EXHIBIT B

Dr. Emily A. Keram Report

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Ramzi Kassem
Main Street Legal Services, Inc.
City University of New York School of Law
2 Court Square
Long Island City, NY 11101

Re: Shaker Aamer

Dear Mr. Kassem:

At your request, I evaluated Shaker Aamer, a 47-year-old married Saudi Arabian national and British resident, who has been detained under the command of Joint Task Force Guantanamo (JTF-GTMO) since February 2002. I met with Mr. Aamer in Camp Echo for approximately 25 hours from December 16-20, 2013.

The following report contains my evaluation and opinions regarding Mr. Aamer. I reserve the right to modify these should additional material become available in the future. I will provide a supplemental report should you request additional opinions in the future.

Qualifications

I am board certified in Psychiatry and Neurology with a sub-specialization board certification in Forensic Psychiatry. I have been in practice for over 20 years. I have treated patients with Posttraumatic Stress Disorder (PTSD) secondary to both combat stress and Prisoner of War confinement, at the US Department of Veterans Affairs Community Based Outpatient Clinic in Santa Rosa, CA for 14 years. I have worked as a clinician and a forensic evaluator in a number of jails and prisons in the Federal Bureau of Prisons, state prisons, and local detention facilities in North Carolina and California. I am familiar with accepted standards of conditions of confinement and provision of medical and mental health services to individuals incarcerated in local, state, and federal confinement facilities in the United States.

I have evaluated several GTMO detainees over the past ten years at the request of the Office of Military Commissions-Defense Counsel, the United States District Court, District of Columbia, and several habeas attorneys. The following are some of the issues I have evaluated in previous assessments of GTMO detainees:

1. Diagnostic assessment, functional assessment, required treatment, and prognosis

2. Capacity to participate in legal proceedings
3. Whether conditions of interrogation at Bagram and Kandahar Airfields and GTMO were consistent with conditions known to be associated with false confessions
4. Rehabilitative potential
5. Effects of conditions of confinement at GTMO on detainee mental and physical health
6. JTF-GTMO Hunger Strike policy and procedures
7. Joint Medical Group (JMG)-GTMO behavioral health services

With respect to testimony, I have qualified as an expert witness in the States of California and Arizona; U.S. District Courts in California, Washington, North Carolina and the District of Columbia; as well as in the tribunal of the Military Commissions at the U.S. Naval Station Guantanamo Bay, Cuba.

Reason for Referral

Mr. Aamer was referred to me for evaluation and opinion regarding his psychiatric and diagnosis and prognosis and his current physical status.

Summary of interviews with Mr. Aamer

1. Conditions of interrogation and confinement

Mr. Aamer has been continuously detained since late 2001. He was first held by the Northern Alliance. On approximately December 24, 2001 he entered American custody and was held in Kabul for several days. He was transferred to Kabul Airfield after several days where he remained for approximately one month. He was subsequently held at Kandahar Airfield until his transfer to Naval Station Guantanamo Bay, where he arrived on February 14, 2002. We discussed his conditions of confinement in each setting.

Mr. Aamer described his detention by the Northern Alliance.

> "I lost all sense of time. I was in a basement with a lot of people who were also being tortured. I was hearing people screaming from the torture day and night. I was treated with respect in terms of privacy in the bathroom, preparing for prayer, and meals. But they would beat you two to three hours a day with a metal braided wire, belts, and a hose. They beat you in public. Everyone could see. Five people would beat you. They'd kick your face, body, and head.
>
> Once I arrived I was beaten up for a few days without interrogation. Then they told me a man would come the next day and that I should tell him whatever he wants to hear and the torture would stop. I said I would. They told me I would have to agree that I was working with bin Laden in a high

> intelligence service like the CIA, working undercover collecting information. I said, 'No problem.'
>
> The next morning a man in western clothing came with a video camera and filmed me and the other brother's in my cell. Then a Northern Alliance interrogator sat at a table with me and the other man videotaped my confession. I said I was working with al Qaeda and was working in high value intelligence. It was a short meeting. The interrogator held up the wire to the camera and said, 'This is how the Taliban torture and get confessions. But as, as you see, our interrogators just sit and talk, and the prisoners voluntarily tell us what they've done.' Two days later I was in American custody."

Mr. Aamer stated he decided to confess to end his torture. He understood from what he had heard about prisons in Saudi Arabia that his maltreatment would end if and when he agreed with his interrogators.

> "This is a transaction, a deal. 'You say what we want you to say and we'll stop torturing you.' It's a deal. The torturing stops if and when I confess. I knew that if I didn't sign I would have more beatings. The decision to make a false confession is not shameful, because it's not about being a man; it's about ending the torture. In Saudi, once you confess you live like a king in prison. You're only there for six months usually. They help your family while you're there. Even if you get sentenced to 15 years, one third will go away for good behavior; one third goes away for memorizing the Koran. At most, you might serve five to seven years."

Mr. Aamer and I reviewed his conditions of confinement at Bagram Airfield. He reported severe maltreatment by guards, interrogators, and medical personnel working in concert, by means of humiliation, sleep deprivation, exposure to cold, manipulation of food and water, stress positions, threats of sexual assault against his young daughter, and beatings.

> "The nakedness made me feel animal-like. I was not a human being anymore. I meant nothing to them. I lost my dignity, my pride, being a man. I had to take off my underwear and hand it to them. You lose your humanity. You are an animal. You know if you don't do it, they will do it by force and it will be a lot worse. I respected and believed they would give me a fair chance because they were Americans. I was happy that I was with Americans because of their human rights.
>
> I had sleep deprivation for 11 days. That made me crazy. They poured cold water over me. They kept me standing for 20 hours a day. I had to hold my hands and arms out. If I dozed off they would bang on the concrete with an axe. The sleep deprivation caused hallucinations. It started with noise. Then I heard old music from my childhood. I wondered, 'Where did they

> get those tapes?' I heard people talking. I started looking for who was talking. There was no one there. No one else heard them. Finally I heard music from my childhood that I knew they never could have found. I talked to the doctor about it. He said I was going crazy. He told me, 'You should talk to the interrogators so then you can relax.'
>
> They withheld food, except for frozen MRE's. They would give you a bottle of frozen water. You didn't want to drink because it would make you have to pee. The guards won't take you to pee so I peed where I was sitting. I didn't have a bowel movement for 25 days. My stomach became like a stone. I didn't see a doctor initially because the interrogators were happy because I was telling them everything, whatever they wanted. [Interrogators controlled access to medical personnel] Then the doctor gave me a laxative. They took me to a hole. Female and male guards were watching. A guard pulled down my coveralls and told me to shit. It was very hard. I had to push hard. The female and male guards were joking. A female said, 'Look, he's having a baby.' I passed what felt like stones. The guards gave me a tissue from an MRE to wipe myself. It was bloody. I felt so humiliated.
>
> All of the statements I made at Bagram were during the sleep deprivation. I would have said anything. I told them, 'I will tell you I am bin Laden if you want me to tell you I am bin Laden.'"

Mr. Aamer described the effects of maltreatment on his mental state.

> "It's a process of losing your mind. First it's knowing you are not in control of yourself anymore. Someone else is in control of you. So you fool yourself and think, 'Well, he's only controlling me physically, but not mentally.' They're not in your head. But then you realize you're wrong and they control your mind.
>
> Then it's welcome to the microwave. It's easy to crack an egg from the outside. It's hard to blow up the egg from the inside. They let you recover so you think you're strong again. And then they break you again. And you thought you were strong again. And you don't know your thoughts anymore. Like the microwave, they boil you from the inside to the outside until you explode.
>
> After the microwave, the eggshell may be intact because the heat penetrated to the inside. The shell looks strong. But if you crack the egg, inside you will see charcoal.
>
> So I would go to the interrogators thinking, 'How can I lower the level of torture? What can I say to please him? I am going to be so easy with him today, I will please him.'"

Mr. Aamer stopped himself at this point. After a moment he explained his fear that the material we discussed would be used as the basis of creating manuals for how to effectively interrogate him or manipulate his behavior in the future.

> "It makes me scared to talk about it. I've been keeping it all inside. I'm scared because they are listening to us now and they're learning; I'm teaching them how to interrogate. And now they will write a whole new book on interrogation with what they have learned.

After a few minutes, Mr. Aamer returned to discussing the interrogations.

> "It's a terrible procedure. The interrogator starts to talk with you about things that are small and well known. You agree. But he is driving you to a cliff. The more you drive with him on his interrogation, he starts throwing out fish bait, so little by little they show you that they are interested in knowing who you are. They do this by saying, 'Shaker Aamer, we know you; we know who you are. We know you are nobody. We know you are a small fish rubbing shoulders with the big fish.'
>
> My goal is, 'How can I minimize the torture? I just want to sleep.' I never had a goal more than that. It was never my goal to get out of the facility and be freed. My goal was just to lessen the torture. The problem is, not all the small fish know the big fish; but you want to lessen the torture.
>
> So, their interest in you makes you trust them. You start to tell them the truth; you build the truth by telling the story in chronological order. You build the building one story at a time. Until I separated from my wife and go [sic] to hide in the mountains and wait for the man to take me through the mountains. The interrogators asked me the name of the mountains, the name of the man who would guide me. I didn't know. And that's when the interrogators went crazy.
>
> The interrogators threw chairs. They put me in a grey disc with my legs spread. They banged the chairs. And you are just trying to avoid any hit. They shook me. They threw me on the ground. They banged my head into the wall.
>
> I was telling them the truth. Their interest made me trust them. It made me hope the torture will decrease. But when I couldn't tell them what they want [sic] to hear they made me stand for hours, they scream at me, they bang into me. You aren't even thinking beyond how to protect yourself and not attack them so that you don't get a bullet in your head. They do that until you are shivering, until they have broken you, until your mind is completely empty. You feel like you're not real anymore. Like it's a dream.

And now the worst part comes. They treat you with kindness. It destroys you completely. Your thinking is paralyzed. Your feeling is paralyzed. And the interrogator says, 'I am trying to help you.' You don't know what to love and what to hate because it's all happening at the same time. You don't know anything anymore. You can't tell apart good and bad, kind and evil. You lose the sense of the meaning of kindness.

You ask yourself, 'Are they really trying to hurt me or are they trying to help me?' You can't tell anymore. They bang your head on the wall and then they give you a hot meal.

One interrogator talked about what he would do to my five-year-old daughter in details that destroyed me. He said 'They are going to screw her. She will be screaming, 'Daddy! Daddy'' You are completely disorganized. You are completely destroyed.

It happened many times. You learn they don't really want to hear what the truth is. The truth only results in the same; more torture. So you begin to follow their story; they ask you questions, they give you descriptions and you agree. What was the color of the car? Did the driver look like this? Was the driver from al Qaeda? I answered, 'How should I know.' They said, 'Well, a taxi driver wouldn't drive to this compound would he, so he must be al Qaeda. The taxi driver takes you to the Arab guesthouse so the taxi driver is al Qaeda and the Arab guesthouse is al Qaeda.'

The interrogators give you the details, but they don't want you to agree. They say have you seen a fat guy? A guy with a turban? This guy? That guy? Guess what? Those guys are al Qaeda. And then you feel like that you are al Qaeda. Then the interrogators tell you that al Qaeda recruited you without you knowing it; they were behind funding your travel.

Then they ask you to sign a statement. When I say no, the whole thing starts again. In the end, I offered to my interrogator to sign that I am al Qaeda, everything the interrogator wanted me to sign, if the interrogator would agree not to interrogate and torture me anymore. And the interrogator said, 'I can't tell you that we won't interrogate you anymore.'

No matter what you said, they still wanted more. So they kept torturing me no matter what. The degree of the torture would change. Maybe they would let me sit for a brief period of time and then it would get worse again.

For the first 25 days at Bagram it was constant severe torture. For the last week they left me alone with the other detainees in a room with a heater. We all had frostbite. The interrogators only asked what we knew about certain people, but they weren't pushing me for specific information.

> I didn't see the sun except twice while I was at Bagram. And then there was 'The Big Goodbye Party' when you leave for Kandahar. I was beaten, shackled, and hooded. The guards laughed and cursed me. I was roped together with other detainees. Then the plane didn't come. The next day they gave us another 'Goodbye Party.' We weren't allowed to use the toilet. The plane came. I was fearful, thinking, 'If this is happening right now, what is coming next? Maybe they're getting ready to shoot me? Maybe it will be something worse than this.'"

Mr. Aamer experienced severe maltreatment at Kandahar Airfield with identical effects on his physical and mental state.

> I was shipped to Kandahar. The airplane was freezing cold. Someone took my socks from me. And then the 'Welcome Party.' They told the soldiers they could do anything they wanted with the detainees. We landed. They put us face first on cold concrete. We were shivering. They hit me with gun butts, kicked me with boots, and stomped on my back.
>
> There was a 17-year-old detainee. They put a gun up his rectum. He was screaming, 'I'm no woman! I'm no woman!' I yelled at the guards to stop in English. Then, because I spoke English the soldiers said, 'He's a traitor. He speaks perfect English.' They beat me even harder. A black female soldier stopped them, saying, 'You've had your fun.'
>
> At about 0600, after 20 minutes of not being beaten, they put me in a cage with a blanket. They put me on my face and unshackled me. Then they ran out. They gave me bread. At about 0730 or 0800 they yelled at me to get up. They put my head on the ground, hooded and shackled me and took me to the interrogators tent. I was kept awake for 10 days.
>
> The torture in Kandahar was more physical than in Bagram. They shook me, threw me on the floor, made me hold my arms out, hit my hands. There was no blanket, just lying on the ground. There was a nice thick blanket lying on the floor, but if I reached for it they would start beating me.
>
> Two interrogators named John and Tony and a guy named Sallie or Sal took turns for three to six hours at a time or two to three hours at a time. There was also an Egyptian. They were with me almost all the time. At least I had my own place in Bagram; I was in a cage and the guards were on the outside. That was a comfort to me. But at Kandahar there was nothing between me and the guards. They were in the tent. If I closed my eyes, the guard would say to open them.
>
> The interrogations at Kandahar had the same process as at Bagram in terms of the interrogators being both cruel and kind. The worst was Sal. He was so kind. He sat me outside the tent with the guards and heated up my food.

> The guards were starting at me. I felt humiliated. Sal talked to me as if I were a human being. Then Sal would say he was going to screw my five-year-old daughter; he was going to do this and that to my daughter sexually; how my daughter would scream and scream. I thought about attacking Sal and getting killed. But I wouldn't do anything aggressive. Force is the weapon of the coward.
>
> This went on for 10 days. It was constant interrogation and torture. I told them the exact same truth that I had told the interrogators in Bagram, plus they had more true information about me. I also told the interrogators things that weren't true in order to decrease the intensity of the torture I was suffering.
>
> In those ten days, I only went to the toilet once. I had sleep deprivation. The ICRC came to see me in Bagram one time. Then they came to Kandahar to see me. They took me to a cage with other detainees. The judge from the ICRC saw me there, a Swiss judge. He gave me a card with my number on it.
>
> After 10 days they sent the Egyptian guy who told me I was going to Guantanamo. They put me in a cage for four days and pretty much left me alone. A British agent came to see me, a young officer with a red beret. I wouldn't talk with him because he said he couldn't do anything to help me. The Americans only asked me questions those last four days at Kandahar like the last days at Bagram. They didn't press me to lie about anything.
>
> After four days they gave me the 'Goodbye Party' at Kandahar and a far worse 'Welcome Party' at Guantanamo."

The maltreatment and its physical and mental effects continued at Guantanamo.

> "The interrogations at Guantanamo have twists. There's a "frequent flyer program" where they move you every two hours. The guards shout at you in the same block. They switch the water off. They spray Pine Sol in my clothes.
>
> It's the same process psychologically; I can't tell cruelty and kindness apart. I told the interrogators everything to decrease the torture severity. Another thing that was at Guantanamo that was not at Bagram was the circles within circles. The guards were connected with medical, were connected with the people who gave supplies like linens, were connected with the administration like the NCO's, were connected with the Navy or the Army, were connected with the CIA, were connected with the FBI, were connected with the Republicans and the Democrats. All of these people want to squeeze my neck at the center of all of the circles. You tell them what they want to hear to decrease the severity of the torture.

> For example, an internist came to see me. I asked for a blanket because I have arthritis and the cold air conditioning makes it worse. The doctor said the arthritis is in my record and agreed that it was cold. The doctor said, 'I will ask permission from the Joint Detention Group (JDG) for a blanket for you.' And the doctor says he's independent.
>
> The worst thing about torture is that you don't know how to think, what to do, how to feel. You know you have your mind, but you don't now how to react, which is horrible because you feel vulnerable. It's terrible. We believed that the people here; the CIA, the interrogators, use 'djinn.' [spirits] The evil djinn. Some of the things that happened, you can't explain. Some people with think that it was drugs or something, but 95% of us believe we got possessed by djinn."

During the time Mr. Aamer was interrogated at Guantanamo he and other detainees would run to use the toilet or experience diarrhea when they were told it was their turn to be interrogated, "We might be tied up and not be allowed to go to the toilet for up to 36 hours at a time." He believed they experienced diarrhea reflexively because they would no be allowed to go to the toilet during interrogations.

2. Other conditions of confinement

Mr. Aamer has experienced especially difficult conditions of confinement throughout the time he has been at GTMO. He was initially housed in an open-air cage in Camp X-Ray. He was exposed to sun, weather, insects, and other pests throughout the time he was confined there. He first undertook a hunger strike while at Camp X-Ray.

Mr. Aamer has been episodically confined in isolation, including a continuous four month period. During this time he had no contact with other detainees and minimal contact with guards. The only natural light in his cell entered via a small panel covered with a translucent barrier. Mr. Aamer experienced severe anxiety and dysphoria during this period of confinement, as well as auditory hallucinations. He developed tinnitus (ringing in the ears) during this period, which has become chronic.

Mr. Aamer frequently participates in the hunger strike. In addition to the toll this has taken on his physical and mental health, use of the feeding chair and enteral feedings have caused him to feel humiliated and degraded.

Use of the toilet remains problematic for Mr. Aamer. He reported that if the guards cannot see him they call out to him. He does not respond because as a Muslim he is proscribed from speaking while using the toilet. When he doesn't answer, the guards call a "Code Snowball" [detainee engaging in self-harm] and rush into his cell. He finds this humiliating and degrading as well.

3. Current psychiatric symptoms

Mr. Aamer currently experiences prolonged psychological distress and physiologic reactivity on exposure to reminders of trauma. Most notably, at numerous times during the five-day evaluation he became visibly agitated and interrupted himself when discussing the severe maltreatment he's experienced. At those times he either stopped talking or repeatedly engaged in apparent efforts to distract himself from painful and disturbing memories by suddenly and loudly singing. The lyrics he sang referred to his maltreatment, "Sweet dreams are made of this. Who am I to disagree? I travel the world and the seven seas. Everybody's looking for something. Some of them want to use you. Some of them want to get used by you. Some of them want to abuse you. Some of them want to be abused." He would then lose the thread of our discussion and have to be brought back to its content.

Mr. Aamer described other examples of psychological and physiological distress when exposed to reminders of trauma. When the Forced Cell Extraction (FCE) team prepares to deploy, even when he is not the target, Mr. Aamer experiences rapid heart rate and anticipatory anxiety. He feels irritable, sad, angry, hopeless, and helpless. Additionally, Mr. Aamer is fearful of using the toilet. Because the opportunity to do so was often withheld from him during interrogations he associates his ongoing painful urinary retention, constipation, and efforts to relieve himself with memories of being interrogated.

Mr. Aamer evidenced efforts to avoid distressing memories associated with traumatic events. As noted above, by distracted himself by singing when discussing maltreatment he experienced during his detention.

With respect to negative alterations in cognitions and mood, Mr. Aamer noted persistent negative trauma-related emotions including fear, anger, and shame. He has markedly diminished interest in significant activities. "You lose an appetite for anything. Your mind becomes numb. You feel you are in a box and you don't know how to get out. I feel useless because I have no ability to change things. I have no good feeling reading, even reading the Koran. You feel you've lost even the Koran."

With respect to alterations in arousal and reactivity, Mr. Aamer reported feeling angry, irritable, and short-fused on a daily basis. He has angry outbursts that he is trying to better control. He experiences chronic initial, middle, and terminal insomnia. He endorsed impaired concentration and memory, hypervigilence, and exaggerated startle response.

Mr. Aamer endorsed current symptoms of depression in addition to those that overlap PTSD symptoms. He noted marked anergia, which is likely also affected by hunger strikes. He feels guilty about not parenting his children. "The most horrible thing is being away from my family for so long."

Mr. Aamer reported that he compulsively cleans his cell twice daily.

Mr. Aamer endorsed paranoid ideation. He believes there is a device implanted behind the wall of his cell that was originally accessed via the utility room and is used to introduce some type of beam into his cell.

> "They are highly advanced in harming human beings. They have devices and the devices have some way of maybe beaming, maybe electromagnetism or some kind of radiation, but it can harm your body from a distance.
>
> I have proof of the existence of the device in my cell. Three times I have heard a certain steady noise and then had fever, failure of my body to move, shaking, a feeling of being in a trance, joint pain, and an abnormal heartbeat. I can tell the concentration of the noise or field. It varies in different places in my cell. I can move my head to different heights and feel the field strengthen and weaken.
>
> I think the device is behind the toilet [of his current cell] because they always used to put me in a side cell but since March 2013 I'm always in the first or second cell. Most of the time they only do it [activate the device] when other detainees are far away. I believe they isolate me so they can do it without the other detainees hearing it or feeling it, so it makes it seem like I've lost my mind."

When asked if he believes the device is real or somehow the product of his mind, Mr. Aamer replied,

> "It's one of two things. Either the device is really there or it's a gimmick. They want me to think there's a device there and make me believe it by pretending to check the device at the same time they say to me, 'You look terrible, are you feeling okay?'"

Mr. Aamer finds it suspicious that guards used to open and close the utility door so often. "Why else why they do that if there's no device there?" Recently a Filipino electrician employed by a base contractor worked in the utility room. Mr. Aamer believes he installed a remote control to operate the device. "Since the Filipino came and installed the remote, they [the guards] never open the door to the utility room again." Whenever he hears the noise from the device, Mr. Aamer checks the strength and concentration of the field.

Finally, I observed that on the first day of the evaluation, Mr. Aamer evidenced a psychiatric symptom known as "loose associations," in which a person loses the ability to maintain their train of thought. This is expressed by jumping from one minimally related topic to the next in thoughts and speech. With more contact and the structure of the evaluation, this symptom resolved over the second day.

4. Review of systems

1. Headaches (likely migraine) with aura, usually lasting six to eight hours, occasionally lasting up to 24 hours and usually resolving with sleep; Headaches may be triggered by exposure to certain fumes, such as the cleaning fluid, Pine Sol, which is used in his housing.
2. Tinnitus consisting of three tones; a constant high pitch, a constant low pitch, and a "thrumming" that sounds like "a hummingbird's wings."
3. Bilateral ear pain
4. Worsening vision
5. Asthma symptoms triggered by exposure to dust, cold, and fumes
6. Urinary retention
7. Bilateral kidney pain, left greater than right
8. Chronic constipation
9. Lower extremity edema

5. Physical exam

Physical exam was limited by the conditions of the evaluation by my medical specialty. Of serious concern was the presence of bilateral lower extremity pitting edema, which worsened over the course of the day, from 1+ to 3+.

Additionally, the junction of Mr. Aamer's ear canal and tympanic membrane was red and weepy bilaterally. Tympanic membranes were visualized bilaterally.

6. Current medical concerns

1. Pitting edema
2. Urinary retention
3. Migraine headaches
4. Asthma
5. GERD (reflux)
6. Constipation
7. Tinniuts (ringing in ears)
8. Otitis media (inflamed middle ear)
9. Rule-out refractive error

Opinions

The following are my opinions to a reasonable degree of medical probability.

Mr. Aamer's current psychiatric diagnoses

Mr. Aamer has suffered psychiatric symptoms throughout his twelve years of detention by American authorities. In accordance with the American Psychiatric Association's Diagnostic and Statistical Manual, 5th edition, 2013, Mr. Aamer's psychiatric diagnosis is Posttraumatic Stress Disorder (PTSD). As described below, he has additional psychiatric

symptoms related to his current confinement that are not included in the diagnostic criteria for PTSD but which also gravely diminish his mental health.

PTSD symptoms are divided into criteria including exposure to a stressor; intrusion symptoms; avoidance; negative alterations in cognitions and mood; and alterations in arousal and reactivity.

As noted above, Mr. Aamer's exposure to traumatic stressors has taken place throughout his confinement. With respect to intrusive symptoms, Mr. Aamer experiences prolonged psychological distress and physiologic reactivity on exposure to reminders of trauma. He feels irritable, sad, angry, hopeless, and helpless on exposure to these reminders. He was visibly agitated when discussing traumatic material. Mr. Aamer is fearful of using the toilet. Because the opportunity to do so was routinely withheld from him during interrogations he associates his ongoing painful urinary retention, constipation, and efforts to relieve himself with memories of being interrogated.

With respect to negative alterations in cognitions and mood, Mr. Aamer noted persistent negative trauma-related emotions including fear, anger, and shame. He has markedly diminished interest in significant activities.

With respect to alterations in arousal and reactivity, Mr. Aamer reported feeling angry, irritable, and short-fused on a daily basis. He has angry outbursts, which he is trying to better control. He experiences chronic initial, middle, and terminal insomnia. He endorsed impaired concentration and memory, hypervigilence, and exaggerated startle response.

Mr. Aamer endorsed current symptoms of depression in addition to those that overlap PTSD symptoms. He noted marked anergia, which is likely also affected by participating in the hunger strike. He feels guilty about not parenting his children.

Mr. Aamer evidenced several symptoms consistent with prolonged incarceration in a profoundly under-stimulating environment. This collection of symptoms is commonly referred to as "Special Housing Unit (SHU) Syndrome." These symptoms appear to have waxed and waned with his conditions of confinement, for example, worsening when held in isolation and improving when able to have some interaction with other detainees. This included profound dysphoria, increased anxiety, and auditory hallucinations. Mr. Aamer experienced hallucinations, dysphoria, and a profoundly disrupted sense of self during the time he was held in isolation. He is at risk for re-experiencing these symptoms in under-stimulating environments and during periods of increased stress.

Mr. Aamer evidenced other psychiatric symptoms as well. As noted above, Mr. Aamer evidenced loose associations on the first day of the evaluation. Loose associations impair function by disrupting focus, attention, and goal-oriented behavior and by making it difficult for listeners to understand conversation. Loose associations are typically a symptom associated with psychotic diagnoses. However, they may also develop in monotonous and under-stimulating environments, such as Mr. Aamer is currently

experiencing. This is likely the cause of his loose associations, as they dissipated over the course of the day in the context of the structure provided by the interview.

Mr. Aamer evidenced paranoid ideation regarding a "device" located outside his cell that guards use to flood his cell with a beam or type of radiation.

As is the case with many detainees, Mr. Aamer is hyper-focused on controlling aspects of himself and his environment that he is able to influence. This is generally understood as an attempt to create and maintain some sense of personhood, dignity, and autonomy in conditions that erode one's sense of their humanity and self-governance.

Mr. Aamer's efforts to control his environment and to bolster his sense of humanity, dignity, and autonomy include his obsessive attention to cleaning his cell, his demand for consistent JTF policies and procedures, and his intermittent oppositional attitude toward guards. He accommodates to a set of camp rules and creates methods for fostering his sense of control and autonomy within those. When these policies and procedures are changed or arbitrarily enforced, his response appears disproportionate because its intensity is driven by the loss of his personhood, and not the issue at hand. In some situations, his "non-compliance" may thus be misinterpreted as primarily driven by a desire to be an irritant.

Mr. Aamer's participation in the hunger strike is another example of his efforts at fostering his sense of humanity, dignity, and autonomy. The hunger strike creates a venue to protest his detention. On a more basic level, it gives him an opportunity to exert control over his body by making decisions about his oral intake.

Psychiatric symptoms related to conditions of confinement are present in every detention facility. Mr. Aamer's symptoms are worsened by the particular environment of his detention as well as its indefinite nature. The uncertainty about his future, and his lack of ability to influence it, further contribute to the erosion of his humanity, dignity, and autonomy.

Psychiatric prognosis

In addition to the psychiatric symptoms discussed above, Mr. Aamer has suffered a profound disruption of his life, dignity, and personhood. His world is severely constricted, with little opportunities for autonomy and meaningful human interaction. Mr. Aamer has used a range of psychological defenses to cope with the thoughts and unrelenting negative emotions generated by this trauma, which is now in its twelfth year.

When Mr. Aamer has more internal reserves, he typically relies on relatively mature defenses such as intellectualization and humor as coping mechanisms. These allow him to tolerate painful thoughts and feelings by considering his confinement in an analytical manner or to deflect them by introducing humor into thoughts and conversation. However, when his situation overwhelms these more mature coping skills, he deploys less effective strategies including denial and paranoia.

The length, uncertainly, and stress of Mr. Aamer's confinement has caused significant disruptions in his underlying sense of self and ability to function. He is profoundly aware of what he has lost. He discussed the struggle he faces if his detention were to continue indefinitely. Additionally, we discussed the struggle he will face, were he to be released, in regaining the ability to function in his family and society. He is aware that it has taken some of the former detainees years to begin to recover to the extent that they have some degree of meaning and productivity in their lives.

The chronic and severe psychiatric symptoms described above have gravely diminished Mr. Aamer's mental health. In order to maximize his prognosis, Mr. Aamer requires psychiatric treatment, as well as reintegration into his family and society and minimization his re-exposure to trauma and reminders of trauma.

The psychiatric treatment Mr. Aamer requires consists of psychotropic medication and psychotherapy delivered in a context that maximizes the opportunity for therapeutic efficacy and reintegration into family and community. Patients with moderate to severe PTSD symptoms, such as Mr. Aamer, usually experience symptoms throughout their lifetime. The goal of treatment is to minimize symptom severity, maximize family and societal function, and to teach the patient to recognize and manage triggers and signs of symptom flares. Thus, for patients with moderate to severe symptoms, PTSD is best thought of as a chronic illness, with waxing and waning symptom intensity, that requires chronic monitoring and treatment.

The most therapeutic medication regimen for PTSD patients is dependent on individual symptom presentation and neurophysiology. In general, serotonin-specific and serotonin-noradrenergic reuptake inhibitors (SSRI's and SNRI's), sub-classes of antidepressants, are the mainstays of PTSD treatment as they have been demonstrated to improve mood and autonomic arousal symptoms of PTSD in a large proportion of patients. If Mr. Aamer is non-responsive to these, other types of antidepressants should be tried.

Because of the severity and variety of PTSD symptoms, patients often respond best to a combination of psychotropic medications. It is likely that Mr. Aamer will require treatment with more than one medication due to the chronicity, severity, and variety of his symptoms.

PTSD patients such as Mr. Aamer who experience sustained irritability, angry outbursts, and/or behavioral dyscontrol may find it beneficial to augment antidepressants with a mood stabilizer or an antipsychotic. Insomnia often does not respond to SSRI's and SNRI's. Sleep medications that cause the development of tolerance should be avoided, as they may induce dependence and disrupt normal sleep architecture.

Mr. Aamer's paranoid ideation is not likely to resolve during his detention. Should this persist beyond that period, treatment with an anti-psychotic medication may be beneficial. As noted abvove, Mr. Aamer experienced hallucinations, dysphoria, and a profoundly disrupted sense of self during the time he was held in isolation. He is at risk

for re-experiencing these symptoms in under-stimulating environments and during periods of increased stress. Anti-psychotic medication may be beneficial in this instance as well.

It is not possible to predict the length of medication treatment Mr. Aamer will need. Medications are administered for a minimum of one year from the time the correct regimen and doses are achieved, judged by maximum symptom response. It usually takes several weeks or months to establish a patient's medication regimen.

A taper of medications may be attempted after one year of optimal symptom relief. However, in my experience and based on the medical literature, PTSD patients with presentations similar to Mr. Aamer require years of medication treatment and often require life-long medication administration.

With respect to psychotherapy, PTSD is most effectively treated by a combination of cognitive behavioral therapy (CBT), skills-based therapies, and supportive psychotherapy. If the patient has a family, marital and family therapy is also required.

CBT is a structured psychotherapy therapy aimed at identifying and improving distorted thoughts and beliefs. When treating PTSD, symptom-specific CBT modalities are employed. For example, Exposure Therapy (ET) may be used to reduce intrusive symptoms, negative cognitions, negative mood, and autonomic arousal. Image-rehearsal Therapy (IRT) may be used to reduce insomnia and nightmares. Thus, patients may be treated with a variety of different CBT approaches depending on their particular symptom experience. Patients with moderate to severe PTSD typically receive psychotherapy for several years. Based on the severity, chronicity, and variety of Mr. Aamer's PTSD symptoms and the unique nature of his traumatic stress, he will likely require continuous psychotherapy for a minimum of three to five years to achieve maximum therapeutic benefit. It is likely that Mr. Aamer will require episodic treatment with psychotherapy throughout his lifetime. His PTSD is likely a chronic condition, the symptoms of which will have a relapsing and remitting course over his life. During periods of stress and life transition it is likely that symptoms will re-emerge that necessitate repetitive courses of psychotherapy.

Skills-based therapy involves teaching the patient techniques that are useful in reducing PTSD symptoms including intrusion, avoidance and autonomic arousal. For example, meditation training, breathing exercises, yoga, and other relaxation techniques are useful in promoting symptom management and a sense of well-being brought about by the capacity for symptom control. Supportive psychotherapy provides empathy and encouragement to patients as they undertake more structured psychotherapies and medication treatment.

A primary goal of PTSD treatment is reintegration into family and community. The opportunity to re-establish family and social relationships and to re-engage in productive activity allows the PTSD patient to deploy what is learned in psychotherapy and

enhances dignity and autonomy. Success in these efforts also re-establishes a sense of purpose and meaning to the patient's life.

Reintegration into family and community is often extremely difficult for PTSD patients, particularly for those who have been separated from their usual life for an extended period of time. Patients often have an idealized image of what family reunification will be like, while at the same time fearing they no longer have a role within the family. Likewise the family must make considerable adjustments in understanding the effect of trauma on their loved-one and creating a new role for them within the family constellation. This reintegration can often be both delicate and traumatic. Given the severity of his PTSD symptoms, the prolonged separation from family, the developmental stages his children have moved through in his absence, as well as other factors, Mr. Aamer requires marriage and family therapy in addition to the above therapeutic approaches.

In all treatment modalities, particular attention should be given to cultural factors inherent in reintegration into family and community.

Mr. Aamer should receive psychiatric treatment in England in order to obtain meaningful therapeutic benefit. Several factors underpin this need. British mental health clinicians have the requisite expertise in treating PTSD and Mr. Aamer's other psychiatric symptoms. Culturally competent British clinicians have experience in the evaluation and treatment of returning Guantanamo detainees. Mr. Aamer's wife and children live in England. Their participation in his treatment is required for his recovery.

The severity of Mr. Aamer's psychiatric symptoms would worsen were he to be involuntarily repatriated to Saudi Arabia. He reported that should this occur he would not be reunited with his family for many years, if ever. His ongoing separation from his family significantly exacerbates his psychiatric symptoms. Additionally, the impact of a move to Saudi Arabia on his family would likely re-traumatize Mr. Aamer, as his wife and children are unaccustomed to Saudi culture. Finally, Mr. Aamer's probable further confinement in the Saudi rehabilitation program would likely be re-traumatizing, as its goal would be to re-acclimate him to the norms of Saudi society. Mr. Aamer identifies as a British Muslim and is most comfortable in that culture.

As noted above, Mr. Aamer's psychiatric condition will not improve without required psychiatric treatment. However, he cannot receive effective treatment from the Joint Medical Group (JMG) at Guantanamo. His conditions of detention are in themselves a constant source of stress and trauma. These conditions and the indefinite nature of his detention exacerbate his psychiatric symptoms reported above.

Furthermore, Mr. Aamer cannot develop a therapeutic doctor-patient relationship with JMG clinicians. I have had direct contact with JMG clinicians related to my evaluations of other Guantanamo detainees. Despite their sincere efforts and good intentions, the ability of JMG clinicians to deliver effective treatment is irreparably damaged by the fact that they work within the context of the JTF. Their treatment recommendations must

take into account the legitimate needs of the Joint Detention Group (JDG), which are sometimes at odds with the legitimate treatment needs of the detainee. JDG has ultimate authority for resolving this conflict when it occurs.

There are other factors that make it impossible for Mr. Aamer to develop an effective treatment alliance with JMG clinicians. JMG participation with interrogations has been well-documented. I have seen direct evidence of this collaboration in the medical records of other detainees. Mr. Aamer has a well-founded and insurmountable mistrust of JMG clinicians as a result. Additionally, there is no expectation or guarantee of clinician-patient confidentiality at Guantanamo. Guards are present when Mr. Aamer sees clinicians. Detainees have been audiotaped in situations in which confidentiality is ordinarily presumed. These above factors undermine Mr. Aamer's trust that JMG clinicians are independent and are working in his best interests.

Other factors make it impossible for Mr. Aamer to recover his mental health at Guantanamo. As noted above, the chronicity, severity, and variety of his symptoms indicate that he will require acute treatment for several years and monitoring of symptoms for an indefinite period of time afterwards. It is important that turnover of clinicians on his treatment team be kept to a minimum, as this makes this difficult to develop trust and facilitate therapeutic benefits. Due to the nature of military service, JMG clinicians rotate at regular intervals. Finally, PTSD treatment is aimed at restoring effective family and societal functioning, which obviously cannot take place while Mr. Aamer is detained.

Current physical status

Mr. Aamer evidenced serious bilateral lower extremity edema of unknown origin. Edema worsened over the course of the day. Each morning he presented with mild to moderate pedal edema, which progressed to moderately severe pedal, ankle, and calf edema by the afternoon. The differential diagnosis of lower extremity edema includes venous insufficiency, heart failure, pulmonary hypertension, lymphedema, and deep vein thrombosis. Liver failure may cause lower extremity edema, but this is usually accompanied by accumulation of fluid in the abdomen (ascites), which I did not observe.

Mr. Aamer's edema requires urgent diagnostic evaluation and treatment as, if left untreated, it may reflect an underlying life-threatening organ or vascular dysfunction. As noted above, such evaluation and treatment cannot be achieved by physicians at Guantanamo due to the absence of a physician-patient alliance.

Mr. Aamer suffers frequent and debilitating headaches that, by his description, are consistent with migraine headaches. These are triggered by exposure to fumes from cleaning fluids such as Pine-Sol. Mr. Aamer reported that throughout the course of his detention some guards have exploited this sensitivity by frequently cleaning or spilling Pine-Sol outside his cell. Mr. Aamer's headache symptoms require urgent diagnostic evaluation and treatment.

Re: Shaker Aamer

Mr. Aamer's asthma is exacerbated by his conditions of confinement. Symptoms are worsened on exposure to dust, cold, and fumes. Mr. Aamer stated that the air vent in his cell emits a steady stream dust and other debris. This is part of the reason for his obsessively cleaning his cell several times a day. A recent communication I received from his attorney stated that Mr. Aamer had given him an envelope containing the materials he collected from his air vent. The envelope contained dust, hair, and other detritus and was approximately one-third full. Mr. Aamer indicated he collected the same amount two to three times daily. Mr. Aamer explained to me that the cold temperature in his camp, as well as exposure to the fumes of cleaning fluid, further exacerbate his asthma symptoms. His asthma requires urgent diagnostic evaluation and treatment.

Mr. Aamer has other serious medical concerns. He has chronic urinary retention, the cause of which has not been investigated, but which may also indicate a serious underlying medical condition. He has suffered from this since early in his detention, which may indicate that it is not simply due to prostatic hypertrophy, which typically begins at a later age. Mr. Aamer's urinary retention requires urgent diagnostic evaluation and treatment.

Mr. Aamer's other medical concerns require evaluation and treatment as well. These include otitis media, tinnitus, GERD, and constipation.

Thank you for referring this matter to me for evaluation and report.

Sincerely,

Emily A. Keram, MD