REBUTTAL REPORT OF DR. SONDRA CROSBY, M.D. April 7, 2017

Introduction

1. I submitted an expert report in this matter on November 21, 2016. That report contained my expert opinion regarding psychological and physical injuries suffered by Plaintiff Suleiman Abdullah Salim in connection with his claims in the present lawsuit.

2. Counsel for Plaintiffs have provided me with a copy of an expert report authored by Dr. Roger K. Pitman, M.D., dated March 24, 2017. Dr. Pitman's report addresses Plaintiff Salim's alleged psychological injuries and was written following his evaluation of Mr. Salim, and also opines on the conclusions I reached in my report.

3. I submit this brief rebuttal to Dr. Pitman's expert report. In particular, I address two issues raised in the report: that I am not qualified to render a forensic psychiatric opinion, and that the conclusions in my report should be discounted because I am "biased."

Qualification to Opine on Psychological Injuries to Mr. Salim

4. Dr. Pitman states that I am "*not qualified to render a forensic psychiatric opinion on Mr. Salim.*" Pitman Report at 25 (emphasis in original). He gives two reasons for this: that I am an internist, and that I have no post-medical school psychiatric training. *Id.* He takes particular issue with the fact that I have diagnosed Mr. Salim with complex post-traumatic stress disorder (PTSD). According to Dr. Pitman, complex PTSD is a "controversial diagnosis" because it is not presently incorporated into the DSM-5 Manual, and I "lack[] the psychiatric training to make such a controversial diagnosis[.]"

5. My qualifications are set out in paragraphs 5-10 of my report, and my resume was attached to that document. Dr. Pitman is correct that I am an internist: I am trained and board-certified in internal medicine. Dr. Pitman is incorrect, however, in stating that as an internist, I am necessarily unqualified to render a forensic psychiatric opinion regarding Mr. Salim. Diagnosis and treatment of common psychiatric diagnoses such as PTSD and depression are well within the scope of practice of primary care physicians.

6. Moreover, as an internist, I have extensive experience over the last 17 years in diagnosing and treating survivors of torture, refugees of war trauma, and victims of sexual and gender-based violence. As noted in my report, I have evaluated and examined approximately 1,000 torture survivors. Crosby Report ¶ 5. The patients I have diagnosed and treated in accordance with my clinical experience have endured a high degree of trauma, and I have acquired extensive experience in diagnosing and treating individuals suffering from PTSD and depression.

7. My expertise in the medical field in diagnosing and treating trauma has been recognized in multiple professional settings. I am on the faculty of the Harvard Program in Refugee Trauma and have taught Harvard's Global Mental Health course in Orvieto, Italy for the last 3 years. I have lectured extensively on the evaluation and treatment of refugees and torture survivors in cross-cultural settings, including evaluation of mental health symptoms. I have been qualified

multiple times as an expert witness to testify about mental health diagnoses in trauma survivors in the U.S. Department of Justice's Boston Immigration Court and the Military Commissions at the U.S. Naval Base at Guantanamo Bay, Cuba.

8. As to Dr. Pitman's more specific concern about my diagnosis of complex PTSD, the diagnosis of complex PTSD is indeed subject to diverse opinions in the literature and among practitioners. I am familiar with the relevant literature and also aware, as I noted in my report, Crosby Report ¶ 95, that complex PTSD is not currently listed in the DSM-5 or International Statistical Classification of Diseases and Related Health Problems (ICD) (10th ed.). However, complex PTSD is soon to be recognized as a discrete diagnosis by its incorporation in the updated eleventh edition of the ICD, which is scheduled to be published this year. I am confident that complex PTSD is an appropriate diagnosis, and I am qualified to make it in light of my considerable experience in working with individuals who have experienced severe, chronic, and sustained trauma, including torture. I am also confident that the diagnosis is accurate in Mr. Salim's case based on his pervasive and prolonged symptoms and functional impairment, as detailed in my report, Crosby Report ¶ 95-97. In fact, the extent of Mr. Salim's functional disability as a result of prior torture is as severe and diverse as I have seen in my clinical experience. Finally, as Dr. Pitman himself concludes, even 14 years after Mr. Salim's initial capture, detention and torture, Mr. Salim is seriously disabled as a result.

Bias

9. Dr. Pitman asserts that my "*report is biased.*" Pitman Report at 26 (emphasis in original). He states that this is because my publications suggest that I am "a long-standing, vocal advocate against torture," and because I acted as a treating physician for Mr. Salim beginning in 2010. *Id.* To support this assertion, Dr. Pitman includes excerpts of what he considers examples of bias in my report.

10. Dr. Pitman is correct that I oppose torture under all circumstances. This is evident from my publications, as he states, but one need not look to my publications to note this. I have made the diagnosis and treatment of torture survivors a central facet of my professional career because I am devoted to assisting those who have endured such inhumane treatment.

11. However, Dr. Pitman makes a logical error in concluding that my opposition to torture generally informs my diagnosis and expert opinion on the facts of this particular case or any case. That I oppose torture does not require or even suggest that I take any particular position as to whether or not a particular individual suffered torture, whether that individual may have resulting injuries, and whether any such injuries are attributable to any particular torture techniques – a matter of particular significance here.

12. To underscore this distinction, between opposition to torture generally and my professional opinion in individual cases, I would note that I am co-founder and Director of the Forensic Medical Evaluation Group (FMEG), which is part of the Immigrant and Refugee Health

Program at Boston Medical Center. At the FMEG, my colleagues and I perform forensic evaluations of persons alleging physical and psychological abuse. I oppose physical and psychological abuse on moral grounds, and have advocated against it, having seen first-hand the harm that it can cause. Nonetheless, in individual cases, I have sometimes declined to provide my expert opinion in support of an asylum claim based on abuse if the medical and psychiatric evidence did not corroborate such a claim. I took the same professional approach to Mr. Salim. My opposition to torture did not inform my evaluation and conclusions as to whether *Mr. Salim* had been tortured, whether he suffered injuries as a result, and which particular forms of torture or hardship caused such injuries. Indeed, I reached the conclusion that Mr. Salim was suffering the severe physical and psychological effects of torture in 2010, long before the initiation of this lawsuit.

13. With regard to Dr. Pitman's claim that I am biased because I previously acted as Mr. Salim's treating physician, it is true that my general practice is not to serve as an expert and a treating practitioner for the same patient. I made a rare exception to this practice in Mr. Salim's case in light of the extraordinary circumstances of my initial evaluation of Mr. Salim in 2010. At that time, I considered Mr. Salim to be seriously impaired by psychiatric and physical injuries and in need of appropriate treatment. However, there were no resources in Tanzania to which I could refer Mr. Salim. Ethically and morally, I could not leave an individual suffering from such serious injuries with no apparent avenue for relief, and I therefore tried to find suitable treatment for him through other practitioners, and kept myself apprised of Mr. Salim's condition through periodic text messages and phone calls with Mr. Salim. I was unable to ensure or provide a full and complete course of treatment for Mr. Salim, but I believe my involvement during that period was justified and necessary, in the circumstances. I refute Dr. Pitman's claim that my evaluation was biased as a result. The fact that I sought to assist Mr. Salim in dealing with his psychiatric injuries has no bearing on the conclusions in my report, many of which Dr. Pitman does not dispute.

14. I also note that there are advantages to the duration of my relationship with Mr. Salim in conducting a forensic evaluation in this case because I have established a relationship of trust and confidence with Mr. Salim. Dr. Pitman, who I understand from his report spent less than a day with Mr. Salim, could not have achieved a comparable level of trust, and that is evident in his report. For example, Dr. Pitman states that Mr. Salim's psychiatric injuries do not "dramatically interfere with his ability to enjoy life" because Mr. Salim told Dr. Pitman that "he is happily married" and "enjoys spending time with his family." Pitman Report at 28. This opinion rests on a faulty factual premise: that Mr. Salim in fact has close, supportive relationships with his family. In fact, I know based on my interactions with Mr. Salim that, since returning to Zanzibar, he has had persistent difficulty with emotional attachments to family members, including his wife. As a result, the relationship with his wife and family is strained. This emotional and relationship avoidance is one of the functional impairments suffered by Mr. Salim, and it causes him ongoing distress. Such pervasive disturbances in relational capacity are one of the hallmarks of complex PTSD. Crosby Report § 86(g). Dr. Pitman recognizes in his report that Mr. Salim practices avoidance in his description of past traumatic events and the way that they affect him. Pitman Report at 11. The amount of time I have known Mr. Salim has allowed me to establish trust so as to break through Mr. Salim's avoidance barriers and develop a

more accurate factual accounting. Far from undermining my objectivity, my previous work with Mr. Salim has in fact enabled a more accurate assessment in this case.

15. Finally, the excerpts of my report included in Dr. Pitman's report do not, in fact, demonstrate bias. For example, Dr. Pitman excerpts my conclusion that Mr. Salim's back and shoulder pain, with low back pain and sciatica in the right leg, is attributable to being shackled with his arms overhead so that his feet barely touched the floor "for several days consecutively." Pitman Report at 27 (quoting Crosby Report ¶ 114). Dr. Pitman states, "[b]eing hanged by one's arms is no doubt a stressful position. However, Mr. Salim told me that this lasted less than two days, not four. More importantly, there is no evidence in the records that Defendants ever devised or advocated such a heinous thing." Pitman Report at 27. First, the fact that Mr. Salim told Dr. Pitman and I, respectively, that this torture lasted for a different number of days is unsurprising—Mr. Salim told me was that he could not entirely accurately estimate the number of days because he could not track the time accurately as this torture occurred; nevertheless, that Mr. Salim estimated a longer number of days in his description to me, as opposed to Dr. Pitman, is not evidence of bias on my part. Furthermore, my understanding from communication with counsel for Mr. Salim is that suspension by the arms in the manner Mr. Salim endured was indeed an established technique for the purpose of sleep deprivation. It would appear that Dr. Pitman is unaware of this fact. I agree, however, with Dr. Pitman's characterization of the technique as "heinous."

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