sentence beginning "They would put."

They would put the shackled detainee on the tarp or plastic-covered concrete floor and the interrogation team would pour water on the detainee from cups, bottles, and buckets.

Are you familiar with the use of water as a technique in SERE in this way?

A. I've -- that's, I assume, standing or laying down. I've never seen that used at survival school, no.

Q. Okay. And this would be -- he would be on the tarp lying down.

A. No, I've never seen that. I mean, that wouldn't -- that wouldn't be very much different than the waterboard in the sense of -- if a person's lying down and has -- is blindfolded and there's water being used, that would -- it would be far more alarming depending on what they feared would happen.

But, no, I've never -- I've never seen that technique used on -- on students at survival school.

Q. When you say the effect would be similar to the waterboard, what do you mean by that?

A. It -- one of the ways we stay alive is by breathing. And the reason why the waterboard is alarming to people is the fear of drowning or suffocation. It -- it's -- you're going to have an obstructed airway.

It's -- and for -- for humans, that's extraordinarily

alarming to our brain, whether there's the possibility of lack of air or drowning. It's meant to induce an incredible amount of anxiety and fear.

If people are grabbing someone near the neck and all that, that makes the amygdala fire very strongly, and it fires extraordinarily strongly if we fear we're drowning or not getting enough air.

When people are being doused laying down, if you can't see what's happening -- I don't know what's in their mind, but there's more of a risk of water going up their nose or into their mouth, that would certainly trigger a much greater fear alarm response than standing up and having cold water maybe sprayed on you from a hose or dumped over you. There wouldn't be the same fear.

Cold stress -- cold-water stress is a stress form that we use. In the lab we don't douse people's whole bodies in cold water, but it's called the cold presser test where you plunge their hands in cold water, ice water, and they have to hold it there.

It's a -- it is more stressful than people believe, and it -- it's one technique in the lab to be able to study brain functioning under stress.

So cold water, in and of itself, is considered an aversive stimulus, and we don't like it, unless, I guess, you're really hot and you like cold plunge baths. But this is a -- this is a situation

where someone's doing it to a person who is blindfolded and it -- which has a form of helplessness to it. So if they're laying down on the floor, that would -- based on what I know, that would be far more stressful than while done standing.

Q. And you see in paragraph 69, the next paragraph, discussion about the use of iced or cold water on Mr. al Baluchi during his water dousing. And relative to what you just said, would the temperature of the water, the iced water, enhance the overall effect of the dousing?

A. Well, I think the -- it -- it should in terms of creating stress, because we know just a water bath as producing stress in the laboratory isn't as effective as ice. And if you do an ice bath, ice water is far more challenging.

And, once again, it's -- whether it is all -- even at -- in the lab, it's even deliberate. A person has agreed you can put my hands in cold water and we'll hold them there. It's still a stressful experience. And this would be involuntary, which would make it more stressful.

And so uncontrollable stress is -- is sometimes created by exposing an animal to cold water and forcing them into it. So it's very uncomfortable and out of their control.

Q. And so, in your opinion, based on this description of Ammar's water dousing using iced water, would that have caused

uncontrollable stress in him?

A. That ----

TC [MR. GROHARING]: Objection, Your Honor.

A. Oh.

TC [MR. GROHARING]: That's an improper opinion.

MJ [Col McCALL]: Objection overruled.

Q. Dr. Morgan, I'd like to call your attention now to -- this is the same document, page 2C-00000443.

ADC [MS. PRADHAN]: Sorry, sir?

MJ [Col McCALL]: No. I overruled the objection, if you wanted to ask that question.

ADC [MS. PRADHAN]: Oh, I'm sorry.

MJ [Col McCALL]: I'm not sure if he answered.

ADC [MS. PRADHAN]: He sort of answered it.

WIT: Oh, I didn't hear. I'm sorry. It's kind of a muffled zone over here, and it -- so it's -- I can't always hear what's going on.

Q. I'm very sorry. We're sort of talking past each other. I apologize.

The question was: Based on the description that you just read of Mr. al Baluchi's water dousing with the use of the ice -- iced water, would that have caused uncontrollable stress in Mr. al Baluchi?

A. I would say yes, definitely.

Q. Thank you. All right. I'd like to move to page 2C-00000443 in the same document.

ADC [MS. PRADHAN]: This continues to be for display to the gallery.

Q. And this is the description of Mr. al Baluchi's walling, beginning at paragraph 67. And let me know when I can turn the page, sir.

[The witness reviewed the evidence.]

A. All right.

[The witness reviewed the evidence.]

A. All right.

Q. All right. So leaving that up for a second, because I have a number of specific questions about what happened there. My first question for you is: How was walling conducted in SERE school?

A. Walling was conducted very similar to this description.

I've seen it done both with and without a towel wrapped around the -- the student's neck to try and control them so their head wouldn't bobble back and forth, although I had seen it done without a towel where the instructors would grab the student's clothing and roll their fists into it as if to turn their hands around.

And that's the form that I experienced, which is why I had

knuckle bruising on my -- on my clavicles. But that was -- I think it varied across the sites, how often, from my observation, towels were used or not used. Over the years, some of the requirements changed. But that description is similar to what I've directly observed, yeah.

Q. Okay. And about how many times would a subject in SERE school be -- be walled in one session?

A. It was typically done in a -- the hard cell, the high-stress interrogation setting where they could be manhandled. There may be dozens of occurrences, but in short bursts. So a student might be walled against the wall three to five times, and then the interrogator would keep yelling at them, hoping for an answer that might be acceptable related to what they had been trained to do.

But over the course of the 25- to 30-minute time period for the hard cell, that might occur, you know, more than a dozen times for that.

And I -- I've gone back and looked at the artifacts in our heart rate data from survival school. So when we analyzed it, students would have a Polar heart rate monitor on so we could measure the -- the intensity of the experience for them from before they went in, throughout the experience, and afterwards.

So their heart rate would typically go from maybe 58 beats a

minute to getting into the -- the -- the interrogation and it would run at about 175 to 180 beats a minute until the experience was done. And throughout, you can see the times they'd been walled because it would jar the instrument and we could see the spiking.

So -- and I know we had to account for that in our data at least a dozen times in a person's data file. So that's why I say it was probably about a dozen times. It may have been more, may have been less for some people, but it was all over in -- in the 25-minute session.

And I didn't observe walling at -- in any other of the dilemmas at survival school. That was traditionally something that would occur in the interrogation setting.

Q. You said a session would be about 25 minutes; is that right?

A. Yes, for the high-stress interrogation form. At some schools -- down at Camp Mackall, it was traditionally 25 to 30 minutes in length. Up at the Brunswick site, it was a little shorter. It was about a 20-minute time frame when they would have the high-stress experience.

And Warner Springs was -- which is also a Navy SERE school, it was very similar. With the Marines' program, it was closer to the one half hour segment when -- when I was evaluating the Marines' site.

I don't recall for the Fairchild site. Theirs was -- their -- I don't know if -- I don't think I observed walling up at the Air Force site. I don't recall if I did, but I know for certain I've seen it at the other sites.

Q. Did you ever observe a walling session that was more than one hour?

A. No.

Q. Okay. How many -- how many interrogators would be in a room when a walling session was occurring in SERE?

A. Either just one or an additional person. If the interrogator was particularly maybe smaller than the student that they had to interact with, they may have had a colleague come in who could actually have the strength to move them up against the wall.

So most of the time it was -- it was a one-on-one sort of experience, but it could be up to two. But it was -- I never observed it, like, with three or four or five people ever.

Q. Did you -- were subjects in SERE school nude during walling?

A. I've never observed that. They -- the times that they were nude would be out in the prison yard during a time frame either when it was very cold outside or very, very hot. And they were expected to begin negotiations with the camp commandant to leverage something to ameliorate their condition and get clothing for their

fellow mock POW members. But I've never observed interrogations where people were stripped and without clothing.

Q. You mentioned a moment ago that if an interrogator was smaller, they might bring in someone larger who could do the walling.

A. Yeah.

Q. Did you ever observe interrogators switching because they were tired of doing the walling?

A. No.

Q. Okay. In your observations at SERE, was walling -- was walling always done with a special wall? I think you testified earlier that there was one.

A. Yes. It is a -- walling was done against a wall that had layers of plywood or something with gaps between them. So there could be kind of a cushioned effect or a bounce effect. I don't remember the exact construction at each site.

Up at Brunswick, the walls were plywood in the -- in the interrogation booth, painted black. And it -- there might be a gap between it and the other one so there was give. There was a give to the wall. So that was to help the bounce.

And there was a board on the floor that they would put their heels against so that they could make sure the students' feet were at the required length away from the wall. There were requirements about from what distance you could do walling, and that helped make

it uniform for the students.

But at times, yes, there was a female interrogator who simply could not manhandle a six-foot-four Ranger or Special Operations guy, so someone else would step in the room to do the walling. So it was a function of size and strength.

Q. Would you ever see interrogators brought in on a smaller-size subject specifically because they were larger interrogators for the purpose of intimidation?

A. I don't recall that -- that being the thinking on the part of the cadre. Remember, it's a school, so it's for training.

The main focus is whether or not the student would experience the aversive -- the aversive experience of being walled. It's really not pleasant and they wanted to make sure they've had that experience.

But I never -- I've never seen the cadre say we should just get somebody bigger because this person is tiny. It may have occurred, but I wouldn't know if it had, you know.

Q. And one question -- one more question about the walling wall. Do you know if those were always available at every site? Were they -- or were there ever situations where there just was not a specific walling wall available but the technique was used?

A. At each of the SERE sites, there -- there was an attempt to have some degree of uniformity in what people would experience.

So in the -- in the Navy and Army and Marine sites, I recall it was a high degree of similarity. The -- the material might be different, but the walling wall might have been painted a different color, but the idea there was a wall that had several layers so there was a flexible nature to the wall.

And I think that was part of what JPRA, or the Joint Personnel Recovery Association, who oversees the training across SERE sites, I think it was an effort to try and have a degree of uniformity in the training, in what students were learning and what they were experiencing.

Q. Did you ever see walling conducted on a non-purpose-built wall, on a regular wall?

A. Not -- no, not at survival school, no.

Q. Okay. Did you observe any other stressors being applied during walling including the use of noise?

A. Including?

Q. The use of noise.

A. Yes.

Q. Okay. And what other stressors would be present during walling, in your experience?

A. There could be noise, facial slaps, belly slaps, stress positions. Those were the most common in the interrogation setting.

Although I read in the OIG report somebody thought the stick

behind the knees was a SERE technique. In all my years at survival school, and I was on the DoD panel for SERE education, that had never been a technique. I don't know if it was in the early '80s, you know, before my time at SERE, but I've never observed that at SERE and I haven't seen it in the curriculum.

But the belly-slapping, the facial grip, facial slaps were all part of the interrogation process.

Q. Well, and let me actually ask you as well about the stress positions of, like, the forehead against the wall. Is that something you observed at SERE?

A. Yes.

Q. And how would that be applied at SERE?

A. It would be applied during the interrogation. If the interrogator felt that the person was not performing in the way they wanted and they would turn them and make them put their head -- and while they continued to interrogate them, the person would be in the stress position.

If it wasn't the head against the wall, it was then the back against the wall with the knees out like in the seated chair position with their arms extended out laterally to each side, and they would have to hold that position while being interrogated.

The instructor at times would put their foot against the student's toes so their feet wouldn't slide out so they could

maintain that invisible chair position. But those were the main stress positions that were used in the years that I was there and what I've seen.

Q. And for how long would they have to use -- hold that stress position, the one that you just described with ----

ADC [MS. PRADHAN]: And for the record, Dr. Morgan put his arms straight out to either side horizontally.

A. In an interrogation cycle, I had never seen someone sit in a stress position more than five or six minutes because most people couldn't hold the position. And they were trying to give the student an experience of many different kinds of things, so it wouldn't be during -- it wouldn't be for the entire 20 -- 20- to 30-minute experience in the interrogation. They would be in that position for maybe three or four minutes, five minutes.

The main thing the interrogator was looking for was when they looked fatigued, right? They wanted -- they would have them in the position until the student really appeared to be visibly uncomfortable with it. And then the teaching point is done, and then they'd move on to some other position or some other technique.

Because that's the point at SERE school for the interrogation is to give the student a mini experience of something that might -- might be done to them in order to force them to go along with something.

So the minute the teaching point was done, they usually shifted a technique to try and get the student's exposure to be as broad as possible to the various unpleasant things that could be done.

ADC [MS. PRADHAN]: I know we're coming up on 1030, sir. I have one more -- well, I probably shouldn't represent that I have only one more question, so I'm happy to break now or keep going, whatever you like.

MJ [Col McCALL]: That's fine. We can go ahead and take a recess now. So let's take a 15-minute recess.

Commission's in recess ----

TC [MR. GROHARING]: Excuse me, your Honor. Is that -- Your Honor?

MJ [Col McCALL]: Yes, Mr. Groharing?

Have a seat, please.

Go ahead, Mr. Groharing.

TC [MR. GROHARING]: If I could just clarify. Is that one more question and the exam will be complete, so we would move on to the next counsel? Or just one more before the break?

ADC [MS. PRADHAN]: No, I'm sorry. I'm emphatically shaking my head, Mr. Groharing.

TC [MR. GROHARING]: Up or down or right or left?

ADC [MS. PRADHAN]: Right or left -- right and left. I have a

little bit beyond that.

TC [MR. GROHARING]: Roger.

MJ [Col McCALL]: All right.

[The witness withdrew from the courtroom.]

MJ [Col McCALL]: The commission is in recess.

[The R.M.C. 803 session recessed at 1027, 07 May 2024.]

[The R.M.C. 803 session was called to order at 1042, 07 May 2024.]

MJ [Col McCALL]: The commission is called to order.

The parties are present. The accused are absent. Dr. Moran is on the witness stand.

[The witness, Dr. Charles Alexander Morgan III, resumed the witness stand.]

MJ [Col McCALL]: Go ahead, Ms. Pradhan.

TC [MR. GROHARING]: Your Honor, could I just have one moment?

MJ [Col McCALL]: Sure. What do you have, Mr. Groharing?

TC [MR. GROHARING]: I just -- I note that the doctor has referred to a number of studies just generally during his testimony, particularly this morning, and I don't believe we've been provided with those studies or data that he referenced this morning. My concern is that we're going to have a delay if I suss this out during cross at some point.

MJ [Col McCALL]: Sure.

TC [MR. GROHARING]: And so -- and examples are, you know, I

think he indicated that extension -- extinction of conditioned fear from -- I'm sorry, extinction of PTSD would never happen and that was based on some kind of study that I don't believe we have that study. He didn't reference what study it was, so we're not able to check.

The -- he referenced the fact that with conditioned fear, he was referring to the diagram drawn by Dr. Mitchell, that the line would never go down. And that was based on some study that he referenced.

There was a reference to fear reduction in PTSD being delayed, and that was based on a study, an unmentioned study. And then he referenced a data from survival school to include use of heart rate monitors and such, that we've never been provided with any data in that regard.

And so I -- to the extent we could address those things now -- and maybe we have that and we -- it's just not clear to us that we do. But I -- but I don't want a lengthy delay for the cross to try to track that material down.

MJ [Col McCALL]: No, I can appreciate that.

Ms. Pradhan?

ADC [MS. PRADHAN]: Certainly. Well, I can provide Mr. Groharing with at least one of the citations immediately. And that's the study that we went through in some detail with Dr. Morgan. It's entitled "Fear-Potentiated Startle Conditioning to Explicit and

Contextual Cues in Gulf War Veterans with PTSD." It's from 1999.

And that was provided to, both provided to the prosecution and is in the record at AE 628ZZZZZ (corrected copy) Attachment B, beginning at AAA-EXP-001118.

Now, Dr. Morgan did refer to a number of replications of that study, but that was the one that we went through in some detail regarding fear reduction in -- in PTSD.

And certainly we can get the additional documents, but we would represent that all of the papers that Dr. Morgan relies on have been produced to the prosecution in advance pursuant to 914.

MJ [Col McCALL]: All right. Understood.

And again, Mr. Groharing, if there is one that you're looking through your records and you can't find it, please confer with Ms. Pradhan, and hopefully she can point you in the record where it's been provided. And if not, obviously I'll give the government time to review that.

TC [MR. GROHARING]: Okay. Your Honor, just for everyone's benefit, I will be asking -- you know, the witness has made several references to studies being replicated but then not explain where or how.

To the extent the court is going to rely on that at all and that forms the basis of his opinion, that's information to which we're entitled. We don't have that, and so I do expect a delay

unless the defense can point us to where they've provided that.

MJ [Col McCALL]: Understood. All right.

Go ahead, Ms. Pradhan.

ADC [MS. PRADHAN]: It occurs to me that this might be something we can hash out over the lunch hour with regards to Dr. Morgan's CV and also the documents that have been previously provided.

MJ [Col McCALL]: Seems reasonable.

Go ahead. You can start questioning Dr. Morgan.

ADC [MS. PRADHAN]: All right. Thank you.

DIRECT EXAMINATION CONTINUED

Questions by the Assistant Defense Counsel [MS. PRADHAN]:

Q. Dr. Morgan, I wanted to ask you now -- we've just been talking about walling. I wanted to ask you about your observation of the use of -- first of all, have you observed standing sleep deprivation in SERE?

A. I have observed standing -- well, I have observed students who are sleep deprived put in standing -- sort of in standing boxes, the cramped confinement. But for the sleep -- sleep deprivation was usually done at SERE by either generation of noise or making them engage in activities.

So I've never seen it as described here where -- they were never chained to anything, forced to be standing, and remain awake in

that passive way. The sleep deprivation was a function of there's always something going on to have their attention, have their engagement, or have them experiencing something.

In isolation stress, students would often try and sleep, but the observer cadre would then bang on the cell and make them wake up. So the students, if they were smart, tried to get as much sleep anywhere they could.

But that -- but that's how the sleep deprivation is done at survival school. The -- there's just a continuous flow of activity and dilemmas that they're being exposed to. And then there is finally a designated period of time where the cadre are told we're not really going to disturb them so they can actually get some sleep.

Q. Okay. And you referred very recently to a stress position that involved extending your arms horizontally outwards; is that correct?

A. Yes.

Q. Did you ever see a stress position that involved the extension of your arms -- of the subject's arms above their heads?

A. Not that I recall. The -- the traditional -- one, the interrogation booth in one site was not that tall, so maybe that was a reason why. But the most traditional stress positions I saw were the chair, forehead against the wall with the -- would be the stress positions that were the most commonly used.

Q. Okay. I'd like to call your attention to -- this is the same document, same record citation, a paragraph in the OIG report at MEA-2C-00000484. I'll put that down for you just one second.

ADC [MS. PRADHAN]: This is for display to the gallery as well, sir.

MJ [Col McCALL]: All right. It can be displayed to the public.

ADC [MS. PRADHAN]: Thank you.

Q. Now, you see reference there in the third line -- fourth line -- excuse me, Dr. Morgan -- to an Interrogator NX2. Do you see that?

A. I do.

Q. All right. Now -- and you may recall from the description of Mr. al Baluchi's EITs that Drs. Mitchell and Jessen did not appear in that description. Do you recall that?

A. I do.

Q. Okay. So the person who does appear is Interrogator NX2. And we've had testimony from Dr. Mitchell that NX2's approach to EITs was, quote: Hurt them 'til they talk, then hurt them some more.

And I wanted to ask you about your interpretation of that phrase in an interrogation setting.

A. My interpretation of the phrase -- because an interrogation is an interaction between two people, is that some

measure of action or force is being applied by the interrogator. It could be physical. It could be verbal.

And then when the person they're interrogating gives them something they like, they change tack. They stop applying the force. It's sort of like your alarm clock, right? It's buzzing and buzzing and buzzing, and you finally hit the buzzer and you get relief from the pressure.

So most interrogations are designed around that principle of applying something when the -- when the person does something you want, gives you information you want, then you -- you stop applying that pressure.

This would imply that no matter what the person was providing, they were then -- pressure was then applied again. So you might say they're being punished, they say something and they get punished some more. That would be the implication from -- in this context of -- of what's being said.

Q. All right. And you see in this particular paragraph Mr. al Baluchi's assertion that this one particular person gave him, quote, psychosomatic attacks. And the conclusion of the IG is that the probably relates to NX2's conduct towards him and may, in fact, have some justification.

So I wanted to ask you: In the context of cue conditioning, is it possible for people to be cues?

A. Absolutely.

Q. Okay. And how would that work?

A. In the same way as an electric shock and bell or light in the laboratory. It means that the person has to be, in the recipient's mind, paired with unpleasant actions and activities.

So if a particular interrogator is associated with a more aversive experience, a more unpleasant or painful or terrifying experience, they become a cue. And that -- the person who's encountering that interrogator would realize that the appearance of the interrogator, whether it's their voice, the way they move, I don't know if they're speaking or not, but the person becomes a -- what we call a conditioned stimulus that's now paired with the unconditioned response. And so the appearance of that person triggers fear, anxiety, and alarm.

The term "psychosomatic attacks" is actually quite descriptive. In PTSD, we refer to that as psychological and emotional reactivity on exposure to a reminder or cue of the event.

But most definitely, it can be a person, it could be the sound of their voice, can be their physical shape. And that may generalize, then, to anyone who kind of looks similar in some way to that person.

But most definitely, people can make -- people can be a cue for the reactivity.

Q. I wanted to ask you if -- if people can be a cue for the reactivity, what would be the impact later in time if those cues reappeared?

A. If the cues -- later in time if -- oh, if -- oh, I think I understand.

Q. I'm happy to ----

A. Say it one more time because I'm not sure. I want to make sure.

Q. My question is -- let me ask you a better question, which is: Does the -- does the phenomenon of a person as a cue diminish over time? Let me ask you that first.

A. If it's the same person, it usually does not.

In PTSD, if someone has been raped or assaulted by a person, in my experience, they -- they have -- they continue to have that reactivity to the person even later in time, such as when they may go to court, and then the accused person has to appear in court. The victim is really -- they describe emotional reactivity. They don't want to be in the room with the person. It's -- they remain a fear-conditioned cue for that individual.

Even for women who are battered and stay married to the person who is beating them, that person is still a conditioned cue. And it's almost as if they've conditioned defeat. They still stay with them, they're attached to them, but that person still triggers

fear, anxiety, and alarm.

It does generalize over time in that the person may become fearful of people they think are kind of like the person who is the source of their trauma as well. And that's what we see in laboratory experience, fear generalizes.

We see that in the clinical world where patients become unnecessarily more anxious and alarmed by things that weren't directly related to their traumatic event. They'll say that wasn't the person, but that's how I react when I'm around them because it's a reminder. It's a cue in their mind.

Q. Well, when you say generalization can occur with people to someone like that, how does that manifest? How has that -- how have you observed that in your studies?

A. It varies. Some of my patients will say that person just looks like them visually, and that is a cued reminder. Others may say it's the cologne they wear, it smells like them. Or the sound of their voice reminds them of someone who had perpetrated an assault.

In -- with -- with -- and when we're not dealing with sexual assault and talking to men who've had combat-related experiences, it may be just the sound of the voice and visual appearance as well.

Q. So in the excerpt that I showed you previously regarding walling, there were a number of what we call unique functional identifiers in that, which refer to specific CIA personnel

who were in the room with Mr. al Baluchi during, for example, his walling.

In your professional opinion, would there be the potential for those people to later -- to become cues?

A. Yes. That's what we observed both in the laboratory and in the real world. It -- it's part of the context that -- that the person's in. And it's very possible for -- as they're trying to figure out who's the most dangerous, who's the most threatening, and who's not, our brains function under the rule of fear first, safety second.

So we initially do fear conditioning to everything in the room if it's an aversive situation. We've seen that in the laboratory where by just showing people neutral lights, as the shocks begin to get introduced, even the healthy subjects consider both lights dangerous, even though one light is not.

They learn how to discriminate, and that was what I was describing. The deficit in people with PTSD, they don't. They have a much more difficult time discriminating between the genuine source of the threat and something that's not threatening. It just has to be a light. So it's -- it's enough like something else. Even though it's a different color, it is a light.

When we translate that into sort of the clinical world, we can see that people who are associated with the event can trigger the

unwanted memories, thoughts, emotional reactions, and attitudes even if that person is benign.

For example, you have combat veterans in a combat trauma group and one might say that they recognize the other veteran and they both went through the same experience, they begin to avoid other veterans because just the sight of the other veteran who was in the same unit and who knows about the trauma was enough to trigger the re-experiencing because they are a cued reminder of the trauma even though that other veteran was in no way involved in doing anything harmful to them. But it is a -- it's a -- it's part of the original traumatic experience. And to their -- to our brains, that triggers a fear-conditioned response.

It's part of memory. It's part of how that memory works. Our brain is saying this is kind of like what happened before, or these people are linked in some way to what happened before. And they're all -- they're all wrapped up in it.

And so in the lab we might separate it out and say one is a cue-specific element and one is a contextual element. But it's very possible for other people standing in the room to be paired with the experience in the mind of the person who's being traumatized.

Q. I'm going to turn you to a paragraph in the report. And this is 2C-00000482, the same document.

ADC [MS. PRADHAN]: This continues to be for display to the

gallery, sir.

MJ [Col McCALL]: All right. It can be displayed to the gallery.

Q. At paragraph 134, where the IG states: The EITs Ammar experienced at Location Number 2 were sufficient to cause him to become, quote, compliant and provide information to his interrogators to try to end the techniques.

His comments in late 2006 to another detainee suggest he feared he would be killed if he did not.

And then later: Ammar fabricated the information he provided while undergoing EITs. And he later admitted to his interrogators and debriefers that he was terrified and lied to get Agency officers to stop the measures.

Now, my first question is: What -- in your opinion, what constitutes -- what is the meaning of the word "compliance" here?

A. Compliance, we typically use the term and say that people are going along with what we're asking them to do.

In our -- in the Gudjonsson compliance scale, it's a little more specifically defined, and says it's going along with what you're being asked to do by someone in authority or who has control over you in some way, but that you may secretly not -- you don't agree with them.

So compliance doesn't mean we agree with someone or that

it's in our interest. It means that we're going along and -- and doing what's requested of us in some way.

So in this -- in this first part of the sentence, I see that was one of the goals of the EIT program, as described by Drs. Mitchell and Jessen, to do fear conditioning so as to get people into a state of mind and action that might not even be in their interest.

And so when I see that the EITs were sufficient to cause him to be compliant and give information, that would be -- that wasn't the goal of the program, to get people to behave in a way that the interrogation team wanted them to behave in. It didn't mean what they were getting was true. It just means the person is now complying with trying to speak.

The -- the second part provides an explanation for why that speaking behavior may occur, which is if it's the belief, the alternative if you're not giving information is, you know, that you might die, then the rule is I guess I'll talk and say anything. It could be true, might not be true. But the rule would be keep giving them -- as long as they believe I'm giving them something, I'm avoiding being killed.

That perception is important to know because it's in the mind of the recipient of the traumatic experience that matters. It's how they perceive the world, and it drives all their chemistry and decision-making and reasoning ability.

Q. You referred in your answer just now to the Gudjonsson compliance chart.

A. Yeah.

Q. Is that the same Gudjonsson who we talked about yesterday?

A. It is.

Q. All right. And the spelling for that is G-U-D-J-O-N-S-S-O-N?

A. That's right.

Q. All right. And can you just briefly explain what that compliance chart is?

A. That compliance chart or scale, it's a measure of degrees of which -- to which a person is compliant. So the scale consists of different attitudes and opinions like it's better to go along to get along. I'm easily swayed by other people. I don't like to disagree with them. I will go ahead and agree even if I secretly don't believe what they're saying to avoid conflict.

It has a number of questions like that, and the person can rate how much or little they have that -- that personality feature.

In the study I talked about yesterday, our main purpose in using that scale in our Special Operations forces is we specifically wanted to find out, does stress exposure to an interrogation stress alter that degree of compliance? And we found that it did in a significant proportion of our Special Operations soldiers when they

were exposed to a mock interrogation. It changed the degree to which they'd be willing to go along with some -- with someone's opinion and do what they asked.

The second part of that study got more specific when we looked at the shift in memory score in the suggestibility scale because they changed what they said they remembered in response to someone in authority saying: You are wrong. Try again. We know better. You're wrong.

Which is sort of a -- sort of a classic approach that police and interrogators use. They're the arbiters of what -- whether what we say is true or not. Until they believe what you have to say, it's either a lie or it's stonewalling or its dissimulation.

So that scale was designed to look at the impact of when you're stressed, do you become more compliant and some -- many people do. In our study, not everyone did.

And with suggestibility and the willingness to change what you remember, we wanted to know how vulnerable that was to stress, and so in that study, that was the first time we were able to see that directly in our Special Operations soldiers.

And that's what we believe is going on here. And I think in sort of -- in the real world when we treat trauma victims, there -- there's just numerous studies on the increased suggestibility in people with PTSD and compliance.

And so there's no one study that is -- that would demonstrate that. It's like the other studies I've referenced. There's really 30 years of data on these things. But the general finding in PTSD is that they -- people who have been traumatized are much more vulnerable to be suggestible and be compliant and go along with what's being said.

Q. Let me show you a statement that's contained at 2C-00000437 of the same document. And this is -- I'm afraid I can't read the footnote number, but it is the footnote on this page. I'll zoom in for you there.

And there are a lot of redactions again. But it states there: During a meeting with an OIG office -- redacted -- in 2003, the chief -- redacted -- Alec Station -- redacted -- gave her view that people associated with the interrogations believed that detainees are compliant when their behaviors change rather than when the intelligence is good.

She stated that compliance to interrogators means the detainee is answering their questions, not how well. The detainees have simply moved from active to passive resistance.

And then asked to comment on the criticism that decisions on whether a detainee is compliant was based more on an analyst's idea of what the detainee should know than actual fact -- redacted -- maybe said or opined, I don't know -- that this

is a problem with the process. They do not have proof of what the detainee knows or the intelligence to say definitely what the truth is.

Is this consistent with what you just described in terms of compliance during interrogations?

A. Yes, it is. It's one of the things that we had discussed -- when I say "we," with the Intelligence Science Board -- in producing the report for Congress called the *Adducing Information Report*.

The risk of doing things like torture is that people will say anything at some point to stay alive. A person is being coerced. There's fear in the back of their mind saying I might die and they know that that is possible to have happen.

So I would -- I would agree with whoever said this in the OIG report. I think it's very accurate to how human beings think. For people who like popular literature, this is -- this is the scene from the -- the *Marathon Man* with Dustin Hoffmann and Sir Lawrence Olivier when he is being tortured by the men putting dental instruments into his mouth and he keeps asking him, you know, "Are the diamonds safe?" And the character is going "Yes." And he's going, "No, they're not safe." "Yes, they are safe." "No, they're not safe." He's oscillating to try out any answer that will please the interrogator.

And I think that -- that -- that film scene captures this, because it doesn't matter what's true. The person being interrogated and tortured is trying any opportunity to have the best resolution to the situation they're in because the other person is really in total control.

Q. So let me show you one more pullout. This is at 2C-00000459. This is a description by Interrogator NZ7, who featured prominently in Dr. Mitchell's testimony, which I know you reviewed, from early 2005. Do you see that?

A. I do.

Q. All right. And NZ7 reports Mr. al Baluchi telling him: When he was captured, he had an initial period when he was afraid to say anything, for he was concerned any answer would be the wrong answer. Quickly, Mr. al Baluchi realized his situation had changed. He would be with Agency officers for a very long time and he could survive only by telling the truth.

What is your interpretation here of Interrogator NZ7's statement that he could survive only by telling the truth after he realized his situation had changed?

A. Well, I think it's the interrogator's opinion and decision as to what's truth. I mean, that was the point of interrogating people. We didn't have ground truth on most things. So that would reflect more of the idea inside the interrogator's head.

The -- the person being interrogated, Ammar, would just realize two things: I may never be leaving and they're going to decide how this will go, is what I would read into -- into that sentence.

Q. The last sentence there: Whether he is actively resisting or not, focused and persistent questioning will yield results.

Is that a sort of demonstration of what you were just describing with the anecdote from *Marathon Man*?

A. It is. And more specifically in -- in the research lane about looking at the generation of false confessions and change. Persistent questioning does yield results. We just don't know if they're true when people are giving us answers.

And there's -- there's a long literature on false confessions that deals with this.

Once again, Gisli Gudjonsson's book, it's about 500 pages long with all of his studies. This has been his life's work, is that one of the risks of grilling people in situations where they do not have power is people will generate answers, but it doesn't necessarily get the truth. We often get very erroneous information, and that's why he became interested in studying false confessions.

Q. I'd like to turn to discuss the period after Mr. al Baluchi's -- after the imposition of enhanced interrogation techniques on Mr. al Baluchi.

Do you recall, Dr. Morgan, reviewing -- and we can discuss this a little bit more in closed session, but do you recall reviewing photos from the five sites in which Mr. al Baluchi was held in CIA custody?

A. I do.

Q. All right. And those sites were COBALT, Location Number 2; Location Number 7, BLACK; Location Number 5, which has no color; Location Number 8, VIOLET; Location Number 9, BROWN. Is that your understanding?

A. That is.

Q. After which he was moved to Camp VII and Camp Echo?

A. That's my recollection, yes.

Q. And I want to show you a document that's in the record at 628FFFFFFF Attachment E. This is government Stipulation of Fact at page 81 and 82.

ADC [MS. PRADHAN]: And this is not appropriate for display to the gallery, sir.

MJ [Col McCALL]: All right.

Q. And I'll flip it over when -- once you're done.

[The witness reviewed the evidence.]

A. I've completed that.

[The witness reviewed the evidence.]

A. All right.

Q. All right. So you see here a description of ----

ADC [MS. PRADHAN]: I'm done with the document camera. Thank you, sir.

MJ [Col McCALL]: All right.

Q. You see a description here of Location Number 7, correct?

A. Yes.

Q. This is the second site in which Mr. al Baluchi was held. My question is: There are descriptions here of certain physical aspects of Location Number 7. Do you recall observing in the photographs that you saw the lack of natural light?

A. Yes.

Q. All right.

A. In part of the cell.

Q. Do you recall observing fluorescent lights?

A. Yes.

Q. Do you recall observing the cell configuration, including a visitor area and a cell -- a sleeping cell?

A. Yes.

Q. All right. Do you recall observing that the air and light controls were outside of the cell -- of the ----

A. I do.

Q. -- cell?

Do you recall this description of a steel mesh sliding door

separates the cell from the visitor area? Yeah, sorry. Do you recall observing the steel mesh sliding door?

A. I do.

Q. All right. It states: The visitor area contains microphones, speakers, lighting, and split pack for heating and cooling, along with two mounted cameras to provide surveillance of the cell.

Do you recall seeing that in the photographs?

A. I do.

Q. All right. There is -- it states here that: Interior cell walls are painted white and covered with impact-resistant glass tiles.

Do you recall the color of the cell that you observed?

A. I do.

Q. Okay. There is a stainless steel anti-suicidal toilet and sink with running water. Do you recall observing that in the photographs?

A. I do.

Q. All right. And there's reference to digital white-noise generators installed above each cell. Do you recall -- do you recall observing those?

A. I don't specifically -- I don't remember if I could see white-noise generators. I -- yeah.

Q. Sure. Do you recall seeing plastic furniture ----

A. I do.

Q. ---- in -- in the photographs of the sites that you saw?

A. Yes.

Q. Okay. So earlier we talked about the -- in the context of fear reduction, we talked about the possibility of exposure therapy. If these conditions that you observed in the photographs -- that are described at Location Number 7 were similar at sites after that that Mr. al Baluchi was held in, would those possibly function as a form of exposure therapy for Mr. al Baluchi?

A. It would depend how he perceived them.

As I said, exposure -- exposure therapy means the deliberate and willing exposure to something that is experienced as unpleasant in a therapeutic setting, learning how to overcome it. Without that, the -- the space is simply part of the contextual conditioning of someone's original experience.

Q. You reviewed the conditions under which renditions took place, correct?

A. I did.

Q. We talked about that earlier.

After each rendition, if Mr. al Baluchi was in a site that had these qualities each time, would that have reduced -- let me ask you a threshold question first. Strike that.

Do you understand the concept, Dr. Morgan, of transfer shock?

A. Yes.

Q. Okay. And what do you understand that concept to be?

A. I understand that to be related to the aversive psychological experience when people are moved against their will from one place to another. Because it's full of anticipatory anxiety, you know, what's going to happen where they're actually going, and whether something will be better or worse or the same as to their present condition.

So it's sort of like the shock of captivity. When people are suddenly apprehended, it is a well-known phenomenon people are dazed, confused. They're trying to orient as to what exactly is going on and what the boundaries of control will be.

And so for transfer shock, it's a similar phenomenon, except it usually refers to when people have already been detained and then moving to another site.

Q. And you understand that Mr. al Baluchi was moved among five different sites?

A. I do.

Q. All right. In your declaration -- excuse me -- your supplemental declaration that's in the record at 628TTTTTTT, at paragraph 11 you stated that: Context conditioning, quote, can

generalize more easily than cue-specific fear conditioning to a room that is, quote, more or less like the room where cue-specific fear conditioning occurred.

In the -- your review of the photographs of the different sites in which Mr. al Baluchi was held and your review of the items that we just talked about, what is the relationship between those descriptors and your statement here that context conditioning can generalize more easily than cue-specific conditioning?

A. Part of what we do as -- as human beings when we orient to our surroundings and to figure out where we are is we look at the space, we look at configuration, and we try and remember something.

When I looked at -- from each of the different locations in the room, I was paying attention to how -- the relative configuration, the use of lights, the use of kind of a sterile environment, the placement of things.

And for conditioning, if I was going to do an experiment and wanted to do contextual conditioning, I would try and make sure that the relative configuration of the room was somewhat the same, whether the type of chairs or where the lights were, the placement.

And in my opinion, looking across the different rooms, they're similar enough in the way they're configured and designed that a reasonable -- a reasonable human would go, this is a lot like a room I've been in before.

If that space has been paired with something traumatic, something aversive, we know full well that not only do people condition to the very spot in which they've been traumatized, they respond with fear, anxiety, alarm and with some of the thinking that goes along with that when they are once again in a location or a spot that reminds them of the place where it happened.

So for -- just as though, those different rooms look similar, I work with victims of trauma, whether it's a woman who's been sexually assaulted in an elevator, it doesn't matter if the elevator looks identical to the elevator in which she was raped. It's still a small space, the doors close, and you're confined.

So it's -- it's in the eye of the beholder. Are there enough similarities that can cue my brain to say I'm -- I'm once again in a similar condition where something terrible happened?

And that is sufficient because our -- like I say, our -- our -- the way our brain is wired, it's as if to say it doesn't have to be the same person who mugged me before, so I'm not -- I don't have to wait until they get as close to me so I can see their eyes are blue rather than green and it was a green-eyed person who mugged me before, but this one is blue, it's a different person -- we don't work that way.

Q. If you could slow down a little bit, Dr. Morgan. Sorry.

A. Got it.

Our brain really functions as I -- is it good enough to remind me of something bad that happened? And so when I looked at the different sites, looking at the photographs and then looking at the sites, in my view, it's a good enough -- can fit with the configuration. Objects are spaced in a very similar configuration in the way the lighting is placed vis-à-vis where a person would be shackled.

So the -- the elements of light, sterility, furniture, physical ability to move in a space were very similar. The color would change. But, in my opinion, that doesn't matter. It's -- it's the -- it's the stark nature that's similar across the spaces.

There's nothing personal, warm and fuzzy to make you feel good, right? The rooms are -- have been deliberately stripped of anything that's sort of personal or warm or endearing, something that might make you feel comfortable. It's meant to be a sterile environment. So there's nothing else the person can really focus on except perhaps what the interrogator wants, where they want their attention. So there's -- there are little distractors. There are no little distracters in the room, so to speak.

So in my opinion, they are similar enough to fit well within the model of context conditioning.

Q. And you conducted a forensic inspection of Camp VII and Camp Echo II. When you entered Echo II, what were your thoughts and

what were your conclusions?

A. Well, my thought was that it was very similar to the previous space that I had seen at VII. In the -- in the configuration, many of the elements were very, very similar. I think I even asked: Did the same person construct both spaces? Was it the same construction company or something.

But they were similar enough where I could see that the -- it would be very reasonable for a person to assume this is just like the last space I was in.

Q. Okay. I want to ask you about -- I can put this back up for you; you can let me know. But the part of Dr. Mitchell's chart that we referred to at the very beginning of the day -- I'll put it -- I'll put it down for you. This is 628MMMMMMMM.

MJ [Col McCALL]: Go ahead.

ADC [MS. PRADHAN]: And this is for publication to the gallery as well, sir.

MJ [Col McCALL]: All right. It can be published to the gallery.

ADC [MS. PRADHAN]: Thank you.

Q. I'll move out. All right. I want to ask you about, again, that part of the chart that -- that has operant conditioning where he says, quote, switch to operant conditioning and start extinction of fear response.

Now, in -- Dr. Mitchell testified that there was a line, and that's what that straight line represents, between interrogation and debriefing.

Do you recall seeing that in his testimony?

A. I do.

Q. Okay. So my first question is: If the -- first of all, if the sites were not intended to cause anxiety or to -- or to trigger fear-conditioned responses, would that intention matter?

A. No.

Q. And why not?

A. I can say why. Because it's in the mind of the beholder. It doesn't depend on what the interrogator thinks or the person who creates a room thinks. It's how it is perceived by the person who was traumatized.

When veterans in our clinic used to go down to the GI clinic to be treated, Dr. Ng, a Vietnamese man, was our physician running the GI clinic. They were veterans from combat in Vietnam.

Dr. Ng is a very nice man, but when he would turn down the lights and start an exam, most would reexperience things. So there was no deliberate attempt to remind them of their experiences from Vietnam, encountering a Vietnamese person, but that would trigger the reactions.

In the same way, in an interrogation, in the mind of the

person running it, you'd say, well, we've gone from interrogation to debriefing. That's all in their mind. That has nothing to do with what's in the mind of the person who is being detained.

So I really view part of this as an -- this is a theoretical drawing from the mind of Dr. Mitchell about what he believes perhaps that he was doing or did, but it -- it does not make any clinical sense at all.

It -- yeah. That's why it's a little hard to make scientific sense of it. This seems to be something that he believes he was doing.

Q. So we've just reviewed a description of Location Number 7. If a walling wall had been present at Location Number 7, do you know what impact that might have had on a detainee who had previously been walled?

A. It's very likely it would trigger. It would be a conditioned cue, and they would remember that it was a walling wall. At some level, they would know.

Q. So I'd like to return to the OIG report at 628RRRRR Attachment C, to page 2C-00000451.

ADC [MS. PRADHAN]: And this is appropriate for display to the gallery, sir.

MJ [Col McCALL]: All right. It can be displayed to the gallery.

Q. And it's beginning at paragraph -- excuse me -- beginning at paragraph 79. It says that: Interrogator -- blank -- we don't know who said this, despite the fact that he says he was present during some debriefings of Ammar -- stated that his role during the debriefings was to be silent and, quote, intimidate by his presence.

He stated that the interrogators wore black clothes to symbolize, quote -- excuse me -- quote, a menacing black presence. And if the detainees tried to give evasive answers, the interrogators would intervene to try to, quote, get them back on track and make -- later in the paragraph -- make veiled references to the previous bad times the detainees went through, meaning when they underwent EITs.

Now, Dr. Mitchell testified that, quote: Threats are good because they facilitate the extinction of fear when EITs are not being imposed.

And I wanted to ask about your opinion of that statement.

A. I think it's ridiculous. The threats are meaningful because the person remembers the horrible thing that happened to them. And if you really take him at his word, Dr. Mitchell is saying by repeatedly threatening someone, you're doing therapy. You're helping them heal. And that makes no clinical sense. It's -- it -- I think it's absurd.

The threats are being done according to their EIT theory and

plan so that they no longer have to do all the hard work of the EITs. You can simply threaten someone and let their brain do all the fear generation for them so that they become compliant.

That was the purpose of his program. And you'd say they did a great job. They were producing conditioned -- conditioned defeats in a person who would comply with what they wanted.

But to say that that was treating people is ridiculous. It's -- yeah, I don't -- I can't explain why he believes that, but it makes no sense.

Q. All right. Well, let me show you a specific incident. This is the previous page, 2C-00000450.

Are you able to see that, Dr. Morgan?

A. 2C-00000450.

Q. Sorry. Paragraph 78 is where I'm trying to ----

A. Oh, yes. I see that.

Q. I'll let you read that. It describes an incident where Interrogator SM1, along with NZ7, who we made previous reference to, confronted Mr. al Baluchi with what she said -- this is the IG stating this -- what she said was their discovery that he had not been truthful in providing them information.

When she presented Mr. al Baluchi with questions and gave him an opportunity to be truthful saying that the information he provided didn't add up, he became very, very nervous.

They then left the room to give him time to, quote, sit and stew. And he appeared, quote, clearly worried, fidgeting and rocking back and forth in his chair.

Later in the paragraph, it states: When she and NZ7 returned to the room, Ammar said he would tell them everything they wanted and gave them the whole story.

I guess my first question is -- well, let me -- let me ask you this. You see here the statement that Mr. al Baluchi looked clearly worried. And Dr. Mitchell testified that at this stage during debriefing, the interrogators or the debriefers, personnel at the sites, didn't need EITs because, quote, they looked nervous if they lied.

And that's in transcript from February 26th, 2024, page 42043.

I want to ask you about the accuracy of that statement, "they looked nervous if they lied."

A. I don't believe that's the case. I think they looked nervous because they realized the person they were speaking to wasn't accepting their response.

Whether it would be a lie or the truth wouldn't matter. The -- the -- the response of the debriefer or interrogator would be what -- what Ammar would be responding to.

And the perception that when he was told it doesn't add up,

that's the threat. And the nervousness and anxiety that are then described are because of the previous EITs. That's the manipulation of the program. They instilled fear and now are doing the operant conditioning of the manipulation of it.

Q. In your experience, given your studies, is it possible to tell when someone is being untruthful if they look or appear to be nervous?

A. No. We know that, both from my studies and from others, that just signs of anxiety are not indicative of deception. It is commonly believed that they are.

And in our studies we found that law enforcement and FBI, people who were involved in doing the study, in their -- in their judgments of whether or not people were lying, they were persuaded by sweating, nervousness, and the appearance of anxiety.

But they were no accurate -- they were not accurate any better than rates expected by chance. In fact, they were slightly less than accurate than one would predict by chance because they used cues that are not valid indicators of deception ----

TC [MR. GROHARING]: Judge ----

A. ---- and nervousness and anxiety is one of them.

MJ [Col McCALL]: Hold on, Dr. Morgan.

Yes, Mr. Groharing?

TC [MR. GROHARING]: This is another example of what I

referred to earlier, Your Honor, as far as the witness talking about studies without referencing the particular study and something that we wouldn't have that he's relying upon for his testimony.

ADC [MS. PRADHAN]: Let me ----

MJ [Col McCALL]: Well ----

ADC [MS. PRADHAN]: Sorry.

MJ [Col McCALL]: And I understand your concern, Mr. Groharing. And, again, before you do your cross-examination, I'll make sure that there's a chance for you to confer with Ms. Pradhan and make sure that you have the documents and you have adequate time to prepare for your cross-examination.

All right. We'll -- did you have more of your answer, Dr. Morgan?

WIT: No. I would say there's an entire volume by Dr. Aldert Vrij, a book called *Detecting Lies and Deceit*. It's one of the sort of largest volumes of research on detecting deception and summaries, and it's easily available, you know, where he has summaries of almost everything we know to date on the cues that are reliably associated with detecting deception. There's chapters on nonverbal behavior, verbal behavior, and he's welcome to read it.

I mean, I've been asked to provide a testimony based on my wealth of experience over 30 years. I'm not relying on any single study, and I -- I don't know how I'm going to give them a paper that

will ----

MJ [Col McCALL]: Well ----

WIT: ---- satisfy, you know ----

MJ [Col McCALL]: ---- and Dr. Morgan, I wasn't asking you to answer ----

WIT: Oh, okay.

MJ [Col McCALL]: ---- Mr. Groharing's ----

WIT: I apologize.

MJ [Col McCALL]: I was trying to have you answer Ms. Pradhan's question.

WIT: Oh, okay.

MJ [Col McCALL]: But, Ms. Pradhan, why don't you go ahead and ----

ADC [MS. PRADHAN]: Yeah.

MJ [Col McCALL]: ---- go to your next question.

ADC [MS. PRADHAN]: Sure, no problem.

Q. Thank you, Dr. Morgan. One more question on this ----

A. Uh-huh.

Q. ---- example. And then I actually do have a paper that I wanted to talk about related to this.

The -- Dr. Mitchell also testified -- and this is a different day, February 21st, 2024, at page 41906 -- that with regards to Mr. al Baluchi -- with regards to -- I believe this

example, but I can double-check -- his fear may have led him -- led to him volunteering the information.

I want to ask you about the use of the word "volunteering" in that line. And would you agree that he volunteered the information in this context?

A. I dis ----

TC [MR. GROHARING]: Judge?

MJ [Col McCALL]: Mr. Groharing.

TC [MR. GROHARING]: That's going to call for speculation, obviously. He's asking whether or not Mr. Ali volunteered information.

MJ [Col McCALL]: Ask your question again, Ms. Pradhan.

ADC [MS. PRADHAN]: I'm happy to actually ask a more general question.

MJ [Col McCALL]: All right. Rephrase.

Objection sustained.

ADC [MS. PRADHAN]: All right.

Q. Let me ask you this, Dr. Morgan: In your experience, does fear lead to voluntary information?

A. It may. I mean, we know that victims of trauma are more compliant, which means they go along with something they're asked to do. So it -- it may. It would depend on knowing more specifics of the situation.

But my understanding of the EIT program's intent was that people would based on fear.

Q. Okay.

A. At least as reflected in the writings of Drs. Jessen and Mitchell, that that was the purpose and intent. Which then begs the question, I don't know what they mean by volunteering, but yes, it may.

Q. And in your experience, when fear causes the -- the relaying of information, do you have any -- do you have any conclusions or do you have any -- in your professional opinion, what is the reliability of that information?

TC [MR. GROHARING]: Objection. Speculation.

MJ [Col McCALL]: Objection overruled.

A. It may depend on the type of information. So we've -- we've sampled many different types of information from -- if I look at the information we've acquired at survival school, lots of the information was of a nonthreatening nature. It's just do you remember a phone, a uniform, a face, and things like that.

And the -- the nature of memory was highly corruptible in nearly everyone. It depended on the type of information we were asking about.

So it's very possible that a person might provide genuine memory, genuine information when they're afraid. And it's very

possible that that information may not be genuine. It just might be false information, but they might believe that it's true. They might give information when they're afraid because they want to deliberately lie about something.

So all three are very, very possible.

Q. All right. I'd like to show you one of your papers, and I'll show you the front matter first. This is contained in the record at AE 628JJJJJJJJJ Attachment C. And the Bates is AAA-EXP-001851 to 001858.

Do you recall this paper, Dr. Morgan?

A. I do.

Q. All right. And I'm just going to -- I'm going to read you a passage from pages 55 to 56. And this is your statement that, quote: Individuals exposed to significant stress may doubt their ability to correctly recall information and when confronted with false data about their responses, may be more inclined to modify those answers. It is not uncommon for interrogators to repeatedly confront subjects with data that the interrogator believes to be true irrespective of its actual veracity as a means of compelling a confession.

ADC [MS. PRADHAN]: And for the record, that's at pages 001855 to 001856.

Q. I want to ask you if the -- when you say

confronted -- that individuals exposed to significant stress, do you mean individuals who are interrogated after exposure to significant stress?

A. In -- in that section I'm referring to, there's a large body of literature on the false confession concern. Saul Kassin is a prominent writer in this, as well as Dr. Gudjonsson.

The idea is that an interrogation ----

Q. Dr. Morgan ----

A. Oh.

Q. ---- just for the record, Saul Kassin is spelled S-A-U-L, K-A-S-S-I-N.

Please go ahead.

A. Both Dr. Kassin's work and Dr. Gudjonsson's work is focused in their career over the issue of why and how do people give confessions to police. So these -- these interrogation settings are considered to be stressful, and most of the work they've done has examined interrogations that came out of what's very popular, the Reid, R-E-I-D, Reid interrogation program. It has influenced both the FBI, the CIA, many other organizations, they get their training.

Anyone is welcome to look that up at FLETC. But the -- the idea in an interrogation is to tell the person they're wrong or that we already know, so you might as well confess. Those are all different techniques of the interrogation process.

So in this paper we were trying to remind people of that, that individuals that are under stress are being told by someone who actually does not know the ground truth that they're wrong or that they need to confess, just to come clean.

One of the differences between the United States and the United Kingdom is our police are allowed to lie to a suspect and say that they have incriminating information when they, in fact, do not.

The worry about that from a psychological perspective is that this makes either people doubt their own view or they become more compliant, hoping that if they say something, they can be released and the pressure will stop. They'll be allowed to eat or get sleep.

So we're speaking to that community of science in this paper because we were finally able to assess some of those traits immediately after stress exposure.

The data from Dr. Gudjonsson had largely been acquired in a retrospective manner, and so there was a possibility that some of what we thought was just derived from recalling memory from a long time ago and that people might not have been accurate.

And so in this study, we were able to test that and test the hypothesis that stress would increase features of compliance and suggestibility in healthy individuals if the stress was considered to be robust and acute. And since we had done so much research at

survival school over the years showing how acute and nearly uncontrollable the stress is, this was an ideal venue to test this idea that has been around for a very long time.

And our findings support that. Our findings support the idea that exposure to high -- high-intensity and acute stress can, even in our Special Operations population, produce a significant increase in compliance in a certain subset of them. But in nearly everybody, we can increase suggestibility and cause them to change what they say they remember when they're challenged by someone in authority who says, "You're wrong. It doesn't add up. Try again."

Q. Thank you, Dr. Morgan.

ADC [MS. PRADHAN]: I'm done with the document camera for now, sir.

Q. I'd like to talk about Mr. al Baluchi's medical state, his various diagnoses. We've discussed generally the -- or you discussed your experience with patients with PTSD. Do you recall that?

A. Yes.

Q. All right. In your experience, what percentage of people subjected to uncontrollable stress meet the diagnostic criteria for PTSD?

A. Well, the percentage is related to the -- the different kinds of traumatic events sort of in the PTSD literature. So without ever meeting a person, it -- understanding they've been in a severe

motor vehicle accident, the base rates of PTSD from a severe motor vehicle accident are between 20 and 40 percent, depending on the severity of was there loss of life, loss of limb, and things like that.

So the literature on motor vehicle accidents and PTSD will generally give a range of the incidence of PTSD in the 20 to 30 percent range.

And as I previously mentioned, if someone has suffered sexual assault, rape, the rates are considerably higher. They may be as low as 48 percent but maybe as high as 60 or 70 percent.

In populations who have been exposed to torture, the rates also vary. In the data on Sudanese refugees, the rates may be around 40 -- 30 to 40 to 50 percent. But in other studies on victims of trauma, the rates are at 67 to 90 percent.

So it depends on the population. And in part, it depends on how post-traumatic stress disorder was assessed.

In lots -- in studies that involve large numbers of people, they're often assessed using what's called the screening instrument, a simple questionnaire that asks: Do you have some distress?

The issue with screening instruments is that although they are sensitive to picking up that someone might have PTSD, they're not specific in that you could also be suffering from depression or anxiety and still check the box and say, yes, I have that, but not

knowing that it wasn't directly related to a traumatic experience.

So screening instruments may cause an over-reporting of PTSD in a scientific paper, and so we often then look at studies where people have been individually interviewed with the instrument I mentioned the other day called the CAPS, which is sort of the gold standard. It is the gold standard way of assessing post-traumatic stress disorder.

When we do that, it gets far more specific about the nature of the symptoms. And the data around that if someone has been exposed to torture, rape, the -- the kind of personal trauma or combat exposure, the rates are much higher if it's been up close and personal. They're usually above 60 percent, but usually in the 70 to 80 percent range. It depends on the population.

For example, in men who have been sexually assaulted, the rates of PTSD are much higher than they are actually observed in women. So there's a different kind of vulnerability, depending on what study has been done.

So in my clinic at the VA where we were primarily treating -- were treating military -- former military personnel, and the range of traumas went from exposure in combat to motor vehicle accidents to sexual assault.

So in the women's PTSD clinic, the rates of PTSD -- you had to have PTSD to be in the clinic, or nearly have it, right, for

treatment. But I would say over -- over half of the women in the clinic had full PTSD, major depression, and some other anxiety-related disorder.

In the general clinic from combat-related PTSD specifically, it was probably slightly less than half of the clinic because people had experienced other kinds of traumas in the course of their military career.

But that was the focus of treatment in our clinic, and the focus of our treatment in our program was assessing PTSD and finding out effective treatments for it.

Q. What is the impact -- did you -- were you able to observe in your practice the impact of separation from loved ones on incidences of PTSD?

A. In -- in my direct work, that has -- that had not been a focus. In my work, sort of looking at the literature and teaching residents in training, we do now know that separation and loss of a loved one, when we look at the data from displaced people, refugees, it accounts for nearly as much of the variance in why people get PTSD as physical beatings and torture, which was a surprise to many people looking at the literature. But it makes sense when you think about it.

If you -- if you're separated from the people you love, your attachment systems are the things that counter our fear systems. And

so at a very early age, we're attached to our parents, our caretaker, and when we're frightened, those attachment systems are turned on to make us return and get comfort and safety from our parents.

The -- but that is the finding now in looking at people who have been tortured and displaced. I believe the largest sample that I've seen are on the Sudanese refugees, but there are a few papers on people displaced, I think, from Bosnia that -- that also -- I'll check on a reference for that, but I know for sure it's in the Sudanese population, the research was found that separation from family was considered one of the most prominent factors that contributed to their psychological distress and PTSD.

TC [MR. GROHARING]: Judge?

MJ [Col McCALL]: Yes, Mr. Groharing.

TC [MR. GROHARING]: This is over and over again. The witness just keeps talking about additional studies, additional data, none of which has been provided to the government.

The process is not for the government to learn when the witness is on the stand for the first time the data that the witness relies upon for their opinions. There's a discovery process, which doesn't appear to have been followed, assuming this is all -- has been prepared where the witness is clearly relying on -- planning to rely on data and studies and articles that we've not been provided.

The defense in this case has not provided an expert report.

We asked on a couple of occasions for the information that the witness was going to rely upon. The defense did not respond. So all we have are two declarations.

And so I'm fearful that this is going to cause a delay or potentially recall of this witness, and I don't think anybody wants that. But even as we go, the witness continues to just reference vague studies with no ability to even -- even determine what study he's referring to.

MJ [Col McCALL]: Understood. And again, I think the way forward will be confer with defense. If this is a new study that has come up during testimony that hasn't been provided to you, defense will provide it to you. And I will make sure that you have enough time to go over that study, discuss it with your expert witness and/or your expert consultant and be prepared for your cross-examination.

I think you know me at this point that I'll make sure that if we have to bring the witness back later, we'll do that. But ----

TC [MR. GROHARING]: Okay.

MJ [Col McCALL]: ---- I'll make sure that the government is not prejudiced. And we'll make sure that you have a chance to review any documents or studies that the witness has relied on.

TC [MR. GROHARING]: All right. Thank you, Your Honor. Appreciate that.

ADC [MS. PRADHAN]: So, Your Honor, I would at this point just like to correct the record, because Mr. Groharing has made a representation that he just does not have these studies.

And we have noticed or we have produced a voluminous number of studies, both by Dr. Morgan and that Dr. Morgan relied upon. And those are in the record. Let me read those record cites in case the prosecution ----

MJ [Col McCALL]: Well, let's ----

ADC [MS. PRADHAN]: ---- has not read them.

MJ [Col McCALL]: Let's not. I mean, because I don't need this back-and-forth.

ADC [MS. PRADHAN]: Okay.

MJ [Col McCALL]: Let's -- while we have the witness on the witness stand, let's get testimony ----

ADC [MS. PRADHAN]: Okay.

MJ [Col McCALL]: ---- and then confer with Mr. Groharing. And if there's a disagreement between the parties, we'll address it after the -- the lunch hour.

ADC [MS. PRADHAN]: All right. Thank you, sir.

Q. Dr. Morgan, in your supplemental declaration in paragraph 10, you concluded that it was within a reasonable degree of medical certainty that Mr. al Baluchi had PTSD by at least 2006. Do you recall that?

A. I do.

Q. All right. And you cited mention of -- you stated that the symptoms noted, i.e. -- and this is -- excuse me, this is in the record at 628TTTTTTT Attachment B.

You stated that: The symptoms noted, i.e., intrusive thoughts about torture, nightmares, anxiety, night sweats, increased heart rate, increased startle, sleep disturbances, symptoms of depression, worries of future exposure to torture, worries that if he didn't make requests properly to the guards that he would be tortured, symptoms of OCD, concentration and attention problems, difficulty completing tasks, indicate that he likely met diagnostic criteria at that time for PTSD.

He was also noted to exhibit a number of other symptoms that are known to be more prevalent in people with PTSD, i.e., multiple somatic complaints, GI distress complaints, general anxiety, and panic-attack-type symptoms.

Now, when you say, Dr. Morgan, it is within a reasonable degree of medical certainty, what do you mean by that phrase?

A. By that phrase, I mean that a physician experienced in that -- that domain of evaluation, someone experienced in the work with PTSD and diagnosing PTSD and doing chart reviews and evaluations, would very likely come to the same conclusion, that -- that there's enough evidence there that a -- that a colleague

would also agree.

This is very common in psychiatry. We even do this for testing our residents. It's done all across the country in different residency programs, where everyone assembles in a room, we watch the same interview with the same patient. And everyone gets to write down, based on the data available, which are the differential diagnoses -- which are -- what are the diagnostic possibilities that are realistically at stake.

And what we consider within a reasonable degree of medical certainty is any combination of the top two or three diagnoses. So some people might say PTSD first, panic second. Somebody else might write panic disorder second, and PTSD here, and major depression first.

But it's within a reasonable degree of medical certainty that we've all concluded these are the options that are the most likely ones that exist that are causing this person's distress.

Within the context of the EITs, knowing what he had been exposed to, it's within a reasonable degree of medical certainty -- meaning that most of my colleagues would look at that and say it's got to be PTSD and probably major depression, because we know there has been a traumatic stress exposure.

If someone did not know what Ammar had been exposed to, they might reasonably conclude that there's major depression and some kind

of an anxiety disorder going on and not be sure about the nature of it. You don't need to be exposed to a traumatic event to develop just major depression on its own, but major depression does emerge in people who have been traumatized and who have post-traumatic stress.

So when I say a reasonable degree of medical certainty, it means in the relevant community of people who work on the issue, most people would come to the same conclusion.

Q. I'd like to show you a page from the OIG report, two pages actually.

ADC [MS. PRADHAN]: And this is 628RRRRR Attachment C at 2C-00000468. And this is appropriate for display to the gallery, sir.

MJ [Col McCALL]: All right. It can be displayed to the gallery.

Q. So let me just zoom in a little. It's hard to read.

All right. I'll just have you read those couple of paragraphs and then I'll turn the page.

In these paragraphs, this is the medical provider from the CIA at the black sites in early -- mid-2005 reporting Mr. al Baluchi complained of attention problems, described symptoms of attention deficit disorder, saying sleep, energy, and concentration were all decreased.

And this is a quote from the medical provider saying: He

was most likely experiencing some anxiety symptoms due to the stress of being in custody.

In the next paragraph, from early 2006, someone from OMS stating -- indicated that she found that Ammar's capacity to -- quote, to effectively cope with sustained confinement had diminished, that he is a, quote, chronic worrier.

Let me turn the page. Further along that paragraph: She reported he had told her he had been experiencing sleep problems.

And, further down, that: He was having startled morning awakenings, occasionally accompanied by night sweats, increased heart rate, and stomach tension.

Now, you recall reviewing the OIG report; is that correct, sir?

A. I do.

Q. All right. And were these -- were these paragraphs among those that you relied upon in forming your conclusion that it was within a reasonable degree of medical certainty that Mr. al Baluchi had PTSD?

A. They are, yes.

Q. And why was that the case?

A. Because the symptoms that are listed, taken together, the most reasonable way of accounting for the symptoms is either saying there's post-traumatic stress disorder and, in addition, another

anxiety disorder and perhaps major depression.

But the -- the other symptoms about the increased heart rate, the night sweats, we know that in PTSD, they're nocturnal panic attacks with night sweating is a symptom, alterations in palpitations in the heart.

The early studies on PTSD published in 1919 on the irritable heart of soldiers and then throughout the literature during World War II and after, there was a term for PTSD historically that was called gastrointestinal neurosis. The idea was that what was on someone's mind was being reflected through their gastrointestinal distress.

So the name evolves over time, but we still see the symptoms of exaggerated startle, night sweats, intestinal distress. Now under the PTSD criteria, those fall under what we call both re-experiencing symptoms and the hyperarousal symptoms.

The sleep disturbances can be middle or morning awakening or difficulty falling asleep. The startle would go along with PTSD. It's an explicit symptom. The increased feelings of anxiety accompanied -- that we see in the paragraph above -- by intrusive thoughts of imagined potential mistreatment while confined, that's a form of the hypervigilance and the intrusive thoughts related to a traumatic event.

So although the person writing it may not say this belongs in the Diagnostic and Statistical Manual for this criterion, I can do

that because I am an expert in the field, and I do that routinely for medical chart reviews in a forensic context and for nonforensic context, but these symptoms hang together and would meet criteria for PTSD.

If I evaluated Ammar, I might be able to delve deeper into some of the symptoms. I know that someone -- Dr. Shea did the CAPS when -- when Dr. Shea evaluated Ammar, and there seemed to be an adequate number -- it's in the severe range -- an adequate number of symptoms have been met, which is consistent with my assessment from the material in the record.

But those are the kinds of symptoms that we pay attention to, that I pay attention to, my colleagues do too, when doing a forensic medical chart review to say what's the basis of what might be the cause of someone's distress.

Q. Thank you, Dr. Morgan.

ADC [MS. PRADHAN]: I note that it's noon. I have probably between five and ten minutes in this section, and I'm very nearly done overall. But I'm happy to push. I'm happy to stop here.

MJ [Col McCALL]: Yeah, we'll adjust the lunch hour. Why don't you go ahead and press forward.

ADC [MS. PRADHAN]: Thank you, sir.

Q. To the extent -- staying on these paragraphs, Dr. Morgan. To the extent that some of these symptoms are self-reported by

Mr. al Baluchi, would that be an indicator of fear reduction later in the program?

A. No. That wouldn't be an indication of fear reduction. Could -- what he is reporting are -- they're classic symptoms seen in someone with post-traumatic stress disorder or an anxiety disorder, not otherwise specified, if someone was skeptical of a PTSD diagnosis or did not know that he had been exposed to the EITs. But, no, his descriptions are naturalistic and they're not reflective of a reduction in fear conditioning at all.

Q. Would the fact that he felt able to express these symptoms or to talk about these symptoms with his -- with CIA personnel be an indicator of fear reduction?

A. It wouldn't be an indication of fear reduction. It's difficult to say what it's a reflection of. There -- as I said, people are -- people who have been traumatized, they'll come to therapy to see people while dreading it at the same time. And I think that's because people who have been traumatized often still hope something might get better.

So when they disclose their symptoms, there are certain symptoms they often feel more comfortable disclosing, which are those that are more physical in nature or to refer to worries. They're typically more uncomfortable discussing the details of what's happened to them because that elicits an even stronger emotional and

physical reaction.

So I don't know why he chose at the time to report certain symptoms. I don't know if those are just the observations on the part of the doctor who met with him. But his descriptions aren't -- they're naturalistic and consistent with what we know in PTSD, but I don't think they tell us anything about his motivation for reporting them.

Q. Thank you, sir. I want to show you a document that's contained in the record at AE 628ZZZZZ Attachment C, and the Bates is MEA-10018-00001107. I'll zoom out so that you can -- so you can see that. So you can see the whole thing. If that -- are you -- are you still able to read that zoomed out that far?

A. I can.

Q. Okay, perfect. Is this a document that you've previously seen?

A. Yes, I have.

Q. All right. And it states at the top that that is a mental health initial assessment dated 8 September 2006. Do you see that?

A. I do.

Q. All right. And that -- I'll represent that's very shortly after Mr. al Baluchi's transfer to Guantanamo Bay.

My first question is: In your work in -- in your work in

correctional facilities, what is a reasonable time for -- what is a reasonable period of time to conduct a clinical evaluation? How long would such an evaluation take upon intake?

A. In part, that depends on the condition of the person. If someone has been transferred and identified as a sort of level 3 mental health risk or something, there's -- there's usually a -- an effort to see them within that first week, if not within the first 48 hours.

But it does depend on the facility. Some facilities just don't have that capacity, and a person may be seen within two weeks of arrival at a facility. At worst case, it might be within a month. So it would -- it would just depend what the -- what the staffing was like in the mental health clinic at a particular prison.

Q. I'd like to call your attention to the paragraph marked -- entitled "ROS" halfway down the page. Do you see that?

A. I do.

Q. And the physician here noted: Hypersomnia and hyperphagia with depressed mood and anxiety.

Do you know what those two -- could you explain those two terms?

A. Yes. First, ROS means review of symptoms. It's a shorthand note that we use when writing a note.

Hypersomnia means sleeping more than a normal amount and

hyperphagia means wanting to eat or eating more. Those are two symptoms that are very common in major depression. We see that in people with that illness where instead of eating less, which they also can do, there is a specific symptom of then just eating more and sleeping more.

Some people resort to sleeping 18 hours a day; they just can't get out of bed. So depending on the setting, we may know whether they're -- the number of hours they're sleeping but it is a classic symptom of major depression. And I think that's why what follows is the -- with depressed mood -- sorry. With depressed mood and anxiety, what the doctor is trying to indicate is a link between these two. That's how in medical -- medical code speak when we write, we'd say -- because if we just say depressed, it's not quite as informative about the symptoms.

And so this person is indicating, by the way, there's -- they're sleeping more, they're eating more, they're depressed, and they have anxiety.

Q. Starting on that second line where it's ending with "and anxiety," there's a parenthetical saying: Acute, quote, uncontrollable symptoms, panic-like, and there's an arrow towards no agoraphobia.

Do you know what that means?

A. I do. In thinking about anxiety disorders, in many

anxiety disorders you can have what's called a sudden attack of anxiety, a panic attack. If those are uncued and simply occur out of the blue randomly, then we'll most likely give a person a diagnosis of panic disorder.

A panic attack is an event of uncontrollable anxiety that comes on really within 30 seconds. We don't really care how long it lasts. That's not part of making a diagnosis. But it has a sudden onset in nature.

Those occur very frequently in post-traumatic stress disorder and they occur very frequently in panic disorder. They can be seen in some people with major depression. But they're most commonly panic disorder and PTSD, the neurophysiology is very similar.

So in our early work at the National Center, the studies that we produced were assessing those kinds of symptoms in our evaluations to try and figure out whether the pathophysiology of PTSD was different than panic disorder. There's a different -- there's a difference when you look at people's family histories. Panic disorder travels in -- there's a genetic -- there's a larger genetic contribution, so the instance of panic is greater in families than it is in PTSD.

But that's what the doctor is signaling, is that not only is Ammar sleeping more, eating more, feeling depressed, having anxiety,

the decreased concentration and the uncontrollable symptoms usually refer to the constellation symptoms of panic.

You can't -- you can't just think about a panic disorder and make it go away. It's uncontrollable. It -- it emerges. Many people may feel like they're having a heart attack. They're often seen by the cardiologist because they don't go to see psychiatrists when they have it. And there's no heart -- there's no heart pathology going on, but the symptoms feel very much just like a genuine heart attack.

Q. And, Dr. Morgan, do you see further in that paragraph -- and I'm going to show you a different document, but further in that paragraph it says -- there's a reference to physical pain and the quote: All over his head randomly.

Do you see that?

A. I do.

Q. All right. I want to -- with that in mind, I want to switch to a document that's in the record at the same place, and it's MEA-10018-00000257.

ADC [MS. PRADHAN]: And court's indulgence, sir? Just one minute.

MJ [Col McCALL]: Take your time.

[Pause.]

ADC [MS. PRADHAN]: Sir, this is not appropriate for display

to the gallery.

MJ [Col McCALL]: All right.

Q. All right. Do you see in the first paragraph -- I don't know how -- if that -- let me see if I can make that a little more clear. Ah, I had it for a second. There we go.

A. There you go.

Q. In that first paragraph, in the second line, stating: History of head injury, secondary to being hit about three or four years ago during interrogation, per detainee.

Do you see that, sir?

A. I do.

Q. Now, would "per detainee" mean -- would that mean according to Mr. al Baluchi?

A. Yes.

Q. All right. Further down in the paragraph marked "A/P" ----

A. That stands -- oh, sorry.

Q. Sorry. What does A/P mean? Let me ask you that.

A. It means assessment and plan.

Q. Thank you. Do you see the line in the middle of the paragraph that says: At this time, after having listed subclinical -- well, anxiety and depressive symptoms as well as subclinical symptoms of anxiety and depression during detention, it

says: At this time, consistent with mixed anxiety, depressive disorder.

Do you see that, sir?

A. I do.

Q. All right. Do you further see: There's need to rule out panic disorder without agoraphobia?

A. I do.

Q. All right. And what test would you administer for what need -- for the -- the list of things there that need to be ruled out?

A. It would require more extensive interviewing. For example, for panic, agoraphobia refers to something slightly different than having a panic attack. It is the fear of being in a space and the need to escape from it.

So -- and it doesn't mean cramped confinement. It just means that a person is suddenly filled with the urge to, like, get out of any situation that's near anybody else. So people with severe agoraphobia generally stay home. They don't venture out into the world.

The -- the two conditions are often paired in that when some people are having these random panic attacks throughout the day, they keep thinking, well, maybe it's because it's caused -- they inappropriately attribute their panic to many other situations, but

it's not -- it's not attached to them. So they resort to hiding in their house and never going out.

That, you have to get by taking a detailed history with a person of when, how, and where did these attacks begin, under what circumstances. And we traditionally create what's called a panic diary with a patient.

So when -- when they're listing rule out panic disorder without agoraphobia, it sounds like they're convinced there's none of the other -- there's none of that -- that hermit quality sort of thing going on, and that they're trying to think about the nature of the panic disorder -- the panic attacks to see if they're uncued or cued.

If they are uncued, then it's very likely a panic disorder that has developed. If they are cued, which is often what we find in PTSD -- that's the kind of panic people have initially -- then it would help make a diagnosis.

So right now, as a physician, when I read that, what -- what this person is saying is I'm pretty sure that I have an anxiety disorder that may not fit any specific criteria in the DSM, the Diagnostic and Statistical Manual, and so I'll call it not otherwise specified at this time. And I need to make sure I don't have an independent medical condition, psychiatric condition, going on called panic disorder.

Also, I need to follow up and make sure I don't have a full major depressive disorder going on. So the diagnosis of major depression has a set of criteria just like PTSD that need to be met to establish whether or not a person is suffering from that condition.

And recurrent versus single episode is a way of designating whether this is the first time a person has experienced depression or whether or not they've had it before in the past. And that helps the doctor think about whether or not they have cyclical depression, like, they have depression that comes and goes or -- and the term at the end that says "dysthymic disorder," that's -- I'm trying to think.

If you're familiar with the characters from *Winnie-the-Pooh*, the character Eeyore is dysthymic. He's just chronically down. He's not depressed, but everything is pessimistic, and his mood is below everybody else's.

That's what dysthymia refers to, is that rather than being in a normal zone, the person always just has a lower-than-normal mood, energy, affect. They're always kind of sad. But they don't quite get as sad as is needed and as depressed as is needed for making a diagnosis of major depression, where we see dysfunction in hedonia, libido, food-consuming behavior, and things -- and suicide -- suicidality and those things.

So that's -- the doctor is indicating there is a problem. There is a psychiatric condition. It has features of anxiety and depression. But I'm not willing yet to call it what it is.

PTSD is noticeably absent. If the doctor didn't know that he had been exposed to EITs, it wouldn't be -- it would be reasonable to not put it in.

When he is reported having a head injury, if I was reviewing the chart, I would say: Have you considered an organic anxiety depressive disorder? Because maybe his head has been banged and it may be due to physical tearing or changes in the brain that are creating anxiety and depression.

If they did know he was exposed to EITs, it would -- it would be problematic not to consider post-traumatic stress disorder, because there clearly is an exposure to highly stressful traumatic events. And at least to rule it out and say, well, this isn't related to that or it is related to that would be what I would expect from someone doing an evaluation. But they may not have known -- they may not have known what was going on. I don't know.

I do know that they were worried in some way in that down below, they do tell themselves they need to report abuse, so...

Q. My question -- my last question on this section was: Does that end -- under "Axis IV" where it says: Report alleged abuse via chain of command -- COC -- as per DoD instruction, does that indicate

to you that the physician may have had an idea that there was previous trauma?

A. Normally, if a physician writes something like that, it means this -- I'm not thinking of something that happened as an accident, right? If we thought it was an accident, we'd typically write.

It wouldn't be under "report that." It would be follow up on head injury and see if he's got brain damage or see what happened to him. But typically, you wouldn't refer to it as abuse unless you thought it -- it was not an accident.

ADC [MS. PRADHAN]: Sir, that's a natural stopping point.

And just for the military commission's assay, I would estimate that I have an additional maybe 30 minutes.

MJ [Col McCALL]: All right. That's fine.

All right. So I want to make sure that I give you the full lunch hour so that you can confer with Mr. Groharing.

ADC [MS. PRADHAN]: Yes, Your Honor.

MJ [Col McCALL]: So let's be back at 1350.

So, again, during the recess, Dr. Morgan, please don't discuss your testimony with anyone, to include counsel for any of the parties.

WIT: Yes, sir. I do have a question for you.

TC [MR. GROHARING]: Sir?

MJ [Col McCALL]: Hold on, Mr. Groharing.

Yes, Dr. Morgan. You had a question?

WIT: If I -- so he had asked about replication studies. I can go look those up and give them to ----

MJ [Col McCALL]: So ----

WIT: ---- to them or ----

MJ [Col McCALL]: I'm not sure what has been provided. Allow counsel to discuss what studies have been provided and haven't been provided. And then, if need be, I'll let counsel confer with you for the limited purpose of what studies might have been referenced and need to be pulled.

ADC [MS. PRADHAN]: Yes, sir.

MJ [Col McCALL]: All right.

WIT: Thank you.

TC [MR. GROHARING]: Judge?

MJ [Col McCALL]: Yes. Go ahead, Mr. Groharing.

TC [MR. GROHARING]: If I could just -- I'd like to be heard outside the presence of the witness before we recess.

MJ [Col McCALL]: All right.

Dr. Morgan, you can go ahead and get an early start on the recess.

WIT: Thank you.

[The witness was warned, was excused, and withdrew from the

courtroom.]

MJ [Col McCALL]: All right. The witness has left the courtroom. Go ahead, Mr. Groharing.

TC [MR. GROHARING]: Thank you, Judge. And I'm planning on meeting with counsel over the break.

MJ [Col McCALL]: Sure.

TC [MR. GROHARING]: But I would just note that in none of the disclosures have counsel referenced any record -- any medical records that the witness was intending to rely upon for his testimony.

We just had two records pulled up that obviously they had planned to rely upon, and there's no indication if there are any other records, what records he might have reviewed.

Obviously, I think everyone would agree this is what forms the basis of his opinions and would be required to be disclosed in advance of the testimony.

So, again, it's inappropriate for the government now to be in a position to attempt to cross-examine this witness where we're learning on the fly of the information that the defense has provided this witness, it sounds like, well in advance of this hearing.

MJ [Col McCALL]: All right. And I see Mr. Connell up.

LDC [MR. CONNELL]: Sir, I handled the discovery part of this, so ----

MJ [Col McCALL]: Okay. That's fine.

LDC [MR. CONNELL]: I asked the paralegals to print the discovery, the 914 disclosures around this witness. And we don't have that much paper in the office, so I had them do it double-sided.

And -- since counsel represented earlier to the military commission that we hadn't provided a report, both reports beginning in 2017 from this witness are in the -- are in the record. They sent us a last-minute discovery request. I complied with the last-minute discovery request, provided an additional 300 pages of documents. The ----

MJ [Col McCALL]: Let's do this -- and I hate to cut you off, Mr. Connell.

LDC [MR. CONNELL]: Sure.

MJ [Col McCALL]: But confer with Mr. Groharing. I will allow the parties to explain their positions after the lunch break if there really is an issue.

LDC [MR. CONNELL]: Understood, sir.

MJ [Col McCALL]: And so I think right now it's a little premature, because I understand the convoluted, voluminous nature of this case with the evidence in this case, and so I can understand why something might have been provided and perhaps it's not readily apparent.

So confer, and then let's discuss if there is an issue after the lunch break.

LDC [MR. CONNELL]: Yes, sir.

MJ [Col McCALL]: So, all right. Anything else just before we recess, 1350?

Go ahead, Mr. Sowards.

LDC [MR. SOWARDS]: Yeah. Can we make that 1400 to return?

MJ [Col McCALL]: That's fine. 1400.

TC [MR. GROHARING]: Real quick, Your Honor. Do any of the other teams plan on examining the witness?

MJ [Col McCALL]: Fair question.

Do any other defense teams plan on questioning Dr. Morgan?

LDC [MR. SOWARDS]: If we ever break for lunch, I do, Your Honor.

MJ [Col McCALL]: Okay. So it sounds like Mr. Sowards does.

Mr. Ruiz?

LDC [MR. RUIZ]: We'll give it some thought and let Mr. Groharing know at the appropriate time.

MJ [Col McCALL]: All right.

TC [MR. GROHARING]: Judge, I'm just trying to figure out for planning ----

[No audio feed.]

TC [MR. GROHARING]: ---- when we should expect to do the cross-exam.

MJ [Col McCALL]: Sure. And, Mr. Engel, do you know, does the

Bin'Attash defense team intend to ----

LDC [MR. ENGLE]: At this point ----

MJ [Col McCALL]: ---- cross-examine or to do a direct on Dr. Morgan? Go ahead.

LDC [MR. ENGLE]: I'm sorry. I didn't mean to speak over you.

At this point, I do not anticipate questioning Dr. Morgan.

MJ [Col McCALL]: All right. And again, Mr. Groharing, I will make sure that you have enough time to be ready to have everything together if -- so don't worry about that.

All right. 1400.

Commission is in recess.

[The R.M.C. 803 session recessed at 1223, 07 May 2024.]

[The R.M.C. 803 session was called to order at 1404, 07 May 2024.]

MJ [Col McCALL]: Commission is called to order.

The parties are present. The accused are absent.

Go ahead, Mr. Connell.

LDC [MR. CONNELL]: All right, sir. I am -- I heard the military commission's message before that you don't want a complete rundown of everything we've done since 2017 discovery around this, but here's what I will tell you: Every piece of paper that we have that has Dr. Morgan's name on it, the government -- we gave to the government.

Some of those we filed in the record because we thought they

were important. Some of those we just sent direct to them because we did not think they were important.

Over the lunch break, Ms. Pradhan, Mr. Groharing, and I got together and discussed the topic areas that the government thought they wanted more information on, some of which they had said during the proceeding and some not.

And so we've produced a document which relates the topic areas that they were asking about to the documents which are in the record with the names of the studies and their Bates numbers and that sort of thing. So we e-mailed that to the government, but we also brought them a hard copy because we know it's hard at the RHR.

If I can approach the court reporters, I can have this marked and we can make it an exhibit.

MJ [Col McCALL]: Perfect.

LDC [MR. CONNELL]: So, sir, here's the state of the discussion. With respect to particular areas that the government asked about, we did the best we can putting -- relating the areas they asked about to specific studies from Dr. Morgan.

We discussed this a little bit with Dr. Morgan, but did not discuss any topic other than relating his studies.

The other questions that the government had were about, number one, the study about the Sudanese refugees, which is we found one -- there were many, many examples, and Dr. Morgan was really

drawing on his corporate knowledge, but we found one that was a good example to use as an exemplar so that we could provide them with that information.

The -- we also on -- as best as we could on short notice, found some examples of the other scientists who have replicated Dr. Morgan's studies, and have copies of those which we can provide to the government, or we can take them away and Bates stamp them and send them. I'll just coordinate with them on what the best way to do that is.

And then the last question that the government had was about the two pages of Mr. al Baluchi's medical records that we provided. And the question -- the government's question was, number one: Was that specific thing in his report? And the answer to that is no, it wasn't.

And their second question was: Did he review any other of Mr. al Baluchi's medical records? And the answer to that is no.

So I think the bubbles are level for the moment. Of course, the government is -- is very likely to have the evening in case there's anything else, and we can continue to sync this up and work this problem.

But fundamentally, we have provided two reports from Dr. Morgan, have provided every study of his that's in our possession, and the -- anything else really seems like appropriate

for cross-examination if they want to -- are you making up numbers? Is that a real study? Did anybody really replicate your work? Are appropriate questions for cross-examination.

MJ [Col McCALL]: All right. I understand your position.

Mr. Groharing?

TC [MR. GROHARING]: Judge, we're -- we're just processing.

And, one, we appreciate the defense providing us this list. We're looking at it. We just got it.

I think, to Mr. Connell's point, it seems unlikely we would get through our examination today. This is something that we can take a look at tonight and just see where we are. It could be the case that we have a request for more information. We don't think this is -- this is complete. Maybe it is. I don't know without looking at it. And then just take it one step at a time whether or not, you know, we're asking for a delay for additional examination on a particular topic.

But our -- we certainly want to cover as much ground as possible with the doctor and complete as much testimony as possible during these proceedings.

MJ [Col McCALL]: All right. Perfect. Got it.

All right. Ms. Pradhan.

Before you come up, any other housekeeping matters?

Apparently not.

All right. Go ahead, Ms. Pradhan.

And if we can get the witness back in here.

[The witness, Dr. Charles Alexander Morgan III, resumed the witness stand.]

ADC [MS. PRADHAN]: Good afternoon, Your Honor.

MJ [Col McCALL]: Good afternoon.

Welcome back, Dr. Morgan. Please have a seat. I just remind you you're still under oath.

Go ahead, Ms. Pradhan.

DIRECT EXAMINATION CONTINUED

Questions by the Assistant Defense Counsel [MS. PRADHAN]:

Q. Good afternoon, Dr. Morgan.

All right. We were talking a little bit about your determination that it was within a reasonable degree of medical certainty that Mr. al Baluchi had PTSD, if you recall.

Have you ever met Mr. al Baluchi?

A. **[No audio feed.]**

Q. I think your mic is ----

A. I -- I was going to say something sounds different.

MJ [Col McCALL]: All right. It sounds amplified now.

WIT: Is that -- how is that?

MJ [Col McCALL]: Much better.

All right.

Q. I'll ask you again: Have you ever met Mr. al Baluchi in person?

A. I have not.

Q. Okay. Have you ever made psychological or psychiatric diagnoses before without meeting a patient in person?

A. I have, many times. I did it for the government in the case against Robert Bales. I've done it for different state authorities.

There are many times a person either refuses to be evaluated or they cannot be evaluated. I've actually done psychological autopsies for insurance forensic evaluations where we had to reconstruct the state of mind of the person at -- or surrounding the time that they -- that they died.

So this is a very common practice in forensic psychiatry. We may or may not evaluate someone. Some people find it a little strange when we say we haven't seen someone, but the scientific data around direct versus indirect assessment of looking at chart material suggests that sometimes it's better to look at the chart than to actually interview a person. And that's because we very often may talk ourselves out of possibilities just because of the way we may feel or react to the person, positively or negatively.

So looking at information from a chart or talking to other people, they're all traditional and well-accepted ways of conducting

an evaluation in forensic psychiatry.

Q. And as an expert on PTSD, how do you -- how do you approach an indirect examination of a patient? Let me ask you that.

A. If the evaluation is indirect, one -- one ability is to look at the notes, notations that have been made about a person at the time from people who may be reasonably expected to appreciate the kinds of signs and behaviors that are relevant to psychiatry.

We also look, in addition, at evaluations performed by other -- other kinds of doctors, if they're not a psychiatrist, a psychologist, and any kind of testing that may have been done on the person in order to formulate what best explains the -- the symptoms that are being recorded and noted in a chart.

We may or may not agree with the diagnoses that someone else made, but the question sometimes is: Given the same amount of information at that time, would that diagnosis have been reasonably reached by a person who is competent in their field?

But that is the general approach. We look at the symptoms that are noted, the diagnoses that are made, and other types of behavioral events.

So in some records from corrections, there are often -- there are sometimes really helpful observations by the -- by the guards or by non-mental-health people. It depends on what the observations are because so many symptoms in psychiatry can't be

observed simply from the outside.

So they usually -- it's -- it's important to know what the person's training is and what their level of experience is in evaluating mental -- mental symptoms in a person.

Q. And do you feel you had sufficient material in this case to make the determination that you did regarding Mr. al Baluchi?

A. I do. Not only was I able to look at the information in the OIG report and in the doctor's notes from 2006, I was also able to review the psychological interviewing and testing material from, I think it was Dr. Xenakis' reports and Dr. Shea's reports and Dr. Hanrahan's report and Dr. Gur's report.

And as I mentioned in my declaration, PTSD doesn't suddenly emerge 20 years after an event. So it is well within a medical reason to see the documentation from 2006 and to see that that was verified with structured clinical interviewing and psychological testing at a later date.

And I will note the psychological testing was valid. There were no indications of malingering or feigning. And the information is compatible with what's been reported previously related to not only the working memory problems and information processing problems, but also the specific symptoms of PTSD.

So taken at large, I see enough symptoms that are documented in 2006 to support a diagnosis of PTSD. I am aware of the EIT

exposure, which means traumatic stress exposure. And then I can see when he was subsequently evaluated in 2016, '17 or -- I think it was 2016 and '17, I think, with Dr. Xenakis. And I believe it's 2019 by Dr. Gur. And Dr. Shea, I think, is 2020 or '21. I'd have to look. But it's completely consistent with that medical formulation.

So if there are other data that would indicate something else, I'd be happy to review it. But right now, the information I've seen, I feel is pretty -- very persuasive that that's the most likely diagnosis of what he had at the time. And the information that's more recent confirms that that is, in fact, what he has from a psychiatric point of view.

Q. Are the phenomena regarding fear-conditioned memories, do those exist only in PTSD patients?

A. No.

Q. Could you expand on that?

A. Yes. I know the other day I spoke about our explicit and cue-conditioning experiment in veterans with PTSD. There's also a safety learning deficit in people with panic disorder. And we also know that people with major depression can exhibit those kinds of symptoms.

So when we translate experimental findings in the lab to try and understand why patients are sick, we often find that different psychiatric disorders have some things in common that underpin them.

So there are startle deficits in people with schizophrenia. There are abnormalities and startle with people with PTSD, as well as in certain substance use disorders and in other kinds of anxiety disorders.

With post-traumatic stress disorder, the -- the deficits that are related to the learning of safety are ones that are found repeatedly. So that there's -- in the field, as we build up knowledge from multiple experiments and we compare that to the literature on -- on the treatment of people, a very common theme is sort of the issues around trust.

Any readily available handbook on cognitive behavioral therapy will identify these themes that clinicians deal with all the time. It is just so common and generally accepted that there wouldn't be any one science paper on it, but it's generally accepted in our community.

Q. All right. Thank you. I'd like to talk a little bit, as much as we can, about Camp VII and Echo II.

A. All right.

Q. You conducted forensic inspections of both sites, correct?

A. I did.

Q. In March of 2022.

A. That's right.

Q. Broadly, could you describe the conditions at Camp VII and

Echo II -- well ----

ADC [MS. PRADHAN]: Court's indulgence's?

MJ [Col McCALL]: Take your time.

[Pause.]

Q. All right. Let me ask you a yes-or-no question, if I may, because of classification issues.

Broadly, did you observe conditions in Camp VII and Echo II relevant to Mr. al Baluchi's context conditioning?

A. Yes.

Q. Okay. And we can go into further details later.

If Mr. al Baluchi was suffering from the effects of uncontrollable stress in 2006 at site BROWN, Location Number 9, which was the last site he was held at, what symptoms would you expect to see in his detention at Camp VII later that same year at Guantanamo?

A. All other things being equal, if nothing had changed, I would expect to see symptoms emerge that have their origin in a previous experience at another site. It's possible that along the way he became sicker.

As we know, conditions can worsen over time, and it may be that some of the displays of symptoms could be worse. Others may not have been worse. They may have been lessened. We'd have to know more detail about how he looked at phases along the way in a detailed way.

Q. Okay. Do you recall reviewing transcripts from the testimonies of FBI Agents Fitzgerald and Perkins?

A. I do.

Q. All right. And you understood that they conducted questioning of Mr. al Baluchi after his arrival at Guantanamo Bay?

A. I do.

Q. Okay. When Mr. al Baluchi was questioned at Echo II, he was specifically told that he did not have to speak to the FBI agents. In your professional opinion, would that have changed his idea of safety in that location and under those circumstances?

TC [MR. GROHARING]: Objection, Your Honor. Calls for an improper opinion.

MJ [Col McCALL]: Objection overruled.

A. It may. It would be -- we'd have to ask -- we'd have to ask him. It's possible that it would, but I don't know.

Q. If Mr. al Baluchi was told that he was in someone else's custody and no longer in CIA custody, would that make a difference in terms of your assessment of his -- of his mental state?

A. No. I think with a person who has post-traumatic stress disorder, one of the issues is worry about trust and relationships with other people. And in our clinic and many other clinicians have -- this is written about a lot -- the changing of custody would more than likely not diminish his PTSD. It would be distressing. It

would cause internal anxiety and stress for him.

Because one of the issues is -- is worrying about what happens next. Can I trust the new situation? That's what's on the mind of a person who's been traumatized, and we can measure that behavior in nonhuman animals as well.

So I wouldn't expect the transfer to diminish anything. It certainly wouldn't -- it wouldn't create a situation in which he did no longer have PTSD. And I know that because he's been diagnosed with it since that time. So it wouldn't make the mental illness go away.

Q. Given -- given your examination or your inspection of Echo II and your observations, which we can go into in more detail in closed session, if Mr. al Baluchi was told -- if Mr. al Baluchi was able to say "I understand that you are different people from the people who had me in custody," would that indicate to you that he felt safe in that ----

A. No.

Q. ---- situation?

A. We know that very objectively from studies in people with PTSD, they can -- they can rationally say a fact that is opposite to the rest of the way their physiology is responding.

Back to the other day when I was talking about our conditioning experiment, they all knew the relationship -- the

patients and the control group knew, I think except one person, the relationship between light and shock. But all their physiology and their -- their brain functioning is measured by what we were measuring with saying the exact opposite. That they did not, in fact, know the relationship between threat and safety.

Q. Would that still be the case if Mr. al Baluchi was able to share a meal with the people who are asking him questions?

A. Yes.

Q. And why do you say that?

A. People with -- people with PTSD are able to meet with other people, talk to other people. They can even mask their symptoms from other people for a period of time. As I mentioned, many of my patients, their spouse or their loved ones may never have known that they had post-traumatic stress disorder or known they had a mental disorder until they decided to admit that they had been traumatized and that they had symptomatology.

So this is not a psychotic disorder, a disorder in which people have poor reality testing as is the case in people who suffer from schizophrenia or other kinds of delusional disorders. In PTSD, certain aspects of one's intellect are fully intact. People can be very smart, they can be regular smart, they can be less than regular smart. And so they can hide many of their symptoms in order to get along with people.

In fact, part of the issue with the increased compliance we see in traumatized victims is that they can appear pro-social and agreeable for a while.

Q. And when you say one of the things we observe with increased compliance, what do you mean by that phrase, increased compliance?

A. I mean that they're willing to acquiesce to someone else's demands or to an opportunity. As I said, people usually hope things will get better when they've been traumatized, so they have a divided interest. There's a part of them that wants to try and trust some new situation, but what's fully at play underneath those statements is, well, we'll wait and see because I'm guessing bad things are going to happen anyway. Even if you say you're good, the assumption is that the other person is not.

ADC [MS. PRADHAN]: Your Honor, may I have a moment to confer?

MJ [Col McCALL]: You may.

[Counsel conferred.]

ADC [MS. PRADHAN]: Your Honor, that's all I have. Thank you.

MJ [Col McCALL]: All right. Thank you.

ADC [MS. PRADHAN]: Thank you, Dr. Morgan.

WIT: You're welcome.

MJ [Col McCALL]: All right. Mr. Sowards?

[END OF PAGE]

DIRECT EXAMINATION

Questions by the Learned Defense Counsel [MR. SOWARDS]:

Q. Good afternoon, Dr. Morgan.

A. Good afternoon.

Q. I apologize. I've been following your testimony aptly but have it written down on several thousand different sheets of paper. And I also apologize that I'm a liberal arts major, so I'm somewhat less than normal smart on the issues you've been discussing. So pardon me if I ask some fairly concrete questions.

The first one I just wanted to clarify to make sure I understand it is: Your experience with observing the SERE training where we were -- I gather the various military branches were trying to prepare our servicemembers for, as you said, to sort of have a taste of what they might unfortunately encounter if they were captive; is that correct?

A. In part, yes.

Q. In part, okay. All right.

A. Yeah.

Q. But -- and what I'm trying to distinguish is, as I understand it, the SERE training exposes these folks to what, at least back in the day, were regarded as sort of enemy tactics that were not actually lawful under the law of war or international law; is that correct?

A. That's my understanding as well from knowing the formation of SERE schools, yes.

Q. Okay. So we weren't -- we weren't preparing our folks to either employ these techniques or think that they would be part of their normal training to use on someone else?

A. Well, that's the irony. We took techniques that we said the enemy would do unethically and then thought we'd export them to use on people who were detained.

Q. Okay. And the -- the ones, though, that you were allowed to -- or participated in observing and, I gather, even had to some degree inflicted on yourself, these were, as far as we understand it, a fairly far cry from what actually happened under Drs. Mitchell and Jessen's program?

A. They were distinctly different, yes.

Q. Okay. Very good. And then -- and just -- I don't know if you're aware of it, but the -- the Senate Select Committee on the RDI program does include communiques from the -- from some of the CIA sites saying that what is -- for instance, what's going on with the waterboard has now moved way beyond SERE and we have a series of near drownings.

So that isn't the sort of thing you were observing?

A. I don't know of anyone drowning at SERE. I know there were different occurrences of accidents. One -- one individual had

died at one point, before I began monitoring the course, from one of the smoking experiences. And other than that, I'm aware of other cases of PTSD that people have from their experiences at SERE school ----

Q. Okay.

A. ---- who had been awarded compensation by the government for their experience of how they were treated at survival school.

Q. Okay. Well, thank you, sir, for that explanation.

And then I wanted to also address one of your comparisons you made. You said that at your clinic, you offered treatment to folks who are diagnosed with PTSD and some people with sort of near-PTSD. Do you recall that?

A. Yes. In the PTSD anxiety clinic, it's a fairly wide net. So that if a veteran met full criteria for PTSD, they were in the clinic. If they didn't meet full criteria but had more anxiety symptoms than symptoms related to depression or schizophrenia, then for their care in the VA, they would be assigned to the anxiety clinic. And many people with partial PTSD will have other anxiety conditions as well, so they would be in that clinic.

But if someone's main issue in life had been something like schizophrenia or bipolar disease or general personality issues, like family issues, marital issues, they might be assigned to the general clinic.

So for a veteran to be in the PTSD anxiety clinic, it was the best ballpark for where the government could say we have doctors who can treat you with your array of symptoms.

Q. Understood. Thank you, sir.

And so from that, did I understand correctly that exposure to extreme, severe stress can produce or be, I guess -- I guess it's the first criterion that you mentioned for a diagnosis of PTSD?

A. Well, it's for exposure to a traumatic event.

Q. Traumatic event.

A. And now that's delineated in certain ways, and it usually entails the direct or threatened injury -- of serious injury to oneself or to another person. And you might be the observer or you might be the target of -- of whatever the trauma is. So there can be risk to physical -- risk of physical injury or risk of emotional sort of fear, horror, dismay.

In the latest version of DSM, that's no longer there because we now accommodate the position that people who may not have been threatened but who had to stand around and watch people get threatened, even if it didn't mean anything to them, years later they may come to the clinic and say I now have symptoms about that experience.

So that's why in the psychiatric community, although we usually emphasize the experience had to be associated with fear,

helplessness, horror, terror, now it's simply was there a realistic threat to their physical integrity or threat to their life, implying that it made them afraid.

But we don't restrict it to that now, so that -- that people who served, for example, if they were drone pilots, are eligible to be assessed for -- for post-traumatic stress disorder following maybe from some of their military service activity.

So that's why the definition has been broadened. But step one is to think about an event as to whether or not it meets the criteria as a traumatic event.

Q. Okay. And once you have that, then, and you do the further diagnoses of them, if they are not -- I guess you would say they're close to but not quite a PTSD diagnosis, the purpose -- the reason your clinic still treats them is the degree of traumatic stress produced by those experiences is still significant in terms of their function?

A. They're a human being who's suffering and they've come to -- they've come for treatment. So we provide care whether or not it exactly meets the criterion that the insurance company will pay for or the criterion that when we're -- when we're doing research, the criterion are held to pretty strictly to make sure that that's the diagnosis we're experimenting with in an experimental design.

Or in litigation, when someone says this happened to me and

you -- you caused my PTSD, then we try and stick with a more strict criterion to be sure that this is the condition that resulted from whatever happened to them.

But in everyday life, when people come to see a doctor, the doctor may not know what to call it ----

Q. Sure.

A. ---- but recognize the person as having emotional distress and would find a way to treat them in some way.

Q. I think -- and I believe you alluded to this a couple of times, but I just want to make sure, perhaps also for Mr. Groharing's benefit, that it's actually mentioned, or has for several editions of the DSM, that the, if not predictive, sort of the -- the most probable source of developing PTSD but certainly significant traumatic stress symptoms comes from the type of trauma that is inflicted by a human agent?

A. That is ----

TC [MR. GROHARING]: Objection, Your Honor, leading.

MJ [Col McCALL]: Objection sustained.

If you could try not to lead, Mr. Sowards.

LDC [MR. SOWARDS]: Okay.

Q. I'm sorry. Did you ----

A. I'm not quite -- repeat it, please. I want to make sure I am answering the question.

Q. Okay. Well, let me -- let me ask it a different -- different way so I'm not leading.

LDC [MR. SOWARDS]: Although, Your Honor, he is an expert and usually some leading with an expert is appropriate. But I understand. I'll follow the court's guidance.

Q. You mentioned that torture and rape were two of the three primary -- or -- or -- or -- or most severe -- or, I'm sorry, sources of most severe traumatic stress; is that correct?

A. What we consider -- what we call a risk ratio ----

Q. Okay.

A. ---- a likelihood that an event can result in PTSD, yes. It's the kind of event like torture or rape where it's far more likely the person will have PTSD as a result from their exposure to that kind of an event.

Q. Okay. And the -- and in terms of the threat to human beings, to oneself or another, would also the threat to kill another person's children whom those -- that person knows is in the -- the abuser's custody, would that also produce a high risk factor for traumatic stress?

A. Yes, it would. Part of the -- one of the most common traumatic events for people across the country is sudden death of a loved one from a heart attack. So the -- the loss or the threatened loss of someone one is attached to would fall into that category very

much so.

If the person believed it was a real threat, that it could really probably happen, we would consider that in the traumatic stress category. That would be considered a traumatic event that could be capable of causing post-traumatic stress.

Q. And can you tell me what, if any, effect it would have in terms of the likely -- the risk factor for traumatic stress if a person's captor, after threatening to kill the person's child, came back to them and said we've -- we've detained your child or your children again?

A. My assumption is it would be very frightening and alarming to them.

Again, I mean, in the context we've been talking about, I think someone who's detained would -- would believe it because they've already been and experienced being controlled, detained.

And I think as long as they believe "I think these people can do that," it would be terrifying.

Q. And you mentioned also in your testimony -- and I know you were not in any way minimizing the horrible experience of a single sexual assault, but I was -- I was wondering, you'd -- you -- you'd also mentioned that even if a person was not detained for years, they can still respond to traumatic cues.

Do you -- do you recall that testimony?

A. I do. What I was -- the idea I was getting at is that a person may experience a traumatic event just once, a single episode that may then scar them for life. They may have post-traumatic stress disorder for the rest of their life from a single event.

Very often when I was working with combat veterans, because they were deployed for a length of time, there were multiple traumatic events they had been exposed to. And very often they could name the one event among them all that seemed to be -- that they would identify as the source, the thing that they would dream about, think about, and that bothered them later.

In -- as a result, this -- there's been a lot of research trying to look at what is -- is there an accumulative effect of trauma on people? So why does it take one time in one person and why does -- why does PTSD not emerge until another person has had a series of traumatic events?

We don't know all the answers about that. We know that if the event has been sufficient to cause post-traumatic stress disorder, it can be for life.

What complicates it is that when a person has been exposed to multiple traumatic events, they can often have what we call complex PTSD, which is a way of saying they have many more symptoms than those listed that you have to have to get a diagnosis of PTSD.

They have chronic pain. They have gastrointestinal

symptoms. They have an array of problems that look cardiovascular in nature that we don't know how that's related to PTSD per se.

Some even say that problems with sugar control and diabetes and hypertension are the aftermath effects of being traumatized. That's still being investigated in the medical community.

But what is accepted is that when people have -- the more trauma people have experienced, the more scarring, if you will -- put that in quotation marks -- because sometimes we just don't know where the damage is in the brain and why, that the more -- the more of a risk there is for PTSD.

But you don't have to be traumatized multiple times to have PTSD that may endure for the rest of your life. It -- it really depends, I guess, on the nature of the event.

Q. Okay. And I want to then also to ask you about the concept of someone being in a situation of prolonged coercive control where they experience a number of events that could match the criterion for a traumatic event. Okay?

A. Yes.

Q. And in particular, let me ask: Are you familiar with and maybe have an opinion about the work of Dr. Judith Herman in trauma and recovery?

A. I do. I actually know Judith Herman.

Q. Okay.

A. I haven't seen her for years, but yes, I am.

Q. I hope that reflects a favorable evaluation of her work.

A. Well, in the -- we are all members of the International Society for Traumatic Stress Studies group, so we're often at similar conferences together.

Q. Okay. And what -- I understood from -- and correct me if I'm wrong or even confirm if I'm right -- that with respect to the conditions for recovery, you mentioned someone could have a traumatic -- the effects of a traumatic episode for the rest of their lives.

The conditions for recovery from traumatic stress are three. One is a -- finding a place of safety. The other is the ability of the individual to voice their narrative about what happened to him or her. And the third is the return to a supportive community. Is that -- is that correct?

A. I don't disagree with her on that. We -- that matches many things sort of my colleagues and I have studied as well about social support and its relationship to PTSD.

But, yes. In fact, that was one of the dilemmas when the war in Iraq started because at the -- at the VA, we had folks who were reservists who deployed but then came back to the VA knowing that they might deploy again.

So unlike treating veterans from the Vietnam War, therapists

were confronted with a new reality. The person they were treating may be going back into battle in the future so that they couldn't say they were now, from now out and forward in a perpetually safe space. They were going to have to go forward.

But the points that -- that you mentioned are considered relevant. We believe that a person has to genuinely understand that they are safe from harm because it takes a while to trust. Like, there's deficits in trust.

And there has to be consistency for them to be able -- when we say to growth, the post-traumatic growth, it's a term we use for people trying to get beyond what happened to them, to get meaning in life.

Now what do I believe about the world and myself and other people? Which is very difficult for some people. And so having a support community around them that helps boost that is thought to contribute greatly to their ability to, as you might say, kind of move on from something terrible without -- without forgetting it. They never forget it.

People may reframe how they view it. So someone may reframe and say I actually wasn't responsible for being raped or I wasn't actually able to save my team member from getting killed when the RPG comes through the Humvee, right?

So people often blame themselves. They're just searching

for any way of explaining why something terrible has happened. And so part of therapy is helping people get some distance from that and reframe it. But they do have to believe over time that they are genuinely safe and that takes a very long time.

Q. Okay. And in the -- and I take it you -- you had referred earlier today, I believe it was -- you may have also touched on it yesterday -- to situations of spouses -- and I understand this could work for both men and women -- spouses who are still living with people who are very abusive to them; is that correct?

A. Yes.

Q. Okay.

A. It's a -- yes.

Q. Okay. And so you have -- you -- is it correct that you have worked with patients or individuals who themselves are the objects or victims of prolonged coercive control by someone else?

A. I have. And usually after -- or when I worked with them, I also then would refer them to our women's clinic at the VA at the time for working with women who were still living with spouses who were abusive.

One of the really significant dilemmas is, you know, is what to do because it's easy to tell a woman you should leave them and it's not possible. Functionally, it's not possible for every woman who's abused by her husband or -- to just get up and leave. They

have the children to take care of or to protect. They still may love the person even though they know the person is abusive.

They behave in such a way -- that's where the clinical term came out of that they -- it's called conditioned defeat. That's -- so learned helplessness when I was talking about it the other day is really an animal model. It's a term we use to describe what nonhuman animals finally do. They give up. They don't seem to be able to make their situation better.

In working with people, perhaps the more appropriate term, it's as if people with PTSD who have been traumatized have now been conditioned to defeat.

And work with abused women can often appear like they're self-defeating. They're staying with someone who keeps abusing them. And therapists really struggle with how do you empower them? How do you get them beyond that point in order to become free?

But their position is often that they can't do anything to change their situation. And that's why truly having them in an environment and a social group that is supportive finally gives people the ability to break free from that view that there's nothing they can do and that they can survive if they're out of that abusive relationship.

Q. And I apologize if this sounds like an obvious question, but can you tell us, then, how it affects the ability to provide

effective therapy in freeing them of -- or ameliorating the effects of their trauma so long as they remain in this unsafe environment?

A. It's very difficult. The focus in therapy at that point is usually trying to help mitigate evoking a violent response from the spouse, beginning to identify the early warning cues. Maybe it's time to leave the house early or the kinds of things to do that may not exacerbate the -- the situation.

But it's very complicated because as a therapist, you're often working with -- you're working with an adult, and only they can make the decision to take those steps. But that's usually where the focus of therapy is. They have someone they can talk to, they can confide in.

And in -- and like with what Judy Herman talks about, they have someone who acknowledges the trauma that they experienced. There's another human being who can say to them: You're right. This is not you. This is -- this is -- the terrible things that are being done to you are because someone else is not -- they're not behaving appropriately.

And lots of victims need that acknowledgment, that -- that what is being done to them is terrible, because very often they want to take the blame for it.

So some women will say, well, you know, I flirted with somebody and they got jealous, right? And that somehow they think

that justifies -- they'll make it work, they'll twist their reasoning around to say, well, I did make him angry.

So part of the therapy is about that, helping people recognize the distortion in their thoughts and their reasoning. That happens because they are traumatized.

So lots of people only think of PTSD as having these conditioned fear responses that are like startle and anxiety. The emotion and thinking circuits are conditioned responses, too.

People get in these loops and their reasoning is affected by being traumatized. This is why they make similar mistakes. A woman may leave the abusive spouse and go find a new one and then suddenly say: I don't know how I did it, but I'm now dating another man who beats me.

And therapists maybe 25, 30 years ago used to say, well, then, this is a real learning problem. If you were Freudian, you'd say, well, this is -- this is the death wish. I've already talked about that. We don't accept that.

Other people said, well, maybe trauma makes people stupid. They can't figure stuff out and how to protect themselves.

We don't think it's that either. We think it's the very distortion of a human's ability to bond with another person. When someone's being abused or tortured, it's very common for them -- they become attached to the source of their torment.

In the past, people have referred to this as Stockholm syndrome, things. But our fear and alarm systems when we're being attacked also activate our attachment and bonding systems in the brain. They're very close to one another. One activates the other. And it produces a strange attachment to the very people who control and abuse you.

So the women are not stupid. They're not dumb. They're not trying to rework a prior experience. They are simply emotionally familiar with the situation and where violence and love are combined.

And it's -- the therapy consists of working to the point where they can be happy in what they'll sometimes refer to as a boring relationship. There's no fireworks for a while. But it takes a very long, very long time.

Q. Okay. And as -- and contrasted with that situation, if someone -- and I obviously have in mind -- and, by the way, I don't know that I mentioned it to you, I'm one of the attorneys for Mr. Mohammad.

But if a -- if a detainee is in custody of one of the rendition sites and he does not have access to a therapist, someone who can kind of model back to him what he's going through and help him try to think it through, can you tell us what the likely clinical medical impact is on his ability to recover or make gains from his trauma?

A. Writ large, the -- there -- there's a limited -- there's a limited way people respond if they can't find a social or support group.

So POW -- from our American POW experiences and the experiences from other POWs, which is part of the SERE curriculum, we've learned that communicating with other detained individuals is beneficial for the person. They can get some social contact, and that reduces stress to a certain degree.

I -- I did measure that at SERE school. When people were in isolation and we'd either have the guards leave the -- leave the slot open or close it. If the slot was open and they could make eye contact with another student, their stress hormone, cortisol was significantly lower than when the doors were closed and they were in isolation.

It did vary between the extroverts and the introverts. So the isolation stress was not as stressful to the person who's fine when other people leave the room, so to speak, versus the extrovert who needs the -- the interaction, the isolation stress was much more significantly seen in the rise in cortisol in those.

So we think that when people are detained, they have a chance to improve psychologically if they can talk to someone. Now, that might be another detained person because there's still someone else who might acknowledge that they have feelings and that their

perception isn't warped and who actually gives them the opportunity to be respected for being an individual who has their own thoughts.

And it does give some people a chance. There are -- there are, you know, individuals we know from looking at the stories of people who have been detained for years in China and they come back out and they go back to protesting. So there are some humans who seem to be able to do something well on their own without contact with other people.

And I think in the field of stress resilience, many of my colleagues are interested in that. Why can some people do that? The majority of people need some sort of social support or recognition from another human because we are a social -- we're a social animal.

But -- so there is a variability. But in general, we think having support is better, having consistent support or at least support that's predictable. If it occurs irregularly, it becomes unpredictable and slightly uncontrollable. But something on a predictable schedule lets the person anticipate when, how, and where to begin disclosing to a person and starting to try to trust them.

Q. Okay. And then in terms of the sort of self-help ability to ameliorate impacts of earlier trauma suffered in the rendition sites, if an individual is prohibited from having any communication with other detainees and is limited to what they call transactional exchanges with guards whose faces are covered, how would that affect

the likelihood of ameliorating the effects ----

A. Oh, yeah.

Q. ---- of the stress as suffered by ----

A. It has a very -- it's -- it's negative. That's why we put limitations on how long people can be in isolation in our own prisons.

We know that isolation stress is very detrimental to the way people can think and feel and produces symptoms of anxiety, despair, depression. It disorganizes the ability -- people's ability to think straight.

If people have a hard -- sometimes people have a hard time understanding that, but that's -- that's a fact. Our brains are organized by interaction with the world.

You may recall, there's -- there was a large report that came out during the pandemic on dementia and hearing aids, and they said the most preventable thing you can do for dementia is, if you have hard of hearing, wear your hearing aids. Because in the very large study, people who didn't wear their hearing aids demented faster. And that's because organized information helps organize our brain and preserves cognitive functioning more than disorganized information.

That was sort of a -- sort of a real-world study that maps onto why does uncontrollable stress of noise or sensory deprivation

disorganize people's thinking? Our brain is a dynamic organ that needs input in order to stay organized.

So when people are in isolation, it is not good. It's not good for organizing thoughts and feelings and regulating emotions, and it's -- it's really -- we know it's detrimental. That's why we put limits on it.

Q. And you mentioned a few moments ago alluding to some of the other symptomatology of traumatic stress and PTSD to include hypervigilance and startle reaction.

I wanted to ask you, in connection with hypervigilance, if there's also the observation of traumatized patients with what's called scanning their environment.

A. Yes. We don't usually use the term "scanning" as the medical terminology, but that's exactly what's going on. Hypervigilance is a term that refers to a set of behaviors linked to the attitude that you never know something bad might happen.

So it's -- it's seen very commonly when a person will always sit so they can see the doors. In fact, we train security personnel to do that, so it's kind of reflexic for them.

But a person who may never have been trained to do that, they'll report I always sit at the back of the room with my back to -- if they go to a theater, say I want to sit at the back so I can see everything and know what everybody's movement is.

They find it very alarming to be walking in a mall because they can't keep track of where everybody is and they'll report that makes them more anxious, although they don't have a specific threat on their mind.

Other veterans I've worked with, they would do patrol at night on their house, going back and checking and rechecking the windows, walking the perimeter, going back in the house, then going back out. And they'll say, "I know it's crazy. I know I don't have to do it, but I have to do it," and they do.

So it's this -- it's this persistent -- it's like paranoia. It's -- and some veterans with PTSD actually become outright paranoid. They actually come up with a whole chain of thoughts and have a delusion about it, but most people do not. But it's -- it's the paranoia that -- that trauma will happen again, and I need to be very vigilant to make sure that it does not.

And then it is usually linked to the irritability, because when they can't do that, they can become a little short with people they love because -- and you may not understand why they get irritable. But in some way it's usually thwarted their ability to scan and recheck and make sure that they're safe.

Q. And when you say the fear that -- the fear that trauma will happen again, that's the -- you're referring to the thing that happened the first time, whether it's some kind of personal assault

or a friend being injured or whatever happened in combat, that particular event will -- will reoccur?

A. Yes. At core for post-traumatic stress disorder, the fear is a traumatic event happening again or something like that traumatic event.

If someone has instead panic disorder, their fear is having another panic attack. If it's social phobia, their fear is being up in front of other people and being thought of critically. If it's a specific phobia like spiders, their fear is of a spider.

But in PTSD, the scanning and the vigilance is about trying to ensure that that event or something like that will not happen again.

Q. And for -- for individuals who are in a prolonged coercive environment where they are the object of, let's say, physical abuse, maybe even sexual assault repeatedly, by an abuser, is it -- is it correct that the -- their concern for the trauma happening again is -- is experiential or fact-based?

A. Yes.

Q. Okay.

A. The -- sometimes you may not detect it quickly if people have also -- they become more depressed or withdrawn in the avoidance cluster of PTSD. They may adopt a rather helpless point of view about it.

But it -- when we interview people and talk about it, the fear is there, the scanning is there. But they may have concluded nothing I can do will stop it from happening again and become resigned to it, but the symptom is there.

Q. And are there also -- does -- do the array of reactions also include individuals who try to watch for or anticipate clues that something is about to happen and -- and perhaps defuse it?

A. I'm not sure of the context, but ----

Q. Oh, I'm sorry.

A. So I can ----

Q. Let's say that -- let's say that the -- an abusive cohabitant ----

A. Yeah.

Q. ---- of the house and the other person is given -- I take it they're not physically -- necessarily physically ----

A. No.

Q. ---- abusive 24/7, but there may be patterns to the abuse?

A. Oh, yeah, there's quite a bit of literature on -- with children in the house, if they've been abused, they become enormously alert to the cues that give them a hint when will the abusive parent come after them, when they won't. The abused spouse becomes very alert. It's like walking on eggshells, paying attention to any cue.

And part of that's normal. We -- it's not normal to go

hoping something bad will happen to you. And so the -- you know, a normal human being starts to go, "How can I figure this out?"

And traumatized victims do that as well. Some of the times they miss the cues, which is actually the focus of research as well. But, yes, they start paying attention to anything that might.

And I referred earlier to the generalization or the overgeneralization. Our brains truly function as it's close enough to a signal that something bad will happen. It doesn't have to be the signal, which is based on that principle of I really don't have to get as close to danger to really verify it was the exact same thing as before, because if I did, it would be maladaptive.

So -- but we're not the only animal that behaves that way, that appraises something in a split second and says it's not good, and makes an instant -- we actually make that decision in about 300 milliseconds. When we see something new, our brain decides do I know it or not? And is it a threat or not? And that happens within -- it's less than a half a second.

Q. And then is there a -- and again, forgive my liberal arts background. But is there sort of an interconnection between that sort of dynamic you're describing and an individual's ability to learn what you called safety signals?

A. There is. It's -- it's a little complicated. I guess what it would be is if a person -- a person who is learning to trust

you, say you're working with someone who may be really working hard to try and trust and believe, you may find at some moment you may say or do something, and they may flare-up and get angry and then say, "Aha, I knew you weren't working for me. I knew you were working with them and you're out to do me harm." And it will appear to you to suddenly come out of nowhere because you're thinking I didn't -- I didn't do anything.

In the mind of the person who's been traumatized, the brain is constantly scanning for any evidence that will support the belief that they firmly have is that I'm going to be harmed again, while they're constantly trying to hope that they won't be. But one doesn't make the other go away.

We were talking about extinction earlier, and it -- so that it's not a misconception, fear conditioning is for life. And the degree to which people function is the degree to which they can finally learn to trust and inhibit the expression of that fear conditioning. So people can hide some of their fear-conditioned responses for a little while, but they are not gone.

And there was something on one of the charts I saw drawn on the Ritz napkin where it was, would fear conditioning come back if they were re-exposed? The answer is definitely yes.

What we know from nonhuman animal experiments and from humans is the same. If an animal has been classically conditioned to

be afraid of something and then we try and teach it for a very long time that it's no longer needed to be afraid and we see the extinction, it only takes one exposure to that very bad thing to get the fully -- the fully trained classical conditioned response, which means the memory never vanished.

If it took the same number of trials to teach the animal the same thing about this bad stimulus, then we'd say, oh, then they -- what extinction means is the memory went away.

But we know it doesn't because it might take 40 trials to train the animal to be terrified to be that -- to that little light and then give them 120 or '30 trials where the light isn't paired with shock, and they finally stop jumping. And you give them one shock and they're startled and their physiology will all go back to its height from when they were originally traumatized.

So that's why we say it's the safety learning, safety signaling and learning is what keeps a cap on it. And they can look very normal and trusting for a while, but what's parallel and actively going on at the same time is complete distrust and a fear that something horrible is going to happen again.

Q. Okay. And I'll represent to you that when Dr. Mitchell testified before this commission, he acknowledged that the purpose of his and Dr. Jessen's program was to condition our clients, the detainees in this case, to speak to anyone who came into a room who

appeared to be what they called a debriefer.

And if I may just educate you for a ----

A. Okay.

Q. Take this as a -- as the facts upon which I want to ask your opinion.

A. Okay.

Q. He distinguished between interrogators and debriefers. And interrogators were people who asked questions and tried to get the detainees to talk. And if they wouldn't, they would be subjected to the EITs, things which we regard as torture, but they regard it as EITs.

And then after a certain period on the chart -- in fact, if I can ----

LDC [MR. SOWARDS]: This is, Your Honor, the Appellate Exhibit 628KKKKKKKK. 628 and then followed by one, two, three, four, five, six, seven, eight Ks (Gov). And this is marked as page 101, and it's MEA-PRG-00001169.

MJ [Col McCALL]: All right.

LDC [MR. SOWARDS]: Okay. I believe this was -- this was approved for display to the gallery.

MJ [Col McCALL]: All right. Go ahead.

LDC [MR. SOWARDS]: No? Maybe not.

MJ [Col McCALL]: Oh.

LDC [MR. SOWARDS]: I thought we had it earlier for the gallery.

MJ [Col McCALL]: It can be displayed to the gallery.

Q. So during the -- as I understood it, during the period of the red portion of the chart to the far left, that was approximately -- he numbered 25 days -- actually, for Mr. Mohammad it was closer to a month -- but in the classical conditioning of subjection to the EITs unless the defendants would talk to him. And then there was a evaluation of whether they appeared to be evasive or not. But the main thing was talk to us or it's EITs.

A. Okay.

Q. And then this other period here that lasts for 1,258 days, which I approximate to be approximately 3.4 years, is what he called the operant conditioning. And during that period, the message was to them: The interrogation portion is over. We're now going to have you speak with debriefers. And as long as you speak to the debriefers, we don't go back to the hard times.

A. Yes.

Q. You with me?

So I'm just asking your -- your understanding of the effect of that on even during the 1,258 days to activate the fear of what occurred to them during this red-line period of EIT and interrogation.

A. The principle of the program, as written out by Drs. Jessen and Mitchell, was that that is the -- that's the foundation that things are derived from. So the fear-conditioning phase means that we're going to have at bedrock the constellation of fear-conditioned memories. That becomes the foundation for the house, if you will.

We'll use a house as a metaphor. It's not going away. It just means that whatever you do in the -- in the living room upstairs, the basement is still EIT. And it is the foundation that supports everything else that goes on with the house.

So I don't know if this is truly what happened or if this is what Dr. Mitchell drew and says he did. It's hard to understand for me. But I know that what we know from behavioral science on it, fear conditioning is for life. It's not going away. In the way he describes the purpose of his program, it's so that later you can shape people's behavior and put them under your control.

This isn't -- this isn't operant conditioning to train someone to be a freethinker in the outside world. This is training someone to become a compliant and useful person within the -- within the confinement.

And the -- the what lurks in the basement all the time, in their mind -- it doesn't even matter if there's nothing in the basement anymore. In their mind, the fear conditioning is present

forever.

And the challenge is, then, how do you use that? So the little hints of we could go back to what we had before.

But it doesn't matter what's in the mind of the interrogator. With trauma, it matters what's in the mind of the person to whom its being done.

The interrogator -- and I know that Drs. Jessen and Mitchell described this. I don't know if it's in the discovery here or not, but there was -- I had read something when we were at the National Science Foundation that if someone held a fake gun to someone's head and was going to shoot them, it couldn't be traumatic because the gun wasn't real.

And that's just crazy. It's ascientific. It makes no sense. Because if the person believes the gun is real, it is traumatic. It doesn't matter if that gun can't fire. In their mind, they believe they could die at any moment. That makes it a traumatic event.

It does not matter what the interrogator's thinking at all, and it makes no difference, and then it developing into PTSD.

So the interrogator could say they were never really threatened. Nothing bad would happen. Those people can be damaged. They can be harmed for life even if the gun isn't real.

So I think where the -- a number of us in our psych

community who know Drs. Jessen and Mitchell were strongly -- we strongly disagreed with them. And we said -- this -- you can't do this. It -- this has the potential to significantly harm people.

They decided to do whatever they did. But it's -- it's ascientific. This is -- if they're telling people we let people get better because we treated them nicely for a long time, A, that's not therapy; and, B, that doesn't mean the conditioned fear -- the trauma -- it doesn't make the trauma go away.

So I think consistent with their model, as they've written it out in their papers, this is exactly what they were trying to do. You have a firm basis that you can -- you can go back to anytime. It would only take one exposure to the EITs to your client to bring back the full -- fully conditioned fear response.

I doubt that anybody's client is any different than when we have mice in the lab and they all look fine. You give them one more shock and it all goes back. It would take them back in a minute. The memories are all still there, which means that when they're interacting in an interview, that is in their mind. They know they're not free. They still know they are detained. So it's the illusion of free choice.

And that's why in my declaration I said that I think they have a manipulated mind. Their choices -- somebody set the choices in front of them, and fear is at the rock-bottom basis of any

decision that they make.

Q. And if during this period, the 1,258 days -- you had mentioned earlier that ----

A. Yeah.

Q. ---- part of this conditioning spares Drs. Mitchell and Jessen or anyone from doing the hard work of the red-line zone.

But if during this 1,258 days Drs. Mitchell and/or Jessen dropped in occasionally on one of -- it happened with Mr. Mohammad -- but anyway, with any of the detainees and said, in effect, "Hey, we hear you're kind of having some backsliding, difficulty cooperating and talking to the debriefers. You know, we wouldn't want to have to go back to the black sites."

Can you tell us what likely effect that would have on -- on the -- on the fear conditioning?

A. It's a realistic threat. They know they could deliver on it. They've had the experience before. In their mind, there wouldn't be any reason to believe that it wasn't a real threat.

And if they came in and if they said that, they would know that was the intended effect or they wouldn't say it, based on what they've written.

When I say they made their work easy, it did, right? You can now control someone with a word rather than maybe hours of -- of beating them. And that's the co-opting and manipulating of another

human being's mind.

Q. And then if -- if there were something of a -- some kind of a hiatus, let's say the folks who were the -- what they called the debriefers, not Mitchell and Jessen, stopped talking with -- I'll use Mr. Mohammad as an example -- stopped visiting him. And then approximately four months later some people came into a room, he was manacled to the floor, set up behind an interview table, three people came in and sat down and said, "We want to talk to you." And he said, "I am a slave."

Would that be consistent with him still having the influence of the fear conditioning working on him?

A. It might be. I -- I would probably have to ask him what he meant by saying "I'm a slave." But it's certainly a possibility.

If he felt I am a slave to do anything you ask me or I'm under your control, that would be consistent with what I've been describing, yes.

Q. Okay. And if he also referred to the torture he had experienced and showed scars on his wrists and indicated them on his ankles, would that be an indication that he is still feeling the influence of what happened to him in the black sites?

A. I don't know. For me, a couple of possibilities if -- when you mention it go through my head. It could be these are the things that can remind both me and you it was real. So is it

kind of like an -- a verification marker that I have been injured and somewhere I've been through that.

So I don't know what it -- I don't know definitely what it would mean. It -- it could mean that. But it -- definitely they serve as a reminder, the scars, at -- and we know this from working with other traumatized people. When they've been injured either during combat or a rape, their own scars can become cues.

I directly treated a woman whose trauma was a violent attack, rape, and a miscarriage. And after that, when she had her menstrual periods, that was a traumatic event. She would -- so, just menstruation in itself. So she asked for a hysterectomy. And she still said even after that, cyclical sort of hormone changes were -- they could evoke symptoms of PTSD.

So a person's scars can be a reminder. It can be what someone else said. They have been paired to events that were traumatic.

Q. Okay. And then the last thing I want to ask you with -- with respect to the charts that were shown you earlier. Showing you Exhibit 628 -- my goodness. It looks like also MMMMMMMM, as in Mike -- my count's off -- page 1 of 2.

MJ [Col McCALL]: And if you want to turn that to -- if you rotate it, Mr. Sowards.

LDC [MR. SOWARDS]: No, I just want to first orient the

witness to the fact that this is ----

Q. It's actually not unclassified Ritz-Carlton stationery, but it is Ritz-Carlton stationery that's since been unclassified. And that it has some of the -- I guess the parameters of the study or what -- what are going to be questions that are going to be answered by Dr. Jessen.

And then you have the other page that you discussed with Ms. Pradhan earlier today.

And I'll represent to you that Dr. Mitchell testified that these charts and this explanation that he's come up with is information that he compiled and data that he was trying to recall from approximately, I guess most recently, 18 years ago before he testified. And that what he did, essentially from memory, was to jot out these -- these dates and times and course of their -- the -- the -- the detainees' treatment and then try to pair that with the results of some published scientific articles that talked about fear extinction in laboratory animals over a period of 72 hours.

And I was just wondering in terms of protocols for what you understand to be reliable scientific studies, would this be consistent with any sort of peer-reviewed article that -- that you have seen in terms of the methodology of trying to ----

TC [MR. GROHARING]: Objection, Your Honor. Misstates the

evidence.

MJ [Col McCALL]: Objection overruled.

A. I think, as I said before, it -- it is a challenge to figure out what Dr. Mitchell's really trying to say here. Is it his -- I don't know if it's his -- his thought about what he did ideally or what he believes actually happened, but there are elements that just are not scientifically accurate.

If I draw -- will this draw a line if I draw on the screen?

This curve here about fear conditioning and extinction, right there, as drawn in the green line, would represent what you'd find in an experiment early on with mice where we condition them to something and then no longer expose them to the stimulus, and we watch fear extinction occur.

It might not be traumatic stress. It might be associative stress. It might be related to food. It could be where they went in the maze. But we would see this decline.

This is the part that is not true as well. It says if they were re-exposed to something, it would be unlikely to see the behavior again.

We know for a fact that is not true from hundreds of conditioning and extinction experiments. The memory is always there. And we re-expose the mouse to the aversive cue, the fear conditioning comes back. There's -- there's -- there are just so many articles

from Joe LeDoux or Dr. Mike Davis who preceded me. Mike Davis was at Yale. I learned from him. Anyone who doesn't think -- anyone who thinks this, in my view, has not -- is not familiar with the science of behavioral conditioning.

Because thinking that it's unlikely -- it says hypothetical, but unlikely. That's just wrong. So it's hard to know how to respond to what his -- the rest of his thinking is. This is not true scientifically.

We know for sure if we've done fear conditioning, a re-exposure to the stimulus will re-evoke the response with even fewer learning trials. So it's not unlikely; it's likely.

That said, the other part that I find untrue with respect to the literature on PTSD, he seems to portray that after exposure to traumatic events -- and the EITs are traumatic events. He may not think so, but the general consensus in the world of psychiatry would say those are traumatic events, because people have died. People were physically injured. There was a true threat to them. Those are traumatic events.

We do not see this kind of a curve over the clinical cycle in people with PTSD with respect to their reactivity to trauma cues. They don't go away.

In studies where we've done flooding that was talked about earlier today, exposing stimuli, we have been able to reduce the

expression of their symptoms, but there's no cure. The memories are still there. The fear-conditioned responding is still there.

So what is -- this -- this graph, while it may represent low-stress experimental findings in people who are doing classical conditioning, it's true. It is not true about traumatic stress events and fear-conditioned events.

So I think it's just -- it was just misleading. And I can't say why -- why he doesn't know those scientific facts. I mean, they're -- they're just generally known. This is what we teach medical students in the first year, second year of medical school. People learn this kind of a theory in college. So I -- yeah, I don't know.

MJ [Col McCALL]: And, Mr. Sowards, the diagram that Dr. Morgan highlighted a couple of points, that's going to be 630CCCCC. And we've already accomplished the screen capture on that.

LDC [MR. SOWARDS]: Okay.

WIT: All right.

LDC [MR. SOWARDS]: And those are, Your Honor, all the questions I have.

MJ [Col McCALL]: All right. Thank you, Mr. Sowards.

All right. Do any of the other defense teams desire to question this witness?

Apparently not.

All right. We've been going for a while. But, Mr. Groharing, are you ready to cross-examine this witness?

TC [MR. GROHARING]: Yes, Your Honor. We'll defer to the court, but we can certainly start tonight. I don't imagine we're going to finish today, but I'm happy to start.

MJ [Col McCALL]: Okay. Got it.

Let's take a 15-minute recess.

[The witness withdrew from the courtroom.]

MJ [Col McCALL]: Commission's in recess.

[The R.M.C. 803 session recessed at 1523, 07 May 2024.]

[The R.M.C. 803 session was called to order at 1538, 07 May 2024.]

MJ [Col McCALL]: If we bring the witness back in here. Hold on.

Mr. Connell?

LDC [MR. CONNELL]: I had one quick thing, Your Honor. Right after lunch I had mentioned that we had located two of the replication studies and one of the Sudanese studies. I wanted to let counsel know that we're e-mailing those out essentially right now in production to the government, the actual studies, and we'll catch that up with the notice of discovery.

Obviously, Mr. Groharing won't have the opportunity to review that, but I think there will be time before tomorrow in case they change anything.

MJ [Col McCALL]: That makes sense.

LDC [MR. CONNELL]: Thank you.

MJ [Col McCALL]: Dr. Morgan, have a seat.

[The witness, Dr. Charles Alexander Morgan III, resumed the witness stand.]

MJ [Col McCALL]: All right. I can see you on the screen, Mr. Groharing. Are you able to see the witness?

TC [MR. GROHARING]: I can see the witness but not you, Your Honor.

MJ [Col McCALL]: Okay. Yeah, I think typically you'll just see the witness and you'll just hear my voice.

All right. Over to you.

TC [MR. GROHARING]: Thank you, Your Honor.

CROSS-EXAMINATION

Questions by the Trial Counsel [MR. GROHARING]:

Q. Good afternoon, Doctor. My name is Jeff Groharing. I'm one of the prosecutors for the United States.

A. Good afternoon.

Q. Sir, I want to ask you about just some of your background and how you came to be involved in this case to start.

You provided a declaration in 2016, and I believe that was in support of a request to appoint you as an expert consultant. Is that your recollection?

A. That's my recollection, yes.

Q. And when that -- that's what was previously provided to the court as AE 425NN. Have you had a chance to review that first declaration in advance of your testimony today?

A. Are you referring to -- I -- you'd have to show me to remind me which document.

Q. Okay. It's the first declaration you provided in 2016 about what you testified.

A. Oh, okay. Now I know what you're referring to.

Q. Okay. I'm only going to ask you about two declarations.

A. All right. Oh, I didn't know if you were asking me about a -- asking me to be considered as a witness back in 2016. That I -- yeah.

Q. My understanding, you were -- you were -- the purpose of that was to get you appointed as a consultant at that point.

A. That was my understanding.

Q. Okay.

A. There were some delays, so I didn't know if -- I don't remember what's on that.

Q. All right. And that request was ultimately approved, obviously.

A. Yes.

Q. And you became a member of the Ali defense team once that

was approved?

A. That's my understanding, yes.

Q. Okay. And you've been with the Ali defense team since then?

A. Yes. As a psychiatrist, I'd word it slightly differently. I am a consultant retained by the defense team.

Q. Okay.

A. But I'm not privy to what goes on on the defense team other than what they ask their independent ----

Q. Right.

A. ---- expert to do, so...

Q. Yeah. You've been working with them since -- beginning in 2016 up until now. Okay to say?

A. Yes.

Q. Okay. Have you been approved as a consultant with any other defense teams at the Office of the Chief Defense Counsel?

A. There was a request for a case but I don't -- I don't know where that went. I don't know if -- if they -- the case didn't go forward. And I don't ----

Q. Okay.

A. I don't recall the name of the case.

Q. Okay. And I don't want to get into anything that might be privileged.

A. Yeah.

Q. Just generally speaking, I wondered if you had been approved. It sounds like that's not the case.

ADC [MS. PRADHAN]: Excuse me, Your Honor.

MJ [Col McCALL]: Ms. Pradhan?

ADC [MS. PRADHAN]: May I just ask Mr. Groharing to please stop talking over the witness?

MJ [Col McCALL]: So far I'm not having trouble understanding both of them, so I think they're just trying to communicate. It's a little more difficult from the RHR sometimes.

But go ahead, Mr. Groharing.

TC [MR. GROHARING]: Thank you, Your Honor.

Q. Doctor, you didn't prepare an expert report in this case. You provided a couple declarations but not an expert report. Is that -- is it normally your practice to provide an expert report?

A. You have vanished from my -- oh, you're over here. I think I can see you on this screen.

It depends what the -- it depends what the retaining attorneys request. I've been in cases where I've been asked to evaluate someone and then they did not want an expert report. I've been in cases where I evaluated people and they wanted a report. I've consulted in cases where it was more like litigation consultation.

Q. Okay.

A. In this particular case, I was asked to make a declaration. So -- but in forensic psychiatry, that's what we do. If you retain me, I am able to tell you whether I can or cannot provide what you are requesting.

Q. Okay. And then counsel decide what format that takes and how it's provided to the court or to the other party, whichever is appropriate?

A. Yes.

Q. What is the American Board of Psychiatry and Neurology?

A. The American Board of Psychiatry and Neurology is our -- our accreditation, the highest accreditation board. If -- if you have trained in any specialty, there is a board for that specialty that can verify that this individual who's passed the board is in that top 5 percent in that profession.

So it's -- it's something where when someone gets their medical degree and then gets their residency specialization, whether it's child psychiatry or whether it's gastroenterology or internal medicine, they may choose or not choose to take the national board -- the board exam ----

Q. Okay.

A. ---- for their specialty. Since I was at Yale, sort of the expectation is our faculty should be board certified, and that's

the certification board.

Q. And the -- their website reflects you as retired. When did you retire?

A. No, I'm not retired. There is another Charles Morgan you're probably confusing me with. There was another Charles A. Morgan at Yale. He is -- he is from the Caribbean. We do not look alike and he has retired.

Q. It's an -- just one second.

TC [MR. GROHARING]: Court's indulgence, Your Honor?

MJ [Col McCALL]: Sure.

[Pause.]

TC [MR. GROHARING]: May I have the display from Table 2, Your Honor?

MJ [Col McCALL]: Sure. Give it a second. It sometimes takes a moment for it to come up down here.

WIT: Oh.

MJ [Col McCALL]: So it's not showing down here yet. Give it a minute.

There. Okay.

A. I do recognize that. That was from -- I don't know if that's the CVS Pharmacy system. They believed that I was retired. My license is fully active and I am still a practicing physician.

In their system, they haven't been able to correct that.

That's in their internal system. They've confused me with the other Dr. Morgan. And we're trying to figure that out because my patients can't fill their prescriptions in their pharmaceutical system.

But my license is active. If you need copies, I can give them to you.

Q. Okay.

A. But I can assure you, I'm not retired.

Q. Okay. Understood.

A. I might retire in a few years, but not yet.

Q. Well, they're ready for you, so, on the website at least.

A. It looks like it, yeah.

Q. Have you ever been subject to any investigations?

A. No.

Q. Your CV indicates that you specialize in forensic psychiatry.

A. Yes. That indicates ----

Q. Is that true?

A. Yeah, the focus of my work.

Q. And that's a subspecialty of psychiatry, right?

A. It is.

Q. And have you ever attempted to become board certified in forensic psychiatry?

A. No, I have not.

Q. And that's something that -- an advanced certification, not unlike the -- the certification you talked about before, kind of the basic psychiatry certification, right?

A. That's correct.

Q. And you've not attempted that -- that certification?

A. No. I was deploying at the time with my Reserve unit when the opportunity was coming around after I had finished the psychiatry forensic fellowship. But then I moved back into the clinic, and then I had Reserve duties at the time.

And it -- the timing wasn't right. And I don't need to be double boarded. So I can spend the $3500 if I wish, but I don't, and it's -- it's not necessary in my field.

Q. And it's fair to say that that's a higher standard, though, and many forensic psychiatrists do seek that certification?

A. Sure. They can.

Since I'm really an expert in traumatic stress disorders, it just didn't feel relevant. I took the fellowship because I was being asked to testify more and more, and the opportunity was available at Yale. But whether I'm board certified or not doesn't make any difference either in my reputation or my skill, so...

Q. In what year was that when -- when you elected not to take it the first time you were eligible?

A. Had to have been around either 2002 or '3, right around

the same time I was being interviewed by the CIA and being asked to do a number of other things.

Q. Okay. And that's something that you can do at any time, right?

A. You could. I could if I wanted, yes.

Q. And when you do get certified, you go back and get recertified from time to time?

A. That depends. Now for any graduate, they would be. They may go back every three to five years. But it depends what year you graduated, what year you got your boards.

The year that I graduated and got my American Board of Psychiatry and Neurology, we were all considered done. And I'm in the -- I'm in the cohort of doctors who do not take that board every five years.

Q. If you had consulted in this case with the government and mental health issues were presented that, you know, that you're talking about here today, would you have been expected to examine the defendant -- or the defendants that you testified about?

A. That would depend on the government, the government's attorney. If they asked me, I probably would have said be careful what you wish for. When I evaluate people, I may find something you don't want to know.

Q. Sure.

A. I tell every attorney that. But -- so some attorneys ask me to evaluate their clients and -- and others say no, we'd rather let you look at information, so...

Q. Okay.

A. I would -- I would -- I would -- that would be a conversation if you retained me that I would have with you and say as a -- as a forensic psychiatrist, my ethical obligation is to be neutral or helpful to your case but not harmful. And if I felt what I was doing would be harmful to your case, I would recuse myself from your case. That's -- that's in our ethical guidelines.

Q. And in some cases, regardless of whether you're on the prosecution side or on the defense side, you could opine that maybe it's not in either side's best interest to conduct an interview because you're worried about what that might disclose?

A. No. That's ----

Q. Is that ----

A. ---- that's not the role I have.

If I'm retained, my relationship -- if you retain me, my communications would be with you related to the questions that you had. And that would depend on what consultation from me you wanted.

If you put an array of options in front of me, I could advise you based on what I knew at the time how I might be best -- best of use to your case, but that would really -- it would

be your judgment call.

Q. Okay. Are there professional ethical guidelines that impact the methodology of your forensic psychiatry evaluations?

A. We have a -- we have a guideline -- ethical guidelines in forensic psychiatry, yes.

Q. All right. And what are those?

A. Oh ----

Q. Where are those found?

A. You can find those online. There are -- there are quite a number divided out into different sections about how we conduct business, relationships with patients, who is the client when we're doing forensic evaluations. So you can find a document online through the APA.

Q. And you -- the APA?

A. Yeah, the American Psychiatric Association. And then you can look for forensic psychiatry and you can see both ethical guidelines. One set of guidelines just extends from the other.

The -- the extensions in forensic psychiatry, where we differ from regular psychiatry, is that we recognize we cannot play a dual role. For example, I cannot be a material witness, a therapist, and an expert witness -- and an expert witness for that person at the same time ----

Q. Sure.

A. ---- because being an expert witness for someone I've treated would make me biased. Because my primary concern would be my relationship with the patient to preserve a therapeutic alliance, and I might have to testify something -- to something that they didn't wish to hear. Whereas, as an expert, my role is to give an opinion based on my assessment of the data.

So, for example, if I'm treating someone with PTSD and they happen to represent a case where they didn't quite have all the symptoms but I'm treating them for that condition, and they were to put in a claim for litigation, and if the VA -- if I was at the VA and the VA disability board wanted to report, I would have to report that they did not fully meet criteria for PTSD. Their claim might be denied, which has a significant impact on them if they're -- if they're not making the money that they were making or that they hoped to make.

So the ethical guidelines in forensics address those kinds of issues of conflict of interest, and then it addresses the other kinds of things like who the client is. Perhaps we can consult the government. And if I work for you, the person I evaluate is not my patient.

And then the ethical guidelines outline what are my responsibilities as a doctor. If I evaluate someone that you've had me evaluate and I think there's a need to have them hospitalized or I

think they need treatment, we delineate what are my responsibilities and are they different than if I was just in a hospital and saw them and thought they needed treatment, so ----

Q. Sure.

A. But, yeah, those are all available online.

Q. And are you familiar with the American Academy of Psychiatry and the Law?

A. Yes.

Q. AAPL, A-A-P-L?

A. Yes. Yes, very much so.

Q. And it's actually that organization that issues the ethical guidelines for forensic psychiatrists?

A. Yes, I work with them. I know them. I know Howard Zonana very well.

Q. Okay.

A. And Dr. Dike. I've presented at that conference, so yes.

Q. And you're familiar with those ethical guidelines?

A. I am.

Q. And one of those reads that: When psychiatrists function as experts within the legal process, they should adhere to the principle of honesty and strive for objectivity. Although they may be retained by one party to a civil or criminal matter, psychiatrists should adhere to these principles when conducting evaluations,

applying clinical data to legal criteria, and expressing opinions.

Are you familiar with that guideline?

A. Yes. I help teach people about that guideline.

What we're getting at there is that I -- it's not my job to help you win your case as a forensic psychiatrist. My job as a forensic psychiatrist is to tell you the kind of case you have based on my knowledge and my profession. And it's up to the attorney to do that.

Lots of attorneys want to hear an opinion from me that would be helpful to them, that's not my job at all. So that ethical guideline there is -- is the -- the ethical emphasis on being objective about the data that you have in front of you and reminding yourself that my job is to help educate a court or a jury or the attorney about the nature of the questions that have been put to me.

Q. Sure. And I think you hit on this.

The guidelines continue that: Being retained by one side in a civil or criminal matter exposes psychiatrists to the potential for unintended bias and the danger of distortion of their opinion.

Have you experienced that in your career?

A. Have -- have I -- are you asking me if I'm familiar with ----

Q. Have you ever had that happen?

A. ---- or have I been distorted?

Q. Have you seen that happen?

A. Not directly. It is something at conferences we do talk about. People have presented case examples. I've contributed to a book that was on ethical examples from one of the professors who was at the Naval Academy who wrote a book on that.

So it's a theme that we discuss with people. I have ----

Q. Sure.

A. Yeah. But my -- in my career, I believe I've been extremely objective and impartial. I -- it's really not my job to win anybody's case, and I don't feel any burden to do that.

Q. Okay. In the -- on page 3, the commentary states that: Psychiatrists practicing in a forensic role enhance the honesty and objectivity of their work by basing their forensic opinions, forensic reports, and forensic testimony on all available data.

They communicate the honesty of their work, efforts to attain objectivity, and the soundness of their clinical opinion by distinguishing, to the extent possible, between verified and unverified information, as well as among clinical facts, inferences, and impressions.

Do you agree with that prescription?

A. I think I already said that. I -- I agree with our ethical guidelines.

Q. Okay. So essentially that says you gather as much

information as possible before rendering an opinion. Is that a fair characterization?

A. Yes. The effort is to acquire as much information as possible given the question we've been asked.

Q. And ----

A. If I feel that more information is needed, I can ask for it. It may or may not be given to me. Attorneys will often compartment their information, as they don't want information introduced into court.

And I am well aware after years of doing this that I may not know what the attorney knows and they may not tell me. That -- I -- that's part of the -- that's part of that nexus between medicine and law. I am not privy to all the information that the attorney may have.

Q. Uh-huh. And if you have faulty data, you can end up with invalid opinions?

A. That's possible, yeah.

Q. If you're unable to access important data, that could likewise affect the validity of your opinion?

A. I would agree if the data were relevant to the questions that I was supposed to ask and if -- if those data were essential sort of in the psychiatric process of determining something, then I would agree with you. It's -- I like -- it -- it would be important

that data be accurate, yeah.

Q. And no matter how qualified you are or how much experience you have, if you don't have the relevant facts, you're unable to provide a very helpful opinion; is that fair?

A. I don't know about the latter. I just know that if I don't have -- if I don't have accurate facts, it is -- it is not possible to then incorporate accurate facts into my conclusions.

So if there's more data, I'm always happy to see it to see if it would help in rendering my opinion.

Q. Do you have any experience evaluating prisoners?

A. I do.

Q. Any training unique to dealing with al Qaeda terrorists detained by the United States?

A. I have not evaluated terrorists from al Qaeda, no.

Q. What training do you have in counterinterrogation techniques by enemy combatants?

A. That's not something we do in psychiatry. I am well familiar with the SERE curriculum which people thought was exported to al Qaeda, which was the basis of the argument that they needed to take the SERE techniques and train ----

Q. Right.

A. ---- them down here or for the EITs. That was the basis early on for the rationale behind it. But, no, I haven't

any -- haven't any training in counterterrorism with respect to that.

Q. Okay. And so you wouldn't know when -- you wouldn't know what to look for if trying to figure out if an al Qaeda terrorist was employing counterinterrogation techniques?

A. To the degree that they might be derived from the U.S. manual on it? Yes, I would. I actually wrote a paper. It's published. Its classified. Its on the high side. You can ask for it.

Q. Okay. And I don't want anything classified, but I ----

A. I'm just saying ----

Q. If you can just ----

MJ [Col McCALL]: I -- so ----

A. ---- I can answer the question but it is -- it is classified.

MJ [Col McCALL]: So if both the witness and counsel, we are now in a place where you're kind of starting to talk over each other. So, again, one of the problems of trying to question a witness when one person is in the courtroom and the other person is in the RHR is it gets a little easy to talk over each other.

WIT: All right.

MJ [Col McCALL]: So go ahead. What was your question, Mr. Groharing?

Q. If -- only if you can explain in an unclassified manner,

the -- further on the nature of this paper. If you can't, that's fine. That's something we can take up in closed. But if you can describe in an unclassified manner you're confident of that, please do so.

A. I am well aware of the resistance training techniques and what was thought that the enemy might be employing, which was the basis and rationale for sending SERE school cadre to participate in setting up things to evaluate people who were detained.

And I have extensively evaluated them and published on that. I published that while I was at the CIA.

Q. Okay. And when -- when did you ----

A. So ----

Q. I'm sorry. When did you write that paper?

A. That paper, when we -- had to be 2000 -- I was in the DI. I would say 2000 -- 2006, 2006 or '7 would be the likely time frame. Because -- I'm estimating it, but because it's published in the journal that's handled by the office I was in in DS&T, and I joined the DS&T by 2005. It -- I'm guessing it's in the 2005, '6, '7 range, but I think probably 2006 or '7.

Q. Okay. And then you provided a second declaration in January 2024, just this year.

A. Yes.

Q. And at the time of providing that, you were aware that

that declaration would be considered by the military commission, correct?

A. It was my understanding, yes.

Q. It was going to be offered for the military commission's consideration on issues pending before the military commission?

A. Yes. My understanding is that they would see it, yes.

Q. It was evidence, essentially. So it would be offered as evidence. Your opinions were offered to be considered by the military judge?

A. I leave that to the attorneys. I knew what I had to say would be presented. I have no control over whether it was entered as evidence and when it would be, so...

Q. Okay. But when drafting it and swearing to it, the point I'm trying to get at is that you knew when you were doing that that the judge would be considering it.

A. I knew ----

Q. You knew that it would be used for ----

A. Yeah. That was my assumption, yes.

Q. And potentially rely on that without the benefit of your testimony?

A. I didn't -- I don't know anything about that, no.

Q. Were you expecting to testify in January 2024 when you swore to that affidavit?

A. I knew it was a possibility. I did not know when. So I can't say definitively yes. I knew that -- I knew that with Attorney Pradhan and her team that that was a possibility and they were trying to figure out when, so I assumed that I would be testifying.

Q. Okay.

A. But I was completely open to the possibility that the schedule might not work and that might not occur.

Q. So with respect to your first declaration, you said you reviewed it in advance of your testimony, 425NN, and you've talked about it.

Is there anything in there that you believe is no longer accurate?

A. You'd have to point out something specific. I have not memorized it. So to the best of my knowledge, I believe things in my declaration are accurate.

Q. You reviewed it in anticipation of your testimony today, right?

A. I have reviewed hundreds of documents. You'll have to show me what you're getting at. This isn't a memory test.

Q. Okay. And we'll talk about the other matters that you've reviewed later.

But when you -- at that time in 2016, in the spring, you testified that you were contacted in March. You completed your

declaration in April.

What sources of information about the CIA RDI program were you relying upon at the time you wrote that first declaration?

A. It would be materials provided to me by the attorneys who retained me.

Q. What were those materials?

A. Well, I'd have to go back and look at the time what I had. Again, I'm not up for a memory test today. If you have a specific question and would like to show me the document, I'd be happy to comment on it.

Q. Did you keep track of what you reviewed?

A. I did. But in this moment, I don't know what you're referring to in my declaration. So if you can tell me what it is, I'd be happy to help you.

Q. I'm just trying to understand the basis of your knowledge at the time you wrote that declaration, what information you're relying on. Obviously, you've been on the case now for eight years. You've learned things over time. I'm trying to figure out when you had access to information along the way, what you had in 2016.

A. Again, it would be helpful for you to show me what you'd like to know and I'd be able to comment on it.

Q. At that point, how much time had you spent studying the CIA RDI program?

A. At this point right ----

Q. In 2016.

A. Thinking back on it? I don't know.

Q. Did you ----

A. I know a great deal about the EI program, but it's not all from this case. So if you're asking me how much time I spent learning the material relevant to this case, I can't tell you.

Q. You reviewed the SSCI Report, right?

A. I have.

Q. Did you review the guidelines on interrogations conducted in the RDI program that were issued by the director of the CIA in January 2003?

A. I'd have to look and see. I believe that I have, but I don't know as I sit here. It sounds reasonable.

Q. All right. So in paragraph 15 of your declaration -- I can -- and I'm happy to pull it up if that's helpful to you or I can read it to you.

A. Yeah.

Q. Why don't we go ahead and pull it up. That might be easier for you.

TC [MR. GROHARING]: If we could have the feed again from Table 2, Your Honor.

MJ [Col McCALL]: Okay. Go ahead.

[Pause.]

Q. Okay. And I'm -- if we can go to paragraph 15.

A. Uh-huh.

Q. In that paragraph, you say that: The effects of harsh treatment, such as techniques used in SERE training on the detainees, would be extremely detrimental to their mental and physical health.

A. Yes.

Q. Do you recall that paragraph?

A. Yes.

Q. And that opinion covered all detainees held in the CIA RDI program, right?

A. That would -- that would -- if they were exposed to EITs, SERE techniques, yes.

Q. So any detainee that were exposed to any technique?

A. That's what I was getting at, is if they were part of that program of enhanced interrogation, which was a bundled set of SERE techniques, then yes.

Q. Yeah. And different detainees had different experiences, right? Is that your understanding?

A. That's my understanding.

Q. Some were subjected to the waterboard; most were not?

A. I don't have the precise number of how many were and were not.

My understanding is that some who did not receive waterboarding were doused while laying down on the floor with water. But I -- I don't know the -- I don't know the number.

But my opinion based on what I do know for sure from those combination of techniques in our own forces going through SERE that the magnitude of the stress that is generated and the destructive effects of the cortisol on their memory, suppression of testosterone, suppression of their immune system, and many other functions that we measure, just from fake interrogation leads me to believe it's worse for anybody having it who's truly detained.

The folks at survival school ask for this experience. They know it's for their own good.

Q. Sure.

A. They believe it will better them professionally.

Q. Right.

A. There are none of those aspects to someone experiencing these techniques, any of them, slapping, chin holds ----

Q. So ----

A. ---- walling, none of that. None of that ----

Q. A detainee being -- a detainee being slapped on the belly a couple times, that would be enough ----

A. It would be if they were frightened. You might not be frightened of it.

But here's the thing about trauma: It's in the eye of the beholder.

Q. Right.

A. If you terrorize a person and you make them afraid and they believe something bad can happen, that can be the cause of PTSD.

Q. Sure.

A. You don't have to physically injure someone to get PTSD to make it destructive.

So, you know, you said it with a little tone, to me, that sounded mocking, a belly slap. I've had one. It's not just a belly pat. And for someone who's having that done involuntarily, they didn't ask for it, it can be -- it can be ----

Q. Okay.

A. ---- just as alarming as having your head wrapped with a towel.

Q. Okay. And according to your declaration, they would then -- because they were subjected to any amount of EITs, they would, not could, not it's possible, they would -- it would be extremely detrimental to their mental and physical health?

A. I believe it would be detrimental to their physical and mental health, yes.

Q. And it's -- it's not necessary at all to consider any individual characteristics of that detainee, right?

A. It's not necessary to consider any -- you broke up. I'm sorry.

Q. Any individual characteristics of that particular detainee ----

A. If there were characteristics ----

Q. ---- not what their background is ----

A. There would be -- if there were characteristics that we knew were signs of additional vulnerability, then yes, those characteristics would give a greater indication of having an adverse effect. We don't have indicators that would indicate they should tolerate it better.

Q. Right.

A. We do in the research world, but we do not in the real world.

Q. And what about hardiness and resilience? You've done research on that and you're familiar with ----

A. I have.

Q. ---- those principles?

All right. But you wouldn't need to even consider that with regard to any particular detainee? You wouldn't have to evaluate their hardiness or resilience, just the mere fact that anyone was subjected to EITs would be extremely detrimental to their mental and physical health?

A. Well, I think, like I've described in the papers I published on resilience, some of the measures that we have, no one assesses in the real world right now.

For example, like, neuropeptide Y. No one's sampling that in a detainee. If they did, the people who are higher in neuropeptide Y would probably be more resistant to the interrogation techniques, just as they were in our soldiers.

In fact, this is why I had several colleagues who were angry with me for doing survival school research. They believed that my discovery of things that helped protect our soldiers were then going to be used by the government, you know, to harm other people.

And I reminded people, I said, no -- I'm probably annoying to everyone -- that there are factors. But -- but the -- the organizations who knew about my data were not employing it.

If they had given detainees a dissociation skill, a dissociation instrument or some of the other measures that we've used, they would have been able to sort ----

Q. Right.

A. ---- based on scientific data who would be more vulnerable or less vulnerable to stress.

Q. Sure.

A. But they didn't do that.

Q. And you didn't do that?

A. I did that at survival school. I did that at dive school.
Q. You didn't do that in this case with these detainees?
A. No.
Q. In 2016, when you swore that any EIT applied to any detainee would be detrimental, you hadn't done any -- any review of any particular detainee's characteristics at all?
A. I wouldn't have to. At SERE school, we could produce negative symptoms ----
Q. The question ----
A. ---- in everyone.
Q. I'm not talking about SERE school.
ADC [MS. PRADHAN]: Objection, Your Honor. Please allow the witness to finish his response.
A. I mean, you're implying ----
MJ [Col McCALL]: Hold on, Dr. Morgan.
So objection sustained.
WIT: All right.
MJ [Col McCALL]: Go ahead, Dr. Morgan. If you can ----
A. Meaning the implication is that ----
MJ [Col McCALL]: ---- answer the question.
WIT: Thank you.
A. The implication is that, you know, I should have. But I'm saying no. In the data from survival school, what we've shown

repeatedly -- and other researchers as well. A guy who learned from me, Marc Taylor, has published multiple studies on SERE school. Harris Lieberman up at USARIEM published another one in 2016. They find the same thing as I have found, that we can -- it -- we can see the negative effect of the stress in nearly every person if -- when they're stressed.

There's a spectrum, but it's not thought to be a good thing, right? But the techniques in a training setting are able to produce cognitive impairment and memory impairment, neurophysiologic changes in nearly everyone who's there.

Q. Right.

A. So I -- I -- I mean, this is the -- this is the thing that -- about us humans. We can then generalize from a scientific finding to do something in the real world and say it's reasonable to assume those techniques applied in people who are involuntarily detained, it would at least have that degree of impact, if not more, because they're helpless.

Q. And no need to interview them, right?

A. No.

Q. At the time you provided the declaration, you had never met a detainee, right?

A. No, I have not.

Q. And you've not -- you had not examined any medical record

of any detainee?

A. Not quite. I have seen the medical records for Ammar, and I've seen the notes in the OIG report and those are medical notes. So I assume ----

Q. But you ----

A. ---- I would have to say yes, I have seen medical records from someone who's been detained.

Q. You saw two medical records from Mr. Ali that you testified about to today.

A. Those are medical records. I've seen ones from a doctor who was going to report the abuse, and then I've seen a whited-out page in a medical record.

Q. Okay.

A. I did see medical records on Mr. al Baluchi from Kuwait. So I have seen medical records ----

Q. Right.

A. ---- of detainees. I don't know which ones you're referring to, so ----

Q. Certainly not in 2016 when you were completing this declaration, you hadn't seen those.

A. It -- it wouldn't matter if I had seen their medical records.

Q. Right.

A. Based on the science, we know what is harmful.

I don't have to evaluate you to know that you will be in distress after a lack of oxygen. I don't have to evaluate your medical records to know if we applied these EITs on you against your will that you would exhibit the features that I've measured in other Special Operations folks.

You're a human, and I think that that was the impact in the science community about my research. We finally had a place where we could study the impact of realistic stress on -- on healthy people, and we are all vulnerable to varying degrees. And most of those degrees are quite impressive to the medical community because it was able to knock out memory and cognition function in people.

Q. And so in 2016, when you swore to this declaration, you hadn't conducted a psychological assessment of any detainee?

A. I think I was clear about that. I have not met with them ----

Q. Right.

A. ---- or evaluated them.

Q. And would you ----

A. It wouldn't be necessary.

Q. Sorry. I thought you were done.

A. No, I just said I haven't and because it wasn't necessary.

Q. And you didn't review any psychological assessments that

other people conducted?

A. At that time I had not seen the assessments that other people had conducted.

Q. And you hadn't interviewed anybody that was involved in interrogating the detainees?

A. No, I hadn't.

Q. You hadn't interviewed any psychologists that were present for the interrogation of detainees?

A. No.

Q. You weren't aware of the intensity of the application of the EITs on any particular detainee?

A. Yes, I was. It would probably be something we'd have to talk about in a closed session.

Q. Okay. When did that -- when did you become aware of that? Just year -- obviously, don't tell me any classified -- after you were a ----

A. A member of the team came to visit me in my office at Langley because they were concerned.

Q. Okay. When was this?

A. In 2000 -- 2006, '7, and '8. I don't remember which.

Q. Okay. At the time -- well, were you aware of medical -- observations of medical professionals -- excuse me -- who had observed applications of EITs?

A. I was aware there were medical professionals because I had backfilled at SERE for the doctor who came down here and another one who was working at another site. So I was aware that medical professionals were involved in the process.

I was aware they were when I was at the CIA. That was one of the nature of the sort of disagreements and tension in OMS. There was ----

Q. All right.

A. There were differences of opinion among the physicians in our group.

Q. And you're -- and you're talking 2005/2006 time frame?

A. Yes. I belonged to OMS during my entire time at CIA. I was simply forward deployed to different sections.

Q. And this is two years after Mr. Ali was subjected to EITs, 2005?

A. As I said, I -- well, the debate inside the organization was pretty clear from day one when I got there in 2003. I don't remember the date, exact date when I was visited by someone who was concerned about the program.

Q. You were not aware, then, about what any detainee had said about how they were impacted by EITs?

A. No, I was not at that time, no.

Q. And at that time you didn't conduct an evaluation of the

program?

A. At which time? Just so I'm ----

Q. Prior to submitting your declaration.

A. Officially, no. I was aware of the program because I was a blue-badger at CIA, so I was aware of parts of the program. I was never asked to evaluate it, but I was -- I was aware of components of it ----

Q. Okay.

A. ---- if that helps you. But nothing specific about the detainee in question, sort of in this case, no.

Q. And you were -- you worked with -- on the case of Gul Rahman for short. Do you recall that case?

A. I don't.

Q. His full name would be Suleiman Abdullah Salim Mahamed Ahmed Ben Soud Obaid Ullah who's a personal representative for Gul Rahman. Does that ring any bells?

A. No. I know I was asked -- I was asked to work on a case, but I don't recall if that case went forward with any assistance from me, so you'll have to remind me. I don't remember.

Q. They were suing Drs. Mitchell and Jessen. Does that help?

A. Oh, it was the Salim v. Mitchell case.

Q. Okay.

A. That's how I know it. Yes. So I was deposed -- yes. So

I didn't recognize the full name. I always think of it in my head as Salim v. Mitchell. I was deposed in that case, yes.

Q. Okay. And in that case, you testified about the RDI program ----

A. Yes.

Q. ---- in the deposition?

A. Yes. That's a little bit why I didn't know how to answer you. Because in that case, as you may know, I was shown information that then hasn't been disseminated and so in this case, I've tried to keep separate from what I learned there to here, so...

You said "were you aware of the program." There -- there are many materials that were declassified or shown to me during the deposition that are not the materials that have been made available to me in this case.

Q. Did ----

A. So ----

Q. Did you consider those to form your opinions in this case?

A. Formally, no. But I don't know technically how you can ----

Q. Yeah.

A. You can't unlearn something you know, right?

Q. Fair enough.

A. But, no, to the best of my ability, my opinion in this

case is formed by the documents I was given to evaluate. I think I'm a responsible adult, and I made every effort to separate what I knew then from what I know now, but yeah.

Q. In that declaration you also opined that your -- your opinion relied on the claim that detainees were led to believe that death may be imminent.

Upon what information did you base that claim?

A. I based that on the information I was given to review looking at the Senate -- at the SSCI Report on what was done to people and knowing that someone had died. I was well aware of other reports. So it would -- it's a very reasonable assumption. People knew ----

Q. But ----

A. ---- death could result from exposure to the techniques.

Q. Not could result. That it was imminent, right?

A. Well, that's usually what makes something effectively coercive to people. They have to believe that there is a threat and they should be afraid.

Q. So ----

A. So that's the point. The point of the technique, whether it's waterboarding or something else, is there's an imminent threat and that ----

Q. And ----

A. ---- as long as you can establish that, then later you can do a, well, it might be a threat in order to evoke the conditioned response.

Q. But there -- certainly other behavior could be used, other techniques could be used in interrogation short of threats of death that would have an impact on someone being interrogated, right?

A. Yeah, I would agree. You're right. I would agree.

Q. Would ----

A. Yeah. It doesn't always have to be an imminent threat.

Q. But at least your understanding in 2016 -- and your opinion relied on this -- was that the detainees, all four in this case, were led to believe that death may be imminent?

A. Yes. That was -- that's my understanding. That's why I would write it down.

Q. What is your understanding of what enhanced interrogation techniques were applied to Mr. Ali?

A. Oh, from what I've read? The enhanced interrogation techniques, there are a number of them that are derived from techniques in the SERE manual between the face hold, the facial slap, walling, stress positions, cold water dousing, the -- I'm trying to think -- the light -- light stress, light and sound deprivation stress, cold stress, being -- being physically restrained and shackled. I mean, there's a number -- a number of them.

Q. So ----

A. Food deprivation I saw on the list, yeah. So there's a wide range of EITs I've seen in there.

Q. And that's based on the information contained in the -- the OIG report regarding Mr. Ali's experience in the CIA RDI program?

A. Primarily from the OIG report, yes.

Q. And how long -- what's your understanding of how long Mr. Ali was subjected to EITs? What was the period?

A. My understanding is maybe two weeks, maybe a month. But my understanding is it's less than a month and around two weeks in duration.

Q. Of the -- and I'm talking about the actual application of enhanced interrogation techniques.

A. My under ----

Q. What's your ----

A. My understanding is that could happen during a period of time over two weeks. I don't have a direct number count. But as I said earlier, you don't need a number count of how many times someone's sexually assaulted or how many times you do uncontrollable stress to them.

I just know that -- my understanding is that it's during a window period where all those things could happen, was at least

during a two-week time frame.

Q. Would it surprise you if it was during a three- or four-day time period?

A. I -- if you showed me data that demonstrated that, I -- I would accept that.

Q. And in that first declaration you opined that any information obtained from the detainees subjected to such treatment is unreliable. I want to ask you some questions about that.

Were you referring to information provided directly in response to EITs?

A. I was referring to sort of information people might think was related to intelligence gathering, which was the function of the program.

Q. And so -- and so any information that -- and what I'm trying to distinguish is, you know, is this during the application of the EITs or does it extend beyond, you know? And then how far beyond does it extend as far as when information would be unreliable?

A. Well, I think it's probably reliable when a detainee is saying, ow, that hurts, stop, please help. I think those communications are probably reliable when this kind of pressure is being applied to a person.

What I was getting at is that the interrogators are wanting useful information. They want to get intelligence from them.

Q. Sure.

A. And I've said this before: It's a bit like banging a hammer on a radio to get a better signal.

The EITs diminish cognitive functioning and memory. And so the expectation that they would result in better information that one could obtain from a person is ridiculous.

So what I'm getting at in that is that any information that people thought was of value that someone might offer would be highly unreliable. You wouldn't be able to know what was true and not true based on -- even if a person's not trying to lie, we know ----

Q. Sure.

A. ---- for sure that exposing even healthy humans to this kind of stress distorts what they know and even how they know it.

So in that sense, I'm just trying to say if you got information from them with these conditions, you -- you wouldn't know what to believe and not believe. So it's -- it's just not -- it doesn't make any sense, right ----

Q. Right.

A. ---- when you say, "I've screwed up your memory, but I'll believe what you tell me."

Q. And ----

A. So that's what I'm getting at in that part of the declaration.

Q. And what I'm trying to get at is -- is how far that extends. So EIT period, assume for Mr. Ali -- and three to four days, even up to two weeks, we'll say, just for -- just for the point of this discussion.

Six months later someone sits down with Mr. Ali and says, "Hey, what do you know about this?" Is it -- is it possible at that point, six months later, for Mr. Ali to provide a reliable statement?

A. It is. It is possible.

What was talked about the other day, when we look at the region of the brain that's affected by trauma, part of the conditioned response that's elicited in his -- that can be elicited in him meeting with people includes a certain way of reasoning.

And what we know for sure is that stress limits the person's ability to explore their own options, to weigh probability. And so part of the conditioned response -- and I think this is what Dr. Jessen and Mitchell are getting at when they write that sentence about doing the EITs so that you have an individual who can be then exploited to act in ways that are not in their own interest.

And so what's happening is not -- it's that that region of the brain that's touching the amygdala is firing and looping, so that when a person -- when a conditioned cue is used on them, it -- it may increase their heart rate, but it's also -- it's increasing the likelihood you're going to see conditioned responding mentally that

limits the way a person can think. And that's why we think that people have an exploitable mind.

Or the other term in -- in the PTSD field is called conditioned defeat. It's used in the literature for women who have been battered, but it's like they -- the trauma has conditioned the person to have a whole mental mindset that's not normal and that is ultimately self-defeating.

And -- and so it doesn't matter if it's a month later or two months later, that -- that -- that's a very real possibility of what's going on.

I can't say ----

Q. Got it.

A. ---- for sure that they could not provide, you know, meaningful information. That's possible.

I'm just saying, given what we know that happened to the person, it's equally possible that you're not getting anything useful, but...

Q. Yeah.

A. But yeah, six months later, it -- it's a possibility. I think it's unlikely, but it's possible, yes.

Q. And you'd have to dig in and maybe see if, you know, there was other information to corroborate it, you know, things like that?

A. Well, exactly. I've testified to that even at The Hague.

And I've said, look, in the absence of independent corroborating evidence, eyewitness report and memory is unreliable.

I did not say it wasn't true. It's just that it keeps morphing and we have no -- there's no way to check its veracity. So there has to be something independent to verify things.

We humans respond to eyewitness information. We tend to believe it more robustly if we hear it from another person. And we want to believe it, but we find out that it's -- it morphs and we don't know which is true. So independent information would be really helpful.

Q. Okay. So if I understand your testimony -- and please correct me if I'm wrong -- you're not saying that a detainee would be incapable of -- of at some point providing reliable information, but it would depend on the particular facts of the case. They may or may not be able to provide reliable information, and it could be unreliable for all the reasons that -- that you've already testified about?

A. Yes, I think that's a -- that's a fair way of saying that.

Q. And some of that would be, you know, a particular detainee's resilience or hardiness. You know, obviously the more resilient or hardy a particular detainee was, is it fair to then say it's more likely they could later be capable of providing a reliable statement?

A. Yes. I mean, if I -- if we trust scientific data, we know that some people are more versus less vulnerable. And to the degree that someone is more hardy, we might expect the distortion to be less. Like, we could distort it in nearly everyone. But yeah, it's a possibility, yeah.

Q. And you could look at things like medical records, if available, to see how -- you know, things going on with that person, and that would help determine how impacted they were?

A. It -- it would depend what they evaluated.

So some of the medical records, frankly, aren't really helpful because people wrote "doing fine," doing this, doing that ----

Q. Sure.

A. ---- and you don't know what it means.

But that -- that always helps to see in medical records what was assessed, how was -- how it was assessed, to see if it's medically credible, is it psychiatrically credible.

Q. Yeah.

A. Those things are important, yeah.

Q. Psych records, you mentioned ----

A. Yeah.

Q. ---- same thing?

If those are available, you know, trained medical

professionals, their observations could have some insight into whether or not a particular detainee could -- could provide a reliable statement?

A. I -- I hope it would. I read a number of notes, so I didn't dismiss all the notes. The notes I was able to read, I'm assuming this is a credible professional providing notes.

But the absence of evidence isn't evidence, right? So when we think about mental illness, when they do mention symptoms, that is meaningful.

When they don't mention symptoms, because of the context and because people who've been exposed to trauma often don't volunteer things, the absence of a symptom doesn't mean it's not there. But when they do describe a symptom, that's very, very helpful.

So the -- going through notes is a complicated -- it's a complicated process, but I ----

Q. Sure.

A. ---- I like to see the medical records if I can, yeah.

Q. And some other observation of -- of a witness to the -- a detainee's behavior at a particular point in time could shed some light on -- on how able or unable they are to provide a reliable statement?

A. Sure. That -- that's often very helpful.

Q. In paragraph 20 of your first declaration, you said that

your understanding from public sources was that CIA interrogations have involved officials exposing the detainees to misinformation in order to trigger confessions.

A. Yes.

Q. And do you still believe that's accurate?

A. I still believe that's accurate.

Q. How do you define a confession?

A. I'm not an interrogator, but it usually means they're saying something -- they're saying I did something that is of interest to the interrogator.

It could be false. It could be true. But the person being interrogated admits to doing something or says they're involved in something that the interrogator believes might actually be true. All right? So then they view that as someone confessing to something they're investigating.

Q. And that's -- that's information about -- unique to themselves, though, right?

A. It could be. It could be about someone else, right? Sometimes people who are detained are asked questions about other people.

Q. But that wouldn't be a confession.

A. It might be. I'd have to know ----

Q. Is that how you interpret ----

A. It would -- I don't know.

You might use it more legally. Confessing means admitting to something or telling something that maybe you didn't say before. But it might be about themselves or it might be about someone else. I -- I'd have to really know the specifics, but...

Q. Okay. Yeah. And -- and confession has a -- obviously is a legal term. And so it doesn't sound like you were using it in that sense.

You were using it ----

A. No.

Q. ---- more, it sounds like, in the sense of to trigger ----

ADC [MS. PRADHAN]: Objection.

Q. ----- information?

MJ [Col McCALL]: Basis?

ADC [MS. PRADHAN]: This whole exchange is argumentative. If counsel had a question to ask about confessions or Dr. Morgan's understanding of confessions in a psychiatric way, then ask it. But going back and forth on what a confession may or may not be seems just argument.

MJ [Col McCALL]: I think counsel is getting to the -- the question on what exactly Dr. Morgan meant when he used the term "confession," so objection overruled.

Q. And so it doesn't sound like it's the case -- and correct

me if I'm wrong -- that the CIA was interested in obtaining confessions for use in a criminal prosecution?

A. Correct. That's -- yeah, the CIA doesn't do that.

Q. Okay. That would be a mischaracterization. If I described your declaration that way, I would be mischaracterizing your declaration?

A. In that way. What I mean when I say to confess to something is -- is not legal, it's more general. That -- because I've done the work on suggestibility and compliance, which are instruments that are used to look at false confessions versus true confessions.

Q. Right.

A. It just means a person -- a person speaking and admitting to something. But I think it's over-reading into it if you wrap it in a legal definition. Yeah.

Q. So do you know the mission of the CIA?

A. I do.

Q. What ----

A. The CIA has a number of missions.

Q. Would it be accurate to say their mission is to gather and share intelligence to protect our nation from threats?

A. Yes. I was sworn in as a blue-badger. I, you know, I was an employee, so I know a number of roles.

Q. Yeah. And ultimately -- and I don't -- I definitely don't want to ask you anything that would cause you to elicit classified information, but your efforts were to help the CIA obtain intelligence?

A. Yes.

Q. Or use intelligence once obtained. And you talked about the President's briefings and things like that. Not for criminal prosecutions.

A. That's correct.

Q. Do you have any evidence to dispute Dr. Mitchell's representation that the United States at the time of these high-value detainees' capture, so for these five, we'll say starting in spring '03, that the United States was interested in actionable intelligence about pending attacks in America?

A. I wouldn't dispute that at all. I would think everybody was rather terrified of what might happen. When I would go to work each day at the Agency, I think that was on everybody's mind and nobody wanted to see something like 9/11 again.

And I think that was very much present on people's minds and that the -- and that the White House wanted something so they could do something.

Q. Right.

A. That was -- that was very evident when I was there. I

wouldn't -- I wouldn't disagree with him on that at all.

Q. And that was -- I mean, you're almost two years after September 11th by the time you're at the CIA, right?

A. Correct.

Q. So it's still ----

A. It was still very much active on every -- everybody's mind, whether we were at the CIA or not, but certainly, yeah, at the CIA, it was.

Q. I -- and I don't -- I may have misheard. You mentioned an exchange you had with Dr. Mitchell ----

A. Yes.

Q. ---- where you were explaining, you know, something you were doing with -- and then I could have gotten this wrong, so please correct me. But you were talking about, I think, providing misinformation in a SERE experiment that then created suggestibility and affected what SERE trainees then ultimately -- their, ultimately, statements. Does that sound right?

A. Yes.

Q. Okay. So you were having some kind of conversation with him about that.

A. Yes.

Q. And -- and what is it that he said back to you that -- you said something like, yeah, that's what we're doing or that's what I'm

doing or something like that. What is the nature of that conversation?

A. Yes. And I could probably elaborate in a closed session. But what I said the other day was the -- his comment was, "Yes, and we're already doing that." And my response was, "Why in the world would you be creating false memories? Because once you do, it's a rabbit hole. You can't tell the difference between a true or a false memory."

Q. And that is -- you just agreed that he was interested in getting actionable intelligence.

A. Yes.

Q. And that implies, I think to most people, accurate, reliable intelligence so that the United States can take action to protect the country, right?

A. I would agree.

Q. And so that -- that seems inconsistent.

A. What seems -- just so we're clear, what is the part you think seems inconsistent?

Q. And maybe I don't understand what he said to you and ----

A. Is it possible to do this in a closed ----

Q. Oh, I ----

A. ---- session just because ----

Q. We'll ----

A. ---- I think to really explain it in context, I'm not -- I'm not sure ----

Q. Okay.

A. ---- what I'm allowed to say. So I just want to be sensitive to that, but ----

Q. That's fine.

A. ---- yeah.

Q. No problem. We'll -- we can take that up later.

A. Okay.

TC [MR. GROHARING]: Could I have the feed from Table 2, please, in the RHR?

MJ [Col McCALL]: Sure.

Q. So this is from the OIG report that you've indicated that you relied upon.

MJ [Col McCALL]: Can you zoom in on that?

Q. So there's text. The bottom text right above the white box, that says that: Both detainees are believed -- referring to Ali and Mr. Bin'Attash -- to have critical perishable information, including possible information on pending terrorist attacks. Therefore, it is imperative that we move quickly to obtain the information from these two terrorists.

Do you have any reason to doubt that the CIA believed Mr. Ali had critical perishable information?

A. I don't doubt. I have no reason to doubt that that's what they believed.

Q. Okay. And you've already explained this, but -- so it wasn't your sense that the CIA was attempting to obtain a confession for criminal purposes from Mr. Ali in the RDI program?

A. No. My -- my understanding is the program was about acquiring intelligence.

Q. Okay. Moving to the second declaration, and that was provided in January. And at that point you had been working with the defense team for Mr. Ali for eight years, starting in 2016, almost eight years.

A. When you say eight, it seems like a long time. That was because of the pandemic. So, like, wow, yeah, eight years. Right.

Q. Yeah. For sure. So I want to, as best as possible, get a granular understanding of --

TC [MR. GROHARING]: And I don't need the feed at this point from Table 2. Thank you.

Q. -- of what you reviewed before providing that declaration, all the information you had at your disposal and considered and so this is our -- this is by January. So pretty much, you know, almost up until now. And then if you -- if you can distinguish between -- if you learned things in between January and now, that's -- that's helpful as well.

So what information were you considering when providing that declaration?

A. I had been able to review interview transcripts with Drs. Jessen and Mitchell. I had been able to review their writings about the program again.

Q. So can I just stop you?

A. Oh.

Q. So interview transcripts? You mean court transcripts or when they were interviewed by the OIG or somebody?

A. I'd have to -- no, I mean the interview -- for the court, some of the deposition ----

Q. Deposition ----

A. ---- deposition transcripts, I believe. I believe I had been able to see those. I'd seen their writings. I had been able to re-review those. I had been able to review documents related to -- I know I had seen the OIG report. The other doctors' evaluations I had seen.

I hadn't seen the drawings that were done at the Ritz until probably maybe a month ago before coming down. I hadn't seen those descriptions of the program from him. And I had the FBI interview transcripts of the FBI agents who spoke with Ammar. I had ----

Q. So -- sir, I'm sorry.

A. Oh. I had ----

Q. As far as ----

A. Oh, sorry. Go ahead.

Q. All right. So FBI, you said, transcripts. Okay. Just -- there's a -- there's a -- what's called a 302, which is a report of interview that documented the interview.

A. Correct. So I had seen the interview about that, like their conversation with Ammar. So I had seen the transcripts of those, like I said, are they deposition transcripts or court recordings or transcripts from court.

Q. Just make sure we're -- I'm tracking.

So there was a report, not a transcript where somebody was asking Special Agent Fitzgerald or Perkins questions or anything, but an actual FBI report. That's -- it was called an LHM, a letterhead memorandum. All right? And so that's about a 40-or-so-page report and there were a bunch of attachments.

A. You'd probably have to show it to me to see if I recognize it, but -- because I had -- I had numerous documents I'd seen.

I think what I've seen since that declaration, the new material that I've seen were the recently produced drawings of extinction and operant conditioning. And since then, I've been able to re-review the psychological -- the psych assessment.

The psychological testing data itself, I hadn't seen the -- I hadn't seen the results of that, but I had -- I'd seen the

results but not the -- I hadn't seen the score sheet. Probably my error in not going completely through the file on that.

Q. Okay. So that -- let's back up for one second.

TC [MR. GROHARING]: If we could have the feed from Table 2.

MJ [Col McCALL]: Go ahead.

TC [MR. GROHARING]: Just the first page of the LHM.

The court's indulgence, Your Honor?

MJ [Col McCALL]: Sure. Take your time.

WIT: See if I recognize it.

[Pause.]

MJ [Col McCALL]: I'll let you know when it shows up down here.

TC [MR. GROHARING]: Thank you, Your Honor.

[Pause.]

TC [MR. GROHARING]: All right. It's coming your way.

MJ [Col McCALL]: And then if we could try to zoom in. We see it, but it's pretty small.

I think that's good.

Q. Doctor, are you able to see the document on the screen?

A. I am.

Q. That is what I was referring to as the LHM.

A. It does -- it looks familiar. I rec -- I saw the paragraph, something about Prilosec, taking the drug Prilosec. I'm

looking -- so I believe I have seen this before.

Q. And so you saw that before you submitted your declaration, your second declaration in January 2024?

A. I believe I have.

Q. When -- when do you recall being provided that document?

A. I don't recall. I might have to go back and look at e-mail traffic and -- and find out.

Q. I ----

A. Documents are usually given to me through a -- through a drop -- like a link.

Q. Sure.

A. It's -- so I don't know, but...

Q. Is that something you're able to do overnight ----

A. I ----

Q. ---- so we can talk about it tomorrow?

A. I don't know. The Internet is an interesting thing at the NGIS. Sorry, I can't promise you that.

Q. Okay.

A. If you -- if you show me what you'd like to ask me about in the document ----

Q. Fair enough.

A. ---- I'd be happy to ----

Q. Don't spend your ----

A. Yeah.

Q. Don't spend more than a minute ----

A. I'm actually doing it. Okay. It's all right.

MJ [Col McCALL]: Just to make clear that this is not being published to the gallery, correct?

If we can just pause for a minute.

TC [MR. GROHARING]: No, Your Honor.

MJ [Col McCALL]: All right.

TC [MR. GROHARING]: My apologies, Your Honor.

MJ [Col McCALL]: No, I mean that's -- yeah, it's not apparently.

All right. Go ahead.

Q. Okay. So that's the -- that's the LHM. You did review that sometime before your declaration, and there were dozens of pages of attachments.

Do you recall those pages of things that Mr. Ali was shown during the interview?

A. You'd have to refresh my memory by showing. I don't remember as I sit here right now, no.

Q. If ----

TC [MR. GROHARING]: 45 pages doesn't have the attachment.

Just one moment, Your Honor.

MJ [Col McCALL]: Take your time.

[Pause.]

TC [MR. GROHARING]: Judge, while we're waiting, I neglected to mention the LHM is in the record at AE 628AA (Gov) Attachment E.

MJ [Col McCALL]: All right. Thank you for clarifying that.

TC [MR. GROHARING]: And the AAPL guidelines I believe have been made an Appellate Exhibit in the 942AA (Gov) series, but I don't know which exhibit -- which the next letter is there.

MJ [Col McCALL]: All right. I'll have the court reporters give you a number for that.

TC [MR. GROHARING]: Thank you, Your Honor.

Q. Okay. So, Doctor, can you see a document on the screen?

A. I can.

Q. The LHM had a number of attachments to it with documents and things. Do you recall seeing those as part of your review?

A. I don't recall this. I -- so I don't know if I've seen it or not. Yeah, I ----

Q. So you might have just -- you might have just read the substance but perhaps not looked at all of the -- the different attachments?

A. I -- again, I don't know. I'd have to go -- go back and look. It's been a while.

Q. Okay. Okay. So you mentioned testimony. So you talked about the testimony of the agents. You referred to it as a

deposition, but were you referring to commission testimony in this case?

A. I -- I have transcripts, and they appear to be speaking in court or ----

Q. Okay.

A. ---- being asked questions, yeah.

Q. And how many pages ----

A. I don't -- I don't -- I don't know the label of the document, but it's -- they're clearly being questioned about their interview ----

Q. Okay.

A. ---- with Ammar.

Q. And who all are you talking about?

A. The -- there are three agents. You just had their names up.

Q. Okay.

A. It was just on the title page.

Q. So Special Agent Fitzgerald ----

A. And Waltz ----

Q. ---- Perkins?

A. Wilkins **[sic]**, yeah. And I don't know the third. I think there were three names.

Q. And would it have been Special Agent McClain?

A. It may have been. If you pull it up, I can ----

Q. Okay.

A. ---- rec ----

Q. Regardless ----

A. Yes.

Q. ---- all three agents, you reviewed the transcript?

A. Yes.

Q. Okay. And ballpark, how many pages?

A. Well, when they printed it out, the stack is -- for their interviews or for this? The -- for the ----

Q. The ----

A. ---- the stack, I've got about an inch thick worth transcript -- reading, reading the interview, reading their comments, what they -- what they said happened and what they observed.

Q. Is that something you -- you reviewed at home or you came in to review?

A. I know I've reread it here. That was in my link, in my -- in the Dropbox I was given. I have those files.

Q. Okay. So you said you reread it here.

So first read it at home and then in advance of your testimony, are you saying, for this week?

A. Yeah, before I came down. Just trying to refresh.

It was finals season at the university. So before I came

down, I was grading. And then I saved a day to start going over materials again to refresh -- refresh my memory.

Q. Okay. So we -- we talked about the OIG investigation. We talked about the LHM. We talked about the transcripts from testimony regarding that LHM. You talked about a couple papers from Dr. Jessen and Dr. Mitchell. You talked about *Principles of Influence* earlier, with the Damasio chart.

A. Yeah.

Q. That's one of them?

A. Yeah. The -- and then they had -- they had written a couple of articles with the *Principles of Influence* and there was another one on memory.

And what I hadn't seen were the new drawings from the Ritz. That was ----

Q. Okay.

A. I saw those maybe -- maybe a month ago is when I first saw them.

Q. And that -- that took place after you submitted your declaration?

A. Correct.

Q. That -- okay.

A. Correct.

Q. Did you -- well, we'll get to -- we'll get to that. Well,

did you review their -- Dr. Mitchell's February testimony?

A. I believe I have. I believe I have. I believe that's in -- in -- I don't remember the date exactly, but I have read his testimony.

Q. Okay. More recent would have been relevant to the diagram that you've already discussed in your testimony, extinction, those types of things?

A. As I said, the -- what the diagram represents is in part not comprehensible scientifically, so ----

Q. I'm not ----

A. Yeah, I ----

Q. I'm not asking your opinion. I'm just trying to ----

A. It didn't help me -- it didn't help me understand.

MJ [Col McCALL]: Dr. Morgan, if you and Mr. Groharing can please try not to speak over each other so ----

WIT: Sorry.

MJ [Col McCALL]: Go ahead, Mr. Groharing.

Q. All I'm trying to figure out is what you reviewed or didn't review. So subject matter-wise, did you review his testimony from February?

A. Well, I -- well, not before I wrote the declaration because that's in January, but I have seen his testimony.

Q. Right. So after February, sometime in advance of this

testimony, obviously ----

A. Right.

Q. ---- you reviewed that subsequent testimony?

A. Yes.

Q. Where did that review take place?

A. In New Haven. I would have been linking up to my box through my computer at home.

Q. Okay. Before you provided that declaration, how much time did you spend reviewing Mr. Ali's medical records?

A. Oh, I didn't time it. I'm not going to venture a guess. I don't remember. I remember going through his medical records. I remember on one page things were in Arabic, and I realized I couldn't read that front page, but I saw things from his youth, from when he was six and older.

So I don't know how much time I spent on it. It was maybe 20 minutes on his Kuwait medical records.

Q. Okay. So with respect to the Kuwait medical records, how many pages of records are we talking about? What would your estimate be?

A. I don't know. I wasn't counting as I was scrolling, but there -- there are a -- there are a number because he suffered from a hydrocele and from a hernia. He had a series of infections, so I don't know the -- what I was looking for from a psychiatric

standpoint was whether or not there were any early indications of trauma, loss, anxiety, psychiatric vulnerability factors because we know that people who have those things may be more vulnerable when exposed to stress to go on to develop something, or to see whether or not there was a pre-existing condition.

Because in one of the notes, I believe it's in the OIG report, there is a reference that says life-long anxiety and something, which doesn't appear in his medical records from before.

So for me, I was trying to figure out, well, does he have a history of psychiatric disorders? If he does, that makes him a much more vulnerable and damaged individual who then gets exposed to EITs. We know that for sure from the psychiatric literature. Those are the child abuse, sexual abuse, neglect, a previous psychiatric condition, all those things increase the risk of developing PTSD when exposed to a traumatic event.

So I don't ----

Q. Did that ----

A. ---- know the page number, but -- but there -- they're not -- it's not short. It's not five pages. It's a number of pages, mainly about medical problems.

Q. And that was before January, before you submitted the declaration or after?

A. I think I'd seen those before, but ----

Q. Okay.

A. ---- it wasn't relevant to the declaration of my -- my thinking about something. If -- I would have mentioned it if he had had a pre-existing condition that made him more vulnerable.

Q. So your -- as far as Mr. Ali's records from Guantanamo Bay, you talked about two records today. Did you review any other medical records of Mr. Ali's from his time at Guantanamo Bay before your declaration?

A. What I've seen, it's been limited. The one that -- one part of the record I saw had been whited -- not whited-out, but blocked out. I don't know why the medical record has been censored, but it's the one on the report where the doctor wanted to report the abuse, and someone has apparently placed a cutout of paper on it and photographed the sheet and then replaced it, I guess, in the medical record, which is odd.

But, yeah. So I've had limited -- I haven't seen his full medical record from while being detained, no.

Q. Mr. Ali's counsel represented to me that there were only two documents from -- two medical records from Guantanamo Bay that they made available to you. Does that sound right? The two that you testified about.

A. That sounds right.

Q. Okay. And did you ask to review the rest of the medical

records for Mr. Ali at Guantanamo Bay?

A. I asked if I could have what I was allowed to see, what would be made available to me.

Q. And who decided that?

A. That would -- that would be the legal team to decide ----

Q. Okay.

A. ---- what -- what I can see.

Q. Right. It wasn't a security concern or anything? You're a clearance-holder. You would -- there were no security issues that prevented you reviewing any medical records, right?

A. I am not aware of any.

Q. Okay.

A. No.

Q. And the same question with psychological records. You know, either a psychological note or a psych tech note, I believe one of the records that you were shown was a psych tech -- maybe both of them, actually -- a psych note. No other psychological records from GTMO, though, right?

A. I haven't seen those. The notes that I have seen have been sufficient to be able to establish that there was a psychiatric illness, or several, going on, which then gets confirmed when he undergoes testing later.

But this is completely compatible and they're valid. So if

anything, if I had seen more documents, it -- it could have helped me flesh out even more detail around the depression, around panic ----

Q. Right.

A. ---- around post-traumatic stress disorder.

Q. You have no idea what they say, though, right?

A. No, I don't. And ----

Q. Right.

A. ---- I -- because ----

Q. You ----

A. ---- at the time, there was -- there were fans of the program and non-fans of the program. I am unsure as to why and how people documented what they saw when they were asked to work there.

Q. Let's focus on GTMO, his Guantanamo Bay medical records.

A. Yes.

Q. It has nothing to do with OMS?

A. Not directly, no.

Q. You -- are you aware that Mr. Ali has hundreds of pages of medical records from his time at Guantanamo Bay?

A. I'm - I'm not aware of the volume.

Q. Just -- just in the period between when he arrived there in September 2006 and the January interview with the FBI, a few -- a few hundred pages.

A. Okay.

Q. Is -- and you didn't seek to review those, though?

A. My role is to ask for what information I need to be shown to be able to answer questions. Again, though, it wouldn't take away from my opinion because there's already data that establishes a psychiatric illness.

So there could be 3,000 pages, there could be 100 pages. If you -- you know, if the point you want me to guess numbers, I can guess numbers. But my point is no, I've told you what I've seen, and it is sufficient to establish a diagnosis.

Q. I'm just trying to square that with the requirements of a forensic psychiatrist ----

A. I ----

Q. ---- to see all available data, which you knowledge are -- are your requirements, right?

A. The requirements are all the available data within the context in which we have been retained in our function.

Q. Okay. So in this case ----

A. In the regular -- no, I'd like to explain because you're implying that I have failed to reach an ethical standard, which is a guideline, anyway. It's not a rule. I value that guideline because it means we strive to get enough data that is required to answer a question. That's professional.

Q. Right.

A. And in many cases, and you know this, attorneys decide how information is getting into the courtroom. The psychiatric evaluation can be one of them. But when we interview people, it can introduce data that they didn't want in the courtroom, so they limit the access for different reasons.

Q. Of course.

A. So it is not unethical to say I can -- I can answer this question even though you haven't shown me all the documents. Our ethical concern is I need to have a sufficient amount to actually render an opinion on the question you've asked.

Q. Okay.

A. I believe that that has occurred with what I have seen because ----

Q. Right.

A. ---- there are explicit symptoms of a known psychiatric condition, or several as a matter of fact, and those have been validated later. So ----

Q. So ----

A. ---- if you have other questions about them, I'm happy to answer ----

Q. All right.

A. ---- but I really don't appreciate you -- you moving in this direction saying I have failed to meet an ethical requirement.

It's -- it's kind of insulting. I'm just going to say ----

Q. That's ----

A. ---- I know my ethical guidelines. I've helped -- I've helped train other people, and I support those guidelines ----

Q. Okay.

A. ---- and I have adhered to them.

Q. Okay. And you -- you believe that reviewing 1 to 2 percent of the available medical information regarding Mr. Ali, then you've satisfied your ethical obligations?

A. I've seen enough symptoms to demonstrate it is ----

Q. Okay.

A. ---- well within a reasonable degree of medical certainty that he has a psychiatric illness, most likely to be PTSD. That was later ----

Q. And ----

A. ---- verified. And I think as the professional in my own field and the expert in my field, I get to be the person who determines what information is necessary to come to a professional judgment about something I know a great deal about.

Q. Sure.

A. I wouldn't try to tell you how to practice law. I don't like you telling me the definitions of how I should come to a point where I can determine a diagnosis. It's just -- it's unprofessional.

Q. Those are ethical guidelines established by AAPL, right? I'm not -- I'm not telling you. Your own governing body is telling you.

A. I helped my own governing body determine what we would emphasize.

Q. Okay. In this -- in this case, then, you didn't follow it.

Let's go to ----

A. No, I ----

MJ [Col McCALL]: Let's ----

ADC [MS. PRADHAN]: Objection. Objection, Your Honor.

MJ [Col McCALL]: Let's move on.

Q. Let's talk about psych records. You also didn't seek to examine available psych records from Guantanamo Bay during the relevant time period either. You didn't need to to make your diagnosis, right?

A. I did not. My opinion is supported by the evaluations of -- that were done on him by Drs. Gur and Shea. And indirect -- indirect assessments are done all the time. It is entirely professional and ethical.

Q. And ----

A. If you have a question that's relevant to that, you know, it -- it is -- I don't like the insinuation, though. I think -- I

don't know why you're doing it. I'm trying ----

MJ [Col McCALL]: Dr. Morgan -- Dr. Morgan, if you can just answer counsel's question and just confine yourself to answering his questions when he has them.

So go ahead, Mr. Groharing.

TC [MR. GROHARING]: Thank you, Your Honor.

Q. Did you ask to see anything other than what you just said you reviewed before signing this declaration?

A. Yeah. I think I've said what I've reviewed before providing the declaration.

Q. Okay. I want to talk to you about PTSD and your finding in that second declaration.

You acknowledged earlier that in litigation there's a stricter standard for PTSD. Did I hear that correctly?

A. In some evaluations, there is, yes.

Q. But in a -- in a forensic evaluation where you're going to testify as an expert in a court of law, it's ----

A. In litigation, where people are asking for money, we often think about monetary secondary gain. And so the scoring on testing, we usually go for a different cutoff score to be pretty sure that the condition exists.

In a criminal case where it's -- someone is trying to say they have an illness maybe for a lighter sentence or a downward

departure, we have to consider secondary gain as well, which is why it was helpful to see Dr. Shea's report where that kind of testing was administered, and there's no evidence of malingering.

Q. Okay.

A. So the principle is to keep that in mind when assessing an evaluation within the context of litigation.

When I look back in a record to see what was documented, it's like the old adage that, you know, the weakest ink is stronger than the best memory.

And what's documented in 2006 is pretty strong. It lists symptoms that describe the condition of post-traumatic stress disorder and major depression and symptoms of panic.

Q. And in that declaration, you opined, based on the information that you just described, that at least as early as 2006, Mr. Ali suffered from PTSD as a result of his exposure to the enhanced interrogation techniques. That's paragraph 10 of the dec.

Does that sound right?

A. That sounds right. I agree with it.

Q. When were you asked to provide your opinion on whether Mr. Ali suffered from PTSD?

A. I don't recall.

Q. When would you estimate?

A. I'm sorry?

Q. When would you estimate?

A. Before I finished writing the declaration, I was asked to evaluate the records and render an opinion.

Q. Was it in December?

A. I don't know.

Q. November?

A. I don't know. I'm telling ----

Q. Was it ----

A. I can say I don't know a number of times if you'd like. I don't recall the exact date.

Certainly by the time I signed the declaration, that was my opinion based on what I had seen.

Q. You don't have any memory issues do you, Doctor?

A. You're making me feel like I do. I didn't sit down to memorize dates of when I arrived at an idea in my head. That is ridiculous.

Q. I asking you ----

A. I could ask -- I could ask you if you remembered exactly what you did at 2:00 in the afternoon three weeks ago. You may or may not remember.

I don't remember when I formed my conclusion in my mind about what I had seen. But certainly by the time I had signed the document, I was convinced there was adequate evidence. And I stand

by my opinion.

Q. The question was when you were asked, not -- not when you signed it or when you formed your opinion.

A. I think we're both having memory issues. I just said I don't know.

Q. And you have no idea?

A. I am not going to guess.

Q. Approximately how many times have you been asked to conduct a forensic examination of a defendant to determine whether they had a mental disease or defect?

A. I've been asked to do that several dozen times. I've been asked to do it for the defense. More recently over the pandemic, I've had five or six federal cases related to that very issue.

Q. Five or six cases over the course of the pandemic?

A. Yes.

Q. And state court or federal court?

A. Federal court.

Q. What was the jurisdiction?

A. Colorado and Wyoming.

Q. So all five or six cases in Colorado or Wyoming?

A. I think three in Colorado and Wyoming. I'd -- I have to go back and check. The other one is in the jurisdiction related to Delaware/New Jersey. I'm -- I'm not sure ----

Q. Okay.

A. ---- the jurisdiction there.

Q. And so did you actually testify in court in those cases or ----

A. In the Colorado cases, yes. I prepared reports and testified.

In one of the cases I was called to testify, and the judge said that he was satisfied with my report, I had answered all his questions and said I did not have to testify and did not send the veteran to prison but sent him to probation and work, so...

Q. Was that in veterans court?

A. I'm sorry?

Q. Was that in veterans court or ----

A. No, it was not. It was regular federal court. He was looking at 40 years.

Q. And did you work for the defendant in that case or for the court?

A. Yeah, I -- it was the defense in that case who retained me ----

Q. Okay.

A. ---- because he was a veteran and he had post-traumatic stress disorder.

That attorney had contacted me because I had previously

worked on another federal case about a veteran who had been arrested during the pandemic, and he had pleaded NGRI, not guilty by reason of insanity. And that defense had been successful.

So as you can imagine, attorneys talk to one another, so the next attorney called me. So that's how those cases evolved.

Q. How many times have you conducted a forensic examination of a witness?

A. A forensic examination for a witness? I don't understand.

Q. I'm sorry. For a defendant.

A. For -- well, typically when I'm retained, it depends what the attorney wants. I would say 75 percent of the time they want me to interview a person and produce a psychiatric evaluation of the person.

And about 25 percent of the time, they just want a record review and an opinion about that. I -- and they may be using that for downward departure or something if someone's going to be convicted if it's in a criminal court.

In -- in civil court, it's -- if I'm hired by the -- by the plaintiff, I would say they typically ask for a full evaluation if I'm hired by the defense. In -- in -- in civil court, they -- they may or may not want me to evaluate someone. It -- that's their -- whatever their legal strategy is.

Q. Did ----

A. I'm employed -- I'm employed by either side about 50 percent of the time. It just depends on the year. Like over the last -- the last two years here, I think I've had more cases with the defense attorney, for the defense, just because of the nature of the case about PTSD. But prior to that, it's been for the prosecution as well.

Q. Would you consider what you -- the work you performed here as a forensic examination of -- of Mr. Ali?

A. It wouldn't be a forensic evaluation of him. It would -- it would be an evaluation of the documentations in order to render opinion about a question that I was asked to address.

Q. Overall, is it fair to say a forensic -- and maybe I'm using the wrong term -- a forensic evaluation of Mr. Ali?

A. It would be a forensic assessment for his case. I did not evaluate him directly. So in -- in psychiatry, if you say I would like a forensic evaluation of this person, that means you are asking me to see them directly.

If you ask for an evaluation of the medical record or the situation and you want an opinion about that and what might be the likely diagnosis, that would be a forensic assessment. But we might not call it a forensic psychiatric evaluation per se.

There's no -- there's no set terminology, but if I'm talking to another physician and I say I did the psychiatric evaluation of

that person, they might understand that to mean I did -- I met with them for several hours to do an evaluation. But -- but the terminology is not fixed.

Q. So you relied on examinations conducted by other psychologists and psychiatrists who were working for Mr. Ali, right?

A. Yes. That's correct.

Q. Which psychologists and psychiatrists?

A. Oh, there was a Dr. Shea, a Dr. Gur -- Dr. Shea did the neuropsych testing and also the evaluation for post-traumatic stress disorder. Dr. Gur had done the brain imaging, the MRI imaging, the volumetric imaging. Then there was a doctor -- I'm not going to say his name right, Hanrahan ----

Q. Hanrahan?

A. ---- Hanrahan, yeah, that I saw. And then a Dr. Hawally? I'm embarrassed. I cannot say his name. I'd have to go back and look at it to pronounce it correctly. But those were the reports that I saw and got to go through. I ----

Q. So ----

A. ---- don't remember any others.

Q. This last one, was that Dr. Hammadi?

A. It's Hammadi. That's the name, yes.

Q. And was his a report or ----

A. It was ----

Q. ---- a video or ----

A. No, that was in court. And he was -- he was talking about trauma, the effects of trauma and I had been asked to look at his statements to see whether or not -- how I felt about those.

Q. Okay. And that didn't have anything to do with Mr. Ali, right? He hadn't examined Mr. Ali?

A. Not to my -- not to my knowledge, no.

Q. Okay.

A. It was more about the topic of stress, trauma, hormones, and things like that.

Q. And he was a Kuwaiti, he was talking about the impact of the Iraq invasion, the impact on the citizenry, PTSD throughout the community, things like that?

A. Yeah, right ----

Q. I just want to make sure we're ----

A. I did read the -- yes, that's the one.

Q. Okay. And so ----

A. And I did see the evaluations from -- from Dr. Xenakis, if I didn't mention it. There were two.

Q. Okay.

A. I think one from 2000 -- either '15 and '17 or '15 and '16. I think it was '15 and '16 but there were two different -- two reports from Dr. Xenakis.

Q. And what was the nature of those reports?

A. The nature of those, it appeared to be a mental health evaluation, a psychiatric exam. And the nature of those primarily was focused in on traumatic brain injury and symptoms that seemed to be related to TBI, or traumatic -- traumatic brain injury from -- from head injury and the sequela of that.

Q. Did you have any conversations with Dr. Xenakis?

A. No. I know him, but I have made no attempt to contact him about them. I haven't spoken to him about them.

Q. Okay. Did you review his notes or any other information or ----

A. I've just read the report ----

Q. Just the report?

A. ---- that he produced and signed, both reports, yeah.

Q. How about Dr. Shea?

A. Dr. Shea, I have read the entire report and the results of the testing. I -- I've not spoken to Dr. Shea.

Q. Have you reviewed his notes?

A. I have not, but with the neuropsychologist, they'll only give their raw data to another psychologist. I am a psychiatrist.

Q. Okay. Fair enough. You wouldn't have the expertise to interpret the nuances and ----

A. Well, I do -- I do on some of the testing but it's a guild

issue. I've actually published on psychological testing and the components in some of the tests. I've actually published on some of the tests that Dr. Shea administered.

So I do know how to read the report. I do know how to understand the report. It's just that according to their ethical guidance, they'll only give raw psychological testing data to another clinical psychologist or neuropsychologist. But yes, I read the report.

Q. So Dr. Gur, you reviewed his report?

A. I did.

Q. Anything other than his report?

A. Not from Dr. Gur. I saw the report, the findings from the MRI. I myself have published an MRI study, so I am familiar with seeing the results from MRIs, and so I was able to look at what he wrote and what he concluded from his findings. But I haven't seen any other materials from him.

Q. And haven't talked to him?

A. No, naturally.

Q. Okay.

A. When I'm retained by an attorney, I only speak to the people that I'm asked to speak to. So it's not unusual that I haven't spoken to any of them.

Q. Sometimes -- have you had the occasion when there's a team

of psychologists/psychiatrists on a particular defense team where you did collaborate and talk with them about whatever issues you ----

A. Yes. I was on the team. I evaluated Bowe Bergdahl for his trial and there were a team -- there were a number of us on the team but we did each work separately in producing our reports and where information -- where there was unnecessary overlap between the information, we could compare findings.

So in a team -- in a team effort, we tried to sort of distribute the functioning. So the psychologist on the team was tasked with evaluating his family. I was tasked with evaluating him and getting the testing done with him and evaluating him, but then we would speak and compare.

And that's because I was going to be asked on the stand not only to give my evaluation of him, but also to make recommendations for treatment. So it would be more natural to begin speaking to other people on a team or to have additional information.

Q. And lastly, Dr. Hanrahan, same? Reviewed his report?

A. The same. I looked at the report and I have not spoken.

Q. And didn't have access to his notes or anything?

A. No. I'm -- I'm trusting my colleagues to have formulated their opinion from whatever they scribbled on paper or whatever they wrote down and they translated into a typed document. That is -- that's standard in -- in medicine.

Q. But you all haven't talked about -- not just the specifics of your different portions of the case or the -- your efforts, big picture, you haven't sat down to talk about the case either, right?

A. No. I haven't -- I haven't spoken to any of them.

Q. No contact with any of them?

A. No, no. I think Dr. Gur and I were on a case over ten years ago out in Colorado, but I -- I've never actually met him directly. He was -- he was one part of the team, but I never met him or saw him, and I've never spoken to him, so...

Q. Now, when you do a study, you have to maintain your data so that it can be peer-reviewed, right?

A. Yes.

Q. And would it be ethically indefensible for you to withhold that data and make it subject to peer-review?

A. Well, peer-review is -- it's not considered an ethical thing. In the science community, we do have to learn to trust one another.

So as people are evaluating the data that other people publish, we ask colleagues sort of a consensus agreement. We want to keep data for at least three years. Some universities will say why not seven years.

And it's functional. It gives you an opportunity if you want to do a study on something I did and you collect your data, you

say can I -- can I analyze your data and compare it to mine?

Other people, if they -- if they serious doubt sort of the impact and the finding of some study, can say can we reanalyze the data, can we look at the statistical analyses you used? So it varies.

From a human studies standpoint, we are required to keep the consent forms for a minimum of three years under federal regulations and up to seven depending on the university's -- just whatever university you're at.

Q. And you indicated you had some expertise in neuropsychology, but that Dr. Gur couldn't share his information with you, though, because you were not a neuropsychologist?

A. Correct. If -- if I was a -- if I was a clinically licensed psychologist, then ----

Q. Right.

A. ---- then -- then they could legally share. They could pass their data.

It -- the purpose of not sharing the raw data from psychological assessments is the companies that own the patents on the instruments don't want the individual items released to just anyone.

Q. Sure.

A. And, two, they want to make sure that a person has the

training to understand the meaning of the findings and what the actual tests mean.

I'm a bit of an anomaly. I was trained by many psychologists. I was actually trained in Rorschach training by the guy who learned it from Hermann Rorschach and through the assessment and selection programs with the military.

I probably have more experience with some of the testing than many psychologists. But in a forensic setting, the psychologist has to go give their data to another one if they want it reanalyzed.

Q. And that neuropsychologist is required to maintain that data, right?

A. I have been assuming that that would be the case. They should.

In my experience, the neuropsychologists that I know, they have. They -- the data that Dr. Shea did -- did collect that I would be able to have if I wanted it, but I was satisfied with how they described their findings would be the -- the assessment of post-traumatic stress.

Q. Okay. Did Dr. Shea -- were you consulted at all about how Dr. Shea should go about his examination with Mr. Ali?

A. No. That -- that would be up to Dr. Shea and the purpose of the evaluation to follow his ethical guidelines and what he needed to do to perform an evaluation.

Q. But nobody said, hey, are there any particular -- particular tests you think would be valuable here ---- A. No. Q. ---- in doing this evaluation or anything like that? It ---- A. I -- I wasn't part of that. I wasn't part of that process, no. Q. All right. Did you know he was doing an evaluation of Mr. Ali? A. I -- I don't think -- I didn't know who was doing an evaluation. I was aware that there were people who were going to evaluate him, but I wasn't part of that conversation until the testing. So when the results were available, then I -- I was told there are reports you can see. But I wasn't -- I wasn't part of that early -- that early phase of however that came about. Q. Did you interview any of Mr. Ali's relatives? A. I'm -- I'm sorry? It broke up. Q. Did you ever interview any of Mr. Ali's relatives? A. No. Q. And other than medical information found in CIA -- otherwise found in CIA records, the few that you mentioned during your testimony, you didn't review medical records from

Mr. Ali's CIA detention, right?

A. No, no. It's from the OIG report and the evaluations that come later. And I explained the rationale in the declaration about ----

Q. Sure.

A. ---- why that creates a stable assessment. It creates a valid assessment based on the data.

I mean, more information is always helpful. If it speaks to the issues that are raised about can you make a diagnosis, a lot of additional information just might not be useful because it wouldn't speak to whether or not certain criteria were or were not met.

Q. Right. But you wouldn't know until you actually saw it, right?

A. Correct. But ----

Q. So ----

A. ---- again, I've said I've already -- I've already seen enough. I saw what's, so to speak, on the menu of symptoms before and after. And now I know a condition has been met and satisfied to say there is a mental illness and this is very, very likely what it is.

Additional data might fill in a gap on all the specific situations in which his symptoms are displayed and not displayed. But from a diagnostic standpoint, I wouldn't need to see any more

information.

He could -- I published a number of papers -- you can see them on my CV -- looking at anniversary reactions and the waxing and waning of symptoms of PTSD.

So over the course of time, depending when a person's evaluated, you may see a number of symptoms and then not so many symptoms and then a number of symptoms and another constellation of symptoms. It's the nature of the illness.

Q. Sure.

A. And so if in the intervening period I saw an evaluation where there weren't many symptoms, it wouldn't tell me that the original assessment was wrong. I would then look, does something come along later? And if I saw something, I would say, oh, this is the waxing and waning. I could establish a little better profile if there were more data in there, but ----

Q. That sounds like forensic examination, right? You dig into it and assess the data, right?

A. You assess what you have, yeah.

Q. And to have it, you have to seek it, right?

A. I think it was -- I think I was clear about what would be helpful to me to make the assessment I needed, and I'm satisfied.

Q. And so is it standard practice knowing that medical records and psychological records are available that would cover a

three-and-a-half-year period to not attempt to review those records when you -- when you're going to provide opinions on the -- the mental health of someone?

A. If I had been asked to directly evaluate him, I would want those records. But I was not evaluating him directly. I was asked to speak to the issue about whether or not he could have post-traumatic stress disorder from exposure to EITs.

And -- but if you had -- if I had been asked to do a direct psychiatric evaluation on him, I would feel that I would -- I would need to see those because I'd want to ask him directly about those things, because I'd want to know at specific periods of time what was someone experiencing because symptoms are visible and then not visible.

But for -- for the kind of forensic assessment I was doing, that's not necessary.

Q. And you were at Guantanamo Bay, right?

A. Yes.

Q. You came down to tour Camp VII and Camp Echo -- or, I'm sorry, Echo II. And you never met Mr. Ali?

A. No. I don't believe I was ever supposed to meet him ----

Q. All right.

A. ---- as I mentioned.

Q. And did you ever ask to meet him?

A. Did I ask someone ----

Q. Did you ask -- it sounds like the attorneys controlled what you did, you know, your efforts.

So did you ask them: I'd like to meet with Ali to do my evaluation?

A. Oh, no. That would be based on a misconception.

I -- I did ask, "Will I see him?" Because we were doing the inspection at 7:00. And I had heard that he was going and I was told, "No, no, no. He's going to go in the morning, you go at a different time."

And I understand that the attorney may have their reasons for me not meeting the client.

For my purpose, that's actually quite helpful, because then I am not influenced about how he may appear to me, whether sympathetically or nonsympathetically, what he may have to say.

My assessment was to look at the site and then to evaluate what's in the record to see if there's evidence that this could have created a condition called post-traumatic stress disorder; search for, you know, cue-specific and contextual conditioning.

So I remember asking, "Oh, will I get to meet him?" But it didn't mean I wanted to evaluate him.

My -- my ----

Q. Did you ----

A. ---- my goal is not to evaluate him, and I didn't want to meet him. I just didn't know if I was meeting him or not.

Q. To be clear, did you or did you not ask to meet with Mr. Ali?

A. No. I asked if I would -- if I would be seeing him when we were doing the site visit. And I was told, no, he would do the site visit at a different time.

Q. So you made no attempt to conduct an interview of Mr. Ali to assess him for PTSD?

A. I don't know how many times I can say this.

ADC [MS. PRADHAN]: Objection, Your Honor.

A. Yeah.

ADC [MS. PRADHAN]: Asked and answered ----

A. No ----

ADC [MS. PRADHAN]: ---- multiple times.

A. ---- I was not ----

MJ [Col McCALL]: Objection overruled.

A. ---- asked to evaluate him.

It was not my role and reason why I was retained; and, therefore, it wouldn't be appropriate for me to meet with him. That was not my job in this case. I don't know how many times I can tell you that.

Q. Okay. Fair enough. AAPL, let's go back to the ethical

guidelines.

One of them says that: Honesty, objectivity and the adequacy of the clinical evaluation may be called into question when an expert opinion is offered without a personal examination.

Are you familiar with that?

A. I would agree with that. That's exactly what you're doing. You're questioning my opinion because I did not directly evaluate him, even though I keep telling you that was not the purpose of my evaluation of the records.

The AAPL guidelines are to remind physicians who are doing an exam, if you're going to be in court saying I -- if I evaluated this person and that people will call it into question if you never met with them.

This happened in the -- in the Bowe Bergdahl case. I evaluated him. The prosecution hired a psychiatrist, Greg Blinkey, and he did not evaluate Mr. Bergdahl before we got into the courtroom.

So when I testified, I could speak directly about the nature and severity of his condition, and the other physician could not. And so the ethical guideline is simply reminding the person who's going to be doing evals, here's going to be the strengths and limitations of what you can do.

I was never asked to evaluate Ammar, and I was asked to

evaluate the context, the -- the EITs, the relationship to my research and what we know about human beings exposed to uncontrollable stress, and then to look in the record to say is -- is there information that you would -- that you could reasonably believe supports a diagnosis of PTSD?

And I said yes. There's plenty of evidence. It's adequate. And there's also subsequent evaluations.

That is a forensic assessment. It is not unethical. It is well within the range of work that I do and that my colleagues do, so...

Q. Do you agree that there are limitations on your opinion based on not performing an examination of Mr. Ali?

A. Yes. There are limitations.

Q. And limitations on your diagnosis of Mr. Ali as having PTSD?

A. No. There's not a limitation on that, but there is a limitation on the degree to which I can speak to prognosis.

Q. Do you agree that there's a limitation on your diagnosis of Mr. Ali based on only reviewing two medical records of Mr. Ali's?

A. Well, I think I've said that, no, I don't think it's limited because the information in those documents is highly relevant to making a diagnosis.

Q. So even if that's -- that's 1 percent of the medical

records of this guy?

A. Percentage doesn't matter. It's not the percentage. It's the quality of the data that you're evaluating. I could evaluate 100 pages of -- excuse my language -- crap. It would be irrelevant to making a diagnosis.

Q. Right.

A. But there might be one page that's entirely relevant. And with the documentation I saw, the information's directly relevant to whether or not there's enough things being documented that would meet medical criteria for the diagnosis of PTSD.

You can disagree with me on it all you want. We simply disagree on this point.

Q. All right.

A. It's my arena of expertise. I don't need to see 500 pages. If I see adequate information in two, that is enough for me to conclude, yes, this disorder exists. If I didn't think there was adequate information, I would not have put in my declaration that I think the condition of PTSD exists. It is something I do ----

Q. Fair enough.

A. ---- care deeply about. I know a lot about it. And you don't have to believe me. It's fine.

Q. Doctor, whether or not I believe you is irrelevant to these proceedings. You're a witness in this court. What matters is

the judge ----

A. I ----

Q. ---- but ----

A. ---- understand. I don't know why you're asking me about page counts, so...

Q. It goes with the territory of being an expert witness.

A. But I've answered it several times.

Q. Okay. Let's talk about your -- what you could have done during an examination of Mr. Ali, okay?

You've done these examinations before, right?

A. Yes. I've done thousands of examinations.

Q. You could have asked him about more details about his detention experience, right?

A. Theoretically, I could have.

Q. You could have asked him how his detention experience made him feel ----

A. In this ----

Q. ---- right?

A. ---- hypothetical scenario, yes.

Q. You could have asked him how he coped with detention, right?

A. In this hypothetical scenario, yes.

Q. You could have asked him what he did that was successful

or not successful in coping with his continued detention?

A. And again, in this hypothetical, yes.

Q. And you could have asked him about what made him anxious during detention, right?

A. It's possible, yes.

Q. You could have asked him what he felt like when he saw plastic chairs?

A. It's possible.

Q. You could have asked him what he felt like when he saw plastic tables?

A. It's possible.

Q. Towels?

A. It's possible.

Q. You could have asked him what he felt like when he saw shackles?

A. It's possible.

Q. How he felt when he was moved by guards?

A. I think that's documented in the record. But yes, I could have asked him that, yes, if I were in a position and asked to evaluate him.

Q. If you did an interview, you could have asked him all of these questions, right?

A. Maybe. I don't know if he'd ----

Q. Correct?

A. ---- I don't know if he'd want to talk about it. But if I hypothetically was asked to interview him, I could ask him those questions.

Q. And this information could help inform your diagnosis of Mr. Ali, right?

A. No. It would enhance the diagnosis I've already made. It ----

Q. Unless he said things inconsistent with what your diagnosis is, right?

A. No. In expanding the information he would have to say about those would give me more examples on the instrument that was used by Dr. Shea, the CAPS. The way the instrument -- the way we created that instrument is so that for each specific symptom of PTSD, for each one that they have, we can elaborate all the different places in which the symptom is displayed, for how long, how often, how much it impairs them, and those help us get to a rating of severity, which Dr. Shea did.

But for purposes of establishing a diagnosis, we only need to have persuasive medical evidence that a symptom criteria is present.

So in an interview with him, I would want to expand on them all if I had been asked to do an evaluation of post-traumatic stress

disorder ----

Q. Sure.

A. ---- because I would want to have a measure of more -- I would have a better detailed knowledge of the severity, which is where Dr. Shea placed his ratings on severity, and that would help -- that's why when you asked me about -- about -- and I said prognosis, you know, I would want to know about a prognosis.

I think knowing more detail about that would help me think if I had been asked about future treatment, then I would be able to make specific recommendations. But because I wasn't asked to do that eval, that was not my purpose and function, I didn't do those things. But if I was ----

Q. As a forensic ----

A. If I was asked, I could ask all those things, yeah.

Q. Okay. Yeah, as a forensic psychiatrist, it certainly would be appropriate to ask those types of questions of someone to evaluate the impact of -- of detention on that person, right?

A. That could be part of an assessment, yes.

Q. Sure. And how he was impacted when he was transferred to Guantanamo Bay in September of 2006, what that felt like to him, what he went through, any symptoms that he felt, those types of things, as a forensic psychiatrist, that's something that you could ask him?

A. If that was part of what the evaluation was about, yes.

Q. And that ----

A. I would ask him.

Q. And that would be helpful information for a forensic psychiatrist -- potentially, depending on his responses -- that would be helpful information for a forensic psychiatrist to have when making a professional forensic diagnosis. Is that fair to say?

A. That's fair to say.

Q. You could ask him about what it felt like to be able to send letters to his family starting in 2006?

A. It's possible. Like I said, I didn't evaluate him, so ----

Q. Right.

A. ---- when we think about a psychiatric evaluation, these are -- these are -- there are many, many questions we'd ask about different domains.

Q. Sure.

A. But that's probably what you should ask the doctors who saw him.

Q. Right.

A. Because we both know right now I did not do that.

Q. Right. And I'm just trying to -- trying to assess all these things you didn't do to determine whether or not that impacts -- the court can determine whether or not that impacts the

value of your diagnosis. So ----

A. Okay.

Q. ---- you -- you could have asked him about how he was using self-help books throughout detention to manage his anxiety. That's something you could have asked him, right?

A. I could have asked him that ----

Q. Okay.

A. ---- had I been asked to evaluate him, yes.

Q. And that information, how he was doing that or not doing that, that would be something that would be helpful for a forensic psychiatrist to know when determining whether or not, one, he was suffering from PTSD and, two, what caused it?

A. No. It would not. It would help me understand the degree to which he's able to read effectively and put exercises related to cognitive behavioral therapy into practice on his own.

Q. What -- what about when he -- what he felt like when he met with the ICRC at Guantanamo Bay? You'd be allowed to ask him about that, right?

A. I'm assuming I'd be allowed to ask him nearly anything.

Q. Right. And that could be something very impactful and important for a forensic psychiatrist, the reaction he had to meet with somebody from the outside world, so to speak, after being detained in CIA custody for over three years, right?

A. I don't know. It might be.
Q. You only would know if you asked him, right?
A. If it was relevant, it might be meaningful. But this is entirely hypothetical, so ----
Q. And you could have asked him, after he met with the ICRC at Echo II, the same room that you examined, how that made him feel, right?
A. No. That's already documented in the record.
Q. You could have asked him and ----
A. I could have asked him, but it -- yeah.
Q. You're -- you're telling me that the record, it's documented how meeting with the ICRC in Echo II made Mr. Ali feel?
A. I'm saying in the record, he's made nervous by the appearance of different people and on the topic, so I could anticipate what his answer probably would be.
Q. Well ----
A. But in all fairness, I didn't evaluate him and I could ask that question if that had been my task.
Q. Do psychologists typically just rely on their professional abilities and opinions and judgments to anticipate what a subject might say and just not ask them because they're so confident in their abilities to know what they're going to say? Is that a typical practice of a forensic psychiatrist?

A. You said psychologist first. I'm not going to speak for them ----

Q. As a psychiatrist.

A. As a psychiatrist, it would depend on what the task was we were asked to perform.

Q. You -- you were asked to perform a task of whether or not this guy had PTSD.

A. I was asked whether or not the conditions that he was in would be likely or not likely.

Q. No ----

A. Could they cause post-traumatic stress disorder and whether or not fear conditioning and contextual conditioning could be at play.

Q. Yeah. I'm not ----

A. Given ----

Q. Go ahead. Please finish.

A. I'm just saying, my task was specific. And you keep asking me to say that my task should have been something else, but please continue.

Q. But you opined not that a person might have PTSD because of their experience in the RDI program, you opined that this person has PTSD ----

A. I'm saying he does, yes.

Q. ---- as a professional forensic psychiatrist ----

A. Yes.

Q. ---- you did that by reviewing two medical records, disregarding thousands of other pages, not even requesting to speak -- to review any other psychological records ----

A. No, that's not ----

Q. ---- and not even interviewing him ----

A. No.

Q. ---- right?

A. That's absolutely incorrect.

I looked at documents that had relevant information from the past in 2006, and I looked at the medical reports, psychiatric reports, psychological reports, neuropsych and testing reports ----

Q. Okay.

A. ---- and those are valid.

So when I do a medical review, I've looked at data that's not from two pieces of paper. I've looked at data that's documented in the past from two documents. And then I've seen the professional evaluations that are valid and well within the range of what I'm used to looking at when I review other doctors' evaluations.

So I think it's a gross misconception for you to say it that way. I've actually reviewed professional medical evaluations by psychologists, psychiatrists, and I accept their view. I accept the

way they did their evaluation. It has high integrity to it.

You may not accept it. I'm just saying they're -- they're good professionals. I accept their opinion and I don't disagree with their opinion.

Q. Did you review the questions that were asked of Mr. Ali?

A. Well, for some of the testing, I know the questions that were asked to him in the evaluation.

Q. But did -- do you know whether he was asked any of the questions that I just asked you?

A. I know if the CAPS was done, and it was done, then they had -- he had to have been asked for examples and -- and circumstances in which specific PTSD symptoms emerge, the cues. I helped design that instrument, and that's what it's designed to do. So he had to be asked the questions. They're structured interviews.

Q. All right. You don't know whether or not he was asked about what it felt like meeting with the ICRC, though?

A. Actually, you'd have to talk to the doctor who talked to him.

Q. Okay.

A. But in the CAPS, in running through the PTSD symptom review, a person is directly asked about multiple situations that can trigger responses and which ones do not, and that very well may be of one -- one of them.

Q. Okay. You agree that would be a valuable -- potentially a valuable question to see that -- the kind of impact that might have on him, right?

A. It's valuable for assessing one symptom cluster in PTSD called "cued reactivity," which is only one of ----

Q. Right.

A. ---- 19 different symptoms. But it would be -- it would provide an example about whether or not the cue was shown or ----

Q. Right.

A. ---- what was made visible by exposure to that or not.

Q. And -- and one thing that would be important is to see what the reaction was of Mr. Ali when being exposed to Echo II, which you've suggested could be a cue for Mr. Ali, right?

A. Maybe. If he didn't display the -- if he doesn't display visibly the cue, that doesn't mean it's not -- it's not -- he's not reacting internally. If he did display it, then it would be present.

I'll give you an example. People think that since startle is a symptom of PTSD, if they slam the door in the evaluation and see the person jump, it proves they have startle. But if they don't jump, then they'll say startle's not there. That's ridiculous. Startle response doesn't work that way.

So whether you see a symptom or not, it has to be put in a context of an evaluation.

Q. And ----

A. So -- but that is something -- I mean, the courts could ask those physicians who saw him directly.

Q. And it could be important.

He went -- at the time, he was under the care of a psychiatrist, was receiving medical care. What he said to them potentially would be very valuable as far as that impact on him, of going to Echo II if that's truly ----

A. Could be. I don't know.

Q. ---- was a cue for him, he could have gone back and demonstrated PTSD symptoms, right?

A. Possibly. I -- I don't know. This is a hypothetical, so...

Q. No, he went -- it's not a hypothetical. He went to Echo II to meet with the ICRC.

A. I don't know what the doctor asked him.

Q. The International Committee of the Red Cross.

A. I'm saying I don't know what their interaction was, so this is hypothetical.

Q. Okay. But if records -- if records reflected that he exhibited symptoms after that, that could be important, right?

A. Depend -- if they're described and they mention the symptoms, that can be useful in a record review ----

Q. Okay.

A. ---- yes.

Q. And so assume that it was a cue and that Mr. Ali all of a sudden saw this room that looked like, you know, the rooms that he was in thousands of times during his CIA detention ----

A. Yes.

Q. ---- and it had a white plastic table and white plastic chairs.

Assume that that triggered this kind of response that you're saying you think it's likely that Mr. Ali would have, the contextual conditioning, right?

A. Yes.

Q. He'd want to avoid that, right? He would want to get out of there as soon as he could, right?

A. That might be one of the things he'd consider.

Q. Well, if it's ----

A. He may have assumed -- he may have learned that it's not possible, but it might be something that would be on his mind, yes.

Q. You're aware he was -- it was his decision whether he got to go meet with the ICRC or not?

A. I'm aware that there are decisions people can make. That doesn't mean they're not having conditioned responses.

Q. So you -- you're suggesting that -- that Mr. Ali, when he

was told that the International Committee of the Red Cross was sending people there to meet with him and that he'd be able to give them letters for his family and they would -- they could give him letters from Mr. Ali's family, that he was conditioned, and then -- and somehow that was an involuntary action that he said, yeah, I'll go talk to these folks?

A. No, that's not at all what I'm saying.

I'm saying that there are two competing things going on. There may be a desire on his part to meet with them for what's advantageous to him, but it doesn't mean that he doesn't have a conditioned reaction when he's in the room sitting at the table.

Q. All right.

A. He very much might be able to interact with them, but if it's been cue conditioned, he -- part of his brain would still be responding the other way. We know that from studying people, so...

Q. Okay. All right. So he could hide his symptoms, but then I think you agree that he'd want to avoid that situation, get a -- likely ----

A. Part of him might want to avoid it, yes.

Q. So he goes back and then meets with them again in December. So six weeks or so later he's advised, hey, ICRC's coming back. You can bring some more letters and meet with them. And he agrees. He says, "Sure, I'll go meet with those folks," same place

that he just went.

A. There is value to sending letters. So when you think about motivation and goals, people fly who are terrified of flying because they want to go see a family member. It doesn't mean they don't have a fear of flying and that they're not -- that they're -- that they're happy and relaxed and comfortable. They do it if one goal overrides the other.

Q. Well, wouldn't -- wouldn't a -- in this situation, assuming that he was cued by, you know, going to Echo II, that he would avoid that. He would -- he would, if he could, send letters outside of going to meet with folks from the ICRC. And he wouldn't sit down and meet with them, right?

A. I don't know. You'd have to ask him.

Q. Well, but -- but you're suggesting that that experience could be traumatizing for him based -- based on those cues, right?

A. I'm saying he'll have a conditioned response to the situation. The degree to which he can override it is directly related to a goal at the time.

Q. And ----

A. Like we can work with people who are psychotic, with schizophrenia, who are hallucinating. When the dinner bell rings, they can get to the table at the hospital and eat, right?

It doesn't mean they're not delusional. It doesn't mean

they're not psychiatrically ill. It means that they're able to perform certain functions. And all I'm saying is that if context conditioning has occurred, the cues of the environment, it depends on that situation, the degree to which he may be able to push through and override that.

That's -- one of the symptoms in PTSD, is that the degree to which someone has to work at -- at sustaining a behavior in the presence of the internal reactivity to the cue. And that's what's being rated on the instrument called the CAPS that Dr. Shea gave. So ----

Q. And ----

A. ---- it -- you -- you -- that is assessed in him. And the conclusion is that he has severe post-traumatic stress disorder.

And so the hypothetical, the ----

Q. Yeah, that's his conclusion, not ----

A. ---- it doesn't really make sense.

Q. We'll talk about your conclusion, right?

A. But my conclusion -- my conclusion is also based on what I've read in the -- in the evaluations of him.

My conclusion's based on those points in time that one anchors the other. I'm saying as early as 2006, there's adequate medical evidence to support a diagnosis of PTSD, among other things. There's plenty of proof for some other diagnoses. And later in time,

that is validated through valid psychiatric testing, psychological testing, and evaluations.

And people don't develop PTSD de novo 20 years later. You don't get PTSD from a traumatic event suddenly 20 years after the event. That does not happen.

It may have been suppressed, it may have been hidden, but it doesn't spontaneously appear magically so many years later. His testing is valid, which means in our profession, we accept it as a real diagnosis, as a real condition.

There's plenty of adequate information in 2006 that supports that, and that is why I can opine it is within a reasonable degree of medical certainty that he had PTSD at that time.

MJ [Col McCALL]: Mr. Groharing, it's 1800. So if you're close to wrapping up, we'll press on a little bit more. If not, then we'll just go ahead and recess for the evening and finish with your questioning tomorrow morning.

TC [MR. GROHARING]: If I could have a few more, Your Honor, I can try to get to the end of this section.

MJ [Col McCALL]: I mean, if it's just this section, let's just go ahead and call it a night.

So -- go ahead. I'm sorry. Did you have something more? All right. Yeah, we're just going to go ahead and call it a night, and we'll start 0900 tomorrow with your cross.

So I'd like the parties to stay in place, though. Just a little bit of housekeeping just to discuss the way forward for tomorrow.

Dr. Morgan, thank you for your testimony. Again, we're going to start back up with your questioning tomorrow morning at 0900.

WIT: All right.

MJ [Col McCALL]: Please don't discuss your testimony with anyone, to include counsel for any of the parties, but you're free to leave the courtroom at this time.

WIT: Thank you.

[The witness was warned, was excused, and withdrew from the courtroom.]

MJ [Col McCALL]: All right. The witness has left the courtroom.

So tomorrow we will continue on with the questioning of Dr. Morgan.

I know, Mr. Connell, you had mentioned this morning that -- and we changed it up depending on the witness and just how it makes sense to move back and forth between open and closed testimony. But -- so my plan would be to continue on with the cross-examination tomorrow morning, then allow for redirect, and recross if the government has that, and then move into a closed session, assuming we

can move into it in the afternoon. If not, then we'll see you when Dr. Morgan is available to finish his testimony.

LDC [MR. CONNELL]: Yes, sir. That makes sense.

MJ [Col McCALL]: And then are we on track to still be able to handle Dr. WK5I Thursday/Friday just given the somewhat time limits on trying to go late on Thursday/Friday?

Because again, I'm just looking at the bigger picture, and perhaps that doctor is available the following week when we have some white space, and then that will allow us not to try to rush to finish off Dr. Morgan, potentially go with him tomorrow and then also on Thursday. But again, I don't know the witness' availability.

Mr. Dykstra?

DMTC [MR. DYKSTRA]: Your Honor -- I just had a teen moment there.

We're inquiring with Dr. WK5I regarding her availability Monday or Tuesday of next week. She has traveled from the NCR. Agent McFadden is a local witness so should have a little bit more flexibility from that standpoint. So -- but we should have more fidelity regarding her availability probably tomorrow.

MJ [Col McCALL]: That's awesome. I appreciate y'all on the -- you know, looking, and the forward lean on that. Good.

DMTC [MR. DYKSTRA]: Anytime, sir.

MJ [Col McCALL]: All right.

Mr. Connell?

LDC [MR. CONNELL]: Only to say it's fine with us whenever she's available.

MJ [Col McCALL]: All right. Got it.

All right. Well, thanks for the hard work today.

The commission is in recess.

[The R.M.C. 803 session recessed at 1801, 07 May 2024.]

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