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Selling Our Souls for Dross¹: The Ethical Failure of Psychologists and the APA in Post 9/11 Interrogations and Torture

Jim Cosgrove

INTRODUCTION

In the wake of the attacks of September 11, 2001, considerable focus was placed on the intelligence failures that preceded the attacks. An intelligence community that had been designed and conditioned to respond to Cold War threats was suddenly required to adapt to a new enemy with new tactics. The aftermath of the attacks underscored the need for human intelligence to understand this new enemy and the threats it posed. When the United States began taking prisoners in Afghanistan, Iraq, and other locations, these prisoners were often taken for their perceived intelligence value.²

As the Bush White House began to develop the legal and policy rationales for treatment of these prisoners, the role of physicians and other medical personnel became central to the administration's policy. As the mistreatment of prisoners has gradually come to light, primarily due to the release of photos from Iraq's Abu Ghraib prison and reports from the International Committee of the Red Cross, many critics of the Bush administration policies have questioned whether physicians and other medical personnel violated medical ethics. Critics have argued that the documents released to date point to medical ethics violations including permitting and

¹ E-mail from The Honorable Craig Murray, British Ambassador to Uzbekistan, (July 2004), in Steven H. Miles, *Oath Betrayed: America's Torture Doctors* (University of California Press 2009), "We receive intelligence obtained from Uzbek intelligence via the U.S. . . . Tortured dupes are forced to sign up to confessions showing what the Uzbek government wants the U.S. and U.K. to believe . . . We are selling our souls for dross."

² In the case of Abu Ghraib, some Army personnel estimated that less than 10% of detainees had any real intelligence value. Miles, at 49.

assisting in coercing interrogations, using medical skills and confidential information for non-therapeutic purposes, misrepresenting and delaying communication of causes of death, and failing to advocate for minimally adequate sanitation, mental health care, shelter from weapon fire, and medical care.³

Among these medical personnel, the role of psychologists was unique. Psychologists had an integral role in the design and application of the so-called “enhanced interrogation techniques”⁴ that became central to military and CIA’s interrogation of detainees.⁵ Psychologists not only helped design the techniques used, they were often in or close to the interrogation room, advising interrogators on the methods to be used and how to adjust them.⁶ Psychologists developed profiles of detainees in order to determine how best to “break them down” and psychologists were there when many of these detainees began to experience serious deterioration in their mental health, with many detainees attempting or committing suicide.⁷

As details of the role of psychologists in these interrogations has come out, there has been considerable dissension within the American Psychological Association, with some members alleging the association has been complicit with torture and has not spoken out loudly against

³ Miles, at 153.

⁴ The term “enhanced interrogation techniques” which became commonplace in the media coverage of the Bush administration’s treatment of detainees appears to have originated with the CIA. See Office of Inspector General, Central Intelligence Agency, Counterterrorism Detention and Interrogation Activities (September 2001 – October 2003), (May 7, 2004) available at http://www.gwu.edu/~nsarchiv/torture_archive/20040507.pdf (last visited May 7, 2012). The writer Andrew Sullivan points out the phrase’s similarity to the German Gestapo’s program, “verschärfte Vernehmung”, which means enhanced, sharpened, or intensified interrogation, available at <http://www.theatlantic.com/daily-dish/archive/2007/05/-versch-auml-rfte-vernehmung/228158/> (last visited May 7, 2012).

⁵ See Katherine Eban, Rorschach and Awe, *Vanity Fair* (July 7, 2007), available at <http://www.vanityfair.com/politics/features/2007/07/torture200707> (last visited May 7, 2012); Jane Mayer, *The Experiment*, *The New Yorker* (July 11, 2005), available at http://www.newyorker.com/archive/2005/07/11/050711fa_fact4 (last visited May 7, 2012), and Sheri Fink, *The Reluctant Enablers of Torture*, *Salon.com* (May 5, 2009), available at http://www.salon.com/2009/05/05/torture_20/singleton/ (last visited May 7, 2012).

⁶ *Id.*

⁷ *Id.* and Miles, 103-07.

torture.⁸ Many of these members argue that psychologists cannot act ethically within the national security interrogation framework.⁹

This paper will argue that the APA should adopt guidelines prohibiting psychologists from having non-therapeutic roles in detention facilities and stating that psychologists outside those facilities should not provide any guidance to interrogators on any techniques that may be deemed physically or psychologically coercive. Part I discusses the legal justification for the use of “enhanced interrogation techniques” in the aftermath of the 9/11 attacks and the contemplated role of medical and psychological personnel. Part II will examine the state of medical and psychological ethics codes that were in place in the post-World War II pre-9/11 era. Part III will then detail the ethical failures of medical and psychological personnel involved in post-9/11 interrogations and torture. Part IV will then discuss the reaction of medical societies to the revelation of detainee abuse and the involvement of medical personnel. Particular attention will be paid to the response of the APA and the ongoing debate within that organization. Part V will then discuss the ethical challenges posed by the involvement of medical and psychological personnel in interrogations, and Part VI will discuss the major bioethical principles that should inform the work of all psychologists, whether clinical or academic.

I. BUSH ADMINISTRATION AUTHORIZATION OF “ENHANCED INTERROGATION TECHNIQUES”

The United States and its allies invaded Afghanistan in October of 2001 and shortly thereafter began taking prisoners there.¹⁰ The first prisoners to be housed in Guantanamo Bay

⁸ See, e.g., Jeffrey Kaye, *Why Torture Made Me Leave the APA*, (March 6, 2008), available at <http://www.alternet.org/rights/78909> (last accessed May 7, 2012).

⁹ *Id.*

arrived in January of 2002.¹¹ The reasons for involvement of medical personnel and particularly psychologists began with the White House's legal justification for the standards of treatment of these detainees. The administration laid the basis for enhanced interrogation techniques by first arguing in a series of memos that the 1949 Geneva Conventions and the U.S. War Crimes Act did not apply to Al Qaeda or the Taliban.¹² Despite opposition from Secretary of State Colin Powell and State Department Counsel Howard Taft IV, this argument prevailed and became official U.S. policy.¹³ A memo from Secretary of Defense Donald Rumsfeld subsequently advised Defense Department personnel that the Geneva Conventions did not apply to Al Qaeda and Taliban, but that detainees were to be treated humanely in a manner consistent with the principles of the Convention "to the extent appropriate and consistent with military necessity."¹⁴

President Bush affirmed this order on February 7, 2002 in his own order accepting the conclusions of the Justice Department that the Geneva Conventions did not apply to Al Qaeda and that the Taliban were unlawful combatants and therefore did not qualify as prisoners of war under Article 4 of the Convention.¹⁵

Having found the Geneva Convention inapplicable to Al Qaeda and the Taliban, the Bush administration next addressed the U.N. Convention Against Torture and Other Cruel, Inhuman

¹⁰ Office of the Surgeon General of the Army, Final Report, Assessment of Detainee Medical Operations for OEF, GTMO, and OIF (Apr. 13, 2005), pg. 2-1, available at http://dspace.wrhc.org/doc/bitstream/2041/85008/02920_050413.pdf (last accessed May 7, 2012).

¹¹ *Id.*

¹² See Memorandum from John Yoo and Robert Delahunty to William J. Haynes, II, General Counsel, Department of Defense, re: Application of Treaties and Laws to al Qaeda and Taliban Detainees (Jan. 9, 2002) and Memorandum from Office of Legal Counsel, U.S. Dep't of Justice to Alberto R. Gonzales, Counsel to the President, re: Application of Treaties and Laws to Al Qaeda and Taliban Detainees (Jan. 22, 2002) reprinted in Karen J. Greenberg and Joshua L. Dratel (eds), *The Torture Papers: The Road to Abu Ghraib*, (Cambridge University Press 2005), at 38 and 81.

¹³ Miles, at 145-46.

¹⁴ Memorandum from Donald Rumsfeld to the Chairman of the Joint Chiefs of Staff, re: Status of Taliban and Al Qaida (Jan. 19, 2002), in Greenberg & Dratel, 80.

¹⁵ Memorandum from George W. Bush to The Vice President et al., re: Humane Treatment of Taliban and al Qaeda Detainees (Feb. 7, 2002) in Greenberg & Dratel, 134.

and Degrading Treatment or Punishment (the “Convention Against Torture”). The Convention Against Torture is codified in the United States Code under 18 U.S.C. §§ 2340-2340A. The Justice Department offered the following interpretation of what constitutes torture under § 2340 in a memo from Office of Legal Counsel Assistant Attorney General Jay Bybee to the President’s Counsel, Alberto Gonzales:

Physical pain amounting to torture must be equivalent in intensity to the pain accompanying serious physical injury, such as organ failure, impairment of bodily function, or even death. For purely mental pain or suffering to amount to torture under Section 2340, it must result in significant psychological harm of significant duration, e.g. lasting for months or even years.¹⁶

The memo further argued that the statute’s specific intent requirement means that for a defendant to have the requisite intent, “the infliction of such pain must be the defendant’s precise objective.”¹⁷ Addressing the Convention Against Torture, the memo noted that the Convention only provides penalties for this extreme conduct, many actions that would constitute “cruel, inhuman, or degrading treatment or punishment” do not rise to the level of torture and parties to the treaty need not criminalize them.¹⁸

¹⁶ Memorandum from Jay S. Bybee, Assistant Attorney General, Office of Legal Counsel to Alberto R. Gonzales, Counsel to the President, re: Standards of Conduct for Interrogation under 18 U.S.C. §§ 2340-2340A (Aug. 1, 2002), in Greenberg & Dratel, 172. The memo went on define the degree of mental harm necessary to constitute torture: “We conclude that mental harm also must result from one of the predicate acts listed in the statute, namely: threats of imminent death; threats of infliction of the kind of pain that would amount to physical torture; infliction of such physical pain as a means of psychological torture; use of drugs or other procedures designed to deeply disrupt the senses, or fundamentally alter an individual’s personality; or threatening to do any of these things to a third party.”

¹⁷ *Id.*

¹⁸ *Id.* The memo notes that even if some conduct arguably violated § 2340A, the statute may unconstitutionally encroach on the President’s Commander-in-Chief power. Further, the memo argues, the defenses of necessity and self-defense may be available in the event of prosecution. Former Office of Legal Counsel Attorney Jack Goldsmith described the effect of this memo: “[V]iolent acts aren’t necessarily torture; if you do torture, you probably have a defense; and even if you don’t have a defense, the torture law doesn’t apply if you act under the color of presidential authority. CIA interrogators and their supervisors, under pressure to get information about the next attack, viewed the opinion as a ‘golden shield’, as one CIA official later called it, that provided enormous comfort.” in Jack Goldsmith, *The Terror Presidency*, (W.W. Norton & Co. 2007), at 144.

Prior to 2002, the Department of Defense had long relied on Army Field Manual 34-52 as the standard source for interrogation doctrine.¹⁹ In October of 2002, the commander of the Guantanamo interrogation teams wrote a memo seeking approval for what would become known as “enhanced interrogation techniques.”²⁰ In a memo supporting the approval of the new interrogation methods, Lieutenant Colonel Diane Beaver, an attorney with Joint Task Force 170 (the unit in charge of the Guantanamo Bay prison), argued that some of the methods would be permissible if done “with appropriate medical monitoring.”²¹ went on to recommend that certain more aggressive techniques “undergo a legal, medical, behavioral science, and intelligence review prior to their commencement.”²² Secretary Rumsfeld approved the use of these additional techniques and proceeded to appoint a working group to develop interrogation policy.²³

Based on the working group’s reports Secretary Rumsfeld issued a memo to the Commander of U.S. Southern Command, whose jurisdiction includes Guantanamo Bay, outlining the interrogation techniques approved for use and how they should be employed.²⁴ As noted by Steven Miles in his book *Oath Betrayed*, the memo “sketch[es] a philosophy of medical partnership with coercive interrogation.”²⁵ The memo notes that “interrogations must always be planned, deliberate actions that take into account . . . a detainee’s emotional and physical

¹⁹ Final Report of the Independent Panel to Review DoD Detention Operations, (August 2004), at 7 available at http://dspace.wrlc.org/doc/bitstream/2041/70989/02578_040824_001display.pdf (last accessed May 7, 2012).

²⁰ Memorandum from Lieutenant Colonel Jerald Phifer to Commander, Joint Task Force 170, re: Request for Approval of Counter-Resistance Strategies (Oct. 11, 2002) in Greenberg & Dratel, pg. 227.

²¹ Memorandum from Lieutenant Colonel Diane Beaver to Commander, Joint Task Force 170, re: Legal Brief on Proposed Counter-Resistance Strategies (Oct. 11, 2001) in Greenberg & Dratel, pg. 229.

²² Id.

²³ Miles, at 149.

²⁴ Memorandum from Donald Rumsfeld, Secretary of Defense to Commander, U.S. Southern Command, re: Counter-Resistance Techniques in the War on Terrorism (Apr. 16, 2003) in Greenberg & Dratel, pg. 360.

²⁵ Miles, at 149.

strengths and weaknesses. Interrogation approaches are designed to manipulate the detainee's emotions and weaknesses to gain his willing cooperation."²⁶ The Secretary's memo also proposes roles for medical personnel in interrogations, including medical and psychological review of the use of the isolation technique, medical clearance of the detainee for interrogation, and the presence or availability of qualified medical personnel as safeguards.²⁷ Rumsfeld's approval and the OLC legal justifications for these techniques came despite the fact that any of the enhanced interrogation techniques alone had been considered torture by the U.N. Committee on Torture and/or the U.N. Special Rapporteur on Torture.²⁸ Those approvals also came despite the fact that the U.S. had considered these practices as torture in other countries.²⁹

III. MEDICAL ETHICS AND TREATMENT OF DETAINEES POST WORLD WAR II

The atrocities of the Nazis during World War II, including many acts perpetrated by doctors, spurred the international community to reiterate its opposition to torture. Both American and world medical societies were unequivocal in stating that torture was wrong and that doctors should not participate or facilitate it in any fashion.³⁰

²⁶ Rumsfeld memo, note 23 supra.

²⁷ Id. Similarly, the CIA's Office of Medical Services described its mandate in the interrogation arena as "assessing and monitoring the health of all Agency detainees subject to 'enhanced' interrogation techniques, and for determining that the authorized administration of these techniques would not be expected to cause serious or permanent harm." Office of Medical Services, Central Intelligence Agency, OMS Guidelines on Medical and Psychological Support to Detainee Rendition, Interrogation, and Detention, (May 17, 2004) available at http://dspace.wrlc.org/doc/bitstream/2041/72435/02793_041200display.pdf (last accessed May 7, 2012).

²⁸ Vincent Iacopino and Stephen Xenakis, Neglect of Medical Evidence of Torture in Guantanamo Bay: A Case Series, PLoS Medicine, Volume 8, Issue 4, (April 2011) available at <http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001027> (last accessed May 7, 2012).

²⁹ Id.

³⁰ Miles, at 37 noting that while torture has been universally condemned by various medical societies, "Professional sanctions against medical personnel are rare enough to be noteworthy."

A. RESPONSE OF INTERNATIONAL AGENCIES AND SOCIETIES

The newly formed United Nations embraced the Enlightenment idea that torture had no place in civilized society and that investigative necessity, war, national sovereignty, or revenge could not justify its use.³¹ One of the United Nations' first acts was the drafting of the Universal Declaration of Human Rights ("UDHR"). The UDHR reaffirms the rights and dignity of all humans and prohibits torture in its Article 5, stating, "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

The Third Geneva Convention made a similar statement in its Article 3, declaring: "(1) Persons taking no active part in the hostilities, including members of armed forces who have laid down their arms and placed hors de combat by sickness, wounds, detention, or any other cause, shall in all circumstances be treated humanely . . . To This end the following acts are and shall remain prohibited at any time and in any place whatsoever with respect to the above-mentioned persons: (a) violence to life and person, in particular murder of all kinds, mutilation, cruel treatment and torture; . . . (c) outrages upon personal dignity, in particular, humiliating and degrading treatment; . . . (2) The wounded and sick shall be collected and cared for."

The International Covenant on Civil and Political Rights reiterated the international community's stated intolerance for torture and degrading treatment in 1966 and by the Helsinki Accords in 1975.

The Nuremberg Trials also incited the international community to focus on doctor participation in torture and the need for ethical standards for physicians in charge of prisoners.³² Twenty-three doctors were indicted, tried and mostly convicted for their involvement in the atrocities of the Nazi regime.³³ The World Medical Association adopted its "Regulations in Time of Armed Conflict" in 1956. These regulations, while not explicitly referencing torture, stated "[t]he primary task of the medical profession is to preserve health and save life. Hence it

³¹ Miles, at 31.

³² Miles, at 33.

³³ Id.

is deemed unethical for physicians to (a) [g]ive advice or perform prophylactic, diagnostic, or therapeutic procedures that are not justifiable in the patient's interest [or to] (b) [w]eaken the physical or mental strength of a human being without therapeutic justification.”³⁴

The World Medical Association later strengthened their language and explicitly rejected the association of medical professionals with torture. Its Declaration of Tokyo provides, in part:

1. The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife. 2. The physician shall not provide any premises, instruments, substances or knowledge to facilitate the practice of torture or other forms of cruel, inhuman or degrading treatment . . . 3. . . . The physician shall not use nor allow to be used, as far as he or she can, medical knowledge or skills, or health information specific to individuals, to facilitate or otherwise aid any interrogation, legal or illegal, of those individuals. The physician shall not be present during any procedure during which torture or any other forms of cruel, inhuman or degrading treatment is used or threatened.³⁵

This declaration proved hugely influential as the U.N. and various world medical societies made their own statements condemning medical complicity with torture.³⁶ The World Psychiatric Association, in its Declaration of Madrid addressed torture, stating, “Psychiatrists shall not take part in any process of mental or physical torture, even when authorities attempt to force their involvement in such acts.”³⁷

³⁴ World Medical Association, *Regulations in Times of Armed Conflict* (1956).

³⁵ WMA Declaration of Tokyo - Guidelines for Physicians Concerning Torture and other Cruel, Inhuman or Degrading Treatment or Punishment in Relation to Detention and Imprisonment, adopted October 1975 and editorially revised in 2005 and 2006. The declaration also stresses the need for a physician's clinical independence and proclaims that a prisoner should not be fed by artificial means where such prisoner has made an unimpaired and rational refusal of nourishment.

³⁶ Miles, at 35.

³⁷ Madrid Declaration on Ethical Standards for Psychiatric Practice (1996).

B. RESPONSE OF AMERICAN MEDICAL SOCIETIES

American medical societies, including the American College of Physicians and the American Medical Association (the “AMA”), followed with their own statements forbidding physician involvement in torture.³⁸ The AMA’s Council on Ethical and Judicial Affairs issued an opinion in 1999, declaring, in part:

“Torture refers to the deliberate, systematic, or wanton administration of cruel, inhumane, and degrading treatments or punishments during imprisonment or detainment. Physicians must oppose and must not participate in torture for any reason. Participation in torture includes, but is not limited to, providing or withholding any services, substances, or knowledge to facilitate the practice of torture. Physicians must not be present when torture is used or threatened. Physicians may treat prisoners or detainees if doing so is in their best interest, but physicians should not treat individuals to verify their health so that torture can begin or continue. . . . Physicians should help provide support for victims of torture and, whenever possible, strive to change situations in which torture is practiced or the potential for torture is great.”³⁹

The psychiatric and psychological communities were similarly opposed to torture; especially as research in the latter half of the century revealed the myriad psychiatric harms brought about by torture.⁴⁰ The American Psychiatric Association and the American Psychological Association issued a joint position statement in 1985 condemning torture and supporting both the U.N. Convention Against Torture and the U.N. Principles of Medical Ethics.⁴¹

Unfortunately the APA ethics code was not entirely clear on what psychologist’s ethical duties were in the national security setting. The APA’s code is titled “Ethical Principles of

³⁸ Miles, at 36.

³⁹ American Medical Association Opinion 2.067 – Torture (issued December 1999.)

⁴⁰ Miles, at 36-37.

⁴¹ Against Torture: Joint Resolution of the American Psychiatric Association and the American Psychological Association (1985).

Psychologists and Code of Conduct,” hereinafter the “Code.”⁴² The Code consists of two sections, “General Principles” and “Ethical Standards.” The General Principles contain five aspirational goals, namely “Beneficence and Nonmaleficence,” “Fidelity and Responsibility,” “Integrity,” “Justice,” and “Respect for People’s Rights and Dignity.”⁴³ The General Principles, in contrast to the Ethical Standards, “do not represent obligations and should not form the basis for imposing sanctions.”⁴⁴

In August of 2002, the APA revised the Code for the first time in ten years. Most notably, the APA Ethics Committee modified Ethical Standard 1.02, “Relationship of Ethics and Law.” The 1992 version of 1.02 stated that when psychologists’ ethical obligations conflict with the law, “psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict in a responsible manner.”⁴⁵ The 2002 amendments kept this language, but added that “[i]f the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority.”⁴⁶ Critics of the APA have argued that this language essentially adopts the Nuremberg defense, a defense that had been universally refused decades before.⁴⁷ While the APA’s opposition to torture was clear, its

⁴² APA Ethical Principles and Code of Conduct, (2010 Amendments) available at <http://www.apa.org/ethics/code/index.aspx> (last accessed May 7, 2012).

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ APA Ethical Principles and Code of conduct, (1992 Amendments) available at <http://www.apa.org/ethics/code/code-1992.aspx> (last accessed May 7, 2012).

⁴⁶ See Redline Comparison of APA Ethical Principles of Psychologists and Code of Conduct, December 1992 and December 2002 available at <http://www.apa.org/ethics/code/92-02codecompare.pdf> (last accessed May 7, 2012).

⁴⁷ Kenneth Pope and Thomas Gutheil, Psychologists Abandon the Nuremberg Ethic: Concerns for Detainee Interrogations, *International Journal of Law and Psychiatry*, Vol. 32, No. 3, at 161-166, (May-June 2009). For its part, the APA has insisted that the change in the Code had nothing to do with the war on terror and was drafted largely in response to conflicts that arise when court issue subpoenas for psychologists’ records. See letter from Melba Vazquez, APA President to Psychologists for an Ethical APA, (December 5, 2011) available at <http://www.apa.org/news/press/statements/ethical-psychologist.pdf> (last accessed May 7, 2012).

guidance for its members in situations where torture or degrading treatment might occur was lacking.

III. PSYCHOLOGISTS' PARTICIPATION IN INTERROGATION AND TORTURE

Despite the Geneva Conventions, the Convention Against Torture, the U.N. Principles of Medical Ethics and ethics codes of medical societies around the world, detainees in Guantanamo Bay, Abu Ghraib, Bagram, and dozens of other U.S. prisons both known and unknown were subject to torture, cruel and inhumane treatment and degradation.⁴⁸ The 2004 International Red Cross report on Iraqi detainees found that those under supervision of military intelligence were “subjected to a variety of harsh treatments ranging from insults, threats and humiliations to both physical and psychological coercion which in some cases was tantamount to torture in order to force cooperation with their interrogators.”⁴⁹ Certain “high value” detainees in CIA custody reported being subjected to continuous solitary confinement, waterboarding, prolonged stress standing, beatings by use of a collar, beating and kicking, confinement in a box, prolonged nudity, sleep deprivation and use of loud music, exposure to cold temperature or cold water, prolonged use of handcuffs and shackles, threats, forced shaving, and deprivation or restricted provision of solid food.⁵⁰ In many cases, doctors were there either facilitating, ignoring or

⁴⁸ See International Committee of the Red Cross, ICRC Report on the Treatment of Fourteen “High Value Detainees” in CIA Custody, (February, 2007), available at http://dSPACE.wrlc.org/doc/bitstream/2041/71001/03083_070214_001display.pdf (last accessed May 7, 2012), Report of the International Committee of the Red Cross (ICRC) on the Treatment by Coalition Forces of Prisoners of War and Other Protected Persons by the Geneva Conventions in Iraq During Arrest, Internment and Interrogation, (February 2004), available at http://dSPACE.wrlc.org/doc/bitstream/2041/84931/01338_040200.pdf (last accessed May 7, 2012).

⁴⁹ Report of the International Committee of the Red Cross (ICRC) on the Treatment by Coalition Forces of Prisoners of War and Other Protected Persons by the Geneva Conventions in Iraq During Arrest, Internment and Interrogation, at 3-4.

⁵⁰ ICRC Report on the Treatment of Fourteen “High Value Detainees” in CIA Custody, at 7-9. The reported methods of ill-treatment largely correspond to methods found in the Office of Medical Services, Central Intelligence Agency, OMS Guidelines on Medical and Psychological Support to Detainee

covering up these abuses.⁵¹ Medical personnel cleared detainees for interrogation and used confidential information to help formulate interrogation plans.⁵² Medical personnel ignored squalid sanitation and proper standards of care for tuberculosis management.⁵³ Medical personnel failed to document signs of abuse on medical records and concealed causes of death on death certificates.⁵⁴ Medical personnel allowed prisoners to be kept in areas that were subject to attack by enemy fire.⁵⁵ There is also evidence that medical care was withheld from detainees during questioning⁵⁶ and some evidence to suggest that detainees were given mind-altering drugs to gain information during interrogations.⁵⁷

Rendition, Interrogation, and Detention, (May 17, 2004) available at http://dspace.wrhc.org/doc/bitstream/2041/72435/02793_041200display.pdf (last accessed May 7, 2012), and methods that had been legally cleared by the Office of Legal Counsel. See Memorandum from Steven Bradbury to John A. Rizzo, Senior Deputy Counsel, Central Intelligence Agency, re: Application of 18 U.S.C. §§ 2340-2340A to Certain Techniques That May Be Used in the Interrogation of a High Value al Qaeda Detainee, (May 10, 2005) available at http://dspace.wrhc.org/doc/bitstream/2041/70996/02929_050510display.pdf (last accessed May 7, 2012), and Memorandum from Steven Bradbury to John A. Rizzo, Senior Deputy Counsel, Central Intelligence Agency, re: Application of United States Obligations Under Article 16 of the Convention Against Torture to Certain Techniques that May Be Used in the Interrogation of High Value al Qaeda Detainees, (May 30, 2005) available at http://dspace.wrhc.org/doc/bitstream/2041/70997/02941_050530display.pdf (last accessed May 7, 2012).

⁵¹ Miles, at 119-33 and Iacopino, at 4.

⁵² Id., at 52-53 and Peter Slevin and Joe Stephens, Detainees' medical files shared: Guantanamo interrogators' access criticized. Washington Post. June 10, 2004:A1.

⁵³ Miles, at 101-03 and 111-12.

⁵⁴ Iacopino, at 4 and Miles, at 74-84.

⁵⁵ Miles, at 112-16.

⁵⁶ Miles, at 61.

⁵⁷ Joby Warrick, Detainees Allege Being Drugged, Questioned, Washington Post, April 22, 2008 available at

http://www.washingtonpost.com/wpdyn/content/article/2008/04/21/AR2008042103399_pf.html (last accessed May 7, 2012). See also Mark Denbeaux et al., Drug Abuse: An Exploration of the

Government's Use of Mefloquine at Guantanamo available at

<http://law.shu.edu/ProgramsCenters/PublicIntGovServ/policyresearch/upload/drug-abuse-exploration-government-use-mefloquine-gunatanamo.pdf> (last accessed May 7, 2012) documenting the "medically inappropriate" administration of the anti-malaria drug mefloquine on Guantanamo detainees. The report concludes that the manner in which the drug was used was either the result of gross medical malpractice, or its use was intended either as an aid to break detainee's resistance, or to test the side effects of mefloquine, or as punishment. A major Department of Defense Office of Inspector General Report on the drugging of detainees in Guantanamo was completed in 2009, but, to date, the report has not been declassified and a Freedom of Information Act request has not been satisfied. See Jeffrey Kaye and Jason

While these acts and omissions of doctors, nurses, and medics are reprehensible and deserving of further discussion, the role of psychologists in post 9/11 interrogation and torture has been unique and presents numerous ethical issues. Psychologists were the primary architects and implementers of the new enhanced interrogation techniques.⁵⁸ Psychologists were often responsible for developing a profile of a detainee and then customizing an interrogation plan based on that profile.⁵⁹ Psychologists were in or near the interrogation room and were available to interrogators to suggest tweaks in interrogation plans.⁶⁰ And psychologists were there when many of these detainees began to experience steep declines in mental health.⁶¹

Many of the techniques used on detainees were based on the military's Survival, Evasion, Resistance and Escape ("SERE") program.⁶² The SERE program was designed to train U.S. soldiers to endure and resist torture techniques used by the Chinese and North Korean governments.⁶³ The program was created after American servicemen captured during the Korean War made false confessions after being tortured.⁶⁴ Multiple reports have named two

Leopold, Government Report on Drugging of Detainees is Suppressed, (September 14, 2010) available at <http://archive.truthout.org/government-report-drugging-detainees-is-suppressed63256> (last accessed May 7, 2012).

⁵⁸ See Eban, note 4 supra.

⁵⁹ See Mayer, note 4 supra, Office of the Surgeon General of the Army, Final Report, Assessment of Detainee Medical Operations for OEF, GTMO, and OIF (Apr. 13, 2005), pg. 18-12, and U.S. Senate Committee on Armed Services Report, Inquiry Into the Treatment of Detainees in U.S. Custody (Nov. 20, 2008), pg. 149.

⁶⁰ Jonathan Marks, Doctors as Pawns? Law and Medical Ethics at Guantanamo Bay, 37 Seton Hall Law Rev. 711, 715 (2007) and Miles, at 53-59. See also, Physicians for Human Rights, Break Them Down: Systematic Use of Psychological Torture by US Forces, pg. 47, available at https://s3.amazonaws.com/PHR_Reports/break-them-down.pdf (last accessed May 7, 2012), quoting one Guantanamo interrogator: "I've met with the BISC (Biscuit) people several times and found them to be a great resource. They know everything that's going on with each detainee, who they're talking to, who the leaders are, etc. I've encouraged the interview teams to meet with them prior to doing their interviews."

⁶¹ Miles, at 103-05.

⁶² Spencer Ackerman, Report Details Origins of Bush-Era Interrogation Policies, The Washington Independent (April 21, 2009), available at <http://washingtonindependent.com/39933/report-details-origins-of-bush-era-interrogation-policies> (last accessed May 7, 2012).

⁶³ Id.

⁶⁴ See Eban, note 4 supra.

SERE psychologists, James Mitchell and Bruce Jessen, as reverse-engineering the SERE program to use on detainees and training interrogators on these techniques, which included sleep-deprivation, exposure to extreme temperatures, and waterboarding.⁶⁵ Despite having little science behind their methods and no experience with interrogations, Mitchell and Jessen's techniques were embraced by the Department of Defense and the CIA.⁶⁶ The techniques they suggested are the same ones that appear in the Office of Legal Counsel and the Rumsfeld memoranda.

The role of psychologists did not end with the design of the enhanced interrogation program. The techniques advocated by Mitchell and Jessen were instilled in and deployed by groups of psychologists, physicians and psychiatrists known as Behavioral Science Consultation Teams ("BSCT"), or "biscuits."⁶⁷ BSCT members reviewed detainee medical information with an eye towards interrogation, "performed psychological assessments, recommended physically and psychologically coercive interrogation plans, monitored and provided feedback during interrogations, and taught behavioral techniques to interrogators."⁶⁸ In addition to monitoring and recommending the use of sleep deprivation and manipulation, stress positions, exposure to loud noise and temperature extremes, BSCT members crafted interrogation plans that exploited detainee phobias of darkness, confined spaces, and insects, as well as cultural sensitivities around

⁶⁵ See e.g., Eban and Ackerman, *supra*. Mitchell and Jessen formed a consulting firm, Mitchell Jessen and Associates, LLC to train government interrogators on how to break down detainees.

⁶⁶ *Id.*

⁶⁷ There seems to have been a preference for psychologists over other professionals among some Pentagon advisers and psychologists largely staffed these positions. Nancy Sherman, *From Nuremberg to Guantanamo: Medical Ethics Then and Now*, 6 Wash. U. Global Stud. L. Rev. 609, 617 (2007). Sherman speculates that psychologists as non-physicians were not perceived to be as strictly bound by the Hippocratic requirement to do no harm.

⁶⁸ Miles, at 54.

sexuality and the Koran.⁶⁹ An Army Surgeon General report described the role of the BSCTs: “[BSCTS are to] check the medical history of detainees . . . and what are their buttons. [BSCTs] will greatly assist [the interrogators] with: obtaining more accurate intelligence information, knowing how to gain better rapport with the detainees and also knowing when to push or not to push harder in pursuit of intelligence information.”⁷⁰

Neglect of mental health was a major problem in prisons at Guantanamo Bay, in Iraq, and in Afghanistan.⁷¹ The Red Cross observed detainees with numerous stress-induced impairments, as well as anxiety and thoughts of suicide.⁷² Numerous suicide attempts have been documented at Guantanamo Bay.⁷³ A 2003 Army report of conditions in Iraqi prisons observed that, “The mentally ill were receiving no treatment . . . Mental illness is a grossly neglected area for the health care of Iraqi detainees.”⁷⁴ In addition, prisons frequently did not have medicines to treat major psychiatric conditions.⁷⁵ Mentally ill prisoners in Iraq and Afghanistan were often confined in the same cellblocks as general population prisoners and subject to heightened abuse from guards and military police.⁷⁶

The ethical failures of the psychological community were not confined to the various war theatres. As noted by psychologist Jeff Kaye, the APA went so far as to conduct a conference on

⁶⁹ U.S. Senate Committee on Armed Services Report, Inquiry Into the Treatment of Detainees in U.S. Custody (Nov. 20, 2008).

⁷⁰ Office of the Surgeon General of the Army, Final Report, Assessment of Detainee Medical Operations for OEF, GTMO, and OIF (Apr. 13, 2005), pg. 19-7.

⁷¹ Miles, at 103.

⁷² Id.

⁷³ Miles, 105.

⁷⁴ Ryder, Major General Donald, Provost Marshal General U.S. Army, Report on Detention and Correction Operations in Iraq (Nov. 5, 2003), pg. 43.

⁷⁵ Office of the Surgeon General of the Army, Final Report, Assessment of Detainee Medical Operations for OEF, GTMO, and OIF (Apr. 13, 2005), pg. 18-5.

⁷⁶ Miles, 104-05.

“deception scenarios” with the CIA and the RAND Corporation.⁷⁷ Among the questions to be discussed were “[w]hat pharmacological agents are known to affect apparent truth-telling behavior?”, “[w]hat are sensory overloads on the maintenance of deceptive behaviors?”, and “[h]ow might we overload the system or overwhelm the senses and see how it affects deceptive behaviors?”.⁷⁸

IV. RESPONSE OF MEDICAL SOCIETIES TO ALLEGATIONS OF PHYSICIAN COMPLICITY IN TORTURE

American medical organizations were quick to condemn the involvement of physicians in torture. In June 2006, the American Medical Association adopted an opinion detailing guidelines for physician participation in interrogations.⁷⁹ That opinion states that “[t]he further removed the physician is from direct involvement with the detainee, the more justifiable is a role serving the public interest.”⁸⁰ While the opinion allows physicians to develop interrogation strategies for “general training purposes,” those strategies must be humane and respect the rights of individuals.⁸¹ Coercive techniques, i.e. techniques that threaten or cause physical injury or mental suffering are prohibited.⁸² Furthermore, physicians are prohibited from conducting or participating in interrogations, as well as monitoring interrogations with the intention to intervene.⁸³ The opinion also places an affirmative obligation on physicians to report violations

⁷⁷ Jeffrey Kaye, *APA Scrubs Pages Linking it to CIA Torture Workshops*, (May 16, 2010) available at <http://my.firedoglake.com/valtin/2010/05/16/apa-scrubs-pages-linking-it-to-cia-torture-workshops/> (last accessed May 7, 2012).

⁷⁸ *Id.*

⁷⁹ American Medical Association Opinion E-2.068 – Torture (adopted Jun. 2006).

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² *Id.*

⁸³ *Id.*

to the appropriate authorities when they believe interrogations are coercive.⁸⁴ The American Psychiatric Association took a similar position in 2006, prohibiting direct psychiatrist involvement in interrogations and requiring psychiatrists to report torture.⁸⁵ The American Psychiatric Association's position statement says, in part:

“No psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere. Direct participation includes being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees. However, psychiatrists may provide training to military or civilian investigative or law enforcement personnel on recognizing and responding to persons with mental illnesses, on the possible medical and psychological effects of particular techniques and conditions of interrogation, and on other areas within their professional expertise.”

Both the AMA and American Psychiatric Association make clear that their professionals have no non-therapeutic role in the interrogation room or behind the glass.

In contrast to the AMA and American Psychiatric Association's position, the American Psychological Association has continued to see a role for psychologists in interrogations—much to the dismay of many critics and APA members. One of the APA's first responses to reports of psychologist involvement in interrogation and torture was the establishment of a Presidential Task Force on Psychological Ethics and National Security (PENS). The PENS Task Force was charged with examining “whether our current Ethics Code adequately addresses [the ethical dimensions of psychologists' involvement in national security-related activities], whether the APA provides adequate ethical guidance to psychologists involved in these endeavors, and

⁸⁴ *Id.*

⁸⁵ American Psychiatric Association Position Statement: Psychiatric Participation in Interrogation of Detainees (approved May 2006). See also Neil A. Lewis, Guantanamo Tour Focuses on Medical Ethics, *N.Y. Times*, (November 13, 2005) available at <http://www.nytimes.com/2005/11/13/national/13gitmo.html> (last accessed May 7, 2012), quoting Steven Sharfstein, President of the American Psychiatric Association, “Our position is very direct. Psychiatrists should not participate on these biscuit teams because it is inappropriate.”

whether APA should develop policy to address the role of psychologists and psychology in investigations related to national security.”⁸⁶ The report described psychologists as having “a valuable and ethical role to assist in protecting our nation, other nations, and innocent civilians from harm, which will at times entail gathering information that can be used in our nation’s and other nations’ defense.”⁸⁷ The report seemed to echo military justifications for the involvement of psychologists, stating, “While engaging in such consultative and advisory roles entails a delicate balance of ethical considerations, doing so puts psychologists in a unique position to assist in ensuring that such processes are safe and ethical for all participants.”⁸⁸

The PENS Report came under immediate attack for maintaining that psychologists could ethically participate in interrogations. Critics pointed to the composition of the PENS Task Force whose ten members included six psychologists employed by the Department of Defense, four of whom had consulted on interrogations in Guantanamo Bay, Iraq, and Afghanistan.⁸⁹ They also pointed to long-standing collaboration and financial ties between the APA and the Pentagon.⁹⁰ In response, the APA has consistently maintained that it is opposed to torture and reiterated its mantra that psychologists can make interrogations “safe and ethical.” In fact, in 2006, the President of the APA, Dr. Gerald Koocher, claimed that psychologists were best placed to detect and prevent “behavioral drift” on the part of interrogators, i.e. the drift into abusive and illegal behavior.⁹¹ But psychologists are just as susceptible to “behavioral drift” as members of any other profession and are subject to the same psychosocial forces.⁹²

⁸⁶ American Psychological Association, Report of the Presidential Task Force on Psychological Ethics and National Security (Jun. 2005).

⁸⁷ *Id.* at 2.

⁸⁸ *Id.*

⁸⁹ Miles, pg. 191.

⁹⁰ *Id.*

⁹¹ Marks, at 727.

⁹² *Id.*

V. THE ETHICAL DILEMMAS PRESENTED BY PSYCHOLOGIST INVOLVEMENT IN INTERROGATION

As the experiences in Guantanamo Bay, Iraq, and Afghanistan make clear, there are significant problems with psychologists' participation in interrogation. As an initial matter, it is exceedingly difficult to define just what torture is. In a recent article, Mary-Hunter Morris McDonnell, Loran Nordgren, and George Lowenstein argue that two separate psychological biases prevent valid evaluations of the severity of interrogation tactics.⁹³ The first bias, the self-serving bias, "motivates evaluators to interpret facts or rules in a way that suits their interests – leads administrators to promote more narrow interpretations of torture when faced with a perceived threat to their nations' security."⁹⁴ Thus, the bar for torture is raised at those times when it is most likely to be used.⁹⁵ The other bias is what's called the "hot-to-cold empathy gap," which captures the idea shown in numerous studies that people who are not experiencing a visceral hot state, such as fear, hunger or pain, routinely underestimate its intensity.⁹⁶ The authors performed experiments that found that individuals who experienced states that can be induced by enhanced interrogation techniques – for example, fatigue, coldness, or social isolation – tended to evaluate that technique as significantly more painful and unethical than participants who were not experiencing the state.⁹⁷ The authors conclude that individuals perceive the line between torture and enhanced interrogation "shifts with the visceral experience

⁹³ Morris McDonnell, Mary-Hunter, Loran Nordgren, and George Loewenstein, *Torture in the Eyes of the Beholder: The Psychological Difficulty of Defining Torture in Law and Policy*, 44 *Vand. J. Transnat'l L.* 87, 94.

⁹⁴ *Id.*

⁹⁵ *Id.*

⁹⁶ *Id.*, at 92.

⁹⁷ *Id.*

of the evaluator.”⁹⁸ These findings suggest that the administrators and judges considering enhanced interrogation techniques are “at risk of systematically underestimating the severity of the tactics,” as they are unlikely to be experiencing a visceral hot state when making their evaluations.⁹⁹

A further challenge posed by psychologist participation in interrogations is the issue of conflicting professional identities. Research in identity theory has found that individuals have multiple identities that exist in a hierarchy of “salience,” or the likelihood of a particular identity being activated.¹⁰⁰ The salience of any particular identity is influenced by individuals’ relationships with other people.¹⁰¹ The degree to which a person’s relationships require that person to have a particular identity or role is termed “commitment” in identity theory.¹⁰² The higher the degree of commitment, the higher the salience of a particular identity will be.¹⁰³ Salience and commitment work to reinforce each other through self-verification.¹⁰⁴ Self-verification is the process by which individuals compare their own sense of self with the feedback they receive from others.¹⁰⁵ Where the two conflict, individuals will often try to reconcile the two whether consciously or unconsciously.¹⁰⁶

In situations where an individual has multiple identities activated, “identity theory predicts that ‘the identity with the higher level of prominence or the identity with the higher level of commitment will guide behavior more than an identity with a lower level of prominence or

⁹⁸ *Id.*, at 93.

⁹⁹ *Id.*

¹⁰⁰ Cassandra Burke Robertson, *Medical/Mental Health Professionals Serving In The Military: Organizational Management of Conflicting Professional Identities*, 43 *Case W. Res. J. Int’l L.* 603, 606.

¹⁰¹ *Id.*, at 607.

¹⁰² *Id.*

¹⁰³ *Id.*

¹⁰⁴ *Id.*

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*, at 608.

commitment.”¹⁰⁷ A large study of in-house counsel found that the salience of the attorney’s dual identities influenced their treatment of professional ethics and that these decisions were largely unconscious.¹⁰⁸ The study suggested that “at least in some cases, the problem is not merely one of moral courage—instead, it appears that at least in certain conditions, professionals may truly fail to recognize the ‘professionally correct’ course of action.”¹⁰⁹

This problem of dual identity or dual loyalty is especially pronounced in the military setting. The military culture is strong and will tend to dominate whatever other professional identities one may have. The love of country and the interests of national security are seen as overarching goods. The problem of dual loyalty for doctors in the military is hardly new:

“An extreme case in recent history occurred in Nazi death camps, where doctors supervised killings and selected which people went into the camps and which were killed. Physicians who interviewed Nazi doctors said most were normal people who went home on weekends to be fathers and husbands. They weren’t killers before serving in the death camps and didn’t continue killing afterward. Those who interviewed U.S. soldiers about atrocities in Vietnam said there’s an internalization of the ethos of the organization that then prompts actions the person wouldn’t ordinarily perform.”¹¹⁰

The psychiatrist Robert Jay Lifton has called this phenomenon “doubling.”¹¹¹ Individuals can be socialized to evil in one environment and act within those rules and behave differently when outside that environment.¹¹²

The Independent Panel to Review DoD Detention Operations that had been tasked by Secretary Rumsfeld to investigate and make recommendations on treatment of detainees in the wake of the release of the Abu Ghraib photos found much in the social

¹⁰⁷ Id., at 609 (quoting Peter J. Burke & Jan E. Stets, *Identity Theory* 133 (2009)).

¹⁰⁸ Id., at 610.

¹⁰⁹ Id., at 611.

¹¹⁰ Alvin Powell, *Why Good Doctors Do Bad Things*, *Harvard Gazette* (Mar. 3, 2005).

¹¹¹ Robert Jay Lifton, *The Nazi Doctors: Medical Killing and the Psychology of Genocide* (Basic Books 1986) at 418-419.

¹¹² Id.

psychology literature that would suggest that there was a heightened chance of abuse in these situations.¹¹³ Factors leading to abuse include groupthink, dehumanization of the enemy, and moral exclusion, “the process whereby one group views another as fundamentally different, and therefore prevailing moral rules and practices apply to one group but not the other.”¹¹⁴ The report further noted that a number of factors could lead to moral disengagement, including moral justification, euphemistic language, advantageous comparison, displacement of responsibility, diffusion of responsibility, and attribution of blame.¹¹⁵

The Independent Panel pointed to a number of environmental factors that similarly exacerbated the potential for abuse. Those factors included “poor training, [constant threat of attack], insufficient staffing, inadequate oversight, confused lines of authority, evolving and unclear policy, and a generally poor quality of life.”¹¹⁶ The report further pointed out that the widespread practice of stripping detainees might have been a significant factor in detainee abuse, noting, “[t]he wearing of clothing is an inherently social practice, and therefore stripping away of clothing may have had the unintended consequence of dehumanizing detainees in the eyes of those who interacted with them.”¹¹⁷

¹¹³ Independent Panel to Review DoD Operations, Final Report, (August 2004), Appendix G, at 4-7.

¹¹⁴ Id.

¹¹⁵ Id. “Moral justification” means the justification of misconduct believed to serve a social good. “Euphemistic language such as ‘softening up’ (and even ‘humane treatment’) can lead to moral disengagement.” “Advantageous comparison” is a factor common to war where abusive behaviors may seem less significant when compared to the surrounding death and destruction. “Displacement of responsibility” means that people view their actions as being caused by social pressures and the orders of others and not something they are responsible for. This response was common from individuals being investigated for abuse. “Diffusion on responsibility” is the phenomenon where individuals feel little responsibility when the whole group is responsible. “Attribution of blame” describes the phenomenon whereby individuals blame the victim for “bringing suffering on themselves.”

¹¹⁶ Id. at 7.

¹¹⁷ Id.

VI. ENHANCED INTERROGATION, TORTURE AND BIOETHICAL PRINCIPLES

Bioethical principles call into question the actions of many psychologists in the post-9/11 era. The bioethical principle of “respect for persons” acknowledges two ethical beliefs, that individuals have a right to autonomy and that those with diminished autonomy deserve protection.¹¹⁸ Psychologists and other medical personnel are morally required to protect those with diminished autonomy, such as detainees. The widespread abuses across Guantanamo Bay, Iraq, and Afghanistan were clear violations of this basic tenet of bioethics. This concept is embodied in the Geneva Conventions, the Universal Declaration of Human Rights and medical ethics codes around the world. Respect for persons was also violated by the routine violation of doctor patient confidentiality.¹¹⁹

The principle of beneficence was also routinely violated. The principle of beneficence has been stated as two complementary rules: “1. do not harm and 2. maximize possible benefits and minimize possible harms.”¹²⁰ Psychologists routinely played an active role in the harm of detainees and, far too often, failed to speak up on the detainee’s behalf. Detainees were subject to torture, squalid conditions, lack of medicine, and exposure to weapons fire, among other abuses. Psychologists and other medical personnel put the interests of the military and national security ahead of the detainees they were supposed to not harm and to protect from harm.

¹¹⁸ National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *The Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research* (1979).

¹¹⁹ Peter A. Clark, *Medical Ethics at Guantanamo Bay and Abu Ghraib: The Problem of Dual Loyalty*, 34 *J. L. Med. & Ethics* 570, 575 (2006).

¹²⁰ Belmont Report.

Psychologists and other medical personnel also did not abide by the principle of justice. Justice recognizes the principle that each person should be treated fairly and equitably.¹²¹ The involvement of medical personnel in torture, abuse and degradation of detainees is clearly an injustice. Psychologists and other personnel caved to institutional pressure to keep detainees, guilty and innocent, healthy and ill in conditions of indefinite detention, abuse, and degradation.

CONCLUSION

The inherent difficulty in defining torture and the overwhelming institutional pressure that the military can exert supports the idea that psychologists should not play any role in the design or implementation of coercive interrogations. The APA's current position allows too much leeway for psychologists to be in situations where their ethics may be compromised and prisoners may be harmed. Contrary to the APA's repeated assertions, psychologists are not any more capable than other individuals to keep interrogations safe and ethical. They are not any more capable than any other professional of determining what constitutes torture when they are placed in prisons around the world as part of the ongoing "war on terror." The abuses at Guantanamo, Abu Ghraib, Bagram and various prisons around the world were the result of a decision by the Bush administration to toss aside the rule of law and redefine torture. It was the cynical argument that torture cannot have occurred if a doctor or psychologist was present. To expect psychologists to stand up to such massive institutional, social, and psychological pressure is a woefully ill-conceived idea. The history of the 20th and 21st centuries is replete with examples of physicians becoming complicit with torture and cruel and inhumane treatment. Nothing other than a bright line prohibition from any involvement in interrogation will protect medical professionals from the threat of becoming complicit with torture. The APA should

¹²¹ Id.

adopt such a bright line rule for the benefit of U.S. detainees worldwide and its membership. If psychologists are in prisons, they should be there in therapeutic roles.

Furthermore, the major principles of bioethics, instilled in the APA's own Ethics Code demand that those psychologists who advise the United States and those who interrogate for the United States do not recommend or provide guidance on any techniques that may be deemed physically or psychologically coercive. The APA should make clear that it will not tolerate psychologists who fail to show a respect for persons, beneficence, and a commitment to justice,