EXHIBIT 5

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF WASHINGTON

AT SPOKANE

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SULEIMAN ABDULLAH SALIM,
MOHAMED AHMED BEN SOUD,
OBAID ULLAH
(as personal representative
of GUL RAHMAN),

Plaintiffs

vs. CA NO. 2:15-CV-286-JLQ

JAMES ELMER MITCHELL
and JOHN "BRUCE" JESSEN,

Defendants

****

VIDEOTAPED DEPOSITION OF:

MATTHEW J. FRIEDMAN, M.D.

WILMER, CUTLER, PICKERING,

HALE & DORR, LLP

60 State Street

Boston, Massachusetts

April 28, 2017 9:09 a.m.

Darlene M. Coppola, RMR, CRR

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Also Present:
Robert Martignetti, Videographer

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EXAMINATION

EXHIBITS

**Exhibits marked out of order by attorney.

THE VIDEOGRAPHER: We are now on the record. My name is Bob Martignetti. I am a videographer for Golkow Technologies. Today's date is 4/28/2017, and the time is 9:09 a.m.

This video deposition is being held in Boston, Massachusetts in the matter of Suleiman Abdullah Salim, et al., v. James Elmer Mitchell, et al., for the U.S. District Court, Eastern District of Washington. The deponent is Matthew Friedman, M.D.

Would counsel please identify themselves.

MR. PASZAMANT: Brian Paszamant for the defendants.

MR. LUSTBERG: Lawrence Lustberg, Gibbons, PC, on behalf of the plaintiffs in this matter, and I'm here with Dr. Friedman.

MR. MCGRADY: Dan McGrady from Gibbons, PC, also on behalf of the plaintiffs.

THE VIDEOGRAPHER: The court reporter is Darlene Coppola and will now swear in the witness.

MATTHEW J. FRIEDMAN, M.D.,
a witness called for examination by counsel for the Plaintiffs, having been satisfactorily identified by the production of his driver's license and being first duly sworn by the Notary Public, was examined and testified as follows:

MR. PASZAMANT: Mr. Lustberg, are you comfortable with entering into the usual stipulations?

And what I mean by that is all objections, except as to form, will be reserved until the time of trial.

MR. LUSTBERG: Yes, sir.

MR. PASZAMANT: Thank you.

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So it was really more of an editorial review than a scientific review of the literature, et cetera.

Q. I see. Thank you for that clarification.

So, within the DSM-IV, Doctor, and the A criteria in particular, are the A1 and the A2 criteria classified as objective and subjective, respectfully?

A. They're often spoken of that way, yes.

Q. So, in the DSM-IV, there's an objective and a subjective Criterion A, correct?

A. Correct.

Q. In the DSM-5, if I understood you correctly, the subjective criteria has fallen away.

A. It hasn't -- it hasn't fallen away. It was felt that the subjective symptoms were sufficiently characterized in the B, C and D criteria, so that the A criteria -- the A2 criterion was unnecessary.

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Furthermore, the important difference, which doesn't seem to have a bearing on this particular litigation, is that in DSM-IV, and actually DSM-III, PTSD was classified as an anxiety disorder.

So that the fear, helplessness and horror of the A2 criterion was really to a fear-based anxiety disorder.

But we now -- it's now been shown that there are other post-traumatic, post-Criterion A emotional reactions beyond fear, helplessness and horror that should be taken into account.

So, essentially, the DSM has opened up PTSD to a wider context.

Q. Okay. So, with regard to the A1 criterion in the DSM-IV, did there need to be either physical harm or a threat of physical harm?

A. A credible threat, yes. Threatened death, injury, sexual violence, terrorism, torture; yeah, that was the A criterion.

Q. A threat of physical harm, correct?

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A. Physical, yes.

Q. Now, sir, notwithstanding your review of Dr. Pitman's report or reports with regard to Mr. Salim and Mr. Soud, is it your intent to offer at trial opinions voicing your critique of those reports?

MR. LUSTBERG: I'm going to object to the question.

But you can answer if you know.

A. I think I am expected to provide a critique of the reports, yes.

BY MR. PASZAMANT:

Q. And --

A. Not to make a specific diagnosis, but a critique of the various reports, yes.

Q. And have you been asked to draft some sort of rebuttal report articulating the specifics of this critique?

A. I think I already answered that.

No, I've not been asked to draft a rebuttal of any sort.

Q. Okay. And sitting here today, you have no intent of drafting such a rebuttal?

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A. I've not been asked to do so.

Q. Okay. You mentioned to me that you read Dr. Crosby's report subsequent to issuing your own report, correct?

A. Correct.

Q. And can you tell me, was there anything that you saw in that report that you disagree with?

A. Yes and no.

I think she did a good job diagnosing PTSD. I think that the -- I think that she also made a diagnosis of complex PTSD, which Dr. Pitman also addressed in his report.

And I think -- I mean, I can -- I can talk about that if you want me to.

Q. Okay. My question is, is there anything that you saw in Dr. Crosby's report that you disagree with?

And if so, sir, could you please tell me what you disagreed with?

A. Well, I disagree that complex PTSD

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is a recognized diagnosis. And I say that from the context of the DSM-5, which is the American Psychiatric Association's diagnostic scheme, with full recognition that the forthcoming ICD-11, which is the World Health Organization's diagnostic scheme, which hasn't been published yet, but will recognize a complex PTSD diagnosis.

So it's a -- so, in that regard, there is a difference between these two diagnostic schemes.

Many of my -- many of my colleagues who work with -- in the refugee and torture field feel that complex PTSD is a useful diagnosis because it includes some symptoms that are often seen in individuals that don't -- that are not included in the PTSD criteria but are clinically significant.

So in that regard, Dr. Crosby identified some of these symptoms that are part of the complex PTSD construct, so that I -- I agree that these symptoms are

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present, such as emotional inability, impulsivity, somatic symptoms.

So the symptoms are there. The question is, what do you do with them?

If you're adhering to DSM-5, you note them but you don't make a complex PTSD diagnosis, because it doesn't exist.

If you're using the ICD, you do.

So it's -- so that the -- the difference is not about the presence or absence of the symptoms. It's about, you know, how do you -- how do you package them? What do you do with them in a final diagnostic summation?

Q. Thank you, sir.

So when you distill it all down, is it that you disagree that complex PTSD is a diagnosis at all?

A. We looked at this very carefully in DSM-5, and we concluded that the evidence was not sufficient to warrant inclusion of that in the DSM-5.

I should add that the ground rules for DSM-5 and ICD-11 are quite different,

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which would explain why the two schemes are going to come out differently on this particular issue.

DSM-5 is very empirically, scientifically based. You had to have very, very strong scientific evidence to make any changes in the DSM-IV.

So, the DSM-IV was kind of grandfathered in, and then you had to have very strong evidence either to add a new symptom to leave a symptom or to revise it.

ICD-11 has no such constraints, so that many of their -- their conclusions are not bound by the best scientific evidence, in my opinion, and they were -- even the leadership of ICD-11 will acknowledge that, that they were not constrained by scientific evidence.

BY MR. PASZAMANT:

Q. Do you believe that the lack of constraints, as you used that terminology, undermines the ICD-11?

A. I do. I think that what they've

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come up with is poor.

Q. And the reason behind that is that it doesn't go through the same scientific rigor that the DSM goes through prior to it being changed?

A. That's my opinion, yes.

Q. Okay. And did you say to me that you considered inclusion of complex PTSD as a diagnosis in connection with DSM-5?

A. It was our job to consider that.

In other words, with DSM-5, you know, what we -- what we did was we looked at all of the literature on post-traumatic symptoms, and complex PTSD has been a term since 1990.

So, here, you know, we started the process in 2008. So there's been -- literature about complex PTSD had been for 18 years. So, it was our job to dig into that literature and to conclude whether or not the scientific evidence was sufficient to propose that as a diagnosis or a PTSD subtype.

Q. And ultimately, you decided it was

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complaint as opposed to somewhere else?
A. It's mentioned in the complaint. I don't know -- I, frankly, don't recall whether it's specifically described in the complaint. I think it was, but I'm -- I'm honestly not sure.
Q. Okay. But the complaint was the only source document that you had --
A. That's correct.
Q. -- for purposes --
A. In fact, I believe that the complaint, and I may be incorrect here -- I believe that the complaint talked about water dousing as approximating similar conditions to waterboarding, but that's my recollection.
Q. Okay. I just -- I'm trying to establish a more fundamental principle, and perhaps I'm not doing it in a particularly artful way.
What I mean by that is can we agree that in your report, when you use the term "waterboarding," for example, that waterboarding, as you use that term,

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is the way that that activity, waterboarding, is identified within the complaint?
A. Yes.
Q. Okay. The same question with regard to water dousing?
A. Yes.
Q. And would it also be the case with regard to the other things that I rattled off a moment ago, including solitary confinement, extreme darkness and so forth?
A. Yes.
Q. Okay. When you use the term "high risk" in connection with this conclusion that I just read to you, what do you mean by that?
A. What I mean by that is, you used the term "potentially traumatic event."
So that a potentially traumatic event is an event that meets the A criterion, and so, potentially, might be responsible for the development of PTSD.
It's a necessary condition for the

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diagnosis but not necessarily a sufficient condition for the diagnosis.
Q. I see. So, just because, for example, somebody may have been waterboarded, as that terminology is utilized within the complaint and, therefore, the way that you use it in your report, am I understanding you correctly that it doesn't necessarily mean that someone who's waterboarded will, in fact, contract PTSD?
A. That's correct.
Q. And you -- a moment ago you used the word "possibility."
Am I right?
A. "Potentially."
Q. "Potentially." Okay.
So, once again, "potentially" does not equate with certainty, correct?
A. That's correct.
Q. Okay. And the reason that it can potentially -- these items could potentially ultimately result in PTSD is because each of these items, as you've

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used them, which is based upon the complaint, is because these items meet the Criterion A.
Do I have that right?
A. Correct.
Q. And why is it that these meet the Criterion A?
A. Because they have been associated with PTSD. They are considered in the PTSD criterion as extreme events with the potential to exceed an individual's coping capacity, and under those circumstances, to be responsible for the development of PTSD.
Q. And just so I'm clear, since we're talking about the year 2002, primarily, with regard to your report, when you're speaking of the A criterion, that's the A1 criterion we discussed earlier --
A. Correct.
Q. -- as opposed to the A2 criterion which then existed, correct?
A. Well, actually, if we're talking 2002, we have to be talking about A1 and

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say "well known," how do you gauge that something was well known by 2002?

MR. LUSTBERG: I'm going to object as asked and answered, but go ahead.

A. So, again, could you show me a sentence where I make the statement so that I can be more responsive?

BY MR. PASZAMANT:

Q. Sure. So, let's look at the top of Page 8 of your report.

A. Okay.

MR. LUSTBERG: You said 8?

MR. PASZAMANT: I did.

BY MR. PASZAMANT:

Q. You see at the very top there, Doctor, it culminates in a sentence that says "This was all well known by 2002"?

A. Yes.

Q. That's one example of where you use "well known" within your report.

A. Okay.

Q. So, my question to you is, what standard did you, in writing this report,

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use to determine whether something was well known and well known as amongst whom?

A. My standard is my understanding of what a practitioner understood about PTSD and what the potential consequences were so that any individual who was diagnosing or treating PTSD should have been aware that there -- that they had to assess danger to self, suicidality.

The -- it should have been well known that individuals with PTSD are intolerant of ongoing stressors.

And it should have been well known that social support was a protective factor, that that was what one would expect of any practitioner dealing with this disorder in the same way that a person treating hypertension, it's well known that lowering salt intake is important; or treating diabetes, it's well known that the amount of sugar intake is an important factor; well known -- for heart disease, well known that exercise is an important aspect of the treatment.

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That's what I mean.

Q. Okay. So when you speak of "well known" in your report, you're talking about well known to those who either diagnose or treat PTSD?

A. That's right.

Q. Okay. You also use the verbiage "well understood" time and time again in your report, right?

A. I think those are interchangeable.

Q. Okay. So when you use those two phrases, you're not trying to draw any sort of a distinction?

A. I don't believe so, but if you can show me a sentence where you think that may be the case, I would be happy to review it with you.

Q. *How did you determine whether, in fact, something was well known in 2002 by those who diagnose or treat PTSD?

A. Well, I determined that, as I've said, number one, in terms of understanding the criteria, understanding -- I think I've just

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answered that -- your question.

I think you're asking me the same question, unless I'm -- unless I'm missing something here.

Q. I didn't intend to ask you the same question, but I would like to hear your response, nonetheless.

So could you please continue.

A. Could you please ask me the question again.

MR. PASZAMANT: Could you read back the question, please.

*(Question read.)

MR. LUSTBERG: I'll object. It's asked and answered four times.

BY MR. PASZAMANT:

Q. You can respond.

A. So, you know, in my position, running the National Center for PTSD, I've been involved with many, many practitioners. I've been involved with a number of clinical practice guideline

Torture," and in particular the chapter "Psychosocial Models" that we discussed earlier, have you authored or co-authored any other articles, chapters, any other publications that address learned helplessness?

A. No, except in a broad sense that we've talked about earlier.

Q. Sir, have any of your publications addressed the CIA's enhanced interrogation technique program?

A. No.

MR. PASZAMANT: Doctor, I have nothing further.

Thank you.

THE WITNESS: Thank you.

MR. LUSTBERG: I have no questions.

Thank you.

THE VIDEOGRAPHER: The time is 4:18 p.m. This deposition has concluded, and we are off the record.

(Deposition concluded at 4:18 p.m.)

CERTIFICATION

I, DARLENE M. COPPOLA, a Notary Public, do hereby certify that MATTHEW J. FRIEDMAN, M.D., after having satisfactorily identifying himself, came before me on the 28th day of April, 2017, in Boston, Massachusetts, and was by me duly sworn to testify to the truth and nothing but the truth as to his knowledge touching and concerning the matters in controversy in this cause; that he was thereupon examined upon his oath and said examination reduced to writing by me; and that the statement is a true record of the testimony given by the witness, to the best of my knowledge and ability.

I further certify that I am not a relative or employee of counsel/attorney for any of the parties, nor a relative or employee of such parties, nor am I financially interested in the outcome of the action.

WITNESS MY HAND THIS 9th day of May, 2017.

DARLENE M. COPPOLA My commission expires:
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ACKNOWLEDGMENT OF DEPONENT

I,____________________, do hereby certify that I have read the foregoing pages, and that the same is a correct transcription of the answers given by me to the questions therein propounded, except for the corrections or changes in form or substance, if any, noted in the attached Errata Sheet.

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