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I, Hawthorne Smith, Ph.D. having been duly sworn, do hereby state as follows:

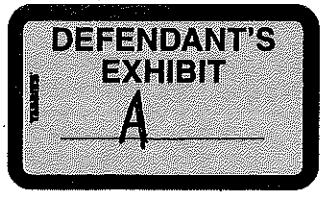
Qualifications:

1. My name is Hawthorne Smith, Ph.D. I am a licensed psychologist in the state of New York (#014355-1). I am the Clinical Director of the Bellevue/NYU Program for Survivors of Torture (PSOT). I have been a clinician with PSOT since its formal inception in 1995, and have served as the Clinical Director for the past 15 years. I hold the academic title of Clinical Associate Professor within the Department of Psychiatry in the New York University School of Medicine.

2. **Domestic focus**. In addition to my clinical training duties within NYU and the local public hospital system in New York City, I have been involved in the training other mental health professionals and graduate students across the country who provide services within the National Consortium of Torture Treatment Programs. For the past seven years I have been one of the senior trainers for the National Partnership for Community Training, a program sponsored by the U.S. Office of Refugee Resettlement, that provides support, consultation and training to resettlement workers and other service providers who work closely with traumatized refugees.

3. **International focus**. Much of my clinical and educational work in the international sphere has focused on low-to-middle-income countries that are under-resourced in terms of responding to the mental health needs. This is particularly true in areas where the indigenous populations have withstood significant social upheaval, warfare, and human rights abuses. My focus on the intersection of trauma, culture and sustainable capacity building has garnered me invitations to train and consult in diverse countries such as: South Africa, Kenya, Uganda, Senegal, Canada, Ghana, Sierra Leone, Austria and Tanzania.

4. **Forensic focus**. The grand majority of clients treated at PSOT are engaged in the asylum process. To date I have provided affidavits and direct testimony; or have supervised the affidavits and direct testimony of trainees, in hundreds of asylum cases. Since 2014, I have served in a consultative capacity for the U.S. Department of Defense's Office of the Military Commission, pertaining to their ongoing inquiry regarding alleged human rights abuses at Guantanamo Bay. In 2012, I evaluated a primary survivor and witness of reported human rights abuses from Nigeria, on behalf of the Center for Constitutional Rights in the Ken Waro-Siwa v. Shell Oil case. In 2012, I also evaluated the main



respondent in an ongoing case involving alleged human trafficking of Nepali workers into wartime Iraq. I consulted again with the Center for Constitutional Rights in 2015 in their work with respondents providing testimony in the civil suit against American pastors who allegedly stoked homophobic persecution in Uganda. In my private practice, which I have maintained since 2007, I have worked largely doing psychological evaluations of immigrants who report abuse by their spouses under the Violence against Women Act (VAWA). In all of these endeavors, issues of trauma and memory are central themes and considerations.

5. **Relevant Presentations (selected from roughly 200 presentations).** All co-presenters listed in full CV.

Assessment and treatment of torture survivors: Integrative approaches to service provision. Featured symposium at the 2016 Convention of the American Psychological Association. Denver, CO. (August 4, 2016).

The interdisciplinary care of torture survivors: Context, culture and self-care. Keynote address for the 2016 Interdisciplinary Conference on Psychology. Sponsored by the Department of Clinical Psychology of the University of Ottawa. Ottawa, Canada. (May 19, 2016).

Group treatment with French-speaking African survivors of torture and its effects on clinical engagement: Can hope be operationalized? Presentation at the 8th Annual Research Symposium of the National Consortium of Torture Treatment Programs. Washington, DC. (February 29, 2016).

Psychological issues and techniques in preparing for the asylum process. Presentation during the "Asylum Law Training" for pro-bono legal representatives. Sponsored by Human Rights First and Davis, Polk & Wardwell, LLP: New York, NY. (October 13, 2015).

Trauma & the law: Healing for our clients, ourselves & our communities. Panel presentation for the "Law for Black Lives" Conference. Sponsored by the Center for Constitutional Rights and Columbia University. New York, NY. (August 1, 2015).

Wisdom, courage and hope: Providing interdisciplinary care for survivors of torture. Grand Rounds Presentation for the Department of Psychiatry at the City of New York Family Court Mental Health Services; NYC Health and Hospitals Corporation. New York, NY. (February 11, 2015).

Multicultural issues in service provision. Workshop presented at the "Building Community Awareness: Responding to the Torture Survivor Experience" Conference (Sponsored by the Indiana State Department of Public Health and Environment and the Office of Refugee Resettlement). Indianapolis, IN. (May 21, 2014).

Empowering the patient: An artistic balance. Presented at the conference: Creating a Healing Environment: The Intersection of Clinical and Artistic Practice. Institute of African Studies; University of Ghana-Legon. Accra, Ghana. (September 25, 2013).

Marginalization and safety: A trauma-informed approach to treatment. Keynote presentation at the conference: "Building Awareness, Skills & Knowledge: A Community Response to the Torture Survivor Experience." Sponsored by the Office of Refugee Resettlement, the national Partnership for Community Training (NPCT) and the Center for Survivors of Torture: Austin, TX. (March 6, 2013).

Le Soin Efficace pour les Survivants de la Torture et les Refugiées Traumatisées. Guest lecture given at : Université Cheikh Anta Diop ; Faculté des Lettres et Sciences Humaines. Département de la Sociologie et Psychologie. Dakar, Sénégal. (February 14, 2013).

Secondary traumatization and self-care: *Considerations for mental health service providers in Africa.* Plenary presentation at "The Peter C. Alderman Foundation's 5th Regional Conference on Psycho-Trauma." Dar es Salaam, Tanzania. (July 16, 2012).

"*Preparing the mental health expert for testimony" and "Affidavit preparation for mental health experts."* Presented at the conference "Torture Survivors Seeking Asylum: The Intersection of Forensic Mental Health Evaluation and Legal Representation" sponsored by the National Consortium for Torture Treatment Programs. Los Angeles, CA. (July 26, 2011).

6. Relevant Publications:

Smith, H., Lustig, S., & Gangsei, D. (2015). Incredible until proven credible: Mental health expert testimony and the systemic and cultural challenges facing asylum applicants. In B. Lawrence & G. Ruffer (Eds.) *Adjudicating Refugee and Asylum Status: The Role of Witness, Expertise, and Testimony, pp. 180-201.* London: Cambridge University Press.

Rasmussen, A., Smith, H., & Keller, A. (2007). Factor Structure of PTSD symptoms among West and Central African refugees. *Journal of Traumatic Stress, 20(3),* 271-280.

Smith H. (2007). Approach to the client in a psychological evaluation. In H. Smith, A. Keller, D. Lhewa (Eds.) *Like a Refugee Camp on First Avenue: Insights and Experiences form the Bellevue/NYU Program for Survivors of Torture, 375-392.* New York: Jacob and Valeria Langeloth Foundation.

Smith H, Keller A, Lhewa D. (Editors). *Like a Refugee Camp on First Avenue: Insights and Experiences form the Bellevue/NYU Program for Survivors of Torture.* New York: Jacob and Valeria Langeloth Foundation 2007.

Keller, A. S., Lhewa, D., Rosenfeld, B., Sachs, E., Aladjem, A., Cohen, I., Smith, H., & Porterfield, K. (2006). Traumatic experiences and psychological distress in an urban refugee population seeking treatment services. *Journal of Nervous and Mental Disease, 194*(3), 188-194.

Keller A, Ford D, Sachs E, Rosenfeld B, Trinh Shevrin C, Meserve C, Leviss J, Singer E, Smith H, Wilkinson J, Kim G, Allden K, Rocklin P. (2003). The Impact of Detention on the Health of Asylum Seekers. *J Amb Care Mgmt. 26 (4):* 383-385.

Smith, H (1988). "Historical Impact of Islam and Its Future Prospects in Africa. Case Studies: Nigeria and Sudan" *Journal for the Institute of Muslim and Minority Affairs, 9(2),* 311-330: London and Riyadh.

Background Information:

1. Although I have never personally interviewed Rasmieh Yousef Odeh, I have reviewed the affidavit submitted by Dr. Mary Fabri before the US District Court Eastern District of Michigan Southern Division, Criminal No. 13-20772, regarding defendant Rasmieh Odeh, July 18, 2014. I have also reviewed the Evidentiary Hearing, US District Court Eastern District of Michigan, Southern Division vs. Rasmieh Yousef Odeh, Defendant, No. 13-cr-20772, in which Dr. Mary Fabri was directly examined and cross-examined on October 21, 2014. Finally, I have reviewed the transcript of the of the US Court of Appeals for the Sixth Circuit October 14, 2015, decided and filed on February 25, 2016, File Name: 16o0051p.06, No. 15-1331 United States v. re: Rasmieh Yousef Odeh, Defendant-Appellant. I have also read the affidavit prepared for this case by. James Jaronson, M.D., in which he addresses the nature and quality of Dr. Fabri's evaluation.

Review of Pertinent Psychological Literature

1. There is a significant body of psychological and psychiatric literature detailing the impact of trauma on memory processes. It is widely accepted among neuroscientists and mental health clinicians that traumatic memories are encoded differently than non-traumatic memories, which can have a variety of implications on the amount of detail in recollection, the consistency of recollection, and meaning-making by the respondent.
2. Theorists are in agreement that "general" memories are gathered by our sensory data and subjective experiences. These data are initially processed through the amygdala, which serves as a sort of "alarm center" in our brain that helps to determine our level of bio-physiological activation. The amygdala lets us know whether we should be alarmed or simply alert due to the sensory data we perceive. Ford (2013) describes this differentiation as the difference between us reacting with our reactive "survival brain" as opposed to our proactive "learning

brain." When the amygdala is excessively activated, or exists in a chronic state of alarm, it impacts our ability to efficiently organize and codify memories through the hippocampus – or the brain's "memory center." For people suffering from chronic traumatic stress, the amygdala is consistently over-excited, while the functioning of the hippocampus, as well as the pre-frontal cortex (which is the brain's "thinking center" and the area of most high-level executive functioning) become more disengaged from the retrieval and reflection processes of remembering (Samuelson, 2011; van der Kolk, 2009). The traumatized person also lacks the capacity to intentionally focus on what is important to the given context. As such, memories may be misfiled, inaccessible, or overly intrusive. Survivors may remain stuck in survival mode, as opposed to being able to engage in learning mode (Ford, 2013).

3. Kolk et al., (1995) similarly found that traumatic memories were initially retrieved as dissociated mental imprints of sensory and affective elements. As such, they are stored as visual, olfactory, auditory, affective and kinesthetic experiences. It was only after time, that some respondents were able to form a coherent personal narrative that one might consider to be "explicit memory." Samuelson (2011) speaks to two possible explanations for this memory dysfunction. It may be that the neuro-biological abnormalities caused by PTSD creates the memory impairment and/or that memory deficits are a risk factor in developing full-blown PTSD after exposure to traumatic events.
4. Many studies touch upon aspects of these generalized processes. For sake of brevity, I will limit myself to a few pertinent contributions to the research literature. Moradi et al, (2008) found that trauma has significant impact on the autobiographical memory functions of traumatized refugees from the former Yugoslavia as well as cancer survivors from Iran. Both studies demonstrated compromised access to specific autobiographical material linked to an internal process of affect regulation. The data indicate that when survivors are deeply troubled by traumatic memories, they try to block or minimize access to details of traumatic memories in order to make the memories less specific. Anderson et al., (2004) have used magnetic imagery to show how the hippocampus and frontal cortex are implicated in active or "motivated" forgetting for people experiencing great distress from traumatic memories.
5. Mollica et al., (2007) examined memory consistency over a three-year period for highly traumatized Bosnian refugees. They found that PTSD symptoms were associated with a "failed extinction" of traumatic memories and that these memories tend to change over time. These changes were linked to many factors, including the current emotional state of the respondent.
6. When assessing the trauma narratives of asylum seekers in the United Kingdom, Herlihy (2002) found that discrepancies in an individual's accounts were common, and were more likely to occur as the time increased between interviews and when the detail in question is viewed as being "peripheral" by the respondent, as opposed to central to their narrative or current context.
7. Behrendt, et al., (2005) found that Senegalese women who suffered from PTSD due to their experiences of female genital cutting also demonstrated significant memory deficits. .

8. In a longitudinal study of veterans of Operation Desert Storm, Southwick et al., (1997) found that traumatic memories are not fixed or indelible. Similarly, Bremner et al., (1993) showed that Vietnam veterans who suffered from PTSD showed deficits in immediate and delayed recall in both verbal and visual memory when compared to vets without PTSD.

Review of Findings by Dr. Fabri.

1. In full disclosure, Dr. Mary Fabri has been known to me in the professional sense for over two decades. She was a Senior Psychologist at the Marjorie Kovler Center for the Treatment of Survivors of Torture when I first entered the field in 1995, and assumed the Directorship of the program in 2000. I have had the occasion to meet and collaborate with her at numerous conferences (for the International Society for Traumatic Stress Studies, and the Office of Refugee Resettlement's National Partnerships for Community Training, etc.). We have also collaborated as members of the National Consortium for Torture Treatment Programs. Across the board, Dr. Fabri is held in high regard as a clinician, researcher, evaluator and program director.
2. In terms of the evaluation, Dr. Fabri followed the general procedures and protocols befitting best practices in the assessment of torture survivors as put forth in the Istanbul Protocol (1999) and other clinical texts (Iacopino et al., 2001; Keller & Smith, 2007). To that end, Dr. Fabri has lectured and written extensively (i.e. Fabri, 2001) about the need to help the respondent feel safe and have a sense of control in such circumstances. Explaining processes and expectations serve as "anticipatory guidance," and normalizing the anxiety and discomfort in the process helps respondents to engage more fully in the evaluation process.
3. As such, Dr. Fabri took adequate time to build rapport and develop a sense of safety, as the clinical evaluation took place over six sessions and approximately 18 hours. She was able to elicit a thorough trauma narrative from the respondent, with ample time to go back and explore potential gaps, inconsistencies or episodes that may have been particularly difficult for the respondent to articulate. This also allows the expert to further assess for issues of malingering or "faking bad" by the respondent.
4. Dr. Fabri also used quantitative measures that are widely recognized as being reliable and valid in assessing symptoms of Posttraumatic Stress Disorder, Major Depressive Disorder and other psychological sequelae among traumatized refugees, asylum seekers, and torture survivors. These measures included: the Clinician Administered Post Traumatic Stress Disorder (PTSD) Scale for DSM 5 (CAPS 5) which is a 30 question standardized interview that is considered a gold standard in PTSD diagnosis including the Life Event Checklist (LEC-5) and the PTSD Checklist (PCL-S). The Hopkins Symptom Checldist-25 (HSCL-25) measuring anxiety and depression was also administered.

5. In addition to the respondent's narrative and responses on self-report measures, Dr. Fabri also supplemented her findings with her behavioral observations gleaned from the 18 hours she spent with the respondent. As such, Dr. Fabri was able to assess the consistency between written and verbal descriptions of the respondent's experiences and current functioning. Dr. Fabri was also able to observe the respondent's mood, affect, speech patterns and thought processes as they discussed varying subject matter across several meetings. Again, this helps the evaluator to gain insight into the internal consistency of the respondent's emotional reactions and interpersonal comportment when discussing traumatic and non-traumatic material.
6. The combination of respondent narrative, quantitative evaluation via validated and reliable self-report instruments, clinical observation, and a review of existing and pertinent records are the basis of a thorough and appropriate psychological evaluation. It is my clinical opinion that Dr. Fabri followed these guidelines and has produced a high quality, professional evaluation.

Clinical Opinion regarding Dr. Fabri's Findings:

1. There is a growing body of psychological literature that speaks to the nature of traumatic memories, and the potential for certain memories to be repressed – particularly when considerable time has passed and the traumatized individual feels under threat or highly stressed.
2. The current court proceedings involve a situation in which the possibility exists that memory repression may play a role in the respondent's behavior and the credibility of her sworn statements.
3. In order to move beyond the mere recognition of the possibility that memory repression may impact this case, and to move toward the exploration as to the probability of such an impact; it would be appropriate to conduct a full and detailed psychological evaluation of the respondent to assess her mental state and the potential ways that her traumatic experiences influence her memory function and behavior as a witness.
4. Such a psychological evaluation has already been ordered and conducted by Dr. Mary Fabri, and was submitted to this court on July 18, 2014.
5. In reviewing Dr. Fabri's affidavit, the court transcript of Dr. Fabri's testimony, and the other documents listed above; it is my clinical opinion that Dr. Fabri has conducted a high quality psychological evaluation that will help the court to shed light on these complex issues raised by this case. I can see no legitimate clinical reason that Dr. Fabri's evaluation not be considered in further understanding an adjudicating this case.

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Respectfully submitted by:

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Sworn before me on October 18th, 2016

(Notary Public)

JOHN WILKINSON
NOTARY PUBLIC, STATE OF NEW YORK
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QUALIFIED IN NEW YORK COUNTY
MY COMMISSION EXPIRES 10/12/2020