

The Role and Responsibilities of Psychiatry in 21st Century Warfare

Stephen N. Xenakis, MD

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When I first worked with detainees at Guantánamo Bay, I was troubled by a peculiar and unsettling awareness, a collision of polar opposites that has shadowed all my experiences there. Here I was, focusing on torture and cruel, inhuman, and degrading treatment of prisoners and yet, these were the very men who were the “enemy.” As a career Army officer, I pledged to protect our nation against all enemies, foreign and domestic. As a physician, I pledged to care for all who were hurting and needed help. Facing some detainees who were tortured because they were our enemies, sometimes with the aid of military physicians, I felt I had entered a domain in which the old paradigms ceased to apply. Perhaps that is one of the fundamental problems with Guantánamo.

In 2004, the news that Americans had committed abuse and mistreatment in Abu Ghraib and Guantánamo was shocking. Even more alarming were the revelations that physicians, psychiatrists, and other mental health professionals had assisted with interrogations that bordered on torture. I found myself in an awkward situation that summer, interviewing for a high-level position at The Department of Defense (DoD). The White House Personnel Office asked for my opinion on the revelations. My response: medical personnel must abide by the ethics codes that have anchored physicians since Galen, Hippocrates, and The Geneva Conventions: “first, do no harm” and at no time should a doctor condone or

participate in harsh treatment or torture. Military doctors are obligated to report any signs or evidence of such practices to higher authorities and investigators. I did not get the job, but was haunted and felt spiritually disoriented. In the span of just two generations, the United States had moved from condemning Nazi physicians at the Nuremberg Trials for their collusion with torture, inhuman experimentation, and cruel mistreatment to justifying waterboarding in the pursuit of better intelligence.

I spent 28 years in uniform, retired as a Brigadier General in 1998, and my entire professional life involved supporting our national security and preparing to go to war wherever and whenever. To learn that our soldiers had systematically tortured others by enacting a government program sanctioning torture and abuse defiled our national honor and our basic principles of justice. I have witnessed similar practices in my travels to other countries, which we regard as known violators of human rights. I have seen police, interrogators, and prison wardens use a common playbook of cruelty and abuse. The authorities feel self-righteous, and they all feel that their personal and political interests justify their actions. This same dynamic has been repeated here in the United States. In fact, it seems that the values of Abu Ghraib led almost inevitably to the situation in Guantánamo Bay.

Over the years of working with other detainees, reflecting on how our system has reacted during a time of terrorism, and working with the military in developing treatment for our soldiers, I have come to believe that we are making a mistake if we consider these to be separate problems. Indeed, they are linked

Dr. Xenakis is a retired Army Brigadier General. Address correspondence to: Stephen N. Xenakis, MD, 2235 Military Road, Arlington, VA 22207. E-mail: stephen.n.xenakis@us.army.mil.

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in important ways, so that crafting solutions to one will have an effect on the other.

The fundamental conflict for military psychiatrists is often simplistically reduced to a question of dual loyalty: allegiance to the command and governmental authorities, as opposed to the duties and responsibilities to the individual and “to do no harm.” Simply stated, the military psychiatrist feels he must choose between the demands of the military mission and the needs of the patient, not just detainees, but also those on active duty who are facing yet another deployment to the war zone.

More than one of my Guantánamo cases provides a vivid example of those choices. I have interviewed several Muslim men, now in their 30s and detained for years in Guantánamo. Most are visibly symptomatic. They arrived in the year after it opened, accused of terrorist acts. More often than not, they were subjected to cruel and abusive treatment or enhanced interrogation techniques (EITs).

Almost all interviews occur in small offices on the compound that had been used for interrogations. The rooms are painted flat white and had obviously been temporary jail cells. A small table is set up in the middle flanked by cheap plastic chairs. The detainees sit across from me with feet shackled to the floor.

Some have been willing to accept treatment from the military clinicians despite reservations over the professionalism of the staff. They have been prescribed almost every psychotropic medicine in the Physicians’ Desk Reference, yet hardly any therapist had ever inquired about what had happened to them. They talk about the diagnosis of posttraumatic stress disorder (PTSD), sleep problems, pain, and fatigue. They are dismayed and pessimistic that the negative political and cultural bias has influenced the health care providers assigned to their cases.

Generalized anxiety disorder is a common diagnosis, and I cannot remember any chart that documented PTSD. The diagnosis of PTSD clearly implies that abuse or trauma had to have occurred in these cases, at the hands of American troops.

Vincent Iacopino and I reviewed hundreds of files from Guantánamo several years ago to research our suspicion that many detainees had encountered such problems with their medical care.¹ Repeatedly, we found, doctors failed to report signs of abuse and changed diagnoses to conform to political and social pressure.

The case of Omar Khadr offers a vivid illustration of how forensic psychiatry has become tightly woven into political concerns and military operations. The defense attorneys (who reviewed the draft of this article and authorized discussion of the case) hired me as an expert consultant for Khadr’s case, a fact that is known and has been frequently reported. I first met Khadr in Guantánamo in 2008. He was just 22 years old and had spent over 6 years in confinement. U.S. forces had imprisoned him, and he had been tortured. The guards, medics, and almost every man or woman who has spent time with Khadr regard him as a decent, thoughtful, and respectful individual who did not consider the United States an enemy he needed to harm. After several hours first talking with him, I came to the same conclusion. A conclusion with which, apparently, only U.S. government prosecutors seem to disagree.

Bias and political influence inordinately distorted expert testimony and professional opinions regarding Khadr. At his sentencing, the prosecution’s expert psychiatrist discussed Khadr’s “marinating” in the culture of “radical jihadism” and occupying the role of “rock star” among the detainees hell bent on harming Americans.² His testimony asserted that simply holding deep faith as a Muslim is radicalizing and an inherent threat to American security. This view anchors much continuing political debate to date.³ A fellow witness to the Senate Judiciary Subcommittee on Guantanamo, July 2013, promoted the bias that deep believers in Islam are a threat and “sharia-adherent jihadists who believe, in accordance with that doctrine, that it is God’s will that they destroy our way of life and subjugate us to theirs.”⁴ Such characterizations clash with American values of tolerance and culture of pluralism.

I am one of more than 50 retired admirals, generals, and senior government officials convened by Human Rights First to take a stand on torture. We developed four straightforward principles: torture is un-American; torture is ineffective; torture is unnecessary; and torture damages not only the victim of torture, but also the torturer, the nation, and the military.⁵ The plain fact is that nothing that has been claimed in the name of defending our country can justify cruel, inhuman, and degrading treatment of another man or woman. Torture, in any form, light or heavy, is not a tool of interrogation or useful for gathering good intelligence. It is not simply a question of the way detainees are treated. Torture is a

propaganda tool and degrades the perpetrator as well as the victim.

Given these principles, psychiatrists and other mental health practitioners are thrust into a unique role when confronted with torture and abuse in the 21st century. Their involvement draws them into the epicenter of the war on terrorism. The realities of modern warfare and terrorism push them beyond the principle of “first do no harm” that has historically grounded the healing professions.

In today’s world, the professional domain of psychiatrists intersects with growing social and political trends, particularly the power of individualism. Emerging social and political dynamics across the globe illustrate how much attention is focused on the personal and individual. Hand-held devices, Twitter, Facebook, and Google deliver information technology to the lone warrior, businessman, or change agent anywhere and at any time. These developments empower individual and human rights in the 21st century, diminish the power of nation states, and reshape the role of individual practitioners like doctors and lawyers.

Over the past years, tumult across the Arab world has demonstrated that seemingly insignificant individuals can command the international spotlight and spark dramatic changes in their governments and societies. The history books have yet to be written, but my guess is that scholars will look back and declare that this has been an unprecedented era of individual and human rights and individual empowerment. The dominance of formal nation states receded with the rise of individuals, social groups, businesses, and crime organizations. These organizations and people have amassed powerful technologies to earn huge profits, but they can and have also inflicted great harm and devastation. On the one hand they have taken down totalitarian regimes, but they have also launched sophisticated operations in the cyber world that endanger the general good.

This backdrop of changing social dynamics, business operations, and means of warfare has stimulated fundamental shifts in military tactics, operations, and strategy. Insurgency and counterinsurgency tactics pivot on the actions and capabilities of individual warriors. Drones target high-value leaders of terrorist organizations. Intelligence gathering relies on the intense and harsh interrogations of selected captives under very secret circumstances. Combat operations have shifted from bombing campaigns and the

movement of large tank units on the battlefield to the close quarters of villages and hills in Iraq and Afghanistan.

Since 9/11, military psychiatrists have been deeply engaged on the front lines of this brave new world. Psychiatrists, psychologists, and general physicians were recruited to help form interrogation teams at Guantánamo and the dark sites. They became integral participants on the Behavioral Science Consultation Teams (BSCTs) that questioned captives. The government has relied on the forensic evaluations of these practitioners for prosecuting the cases in the military commissions and federal courts.

All this has come at a tremendous cost. I am concerned that politics and public sentiment have corrupted the ethics of our profession. Torture has become more sophisticated, the damage inflicted leaves less visible and physical scars, but profound psychological ones. The torturers inflict sleep deprivation, overwhelming sensory overload, solitary confinement, and conditions of extreme hot and cold to break down their victims. Their victims are damaged, but find it harder to explain the nature of their injuries. Psychiatrists and other mental health professionals are called in to assess debilitation and impairment and diagnose the wreckage following the procedures. The fallout in the courtroom often comes down to an arcane debate over posttraumatic stress, sleep deprivation, malingering, and personality disorder. Somehow the basic question of whether these men and women were tortured and whether the psychological mind games played on them left scars gets lost in recondite colloquies.

Ironically, few, if any, governmental authorities who are responsible for these policies seem to reflect on the adverse consequences of this very behavior on our national security. Very little has been written about the disruptive and incendiary effects of grabbing men in villages in Iraq and Afghanistan, jailing them under harsh conditions, and then releasing them back home with little thought over how much it may have angered or radicalized them. The detainees in Guantánamo get a bit more attention and some are sent to rehabilitation centers in Saudi Arabia and Yemen after their release. Many are released to their homes, or any country that will accept them, and left to fashion a new life. Of course, the chance that some detainees face indefinite detention obviates any realistic consideration for rehabilitation or treatment.

Across the globe, more physicians and legal experts are seeing victims of cruel, inhuman, and degrading treatment, and the destabilizing effects it has on the societies. These factors cast human rights in a different light and frame an increasingly important impact on national security, peace, and stability. In the American military, the involvement of clinicians and mental health professionals in interrogations is unprecedented. The convergence of needing to protect our citizens against terrorism, the nature of insurgency and counterinsurgency warfare, and the impact of harsh interrogations on subjects thrusts the role and responsibilities of psychiatrists front and center. It has influenced the tactics of the forensic psychiatrists conducting evaluations and swept the profession into the spotlight of counterterrorism strategy.

The danger is that clinical medicine and mental health have become politicized, a danger that was most grotesquely expressed in the former Soviet Union and Nazi Germany. We are not close to becoming pawns of governmental or military authorities, but the drift in that direction is insidious and destructive. Under the Soviet regime, political dissidents were accused of insanity simply because they had the audacity to challenge the system. The medical profession, especially psychiatry, was a political instrument of control and repression. Although we are hardly in that situation today, we cannot let that happen in this country or in any societies that aspire to be free and democratic.

The Obama administration in 2009 repudiated the CIA's evasion on the prohibition of cruel, inhuman, and degrading treatment and issued an executive order adopting Common Article 3 of the Geneva conventions for all detainees in custody. The Department of Defense had rejected most forms of torture, including most SERE (survival, evasion, resistance, escape) methods, by 2006.⁶ By 2008, the American Medical Association, the American College of Physicians, and the American Psychiatric Association protested the involvement of physicians and health professionals in interrogations and mistreatment of detainees and prohibited direct medical involvement in those activities. But, the Army Medical Command worked around the official positions of the professional associations and issued guidance in 2010 designating health professionals assigned to interrogation teams as "combatants," not permitting them to have clinical privileges while operating in their intel-

ligence capacity.⁷ Doctors, psychologists, and other clinicians are assigned to Behavior Science Consultant Teams (BSCTs) and still work closely on interrogations of detainees.

So as a psychiatrist (and, in my case, a retired general), how does one sustain personal integrity in this confusing and often contradictory landscape? I have always believed that doctors are champions of human rights, no matter what role or assignment we accept. After all, every society endows their doctors and healers with special trust and confidence. We symbolically wear the white coat at all times, even as psychiatric experts for the prosecution or in military uniform. We enjoy the implicit respect of our patients and subjects who depend on us to perform our examinations and clinical duties according to the highest standards.

Our ideals and principles cannot be compromised for any political purpose or personal agenda. But, an erosion of medical integrity has shadowed the war on terror. Psychiatric evaluations have been unduly influenced by military commanders and simply do not conform to standards of clinical practice. Too often, interviews and clinical examinations have been conducted to fit predetermined conclusions rather than to get the best possible information without bias or prejudice.

The shifts in practice and values extend far beyond the military and the prisons of Guantánamo Bay. The failure to conform to the accepted standard practices that have been drilled into doctors from the first days of medical school profoundly affects military medicine and generalizes across the professions. Shortcuts in one setting of clinical practice spill over into other clinical venues. Experts fail to document relevant history and clinical information. Without adequate background information, they make inadequate formulations of cases.

Much has improved since the dark days of 9/11, but our nation has been damaged. Where once the symbol of our great democracy was the Statue of Liberty, it has now become the image of that poor hooded man in detention with wires strung from his hands and feet. We are not safer because of misguided policies. It is time to right our wrongs. We all have a collective duty to uphold our shared beliefs and convictions, and mental health professionals have a unique responsibility to see that we do. When medicine is practiced in compliance with widely accepted medical ethics, the profession derives great

moral authority and legitimacy. The health care professions rely on trust, a central pillar of which is the premise that under no circumstances can a practitioner abandon his role to competing interests, including the security interests of the government in time of war.

References

1. Iacopino V, Xenakis SN: Intentional harm: neglect of medical evidence of torture in Guantánamo Bay. *PLoS Med* 8:e1001027, 2011
2. Welner MW: Testimony at the Sentencing of Omar Khadr, Office of the Military Commissions, August 2010
3. Xenakis SN: Testimony submitted before the Senate Judiciary Subcommittee on the Constitution, Civil Rights, and Human Rights, July 24, 2013
4. Gaffney FJ Jr: Testimony submitted before the Senate Judiciary Subcommittee on the Constitution, Civil Rights and Human Rights, July 24, 2013
5. Xenakis SN: No torture, no exceptions. *The Washington Monthly*. March 2008
6. DoD Directive 3115.09
7. U.S. Army Behavioral Science Consultation To Detention Operations, Intelligence Interrogations, Detainee Debriefing, and Tactical Questioning, January 2010