FAX COVER SHEET

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Central Intelligence Agency

Washington, DC 20505

4 May 2005

To:	**DOJ Command Center** **For Steve Bradbury**
Organization:	**Office of Legal Counsel** **U.S. Department of Justice**
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Number of pages (including cover sheet):

Comments: (U//~~FOUO~~) Steve, Answers to your questions faxed to me yesterday. (b)(3) CIAAct (b)(6)

~~FOUO~~ upon removal of attachment

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Washington, D.C. 20505

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<u>Transmitted by Secure Facsimile</u>
Steve Bradbury
Acting Assistant Attorney General
Office of Legal Counsel
Department of Justice
Washington, DC 20530

(b)(1)
(b)(3) NatSecAct

Dear Mr. Bradbury:

(~~TS~~// /~~NF~~) Please find below answers to the questions you faxed to me yesterday. These answers were composed by the CIA's Office of Medical Services (OMS) after consideration of the medical journal articles you referenced.

1. Does OMS accept the findings of the studies that sleep deprivation can lower the threshold of pain?

Answer: OMS believes the studies on sleep deprivation and pain threshold remain inconsistent in their findings in healthy subjects, even in the papers cited. Where differences in pain threshold may have been demonstrated (i.e. increased sensitivity to heat, nonsignificant or no differences in cold, nonsignificant changes in perception to pressure), they are not germane to the techniques used in the interrogation program. None of CIA's methods are designed to induce pain under any circumstances; to the extent that they might (i.e. facial slap, abdominal slap), they do not involve application of heat, cold, pressure, any sharp objects (or indeed any objects at all).

2. If this lowering of the threshold can exist, has OMS evaluated how the lowering would affect the use of other interrogation techniques?

Answer: See above, which informs below comments.

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-- Stress positions, slaps, walling, cramped confinement, and water dousing all might cause some pain. How would the lowered threshold change the effects of the techniques?

Answer: We believe that because of fatigue (not increased sensitivity to pain), sleep deprivation would reduce the ability to maintain a stress position compared to normal subjects, leading to sooner release from the position, not greater pain. In other words, when the individual reaches his limit, the technique ends, and we would expect him to reach that limit sooner under conditions of sleep deprivation. We have no reason to believe slaps are more painful, and no reason to believe, based on CIA or SERE experience, that they would induce severe or permanent injury. The same is true for walling. As for cramped confinement, our limited experience indicates that subjects use the opportunity to sleep, mitigating any concern about pain. Finally, we are aware that the temperature-lowering effect of sleep deprivation creates a potential increased risk of hypothermia with water dousing compared to that in normal subjects (and thus monitor for that effect), but at the temperatures of water we have recommended for the program the likelihood of induction of pain by water dousing is very low under any circumstances, and not a phenomenon we have seen in detainees subject to this technique.

-- Standing sleep deprivation can lead to edema. With a lowered threshold, would the edema become painful? Would shackling become painful?

Answer: We have not observed this phenomenon in the interrogations performed to date, and have no reason to believe on theoretical grounds that edema or shackling would be more painful, provided (a) shackles are maintained with appropriate slack; and (b) interrogators follow medical officers' recommendation to end standing sleep deprivation and use an alternate technique when the medical officer judges that edema is significant in any way. Detainees have not complained about pain from edema, however, and we have no information to suggest otherwise. Further, OMS's experience is that medical officers' recommendations are always followed; its relationship with the interrogators has been one of close and mutual collaboration on all medical recommendations.

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4. In the monitoring of detainees undergoing interrogation, is it possible to tell reliably (e.g. from outward physical signs like grimaces) whether a detainee is experiencing severe pain? If so, how?

Answer: As the memo and all supporting literature notes, all pain is subjective, not objective. Medical officers can monitor for evidence of condition or injury that most people would consider painful, and can observe the individual for outward displays and expressions associated with the experience of pain. Medical officer can and do ask the subject, after the interrogation session has concluded, if he is in pain, and have and do provide analgesics, such as Tylenol and Aleve, to detainees who report headache and other discomforts during their interrogations. We reiterate, that an interrogation session would be stopped if, in the judgment of the interrogators or medical personnel, medical attention was required.

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-- If not, are there additional safeguards or limits that might be appropriate?

Answer: It is OMS's view that based on our limited experience and the extensive experience of the military with these techniques, the program in place has effectively avoided severe physical pain and suffering, and should continue to do so. Application of the thirteen techniques has not to date resulted in any severe or permanent physical injury (or any injury other than transient bruising), and we do not expect this to change.

(U//~~FOUO~~) If you have any additional questions, please give me a call.

Sincerely,

(b)(3) CIAAct
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Associate General Counsel

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