

Implications of the 2014 Senate Select Committee on Intelligence Report for Forensic Mental Health in the War on Terror

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In December 2014, the Senate Select Committee on Intelligence released a declassified executive summary on the use by the Central Intelligence Agency (CIA) of enhanced interrogation techniques against suspected terrorist detainees in the War on Terror. The report relies on 6 million pages of documents that describe the CIA's Detention and Interrogation Program, providing a systematic and comprehensive investigation into covert military and intelligence practices after the attacks on September 11, 2001. This article presents an analysis of key findings related to forensic mental health. I explore their implications for the ethics of mental health professionals who work with military and intelligence agencies and for facts disputed within the Guantánamo military commission system. Opportunities for further study and theoretical development are outlined.

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On December 9, 2014, the Senate Select Committee on Intelligence released a declassified executive summary concluding that the enhanced interrogation techniques (EITs) used by the Central Intelligence Agency (CIA) on suspected terrorist detainees in the War on Terror were “far worse” than represented, did not provide intelligence beyond conventional techniques, and were used on 39 of 119 CIA detainees.¹ Investigations began on December 11, 2007, after then-CIA Director Michael Hayden informed Committee members that videotaped interrogations of two detainees had been destroyed.¹ The Committee's 525-page summary is based on 6 million pages describing the CIA's Detention and Interrogation Program (DIP) from September 2001 to January 1, 2009.² CIA Director John Brennan acknowledged

that “the Agency made mistakes,” but reiterated that “intelligence gained from the program was critical to our understanding of al-Qa’ida.”³ Journalists praised Committee Chairman, Senator Dianne Feinstein, for releasing the summary despite political pressure,⁴ and some have suggested prosecuting those who violated international treaties against torture.⁵ President Barack Obama stated that he ended the DIP on assuming office and supported the summary's declassification.⁶

This article reviews the executive summary¹ and the CIA's response⁷ to consider their implications for forensic mental health in the War on Terror. First, the summary's description of psychiatrists and psychologists working with the CIA is analyzed. The summary introduces new information on psychologists conflicted between healing and consulting responsibilities. This information supports recommendations that forensic psychologists may need to rethink their ethics-related responsibilities in the War on Terror. Second, the summary explains the DIP treatment of certain detainees, a point long debated within the Guantánamo military commission

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system as a cause of mental illnesses, such as posttraumatic stress disorder (PTSD). Introducing the summary as evidence may affect forensic concerns such as sentencing considerations, as is illustrated by the case of one detainee. New Committee Chairman Senator Richard Burr wrote to President Obama asking for all copies of the full 6,700-page report to be returned rather than declassified, contending that the former committee acted to malign President George Bush's administration.⁸ These developments make a close analysis of the executive summary timely, because the full report may not be declassified. This article draws from the Committee's summary¹ and the CIA's response⁷ as primary sources, because most of their supporting documents remain classified or heavily redacted. The article quotes only texts in the public domain from the open court system at Guantánamo when discussing individual detainee cases, to balance respect for individuals with the advancement of scientific knowledge.⁹

The Ethics of Forensic Psychologists in Detainee Interrogations

The executive summary reviews counterterrorism policies after the September 11, 2001, attacks (9/11), establishing the basis for CIA detainee interrogations. Six days after 9/11, President Bush signed a covert Memorandum of Notification permitting the CIA "to capture and detain persons who pose a continuing, serious threat of violence or death to U.S. persons and interests or who are planning terrorist activities" (Ref. 1, p 10). On February 7, 2002, President Bush issued another memorandum that detainees, as enemy combatants not as part of any state military, did not qualify for protections as prisoners of war under the Geneva Conventions, initiating deliberations among the CIA, Department of Justice, and advisors to the National Security Council on detainee treatment.¹ Eventually, Assistant Attorney General Jay Bybee issued a memo to White House Counsel Alberto Gonzalez in August 2002 defining physical and mental torture outside of the Geneva Conventions, which pertain only to state signatories.¹¹ Rather than human rights standards, definitions were based on biomedical standards of "organ failure" and "psychological harm of significant duration," enabling clinician participation in interrogations.¹⁰

Although the above facts have been deduced through previously available documents, the execu-

tive summary's unique contribution is its account of the events leading to psychologists' involvement in detainee interrogations. Two psychologists, Grayson Swigert and Hammond Dunbar (the pseudonyms used in the report), developed EITs based on the theory of learned helplessness, defined in the summary as situations "in which individuals might become passive and depressed in response to adverse or uncontrollable events" (Ref. 1, p 21). (Psychologist Martin Seligman recently stated that he was "horri-fied" that his theory "may have been used for such dubious purposes" and denied discussing his work with them.¹²) The summary remarks on the psychologists' lack of relevant qualifications: "Neither psychologist had experience as an interrogator, nor did either have specialized knowledge of al-Qa'ida, a background in terrorism, or any relevant regional, cultural, or linguistic expertise" (Ref. 1, p 21). The CIA's response to the summary dissented, noting that the contractors "had the closest proximate expertise available to CIA" and that they had "written a number of research papers on such topics as resistance training, captivity familiarization, and learned helplessness" (Ref. 7, p 49). The CIA's response does not address the qualifications specified in the executive summary, proposing its own relevant qualifications.

Another contribution is the summary's details on the mental health consequences of EIT. An extant CIA contractor, Swigert proposed 12 techniques from the military's Survival, Evasion, Resistance and Escape (SERE) school as EITs in July 2002 and suggested that he and Dunbar be further contracted for services.¹ The Attorney General approved 11 EITs that month, including waterboarding, facial slap, cramped confinement, wall standing, stress positions, sleep deprivation, and use of diapers on detainees.¹ Abu Zubaydah was the first detainee to experience EITs, from August 4 through August 23, 2002, on a "near 24-hour-per-day basis" with waterboarding two to four times daily and confinement in a box lasting 266 hours (11 days, 2 hours).¹ Detainees were transported to rendition sites abroad where they received buckets for human waste and were chained to bars above their heads for sleep deprivation, such that Ridha al-Najjar was described in September 2002 as "a broken man."¹ In November 2002, Gul Rahman was found dead of hypothermia after his clothing was removed for not cooperating during an interrogation.¹ In October 2003, after 56 hours of sleep de-

privation, Arsala Khan was “barely able to enunciate” and “visibly shaken by his hallucinations depicting dogs mauling and killing his sons and family” (Ref. 1, p 109). In January 2004, Hassan Ghul experienced hallucinations after 59 hours of sleep deprivation, but a psychologist told him that his reactions were “consistent with what many others experience in his condition” (Ref. 1, p 132) and sleep deprivation continued. Three additional detainees (Janat Gul, Sharif al-Masri, and Ahmed Khalfan Ghailani) “experienced auditory hallucinations following sleep deprivation” (Ref. 1, p 139). The summary’s example of the longest period of sleep deprivation with psychologist oversight occurred with Muhammad Rahim:

Rahim was subjected to 104.5 hours of sleep deprivation from July 21, 2007, to July 25, 2007. Sleep deprivation was stopped when Rahim “described visual and auditory hallucinations.” After Rahim was allowed to sleep for eight hours and the psychologist concluded that Rahim had been faking his symptoms, Rahim was subjected to another 62 hours of sleep deprivation. A third, 13-hour, session was halted due to a limit of 180 hours of sleep deprivation during a 30 day period [Ref. 1, p 165].

These examples substantiate speculations that psychologists were systematically involved in detainee interrogations. The CIA’s response to the summary affirms that hallucinations occurred and disappeared upon sleep: “A review of the cases cited in the Study indicates that short periods of sleep effectively addressed the hallucinations and that the detainees were conscious of the fact that they had hallucinated” (Ref. 7, p 55). Civilian bioethicists have warned that interrogators could be more aggressive if health professionals are present to examine detainees and render them medically fit for further interrogations.^{13,14} A chart review of nine Guantánamo detainee records has also demonstrated that temporary psychological symptoms such as hallucinations after EITs did not lead psychologists to recommend treatment.¹⁵ The executive summary and the CIA response indicate that interrogators acted with psychologists’ involvement and that psychologists may have recorded mental health symptoms without recommending treatment aside from sleep.

The executive summary also shows that health professionals raised unheeded ethics-based warnings. One CIA psychologist wrote to the Office of Medical Services (OMS) objecting that the two psychologist contractors interrogating Khalid Sheikh Mohammed, the alleged mastermind of 9/11, were also entrusted with assessing his “psychological stability”

(Ref. 1, p 65). In March 2003, the chief of base detaining Mohammed prohibited the on-site medical officer from reporting on the interrogation to OMS outside of official CIA cables.¹ In another case, a draft cable from CIA headquarters that went unsent raised a conflict of interest in ‘Abd al-Rahim al-Nashiri’s interrogation: “We note that [the proposed plan] contains a psychological interrogation assessment by [REDACTED] psychologist [DUNBAR] which is to be carried out by interrogator [DUNBAR]. We have a problem with him conducting both roles simultaneously” (Ref. 1, p 72). The CIA’s response denied these allegations: “Early in 2003, Headquarters promulgated guidance on the scope of the contractor psychologists’ involvement in individual interrogations. It affirmed that no contractor could issue the psychological assessment of record” (Ref. 7, p 48).

It remains unclear why some CIA health professionals continued to raise objections about the dual clinical–forensic role of the psychologist contractors if CIA headquarters promulgated such guidance. What is clear is that some health professionals attempted to differentiate clinical responsibilities to detainees from forensic duties to the CIA, challenging any portrayal of the intelligence agency as monolithic in practice. Some observers have suggested a need for more bioethics training among military and intelligence health professionals so that they can better appreciate differences between their clinical and forensic roles.¹⁶ The executive summary and the CIA response indicate that the problem seems not to be a lack of such appreciation, but with commanding personnel’s prioritizing forensic over clinical responsibilities or problems with the implementation of existing policies.

For this reason, the Committee’s summary should reinvigorate debates on the ethics-based responsibilities of forensic psychologists. By appealing to the Geneva Conventions against torture, civilian bioethicists have demanded that health professionals avoid detainee interrogations, whether planning EITs, sharing clinical information, or examining detainees for further interrogations.^{14,17,18} Simply stated, their argument is that military bioethics do not differ from civilian bioethics.¹⁹ However, military bioethicists have countered that military health professionals, like soldiers, prioritize organizational imperatives to fulfill their mission above all else and that new policies in the War on Terror obfuscate what types of treatment constitute torture.^{20,21} The

executive summary insinuates that CIA headquarters prioritized a mission to conduct interrogations over medical care starting in July 2002,¹ a trend that had only been suspected when President Obama declassified EIT guidelines from the CIA's OMS in 2009.²²

The executive summary therefore raises crucial questions for forensic mental health based on changed social and legal circumstances in the War on Terror. First, are the bioethics responsibilities of health professionals to nonstate detainees the same as to state soldiers protected under the Geneva Conventions? Some have argued that medical ethics should not be changed if new policies seem to negate decades of international precedents.²³ At the same time, international treaties against torture have addressed medical protections for soldiers of state militaries, and invoking such treaties for detainee bioethics risks irrelevance to real-life practice if military and intelligence agencies can claim that they are not breaking laws.²⁴ For example, CIA psychologists operated under new legal definitions of torture that were created after conscious deliberation among government attorneys. Similarly, even though President Obama's administration has applied the Geneva Conventions to detainees, Army Medical Command has designated health professionals in interrogations as "combatants" and stripped them of clinical privileges.²⁵ The executive summary should therefore invite discussions on the extent to which the inapplicability of medical protections under the Geneva Conventions to detainees was illegal or unethical.

Second, how should conflicts between core bioethics principles be resolved, when nonmaleficence against individuals conflicts with social justice? The CIA invoked social justice to justify EITs against individual detainees: "The use of more aggressive methods is required to persuade Abu Zubaydah to provide the critical information we need to safeguard the lives of innumerable innocent men, women and children within the United States and abroad" (Ref. 1, p 33). Some may object, believing that the use of aggressive methods does not necessarily guarantee the production of critical information to safeguard innumerable lives. Others can object on the ground that society's ethics standards may be eroded if a precedent is set permitting the use of aggressive methods with certain individuals. Despite such objections, however, justifications such as the CIA's may persist as long as there are no guidelines for

reasoning through conflicting bioethics principles or independent mechanisms for adjudication, such as referral to third parties.

Third, what are the bioethics-related responsibilities of health professionals who work with military and intelligence organizations? Some believe that rather than pointing out the conflicts for military physicians who function simultaneously as physicians and soldiers, it may be more useful to contemplate the bioethics of the physician-soldier in a joint role.²⁶ Although this suggestion covers military psychiatrists, it may not cover military psychologists who remain professionally divided over their roles in ensuring national security.²⁷ It also does not cover the psychologists who proposed EITs as consultants working with, but not within, the CIA, raising questions about professional liability for independent contractors working with governments.^{28,29} It is unclear whether the Geneva Conventions apply directly to independent contractors, because only state governments are official signatories designated to provide medical protections to prisoners of war. The executive summary notes that the CIA has indemnified both contractors mentioned in the report for liability expenses until 2021.¹

EIT Use in CIA Custody Affecting Detainee Mental Health in Ongoing Cases

The executive summary notes that destruction of videotaped CIA interrogations for two detainees sparked the Committee's investigation.¹ Attorneys in the Guantánamo military commission (the Commission) for one of these two, 'Abd al-Rahim al-Nashiri, have consistently stated that the CIA's EIT use against him from 2002 to 2006 led to the development of PTSD. The Guantánamo military commission has maintained a public record (1,660 legal texts for al-Nashiri as of February 5, 2015) archiving legal motions, judicial orders, and court transcripts. One type of cultural analysis in forensic psychiatry has been the examination of legal texts as primary data sources for their constructions of narrative, presentations of evidence, and medicolegal interpretations seeking to persuade judicial opinion.^{24,30} Texts from al-Nashiri's case reveal crucial differences among legal parties in constructing narratives of mental illness, presenting evidence, and drawing medicolegal interpretations based on prior gaps in facts, such as EIT use, that have now been filled by the executive summary. These texts, along with court

transcripts, provide a more complete picture of legal debates on mental illness than sole reliance on a single party's view.

A major difference between the government and defense legal teams has been whether al-Nashiri's current behaviors reflect the mental health consequences of EIT use. For his involvement in attacks on three warships, al-Nashiri has faced capital charges since September 15, 2011, of perfidy, murder in violation of the law of war, attempted murder in violation of the law of war, terrorism, conspiracy, intentionally causing serious bodily injury, attacking civilians, attacking civilian objects, and hazarding a vessel.³¹ On March 9, 2012, his attorneys asked that he not be restrained during their legal visits since "during his incarceration with the CIA, the accused was tortured while shackled" and "the use of restraints is a retraumatization of his torture" (Ref. 32, p 1). In response, prosecution attorneys requested the Commission to compel production of his medical records and make him available for a mental health examination, since defense attorneys placed his mental health at issue.³³ Defense attorneys then sought broad access to al-Nashiri's medical records to include those while he was in CIA custody, not just those from his later detention in Guantánamo as requested by prosecution attorneys.³⁴ Narratives are thus constructed around al-Nashiri's not wanting restraints during attorney meetings, and legal parties have contested whether this behavior is a manifestation of a mental illness.

The type of evidence that could explain al-Nashiri's behavior has also been contested. In November 2012, prosecution attorneys requested a mental evaluation to assess al-Nashiri's capacity to stand trial based on his statements that "I might be going under threats" and "my nerves are also bad" as reasons for not attending hearings.³⁵ Defense attorneys responded that a Commission mental evaluation would be premature, because the defendant has understood his legal proceedings and cooperated in his defense despite having "serious, long term, and untreated PTSD."³⁶ Defense attorneys attached in their motion the declassified *Background Paper on CIA's Combined Use of Interrogation Techniques* to support their inference that the CIA's use of EITs led to al-Nashiri's PTSD.³⁶ His attorneys also contended in January 2013 that Guantánamo's mental health evaluation would be biased if based only on the work of experts chosen by the Commission.^{37,38}

Other detainee attorneys have also alleged bias, in that a board of military mental health officers conducts Commission evaluations, no defense experts are on this board, and defense experts are included only at the discretion of Guantánamo's presiding official.³⁹ The judge ruled that a Commission should evaluate al-Nashiri's capacity to stand trial, but also that records from CIA custody should be produced and testimony of a defense expert should be allowed.⁴⁰ Court transcripts of the defense expert's testimony, a senior author of the United Nations Istanbul Protocols on proper medical documentation for torture victims, have demonstrated contestations over the causes of al-Nashiri's behavior. In the following fragment, the expert began discussing the neurological effects of certain EITs until the prosecution attorney and judge interrupted because it had not yet been factually established that al-Nashiri experienced EITs:

A. I know in my own experience of evaluating medical records and examination of Guantánamo detainees, that there was a very high rate of suicidal attempts. So that something that comes to play in a person's behavior and their thinking and so forth, their decision-making.

Also with individuals who have had head trauma and/or asphyxia where there's a decrease of blood flow to the head from choking or—

Q. Let's not get into any specifics just because—

A. Well,—

MJ [COL. POHL]: Just don't (Ref. 41, pp 1711–12).

Even the Commission's evaluation has been subject to contrasting narratives and interpretations based on lack of factual information on EIT use. The evaluation, publicly accessible in part, noted that al-Nashiri was diagnosed with PTSD, major depressive disorder, and "Narcissistic, Antisocial, and Histrionic Personality features," and that he could understand the nature of proceedings and participate in his defense.⁴² Defense attorneys reiterated that his treatment in CIA custody caused these disorders,⁴³ though prosecution attorneys responded that the Commission's evaluation stated no actual cause.⁴⁴ A subsequent evaluation from a defense medical expert found that PTSD and depression had impaired al-Nashiri's ability to communicate with attorneys and that he had not received adequate treatment, because his "torture" had not been addressed.⁴⁵ Both legal teams agreed with his diagnoses, but differed over its causes.

In this light, the executive summary complicates the relationship between al-Nashiri's experience in CIA custody and his psychiatric disorders. In January 2014, defense attorneys motioned to compel production of the Senate Select Committee's full report, first drafted in 2012, arguing that "the accused was a central figure" in the DIP.⁴⁶ The prosecution responded in February 2014 that the full report had not yet been completed.⁴⁷ In February 2015, defense attorneys filed an emergency motion for the government to produce one copy of the full report,⁴⁸ lest the Committee's new leadership force the return of all copies "to avoid judicially-ordered production" (Ref. 49, p 2). Defense attorneys also filed a motion to compel all documents related to al-Nashiri cited in the executive summary,⁵⁰ to which prosecutors objected.⁵¹ Military judge Colonel Vance Spath ruled in April 2015 that although the report includes "discoverable information," prosecution attorneys can provide this information to defense attorneys as has occurred in the past with classified information,⁵² including all documents cited in the executive summary.⁵³

In fact, the executive summary offers details of al-Nashiri's treatment that were previously classified. He was waterboarded three times in one rendition site, transferred to another rendition site, ordered in standing stress positions for 2.5 days, and intimidated with a pistol placed near his head while blindfolded.¹ From June 2003 through September 2006, al-Nashiri was transferred to five other facilities and diagnosed by some CIA psychologists with an anxiety disorder and major depressive disorder.¹ In July 2005, CIA Headquarters expressed concern over his "continued state of depression and uncooperative attitude," and days later a CIA psychologist assessed that he was on the "verge of a breakdown."¹ In its response, the CIA stated that "the senior officer present, who authorized use of the gun and drill as fear-inducers, retired and was therefore beyond the reach of meaningful discipline."⁷ However, the subordinate officer "received a letter of reprimand, was blocked from receiving pay increases or promotions for two years, suspended without pay for a week, and removed from the program" (Ref. 7, p 46). The CIA response is not disputing EIT use; it is disputing the claim that there was no organizational accountability of its officers.

The executive summary therefore clarifies certain points, but not others. The facts establishing

EIT use with al-Nashiri in CIA custody are now specified, as is evidence of an anxiety and depressive disorder while he was in CIA custody and his functioning after EIT use. What is unclear is his premorbid functioning before CIA custody, whether the anxiety disorder diagnosed by CIA psychologists was or developed into PTSD, and whether there are similarities between his symptoms in CIA custody and now at Guantánamo. It remains to be seen whether the full report produces discoverable information that clarifies certain facts in the executive summary, and if not, whether the executive summary alters constructions of narrative and medicolegal interpretations among prosecution and defense teams moving forward.

Conclusion

The Senate Select Committee on Intelligence's December 2014 executive summary and the CIA's response provide a glimpse into the interface of law and mental health in the War on Terror. Both documents present the bioethics dilemmas of psychologists working in intelligence and military organizations when interrogation techniques do not meet legal standards of torture. In 2005 and 2006, The American Medical Association,⁵⁴ the American Psychiatric Association,⁵⁵ and the American Academy of Psychiatry and the Law⁵⁶ took positions against physician involvement in interrogations, to avoid undermining the physician's role as a healer. Even when interrogation techniques do not qualify under the legal definition of torture, the possibility of deception and coercion places a greater burden on the psychiatrist to strive for honesty, objectivity, and respect for the evaluatee.⁵⁷ In contrast, the American Psychological Association justified psychologists' participation in interrogations under the pretext of conducting research⁵⁸ until 2013, when it took a stand against psychologists participating in interrogations.⁵⁹ The American Psychiatric Association and the American Psychological Association notably issued a joint statement in 1985 against their members' involvement in torture as defined in the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment.⁶⁰ Therefore, new interpretations of torture in 2002 that differed from precedents in international treaties seem to have led to alternate responses, even within the mental health community. Hence,

the executive summary and the CIA's response act as unique archival sources that illuminate the use of psychologists in detainee interrogations during the early years of the War on Terror and the differing trajectories of professional ethics among psychiatrists and psychologists.

In addition, the executive summary and the CIA's response suggest that the fields of psychiatry and psychology would benefit from bioethics debates on the rights and responsibilities of detainees and psychologist-independent contractors that are not addressed in treaties such as the Geneva Conventions. Forensic work can be complicated by conflicting principles of ethics,³⁰ and both documents suggest that health professionals experienced principled conflicts in interactions with detainees in CIA custody. If 21st century warfare is characterized by the appearance of nonstate actors such as militants,²⁵ who are not protected under extant international treaties, then forensic medical ethics should develop alongside changing social and legal circumstances.

Moreover, the executive summary and the CIA's response call attention to the role of narrative and interpretation in medicolegal practice. The forensic report has been conceptualized as a performance in which experts use language to construct data-driven narratives intended to persuade audiences.^{30,61} This insight can be extended to legal documents, such as motions and reports from defense and prosecution teams that must also persuade judges and juries about mental illness in adversarial settings.²⁴ Critical analysis of such documents can advance theory development in forensic mental health. Analysis of narrative and interpretation among prosecution teams, defense teams, and judges can impart an understanding of how mental illness is debated and resolved in certain jurisdictions. For example, the lack of evidence on al-Nashiri's treatment in CIA custody before the release of the executive summary led both legal teams to craft narratives, supply evidence, and draw different interpretations of his behavior. A longitudinal analysis of such documents provides a perspective on the institutional mechanisms used to adjudicate debates, such as the Commission's mental health board. Similar analyses can be performed with respect to other detainees with pending cases, enriching our knowledge about forensic mental health in the War on Terror.

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