

# Complainant Exhibit 20

**ATTACHMENT B**

**ARMY REGULATION 15-6: FINAL REPORT.**

**Investigation into FBI Allegations of Detainee Abuse  
at Guantanamo Bay, Cuba Detention Facility.**



## **Army Regulation 15-6: Final Report**

### **Investigation into FBI Allegations of Detainee Abuse at Guantanamo Bay, Cuba Detention Facility**

#### **EXECUTIVE SUMMARY**

Detention and interrogation operations at Joint Task Force Guantanamo (JTF-GTMO) cover a three-year period and over 24,000 interrogations. This AR 15-6 investigation found only three interrogation acts in violation of interrogation techniques authorized by Army Field Manual 34-52 and DoD guidance. The AR 15-6 also found that the Commander of JTF-GTMO failed to monitor the interrogation of one high value detainee in late 2002. The AR 15-6 found that the interrogation of this same high value detainee resulted in degrading and abusive treatment but did not rise to the level of being inhumane treatment. Finally, the AR 15-6 found that the communication of a threat to another high value detainee was in violation of SECDEF guidance and the UCMJ. The AR 15-6 found no evidence of torture or inhumane treatment at JTF-GTMO.

#### **INTRODUCTION**

In June 2004, the Federal Bureau of Investigation (FBI) began an internal investigation to determine if any of its personnel had observed mistreatment or aggressive behavior towards detainees at Guantanamo Bay, Cuba (GTMO). On 9 Jul 04, the FBI – Inspection Division (INSD), sent an e-mail message to all FBI personnel who had served in any capacity at GTMO. The e-mail stated in relevant part:

“You have been identified as having conducted an assignment at GTMO, Cuba since 9/11/2001. The Inspection Division has been tasked with contacting those employees who have served in any capacity at GTMO and obtain information regarding the treatment of detainees. Employees should immediately respond to the following:

- 1) Employees who observed aggressive treatment, which was not consistent with Bureau interview policy guidelines, should respond via e-mail for purposes of a follow-up interview.
- 2) Employees who worked at GTMO and observed no aggressive treatment of detainees should respond via an EC documenting a negative response...”

The above e-mail message was sent by INSD to 493 FBI personnel who had served in GTMO between 9 Sep 01 and 9 Jul 04. INSD received 434 total

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responses, and 26 agents stated that they had observed aggressive treatment of detainees at GTMO.

In response to FBI agent allegations of aggressive interrogation techniques at Joint Task Force Guantanamo Bay (JTF-GTMO) Cuba, that were disclosed in Dec 04 as a result of FOIA releases, General (GEN) Bantz J. Craddock, Commander United States Southern Command (USSOUTHCOM), ordered an AR 15-6 investigation and appointed Brigadier General (BG) John T. Furlow, United States Army South Deputy Commander for Support, as the investigating officer. BG Furlow was directed to address the following allegations:

- a. That military interrogators improperly used military working dogs during interrogation sessions to threaten detainees, or for some other purpose;
- b. That military interrogators improperly used duct tape to cover a detainee's mouth and head;
- c. That DoD interrogators improperly impersonated FBI agents and Department of State officers during the interrogation of detainees;
- d. That, on several occasions, DoD interrogators improperly played loud music and yelled loudly at detainees;
- e. That military personnel improperly interfered with FBI interrogators in the performance of their FBI duties;
- f. That military interrogators improperly used sleep deprivation against detainees;
- g. That military interrogators improperly chained detainees and placed them in a fetal position on the floor, and denied them food and water for long periods of time;
- h. That military interrogators improperly used extremes of heat and cold during their interrogation of detainees.

Subsequent to the initial appointment, GEN Craddock directed BG Furlow to investigate two additional allegations concerning a female military interrogator performing a "lap dance" on a detainee and the use of faux "menstrual blood" during an interrogation. Finally, the appointment letter directed BG Furlow to not limit himself to the listed allegations.

On 28 Feb 05, after two months of investigation, BG Furlow advised GEN Craddock that he needed to interview officers senior in grade to himself. On 28 Feb 05 GEN Craddock appointed Lieutenant General (Lt Gen) Randall M. Schmidt, United States Southern Command Air Forces Commander, Davis-

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Monthan AFB, AZ, as the senior investigating officer. This report reflects the combined findings and conclusions of the initial investigative efforts and the combined investigative efforts of both BG Furlow and Lt Gen Schmidt.

After submission of the AR15-6 Report of Investigation on 1 Apr 05, CDR USSOUTHCOM directed on 5 May 2005 that the investigation be reopened to consider memos dated 11 Dec 04 and 24 Dec 04, that had recently been discovered, regarding the subject of the second Special Interrogation Plan. Prior to completion of the follow-up, CDR USSOUTHCOM directed on 2 Jun 05 that the investigation should also address new allegations made by the subject of the first Special Interrogation Plan.

### **SCOPE OF REVIEW**

This investigation was directed and accomplished under the "informal procedures" provisions of Army Regulation 15-6, Procedures for Investigating Officers and Boards of Officers, dated 30 Sep 96, (AR 15-6). This AR 15-6 investigation centered on alleged abuses occurring during interrogation operations. This AR 15-6 found incidents of abuse during detention operations; all of which were appropriately addressed by the command. The investigation team conducted a comprehensive review of thousands of documents and statements pertaining to any allegations of abuse occurring at GTMO, to include the complete medical records of the subjects of the first and second Special Interrogation Plan. The team interviewed 30 FBI agents, conducted interviews of over 100 personnel from 6 Jan 05 to 24 Mar 05 and had access to hundreds of interviews conducted by several recent investigations. These interviews included personnel assigned to GTMO, USSOUTHCOM, and OSD during the tenure of JTFs 160, 170, and GTMO. It included nine DIA personnel, including every Joint Intelligence Group Chief and every Intelligence Control Element Chief. It included 76 DoD personnel, to include every General Officer who commanded Joint Task Force 160, Joint Task Force 170 and Joint Task Force GTMO. DoD personnel interviewed also included personnel who served as interrogators at GTMO and instructors at the US Army Intelligence School and Center. During the course of the investigation, the team visited Birmingham, AL; Chicago, IL; Ft Bragg, NC; Ft Devens, MA; Ft Huachuca, AZ; GTMO (twice); Los Angeles, CA; Miami, FL; and Washington D.C. (five times).

The investigation team attempted to determine if the allegations alleged by the FBI, in fact, occurred. During the course of the follow up investigation the AR15-6 also considered allegations raised specifically by detainees the subject of the first and second Special Interrogation Plans. The investigating team applied a preponderance standard of proof consistent with the guidance contained in AR15-6. The team also applied guidance contained in FM 34-52, CDR USSOUTHCOM, and SECDEF memorandums authorizing special interrogation techniques in deciding if a particular interrogation approach fell properly within an authorized technique. In those cases in which the team concluded that the

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allegation had in fact occurred, the team then considered whether the incident was in compliance with interrogation techniques that were approved either at the time of the incident or subsequent to the incident. In those cases where it was determined the allegation occurred and to have not been an authorized technique, the team then reviewed whether disciplinary action had already been taken and the propriety of that action. On 28 Mar 05, GEN Craddock, as the investigation appointing authority, asked Lt Gen Schmidt to determine accountability for those substantiated violations that had no command action taken.

The team did not review the legal validity of the various interrogation techniques outlined in Army Field Manual 34-52, or those approved by the Secretary of Defense.

### **BACKGROUND**

On 7 Mar 05 Vice Admiral A.T. Church, III submitted his final report of detention operations and detainee interrogation techniques in the Global War on Terror to the Secretary of Defense. (hereinafter "Church Report") That report included a thorough background discussion of detainee operations at GTMO. Our investigation independently researched the genesis and adjustments to policy and interrogation techniques from the origination of GTMO to the present. Our independently derived findings regarding the development and adjustments to policy and interrogation techniques are identical to the Church report. Therefore, I have adopted relevant portions of the Church report to show the development of permissible interrogation techniques.

Interrogation operations at GTMO began in January 2002. Initially interrogators relied upon the interrogation techniques contained in FM 34-52. These techniques were ineffective against detainees who had received interrogation resistance training. On 11 Oct 2002, Major General Michael E. Dunlavey, the Commander of Joint Task Force (JTF) 170, the intelligence task force at GTMO, requested that the CDR USSOUTHCOM, GEN James T. Hill, approve 19 counter resistance techniques that were not specifically listed in FM 34-52. The techniques were broken down into Categories I, II, and III, with the third category containing the most aggressive techniques. On 25 Oct 02 CDR USSOUTHCOM forwarded the request to the Chairman of the Joint Chiefs of Staff, General Richard B. Myers. On 2 Dec 02, the Secretary of Defense approved the use of all Category I and II techniques, but only one of the Category III techniques (which authorized mild, non-injurious physical contact such as grabbing, poking in the chest with a finger, and light pushing). In the approval memorandum, the SECDEF approved the techniques for use by CDR USSOUTHCOM, who subsequently verbally delegated the authority to approve and apply these techniques to CDR JTF-GTMO.

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On 15 Jan 03, SECDEF rescinded his approval of all Category II techniques and the one Category III technique leaving only Category I techniques in effect. The SECDEF memo permitted use of Category II and III techniques only with SECDEF approval. No approval was requested or granted.

On 16 Apr 03, the Secretary of Defense issued a new policy accepting 24 techniques, most of which were taken directly from or closely resembled those in FM 34-52. The Secretary's guidance remains in effect today. This policy memorandum placed several requirements on CDR USSOUTHCOM. First, it required all detainees to continue to be treated humanely. Second, it required SECDEF notification prior to the implementation of any of the following aggressive Interrogation techniques: Incentive/Removal of Incentive; Pride and Ego Down; Mutt and Jeff; and Isolation. Third, it specifically limited the use of these aggressive techniques to circumstances required by "military necessity." The memorandum did not attempt to define the parameters of "humane treatment" or "military necessity."

The CDR USSOUTHCOM issued a memorandum on 2 Jun 03 providing further guidance on the implementation of the 16 Apr 03 SECDEF approved techniques. This guidance provided that prior to the use of any of the specified aggressive techniques, the JTF Commander would submit the request in writing to CDR USSOUTHCOM for submission to SECDEF. The guidance also stated that "specific implementation guidance with respect to techniques A-Q is provided in Army Field Manual 34-52. Further implementation guidance with respect to techniques R-X will need to be developed by the appropriate authority." GTMO standard operating procedure on interrogations provides guidance for interrogations.

In addition, the CDR USSOUTHCOM guidance provided the following clarification to the SECDEF's 16 Apr 03 memorandum: **(quoting)**

- (a) Reference Technique B, the Working Group was most concerned about removal of the Koran from a detainee—something we no longer do. Because providing incentives (e.g., McDonald's Fish Sandwiches or cigarettes) is an integral part of interrogations, you will notify me in writing when the provided incentive would exceed that contemplated by interrogation doctrine contained in Army FM 34-52, or when the interrogators intend to remove an incentive from a detainee;
- (b) Reference Techniques I and O, you will notify me in writing when use of these standard interrogation techniques goes beyond the doctrinal application described in Army FM 34-52. When use of the technique is consistent with FM 34-52, you do not need to notify me;
- (c) I define "sleep deprivation", referenced in Technique V, as keeping a detainee awake for more than 16 hrs, or allowing a detainee to rest

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briefly and then repeatedly awakening him, not to exceed four days in succession;

- (d) Reference Technique X, I do not consider the use of maximum-security units as isolation. A detainee placed in a maximum-security unit is segregated, but not truly isolated;
- (e) I define the "least intrusive method" as the technique that has the least impact on a detainee's standard of treatment, while evoking the desired response from the detainee during interrogations;
- (f) Except in the case of Techniques B, I, O, and X, I have determined that the first O-6/GG-15 in the chain of command or supervision, is the "appropriate specified senior approval authority," unless approval authority is withheld from that individual by higher authority.

Lastly, I have told the Secretary of Defense his 16 April guidance applies to all interagency elements assigned or attached to JTF GTMO. (end quote)

There have been over 24,000 interrogation sessions at GTMO since the beginning of interrogation operations.

## **FINDINGS**

### **GENERAL DETAINEE POPULATION**

**Allegation:** That DoD interrogators improperly impersonated FBI agents or Department of State officers during the interrogation of detainees.

**Finding #1:** On several occasions in 2003 various DoD interrogators impersonated agents of the FBI and the Department of State.

**Technique: Authorized:** FM 34-52 (p. 3-13); Category I technique approved by SECDEF – Deceiving interrogator identity

**Discussion:** The Chief of the Special Interrogation Team directed two interrogators to pose as US State Department representatives during an interrogation. In addition another interrogator posed as an FBI agent on one occasion. This impersonation came to the attention of the Senior Supervisory Agent (SSA) of the FBI at Guantanamo Bay when several other agents advised him that detainees were complaining during interviews that the FBI had already asked them the same questions. The SSA approached the Joint Interrogation Group (JIG) Chief, with his agents' concerns. According to the SSA, the JIG Chief did not contest the FBI agents' accusations. In fact, the JIG Chief knew of at least one military interrogator who had impersonated an FBI agent. After the

meeting, the JIG Chief agreed to stop the practice of DoD interrogators impersonating FBI agents without prior FBI approval. The SSA made it clear to the investigation team that he did not believe the impersonation interfered with FBI operations and was pleased with the JIG Chief's rapid and thorough response to the situation.

**Organizational response:** Immediately stopped the practice.

***Recommendation #1: The allegation should be closed. The technique, while authorized, was undermining the inter-agency working relationship. No additional corrective action is necessary or appropriate.***

**Allegation:** That a female military interrogator performed a "lap dance" on a detainee during an interrogation. I have expanded this allegation to "That female military interrogators performed acts designed to take advantage of their gender in relation to Muslim males."

**Finding #2a:** On one occasion between October 2002 and January 2003, a female interrogator put perfume on a detainee by touching the detainee on his arm with her hand;

**Technique: Authorized:** FM 34-52 (p. 3-11); Category III technique approved by SECDEF – Mild, non-injurious physical touching

**Discussion: a.** On at least one occasion in late 2002, a female interrogator rubbed perfume on a detainee. The Interrogation Control Element (ICE) Chief stated that he specifically directed the interrogator to go to the PX and purchase rose oil with the intent of rubbing a portion of the perfume on the detainee's arm to distract the detainee. The interrogator admitted to using this approach with a detainee. At the time of the event the detainee responded by attempting to bite the interrogator and lost his balance, fell out of his chair, and chipped his tooth. He received immediate and appropriate medical attention and did not suffer permanent injury.

**Organizational response: a.** The interrogator was not disciplined for rubbing perfume on a detainee since this was an authorized technique.

**Finding #2b:** During the month of March 2003, a female interrogator approached a detainee from behind, rubbed against his back, leaned over the detainee touching him on his knee and shoulder and whispered in his ear that his situation was futile, and ran her fingers through his hair.

**Technique: Authorized:** FM 34-52 technique – Futility – Act used to highlight futility of the detainee's situation.

**Discussion: b.** On 17 Apr 03, An interrogation supervisor supervised a female interrogator as she interrogated a detainee with her BDU top off<sup>1</sup>, and subsequently the interrogator ran her fingers through the detainee's hair. The interrogator also approached the detainee from behind, touched him on his knee and shoulder, leaned over him, and placed her face near the side of his in an effort to create stress and break his concentration during interrogation.

**Organizational response: b.** The interrogation supervisor was given a written letter of admonishment for failure to document the techniques to be implemented by the interrogator prior to the interrogation. There is no evidence that either activity ever occurred again.

**Recommendation #2: Command action was effective and sufficient with respect to the individual interrogators. AR 15-6 recommends that the approval authority for the use of gender coercion as futility technique be withheld to the JTF GTMO-CG.**

**Allegation:** That a female military interrogator wiped "menstrual blood" on a detainee during an interrogation.

**Finding #3:** In March 2003, a female interrogator told a detainee that red ink on her hand was menstrual blood and then wiped her hand on the detainee's arm.

**Technique: Authorized:** FM 34-52 technique – Futility – act used to highlight futility of the detainee's situation

**Discussion:** The female interrogator is no longer in military service and has declined to be interviewed. According to a former ICE Deputy the incident occurred when a detainee spat in the interrogator's face. According to the former ICE Deputy, the interrogator left the interrogation room and was crying outside the booth. She developed a plan to psychologically get back at him. She touched the detainee on his shoulder, showed him the red ink on her hand and said; by the way, I am menstruating. The detainee threw himself on the floor and started banging his head. This technique was not in an approved interrogation plan.

**Organizational response:** The ICE Deputy verbally reprimanded the interrogator for this incident. No formal disciplinary action was taken. There is no evidence that this happened again.

**Recommendation #3: Command action was inadequate with respect to the individual interrogator. The interrogator should have been formally admonished or reprimanded for using a technique that was not approved in advance. Advance approval ensures that retaliatory techniques are not**

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<sup>1</sup> It was common practice at GTMO to conduct interrogations in a t-shirt with the BDU top removed because of the heat and humidity.



***employed on impulse. Considering the lapse in time, recommend this allegation be closed.***

**Allegation:** That DoD interrogators improperly played loud music and yelled loudly at detainees.

**Finding #4:** On numerous occasions between July 2002 and October 2004, detainees were yelled at or subjected to loud music during interrogation.

**Technique: Authorized:** FM 34-52 technique – Incentive and Futility – acts used as reward for cooperating or to create futility if not cooperating.

**Discussion:** Almost every interviewee stated that yelling and the use of loud music were used for interrogations at GTMO. On a few occasions, detainees were left alone in the interrogation booth for an indefinite period of time while loud music played and strobe lights flashed. The vast majority of yelling and music was accomplished with interrogators in the room. The volume of the music was never loud enough to cause any physical injury. Interrogators stated that cultural music would be played as an incentive. Futility technique included the playing of Metallica, Britney Spears, and Rap music.

**Organizational response:** None.

***Recommendation #4: The allegation should be closed. Recommend JTF-GTMO develop specific guidance on the length of time that a detainee may be subjected to futility music. Placement of a detainee in the interrogation booth and subjecting him to loud music and strobe lights should be limited and conducted within clearly prescribed limits.***

**Allegation:** That military interrogators improperly used extremes of heat and cold during their interrogation of detainees.

**Finding #5:** On several occasions during 2002 and 2003, interrogators would adjust the air conditioner to make the detainee uncomfortable.

**Technique: Unauthorized prior to 16 Apr 03:** SECDEF did not approve exposure to cold in his 2 Dec 02 list of approved techniques

**Technique: Authorized after 16 Apr 03:** SECDEF approved technique. This technique was officially permitted under 16 Apr 03 SECDEF Memorandum – Environmental Manipulation

**Discussion:** Two FBI agents indicated that they were aware of DoD interrogators using temperature adjustment as an interrogation technique. Many interviewees, FBI agents and military interrogators, believed the hot climate at GTMO and the detainee's comfort in a hot climate caused a differing in opinions

regarding the use of the air conditioning units in the interrogation booths. There were several individuals who were interviewed who acknowledged that certain military interrogators would adjust the air conditioning down (cool) in an attempt to make the detainee uncomfortable for the interrogation. Several witnesses indicated that the practice of adjusting the temperature ceased when CDR JTF-GTMO directed that the practice no longer be employed. The current GTMO SOP still permits interrogators to adjust the temperature. In addition, one interrogator supervisor stated that detainees were interrogated at Camp X-Ray, where the "booths" were not air-conditioned, to make the detainees uncomfortable.

**Organizational response:** No disciplinary action required.

***Recommendation #5: The allegation should be closed.***

**Allegation:** That military interrogators improperly used sleep deprivation against detainees.

**Finding #6:** During 2003 and 2004 some detainees were subjected to cell moves every few hours to disrupt sleep patterns and lower the ability to resist interrogation. Each case differed as to length and frequency of the cell moves.

**Technique:** Unauthorized prior to 2 Dec 02 and between 15 Jan 03 and 16 Apr 03: Neither sleep disruption or deprivation is an authorized FM 34-52 technique

**Technique:** Authorized between 2 Dec 02 and 15 Jan 03 and after 16 Apr 03: The exact parameters of this technique remained undefined until 2 Jun 03 when CDR USSOUTHCOM established clear guidance on the use of sleep adjustment. His guidance prohibited the practice of keeping a detainee awake for "more than 16 hours or allowing a detainee to rest briefly and then repeatedly awakening him, not to exceed four days in succession."

**Discussion:** Only one FBI agent alleged sleep deprivation; his complaint was that an individual was subjected to 16 hours of interrogation followed by four-hour breaks. He says he was told about these sessions by DoD interrogators and they implied that these 16 hour interrogations were repeated on a 20 hour cycle, but he did not know for certain what in fact occurred. The FBI agent was at GTMO from 2 Jun 03 to 17 Jul 03. Under CDR USSOUTHCOM's 2 Jun 03 guidance, 16 hour interrogations were permitted and do not constitute sleep deprivation if done on a 24 hour cycle. During the course of the investigation of the FBI allegation, the AR 15-6 did conduct a review of the interrogation records to see if there was any evidence that corroborated this allegation. While not directly supporting the FBI's allegation, records indicated that some interrogators recommended detainees for the "frequent flyer program." A current GTMO interrogation analyst indicated that this was a program in effect throughout 2003

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and until March 2004 to move detainees every few hours from one cell to another to disrupt their sleep. Documentation on one detainee indicated that he was subjected to this practice as recently as March 2004.

**Organizational response:** None. Current JTF-GTMO Commander terminated the frequent flyer cell movement program upon his arrival in March 04.

***Recommendation #6: The allegation should be closed. Recommend USSOUTHCOM clarify policy on sleep deprivation.***

**Allegation:** That military interrogators improperly used duct tape to cover a detainee's mouth and head.

**Finding #7:** Sometime in October 2002 duct tape was used to "quiet" a detainee.

**Technique: Unauthorized**

**Discussion:** In his testimony, the ICE Chief testified that he had a situation in which a detainee was screaming resistance messages and potentially provoking a riot. At the time of the incident there were 10 detainees in the interrogation section and the ICE Chief was concerned about losing control of the situation. He directed the MPs to quiet the detainee down. The MP mentioned that he had duct tape. The ICE Chief says he ultimately approved the use of duct tape to quiet the detainee. The MP then placed a single strand of duct tape around the detainee's mouth. The single strand proved ineffective because the detainee was soon yelling again. This time the MPs wrapped a single strand of duct tape around the mouth and head of the detainee. The detainee removed the duct tape again. Fed up and concerned that the detainee's yelling might cause a riot in the interrogation trailer, The ICE Chief ordered the MPs to wrap the duct tape twice around the head and mouth and three times under the chin and around the top of the detainee's head. According to an FBI agent, he and another FBI agent were approached by the ICE Chief who was laughing and told the agents that they needed to see something. When the first agent went to the interrogation room he saw that the detainee's head had been wrapped in duct tape over his beard and his hair. An interrogator testified that another interrogator admitted to him that he had duct taped the head of a detainee. According to the first agent, the ICE Chief said the interrogator wrapped the detainee's head with duct tape because the detainee refused to stop "chanting" passages from the Koran.

**Organizational response:** The JTF-170 JAG testified that she became aware of the incident and personally counseled the ICE Chief. The counseling session consisted of a verbal admonishment.<sup>2</sup> The ICE Chief did not receive any formal

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<sup>2</sup> While the ICE Chief testified that he was counseled by the JTF-GTMO Commander this is not possible. The Commander in question did not arrive until the month following the event. The previous Commander has no recollection of the event.

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discipline action. We have no evidence that duct tape was ever used again on a detainee.

***Recommendation #7: Command action was inadequate with respect to the ICE Chief. He should be formally admonished or reprimanded for directing an inappropriate restraint to be used on a detainee.***

**Allegation:** That military interrogators improperly chained detainees and placed them in a fetal position on the floor

**Finding #8:** On at least two occasions between February 2002 and February 2003, two detainees were "short shackled" to the eye-bolt on the floor in the interrogation room.

**Technique: Unauthorized.**

**Discussion:** Two FBI agents each stated that they witnessed a detainee in an interrogation room that had been "short shackled" to the floor. Short shackling is the process by which the detainee's hand restraints are connected directly to an eyebolt in the floor requiring the detainee to either crouch very low or lay in a fetal position on the floor. The FBI agents indicated that each of the detainees was clothed. Another FBI agent stated she witnessed a detainee short shackled and lying in his own excrement. The AR 15-6 was unable to find any documentation, testimony, or other evidence corroborating the third agent's recollection, to this allegation or her email allegation that one of the detainees had pulled his hair out while short shackled. We also found that 'short shackling' was initially authorized as a force protection measure during the in processing of detainees.<sup>3</sup>

**Organizational response:** None. JTF-GTMO has implemented SOPs that prohibit short shackling.

***Recommendation #8: The allegation should be closed. The AR 15-6 was not able to find any evidence to adequately assign responsibility for these actions. This practice is now specifically prohibited by current GTMO interrogation policy.***

**Allegation:** That military personnel improperly interfered with FBI interrogators in the performance of their FBI duties.

**Finding #9:** We discovered no evidence to support this allegation.

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<sup>3</sup> During the course of a site visit to GTMO several detention operations personnel indicated that they understood that short shackling was permitted in the early days of GTMO as a force protection measure. They all stated that it was no longer authorized as either a detention measure or during interrogations.

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**Discussion:** This allegation stems from an FBI agent objections to a proposed Special Interrogation Plan. The dispute resulted in a DoD official being rude to the FBI agent. The team did not find any evidence of "interference" with FBI interrogations that extended beyond the dispute over which techniques worked best in interrogation. During the infancy of interrogation operations at GTMO, it was obvious that the different investigative agencies had different interrogation objectives. Law enforcement agencies were primarily interested in interviews that would produce voluntary confessions that would be admissible in U.S. Federal District Courts. Conversely, DoD interrogators were interested in actionable intelligence and thus had greater latitude on the techniques used during the interrogations. These different goals created friction.

***Recommendation #9: The allegation should be closed.***

**Allegation:** That military interrogators denied detainees food and water for long periods of time.

**Finding #10:** We discovered no evidence to support the allegation that the detainees were denied food and water.

**Discussion:** This allegation stems from the statement of an FBI Agent. She reports two incidents of observing two detainees in "the fetal position and lying on the floor of interview rooms." And that there was no "evidence of any food or water." The Agent admits in her statement that she made an assumption that the detainees were denied food and water based solely upon their appearance. The Agent was unable to provide any specific information as to the day she made these observations to permit additional proof or assignment of responsibility.

***Recommendation #10: The allegation should be closed.***

## **SPECIAL INTERROGATION PLANS**

During the course of interrogations certain detainees exhibited refined resistance techniques to interrogations. These detainees were suspected to possess significant current intelligence regarding planned future terrorist attacks against the United States. For these reasons Special Interrogation Plans were proposed and approved for the detainees. A total of two Special Interrogation Plans were carried out. They are referred to herein as the "First Special Interrogation Plan" and the "Second Special Interrogation Plan".

### **THE FIRST SPECIAL INTERROGATION PLAN**

On 23 Nov 02 interrogators initiated the first Special Interrogation Plan. The interrogation plan was designed to counter resistance techniques of the subject

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of the first Special Interrogation Plan. The memo authorizing the techniques for this interrogation was signed by SECDEF on 2 Dec 02. These techniques supplemented techniques already permitted under the provisions of FM 34-52.

**Allegation:** That military interrogators improperly used military working dogs (MWD) during interrogation sessions to threaten detainees, or for some other purpose.

**Finding #11a:** On one occasion in October 2002 a military working dog was brought into the interrogation room and directed to growl, bark, and show his teeth at the subject of the first Special Interrogation Plan.

**Technique:** Unauthorized prior to 12 Nov 02.

**Discussion: a. October 2002 incident:** GTMO records indicate that on 01 Oct 02, the Commander of JTF-170 requested Joint Detention Operations Group (JDOG) support for interrogation operations to interrogate the subject of the first Special Interrogation Plan. The dog was requested to assist in the movement of the subject of the first Special Interrogation Plan between Camp X-ray and the GTMO Naval Brig to "discourage the detainee from attempting to escape." The interrogation plan (IP) indicates that the interrogation would begin on the 2nd or 3rd of October 2002. One FBI agent in his statement recalls the MWD being used on or about 05 Oct 02. He indicated that the events were notable for several reasons. He had recently purchased a German Shepard and wanted to get some "tips" from the dog handlers. The FBI agent noticed that there were two working dog teams (one Navy and one Army) present for the interrogation of the subject of the first Special Interrogation Plan. Finally, the FBI agent recalled that he and his partner left the observation room when the MWD was introduced into the interrogation room. The FBI agent's partner corroborates this statement.

In addition an interrogator indicated that she recalled a MWD being brought into the interrogation room during interrogation of the subject of the first Special Interrogation Plan at Camp X-ray, between 02-10 Oct 02. She stated that the dogs were used only "briefly." She stated that the use of the dog was documented on the IP and approved by the ICE Chief and CDR, JTF-GTMO

**Finding #11b:** In November 2002 a military working dog was brought into the interrogation room and directed to growl, bark, and show his teeth at the subject of the first Special Interrogation Plan.

**Technique: Authorized:** SECDEF approved the use of Category I and II techniques for the subject of the first Special Interrogation Plan. Category II technique permits the use of dogs to exploit "individual phobias" during interrogations.

**Discussion: b.** An interrogator testified that the MWD was in the booth on one occasion for the subject of the first Special Interrogation Plan. He testified that he was approached by another interrogator and discussed the use of a MWD in an interrogation session. Specifically, the first interrogator stated that the second interrogator told him that a MWD was brought into the doorway of the interrogation room and ordered by the dog handler to growl, show teeth and bark at the detainee. In addition a psychologist assigned to the Behavioral Science Consultation Team (BSCT) for JTF-170/JTF-GTMO witnessed the use of a MWD named "Zeus" during a military interrogation of the subject of the first Special Interrogation Plan during the November 2002 time period. In his interview, the ICE Chief acknowledged that an MWD had entered the interrogation room of the subject of the first Special Interrogation Plan under the authority of a "special IP" for the subject of the first Special Interrogation Plan. The unsigned but approved interrogation plan for the subject of the first Special Interrogation Plan is from 12 Nov 02. (Church p. 115) It indicates dogs will only be used in interrogation if approved in writing, in advance. Both JTF-GTMO Commanders who were in charge during the execution of the special interrogation plan deny that they authorized the use of MWDs in the interrogation room.

**Organizational response: a. and b.** None. Current SOPs expressly prohibit the use of MWDs in the interrogation room. There is no evidence that this has ever happened again.

**Recommendation #11:** *The allegation should be closed. While the ICE Chief was aware of and condoned the first use of the MWD, additional corrective action is not necessary. The event occurred on two occasions and was expressly approved after the first occasion for this detainee. This practice is now specifically prohibited by current GTMO interrogation policy.*

**Allegation:** That a female military interrogator performed a "lap dance" on a detainee during an interrogation. I have expanded this allegation to "That female military interrogators performed acts designed to take advantage of their gender in relation to Muslim males."

**Finding #12a:** On 21 and 23 Dec 02, MPs held down a detainee while a female interrogator straddled the detainee without placing weight on the detainee;

**Technique: Authorized:** FM 34-52 technique – Futility – Act used to highlight futility of the detainee's situation.

**Finding #12b:** On 04 Dec 02, a female interrogator massaged the detainee's back and neck over his clothing;

**Technique: Authorized:** FM 34-52 technique – Futility – Act used to highlight futility of the detainee's situation.

**Finding #12c:** On various occasions between October 2002 and January 2003, a female interrogator invaded the private space of a detainee to disrupt his concentration during interrogation;

**Technique: Authorized:** FM 34-52 technique – Futility – act used to highlight futility of the detainee's situation.

**Discussion:** Interrogation logs and MFRs for the subject of the first Special Interrogation Plan document that on both 21 and 23 Dec 02, a female interrogator straddled, without putting any weight on the detainee, the subject of the first Special Interrogation Plan while he was being held down by MPs. During these incidents a female interrogator would tell the detainee about the deaths of fellow Al-Qaeda members. During the straddling, the detainee would attempt to raise and bend his legs to prevent the interrogator from straddling him and prayed loudly. Interrogation MFRs also indicate that on 04 Dec 02, a female interrogator began to enter the personal space of the subject of the first Special Interrogation Plan, touch him, and ultimately massage his back while whispering or speaking near his ear. Throughout this event, the subject of the first Special Interrogation Plan prayed, swore at the interrogator that she was going to Hell, and attempted to get away from her. The female interrogator admitted in her interview that she personally prepared portions of the MFRs of the the subject of the first Special Interrogation Plan interrogations. She asserts that she had permission to employ all these techniques. We have found no evidence of a lap dance ever occurring.

**Organizational response:** No disciplinary action taken. The ICE Chief approved these techniques at the time.

**Recommendation #12:** *The allegation should be closed. No command action is necessary with respect to the individual interrogators. Their supervisor acknowledged that he approved the approaches at the time of the interrogation. AR 15-6 recommends that the approval authority for the use of gender coercion as futility technique be withheld to the JTF GTMO-CG.*

**Allegation:** That DoD interrogators improperly played loud music and yelled loudly at detainees.

**Finding #13:** On numerous occasions between November 2002 and 15 Jan 03, the subject of the first Special Interrogation Plan was yelled at or subjected to loud music during interrogation.

**Technique: Authorized:** FM 34-52 technique – Incentive and Futility – acts used as reward for cooperating or to create futility in not cooperating.



**Discussion:** See above discussion for Finding #4.

**Organizational response:** No disciplinary action required; technique authorized.

**Recommendation #13:** *The allegation should be closed. Recommend JTF-GTMO develop specific guidance on the length of time that a detainee may be subjected to futility music. Placement of a detainee in the interrogation booth and subjecting him to loud music and strobe lights should be limited and conducted within clearly prescribed limits.*

**Allegation:** That military interrogators improperly used extremes of heat and cold during their interrogation of detainees.

**Finding #14:** On several occasions between November 2002 and January 2003 interrogators would adjust the air conditioner to make the subject of the first Special Interrogation Plan uncomfortable.

**Technique: Unauthorized prior to 16 Apr 03:** SECDEF did not approve exposure to cold in his 2 Dec 02 list of approved techniques

**Discussion.** There are no medical entries indicating the subject of the first Special Interrogation Plan ever experienced medical problems related to low body temperature. The subject of the first Special Interrogation Plan's medical records do indicate that he did have a body temperature between 95 and 97 degrees twice. The subject of the first Special Interrogation Plan's medical records do indicate that from 7-9 Dec 02 he was hospitalized for observation after an episode of bradycardia. He was released within forty-eight hours, after the bradycardia resolved without intervention and he maintained stable hemodynamics.<sup>4</sup> He experienced a second episode of bradycardia in Feb 03.

**Organizational response:** None

**Recommendation #14:** *The allegation should be closed.*

**Allegation:** That military interrogators improperly used sleep deprivation against detainees.

**Finding #15:** From 23 Nov 02 to 16 Jan 03, the subject of the first Special Interrogation Plan was interrogated for 18-20 hours per day for 48 of the 54 days, with the opportunity for a minimum of four hours rest per day.

**Technique: Authorized:** SECDEF approved technique. This technique was officially permitted under 2 Dec 02 SECDEF Memorandum – The use of 20-hour interrogations

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<sup>4</sup> Bradycardia is a relatively slow heart; hemo dynamics are mechanics of blood circulation.

**Discussion:** SECDEF approved 20 hour interrogations for every 24-hour cycle for the subject of the first Special Interrogation Plan on 12 Nov 02. Later, CDR USSOUTHCOM formalized the definition of sleep deprivation in his 02 Jun 03 memorandum "promulgating" SECDEF's interrogation techniques of 16 Apr 03. He defined sleep deprivation as keeping a detainee awake for more than 16 hours, or allowing a detainee to rest briefly and then repeatedly awakening him, not to exceed four days in succession.

**Organizational response:** None. This was an authorized interrogation technique approved by SECDEF.

***Recommendation #15: The allegation should be closed. Recommend USSOUTHCOM clarify policy on sleep deprivation.***

**Additional Allegations, Re: The subject of the first Special Interrogation Plan:** In addition to the FBI allegations addressed above, the following additional interrogation techniques (not all inclusive) were used in the interrogation of the subject of the first Special Interrogation Plan. Each act is documented in the interrogation MFRs maintained on the subject of the first Special Interrogation Plan.

**Finding #16a:** That the subject of the first Special Interrogation Plan was separated from the general population from 8 Aug 02 to 15 Jan 03.

**Technique: Unauthorized prior to 12 Nov 02:** SECDEF did not approve movement of detainee to an "isolation facility" for interrogation purposes prior to approval of Category II techniques for the subject of the first Special Interrogation Plan on 12 Nov 02.

**Technique: Authorized after 12 Nov 02:**

**Discussion:** The subject of the first Special Interrogation Plan was never isolated from human contact. The subject of the first Special Interrogation Plan was however placed in an "isolation facility" where he was separated from the general detainee population from 8 Aug 02 to 15 Jan 03. The subject of the first Special Interrogation Plan routinely had contact with interrogators and MPs while in the "isolation facility." The SECDEF did not define "isolation facility" when he approved the use of an "isolation facility" for up to 30 days with additional isolation beyond 30 days requiring CDR JTF-GTMO approval on 12 Nov 02. Prior to the SECDEF's approval, placement in an "isolation facility" was not an authorized interrogation technique.

**Organizational response to Additional Allegations, Re: The subject of the first Special Interrogation Plan:** None taken.

**Eight Techniques Below: Authorized:** FM 34-52 technique – Ego down and Futility.

**Finding #16b:** On 06 Dec 02, the subject of the first Special Interrogation Plan was forced to wear a woman's bra and had a thong placed on his head during the course of the interrogation.

**Finding #16c:** On 17 Dec 02, the subject of the first Special Interrogation Plan was told that his mother and sister were whores.

**Finding #16d:** On 17 Dec 02, the subject of the first Special Interrogation Plan was told that he was a homosexual, had homosexual tendencies, and that other detainees had found out about these tendencies

**Finding #16e:** On 20 Dec 02, an interrogator tied a leash to the subject of the first Special Interrogation Plan's chains, led him around the room, and forced him to perform a series of dog tricks.

**Finding #16f:** On 20 Dec 02, an interrogator forced the subject of the first Special Interrogation Plan to dance with a male interrogator.

**Finding #16g:** On several occasions in Dec 02, the subject of the first Special Interrogation Plan was subject to strip searches.<sup>5</sup> These searches, conducted by the prison guards during interrogation, were done as a control measure on direction of the interrogators.

**Finding #16h:** On one occasion in Dec 02, the subject of the first Special Interrogation Plan was forced to stand naked for five minutes with females present. This incident occurred during the course of a strip search.

**Finding #16i:** On three occasions in Nov 02 and Dec 02, the subject of the first Special Interrogation Plan was prevented from praying during interrogation

**Finding #16j:** Once in Nov 02, the subject of the first Special Interrogation Plan became upset when two Korans were put on a TV, as a control measure during interrogation, and in Dec 02 when an interrogator got up on the desk in front of the subject of the first Special Interrogation Plan and squatted down in front of the subject of the first Special Interrogation Plan in an aggressive manner and unintentionally squatted over the detainee's Koran.

**Finding #16k:** On seventeen occasions, between 13 Dec 02 and 14 Jan 03, interrogators, during interrogations, poured water over the subject of the first Special Interrogation Plan head.

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<sup>5</sup> The subject of the first Special Interrogation Plan alleges that he was subject to "cavity searches." During the course of interrogation, the subject of the first Special Interrogation Plan was strip searched. The AR 15-6 was unable to determine the scope of these strip searches.

**Discussion:** the subject of the first Special Interrogation Plan was a high value detainee that ultimately provided extremely valuable intelligence. His ability to resist months of standard interrogation in the summer of 2002 was the genesis for the request to have authority to employ additional counter resistance interrogation techniques. The techniques used against the subject of the first Special Interrogation Plan were done in an effort to establish complete control and create the perception of futility and reduce his resistance to interrogation. For example, this included the use of strip searches, the control of prayer, the forced wearing of a woman's bra, and other techniques noted above. It is clear based upon the completeness of the interrogation logs that the interrogation team believed that they were acting within existing guidance. Despite the fact that the AR 15-6 concluded that every technique employed against the subject of the first Special Interrogation Plan was legally permissible under the existing guidance, the AR 15-6 finds that the creative, aggressive, and persistent interrogation of the subject of the first Special Interrogation Plan resulted in the cumulative effect being degrading and abusive treatment. Particularly troubling is the combined impact of the 160 days of segregation from other detainees, 48 of 54 consecutive days of 18 to 20-hour interrogations, and the creative application of authorized interrogation techniques. Requiring the subject of the first Special Interrogation Plan to be led around by a leash tied to his chains, placing a thong on his head, wearing a bra, insulting his mother and sister, being forced to stand naked in front of a female interrogator for five minutes, and using strip searches as an interrogation technique the AR 15-6 found to be abusive and degrading, particularly when done in the context of the 48 days of intense and long interrogations.<sup>6</sup> While this treatment did not rise to the level of prohibited inhumane treatment the JTF-GTMO CDR was responsible for the interrogation of the subject of the first Special Interrogation Plan and had a responsibility to provide strategic guidance to the interrogation team. He failed to monitor the interrogation and exercise commander discretion by placing limits on the application of otherwise authorized techniques and approaches used in that interrogation. The Commander stated he was unaware of the specific details or impacts of the techniques on the detainee for this important interrogation. His failure to supervise the interrogation of the subject of the first Special Interrogation Plan allowed subordinates to make creative decisions in an environment requiring extremely tight controls<sup>7</sup>.

***Recommendation #16: The Commander JTF-GTMO should be held accountable for failing to supervise the interrogation of the subject of the first Special Interrogation Plan and should be admonished for that failure.***

<sup>6</sup> The AR 15-6 found no evidence that the subject of the first Special Interrogation Plan was ever physically assaulted. His medical records show no evidence of any physical assaults. A medical examination completed on the subject of the first Special Interrogation Plan on 16 Jan 03 found no medical conditions of note.

<sup>7</sup> The JTF-GTMO Commander's testimony that he was unaware of the creative approaches taken in the interrogation is inconsistent with his 21 Jan 03 letter to CDR USSOUTHCOM in which he asserts that the CJTF approved the interrogation plan in place and it was followed "relentlessly by the command."

**Allegation:** In addition to the allegations above, the AR 15-6 also considered additional allegations raised specifically by the subject of the first Special Interrogation Plan.

**Finding #17:** The AR 15-6 was unable to corroborate the subject of the first Special Interrogation Plan's allegations to the point of concluding that they had occurred by a preponderance of the evidence. Specific findings include:

The AR 15-6 did find that the subject of the first Special Interrogation Plan was required to stand for periods of time which he may have interpreted as forced positions.

There is evidence that the subject of the first Special Interrogation Plan regularly had water poured on his head. The interrogation logs indicate that this was done as a control measure only.

There is no evidence that the subject of the first Special Interrogation Plan was subjected to humiliation intentionally directed at his religion. It is however possible that the subject of the first Special Interrogation Plan interpreted many of the interrogation techniques employed to be religious humiliation.

The AR 15-6 found no evidence that the subject of the first Special Interrogation Plan was threatened with homosexual rape. He was told on 17 Dec 02 that he was a homosexual but not threatened in any manner.

There is no evidence, to include entries in his medical records, that either occurred regarding the subject of the first Special Interrogation Plan or any other detainee.

**Discussion:** In reaching conclusions on the treatment of the subject of the first Special Interrogation Plan the AR 15-6 relied heavily on the interrogations logs. The level of specificity of the logs strongly supports their credibility regarding the interrogation of the subject of the first Special Interrogation Plan and thus they carried considerable weight on the findings.

**Recommendation #17:** *The allegation should be closed*

## **THE SECOND SPECIAL INTERROGATION PLAN**

In July 03 interrogators initiated a request for approval of a Special Interrogation Plan for a detainee. This plan was approved by SECDEF on 13 Aug 03. Interrogation logs indicate that the techniques were never implemented because the subject of the second special interrogation plan began to cooperate prior to the approval.

In addition to the interrogation logs, the AR 15-6 also considered allegations of abuse raised by the subject of the second special interrogation, himself. Specifically, after months of cooperation with interrogators, on 11 Dec 04, the subject of the second special interrogation notified his interrogator that he had been "subject to torture" by past interrogators during the months of July to October 2003.<sup>8</sup>

**Allegation:** That military interrogators improperly used extremes of heat and cold during their interrogation of detainees.

**Finding #18:** During the summer of 2003, interrogators would adjust the air conditioner to make the subject of the second special interrogation uncomfortable.

**Technique: Authorized:** SECDEF approved technique. This technique was officially permitted under 16 Apr 03 SECDEF Memorandum – Environmental Manipulation.

**Discussion:** The interrogation logs of the subject of the second Special Interrogation Plan indicate that on at least two occasions on 10 and 11 Jul 03 the air conditioner was turned off to heat up the room. In addition the subject of the second special interrogation alleges that on repeated occasions from Jul 03 to Oct 03, he was subjected to placement in a room referred to as the "freezer."

**Organizational response:** No disciplinary action required. Environmental manipulation was expressly permitted in the 16 Apr 03 SECDEF Memorandum. There is no evidence in the medical records of the subject of the second special interrogation being treated for hypothermia or any other condition related to extreme exposure.

***Recommendation #18: The allegation should be closed.***

**Allegation:** The subject of the second special interrogation alleges that female military interrogators removed their BDU tops and rubbed themselves against the detainee, fondled his genitalia, and made lewd sexual comments, noises, and gestures.

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<sup>8</sup> He reported these allegations to an interrogator. The interrogator was a member of the interrogation team at the time of the report. The interrogator reported the allegations to her supervisor. Shortly after being advised of the alleged abuse, the supervisor interviewed the subject of the second special interrogation, with the interrogator present, regarding the allegations. Based upon this interview, and notes taken by the interrogator, the supervisor prepared an 11 Dec 04 MFR addressed to JTF – GTMO JIG & ICE. The supervisor forwarded his MFR to the JTF – GTMO JIG. The JIG then forwarded the complaint to the JAG for processing IAW normal GTMO procedures for investigating allegations of abuse. The JAG by email on 22 Dec 04 tasked the JDOG, the JIG, and the JMG with a review of the complaint summarized in the 11 Dec 04 MFR and directed them to provide any relevant information. The internal GTMO investigation was never completed.

**Finding #19:** The AR 15-6 was unable to corroborate the allegations to the point of concluding that they had occurred by a preponderance of the evidence.

**Discussion:** The interrogation logs for the subject of the second special interrogation indicate that on a number of occasions female interrogators used their status as females to distract the subject of the second special interrogation during the interrogation but there is nothing to corroborate the allegation of the subject of the second special interrogation.

**Organizational response:** No disciplinary action taken.

**Recommendation #19:** *The allegation should be closed.*

**Allegation:** The subject of the second Special Interrogation Plan alleges that in late summer of 2003 he was hit by guards and an interrogator "very hard" and "with all their strength" he was hit "all over."

**Finding #20:** The AR 15-6 was unable to corroborate the allegations to the point of concluding that they had occurred by a preponderance of the evidence.

**Discussion:** The interrogation logs contain no reference to any physical violence against the subject of the second Special Interrogation Plan. His medical records indicate that in August 2003 the subject of the second special interrogation reported "rib contusions" from an altercation with MPs when moved between camps. During this examination the physician also noted an "edema of the lower lip" and a "small laceration" on his head. There are no other medical entries of any other physical injuries. There are no indications of swelling or contusions to support a conclusion that the subject of the second special interrogation was hit "very hard all over."

**Organizational response:** No disciplinary action taken. The allegation was not substantiated.

**Recommendation #20:** *The allegation should be closed. There is no evidence to support the subject of the second special interrogation's allegation of physical abuse.*

**Allegation:** A DoD interrogator improperly impersonated a Navy Captain assigned to the White House.

**Finding #21:** The Special Team Chief impersonated a USN Captain assigned to the White House during interrogation of the subject of the second special interrogation.

**Technique: Authorized:** This technique is permitted under FM 34-52 – Deception.

**Discussion:** On 2 Aug 03 the Special Team Chief presented himself to the subject of the second special interrogation dressed as a Captain in the USN and indicated he was from the White House in an effort to convince the subject of the second special interrogation that he needed to cooperate with his interrogators. The Special Team Chief presented a letter to the subject of the second special interrogation, which indicated that because of the subject of the second special interrogation's lack of cooperation, U.S. authorities in conjunction with authorities from the country of origin of the subject of the second Special Interrogation Plan would interrogate the mother of the subject of the second Special Interrogation Plan. The letter further indicated that if his mother was uncooperative she would be detained and transferred to U.S. custody at GTMO for long term detention. While the JTF-GTMO Commander acknowledges that he was aware of the intent by the interrogator to wear Captain's rank and purport to be from the White House, he stated that he was not aware of the intention to convey a threat or the plan to use a fictitious letter.

**Organizational response:** None taken.

**Recommendation #21:** *The allegation should be closed. No further action necessary.*

**Allegation:** That Military interrogators threatened the subject of the second special interrogation and his family.

**Finding #22:** The Special Team Chief threatened the subject of the second special interrogation and his family in July, August and September 2003.

**Technique: Unauthorized:** This technique was rejected by SECDEF on 2 Dec 2002

**Discussion:** During the interrogation of the subject of the second special interrogation, a masked interrogator was used to interrogate the subject of the second special interrogation<sup>9</sup>. On 17 Jul 03 the masked interrogator told that he had a dream about the subject of the second special interrogation dying. Specifically he told the subject of the second special interrogation that in the dream he "saw four detainees that were chained together at the feet. They dug a hole that was six-feet long, six-feet deep, and four-feet wide. Then he observed the detainees throw a plain, pine casket with the detainee's identification number painted in orange lowered into the ground." The masked interrogator told the detainee that his dream meant that he was never going to leave GTMO unless he started to talk, that he would indeed die here from old age and be buried on "Christian... sovereign American soil." On 20 Jul 03 the masked interrogator, "Mr.

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<sup>9</sup> The interrogator was a DoD interrogator who was masked so as to preserve the identity of the interrogator. This was done in case the interrogation team wanted to use that interrogator later in another role.



X", told the subject of the second Special Interrogation Plan that his family was "incarcerated." On 2 Aug 03, the Special Team Chief, while impersonating a USN Captain from the White House, told the subject of the second special interrogation that he had a letter indicating that the subject of the second special interrogation's family had been captured by the United States and that they were in danger.<sup>10</sup> He went on to tell the subject of the second special interrogation that if he wanted to help his family he should tell them everything they wanted to know. The MFR dated 02 Aug 03 indicates that the subject of the second special interrogation had a messenger that day there to "deliver a message to him". The MFR goes on to state:

"That message was simple: Interrogator's colleagues are sick of hearing the same lies over and over and are seriously considering washing their hands of him. Once they do so, he will disappear and never be heard from again. Interrogator assured detainee again to use his imagination to think of the worst possible scenario he could end up in. He told Detainee that beatings and physical pain are not the worst thing in the world. After all, after being beaten for a while, humans tend to disconnect the mind from the body and make it through. However, there are worse things than physical pain. Interrogator assured Detainee that, eventually, he will talk, because everyone does. But until then, he will very soon disappear down a very dark hole. His very existence will become erased. His electronic files will be deleted from the computer, his paper files will be packed up and filed away, and his existence will be forgotten by all. No one will know what happened to him and, eventually, no one will care."

Finally, interrogator MFRs dated 08 Sep 03 indicate that the subject of the second special interrogation wanted to see "Captain Collins" and that they "understood that detainee had made an important decision and that the interrogator was anxious to hear what Detainee had to say. Detainee stated he understood and will wait for interrogator's [Captain Collins] return and that the subject of the second Special Interrogation Plan "...was not willing to continue to protect others to the detriment of himself and his family."

In investigating the actions above, the AR 15-6 focused on the threat made by the Special Team Chief.<sup>11</sup> When questioned about the threats to the subject of the second special interrogation, the Special Team Chief indicated that prior to the "threat" to detainee the subject of the second special interrogation he cleared the proposal and the letter with the senior judge advocate who approved the technique as a "deception." As written the letter does contain a threat to detain the subject of the second special interrogation's mother but does not contain any threat on her life or that of her family. The SJA indicated in his initial interview

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<sup>10</sup> The actual content of the letter simply indicates that his mother will be taken into custody and questioned.

<sup>11</sup> Mr. X's dream story does not rise to the level of a threat. It appears to be a staged prelude to the direct threat made by the Special Team Chief.

that he did not recall the letter. He subsequently elected to exercise his Article 31 rights and declined to answer direct questions about the letter and the threats. The Special Team Chief also indicated that both JIG Chiefs in charge during the promulgation of the Special Interrogation Plan<sup>12</sup> were also aware of the threat letter. The first JIG Chief has retired and was unwilling to cooperate with this investigation. The second JIG Chief indicated under oath that he was unaware of the interrogation events discussed above. He recognizes, that read in conjunction with each other, they indicate a threat. He believes that the Commander of JTF-GTMO was not aware of the threat since the second JIG Chief was not aware of the threat. The second JIG Chief stated that they had weekly meetings with the Commander to discuss interrogations but they would not have covered this level of detail in that meeting. Neither he nor the Commander read interrogation MFRs on a regular basis. Finally, the Commander denies any knowledge of the existence of the threat or the letter. He does not recall ever discussing the issue of threats with the interrogators. He is aware that this is a prohibited practice and would not have permitted it if he had been aware of the plan.

Taken as a whole, it appears that the decision to threaten the subject of the second Special Interrogation Plan was made by the Special Team Chief. He claims that he cleared the plan with the senior judge advocate but not with his supervisors. Considering the actual content of the letter, it is reasonable to conclude that the JAG advised that the letter was a proper deception and therefore additional approval was not required. The Special Team Chief knew that under FM 34-52 deception did not require additional approval.

Despite the fact that the letter may be a proper deception technique under FM 34-52, the interrogation logs clearly indicate that the interrogation went well beyond the "threat to detain" made in the letter, and in fact was a threat to the subject of the second special interrogation and his family that violated the UCMJ, Article 134 Communicating a threat.

**Organizational Response:** None taken.

***Recommendation #22: While the threats do not rise to the level of torture as defined under U.S. law, the facts support a conclusion that the Special Team Chief violated the UCMJ, Article 134, by communicating a threat. Recommend his current commander discipline the Special Team Chief.***

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<sup>12</sup> The first JIG Chief was in charge during the approval process for the second Special Interrogation Plan and then rotated out of JTF-GTMO. The second JIG Chief was in charge during the execution of the second Special Interrogation Plan

**SUMMARY OF FINDINGS**

The findings above fall into three categories: Techniques that were authorized throughout the interrogation periods; techniques that were never authorized and finally, techniques that were originally unauthorized, and then subsequently authorized. The summary below only outlines the latter two categories of techniques to address whether the findings violated the UCMJ, international law, U.S. Law, regulations or directives.

**Techniques that were never authorized:** AR 15-6 determined the following acts were NEVER authorized under any interrogation guidance:

- a) On at least two occasions between February 2002 and February 2003, two detainees were "short shackled" to the eye-bolt on the floor in the interrogation room;
- b) Sometime in October 2002 duct tape was used to "quiet" a detainee.
- c) Military interrogators threatened the subject of the second special interrogation and his family;

**Techniques that became authorized after the fact:** AR 15-6 determined the following acts were initially not authorized under existing interrogation guidance but later authorized as an approved technique.

- a) On several occasions during 2002 and 2003, interrogators would adjust the air conditioner to make the detainees, to include the subject of the first Special Interrogation Plan, uncomfortable. This technique is now permitted under the SECDEF 16 Apr 03 guidance.
- b) On several occasions prior to 2 Dec 02 and between 15 Jan 03 and 16 Apr 03 interrogators had detainees moved from one cell to another every few hours to disrupt sleep patterns and lower the ability to resist interrogation. This technique is now permitted under the SECDEF 16 Apr 03 guidance.
- c) In October 2002 a Military Working Dog was brought into the interrogation room during the course of interrogation of the subject of the first Special Interrogation Plan and directed to growl, bark, and show his teeth at the detainee. This technique is subsequently approved for the interrogation of the subject of the first Special Interrogation Plan by SECDEF on 12 Nov 02.
- d) The subject of the first Special Interrogation Plan was separated from other detainees in an isolation facility away from the general population from 8 Aug 02 to 12 Nov 02. This technique was subsequently approved

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for the interrogation of the subject of the first Special Interrogation Plan by SECDEF on 12 Nov 02.

In each of the incidents above the violations can best be characterized as violations of policy. The SECDEF's subsequent approval of each of the techniques clearly establishes the ultimate legitimacy of that technique and thus additional corrective action is not necessary.

**Additional Matters:** In addition to findings outlined above it is important to document some additional findings:

- a) The team found no evidence that any detainee at GTMO was improperly documented or unaccounted for at any time. Every agency interviewee clearly indicated that they never knew of any "ghost detainees" at GTMO;
- b) Several past interrogators at GTMO declined to be interviewed. In the case of personnel who are currently in a civilian status we had extremely limited authority to compel the individuals to cooperate with this investigation; of particular note was former SGT Erik Saar who has written a book into "activities" at GTMO. Despite repeated requests he declined to be interviewed;
- c) During the course of this investigation, JTF-GTMO CG investigated and took action for personal misconduct of senior DoD personnel on GTMO. These allegations were reviewed and it was determined that they were not relevant to this investigation, and did not rise to a level to suggest a leadership environment with any impact on interrogation or detainee operations.

### **ADDITIONAL RECOMMENDATIONS**

This AR15-6 recommends consideration of the following:

- a) **Recommendation #23** Recommend a policy-level review and determination of the status and treatment of all detainees, when not classified as EPWs. This review needs to particularly focus on the definitions of humane treatment, military necessity, and proper employment of interrogation techniques. (e.g. boundaries or extremes);
- b) **Recommendation #24** Recommend study of the DoD authorized interrogation techniques to establish a framework for evaluating their cumulative impact in relation to the obligation to treat detainees humanely;

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- c) **Recommendation #25** Recommend a reevaluation of the DoD and Inter-agency interrogation training consistent with the new realities of the requirements of the global war on terror;
- d) **Recommendation #26** Recommend a policy-level determination on role of Military Police in "setting the conditions" for intelligence gathering and interrogation of detainees at both the tactical level and strategic level facilities;
- e) **Recommendation #27** Recommend an Inter-Agency policy review to establish "standards" for interrogations when multiple agencies and interrogation objectives are involved. Particular emphasis should be placed on setting policy for who has priority as the lead agency, the specific boundaries for the authorized techniques in cases with multiple agencies involved, a central "data-base" for all intelligence gathered at a detention facility, and procedures for record keeping to include historical, litigation support, lessons learned, and successful/unsuccessful intelligence gathering techniques.

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## NONCONFIDENTIAL POLICY DOCUMENT

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**ETHICS COMMITTEE NONCONFIDENTIAL POLICY DOCUMENT**  
(March 5, 2001)

**POLICY DOCUMENT PROCEDURES**

1. The Policy Document is composed of actions taken by the APA Ethics Committee that are (a) modifiable by the Committee at any future point on its own authority and (b) to be considered guidelines and advisory rather than rules and binding. These policies may be changed or suspended based on reasonable concerns in the view of the Committee at the time. Some policies require special consideration in making changes, for example, those that have been published.
2. By the adoption of this Policy Document, the policies stated herein formally supersede previous policy statements on those topics, as will future revisions. Adoption may require that notice be given when some policies are passed and/or deleted. This determination will be made at the time policies are adopted, or as soon as practical, for example after consultation with legal counsel.
3. The Policy Document will be updated continuously, based on action at each meeting of the Committee. An item approved for the Policy Document will be updated and distributed for approval with the rough minutes.
4. The basic document includes the following: (a) title and text of the policy (with a reference to the relevant ethical principle or section of the Rules), and (b) date of most recent action. The code that accompanies each action is the source of the action: the meeting date (year, then month) and the agenda reference (confidential or non-confidential and item number). Positions that have been published include the full publication citation.
5. The policies are organized by issues addressed as follows:

Adjudicative:	interpretations of the Rules and Procedures
Committee:	noncase Committee procedures/administration
Educative:	interpretations of the Ethics Code
Appendixes:	longer policies, referenced in main sections
6. Following action by the Ethics Committee at its November 1993 meeting, policies in the main body of this document are designated nonconfidential. Policies requiring a confidential designation are grouped in a separate section confidential document.

### Adjudication Issues

#### I 2.5

##### Rules and Procedures

The Committee adopted a policy that revision of the "Rules and Procedures" will be handled in the confidential agenda because the entire document involves review that is governed by attorney-client privilege. Actions taken related to a revision will be reported as appropriate in the nonconfidential agenda. 96-03-CF-10

#### II 2.

##### Qualifications of Ethics Decisionmakers

The Committee adopted a nonconfidential policy on qualifications of ethics decisionmakers, with an effective date of July 1, 1998. (See Appendix H to nonconfidential policy document.) 98-07-CF-08

#### II 3.1

##### Notification of Final Actions: Educative Letters Not Released to State Licensing Board

The Committee adopted a nonconfidential policy that it will not release an educative letter to a state licensing board unless compelled to do so by a valid subpoena despite a provision in the 1996 Rules and Procedures permitting release of information to state boards without such a subpoena. 97-07-CF-07

#### II 3.2

##### Conflict of Interest

The Committee adopted a modification to the nonconfidential Conflict of Interest Guidelines for consistency with the 1996 "Rules and Procedures." (See Appendix A.) 96-03-CF-08

#### II 3.2

##### Conflict of Interest on the Part of Legal Counsel

Outside counsel will be obtained by APA when there is a conflict of interest for current counsel. 88-02-NC-08

#### II 3.2

##### Expert Consultation

Outside experts in case adjudication will be chosen collaboratively by the Committee and the office staff and are to be told at the very beginning that their report will be sent to the respondent (without their name). The Committee will release their name only under a legitimate court order. Experts are to be told that they should identify areas in which there is controversy and in their report to differentiate between opinion and fact. 88-02-NC-09

## II 3.3

### Notification of Final Actions: General

The Committee adopted a nonconfidential policy providing general guidance for making notifications of final disposition under Rules and Procedures Part II Section 3.3.5 and Part IV Section 12.1.2. This policy addresses only discretionary notifications by the Ethics Committee. Several sections of the Rules provide for notifications that are required<sup>1</sup> and other sections provide the discretion to entities other than the Ethics Committee.<sup>2</sup>

Regarding Part II Section 3.3.5, the Committee will only authorize such notifications when the Committee determines that each such notification is necessary for the protection of the Association or the public or to maintain the standards of the Association. Absent sufficient reason for specific notification, the Ethics Committee will not issue notifications in cases where the sanction is reprimand.

The Committee considers that it is necessary for the protection of the public and the profession to notify other groups that have an interest in monitoring the discipline of psychologists of all disciplinary actions, except for cases in which the sanction is reprimand, there are substantial mitigating factors, or in which any lesser violation has been or is likely to be corrected. Such groups include but are not limited to the respondent's state psychology licensure board, state psychological association, Association of State and Provincial Psychology Boards (ASPPB), American Board of Professional Psychology (ABPP), and the National Register of Health Service Providers in Psychology (NR). For respondents who are licensed, or otherwise identified with other mental health professions, such groups include but are not limited to the respondent's nonpsychology state professional licensure board, state nonpsychology professional association, and the appropriate primary national membership association. It is not necessary that the respondent be a member of such groups, since such groups need to be aware of actions taken against unlicensed psychologists or nonmembers of their groups who may later apply for licenses or memberships.

The Committee considers that it is necessary for the protection of the public and the profession to also notify groups or persons of disciplinary actions for which the group or

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<sup>1</sup>These include Rules Part II Section 3.3.1, which requires that the Respondent be notified; 3.3.2, which requires that the complainant be notified; 3.3.3, which requires that the APA Membership be notified of all expulsions and voided memberships and all stipulated resignations in which it was so stipulated; and 3.3.4, which requires that the Council of Representatives be notified of all stipulated resignations.

<sup>2</sup>These include Rules Part II Section 3.1, which provides discretion to the Director when requests are received from licensure boards and to the Chair and Director in certain circumstances; and 3.3.6, which provides discretion to the Director to inform "other parties informed of the complaint." See below regarding Committee guidance to the Director in the Director's discretion under Part IV Section 12.1.2, regarding notifications in Stipulated Resignations with Admission of Violation.

person would need the information in order to ensure that appropriate corrective, preventive, or rehabilitative needs are evaluated, and that such actions are taken. Examples of such situations include, but are not limited to, informing appropriate persons and groups a) in the APA Publications and Communications program of a violation involving plagiarism, b) in the APA Accreditation program of misconduct by officials in accredited programs, or c) in a university program that employs as a supervisor a psychologist found in violation for unethical supervision.

The Committee also recognizes that in particular cases, additional notifications may be appropriate. Accordingly, the Committee reserves the discretion to determine on a case by case basis whether additional notifications permitted under Rules Part II Section 3.3.5 may be warranted.

In any of these matters, the rationale may also be included as part of the notification as provided in the Rules Part II Section 3.3.

Regarding Part IV Section 12.1.2, the Committee recommends to the Director that ordinarily notifications for stipulated resignations with admission of violation should include licensure boards, state/provincial associations, ASPPB, ABPP, NR, and other appropriate groups and that such resignation should be reportable under Part II, Section 3.3.10 to individuals requesting information on former members. The Committee recommends that ordinarily such stipulations should not include reporting to the membership of APA. Specifying notifications to be included in the offer of stipulated resignation with admission of violation is at the discretion of the Director, who may be guided by this Committee policy.

The content of notifications under this policy will be determined by Rules and Procedures Part II Section 3.3 01-03-CF-06

## II 3.5

### Contacting Possible Complainant

The Committee adopted a nonconfidential policy that it will initiate contact with possible complainants when appropriate. When the request is made by another complainant, the original complainant ordinarily will be told that he/she can contact the third party him/herself. 96-07-NC-24

## II 3.5

### Contacting Potential Witnesses

The Committee adopted a policy that ordinarily it will not contact potential witnesses for either the complainant or the respondent, but that the decision will be made on a case-by-case basis, based upon a showing by the complainant or respondent of good cause for the Committee to solicit the information. 94-07-CF-06

## II 5.

### Jurisdiction for Behaviors of Members Before They Became Members

Only complaints alleging behaviors occurring while the member was a member will be considered. The Ethics Office will implement procedures to identify whether or not a respondent had been a member at the time of the alleged unethical behaviors. 93-11-CF-21

#### II 5.3.5.1.1

##### Explication of "Other Behavior Likely to Cause Substantial Harm"

The Committee adopted a nonconfidential policy that the phrase "...other behavior likely to cause substantial harm..." as used in the Rules and in Committee policies, should generally be interpreted as "of a kind similar to sexual misconduct; felony conviction; insurance fraud; plagiarism; noncooperation; and blatant, intentional misrepresentation." The named behaviors are consistent with Part II, Section 5.3.5.1.1 of the Rules (Criteria for Determining Exceptions to Time Limits) and the policy on consistency of sanctions. 96-11-RT-07

#### II 5.4

##### Resignation Upon Closure of Pending Matter(s): Informing Committee

The Committee adopted a nonconfidential policy that the Committee shall not be informed if a respondent under the Committee's scrutiny elects to execute an affidavit that would provide for his/her resignation upon closure of the pending matter(s). 99-07-CF-09

#### II 5.5

##### Notification of Final Actions: Sharing Rationales with Complainants When Complaints Are Closed

The Committee adopted a nonconfidential policy that if a complainant requests additional rationale subsequent to receiving notification that his or her case was closed and having been given general reasons for not opening complaints, staff may indicate which possible reason(s) for closing complaints most closely explains why the complaint was closed. 97-07-CF-07

#### II 5.5 5.6

##### Staying Investigations

The Committee adopted a nonconfidential policy that the Chair or Monitor, as appropriate, and Investigator will stay investigations on a case-by-case basis, considering a) probability of relevant evidence being generated by other investigations or actions, b) respondent behavior that is continuing or not yet resolved (e.g., the behavior of a forensic evaluator in a custody proceeding that is not complete), c) appeals of actions that are predicates for show cause proceedings, and d) any other relevant factors. Ordinarily, a complainant matter will be opened as a case before the investigation is stayed. 96-11-CF-14

#### II 5.6.1

##### Not Opening Case When State Board Action Complete

The Committee adopted a nonconfidential policy that the Vice-Chair and Investigator will not ordinarily open inquiries as sua sponte and show cause cases when (a) another body has taken disciplinary action against a member; (b) the action is final and the member has completed all directives, probation, or other disciplinary requirements; and (c) the behaviors at issue would not indicate loss of membership as defined by the Consistency of Sanctions policy. Instead, the member will be written, informed that the matter has been reviewed and that, in light of action already taken by the previous disciplining body, the Committee will take no further action. The Investigator and Vice-Chair would open a case to address additional directives if, in their judgment the previous disciplining body had provided an insufficient response to the misconduct and this would be done only in unusual circumstances. 96-11-RT-07

#### II 5.6.2

##### Not Opening Case When State Board Action Incomplete

The Committee adopted a nonconfidential policy that in cases in which the conditions stated in Part II, Section 5.6.2 of the 1996 Rules and Procedures (Nonfinal Disciplinary Action by Another Body) are met, the Chair, Vice-Chair, and Investigator will not open sua sponte and show cause cases and that, except in unusual circumstances, the determination not to open will be made when the decision is made to monitor. 96-11-RT-07

#### II 5.6, 3.3.6

##### Concurrent Investigations

The Committee adopted a policy that

1. When investigation of a complaint is delayed pending action by an SPPA (State and Provincial Psychological Association) Ethics Committee, the APA Ethics Committee will, unless contraindicated in the specific case, inform the SPPA chair and ask to be informed of that group's final action.
2. When an SPPA has been informed that we are delaying investigation, or is otherwise informed by us of the presence of a complaint, staff summaries will call the APA Ethics Committee's attention to that fact and to the Rules and Procedures Part II Section 3.3.6. It will be the Committee's decision whether or not to report the final APA action to the SPPA. 94-03-CF-03

## II 8

### Correspondence to Complainants: Sharing with Committee and Respondents

The Committee adopted a nonconfidential policy that the Committee and respondents will receive copies of correspondence sent to complainants or potential witnesses that are in the file. This policy will be implemented for all complainant-brought ethics matters in which the completed complaint form is received on or after September 1, 1995, and for all show cause or sua sponte cases in which the initial information is received on or after September 1, 1995. 96-07-CF-10

## II 8.1

### Correspondence with Ethics Committee Members

The Committee adopted a policy that case- and non-case-related correspondence is processed through the Ethics Office, and Ethics Office staff members do not provide Committee members' addresses or phone numbers to complainants, respondents, or others with exceptions made by the Director in consultation with the Chair. Materials received by Committee members are forwarded to the office. 96-07-CF-07

## II 8.1

### Faxed Complaints Forms

The Committee adopted a nonconfidential policy that complaint forms may be sent by fax provided that follow-up hard copy with an original signature is sent and postmarked within 24 hours of the date the fax was originally sent. If this condition is met, the date the fax is received will be treated as the date the complaint was filed. Otherwise, the date the hard copy is received will be the effective filing date. 96-11-CF-30

## II 8.3

### Audio- and Videotape Policy

The Committee stated that audio- and videotapes will not be accepted if the Ethics Committee discovers they have been made illegally. In addition, the Committee pointed out that the Rules (II, 8.3) require all audio- and videotapes to be accompanied by a typed transcript. 93-07-CF-17

## II 11

### Mitigating and Aggravating Factors in Recommending Sanctions

The Committee adopted a policy that the following are generally considered mitigating factors: adequacy of, compliance with, and completion of a rehabilitation program; severity of penalties from other bodies; behaviors that reduce harm to persons/profession; quality of response (e.g., remorse and recognition of ethical issues and principles involved; acceptance of responsibility for behaviors); and evidence of lasting change. The following are generally considered aggravating factors: inadequate rehabilitation program; inadequate cooperation with required rehabilitation program; inadequate penalty from other body; recognizable vulnerability of person involved; history of violation/unethical behaviors; and inadequate response (e.g., lack of remorse or awareness of ethical issues and principles; disowning responsibility). 95-03-CF-06

## II 11

### Impairment as Mitigating Factor

The Committee adopted a nonconfidential policy that the following may be relevant when determining whether or not to consider impairment a mitigating factor in the determination of sanction (for example, in the reduction of expulsion to stipulated resignation):

- (1) Was the respondent operating under an impairment at the time the unethical conduct occurred?
- (2) Does the unethical conduct have a substantial causative nexus with the impairment?
- (3) In communications with the Committee, has the respondent acknowledged his/her impairment and the wrongfulness of the conduct?
- (4) Has the respondent voluntarily and consistently pursued relevant treatment or rehabilitation?
- (5) Has the respondent established and maintained reasonable safeguards (a) against a relapse into impairment, and (b) for avoiding any subsequent unethical conduct (or is there evidence that he or she will do so when again in practice)? 00-03-CF-09

## II 11.3

### Consistency of Sanctions

The Committee adopted a policy that the following behaviors generally "indicate" consideration of loss of membership: sexual misconduct; felony conviction; insurance fraud; plagiarism; noncooperation; blatant, intentional misrepresentation; and other behavior likely to cause substantial harm. The Committee may, on a case-by-case basis, recommend loss of membership as the appropriate sanction for any behavior consistent with the definition in Part II, Section 11.3 of the Rules and Procedures. 95-03-CF-06



II 12, IV 6.3.1, V 7.4  
Psychology of Gender Education

The Committee adopted a nonconfidential policy that in general, when sexual misconduct is part of violations found and education, training, or tutorial directives are recommended, the education plan will include the psychology of gender in addition to psychological ethics. 97-03-CF-15

II 12.3  
Criteria for Approval of Supervisors

- a. Be licensed as a psychologist in the state where supervision will occur;
- b. Have no ethics or licensure actions against him or her as determined by checking with the state licensure board, Ethics Office records, and National Register (must sign release giving permission to check);
- c. Submit his or her vita and demonstrate competence in the area of supervision;
- d. Show evidence of good standing in the profession (membership in professional associations);
- e. Submit a statement as to nature of any previous relationship with the supervisee;
- f. Submit a written supervision plan acceptable to the Ethics Office, detailing:
  - i. Goals of the supervision
  - ii. Length of time planned (or objectives)
  - iii. Frequency of meetings
  - iv. Nature of supervisor (legal responsibility)
  - v. Plan for monitoring compliance of supervisee (particularly if not in same office)
- g. ABPP (in area required by C) or listing in the National Register will be considered to satisfy sections A-B. 91-03-NC-14

II 12.4  
Workshop Hours Toward Tutorials

The Committee adopted a policy to allow staff to approve substituting workshop hours for tutorial hours, up to 40% of the total, where the workshop content is APA Continuing Education approved, and the workshop is clearly relevant and part of the overall tutorial plan submitted and approved. 96-03-CF-10

III 1  
Monitors for Membership Applications

The Committee adopted a policy that staff will assign a Committee member or associate as a monitor for applications referred for review of possible preadmission unethical conduct. 94-07-CF-04

### III 1.2

#### Review of Membership Applications

The Committee adopted a policy that the Chair and Investigator can approve applications in which the misconduct is judged to be trivial. Examples include draft evasion during the Vietnam War and problems listed on applications that are not required in response to the question.

The Monitor, Chair, and Investigator may also decide to submit any applications for approval by mail vote of the Committee. 95-03-NC-16

### III 2.3

#### Definition of Technical and Ethical Qualifications

The Committee adopted a policy that

1. "technically qualified" will mean meeting APA's regular requirements for membership, as determined by the Membership Office and/or Committee; and
2. "ethically qualified" will be determined on a case-by-case basis. Evidence of ethical qualifications may include but is not limited to (a) current licensure and (b) completion of education and training focused on remediation of the problem leading to loss of membership (to include workshops, seminars, supervised experience, and/or reports from therapists).

Applicants are encouraged to include a statement explaining how they meet the Ethics Committee's requirements. 94-10-CF-07

### IV 12.1.2

#### Stipulated Resignations with Admission of Violation: Time Prior to Reapplication for Membership

The Committee adopted a nonconfidential policy that for stipulated resignations with admission of violation, the Director will ordinarily specify in the affidavit of resignation a 3-year period of time during which the resigned member ordinarily shall be ineligible to reapply for membership except in cases in which the admitted underlying violation involves one of the following: sexual misconduct; felony conviction; insurance fraud; plagiarism; noncooperation; blatant, intentional misrepresentation; or other behavior likely to cause substantial harm. In cases involving such behavior, the Director will ordinarily specify a 5-year period before the resigned member is eligible to reapply for membership. Exceptions will be approved by the Chair. 96-11-CF-11

### V 2.

#### Information for Individuals Filing or the Subject of Complaints

The Committee approved staff plans to mail an information enclosure to complainants and respondents after further modification. 92-03-NC-33

## V 2.5

### Anonymous Statements Submitted as Part of a Complaint

The Committee adopted a nonconfidential policy that (a) anonymous statements are presumptively excluded from the record; (b) anonymous supporting material (but not complaints that are submitted anonymously) can be considered by the Committee only if the Chair and Director agree that this is appropriate; and (c) if anonymous material is included, the Committee will consider whether the anonymous nature impedes the respondent's ability to address the allegations (or the Committee's capacity to evaluate them), in deciding whether any weight should be given to the material. 97-03-CF-11

## V 3.

### Ethics Complaint Form

The Committee adopted a nonconfidential policy that the complaint form shall include the name of the person filing the complaint, the person(s) filed against, a list of other complaints that have been filed by the complainant, a description of alleged unethical behavior, and execution of releases providing (a) APA permission to send copies of materials submitted by the complainant or on the complainant's behalf to the respondent, (b) the respondent permission to release confidential information regarding the complainant to APA, and (c) a waiver of any right to subpoena from the APA Ethics Committee or its agents, for the purposes of private civil litigation, any documents or information concerning the matter that is the subject of the complaint. The format and any other content of the form, such as requests for address, phone numbers, or dates of the occurrence of alleged unethical behaviors, will be at the discretion of the Director. 95-07-CF-23

## V 3.2

### Complainant Request for Respondent Response

The Committee adopted a nonconfidential policy that when the complainant has requested the respondent's response, the respondent will be written for permission to release his/her response to the complainant. The respondent will be told that the complainant has requested a copy of the respondent's response to the complaint, that APA does not ordinarily release the information solely at the request of the complainant and without the respondent's permission, and that the respondent is not required to provide the release. 97-11-CF-06

## V 5.6 7.3

### Educative Letters to Respondents

The Committee adopted a nonconfidential policy that educative messages will be included in a cover letter to the respondent. The cover letter will accompany the Committee's recommendation. The educative message will be communicated in confidence. 97-11-CF-06

V 6

Closing Cases Without Committee Review

The Committee adopted a nonconfidential policy that a monitor may recommend that a case be dismissed at any point during the investigation if the monitor believes that the Committee cannot reasonably find a violation. If the investigator agrees, the matter will be closed. If the case is closed, the monitor and investigator may issue an educative letter. If the investigator does not agree to close the case, the case will continue and be resolved by the Committee. 97-03-CF-13

V 6

Withdrawn Complaints

The Committee adopted a nonconfidential policy that it may elect to proceed with a case following withdrawal by the complainant even without formal conversion to a sua sponte action. The Committee will continue with such cases where (a) the complainant has not retracted the allegations or (if there has been a retraction) there is other evidence that clearly corroborates the allegations; (b) continued cooperation by the complainant is not required to review the matter fairly; and (c) the alleged violation if proven, would warrant expulsion. 96-03-CF-19

V 6.1.3

Adding to Initial Charges Against a Respondent

The Committee adopted a policy to delegate the Chair's responsibility under Part V, Section 6.1.3 ("Issuance of Charge Letter to Conform to Evidence Discovered During Investigation") of the Rules to the Monitor of the case. This procedure should be used sparingly. 94-03-CF-03

V 7.2.2

Dismissal as Likely to be Corrected

The Committee adopted a policy that when under Part V, Section 7.2.2 of the Rules a case is dismissed as likely to be corrected, the respondent need not be found in violation of the principles charged. 94-03-CF-03

V 7.2.2

Dismissal as Likely to be Corrected in Show Cause and Sua Sponte Cases

The Committee adopted a policy that dismissal as likely to be corrected is generally not considered in cases in which (a) requirements of the licensing board have not been completed and (b) loss of membership would be considered, unless the balance of mitigating to aggravating factors is dramatically in favor of less severe sanction. (This pertains primarily

when the behavior occurred a long time ago.)

The Committee adopted a policy that for complaints involving behaviors that would not warrant loss of membership, the presence of a substantial number of mitigating factors argues for dismissal as likely to be corrected and the presence of a substantial number of aggravating factors argues against such a dismissal. 95-03-CF-06

### V 7.3

#### Finality of Educative Letter

The Committee adopted a policy that an educative letter is a final action that is not subject to modification by an Independent Adjudication Panel. 95-11-CF-04

### V 9.2.7, 10.2.5

#### Notification of Final Actions: Adjudications and Review of Notification Decisions

The Committee adopted the following as nonconfidential policy:

The scope of review by an Independent Adjudication Panel under Part V, Section 9.2.7 of the Rules will include findings of violation, sanction, and directives, and will not include notifications. The Committee's decision regarding notifications will be implemented if the findings of violation and sanction are upheld by an adjudication panel. If the adjudication panel dismisses any finding of violation or reduces the sanction, the issue of notifications will be returned to the Committee for reconsideration. If all findings of violation are dismissed, the notification decision will not be implemented.

For Hearing Committees (and Independent Adjudication Panels acting in lieu of a Hearing Committee), the scope of review under Part V, Section 10.2.5 of the Rules will include findings of violation, sanction, and directives, and will not include notifications. The Committee's recommendation regarding notifications will be forwarded to the Board of Directors, which will make the final decision regarding notifications to be implemented as part of the final disposition of the matter. If the case is dismissed by the Hearing Committee or Independent Adjudication Panel (under Part V Section 10.2.5.3), the notification recommendation will not be implemented.

The policy will be applied to cases reviewed by the Committee at or following the November 1997 meeting of the Ethics Committee. 97-11-CF-10

### V 10.2.4

#### Guidelines for Formal Hearings

The Committee adopted a modification to the Guidelines for Formal Hearings for consistency with the 1996 "Rules and Procedures." (See Appendix B.) 96-03-CF-08

### Committee Issues

#### American Psychologist Committee Report: Actions by Other Tribunals

The Committee adopted a policy that in order to ensure that the membership does not lose the educational value of processing state board actions, the annual report in the American Psychologist shall include data (as of 1996) on actions involving APA members taken by state boards and other bodies. The report will include information on the underlying behaviors and types of actions taken by APA in response. Actions concerning nonmembers will be included if possible. The report will state the Committee's criteria for reviewing or not reviewing actions secondary to state boards. 95-11-CF-05

#### American Psychologist Committee Report: Chair Responsibility

It is the Chair's responsibility to coordinate the annual article. If availability of data by deadline is a problem, the report should appear without data for that year. 92-11-NC-27

#### American Psychologist Committee Report: Exemplary Case Studies

The Committee voted to continue and broaden its policy of including exemplary case studies in the annual American Psychologist report by allowing the inclusion of synthesized cases. 96-11-NC-09

#### Criteria for Assignment of Confidential Designation for Agenda Items and Policy Statements

Issues involved include the need for confidentiality in the deliberative process, the need to protect certain documents used in the process, and the need for confidentiality of final policies.

1. Disclosure of the information might unreasonably increase APA's legal liability.
2. Confidentiality is required by the R & Ps. (Applies to case-related material)
3. Disclosure would result in loss of the protection afforded by the privileged nature of communication with legal counsel.
4. Disclosure would impair the Committee's or staff's ability to investigate.

Note that when the issue is whether to keep a completed statement of policy confidential, only the criterion related to legal liability appears to apply. 93-11-CF-25

#### Distribution of Endorsed Statements

The Committee agreed that routine distribution of any endorsed statement includes Council, the Board of Directors, and all interested Boards and Committees. 93-04-NC-09

#### Editorial Changes

The Committee adopted a policy that gives the Ethics Staff leeway to make editorial changes in such documents as policy statements, minutes of meetings, position papers, educational statements, and communications with other groups with the understanding that any changes will (a) not alter the meaning of the Committee's statement, (b) be approved by the Chair, and (c) be reported to the Committee (except very minor changes). 94-03-NC-10

#### Educative Opinion Not Legal Advice

The Ethics Committee cannot provide legal advice and therefore, any response from the Ethics committee [is] limited to a discussion of the ethical issues involved. 88-10-NC-15

#### Ethical Principles Revision: Task Force

It was clarified that revision task forces or subcommittees report to the Ethics Committee and that the revision is a product of the Ethics Committee. 91-03-NC-03

#### Ethics Code Task Force: Appointments

The Committee reaffirmed and voted to adopt as nonconfidential policy that the Ethics Committee will not appoint as a member of the Ethics Code Task Force (ECTF) any individual who would be a sitting member of the Ethics Committee during service on the ECTF. 97-07-NC-05

#### Ethics Code Task Force: Comment Processes

The Committee adopted a nonconfidential policy to conduct its comments regarding the Ethics Code confidentially where appropriate to maintain applicable privilege, to include legal counsel for Ethics Code discussions, and to evaluate on an ongoing basis what information can be provided nonconfidentially to the Ethics Code Task Force. 98-07-CF-06

#### Ethics Code Task Force: Mission

The Ethics Committee adopted a nonconfidential policy to continue the Ethics Code Task

Force (ECTF) with its mission being to implement the Ethics Committee's plan for the next review of the Ethics Code, to report to the Ethics Committee regularly regarding revision processes, and to submit to the Ethics Committee a proposed revision of the "Ethical Principles of Psychologists and Code of Conduct." 98-03-NC-07

#### Ethics Committee Associates

The Committee adopted a policy that the title for the nonvoting positions on the Ethics Committee will change from Ethics Committee Fact Finder to Ethics Committee Associate. 95-03-NC-03 (Note. In phone conversation with the Chair and Vice Chair, following the meeting, an effective date of May 1, 1995, was chosen for implementation of the policy.)

#### Associate Procedures

The Committee adopted a policy as a general guideline regarding associates, which may vary at the Committee's discretion on a case-by-case basis. Associate's terms will be 2 years. Ordinarily, an associate will be limited to one full term, though a partial term preceding a full term is not counted. Also, nonconsecutive terms are acceptable. (If a person is appointed after being a member of the Committee, the term may be shorter.) The term will begin and end at the conclusion of the first meeting of each association year in order to provide better continuity with Committee members who change prior to that meeting. Associates will be nominated and elected by the voting members of the Ethics Committee. No current associate, or individual who has just completed an associate term, will be recommended by the Committee for a slate for election to the Ethics Committee. The Committee will apply the same association "joint service" rules that would apply if the associate were becoming a Committee member: no member of one standing or continuing board/committee may simultaneously serve on any other standing or continuing committee. 95-03-NC-03

#### Hypothetical Educative Opinions

As a matter of policy, the Committee will defer giving opinions regarding hypotheticals when it only has one side of the issue before it. In such cases, it would need to have a formal complaint and a full investigation in order to make any determination. 87-06-CF-03

#### Members Voting on Own Candidacy

The Committee adopted a nonconfidential policy that when a vote is being taken that involves a member of the Committee as a candidate, the member affected should be out of the room during the discussion by the Committee, but may return to the room to cast a written vote. 99-03-NC-20



#### Modified or Deleted Policy Statements

The Committee adopted a nonconfidential policy that policy statements that are modified within or deleted from the Ethics Policy Documents for consistency with revisions of the "Rules and Procedures" will be available to the Committee as originally stated if and when those policies are needed to ensure that a respondent is not adversely affected by changes to the Rules. 96-07-CF-08

#### Monitors from Divisions and Boards and Committees

Draft nonconfidential minutes (after initial review by the Committee) will be mailed to individuals identified as monitors from boards and committees and divisions. 91-06-NC-25

#### Nominations

The Ethics Committee voted to describe service on the Committee as follows:  
The Ethics Committee evaluates candidate experience in evaluation or investigation of ethical conduct of psychologists (e.g., state association ethics committee, state board of psychology, or human subjects institutional review board) or in ethics education. Ethics Committee members must be willing to commit approximately 20 hours per month to ongoing committee work and approximately 40 hours in preparation for each of the 3-4 meetings per year of 3 days each. Meetings are held at APA headquarters in Washington, D.C., and members' travel, lodging, and meal expenses are covered by the committee's budget. The Committee also gives presentations at convention and attendance (at your own expense) is ordinarily expected. 00-11-NC-05

#### Public Member Election

The Committee adopted a policy that the public member of the Committee be elected by the same process as any other Ethics Committee member. That process is election by the Council of Representatives from a slate of one or more individuals nominated by the Committee and approved by the Board of Directors. 94-07-NC-10

#### Publication of Ethics "Rules and Procedures"

The Committee adopted a policy to continue publishing revisions of the "Rules and Procedures" in the American Psychologist for access by members and for archival purposes. Exceptions to this policy would be very minor revisions, which will be reported in the Ethics Committee's annual report in the AP and the Association minutes in the AP. 94-03-NC-26

## Resource Center

The Ethics Committee adopted a nonconfidential policy providing for the Chair and the Director to approve articles to be included in the Educational Resource Center. 96-03-NC-09

## Standard Format for Policies

The Committee adopted a policy that establishes a standard format for the statement of its policies. That format is shown in the wording used in the introductory sentence of this policy statement. Future statements will begin with this wording; existing statements will be edited to conform to this format as staff time allows. 94-03-NC-10

## Summary Record of Confidential Actions

The nonconfidential minutes will include a summary of confidential actions from each meeting. 91-09-NC-17

## Educative Issues

### 1.02, 8.03, Introduction Conflicting Ethics Codes

Conflict between ethical codes is an important issue that, while not explicitly addressed in the Ethics Code, is similar to conflict between the standards and laws (1.02) and institutional rules (8.03). If the standards can be placed in a hierarchy, the psychologist should adhere to the higher standard. When the code is in direct conflict with the APA standards, the APA member will be held accountable by APA to the APA code. The Ethics Committee can address conflicts only on a case-by-case basis and with regard to specific instances of conflicts. 93-07-CF-17

### 1.04 Services by Telephone, Teleconferencing, and Internet

The Committee adopted a policy on Services by Telephone, Teleconferencing, and Internet to replace its earlier statement on Telephone Therapy. See Appendix C for this policy, which was also published in the January 1998 issue of the APA Monitor and the August 1998 issue of American Psychologist. 97-07-NC-11

### 1.10 Professional Ethics as Related to Persons with Disabilities

The Ethics Committee is not in a position to determine the effect of the "Americans with Disabilities Act" on the interpretation of this standard. Each complaint will be evaluated on its own merits. 93-07-CF-17

1.17, 1.19

Multiple Relationships in Faculty and Student Client Relationships: Personal Disclosure in Class

Regarding classes that are "very much like a group therapy session," and which appeared to the Committee to essentially require personal disclosure as a condition of completing the program, the Committee stated that:

While this practice occurs in some programs, the Committee believes that required disclosure is problematic. It is difficult to protect the student-client's welfare, and puts both the student and the professor at risk. 93-07-NC-15

1.17, 1.19

Psychotherapy with Students

The Committee adopted a policy that a professor accepting his/her student as a client runs a substantial risk of violating the multiple relationship and exploitation standards, as well as risking the welfare of the client generally. (Standards to reference include 1.17, Multiple Relationships, and 1.19, Exploitative Relationships.) 94-03-CF-03

1.17, 1.21, 4.03, 5.01, 7.03, 7.05

Police Psychologists

Treating and Evaluating

The Committee adopted a policy that the evaluation and treatment of the same client by psychologists practicing in police agencies is not unethical per se, though it may be in some circumstances. Issues to consider include role clarification (especially as addressed in Standard 1.21), limits of confidentiality (see Standard 5.01), and the psychologist's objectivity. Standards 7.03 and 7.05 may be relevant where forensic reports or testimony is involved. 94-03-CF-03

1.17, 5.02

Insurance

Advocacy Issues

- Regarding potential for dual relationship problems when a clinician encourages a patient to pursue a formal complaint against an insurance company, a psychologist would not be unethical in encouraging action believed to be in the client's best interest. The issues in dual relationship are exploitation or loss of objectivity.
- Regarding steps to take to protect client confidentiality in a formal complaint filed by the client against an insurance company, this would be largely a matter of law, but information would not normally be provided without a release from the client. 91-03-NC-05

1.19, 1.26, 1.27

Student Employees in Private and Consulting Practices

The Committee adopted a policy about the employment of students by faculty members in private and consulting practices.

1. Each case needs to be evaluated individually but the faculty needs to develop adequate means to avoid exploitation of students and/or loss of objectivity.
2. Burden of proof ought to lie with the faculty member/supervisor to show that safeguards for avoiding exploitation of students and loss of objectivity do exist.
3. Faculty members should identify ways to assure appropriate insurance billing (consistent with 1.26) and that fees are consistent with 1.27, Referrals and Fees. 94-03-CF-03

1.27

Referrals and Fees

The following statement was approved for publication in the "Briefly" section of the APA Monitor, March 1995, p. 18.

Standard 1.27, Referrals and Fees, does not prohibit an independent contractor from paying a percentage of a fee to a colleague as long as the payment is within a reasonable range of the fair market value of the services provided. Services are defined broadly and include, for example, mentoring and promotional activities. 95-03-NC-08

2.02, 2.04a, 2.10

Procedures for Administration of MMPI

The Committee will continue to consider cases involving the issue of whether tests may be taken home on a case-by-case basis. However, the Committee issued a policy statement, which was published in the "Briefly" section of the Monitor, April 1993, p. 41. (See Appendix D.) 93-04-NC-12

3.02a,b; 3.03a; 6.23a,b

Advertising and Canned Columns

The following statement was approved for publication in the "Briefly" section of the Monitor, September 1993, p. 51.

Identifying oneself as the author of canned columns or pre-authored newsletters (using the term "by") is unethical because it violates Standards 3.02a, b (Statements by Others), 3.03a (Avoidance of False or Deceptive Statements), and 6.23a, b (Publication Credit) of the 1992 "Ethical Principles of Psychologists and Code of Conduct." Such columns must clearly identify the source of the material. 93-07-CF-17

3.03a

Doctoral Degree Representation

The Committee adopted a policy that faculty or students who knowingly present themselves as holding an earned doctorate prior to the completion of all degree requirements are in violation of Standard 3.03a. 94-03-CF-03

3.03a

Use of Fellow Designation (F.A.P.A.)

The Committee adopted a policy that the code does not explicitly address the use of designations of fellow status, and that this is not a per se violation of the code. The relevant standard is 3.03a, Avoidance of False or Deceptive Statements. 94-03-CF-03

5., 1.14, 1.19a

Internship Applications and Confidential Client Materials

The Committee approved the PETF's revision of its earlier draft of a statement on internship applications and confidential client materials. The statement was published in the "Briefly" section of the Monitor, September 1993, p. 51. (See Appendix E.) 93-04-NC-09

5.1-11, 4.01, 1.02, 1.24, 8.04

Military Psychologists and Confidentiality

The Committee approved the revision of a statement originally adopted at its March 1992 meeting and revised at its April 1993 meeting. The statement has been published in the "Briefly" section of the Monitor, September 1993, p.51. (See Appendix F.) 93-07-CF-17

6.04

Limitation on Teaching

The following statement was approved for publication in the "Briefly" section of the APA Monitor, March 1995, p. 18.

Standard 6.04, Limitation on Teaching, prohibits teaching the use of techniques that require specialized training to individuals who lack the appropriate training or credentials. Teaching about such techniques, as in an undergraduate introductory course, is not prohibited. The standard also does not prohibit teaching a technique that individuals may apply in their own therapeutic programs, such as self-hypnosis. Similarly, teaching the use of specialized techniques to graduate students who are part of an integrated program of study and whose work will be supervised, is not prohibited. However, the student must have the necessary prerequisites to be in the program/course. 95-03-NC-08

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8.04, 8.05  
Ethics in Publishing

The Committee approved a statement on ethics in publishing with regard to plagiarism. (See Appendix G.) 93-07-CF-17

## APPENDIXES

Appendix A: Conflict of Interest Guidelines for All Official Participants in the Ethics Process

Appendix B: Guidelines for Formal Hearings

Appendix C: Services by Telephone, Teleconferencing, and Internet

Appendix D: Policy Statement Regarding "Take Home" Tests

Appendix E: Internship Applications and Confidential Materials

Appendix F: Policy Statement of the APA Ethics Committee Regarding Military Psychologists  
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Appendix G: Ethics in Publishing

Appendix H: Policy Regarding Qualifications of Ethics Decisionmakers

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CONFIDENTIAL POLICY DOCUMENT

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**ETHICS COMMITTEE CONFIDENTIAL POLICY DOCUMENT**  
(March 5, 2001)

**INTRODUCTION**

General procedures regarding the Policy Document are explained at the beginning of the non-confidential section. This section contains policies that have been designated confidential by the APA Ethics Committee. Criteria for determining confidential designation are stated in the non-confidential policy document and repeated here.

Criteria for Assignment of Confidential Designation  
for Agenda Items and Policy Statements

The issues involved include the need for confidentiality in the deliberative process, the need to protect certain documents used in the process, and the need for confidentiality of final policies.

1. Disclosure of the information might unreasonably increase APA's legal liability.
2. Confidentiality is required by the R & Ps. (Applies to case-related material)
3. Disclosure would result in loss of the protection afforded by the privileged nature of communication with legal counsel.
4. Disclosure would impair the committee's or staff's ability to investigate.

Note that when the issue is whether to keep a completed statement of policy confidential, only the criterion related to legal liability appears to apply.

### Adjudication Issues

#### Application of 1990 Ethical Principles of Psychologists

The Ethics Committee reviewed the Guidelines as adopted at its March 1992 meeting and voted to amend its earlier decisions as follows:

General Principle 1: General Principle 1 will no longer be charged. However, if this principle has been charged and the respondent is found in violation of any other principle (other than the Preamble), the respondent is automatically in violation of this principle.

Principle 1.f: Principle 1.f is only used in conjunction with a clear finding of violation of another relevant principle.

General Principle 2: General Principle 2 is applicable if the member's education and training does not qualify him/her to practice in a given area but not for a member who is competent by training and experience and who performs poorly.

General Principle 3: General Principle 3 is only applicable to behaviors directly related to the member's work.

Principle 3.d: Principle 3.d (the portion pertaining to relevant governmental laws) is applied only to findings of violation of the law. The Ethics Committee is not in a position to determine whether or not a law has been broken.

Principles 4.b.i, ii, and iii. Principles 4.b.i, ii, and iii are only applicable to announcements or advertisements of the availability of psychological products, publications, or services.

Principle 4.k: Principle 4.k is only applicable to personal advice given by means of public lectures or demonstrations, newspaper or magazine articles, radio or television programs, mail, or similar media.

Principle 6.d: Holding records hostage may be acceptable under this principle only if the client was given advance notice that records would not be released until payment for services was received. 92-07-CF-15

#### Assignment of Monitors with Regard to State of Residence

The Committee adopted a policy to not assign Members or Associates as Monitors on cases that involve individuals in the state in which the Monitor resides. 94-03-CF-02

## Ethics Committee Manual

The Committee adopted a modification to the Ethics Committee Manual for consistency with the 1996 "Rules and Procedures." 96-07-CF-08

## Primary and Secondary Reader Assignments

The Committee adopted a confidential policy that the Committee monitor on a case will not be assigned as either the primary or secondary reader on that case. 95-03-CF-03

## Reader Summary Format

The Committee adopted a confidential policy that reader summaries should include proposed rationale, directives, and notifications for the action recommended by the reader. 98-07-CF-05

## Reader Summary Format for Ethics Cases

The Committee superseded the existing policy on reader summary formats and will provide a new policy after the March 1995 meeting. 94-10-CF-02

## Recusal Policy

The Committee adopted a policy that a recusal form will be sent with cases for each Committee meeting. A member who needs to recuse himself/herself on any case(s), will return the form to the Ethics office. The case(s) can be mailed back to the office, brought back to the meeting, or destroyed. A member who does not determine the need to recuse himself/herself until some later point will do so at that time. The Ethics office will not send additional materials on cases to members who have recused themselves. 94-03-CF-02

## Structure for Adjudicating Ethics Cases

The Committee voted to approve a structure for adjudicating cases that is parallel to the approved reader summary format. (See policy on Reader Summary Format for Ethics Cases.) 96-03-CF-10

II 3.3., 3.3.1--3.3.10

Notification of Final Actions: Actions Prior to 1996 Rules

The Committee adopted a confidential policy on notification of final actions. The policy clarifies what information is provided and to whom. (See Confidential Appendix 1.) This policy will be retained and applied as long as there are cases that must be processed under the 1992 Rules. 97-07-CF-07

II 3.3.3, 3.3.4

5.05

Confidentiality of Ethics Actions Reported in APA Dues Notice

The Committee adopted a policy to (a) continue to label as confidential the dues notice and other notices that the 1992 Rules require be confidential, (b) not sanction disclosure of such information as a confidentiality violation, (c) encourage that information be kept confidential when asked generally, and (d) advise a member, if a direct question is asked, that truthful disclosure by a member of disciplinary action against another member, while contrary to the Bylaws, will not give rise to disciplinary action by the Association. 96-03-CF-10

IV 3.

Lack of Due Process Defense to Show Cause Cases

The Committee adopted a confidential policy that when evaluating lack of due process defenses in show cause cases, the Committee will consider the principles suggested by legal counsel. (See Appendix 2 to the confidential policy document)  
98-07-CF-25

V 7.

Multiple Findings in APA Proceedings

The Committee adopted a policy to make recommendations that can be adequately defended in court. The decisions of the Ethics Committee (and any independent review panel) should explicitly state, if it is true, that any of the grounds relied upon are sufficient (standing alone) to justify the penalty recommended. 94-03-CF-03

V 7.

Panel System for Review of Cases

The Committee adopted a confidential policy that it will implement the following system for panel review of cases.

The Panels and Committee will devote sufficient time to each case to ensure a fair review, but for purposes of staff planning the meeting schedule, allow:

- (a) in panels, 50 minutes per complainant case and 20 minutes per sua sponte and show cause case,
- (b) in full Committee following panel review, 15 minutes per complainant case and 10 minutes per sua sponte and show cause case,
- (c) take as many cases as possible for each meeting (rather than to defer to a future meeting based solely on caseload) and, instead, forgo other agenda items.

Panels of 5 persons will be used for complainant matters. Panels of 3 persons will be used for sua sponte and show cause matters.

Panel recommendations will be voted upon by the full Committee, as follows:

- (a) The panel recommendation will be presented without extended description or discussion.
- (b) Only elected Committee Members will vote.
- (c) The vote will be taken on the entire recommendation, except that any voting member may ask for detailed discussion and vote of any recommendation about which they have strong objections.
- (d) All voting members must read all cases on which they vote. 98-03-CF-05

V 7.

Panel System for Review of Cases: When to Use

The Committee adopted a confidential policy not to use panels for meetings unless there are more than 20 cases for review. In that case, the Director and the Chair will decide whether to use panels. 98-11-CF-05

V 9.2.2

IV 9

Committee Statements to Rationales for Nonacceptance and to the Board

The Committee adopted a confidential policy to place the responsibility for the decision as to whether or not a statement is needed under Part V, Section 9.2.2 and Part IV, Section 9 of the Rules with the Primary and Secondary Readers. The Monitor may be consulted on an advisory basis. If the Readers disagree as to whether to make a statement, the Chair will make the final decision. A statement should ordinarily be provided except when it is felt that the Independent Review Panel or Board will be persuaded by the Committee's original rationale for its recommendation.

If no statement is provided, the reviewers should select a) a letter indicating that the Committee believes the rationale previously stated is sufficient to support its recommendations or b) no statement. A copy of this letter will be included in the record provided to the Independent Adjudication Panel or Board.

The statement should include such information and argument as necessary to prove the charges by a preponderance of evidence and to support recommended sanctions and directives to the Independent Adjudication Panel or Board. The statement should specifically address new information or new arguments that might preclude the Independent Review Panel or the Board of Directors from understanding or being persuaded by the Committee's rationale. The Primary and Secondary Readers develop the statement, with assistance from the Investigator and legal counsel. The Chair of the Committee approves the statement.

If both Readers determine that based on the rationale for nonacceptance of the Committee's recommendation, the Committee should reconsider its original recommendation and the Chair agrees, then the Readers will propose a revised recommendation, which will be sent along with the respondent's rationale to Committee members for a mail vote. The Committee can vote to recommend a greater or lesser sanction or reaffirm their original recommendation.

If in staff discretion one or both of the readers are unavailable in a timely manner, the above process will go forward based on decisions of those parties who are available. Staff may choose one or more alternatives if both readers are unavailable. If both the Chair and the ViceChair are unavailable, staff will choose a voting member of the Committee to act for the Chair. 97-03-CF-05



**CONFIDENTIAL APPENDIXES**

- Appendix 1: Policy on Notification of Final Actions
- Appendix 2: Lack of Due Process Defense to Show Cause Cases

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Number of cases heard by the Ethics Committee, by year, as reflected in Ethics Committee  
Annual Reports published in American Psychologist

1995: 102

1996: 50

1997: 59

1998: 62

1999: 42

2000: 47

Ethics program reforms/Stephen Behnke becomes Ethics Office director

2001: 13

2002: 12

2003: 6

2004: 3

2005: 8

2006: 7

2007: 5

2008: 12

2009: 7

2010: 4

2011: 5

2012: 2

2013: 2

*(The 2014 August American Psychologist published data from 2013; data from 2014 will be published in the 2015 August American Psychologist.)*

**ETHICS**

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Ethics Adjudication

Issue

For over four years the Board of Directors has intermittently discussed possible changes to the scope of APA's enforcement of its Ethics Code. At the April retreat, the Board discussed APA's role in adjudicating cases involving alleged ethics violations.

By way of background, under the current system, there are three primary routes by which allegations of unethical conduct are presented to APA as bases for sanctions:

1. Through "Show Cause" cases under Part IV of the Rules and Procedures. Show cause cases are initiated by the Ethics Committee when APA is advised by a state board, state professional association or similar body that a member has lost his or her professional license, or had it suspended or learns from anyone that a member has been convicted of a serious crime. Show cause cases, which are based on the action of another body, place the burden of proof on the member to establish why he or she should not be expelled. Only the Board reviews the Ethics Committee's decision in a show cause case.
2. By a complaint from a third party under Part V of the Rules and Procedures. In complaint cases, the burden is on the Ethics Committee in the event it finds that a violation has occurred to establish that its decision is justified by a preponderance of the evidence. Appeals to an independent hearing panel are de novo (i.e. there is no deference to the Ethics Committee's decision at the appeal level). If the recommended sanction is expulsion, this hearing may be in person at the respondents' request. If the recommended sanction is censure or reprimand, the appeal is on a written record. Where the Ethics Committee has recommended expulsion, these cases are automatically reviewed by the Board, unless the appeal panel completely dismisses the case.
3. By a "Sua Sponte" complaint under Part V. Such a complaint is filed by the Ethics Committee based on information learned from other sources, e.g. the same entities that are sources for show cause complaints where there is not a sufficient basis for a show cause case (e.g. no loss or suspension of license), from the news media, or from third parties who do not want to file complaints. These cases are subject to the same rules as third party complaint cases.

At the retreat discussion, the Board identified the following arguments for imposing new limitations on APA's ethics review process:

1. Some members felt that, notwithstanding the fact that the current system satisfies the legal requirements for due process, from a policy perspective it would be desirable to have in person hearings for all Members charged with ethics violations. The current system does not provide for in-person hearings for complaint cases resulting in censure or reprimand. In-person hearings for those complaint cases in which the Ethics Committee recommends expulsion do not occur until the "formal hearing stage", where there is de novo review of the Ethics Committee's recommendation.
2. Other bodies (licensing boards, state associations, peer review groups, university governance processes) may be better positioned to access all the facts, interview witnesses and hold in person hearings. What do we add to that process by having a separate adjudication process?

3. In some cases, because of changes in managed care self-reporting requirements, the consequences of an APA finding of an ethics violation are now greater than they were when the adjudication system was designed. This is particularly true in censure and reprimand cases. Previously, if APA decided not to notify third parties, censure and reprimand cases could be relatively confidential. Today such findings may be reportable to managed care by the psychologist regardless of APA's decision not to notify others or to limit notification.
4. The amount of money spent to process a relatively small number of cases, which results in findings of violation in an even smaller number of cases, is excessive.
5. The low number of violations and expulsions ultimately upheld, coupled with the effort to contain legal risk by keeping the results confidential (privileged), makes the adjudication process a public relations problem.
6. In some cases, we are used by competitors or angry family members for revenge, which is not an inherently worthy goal.
7. Concerns were expressed about the length and complexity of the process.

After considerable discussion, the Board narrowed its consideration to five options for final consideration at the June meeting:

- 1) elimination of adjudication of any ethics cases;
- 2) elimination of all complaint-based cases;
- 3) restriction of complaint-based cases to those that a) involve behavior that is likely to lead to expulsion and/or b) for which there is no adequate alternative forum;
- 4) allowing respondents in ethics cases to resign provided that APA members and inquiring members of the public are notified that the individual "resigned while under the scrutiny of the Ethics Committee" or "with an ethics investigation pending";
- 5) implementing automatic loss of membership, with a right of appeal, for members who are subject to the "show cause" procedures, i.e. have "a) been found guilty of a felony or equivalent offense, b) been expelled or suspended from a state or regional psychological association, c) been denied a license, certificate or registration, been unlicensed, decertified or deregistered; had same revoked or suspended; or voluntarily surrendered same or d) been the subject of any of the above actions by a state or local board that has been stayed or postponed." Rules and Procedures, Part IV.

### **Implementation Issues**

Changes to the ethics adjudication process are subject to the APA corporate documents. The Bylaws provide that:

Article II.15 - A Member (to include Fellows), Associate member or Affiliate may be dropped from membership or otherwise disciplined for conduct which violates the Ethical Principles of the Association, which tends to injure the Association or to affect adversely its reputation, or which is contrary to or destructive of its objects. Allegations of such conduct shall be submitted to the Ethics Committee.

The Ethics Committee shall formulate rules and procedures governing the conduct of the ethics and disciplinary process. However, such rules and procedures and any changes therein must be approved by the Board of Directors acting on behalf of Council. The Ethics Committee, acting at its own discretion or on direction of the Board of Directors, shall review such rules and procedures periodically and may amend them from time to time, subject to the approval of the Board of Directors, provided, however, that no such

amendment shall adversely affect the substantive right of a Member, whose conduct is being investigated or against whom formal charges have been filed at the time of amendment.

Article II.17 - Resignations of Members, Associate members or Affiliates may be accepted only by the Board of Directors. In the ordinary course, the Board of Directors will, in its discretion, refuse to accept a resignation tendered by a Member, Associate member or Affiliate while such Member, Associate member or Affiliate is under scrutiny of the Ethics Committee.

The Bylaws also address the duties of the Ethics Committee. In pertinent part they provide:

The Ethics Committee shall have the power to receive, initiate, and investigate complaints of unethical conduct of Members; to report on types of cases investigated with specific description of difficult or recalcitrant cases; to dismiss or recommend action on ethical cases investigated; to resolve cases by agreement where appropriate; to formulate rules or principles of ethics for adoption by the Association; to formulate rules and procedures governing the conduct of the ethics or disciplinary process for approval by the Board of Directors acting on behalf of Council; and to interpret, apply, and otherwise administer those rules and procedures. Article XI.5

The Bylaws designate the Board of Directors as the primary overseer of the Ethics Committee, which in turn is expressly empowered to "receive, initiate, investigate" complaints; "dismiss or recommend action" and formulate Rules subject to Board approval.

The Association Rules and the rules governing the ethics process ("Ethics Rules") are additional articulations of APA enforcement policy that are implicated by the changes the Board is considering.

#### Bylaws Amendments

The Bylaws are intended to be flexible, allowing considerable discretion in how they are implemented. Thus, there are already numerous restrictions on what complaints will be accepted (e.g., statute of limitations, no anonymous complaints) and how they are processed that are nonetheless consistent with the Bylaws empowerment of the Ethics Committee to receive and resolve complaints about unethical conduct. Option 1 (elimination of adjudication) goes sufficiently beyond the Bylaws to require an amendment.

Option 2 (elimination of complaint based cases, except sua sponte) arguably could be implemented without a Bylaws change. Under Article XI.5 the Ethics Committee "shall have the power to receive, initiate, investigate complaints." This language empowers but does not require the Committee to adjudicate complaints. Article II.15, however, provides that members may be dropped for three categories of behavior 1) unethical conduct; 2) conduct that injures the Association, and 3) conduct that is contrary to or destructive of APA's objects "allegations of ethical conduct shall be submitted to the Ethics Committee". Does the word "allegations" necessarily require that APA adjudicate complaints from third parties? An argument can be made that linking adjudication to only cases that meet the "show cause" category, excluding complaint cases, could satisfy this language. The better course is probably to amend the Bylaws.

Option 3 (increasing filters on complaint cases) can arguably be accomplished without a Bylaws amendment.

As discussed below, Options 4 and 5 can fall within the Board's discretion to implement the Bylaws.

### Board Authority

A further issue involves the balance between the Board's authority regarding the ethics process and the Ethics Committee's responsibility under the Bylaws to "formulate rules and procedures governing the conduct of the ethics and disciplinary process for approval by the Board of Directors acting on behalf of Council." The Bylaws provide that the Ethics Committee shall propose amendments to the Rules either at its own discretion or when directed by the Board of Directors. Article II.15 Coordination with the Ethics Committee on any implementation plan is important.

### Review by Council

Legally, 4, 5, and probably 3 could be accomplished by Board motions and resolutions and changes to the Rules of the Ethics Committee, approved by the Board of Directors "acting on behalf of Council." Article II.15 The Board needs to decide how it wishes to apprise Council of any changes. If the Board adopts very broad filters on complaints (see 3 below) that could reasonably be viewed as more substantive than procedural, Council should probably be asked to approve or at least be advised of the changes.

### Fiscal Implementations

Each of the proposals would save money in the long run. The amount of savings cannot be estimated reliably at this point.

### Discussion and Proposed Motions

The following presents motions to implement each of the options discussed at the retreat along with a brief description and identification of the problems each addresses. Each motion directs the Ethics Committee and staff to develop an implementation plan, including Rules changes, Board resolutions, etc. for Board action at the December 2000 meeting. Prior relevant Board actions are noted in italics at the beginning of each item.

#### 1. Elimination of All Adjudication

Elimination of all adjudication would save money, substantially reduce legal risk and allow refocus of significant resources on education.

Main Motion #1 - The Board of Directors vote that it is the Board's intention to take action for APA to cease adjudicating cases regarding violation of the APA Ethics Code and the staff should prepare a plan to implement this decision for action at the December 2000 meeting of the Board. Including Bylaws amendment to be approved by the Board, Council and membership and changes to the Ethics Rules and Procedures and Association Rules.

#### 2. Elimination of All Complaint-Based Cases

*Prior Relevant Board Action - June 7-8, 1998 the Board voted against a motion to eliminate the complaint process.*

Elimination of all complaint-based cases, leaving the "show cause" cases (based on actions by other bodies) would address the same problems identified regarding 1 above to a lesser, but nonetheless significant, extent.

Note that Alternate Main Motion 2 preserves the option of "sua sponte" complaints. Part V of the Ethics Rules and Procedures provides for both third party complaints and "sua sponte" complaints initiated by APA in cases that do not meet the criteria for "show cause" but which involve serious violations made known by the media or other avenues.

Main Motion #2 - That the Board of Directors vote that APA should cease adjudicating cases initiated by complaints under Part V of the 1996 Ethics Rules and Procedures. Staff should prepare a plan, with consultation with the Ethics Committee, to implement the Board's decision to be submitted to the Board in December 2000 including possible Bylaws amendment; changes to Ethics Rules and Procedures and Association Rules.

Alternate Main Motion #2 - That the Board of Directors vote that APA should cease adjudicating cases initiated by complaints under Part V of the 1996 Rules other than sua sponte complaints and staff should prepare a plan, in consultation with the Ethics Committee, to implement their decision for action at the December 2000 meeting of the Board, possible Bylaws amendment; changes to Ethics Rules and Procedures and Association Rules.

3. Restriction on Complaint-Based Cases

*Prior Relevant Board Action - December 1998, Board postponed discussion to later retreats of restrictions on the complaint process that would exclude complaint-based cases involving non-expellable conduct unless the complainant had no other forum to address the underlying behavior.*

At the April 2000 retreat, the Board discussed ways to increase the filter on complaint-based cases in two respects: 1) only accepting complaints that involve behavior that is likely to lead to expulsion and 2) only accepting complaints where there is no other forum to address the behavior. The Board would adopt either of these restrictions; both of them; or the substantially lesser alternative restriction deferred by the Board in 1998.

a) Restricting Complaints to "Serious Conduct"

Currently the Ethics Office only opens cases in "show cause" cases (based on findings and/or disciplinary actions by other bodies) if the behavior involved is sufficiently serious that it is likely to lead to expulsion. Under its "consistency of sanctions" policy, the Ethics Committee has defined the following behaviors as generally warranting expulsion: "sexual misconduct, felony conviction, insurance fraud, plagiarism, non-cooperation, blatant, intentional misrepresentation, and other behavior likely to cause harm". Ethics Committee Policy 95-03-06. See also Ethics Committee policy "Explication of Other Behavior Likely to Cause Substantial Harm".

The proposal under consideration would impose similar restrictions on the complaint process. Allegations of non-expellable conduct would not be adjudicated for violation and sanctions.

Problems addressed - There is concern that we are processing complaints on a paper record. APA currently provides opportunity for an in-person hearing for each respondent who the Ethics Committee recommends lose his or her membership due to a complaint. APA does not have the resources to provide in person hearings for each respondent who is found to have engaged in non-expellable conduct. Eliminating adjudication of complaints involving non-expellable conduct will substantially reduce the complaint cases that are resolved only on paper.

Increasingly, a finding of violation resulting in censure or reprimand can have adverse professional consequences for a member due to self-reporting requirements of managed care. By eliminating ethics cases involving non-expellable conduct, APA will focus the sanctions process on those who have engaged in the most egregious conduct.

There is also concern that too much money is being spent on cases. Eliminating these cases will reduce adjudication costs over time.

Main Motion 3a - That the Board of Directors vote that APA should decline to process a complaint under Part V of the 1996 Rules unless the complaint involves allegations of conduct which, if proven to be true, would likely result in loss of membership under the Ethics Committee policy defining such behavior. The Board directs the Ethics Committee to consider, with the assistance



of staff, how to accomplish the above including Board action and amendments to the Ethics Rules, further definition of expellable conduct, and any other necessary steps and prepare a report for the Board regarding such steps for consideration by the Board at its December 2000 meeting.

b) Declining to adjudicate complaints where the behavior could be addressed in another forum

The second prong of this proposal reflects the fact that since the time APA began enforcing the Ethics Code, regulatory bodies, professional organizations, the government and academic institutions have begun to enforce practice and conduct standards, including in many cases APA's ethical standards. Thus, APA no longer stands as the primary enforcer in many cases. Limiting APA's adjudication process to cases in which the behavior cannot be addressed elsewhere would reflect this change. Defining what other fora will satisfy this criteria and designing a mechanism to ascertain availability in each case will require careful thought. The current motion identifies licensure boards, APA-affiliated state psychological associations, institutional review boards, university grievance processes as alternative for a that are deemed to be comparable.

Problems addressed - There is a sense among Board members that frequently we are repeating case review that has already occurred before other regulatory bodies or we are being used as an alternative for complainants who are intent on revenge but whose claims have been rejected elsewhere. Each of the ethics-related lawsuits that APA has been involved in over the last decade has arisen in cases in which state licensure boards have refused to act but APA has sanctioned the member. The Board's concerns resulting from lack of personal hearings and lack of subpoena power are addressed by relying on other fora that have more direct access to witnesses. This restriction also removes the concern of "piling on" where a member is facing claims in several fora.

By restricting ethics adjudication to cases where there is not another comparable grievance forum available to address the behavior alleged, APA will be in a position to act where there is a need for enforcement but conserve resources for education where alternative fora exist to handle the problem. (If the alternative fora take action sufficient to invoke the show cause procedure--see 5 below--expulsion, or another sanction, would subsequently likely occur)

Restricting complaint cases in this manner will substantially reduce costs over time.

Main Motion 3b - That the Board of Directors vote that APA should decline to process a complaint under Part V of the 1996 Rules unless the complaint involves allegations of conduct which, if proven to be true, would likely result in loss of membership under the current Ethics Committee policy defining such behavior there is not an alternative forum (state psychology licensure board, affiliated state psychological association, institutional review board, university grievance process or other comparable fora) available to address the behavior and sanction the offending member, if appropriate. The Board directs the Ethics Committee to consider, with the assistance of staff, how to accomplish the above including Board action and amendments to the Ethics Rules, further definition of adequate alternative fora, and any other necessary steps and prepare a report for the Board regarding such steps for consideration by the Board at its December 2000 meeting.

c) Developing an educative track for complaints alleging non-expellable conduct

The Board discussed the possibility of using an educative letter process, rather than an adjudicatory process for "non-serious" cases. Under this scenario, allegations of non-expellable conduct could be diverted to an educative route which would not result in a finding of ethics violation but rather an educative letter, which would be non-disciplinary in nature.

Main Motion 3c - That the Board of Directors vote that APA should develop an educative track for complaint cases that involve non-expellable conduct and that the Ethics Committee should develop an implementation plan with the assistance of staff, for consideration by the Board at its December 2000 meeting.

#### 4. Resignation Under Ethics Investigation

*Prior Relevant Board Action - December 1998, Board voted in principle to support such an approach for show cause cases, under conditions recommended by the Ethics Committee for implementation specifically*

- i. that the offer of resignation be included in the first letter sent to the respondent at whatever stage that occurs;*
- ii. that a deadline be given for exercising the option, and that the option not be available thereafter*
- iii. that a written agreement include the extent to which the resignation will be disclosed, and that disclosures follow provisions similar to those used with stipulated resignations with admission of violation. (See Rules Part IV Section 12.1.2.);*
- iv. that disclosures include acknowledgment of the resignation in response to a written request. (See Rules Part II Section 3.3.10, which will need modification to include this non-disciplinary resignation.);*
- v. that the agreement specify that the member may not reapply for at least five years, and that the burden is on the applicant to show convincingly why he or she should be readmitted;*
- vi. that the committee's review of the reapplication will be limited to readmission of the applicant and not to determine a retroactive sanction or to conduct an investigation beyond that needed to address the readmission request.*

Implementation of this motion was deferred pending the larger ethics discussion and the complete staffing of the Ethics Office. At the April 2000 retreat, the Board discussed allowing any member who is the subject of a complaint or show cause proceeding to have the option of resigning "under ethics investigation". The discussion involved a process similar to that outlined above for use in all ethics cases - complaint and show cause - with the understanding that APA members would be notified of all such resignations and that similarly upon inquiry, any member of the public would be informed that the individual "resigned under ethics investigation".

The Bylaws provide that "in the ordinary course, the Board of Directors will, in its discretion, refuse to accept a resignation tendered by a member...while such member...is under the scrutiny of the Ethics Committee." The paramount issue is when a member comes "under the scrutiny of the Ethics Committee", absent a Bylaw amendment, the Board could not adopt a policy that allowed any member to resign at any point in a case. The mechanism voted by the Board in 1998 was intended to avoid any conflict with this provision by 1) requiring that the member opt to resign early in the process and 2) attaching real consequences to the decision to resign, including notifications. In 1997, the Board defined "under the scrutiny of the Ethics Committee". (Attachment #1) as part of implementing a resignation option a new resolution conforming the Board's interpretation of "under the scrutiny of the Ethics Committee" will be fashioned.

Problem addressed - allowing members the option of resigning "under pending ethics investigation" 1) removes APA from the struggle reflected in many show-cause and complaint-based cases alike with members who simply want out of APA and the expense or inconvenience of defending against an ethics case 2) by virtue of public notice, does not compromise the integrity of APA or the Ethics Code and still serves to protect the public 3) saves investigatory costs.

Main Motion 4 - That the board votes that APA members who are the subject of an ethics investigation, complaint, or a charge under either part IV or part V of the Ethics Rules, be offered an opportunity, when first contacted by the ethics office regarding the potential case, to resign from APA with the understanding that such resignation will be deemed for all purposes to be a resignation "under ethics investigation", that the membership and any inquiring third party will be so informed and other conditions described in a similar motion regarding non-complainant matters passed by the Board in 1998 will be imposed. The Board votes that this option [will, will

not] be made available to all respondents currently under Committee scrutiny, regardless of the stage at which their case is in the process.

The Board directs the Ethics Committee to consider, with the assistance of staff, how to accomplish the above including amendments to the Ethics Rules, Board resolutions and any other necessary steps and prepare a report for the Board regarding such steps to be acted on by December 2000.

5. Automatic expulsion for show cause cases

*Prior Relevant Board Action - December 1998, Board approved a motion that "automatic expel with appeal" be used for show cause cases and that Ethics staff recommend Rules changes to implement.*

Implementation of this motion was deferred pending the larger ethics discussion and the arrival of a new Director of the Ethics Office and completed staffing of the office.

Moving to automatic expulsion with a right of appeal for cases opened under the "show cause" procedure will eliminate investigatory costs for some portion of these cases and will expedite the processing of the remaining cases. Respondents will still be able to present their cases to the Ethics Committee and then the Board, but only if they affirmatively elect to do so.

If the Board opts to filter out complaint cases that may be handled by other bodies, as described in 3, it may wish to adjust the fora whose actions will trigger "show cause" proceedings to be coextensive with the fora that are deemed "comparable" for purposes of excluding complaint cases. (See alternate Main Motion 5)

Main Motion 5 - That the Board votes to reaffirm the similar motion passed in December 1998 and directs APA staff to develop a plan, in conjunction with the Ethics Committee, to implement this change within the next 6 months.

Alternate Main Motion 5 - That the Board votes to reaffirm the similar motion passed in December 1998, with the understanding that the list of actions that will trigger show cause cases be expanded to include appropriate findings by any of the enumerated alternative fora used to screen complaint cases, and directs APA staff to develop a plan, in conjunction with the Ethics Committee, to implement this change within the next 6 months.

APA Board of Directors  
Policy Regarding Barring of Resignations During Ethics Investigations  
August 1997

In the normal course of events, no one under the scrutiny of the Ethics Committee will be permitted to resign by letter of resignation, non-payment of dues, or otherwise. The Ethics Office shall advise the Membership Office whenever a member is under Ethics Committee scrutiny, and after receipt of such notification, the Membership Office shall not accept resignation in any form by such member.

A member will be considered under the scrutiny of the Ethics Committee:

1. when the member is first brought to the Committee's attention as a result of disciplinary or criminal investigations or actions by other bodies or
2. for other matters, when a complaint or other investigation is not dismissed after an initial review by the Chair and Director.

The Ethics Office will notify the member of the bar to resignation when it has opened a preliminary investigation, opened a case, or otherwise contacted the member in connection with the matter under scrutiny, or, if such actions have not been taken and the matter has not been closed within six months of notification of the membership office, the member will be informed of the bar to resignation at that time.

Upon execution of an affidavit committing a member who is under the scrutiny of the Committee to resign when the member is no longer under scrutiny, such a member will not come under the scrutiny of the Committee for any new matters. When the scrutiny of such member by the Ethics Committee has terminated, the Ethics Office shall notify the Membership Office that the member has resigned, effective on the date that the scrutiny terminated. Should the member later apply for readmission, the member's readmission shall be processed according to provisions in the affidavit, which shall include an agreement that the member shall not be eligible for readmission for 3 years from the effective date of the resignation and that the reapplication will be processed as a readmission under the Ethics Committee Rules and Procedures. The resignation shall not be considered a disciplinary action.

The member is no longer under the scrutiny of the Committee when all matters regarding the member that are under the scrutiny of the Committee are closed. When the scrutiny of such member by the Ethics Committee has terminated, the Ethics Committee shall so notify the Membership Office and the Membership Office shall remove the bar to resignation.

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### III. ETHICS

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#### Ethics Committee Rules and Procedures

##### Issue

This item is provided to inform the Council of Representatives that at its August 2001 and December 2001 meetings, the Board of Directors voted to approve changes to the Ethics Committee's *Rules and Procedures* (1996). (The revisions were primarily approved at the August meeting; further minor modifications were needed in December to implement fully the previously approved changes).

In summary, the changes provide that:

- (1) respondents will be allowed an opportunity to resign while under ethics investigation; and
- (2) in show cause matters respondents will be expelled automatically, unless the respondent requests review of the matter by the Ethics Committee. ("The show cause procedure... can be used when another body – including criminal courts, licensing boards, and state psychological associations – has already taken specified serious adverse action against a member." Overview to the APA Ethics Committee *Rules and Procedures*, [1996]).

The proposed changes apply to complaints and to notifications for show cause proceedings received by the APA Ethics Office after September 30, 2001. Exhibits 1 and 2 excerpt the revisions as approved by the Board of Directors at its August 2001 and December 2001 meetings, respectively.

##### Implementation Plan

The proposed changes apply to complaints and to notifications for show cause proceedings received by the APA Ethics Office after September 30, 2001. As with past changes to the *Rules and Procedures*, notice of the revisions will be provided to the membership in an association-wide publication such as the *Monitor*. The Ethics Office shall provide notification to affected respondents.

##### Fiscal Implications

None.

##### Main Motion

None.

##### Recommendation

None.

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##### Exhibits

1. Revisions as approved by the Board of Directors at its August 2001 meeting.
2. Revisions as approved by the Board of Directors at its December 2001 meeting.

Stephen Behnke, JD, PhD  
Ethics Office

**Office  
Copy**

**Response of the Ethics Committee to the  
Board of Directors' Proposals Concerning  
Ethics Adjudication**

***Prepared for the February 2001 meeting of the Council  
of Representatives***

## **CONFIDENTIAL**

### **REPORT ON ETHICS COMMITTEE ACTIONS REGARDING ADJUDICATION REFORMS**

Following is a full description of the Ethics Committee's actions in response to the Board of Director's June 2000 motions regarding the ethics program.

The Committee believes that the proposals it is recommending will further the goals of the organization while at the same time reduce adjudication. The adjudication program will be streamlined when members who have been seriously disciplined by their state boards either accept expulsion or choose to resign "under ethics investigation." Complainant matters will also be reduced and improved when only allegations of expellable misconduct are adjudicated and respondents have the ability also to resign "under ethics investigation." The program will be enhanced by increased educative efforts and the ethical behavior of members will likely improve.

#### **I. Complainant Cases**

##### **A. Expellable Behavior**

By a 10 to zero vote, the entire Committee, including Associate Members, is proposing, as the Board of Directors recommended, that behavior unlikely to lead to expulsion will not be adjudicated. Rather, these complaints will be evaluated for purposes of providing educative assistance to the respondent. Only behavior that is deemed likely to cause substantial harm and thus expellable will be considered appropriate for adjudication. The same standards that currently apply, that the evidence can be proved by a preponderance of the evidence, will determine whether a case may be opened.

Also by a 10 to zero vote, the Committee voted to define expellable behavior as behavior likely to cause substantial harm to persons or groups with whom the psychologist works or to the profession. The proposed rules provide as examples of expellable behavior sexual misconduct; felony conviction; insurance fraud; plagiarism; non-cooperation; blatant and intentional misrepresentation; gross misuse of techniques likely to result in substantial harm and/or significantly mislead a finder of fact in forensic matters; exploitative relationships that could have resulted in substantial harm; gross incompetence; and reckless disregard for the rights and interests of a patient or client. The examples cited are intended solely as illustrative and are not meant to exclude other behavior likely to cause substantial harm or to mean that all enumerated behavior would be viewed as expellable when in the alleged circumstance it is unlikely to cause substantial harm.

##### **B. Alternative Forums**

The Board has recommended strongly that the Ethics Committee not accept complaints when there is an alternative forum to address the behavior. The Committee spent the majority of its time at both its recent meetings examining how such a change could be implemented. After researching the matter, the Committee came to recognize that for all intents and purposes failing to adjudicate cases that could be investigated by another forum is tantamount to accepting almost no complainant cases. Almost all respondents against whom a complaint is lodged are licensed by their states or are members of an organization that could review their behavior. Given the small number of prospective complaints that would remain, one way to implement the Board's proposal is to eliminate complainant ethics matters entirely. However, concerns were raised about this course, including a), the effective surrender of membership decisions to other bodies; b), the resulting limit in the ability of APA to protect the public

and vulnerable complainants; and c), the surrender of the APA Ethics Code for enforcement to other bodies when the APA is unprepared to enforce our own Code.

Although eliminating complainant ethics matters entirely is a method of implementing the Board's motion, the Ethics Committee, including Associate Members, voted unanimously against ending review of complainant cases and in favor of continuing adjudication of such cases particularly if adjudication is limited to cases where the alleged misconduct could potentially lead to expulsion. The Committee is not endorsing a plan that would result in elimination of adjudication. However, the Committee did endorse a number of reforms to increase fairness, accessibility, and efficiency, and place an emphasis on professional education rather than adjudication in many cases.

In an attempt to find a workable method of defining alternative forums, the Ethics Committee explored various possibilities. The Committee looked into the appropriateness of considering academic governance processes and IRB's as alternative forums. It decided that many of these are not appropriate alternatives to APA adjudication because they lack the independence from all parties that the Committee thinks is necessary and because it is unlikely that IRB's would report their results to APA even if they were to review complaints. Among the concerns the Committee discussed in reaching this decision is that in evaluating a complaint, universities may see it in their interest to side with the professor against the student, or the tenured professor against the junior faculty member or student, or the holder of a grant over an assistant. The Committee was also concerned that the vast number of academic institutions in the country would eliminate any possibility that there are uniform standards among the schools, either for ethical standards or procedures. The Committee also believed it was not feasible to ask the Ethics Office staff to make a case by case evaluation of the academic governance bodies before deciding whether there was an alternative forum that could address the complaint. By total agreement among the Committee members, the Committee believes these bodies are not appropriate practical alternative venues.

After discussing the pros and cons of state boards and associations, the Committee voted 10 to zero against accepting all state licensing boards and all state psychological associations as appropriate alternative forums. If all complaints that could be addressed by state licensing boards or state psychological associations were denied adjudication, almost all complaints currently received by the Ethics Office would be refused. Additionally, the possible encouragement of state board review of members' conduct may lead to uneven or disproportionate results, especially if the Ethics Committee will treat cases that could not result in expulsion with non-disciplinary educative advice. The vast majority of complaints received by the Ethics Office are against psychologists who are licensed by state boards. Very few complaints are received against other types of psychologists. Under this plan, almost all complainant cases would cease, and the Committee is against the effective elimination of complainant cases.

The Committee looked carefully at the advisability of refusing to adjudicate cases over which state boards and/or state associations have jurisdiction. It recognized that a blanket recognition that state boards and associations could address these cases would provide ease of administration to APA and proximity to psychologists and complainants. The psychologist may admittedly be more familiar with the licensing board than with APA and in some situations, the cost to the psychologist could be lower. Costs to APA might decrease. The outcome would possibly be more timely. However, if more cases were to be investigated by state boards, attorney's fees for more respondents could increase and insurance rates for members in general might rise. More respondents could also be exposed to civil liability when fewer complainants get satisfaction from APA. Committee members also expressed concern for the possibility of increased hardship to vulnerable patients. The Committee was also concerned that APA would be abdicating oversight and accountability of our members to the state boards, thus enabling state boards to determine our membership in these cases. It believed that APA should maintain such oversight.



A primary reason for determining that all state boards are not appropriate alternative forums is the Committee's concern about the remarkable variability of state boards in terms of their reliance upon the APA Code and outcomes among cases. State licensing boards discipline at significantly varying rates, have varying resources at their disposal, and utilize varying procedures and various codes of behavior. Such variability could cause serious inequities to APA members, which the Committee believes is extremely undesirable.

The Committee made a determined effort to define the qualities of state licensing boards that would enable it to support relying on selected state boards. The Committee considered two separate groups of defining characteristics and then voted whether the Committee considered such characteristics sufficient for such reliance and whether such a plan would be feasible.

One list of criteria was:

- At least 25% of Board members are psychologists
- Enforces a code that is comparable to APA Code
- Provides a paper review or in person hearing
- Adjudicates at least three times a year
- Has support staff

The Committee voted unanimously that this group of qualities would not produce state licensing boards that would be appropriate alternative venues. In addition, the Committee believed that using this list of criteria would not be workable. The Committee did not think it was appropriate for a professional psychological organization to rely on boards comprised of only 25% psychologists to determine its membership and hold its members accountable. It further recognized the extreme difficulty of determining what state codes were "comparable" to the APA Code. Utilizing this list would require case by case evaluation by Ethics Office staff, which the Committee viewed as undesirable and impractical.

The second group of qualities considered was:

- Follows the current APA Code
- Majority of Board consists of psychologists
- At least one public member on the Board
- Provides in-person hearings
- Has appeals process in place
- Adjudicates at least three times a year
- Has trained, professional staff

The Committee was divided on whether a state board with these qualities would be sufficient. The Committee also considered whether a plan where some licensing boards satisfied these criteria and some did not was workable by the Ethics Office and Committee. Seven Ethics Committee members, including five Full Members and two Associate Members, opposed this plan; three members, that is, two Full Members and one Associate, supported it. The Committee requests the Board's comments regarding the acceptability of these characteristics.

The majority of the Committee felt relying on the states whose boards met the criteria in the second list would probably assure respondents of due process. But an over-arching concern of the Committee was to ensure comparable and consistent results for respondents who engage in similar behavior in different states. Assuming that complaints would be heard by this variety of states would not necessarily provide

comparative and consistent results. Adjudication by state boards could well exacerbate the inequity to members.

The Committee also looked into the feasibility of defining state psychological associations as appropriate alternative forums. Only 14 of the state associations have full adjudicative programs, which immediately eliminates the possibility of the other states exercising that role. In general, state associations do not act in the role of sanctioning members; state associations rarely discipline a member and notify APA of the action. All members of the Committee opposed qualifying as an alternative forum a state psychological association merely by virtue of its having a full adjudicative program. Two Committee members thought it possible to define characteristics that would indicate a state association could adequately review complaints to the satisfaction of APA. These qualities include having delineated procedures, including procedures for recusal; a board comprised by a majority of psychologists with at least one public member; and an appeals process in place. The majority of the Committee felt that the variability of state associations and the few number of them that adjudicate precluded the suitability of defining state associations as alternative forums.

In the end, the Ethics Committee voted eight to one, with one abstention (Full Members: 6-1; Associates, 2-0-1), not to endorse relying on other venues to review complaints.

In making this decision, the Committee considered many factors. As state licensing boards are presently constituted, 28 enforce the current Ethics Code. All but three of those states have boards a majority of whose members are psychologists, and all but two have a public member. Only fourteen state psychological associations have full adjudication programs; another eight open show cause cases based on actions by their state licensing boards.

Even accounting for who sits on state licensing boards and the Ethics Code they enforce, the state boards exercise their authority very differently. In the last two years, the Ethics Office has received no show cause cases from 24 states. There is a tremendous range in the rate of show cause cases that come from the eight states that contribute the most members to APA. The rate by which California (the highest) disciplines its psychologists is five times higher than Massachusetts and New York. There are four states that in five years have not disciplined any APA members such that the Ethics Committee has opened either a show cause or sua sponte case; another eight states have not referred any show cause cases in at least five years. While there may be differences between psychologists in California and those in Massachusetts and New York, the rate of complaints that are received by the Ethics Office does not vary significantly by state.

Having explored methods by which to implement a plan of relying on state licensing boards and/or state psychological associations before addressing allegedly unethical conduct, the Ethics Committee is recommending that the Committee continue to review all complaints alleging expellable behavior regardless of the availability of review by other forums. The Committee believes it is not possible to define alternative forum in a way that would be workable and serve our members, the profession, and the public.

The Committee has come to this conclusion partly because of the extreme variability of the forums available. It does not want to be in the position of evaluating each state board or association individually. After considerable fact gathering by staff, it was apparent that the practices and procedures of the boards and associations vary dramatically from state to state. The Committee has come to the conclusion that it is not feasible to make distinctions among the state boards and associations. It feels it would not be appropriate to adjudicate cases against psychologists from one state whose board or association does not

satisfy certain criteria but to rely on an alternative forum for cases alleging the same behavior forum by another psychologist from a different state.

The Committee is also concerned with possibly encouraging complainants to file complaints with state boards who would not otherwise file. We do not have firm data, but, contrary to what we expected, we believe that a significant number of complainants who file with APA currently do not file charges with the relevant state board or association. Failing to investigate complaints and leaving it up to state boards could increase the number of members who become enmeshed with state boards, perhaps without a reasonable basis for the complaint.

While the Committee fully recognizes that APA's public image and the organization's relationships with state psychological associations are not within its purview, and are appropriately within the Board's areas of authority, members of the Committee expressed concerns on both topics. Some Committee members have heard that some state psychological associations are worried that APA is shifting too much responsibility on them when they do not have the resources to assume these tasks. Sentiment was expressed that adopting the proposed plan on alternative forums could increase those worries and increase the burden on the state associations. Committee members also expressed the concern that if APA eliminates adjudication of complainant matters, APA's public image may be adversely affected. In a variety of matters, the public has come to trust APA. The public member believes the public may expect APA to hold its members accountable for unethical behavior. Eliminating or curtailing adjudication could alter the public's positive view of APA.

For all these reasons, the Ethics Committee recommends against adopting at this time the plan to refrain from addressing allegations of expellable conduct when there is an alternative forum. The Ethics Committee will still be able to stay investigations pending the review by other forums or to refer complaints while retaining jurisdiction when such action is considered appropriate. The Committee would not adjudicate cases of non-expellable conduct. The Committee is interested in exploring attempts to work with state boards so that this plan may seem more feasible in the future.

### C. Educative Assistance

By a series of 10 to zero votes, including Associate Members, the Committee developed a plan for providing educative assistance to respondents against whom there are complaints of behavior unlikely to result in expulsion. The plan calls for the Committee to consider the merits of the complaint and determine whether an educative letter or other advisory response is called for. Upon deciding that a response is appropriate, the Committee would consider one of four actions. It could send a respondent an educative letter or other advisory response alerting the member to concerns. The letter could also suggest mediation or other alternative dispute resolution methods or recommend that the respondent engage in specific corrective or educational action. In rare cases of a respondent alleged to have engaged in repeated unethical behavior that would not be likely to result in expulsion, the Committee could consider requiring specific directives. It is not anticipated that this last form of educative assistance would be exercised often. Enforcement of the required directives would be through the adjudicative process.

## II. Opportunity to Resign While under Investigation

Again by 10 to zero votes, the Committee developed language to implement the opportunity to resign when the respondent first learns of an investigation in both complainant and show cause matters. In both types of matters, if a respondent exercised this right, no notifications would be made except to the membership through the dues notice and to anyone who requests information about the respondent; in the

case of a complainant matter, the complainant would be told of the resignation. In all cases, the resignation of the member would be deemed "under ethics investigation" or similar language.

### III. Automatic Expulsion with Right to Review

The Committee developed language, by a 10 to zero vote, to allow for a respondent in what is now a show cause case to be expelled automatically unless he or she explicitly requests an appeal. If a respondent appealed, the case would be reviewed in the same manner as show cause cases currently. This kind of case could be opened if a state board takes an adverse action as a result of alleged unethical behavior that meets the definition of behavior likely to lead to expulsion. The only cases that could be opened this way are ones in which a state has suspended or revoked a member's license, a member has surrendered his license, a member has been convicted of a felony, or there is a finding of fact or stipulated agreement supporting the allegations.

### Conclusion

The Ethics Committee worked diligently to meet the Board of Director's request to implement certain changes in its program. While it has proposed changes to its rules that satisfy most of the Board's requests, it has not been able to develop rules that it thinks will be successful in implementing one of the Board's recommendations. The Committee is eager to work with the Board to further our mutual goals.

## LIST OF ATTACHMENTS

1. Table, States Enforcing APA Ethics Code
2. Table, Composition of State Psychological Licensing Boards
3. Adjudicative Programs of State Psychological Associations
4. Table, Licensed APA Members by State, 1999
5. Table, Major States Represented in APA Ethics Office Database, 1995-1999
6. Table, Disciplinary Reporting in Relation to Jurisdiction
7. Tables, Ethics Office Statistics by State, 1995-1999
8. Randolph P. Reaves, "Destroying the Myths about Psychology Regulatory Boards"
9. Table, Comparison of Peer Review Processes
10. Summary, Peer Review Processes
11. Graphs, Ethics Office Statistics, 1994-1999
12. Ethics Program Fact Sheet
13. Report of the Ethics Committee, 1999

## **Table, States Enforcing APA Ethics Code**

3/29/00

These states follow the 1992 APA Code – 29 states

(Note – In addition to following the APA Code, some states also have conduct-related statutes or rules of their own as noted on the accompanying chart. These provisions are more detailed than the basic statutory provisions concerning the grounds for disciplining psychologists which are found in many states.)

Alabama	Idaho	Nevada*	Tennessee**
Alaska	Illinois	New Hampshire +	Utah
Arkansas	Iowa	New Jersey	Vermont
California	Louisiana #	North Carolina * +	West Virginia
Colorado +	Maine	North Dakota #	Wyoming
Delaware	Massachusetts*	Oklahoma	
District of Columbia	Mississippi	Oregon	
Florida	Nebraska	Rhode Island	

\* Except where conflicts with statute

\*\* Does not include APA's Ethical Principles

These states follow an earlier version of the APA Code – 1 State  
Pennsylvania (1981)These states do not follow the APA Code – 21 States  
(Many considered the APA's Code when drafting their Own Code)

Arizona	Kentucky	New Mexico	Virginia
Connecticut ****	Maryland	New York	Washington
Georgia	Michigan	Ohio ***	Wisconsin
Hawaii	Minnesota*** +	South Carolina ***	
Indiana	Missouri ***	South Dakota (ASPPB 5/91)	
Kansas +	Montana	Texas +	

\*\*\* (APA's Code is used as aid in resolving ambiguities.)

\*\*\*\* Connecticut has adopted neither a code of ethics nor specific guidelines for conduct and, although the APA's Code may be considered when a complaint is reviewed by an outside consulting psychologist or the board, there is no affirmative requirement in statute or regulations that it be considered.

+ **Minority of Psychologists on Board**

# **No public member**

Note – "Own Code" refers to either a defined code of ethics adopted by a particular state or statutes or regulations governing similar behaviors such as sexual misconduct, advertising, and confidentiality.

3/29/00

State/Province	What has State/Province Adopted?	If APA Code, What Version and it is Always the Latest Version?	Are there any Exceptions to Following the APA Code?
Alabama	APA Code – 1992	1992 version	
Alaska	APA Code – 1992	1992 version	
Arizona	Own Code (Unprofessional conduct statute and regulations on client records)		
Arkansas	APA Code – 1992	1992 version. The regulations cite the "Ethical Principles of Psychologists and Code of Conduct" by name but do not give a date.	Regulations say that the Ethical Principles "shall constitute one standard by which appropriate professional practices are determined."
California	APA Code – 1992 plus some additional rules of professional conduct	1992 version. The APA Code is adopted by statute and the board interprets the statute to mean the current version as amended from time to time.	
Colorado	APA Code – 1992 plus some additional statutory provisions and regulations  APA is indirectly followed because statute requires that psychologists practice within the generally accepted standards of the profession and Colorado's board interprets this to include the current APA Code.	1992 version	

Note – "Own Code" refers to either a defined code of ethics adopted by a particular state or statutes or regulations governing similar behaviors such as sexual misconduct, advertising, and confidentiality.



3/29/00

Connecticut	According to the licensing board, its legal office, and its investigations office, Connecticut has adopted neither a code of ethics nor specific guidelines for conduct. The APA's Code may be considered when a complaint is reviewed by an outside consulting psychologist or the board. However, there is no affirmative requirement in statute or regulations that it be considered. The consultant and the board make decisions based on the individual facts of each case.		
Delaware	APA Code – 1992	1992 version - Statute cites the "Ethical Principles of Psychologists and Code of Conduct" by name but does not give a date. 1992 version	
District of Columbia	APA Code – 1992 Statute permits the board to bring disciplinary action against a licensee who "fails to conform to standards of acceptable conduct and prevailing practice" and this is interpreted by the board to include the APA code.		

Note – "Own Code" refers to either a defined code of ethics adopted by a particular state or statutes or regulations governing similar behaviors such as sexual misconduct, advertising, and confidentiality.

3/29/00

Florida	<p>APA Code – 1992 plus some statutory provisions and regulations on behavior</p> <p>Board stated that, although there is no statute or regulation stating that a licensed psychologist must follow the APA Code, they require that it be followed and use it when disciplining psychologists.</p>		
Georgia	<p>Own Code</p> <p>Have adopted APA Principles verbatim, but have their own Code of Ethics. Some of the Code of Ethics is similar to the APA's 1992 version.</p>	Principles are 1992 version (but have own Code)	
Hawaii	Own Code (Ethical Standards of Practice)		
Idaho	APA Code – 1992	1992 version. Statute says "as future amended"	
Illinois	APA Code – 1992	1992 version only - "with no later amendments or editions"	
Indiana	<p>Own Code (Code of Professional Conduct)</p> <p>Some regulations very similar to APA's</p>		

Note – "Own Code" refers to either a defined code of ethics adopted by a particular state or statutes or regulations governing similar behaviors such as sexual misconduct, advertising, and confidentiality.

3/29/00

Iowa	APA Code – 1992	1992 version only - "Later amendments or editions of the Principles are not included in this rule."	
Kansas	Own Code (Unprofessional Conduct regulations)		
Kentucky	Own Code (Code of Conduct)		
Louisiana	APA Code – 1992	1992 – The regulations list verbatim the 1990 version, but specifically state that "any amendment of the ethical standards adopted by the APA are automatically accepted and adopted by the Louisiana State Board of Examiners of Psychologists."	
Maine	APA Code – 1992	1992 – Statute has shall adopt a code "in keeping" with the APA. 1992 version adopted by regulation.	
Maryland	Own Code (Code of Ethics and Professional Conduct) Board is required to consider APA Code when promulgating rules.		

Note – "Own Code" refers to either a defined code of ethics adopted by a particular state or statutes or regulations governing similar behaviors such as sexual misconduct, advertising, and confidentiality.

3/29/00

Massachusetts	<p>APA Code –1992 plus some additional rules on behavior)</p> <p>Statute says a person desiring a license must furnish evidence of conducting professional activities “in accordance with accepted standards, such as the Ethical Standards of Psychologists of the APA.” Board adopted the “Ethical Principles of Psychologists” except as deviates from Mass. statute (and also various APA publications as guides). This includes the Code of Ethics because the complete 1992 APA document is filed with the Secretary of State.</p>	1992 version - “As amended from time to time”	If conflicts with Mass statutes governing psychologists, Mass statutes prevail
Michigan	<p>Own Code (which is a few statutory provisions governing unethical business practices and unprofessional conduct that Michigan does not refer to as a Code of Ethics)</p> <p>The office stated that the board may look to the APA Code for standards of practice in particular case.</p>		

Note – “Own Code” refers to either a defined code of ethics adopted by a particular state or statutes or regulations governing similar behaviors such as sexual misconduct, advertising, and confidentiality.

3/29/00

Minnesota	Own Code (Rules of Conduct)		1992 APA Code is used to resolve ambiguity but Minn. Code prevails if conflict
Mississippi	APA Code --1992 The statute permits the board to adopt a different code than the APA's but the board has not done so.	1992 - Statute says current code.	
Missouri	Own Code (Ethical Rules of Conduct) Statute requires that the Ethical Code be "based upon the Ethical Principles promulgated and published by the APA." The regulations use the APA's Ethical Principles in resolving ambiguities except that the Missouri regulations would prevail in a conflict.		If there is a conflict, the Missouri regulations prevail.
Montana	Own Code (Unprofessional conduct regulations) Some provisions similar to APA Code (e.g., sexual intimacies)		
Nebraska	APA Code -- 1992	1992 version	

Note -- "Own Code" refers to either a defined code of ethics adopted by a particular state or statutes or regulations governing similar behaviors such as sexual misconduct, advertising, and confidentiality.

3/29/00

Nevada	APA Code – 1992 plus some additional standards of conduct	1992 version	Except where conflicts with the Nevada regulations
New Hampshire	Nevada's prevail if conflict APA Code – 1992	1992 version – regulations say "most recent version"	
New Jersey	APA Code 1992 plus some additional regulations  APA Code is followed indirectly because the regulations state that "A licensee shall meet ... to the public as professional responsibilities determined by accepted standards of practice, law, or rules."	1992 version	
New Mexico	Own Code (Code of Conduct)  Some portions verbatim from the 1992 APA Code. This new Code adopted by regulation effective 4/16/00.		
New York	Own Code (Unprofessional Conduct Regulations)		
North Carolina	APA Code – 1992	1992 – statute says "then current code of ethics of the American Psychological Association"	Except where the APA Code conflicts with the North Carolina statute which then prevails

Note – "Own Code" refers to either a defined code of ethics adopted by a particular state or statutes or regulations governing similar behaviors such as sexual misconduct, advertising, and confidentiality.

3/29/00

North Dakota	APA Code – 1992	1992 version. Statute says “or revised additions if adopted by the board by rule.”	
Ohio	Own Code (General Rules of Professional Conduct)  APA code is an aid in resolving ambiguities in interpretation of the Ohio rules.		
Oklahoma	APA Code – 1992	1992 version. Regulations (Appendix 1) restate the 1992 APA Code verbatim.	
Oregon	APA Code – 1992	1992 version adopted by regulation	
Pennsylvania	APA Code – 1981	No – 1981 version	
Rhode Island	APA Code – 1992	1992 version	
South Carolina	Own Code (Code of Ethics)		APA's 1989 “Ethical Principles of Psychologists” can be used to aid in resolving ambiguities except when conflict with South Carolina's regulations
South Dakota	AASPB of May 1991		
Tennessee	APA Code – 1992	1992 version has been adopted verbatim into regulations (without the accompanying principles). There are a few errors in their version.	
Texas	Own Code (Rules of Practice)		
Utah	APA Code – 1992 plus some additional statutes and regulations on unlawful and unprofessional conduct	1992 version incorporated by reference into the regulations	

Note – “Own Code” refers to either a defined code of ethics adopted by a particular state or statutes or regulations governing similar behaviors such as sexual misconduct, advertising, and confidentiality.

3/29/00

Vermont	APA Code – 1992 plus a short statute on unprofessional conduct	1992 version adopted by regulation	Although regulation says the APA Code is a guide and not additional grounds of unprofessional conduct, the board says the Code is incorporated and must be followed.
Virginia	Own Code (Standards of practice; Unprofessional Conduct)		
Washington	Own Code (Rules of Ethical Conduct) Some provisions similar to APA Code.		
West Virginia	APA Code – 1992	1992 version. Regulation is silent as to date but board stated that they follow the current version	
Wisconsin	Own Code (Rules of Conduct) Statute says "Ethical Standards of Psychologists" of the APA was to be used as model		
Wyoming	APA Code – 1992	1992 – Regulation says both "current version" of principles and "current version" of code of ethics	

Note – "Own Code" refers to either a defined code of ethics adopted by a particular state or statutes or regulations governing similar behaviors such as sexual misconduct, advertising, and confidentiality.



# **Table, Composition of State Psychological Licensing Boards**

### Composition of State Psychological Licensing Boards<sup>1</sup>

State	Number of Board Members	Number who are Psychologists	Number of other psychology-related members	Number of Public/lay members; Other specified members	Appointment is by Governor unless otherwise noted	Term of Appointment	Percentage Psychologists or other mental health professionals
Alabama	8	5	1 psychological technician	2		5 years	75%
Alaska	5	3 (licensed)	1 licensed psychological associate	1		Term not listed in information	80%
Arizona	9	7 licensed (2 of whom are full-time faculty at state universities and 2 of whom are in private practice)	0	2		5 years	77%
Arkansas	8	4 psychologists	2 psychologist examiners	1 senior citizen representative; 1 consumer representative		5 years	75%

<sup>1</sup> The information in this chart was obtained from the Handbook of Licensing and Certification Requirements for Psychologists in the U.S. and Canada (January 1999) published by the ASPPB, except where information concerning board composition did not clearly specify the number of psychologist-members. In such cases, the state statute governing the composition of the board was reviewed.

California	9	5 (licensed)	0	4	7 by governor; 1 by assembly speaker; 1 by senate president	4 years	56%
Colorado	7	3 (licensed)	0	4		3 or 4 years	43%
Connecticut	5	3	0	2	(Information does not state who appoints)	4 years (can serve no more than 2 consecutive)	60%
Delaware	9	5	0	4		3 years	56%
DC	5	4	0	1	By mayor with advice and counsel of DC Council	3 years	80%
Florida	7	5 (licensed)	0	2		4 years	71%
Georgia	6	5	0	1		5 years	83%
Hawaii	7	5 (licensed)	0	2		4 years (2 max.)	71%
Idaho	4	3 (licensed)	0	1		3 year term	75%
Illinois	7	4 (licensed); 2 full-time faculty members	0	1		4 years	86%
Indiana	7	6 (licensed)	0	1		3 years	86%
Iowa	7	5	0	2		3 years	71%

Kansas	11	2 (licensed)	2 Social workers; 1 licensed master's level psychologist; 1 licensed professional counselor; 1 licensed marriage and family therapist	4		4 years	64%
Kentucky	9	6 (licensed)	2 certified psychological associates	1		3 years	89%
Louisiana	5	5 (licensed)	0	0	From list elected by licensed psychologists	5 years	100%
Maine	9	6	1 psychological examiner	2		3 years	78%
Maryland	9	7 (licensed) of whom 2 must be engaged primarily in providing psychological services and 2 in teaching, training and research in psychology	0	2	With advice of Secretary and advice and consent of Senate from list compiled by the Maryland Psych. Association.	4 years	78%
Massachusetts	9	7 (licensed)	0	2		5 years	78%

Michigan	9		5 (includes at least 1 non-doctoral licensee)	0	4			2 to 4 years	56%
Minnesota	11		3 (licensed) doctoral level; 1 (not necessarily licensed) representing doctoral training program	2 (licensed) master's level; 1 (not necessarily licensed) master's level representing masters training program; 1 (licensed or qualified to be licensed) psychological practitioner	3			4 years	73%
Mississippi	7		6 (licensed)	0	1			5 years	86%
Missouri	8		7 (licensed)	0	1			5 years	88%
Montana	6		2 (licensed) in private practice; 1 (licensed) working in public health; 1 (licensed) engaged in teaching psychology	0	2		With consent of Senate	5 years (1 term only with reappointment possible after 5 years)	67%
Nebraska	6		5 (licensed)	0	1		By State Board of Health	5 years	83%
Nevada	5		4	0	1			4 years	80%

New Hampshire	7	1	1 clinical social worker; 1 clinical mental health counselor; 1 pastoral psychotherapist; 1 marriage-family therapist	2			Term not listed in information	71%
New Jersey	10	7 (licensed)	0	2; 1 government member			3 years	70%
New Mexico	8	4	1 psychologist associate	3		By governor from recommendations by associations	3 years	63%
New York	14	11 (licensed)	0	3		By NY Board of Regents	5 years	79%
North Carolina	7	3 (licensed)	2 licensed psychological associates	2			3 years	71%
North Dakota	5	5 (Must be licensed at least 5 years in ND and 1 must be primarily a service provider and 1 primarily an academician)	0	0			3 years	100%
Ohio	7	6	0	1			5 years	86%
Oklahoma	7	5	0	2			4 years	71%
Oregon	7	5 (licensed)	0	2		Senate confirmation needed	3 years (max. 2 terms)	71%

Pennsylvania	9	6 (licensed)	0	2; 1 Commissioner of the Bureau of Professional and Occupational Affairs	With advice and consent of Senate	4 years	67%
Rhode Island	5	4 (licensed)	0	1	By director of health with governor's approval	3 years	80%
South Carolina	8	7	0	1		5 years	88%
South Dakota	5	4	0	1		3 years	80%
Tennessee	7	5 (licensed)	1 licensed psychological examiner	1		5 years	86%
Texas	9	4	2 psychological associates	3		6 years	67%
Utah	5	4 (licensed)	0	1		Term not listed in information	80%
Vermont	5	3 (licensed)	0	2	With advice and consent of Senate	5 years	60%
Virginia	9	5 clinical; 1 school; 1 applied	0	2	Information not given	Information not given	78%
Washington	9	7 (licensed)	0	2		5 years	78%

West Virginia	7	5 (licensed), 1 of whom is school psychologist)	0	2		3 years	71%
Wisconsin	6	4 (licensed)	0	2		4 years	67%
Wyoming	9	5 (licensed); 1 school psychologist	1 psychological practitioner	2		5 years	78%



# **Adjudicative Programs of State Psychological Associations**

# Adjudicative Programs of the State Psychological Associations

## **States With Full Adjudicative Programs:**

Alabama  
California  
Colorado  
Iowa  
Illinois  
Massachusetts  
Maryland  
Michigan  
New Jersey  
Oregon  
Tennessee  
Utah  
Vermont  
Wisconsin

## **States With Limited\* Adjudicative Programs:**

Georgia  
Idaho  
Kansas  
Maine  
Missouri  
Montana  
North Carolina  
Pennsylvania

\* These states adjudicate according to specific criteria; generally they only take action secondary to state regulatory boards or court actions.

**States With No Adjudicative Programs:**

Alaska  
Arkansas  
Arizona  
Connecticut  
Delaware  
District of Columbia  
Florida  
Hawaii  
Indiana  
Kentucky  
Louisiana  
Minnesota  
Mississippi  
Nebraska  
New Hampshire  
New Mexico  
New York  
Nevada  
Ohio  
Oklahoma  
Rhode Island  
South Carolina  
Texas  
Virginia  
Washington  
West Virginia  
Wyoming

**States with No Ethics Programs:**

(i.e. No Ethics Committee)

North Dakota  
South Dakota

## Bottom Line

Out of all 50 States and the District of Columbia:

- 14 out of the 51 Associations or 27.45 % have full adjudicative programs.
- 8 out of the 51 Associations or 15.69 % have limited adjudicative programs.
- 27 out of the 51 Associations or 52.49 % have no adjudicative programs.
- 2 out of the 51 Associations or 3.92 % have no Ethics Programs and therefore no Ethics Committee.

## **Table, Licensed APA Members by State, 1999**

Licensed APA Members by State: 1999

	Licensed and/or certified		Total	%
	N	%	N	
N =	49,949	60.0	83,260	100.0
Alabama	360	57.9	622	100.0
Alaska	109	58.0	188	100.0
Arizona	810	63.6	1,274	100.0
Arkansas	195	63.3	308	100.0
California	6,977	60.1	11,610	100.0
Colorado	998	61.7	1,617	100.0
Connecticut	950	59.4	1,598	100.0
Delaware	158	63.5	249	100.0
DC	448	51.7	867	100.0
Florida	2,189	60.3	3,633	100.0
Georgia	1,071	57.7	1,857	100.0
Hawaii	278	64.7	430	100.0
Idaho	105	60.7	173	100.0
Illinois	2,182	55.6	3,921	100.0
Indiana	685	56.6	1,210	100.0
Iowa	290	51.7	561	100.0
Kansas	361	53.0	681	100.0
Kentucky	383	56.7	675	100.0
Louisiana	305	54.6	559	100.0
Maine	284	66.0	430	100.0
Maryland	1,377	56.0	2,458	100.0
Massachusetts	2,797	64.3	4,352	100.0
Michigan	1,491	53.7	2,776	100.0
Minnesota	967	63.2	1,529	100.0
Mississippi	179	58.1	308	100.0
Missouri	830	60.2	1,378	100.0
Montana	144	67.9	212	100.0
Nebraska	225	58.3	386	100.0
Nevada	188	59.9	314	100.0
New Hampshire	324	67.4	481	100.0
New Jersey	1,819	57.5	3,161	100.0
New Mexico	321	62.7	512	100.0
New York	5,926	61.0	9,717	100.0
N Carolina	1,106	60.1	1,841	100.0
N Dakota	99	63.9	155	100.0
Ohio	1,979	67.3	2,941	100.0
Oklahoma	334	57.4	582	100.0
Oregon	631	63.5	993	100.0
Pennsylvania	2,852	62.1	4,595	100.0
Rhode Island	241	56.2	429	100.0
S Carolina	295	53.2	555	100.0
S Dakota	82	57.7	142	100.0
Tennessee	744	64.5	1,154	100.0
Texas	2,083	59.7	3,491	100.0
Utah	325	60.2	540	100.0
Vermont	232	70.1	331	100.0
Virginia	1,102	54.4	2,024	100.0
Washington	1,055	61.8	1,707	100.0
W Virginia	158	59.8	264	100.0
Wisconsin	810	61.4	1,319	100.0
Wyoming	95	63.3	150	100.0

Source: 1999 APA Directory Survey. Compiled by APA Research Office.

**Table, Major States Represented in APA  
Ethics Office Database, 1995-1999**

DATA ADDENDUM  
MAJOR STATES REPRESENTED IN  
APA ETHICS OFFICE DATABASE  
1995-1999

COMPLETED COMPLAINT FORMS= 558

CALIFORNIA	= 97	(17.0%)
NEW YORK	= 53	( 9.5%)
PENNSYLVANIA	= 39	( 7.0%)
FLORIDA	= 30	( 5.4%)
ILLINOIS	= 28	( 5.0%)
MICHIGAN	= 28	( 5.0%)

COMPLAINANT CASES OPENED= 119

CALIFORNIA	= 19	(16%)
NEW YORK	= 14	(11.8%)
MICHIGAN	= 8	( 6.7%)
FLORIDA	= 7	( 6%)
ILLINOIS	= 6	( 5%)
VIRGINIA	= 6	( 5%)

INCOMING SUA/SHOW CAUSE MATTERS=514

CALIFORNIA	= 120	(23%)
ILLINOIS	= 29	(5.6%)
COLORADO	= 29	(5.6%)
NEW YORK	= 26	(5%)
GEORGIA	= 20	(4%)

SUA/ SHOW CAUSE CASES OPENED=241

CALIFORNIA	= 73	(30.3%)
GEORGIA	= 13	( 5.4%)
NEW YORK	= 12	( 5%)
OHIO	= 10	( 4.2%)
N. CAROLINA	= 9	( 3.7%)

LICENSED APA MEMBERS RESIDING IN THESE STATES\*

CALIFORNIA	= 6799	(14.0%)	MICHIGAN	= 1491	(3.0%)
NEW YORK	= 5926	(12.0%)	N. CAROLINA	= 1106	(2.2%)
PENNSYLVANIA	= 2852	( 5.7%)	VIRGINIA	= 1102	(2.2%)
FLORIDA	= 2189	( 4.4%)	GEORGIA	= 1071	(2.1%)
ILLINOIS	= 2182	( 4.4%)	COLORADO	= 998	(2.0%)
OHIO	= 1979	( 4.0%)			

ADJUDICATIVE AVAILABILITY IN THESE STATES' PSYCHOLOGICAL ASSOCIATIONS

F = FULL (WILL TAKE ALL ALLEGATIONS AND ACT SECONDARY TO OTHER ACTIONS)  
L = LIMITED (SOME RESTRICTIONS ON CASES; GENERALLY SECONDARY ONLY)  
N = NO ADJUDICATION PROGRAM

F = CALIFORNIA, MICHIGAN, ILLINOIS, COLORADO  
L = GEORGIA, PENNSYLVANIA, NORTH CAROLINA  
N = NEW YORK, FLORIDA, OHIO, VIRGINIA

\* 1999 APA licensed members (APA Research Office)



# **Table, Disciplinary Reporting in Relation to Jurisdiction**

**SUMMARY OF DISCIPLINARY REPORTING IN RELATION TO JURISDICTION, CATEGORY & AVERAGE DISCIPLINARY  
ACTIONS REPORTED AS OF 10/15/99**

JURISDICTION	YEAR OF ORIGINAL LICENSURE LAW	# OF LICENSED PSYCHOLOGISTS as of 1/99	# OF DISCIPLINARY ACTIONS	CATEGORY	AVG. # OF DISCIPLINARY ACTIONS PER CATEGORY	DATE OF 1st REPORTED ACTION	DATE OF LAST REPORTED ACTION
Alabama	1963	608	25	3	20.1	7/86	10/99
Alaska	1967	212	8	1	3.4	4/89	10/99
Alberta	1960	2072	4	7	33.6	7/87	4/89
Arizona	1965	1,539	61	6	40.4	1/87	10/99
Arkansas	1955	834	18	4	18	4/87	4/99
British Columbia	1977	1,014	4	5	22.8	1/86	7/96
California	1957	Approximately 17,700	344	11	22.1	7/88	4/99
Colorado	1961	1,790	60	6	40.4	8/83	4/97
Connecticut	1945	1,406	33	5	22.8	1/85	10/99
Delaware	1962	340	4	2	9	1/94	4/98
District of Columbia	1985	Approximately 1,200	1	5	22.8	1/94	1/94
Florida	1961 Sunset 2 years (1980-1982)	3,886	50	8	94.5	4/87	10/99
Georgia	1951	1,536	31	6	40.4	7/87	10/99

JURISDICTION	YEAR OF ORIGINAL LICENSURE LAW	# OF LICENSED PSYCHOLOGISTS as of 1/99	# OF DISCIPLINARY ACTIONS	CATEGORY	AVG. # OF DISCIPLINARY ACTIONS PER CATEGORY	DATE OF 1st REPORTED ACTION	DATE OF LAST REPORTED ACTION
Guam	1987	8	0	1	3.4		
Hawaii	1967	464	6	2	9	7/89	10/97
Idaho	1963	221	5	1	3.4	1/85	7/96
Illinois	1963	5,593	97	10	90.8	4/87	10/99
Indiana	1969	1,541	20	6	40.4	7/85	10/99
Iowa	1975	470	21	2	9	4/88	1/99
Kansas	1967	1,052	21	5	22.8	1/87	4/98
Kentucky	1948	1,313	37	5	22.8	7/91	10/99
Louisiana	1964	501	15	3	20.1	10/90	10/98
Maine	1953	545	25	3	20.1	8/83	1/99
Manitoba	1966	205	6	1	3.4	1/97	1/98
Maryland	1957	Approximately 2,700	27	7	33.6	1/85	10/99
Massachusetts	1974	4,744	49	9	49	1/87	10/99
Michigan	1959	6,361	124	10	90.8	1/88	10/99
Minnesota	1951	3,697	146	8	94.5	1/86	10/99
Mississippi	1966	355	11	2	9	8/83	10/97
Missouri	1977	1,822	39	6	40.4	1/95	7/99
Montana	1971	215	6	1	3.4	10/89	7/98

JURISDICTION	YEAR OF ORIGINAL LICENSURE LAW	# OF LICENSED PSYCHOLOGISTS as of 1/99	# OF DISCIPLINARY ACTIONS	CATEGORY	AVG. # OF DISCIPLINARY ACTIONS PER CATEGORY	DATE OF 1st REPORTED ACTION	DATE OF LAST REPORTED ACTION
Nebraska	1967	357	11	2	9	1/86	1/99
Nevada	1963	265	7	2	9	10/91	10/97
New Brunswick	1967	241	0	1	3.4		
New Hampshire	1957	598	27	3	20.1	4/87	7/99
New Jersey	1966	2,681	37	7	33.6	1/85	10/99
New Mexico	1963	537	11	3	20.1	10/87	10/99
New York	1956	Approximately 14,000	98	11	221	1/85	10/99
Newfoundland	1985	Approximately 200	1	1	3.4	10/98	10/98
North Carolina	1967	3,236	65	8	94.5	8/83	7/99
North Dakota	1967	189	1	1	3.4	1/89	
Nova Scotia	1980	319	8	2	9	7/88	4/95
Ohio	1972	3,896	117	8	94.5	8/83	10/99
Oklahoma	1965	545	25	3	20.1	1/87	10/98
Ontario	1960	2,311	32	7	33.6	1/88	7/98
Oregon	1963	1,021	41	5	22.8	7/87	10/99
Pennsylvania	1976	Approximately 6,100	79	10	90.8	7/88	10/99
Quebec	1962	Approximately 6,320	29	10	90.8	4/88	10/99

JURISDICTION	YEAR OF ORIGINAL LICENSURE LAW	# OF LICENSED PSYCHOLOGISTS as of 1/99	# OF DISCIPLINARY ACTIONS	CATEGORY	AVG. # OF DISCIPLINARY ACTIONS PER CATEGORY	DATE OF 1st REPORTED ACTION	DATE OF LAST REPORTED ACTION
Rhode Island	1969	441	2	2	9	4/97	7/97
Saskatchewan	1962	92	0	1	3.4		
South Carolina	1968	500	11	2	9	4/90	4/99
South Dakota	1967 Sunset 2 years (1979-1981)	164	5	1	3.4	4/93	1/99
Tennessee	1953	Approximately 2,250	58	7	33.6	7/89	7/99
Texas	1969	5,125	125	10	90.8	8/83	10/99
Utah	1959	570	21	3	20.1	8/83	10/98
Vermont	1975	535	29	3	20.1	1/88	10/99
Virginia	1946	1,937	38	6	40.4	1/88	10/99
Washington	1955	2,099	44	7	33.6	1/87	7/99
West Virginia	1970	652	3	3	20.1	1/92	4/97
Wisconsin	1969	1,561	34	6	40.4	8/83	7/99
Wyoming	1965	155	5	1	3.4	4/89	10/99

Category 11--Over 10,000 Licensees

Category 6 -- 1,501 to 2,000 Licensees

Category 1 -- 250 Licensees and under

Category 7 -- 2,001 to 3,000 Licensees

Category 2 -- 251 to 500 Licensees

Category 8 -- 3,001 to 4,000 Licensees

Category 3 -- 501 to 750 Licensees

Category 9-- 4,001 to 5,000 Licensees

Category 4 -- 751 to 1,000 Licensees

Category 10 -- 5,001 to 10,000 Licensees

Category 5 -- 1,001 to 1,500 License

# **Tables, Ethics Office Statistics by State, 1995-1999**

# *Ethnic Office Statistics, 1995-2000*

STATE	APA CODE	MAJ PSYC BD	SPA ADJ	APA MEMB	EC SHOW CAUSE	EC SUA	COMPLAINT CASES	INQUIRIES	FORMS	NO FORMS
Alabama	Y	Y	Y	622	-	1	-	3	-	3
Alaska	Y	Y	N	188	-	1	-	4	-	4
Arizona	N	Y	N	1274	4	11	4	16	9	7
Arkansas	Y	Y	N	308	1	1	3	7	5	2
California	Y	Y	Y	11,610	44	76	23	202	80	122
Colorado	Y*	N	Y	1617	3	23	3	15	4	11
Connecticut	N	Y	N	1598	4	12	2	16	7	9
Delaware	Y	Y	N	249	-	2	-	3	2	1
Florida	Y	Y	N	3633	3	15	8	63	22	41
Georgia	N	Y	SC	1857	11	8	1	12	8	4
Hawaii	N	Y	N	430	1	-	3	14	4	10
Idaho	Y	Y	SC	173	-	-	-	7	1	6
Illinois	Y	Y	Y	3921	5	23	8	63	23	40
Indiana	N	Y	N	1210	1	3	1	23	4	19
Iowa	Y	Y	Y	561	4	3	-	4	1	3
Kansas	N	N	SC	681	-	5	2	13	6	7
Kentucky	N	Y	N	675	2	6	1	10	1	9
Louisiana	Y	Y	N	559	1	4	-	5	2	3
Maine	Y	Y	SC	430	3	7	-	1	-	1
Maryland	N	Y	Y	2458	2	2	6	36	12	24
Massachusetts	Y	Y	Y	4352	3	8	2	28	11	17
Michigan	N	Y	Y	2776	4	9	8	49	20	29
Minnesota	N	N	N	1529	2	15	2	13	-	13
Mississippi	Y	Y	Y	308	-	-	1	1	-	1
Missouri	N	Y	SC	1378	2	6	3	31	12	9
Montana	N	Y	SC	212	-	1	2	2	2	-
Nebraska	Y	Y	N	386	1	-	-	2	-	2
Nevada	Y	Y	N	314	1	2	1	5	2	3
New Hampshire	Y	N	N	481	4	6	-	11	2	9
New Jersey	Y	Y	Y	3161	7	9	4	32	19	13
New Mexico	N	Y	N	512	1	-	2	6	1	5
New York	N	Y	N	9717	8	22	18	110	39	71

STATE	APA CODE	MAJ PSYC BD	SPA ADJ	APA MEMB	EC SHOW CAUSE	EC SUA	COMPLAINT CASES	INQUIRIES	FORMS	NO FORMS
North Carolina	Y	N	SC	1841	8	5	-	23	12	11
North Dakota	Y	Y	N	155	-	-	1	7	4	3
Ohio	N	Y	N	2941	7	10	2	26	10	16
Oklahoma	Y	Y	N	582	1	1	1	5	4	1
Oregon	Y	Y	Y	993	6	8	1	28	10	18
Pennsylvania	1981	Y	SC	4595	5	16	5	65	32	33
Rhode Island	Y	Y	N	429	-	1	1	3	-	3
South Carolina	N	Y	N	555	1	2	1	4	-	4
South Dakota	N	Y	N	142	2	-	-	1	-	1
Tennessee	?	Y	Y	1154	-	1	4	17	8	9
Texas	N	N	N	3491	6	15	4	31	12	19
Utah	Y	Y	Y	540	2	3	1	11	3	11
Vermont	Y	Y	Y	331	1	6	-	1	-	7
Virginia	N	Y	N	2024	2	2	6	38	10	28
Washington	N	Y	N	1707	4	7	2	28	10	18
West Virginia	Y	Y	Y	264	-	-	-	2	-	2
Wisconsin	N	Y	Y	1319	1	4	-	14	5	9
Wyoming	Y	Y	N	150	-	4	-	3	-	3

\*no child custody



SHOW CAUSE CASES as a % of membership in states with more than 1000 members, 1995-2000

STATE	APA MEMBERS	EC SHOW CAUSE CASES	SHOW CAUSE CASES as % of members
Georgia	1857	11	0.0059
North Carolina	1841	8	0.0043
California	11,610	44	0.0038
Arizona	1274	4	0.0031
Connecticut	1598	4	0.0025
Ohio	2941	7	0.0024
Washington	1707	4	0.0023
New Jersey	3161	7	0.0022
Colorado	1617	3	0.0019
Texas	3491	6	0.0017
Missouri	1378	2	0.0015
Michigan	2776	4	0.0014
Minnesota	1529	2	0.0013
Illinois	3921	5	0.0013
Pennsylvania	4595	5	0.0011
Virginia	2024	2	0.0010
Indiana	1210	1	0.0008
Florida	3633	3	0.0008
New York	9717	8	0.0008
Maryland	2458	2	0.0008
Wisconsin	1319	1	0.0008
Massachusetts	4352	3	0.0007
Tennessee	1154	0	0.0000

**SUA SPONTE CASES as a % of membership in states with more than 1000 members, 1995-2000**

<b>STATE</b>	<b>APA MEMBERS</b>	<b>EC SUA SPONTE CASES</b>	<b>SUA SPONTE CASES as % of members</b>
Colorado	1617	23	0.0142
Minnesota	1529	15	0.0098
Arizona	1274	11	0.0086
Connecticut	1598	12	0.0075
California	11,610	76	0.0065
Illinois	3921	23	0.0059
Missouri	1378	6	0.0044
Georgia	1857	8	0.0043
Texas	3491	15	0.0043
Florida	3633	15	0.0041
Washington	1707	7	0.0041
Pennsylvania	4595	16	0.0035
Ohio	2941	10	0.0034
Michigan	2776	9	0.0032
Wisconsin	1319	4	0.0030
New Jersey	3161	9	0.0028
North Carolina	1841	5	0.0027
Indiana	1210	3	0.0025
New York	9717	22	0.0023
Massachusetts	4352	8	0.0018
Virginia	2024	2	0.0010
Tennessee	1154	1	0.0009
Maryland	2458	2	0.0008

**SUA SPONTE + SHOW CAUSE CASES as a % of membership in states with more than 1000 members, 1995-2000**

STATE	APA MEMBERS	SHOW CAUSE + SUA	SHOW CAUSE + SUA SPONTE as % of members
Colorado	1617	26	0.0161
Arizona	1274	15	0.0118
Minnesota	1529	17	0.0111
California	11,610	120	0.0103
Georgia	1857	19	0.0102
Connecticut	1598	16	0.0100
Illinois	3921	28	0.0071
North Carolina	1841	13	0.0071
Washington	1707	11	0.0064
Texas	3491	21	0.0060
Missouri	1378	8	0.0058
Ohio	2941	17	0.0058
New Jersey	3161	16	0.0051
Florida	3633	18	0.0050
Michigan	2776	13	0.0047
Pennsylvania	4595	21	0.0046
Wisconsin	1319	5	0.0038
Indiana	1210	4	0.0033
New York	9717	30	0.0031
Massachusetts	4352	11	0.0025
Virginia	2024	4	0.0020
Maryland	2458	4	0.0016
Tennessee	1154	1	0.0009

COMPLAINANT CASES as a % of membership in states with more than 1000 members, 1995-2000

STATE	APA MEMBERS	COMPLAINANT CASES	COMPLAINANT CASES as % of members
Tennessee	1154	4	0.0035
Arizona	1274	4	0.0031
Virginia	2024	6	0.0030
Michigan	2776	8	0.0029
Maryland	2458	6	0.0024
Florida	3633	8	0.0022
Missouri	1378	3	0.0022
Illinois	3921	8	0.0020
California	11,610	23	0.0020
Colorado	1617	3	0.0019
New York	9717	18	0.0019
Minnesota	1529	2	0.0013
New Jersey	3161	4	0.0013
Connecticut	1598	2	0.0013
Washington	1707	2	0.0012
Texas	3491	4	0.0011
Pennsylvania	4595	5	0.0011
Indiana	1210	1	0.0008
Ohio	2941	2	0.0007
Georgia	1857	1	0.0005
Massachusetts	4352	2	0.0005
North Carolina	1841	0	0.0000
Wisconsin	1319	0	0.0000

**Randolph P. Reaves, “Destroying the Myths  
about Psychology Regulatory Boards”**

## **Destroying The Myths About Psychology Regulatory Boards**

**Randolph P. Reaves, J.D.**  
**American Psychological Association**  
**August 6, 2000**

The profession of psychology is now regulated in fifty-four U.S. jurisdictions and eleven Canadian provinces. The regulation is not completely consistent since a significant percentage of regulatory laws protect only the title, not the practice of the profession.

Of these sixty-five jurisdictions in the U.S. and Canada, sixty-two belong to the Association of State and Provincial Psychology Boards (ASPPB). In 1983, ASPPB created its Disciplinary Data System and for the past eighteen years has solicited, from its member boards, all disciplinary sanctions, greater than a reprimand, issued against a licensee.

In the early years, reporting to the ASPPB Disciplinary Data Bank was sporadic and inconsistent. However, since 1990, reporting to the data bank has become a routine matter for the vast majority of psychology regulatory boards. Only a handful fail to make timely reports if a disciplinary sanction is issued against a license. And the member boards have, for the most part, been cooperative in producing historical disciplinary data. There are approximately 2,400 sanctions in the data bank. Those who have studied the contents of the data bank are convinced it contains 90-95% of all the sanctions, greater than a reprimand, ever issued by a psychology regulatory board in the two countries.

For more than a decade, the ASPPB Central Office staff have collected the disciplinary data, organized it, and re-distributed the collective data to all the member jurisdictions on a quarterly basis. Other entities such as the APA Ethics Committee also received the collective, organized data reports. Periodically, the data on sanctions is tabulated and the top ten reasons for disciplinary sanctions are identified.

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## REPORTED DISCIPLINARY ACTIONS FOR PSYCHOLOGISTS

August 1983 - April 2000

Compiled from actions reported to the ASPPB Disciplinary Data System by  
ASPPB member boards.

<b><u>Reason for Disciplinary Action</u></b>	<b><u>Number Disciplined</u></b>
Sexual/Dual Relationship with patient.....	709
Unprofessional/unethical/negligent practice.....	654
Conviction of crimes.....	190
Fraudulent acts.....	166
Breach of confidentiality.....	97
Inadequate or improper supervision.....	93
Improper/inadequate record keeping.....	90
Impairment.....	88
Fraud in application for license.....	47
Failure to comply with continuing education requirements.....	42
TOTAL.....	2,176*

\* The difference in the total number of reported disciplinary actions (2,362) and this total is that some jurisdictions do not report reasons or the reason reported does not fall into one of the above listed categories.

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The fastest growing reason for disciplinary sanctions is failure to comply with continuing education requirements. For example, in 1998 and 1999, the state of Pennsylvania issued 36 sanctions to licensees. Of those, 19 were for failing to obtain required CE credits.

**Myth #1      The psychology regulatory boards in the U.S. are out of control and are issuing far too many sanctions against licensees.**

Of all the myths about ASPPB and its member boards, this is the most outrageous. It can be totally debunked by simply reviewing the number of sanctions, greater than a reprimand, issued by

the regulatory boards. For example:

A. Some jurisdictions in the U.S. and Canada have never reported a disciplinary sanction to the ASPPB Disciplinary Data Bank:

1. District of Columbia; Guam; New Brunswick, Saskatchewan

B. Fifteen other boards have reported fewer than ten sanctions:

1. Alaska, Alberta, British Columbia, Manitoba, Montana, Newfoundland, North Dakota, Rhode Island, South Dakota, West Virginia, and Wyoming

The figures would be interesting if the regulation of psychologists was a recent phenomenon. Such is not the case.

<b>Jurisdiction</b>	<b>Year of Original Licensure</b>	<b>Disciplinary Sanctions Reported</b>	<b>Current # of Licensees</b>
Connecticut	1945	33	1,406
Virginia	1946	38	1,937
Georgia	1951	31	1,536
New York	1956	101	14,000
Maryland	1957	27	2,700
Ontario	1960	32	2,311
Florida	1961	51	3,886

To some these figures are shocking, particularly in light of the most common reasons for sanctions. Number one on the list is sexual misconduct. Many readers will recall the studies conducted by Holroyd and Brodsky during the seventies. In 1973, 5.5% of male psychologists reported sexual intercourse during therapy and 0.6% of females reported the same. In the 1977 follow-up study, within three months of the termination of therapy an additional 2.6% of males reported sexual intercourse with "former" clients and an additional 0.3% of female psychologists



reported sexual intercourse. How many psychologists are currently impaired due to alcohol, drugs, depression, stress, bipolar disorder and/or a host of other debilitating causes?

Granted these numbers change when the more recent years are analyzed. For many of the aforementioned jurisdictions the number of sanctions have increased in the last half of the nineties. Still compared to the number of years of practice involved, the numbers are still low.

<b>Jurisdiction</b>	<b>Disciplinary Sanctions Reported During 1995-1999</b>	<b>Current Number of Licensees</b>
Connecticut	24	1,406
Virginia	16	1,937
Georgia	16	1,536
New York	48	14,000
Maryland	7	2,700
Ontario	6	2,311
Florida	17	3,886

In an abundance of fairness we can compare the number of disciplinary actions for the top seven and the bottom seven.

<b>Jurisdiction</b>	<b>Year of Original Licensure</b>	<b>Disciplinary Sanctions Reported</b>	<b>Current Number of Licensees</b>
California	1957	387	17,500
Minnesota	1951	152	3,697
Michigan	1959	132	6,361
Texas	1969	130	5,125
Ohio	1972	119	3,896
New York	1956	102	14,000
Illinois	1963	99	5,593
Rhode Island	1969	2	441

North Dakota	1967	1	189
District of Columbia	1975	1	1,200
Newfoundland	1985	1	200
Guam	1987	0	8
New Brunswick	1967	0	241
Saskatchewan	1962	0	92

These numbers can be compared in yet another way. Compare them over time by number of disciplinary actions per 100 licensed psychologists.

<b>Jurisdiction</b>	<b>Year of Original Licensure</b>	<b>Number of Disciplinary Actions</b>	<b>Number of Licensees</b>	<b>Number Per 100 Licensees</b>
Vermont	1975	29	535	5.42
Iowa	1975	23	470	4.89
New Hampshire	1957	29	598	4.85
Maine	1953	25	545	4.59
Oklahoma	1965	25	545	4.59
Oregon	1963	44	1,021	4.31
Alabama	1963	26	608	4.28

Rhode Island	1969	2	441	0.45
British Columbia	1977	4	1,014	0.39
Alberta	1960	4	2,072	0.19
District of Columbia	1975	1	1,200	0.08
Guam	1977	0	8	0.00
New Brunswick	1967	0	241	0.00
Saskatchewan	1962	0	92	0.00

**Myth #2      The California Board of Psychology is on a witch hunt.**

There are over 17,500 licensees in the state of California. That jurisdiction has been licensing psychologists since 1957. To date, 387 sanctions have been reported and the first reported sanction was not received by the ASPPB Disciplinary Data Bank until July, 1988. When the psychology regulatory boards are compared by the number of disciplinary sanctions per 100 licensed psychologists, California ranks 32nd on the list with 2.19 sanctions per 100 licensees. In fact, during calendar year 1998 only 23 sanctions were issued and in 1999 only 35 were issued.

Critics will argue that these figures are meaningless without information on the number of complaints received. That information is not available in many jurisdictions. California does compile this data, but compiles it by the state's fiscal year (FY). For FY 97-98 the California Board of Psychology received 521 complaints and opened 141 investigations. Of those, 65 cases were sent to the Attorney General for further proceedings. In FY 1998-99 that board received 520 complaints and 122 investigations were opened. That fiscal year, 62 cases were sent to the Attorney General.

**Myth #3      Psychology regulatory boards are extremely punitive when issuing sanctions.**

This myth should have been debunked completely by the recent series of articles appearing in the Cleveland Plain Dealer in December, 1999. Some of the more interesting headlines:

- ◆ Psychology's dysfunctional discipline
- ◆ Complaints to board languish
- ◆ Disciplined psychologists face few consequences
- ◆ Regulators spare rod, try to heal psychologists
- ◆ Healers who need healing
- ◆ Penalty sought for therapists who seduce - state senator wants abuse made a felony

Ohio is not the only state whose board was taken to task for leniency in dealing with licensees. The reporter gained access to most of the ASPPB Disciplinary Data Bank. The examples utilized to buttress his theory that psychologists face few consequences for misconduct came from a dozen jurisdictions. It is also worthy to note that when it became known that the Nevada board had

attempted to sanction a former board member in secret, consumer advocates were outraged. One of the more interesting states in terms of discipline is Colorado. With 60 disciplinary sanctions and 1790 licensees it ranks 13th on ASPPB's list of number of disciplinary sanctions per 100 licensed psychologists. However, of those 60 sanctions, 28 are letters of admonition (LOA). An LOA is strikingly similar to a reprimand, although Colorado insists it's not. If the LOA's are deleted, Colorado drops to 34th on the ASPPB list.

**Myth #4      Psychology regulatory boards are issuing large numbers of sanctions for complaints arising from child custody disputes.**

This myth has been growing by leaps and bounds for no legitimate reason whatsoever. If the small number of sanctions in most jurisdictions doesn't dispel this myth, a study by Kirkland and Kirkland should do so. Accepted for publication by *Professional Psychology: Research and Practice*, the study reveals that 34 of the ASPPB member boards responded in 1998-99 to a survey regarding child custody complaints. In those 34 jurisdictions, between January, 1990, and August, 1999, there were a total of 2,413 complaints filed against licensed psychologists involving child custody evaluations. Of those 2,413 complaints, only 27 or 1.1% resulted in findings of formal fault or probable cause against licensees. Disciplinary sanctions ranged from requiring continuing education in the area of child custody evaluations to five years probation. Of the 2,413 complaints, 1,660 were received by the California Board of Psychology and those resulted in 1 actual disciplinary sanction. It should also be noted that in 1998, the Colorado legislature passed a statute prohibiting child custody evaluations from being the subject of discipline by the state psychology board.

**Myth #5      Psychology regulatory boards do not afford licensees due process of law.**

All professional licensees, whether they be accountants, pharmacists, physicians or psychologists are protected, not only by the due process clause of the U.S. Constitution, but by a similar clause in each state's constitution. More importantly, every U.S. jurisdiction has passed an administrative procedure act that provides additional legal protections for all licensees. These "due process" rights include:

- 1) Adequate notice of the charges

- 2) An opportunity for a hearing
- 3) A fair and impartial tribunal
- 4) The right to be represented by counsel
- 5) The opportunity to confront and cross-examine adverse witnesses
- 6) The ability to compel the attendance of witnesses
- 7) A decision based on the evidence presented
- 8) A record of the proceedings
- 9) Judicial review of the agency's decision

Given the numbers previously cited, it would be far easier for consumer advocates to make a case that psychology boards are protecting psychologists rather than the public. Just as important, in many jurisdictions, particularly the larger states ie., California, Florida, New York, the fairness of the process is controlled by Administrative Law Judges (ALJs), not the psychology regulatory boards. Those ALJs are responsible for seeing that constitutional and statutory protections are enforced. If the current statutory protections are insufficient, it is the responsibility of the legislature, not the psychology regulatory boards to add to them. The number of lawyers truly qualified to deal with regulatory complaints is very small. It is much more likely that many psychologists choose lawyers unfamiliar with the processes involved who don't adequately protect their clients' rights.

Of the mini-myths within Myth #5 is the claim that appellate review of psychology board decisions is non-existent. Note a number of recent decisions rendered by appellate courts across the U.S.

Aguilera v. Dept. of Health, Board of Psychology, 743 So. 2d 1153 (Fla.App. 3 Dist. 1999). (Appropriateness of education and training).

Batoff v. State Board of Psychology, 718 A.2d 364 (Pa.Cmwlth.1998); rev'd. 750 A.2d 835 (Pa.2000). (Sufficiency of proof of negligence).

Caddy v. Florida Dept. of Health, Board of Psychology, 2000 WL 282539 (Fla. App. 1 Dist.) (Sexual misconduct - striking down the perpetuity rule).

Elliott v. North Carolina Psychology Board, 498 S.E. 2d 616 (N.C. 1998). (Sexual misconduct).

Poliak v. Board of Psychology, 63 Cal. Rptr. 2d 866 (Cal. App. 3 Dist. 1997) (Sexual

misconduct).

Schultz v. Minnesota Board of Psychology, 1999 WL 1101219 (Minn.App.) (Supervised experience issue).

Each of these decisions reversed a board's decision. And these are the cases that appear in the appellate reporters. It should be noted that the majority of all disciplinary cases against psychologists are resolved informally through guilty pleas and/or consent orders which are not appealed. Of those decisions that are appealed, a significant number will be reversed or modified by a trial court and will not appear in an appellate reporter.

### **Conclusion**

The profession of psychology is regulated throughout the U.S. and Canada by state and provincial psychology boards. Those boards are charged with the responsibility of protecting the public, not the profession. In reality, there are very few disciplinary sanctions issued against psychologists. The myths that psychology regulatory boards are out of control and overly punitive are simply not supported by existing data. They are nothing more than myths.

## **Table, Comparison of Peer Review Processes**

# Comparison of Peer Review Processes

Step or Item	AAMFT	ACA	NASW	Psychiatrists	Psychologists
<i>Code of Ethics Name/Date</i>	<u>AAMFT Code of Ethics, 1998</u>	<u>ACA Code of Ethics, 1995</u>	<u>NASW Code of Ethics, 2000</u>	<u>The Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry, 1998</u>	<u>Ethical Principles of Psychologists and Code of Conduct, 1992</u>
<i>Who manages the Peer Review Process?</i>	Staff at national office	Ethics Committee Liaison (natl staff)	Chapter Executive or staff, and national office staff. The process is managed primarily at the chapter level	National and regional staff and volunteers.  The review process is almost exclusively regional	Staff at national office
<i>How far back in time can a complaint reach?</i>	No limit	No specific guidance	1 year - Ethics 6 mo - Personnel Standards/Professional Action Some exceptions	No limit	Generally, no more than ten years (exceptions may be allowed), dependent on nature and source of complaint.
<i>May a complaint be lodged against a member who was not a member at the time of the alleged infraction?</i>	Yes	No	No	No	No



Step or Item	AAMFT	ACA	NASW	Psychiatrists	Psychologists
# of members	22,000	55,000	155,000	40,000	160,000
Cases per year					
1993					113
1994	90		115		129
1995	78		87		118
1996	44	18 cases currently open, spanning two years	95	Currently, approximately 150-200 open cases.	89
1997	49		81		121
1998	74		93		85
1999	44		72		The above represents # of new complaint forms, not "show cause".
	The above represent # of new complaint forms, not "show cause"		61		
# of staff in process	2	.5	2.6	1 Full time	12
How many organizational levels does the peer review process involve?	3	2	3	3	3
What levels?	-Ethics Committee -Judicial Committee -Board of Directors	-Ethics Committee -Appeal Board	-Local chapter -National Committee On Inquiry (NCOI) -Executive Committee	-District -National Ethics Committee -Appeals Board -Board of Trustees (for expulsions only)	-Staff/chair or vice-chair of the Ethics Committee. -Board of Directors -Standing hearing panel committee
How long from start to finish? <sup>1</sup>	Approximately 1 year	Approximately 1 year	Approximately 1 year	Approximately 1 year	Approximately 1 year

<sup>1</sup> Most organizations' processes exceed one year for many cases. Some cases are handled in a short period of time. Their procedures note the intention to limit the process to approximately one year.

Step or Item	AAMFT	ACA	NASW	Psychiatrists	Psychologists
<i>How are complaints reviewed for acceptance?</i>	Staff and Ethics Committee chair review for acceptance Staff review for jurisdiction and merit. Staff prepare recommendations to Ethics Comm. and Chair based on the Code and Precedent. Only Ethics Comm and/or Chair have authority to open a case.	Staff reviews for membership. Ethics chair approves, rejects, requests information	Committee on Inquiry reviews against criteria for acceptance	District Branch Ethics Committee reviews for acceptance/rejection	Staff reviews for correctness, etc. Staff and Ethics chair review for "fit" with Code. Staff sends recommendations to chair or vice-chair of ethics committee
<i>Consultants to parties?</i>	No mention	No specific mention	Yes – can be offered to both parties	District branch can assign ombudsmen	
<i>Is the procedure on the Web?</i>	Yes. <a href="http://www.aamft.org">www.aamft.org</a>	Yes. <a href="http://www.counseling.org">www.counseling.org</a>	No. The Code of Ethics is.	Yes. <a href="http://www.psych.org">www.psych.org</a>	Yes <a href="http://www.apa.org/ethics">www.apa.org/ethics</a>
<i>How often are complaints reviewed for acceptance?</i>	Processed as received. Ethics Committee meets twice yearly	Staff reviews as they are received. Committee meets twice yearly	Processed as received	As needed	Processed as received

Step or Item	AAMFT	ACA	NASW	Psychiatrists	Psychologists
<i>What decisions can be appealed?</i>	Judicial Comm. Decisions: serious procedural irregularities or impaired member defense; Ethics Comm. Decisions: Inaccurate findings of fact; Findings not sonsonant with facts; Recommended actions not appropriate; Procedural irregularities	Ethics committee decisions Complainant has no appeal rights	Acceptance or rejection of case Panel Report Termination of an inquiry Decision to proceed against the wishes of complainant and respondent NCOI decisions Adverse chapter ruling on respondents' request to have sanctions lifted	Decision of Ethics Committee (district branch –reviewed by national) Complainant has no appeal rights except when case is not investigated by District branch – can request review by APA secretary	Ethics Committee recommendations (not technically an appeal – but can request hearing or panel)  Complainant has no appeal rights except for submission of significant new evidence.

	actions are inappropriate -Procedural irregularities				
<i>What are the conditions for appeals?</i>	Judicial Committee decisions: serious procedural irregularities or impartial member defense Ethics committee: Inaccurate findings of fact; findings not consonant with facts; recommended actions are inappropriate; procedural irregularities	Decision was "arbitrary or capricious": Serious procedural errors were made	Serious departure from procedure Findings of fact were inaccurate Conclusions reached by panel were inconsistent with findings of fact New evidence Inappropriate recommendations	Procedural irregularities Improper application of ethics principles Findings or sanctions not supported by evidence New evidence	Responses are allowed throughout the process, and levels of review are part of the process
<i>What is the organization's relationship with regulatory boards?</i>	AAMFT presumes that regulatory board decisions are correct, and can take action based on them unless the member demonstrates that the investigative process was seriously flawed, or the action taken was too severe for the infraction.	When regulatory board action is reported, ACA informs the member that information has been received, and invites their response for the file. No further action is taken.	Variable among chapters and state boards NASW chapters may process board actions as surrogate complaints.	Reports are made to regulatory boards when required by state or federal laws or regulations, or as an outcome of the process.	APA has "show cause" procedures which allow APA to take action against the member who has been disciplined or convicted, unless s/he provides compelling reasons why they should not.

Final informational notes

It appears that some, if not all organizations surveyed, may retain complaint documentation filed against non-members as well as members against whom complaints have been made. (NASW's procedures require that membership status is verified before a case is opened. Materials are sent back to the complainant if the individual against whom allegations are made is not a member.

In those instances where a hearing is conducted, it appears that the costs of travel and attendance at these hearings must be borne by the parties. The procedures do not note that any financial assistance is available to the parties.

Step or Item	AAMFT	ACA	NASW	Psychiatrists	Psychologists
<i>Does the organization maintain a peer review database?</i>	Yes – Access	Yes	Partial	In process	Yes
<i>Other information</i>		ACA provides ethics consulting for a fee to non members, free to members  Cyber counseling standards are being drafted		APA has a 4 page article that describes the PR process for the complainant	
<i>When is the respondent advised of complaint?</i>	After acceptance as complaint	After acceptance as complaint, and all complainant's materials are complete	After the Request for Professional Review has been filed	After acceptance as complaint	After acceptance as complaint
<i>What changes to the process are being contemplated?</i>	Considering a ten year statute of limitations	Process is under review – considering modifications which may create a pool of panelists		Some discussion of abolishing the process and referring all complaints to state licensing boards	Additional staff requested

#### Final informational notes

It appears that some, if not all organizations surveyed, may retain complaint documentation filed against non-members as well as members against whom complaints have been made. (NASW's procedures require that membership status is verified before a case is opened. Materials are sent back to the complainant if the individual against whom allegations are made is not a member.

In those instances where a hearing is conducted, it appears that the costs of travel and attendance at these hearings must be borne by the parties. The procedures do not note that any financial assistance is available to the parties.

# **Summary, Peer Review Processes**



**Summary of Peer Review Processes**  
**American Association for Marriage and Family Therapy, American Counseling**  
**Association, American Psychiatric Association and American Psychological**  
**Association**

The following are very brief summaries of the ethics complaint investigation procedures used by four organizations with some similarities to NASW. The summaries have been reviewed and revised by representatives of the organizations. Although this review provided some assurance that the information is correct, the summaries cannot capture the depth, intricacies and nuances of the processes.

**American Association for Marriage and Family Therapy (AAMFT)**

The AAMFT procedures for investigating ethics complaints against its members primarily involve a "paper review" process. Complaints may be lodged by members of AAMFT, non-members of the AAMFT Ethics Committee. In all but those cases which are filed by the AAMFT Ethics Committee, the complainant must have personal knowledge about the issue, or be able to provide relevant testimony related to it.

In the event a member has been disciplined by a regulatory body, the AAMFT presumes that the conclusions reached regarding the member are true, and offers the member an opportunity to "demonstrate evidence to overcome this presumption." To overcome this presumption, the member must demonstrate either: the investigative process was flawed and resulted in an incorrect outcome, or that the action taken was too severe for the type of infraction.

Upon receipt of a complaint alleging violations of the AAMFT Code of Ethics ("Code"), ethics staff review for jurisdictions, filing deadlines, merit and precedent. For a case to proceed, complainants must waive therapist-client privilege and permit the use of their name and provision of a copy of the allegations to the respondent member. All applicants and members are held to the Code, as are resigned members for one year after resignation. If the complaint is judged to have merit under the Code, staff draft charges and present the case to the Chair of the Ethics Committee for consultation and approval or modification. The Ethics Committee, usually acting through the Chair, has the sole authority to make charges against respondents. Once the respondent is charged, the full investigative process is engaged and the complainant is notified. The respondent is required to address the allegations and present a defense within thirty days. If the respondent resigns in anticipation of, or during the course of an ethics investigation, the Ethics Committee will complete its investigation. Any publication of action taken by the Association will include the fact that the respondent attempted to resign during the investigation. At any point in the process, the Chair of full Ethics Committee may close the case for lack of merit or hold it in abeyance if the allegations appear to be more appropriately handled by another professional, civil or regulatory body.

When case materials are complete. Staff prepare and present them to the Ethics Committee for deliberation. Only the full Committee can make a finding that a violation

has occurred. "Preponderance of evidence" is the standard of proof, and no respondents or witnesses attend Committee meetings, which are held each spring and fall. The Committee is composed of four Clinical Members and two public members.

For the most serious violations, the Committee may recommend a permanent termination of membership, which is the only sanction that is made public. For lesser violations, the Committee may seek rehabilitation of the respondent through a "mutual settlement" in which the respondent agrees to mandated education, supervision, therapy, suspension or other actions. If the respondent is an applicant, the Committee makes a report to the Standards Committee recommending that the application proceed or be denied. The Committee also issues warnings or reprimands as deemed appropriate. Respondents found in violation of the Code have the right to a hearing before the AAMFT Judicial Committee. If an appeal hearing is not requested, the Ethics Committee's findings and sanctions become final.

If the Judicial Committee's Hearing Panel conducts a hearing, the Ethics Committee will present the charges against the member. At the hearing, the Ethics Committee and the respondent may be assisted by counsel, present witnesses, cross-examine witnesses and make brief opening and closing statements. An audiotape will be made of the hearing. The Ethics Committee has the burden of proving the charges against the member, by a preponderance of the evidence. The Hearing Panel will issue a decision within 30 days, indicating whether or not a violation was found, and if violation is found, ordering action to be taken.

The respondent may appeal to the Board of Directors if he/she believes that procedural irregularities impaired his or her defense. The Board will rule on the appeal at its next meeting, based on the written appeal request from the respondent and the response from the Judicial Committee or AAMFT's legal counsel. The Board may affirm the Judicial Committee's decision or order a new hearing.

AAMFT's web site provides guidance regarding how to file a complaint.

### **American Counseling Association (ACA)**

ACA's ethics-complaint investigation process is primarily a paper review process. If ACA receives notification from the American Association of State Counseling Boards that the National Board for Certified Counselors and/or a state mental health counseling board has taken disciplinary action against a member, it notifies the member of this communication, invites the member to send documentation for the ACA file, but usually does not take further action (the Committee does reserve the right to do so. When a complaint is filed against a member, the respondent ("accused") has an opportunity to provide rebuttal information to the complaint, and to appeal the decision by the Ethics Committee.

It is managed by a staff person (the Ethics Committee Liaison) at the National ACA office, in coordination with ACA's Ethics Committee. When a complaint is received, it is reviewed by the Ethics Committee Liaison who verifies the membership of the accused, and acknowledges receipt of the complaint to the complainant. The Ethics Committee co-chair reviews and accepts, rejects or returns the complaint for further information. If the complaint is rejected, the complainant is notified. If further information is required to determine the eligibility of the complaint, the Liaison requests this from the complainant. If it is accepted, potential ethics code violations are identified, a formal statement is drafted by the Liaison, and a release of information, verification affidavit and the formal statement are sent to the complainant for signature. When these forms are received, the respondent is sent copies of all forms and evidence. The respondent can then send a response, and identify witnesses and evidence for review by the Ethics Committee. The Liaison sends the formal statement, evidence from the complainant and respondent and the accused's written response to the Ethics Committee for its review.

The Ethics Committee can request a hearing to gather additional information. Further, the accused may request a hearing, and bears the expense related to appearing before the Committee. When deliberations are handled via regular Ethics Committee meetings, the Committee determines the outcome of the complaint at its next scheduled meeting. The Committee can dismiss the complaint, dismiss charges within the complaint, or impose sanctions. Sanctions may include: reprimand, continuing education, probation, suspension, expulsion, or other actions deemed appropriate by the Ethics Committee. The accused is notified of the Committee's decision and has the right to appeal. Once the period of time allowed for appeal has elapsed, the complainant is notified of the Ethics Committee action. If the accused believes that the Committee's decision was arbitrary or capricious, or alleges serious procedural errors, an appeal can be filed. The appeal is reviewed by a panel of three ACA members consisting of two former Ethics Committee members and one member of the ACA division to which the accused belongs.

ACA's procedures for handling ethics complaints are posted on the World Wide Web. ACA also provides ethics consultations to members as a membership benefit – a service

### **American Psychiatric Association (APA)**

Ethics complaints with APA are generally handled at the district branch level of APA. Exceptions to this local preference can be made for compelling reasons. After a complaint is filed, it is reviewed to determine if it should be accepted, rejected, or if further information is required in order to make a determination regarding its appropriateness. If the complaint is rejected, the complainant may appeal the rejection. If the complaint is accepted, the APA Secretary, respondent and complainant are advised of this. At this time the respondent is advised of rights to be represented by an attorney, the appear at a hearing, and to appeal an adverse decision.

The complaint investigation process includes interviews of the complainant and respondent, and may be conducted by one member of the Ethics committee. A hearing

will be conducted in all cases in which a decision adverse to the respondent is possible. (The respondent and complainant are generally required to be present unless the Committee has determined that there is sufficient extrinsic evidence with which to make a determination.) The hearing may be conducted by the district branch Ethics Committee or by a special panel of at least four members, one of whom must be a member of the district branch in which the respondent is a member. The respondent may represent him/herself or be represented by counsel at this hearing, and may introduce evidence, examine and cross-examine witnesses, and make opening and closing statements. The Complainant is generally expected to testify regarding his/her charges. A stenographic or tape recording is made of the hearing.

Once the investigation is complete, the Ethics Committee or panel recommendations are put in writing. Sanctions that may be recommended include: admonishment, reprimand, suspension, expulsion. The Committee or panel may also recommend conditions such as educational or supervisory requirements, and will specify monitoring procedures that ensure adherence to such recommendations. All recommendations and review information is then sent to APA's Ethics Committee for consideration of sanctions. The Committee may accept sanction recommendations or return the recommendation to the district for reconsideration. If the Committee accepts recommended sanctions, the respondent is so notified, and advised that she/he has the right to appeal. If Expulsion is recommended and accepted as a sanction, this must be approved by the APA Board of Trustees.

Appeals can be made by the respondent on grounds of significant procedural irregularities, improper application of Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry, insufficient evidence to substantiate imposed sanctions, or the provision of new evidence. Appeals are heard by a special Appeal Board comprised of The APA Secretary, two past Presidents of APA, a past Speaker of the APA Assembly, the chair of the APA Ethics Committee and a current chair of a district branch Ethics committee. The Ethics Appeals Board may: affirm the decision, alter the sanction, reverse the district's decision and terminate the case, or remand the case to the district with instructions for reconsideration.

Once the Ethics Appeals Board has reached a decision, the respondent and district branch are notified of its decision. If expulsion is recommended, the APA Board of Trustees will review the case based on a presentation by the APA Secretary or designee and the case documentation. The Board of Trustees may affirm expulsion, impose a lesser sanction or return the case to the Ethics Appeals Board for reconsideration.

Decisions are final when the Board of Trustees has acted or has approved action taken on the Appeal Board's reconsideration. The complainant is notified when the decision is final and all appeal options have been exhausted.

**American Psychological Association (APA)**

APA has two types of investigations: Show cause proceedings and reviews of alleged unethical behavior, according to the APA Ethics Committee's Rules and Procedures (1996). Both processes rely almost exclusively on reviews of written material.

*Show cause* procedures are used when a licensing body, court or association has taken serious action against an APA member. Under this procedure, a member-respondent is asked to explain why he or she should not be expelled from APA membership for reasons related to the action taken by the other body. After reviewing information provided by the respondent, the Ethics Committee ("Committee") recommends action to the Board of Directors ("Board"). Possible recommendations include: dismissal, reprimand, censure, "resignation under stipulated conditions," or expulsion. The respondent is provided an opportunity to submit a statement to the Board, and the Committee may submit a response to the respondent's statement. If a response is submitted by the Committee, the respondent will have a final opportunity to submit a statement, in response to the Committee's statement, to the Board. The Board will review the record, including the Committee's recommendation, any written response by the respondent, any statement submitted by the Committee, and any final statement submitted by the respondent. The Board "may select a sanction more or less severe than that recommended by the Committee, or it may remand the matter to the Committee for further consideration."

*Procedures for alleged violations of the Ethics Code* are used when members, nonmembers, or the Committee initiates complaints. Complaints are evaluated by the Director of the Ethics Office<sup>1</sup> ("Director") to determine whether they are complete, within the established time limits and within the jurisdiction of the Committee. Following this, the Director and the Chair<sup>2</sup> of the Committee review the complaint to determine whether there is "cause for action" to be taken by the Committee. If the jurisdiction and "cause for action" criteria are met, the Director opens a case, issues a charge letter to the respondent and opens an investigation. The respondent is requested to write a response to the charge letter. Additional information may be requested from the complainant, respondent or other sources during the investigative phase. The Committee Chair or Director may request that the respondent appear before the Committee, but the respondent does not have the explicit right to do so. When the investigation is complete, it is referred to the Committee for review. Once review is complete, the Committee may vote to take one of the following actions: 1) to dismiss the case or remand it for further investigation, or 2) to recommend sanctions such as reprimand, censure, stipulated resignation or expulsion. The Committee may also vote to issue an educative letter, with or without a recommended sanction.

If the Committee recommends reprimand or censure, the respondent is notified and given an opportunity to accept the recommendation or request an independent adjudication<sup>3</sup> based on the written record. The decision of the adjudication panel cannot be appealed. The complainant and respondent are notified in writing of the final outcome.

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<sup>1</sup> Director in this instance means Director of the Ethics Office or designee, such as staff investigator.

<sup>2</sup> Chair in this instance means Ethics Committee Chair or designee, such as Vice Chair.

<sup>3</sup> An independent adjudication is a paper review by a 3-person panel.

If the Committee recommends stipulated resignation, the respondent may accept the recommendation or reject the stipulated resignation. In the event the respondent rejects the stipulated resignation option, the Committee may make an alternative sanction recommendation. In most instances, the Committee will recommend a contingent action (such as expulsion) in the event the stipulated resignation is rejected.

If the Committee recommends expulsion, the respondent may accept the recommendation or request either a formal hearing,<sup>4</sup> or an independent adjudication. If a hearing is conducted, the respondent may be represented by an attorney. The Committee and the respondent may present witnesses, documents, evidence, object to the introduction of evidence, and cross-examine witnesses. The Committee bears the burden of proof, according to the standard of "preponderance of the evidence." If expulsion is recommended by either an independent adjudication panel or a hearing committee, the Board of Directors ("Board") will be responsible for taking final action. The Board can vote to adopt the recommendation to expel or to not adopt the recommendation to expel for the following reasons: a) incorrect application of the ethical standards, b) erroneous findings of fact, c) procedural errors, or d) excessive sanctions. In the event the Board votes not to adopt the recommendation to expel, the case will be remanded to the Committee, and the procedures for investigation described above will be repeated.

Essentially, this process allows review on two levels, and involves staff and the Committee in gathering information and determining the appropriateness of the case. It allows responses from the respondent upon issuance of the charge letter, throughout the investigation and when recommendations of sanctions are made. When a hearing committee or independent adjudication panel is convened, the respondent has the right to review and recommend hearing committee members. Decisions made by the independent adjudication process are unappealable. The complainant has no appeal rights, but is notified of the final decision in the matter.

**The National Association of Social Workers** considers Requests for Professional Review (RPRs) in three different categories: Ethics; Personnel Standards and Professional Action. Generally, NASW chapter Committees on Inquiry manage the professional review process for each individual RPR. Except in matters involving matters of national significance or possible local conflict of interest (such as a RPR involving a chapter Board member), the local Committee on Inquiry reviews the RPR and determines whether or not the matter meets basic acceptance criteria. If the COI accepts the RPR, the matter is thereafter considered a complaint and a hearing is scheduled to allow a panel of 3-4 members of NASW to examine evidence, listen to testimony, determine the facts, draw conclusions regarding the alleged violations, and make recommendations in keeping with the conclusions. These findings, conclusions and recommendations are summarized in a chapter report which is sent to the Respondent and Complainant.

Decisions to accept an RPR can be appealed to the National Committee on Inquiry. Chapter Reports and hearing panel conclusions and recommendations can be appealed to

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<sup>4</sup> A formal hearing is an in-person review before a 3-person hearing committee.

the National Committee on Inquiry (NCOI), and decisions by the NCOI (except acceptance or rejection of RPRs) can be appealed to the Executive Committee of the National Board of Directors. Executive Committee decisions on appeals are final.

RPRs regarding ethics may be considered if the respondent was a member of NASW at the time of the alleged violation, the alleged violation occurred or became known to the requester within one year of the RPR. Waivers of this time limit may be granted by the NCOI for matters involving serious allegations.

RPRs can be filed by members of NASW who allege that their employer violated the agency's written standards of personnel practices. The RPR will be considered if the request is made no more than 60 days after the alleged violation occurred, excluding the time during which reasonable efforts to use intra or extra-agency mechanisms to resolve the complaint were underway.

RPRs can be filed by members of NASW who allege that their agency imposed limitations on or imposed penalties for professional actions on behalf of clients. As with Personnel standards RPRs, The RPR will be considered if the request is made no more than 60 days after the alleged violation occurred, excluding the time during which reasonable efforts to use intra or extra-agency mechanisms to resolve the complaint were underway.

The mechanism for accepting RPRs is the same in all three categories: the chapter Committee on Inquiry examines the RPR and decides whether to accept or reject the RPR in keeping with certain threshold criteria. The Requester must be personally or directly affected by the alleged violation or have direct knowledge of the alleged violation, and be able to provide evidence and be willing to testify to support the allegations. A chapter member or chapter delegate may act as surrogate Requester when a member appears to have violated the Code of Ethics and information regarding this in a matter of public record. A person other than the individual with direct knowledge of the situation may serve as a substitute requester if the affected person is incapacitated, unavailable or a minor child, but only with NCOI permission. Acceptance of the case can be appealed to the NCOI. Once the case is accepted and appeals of acceptance exhausted, the chapter conducts a hearing

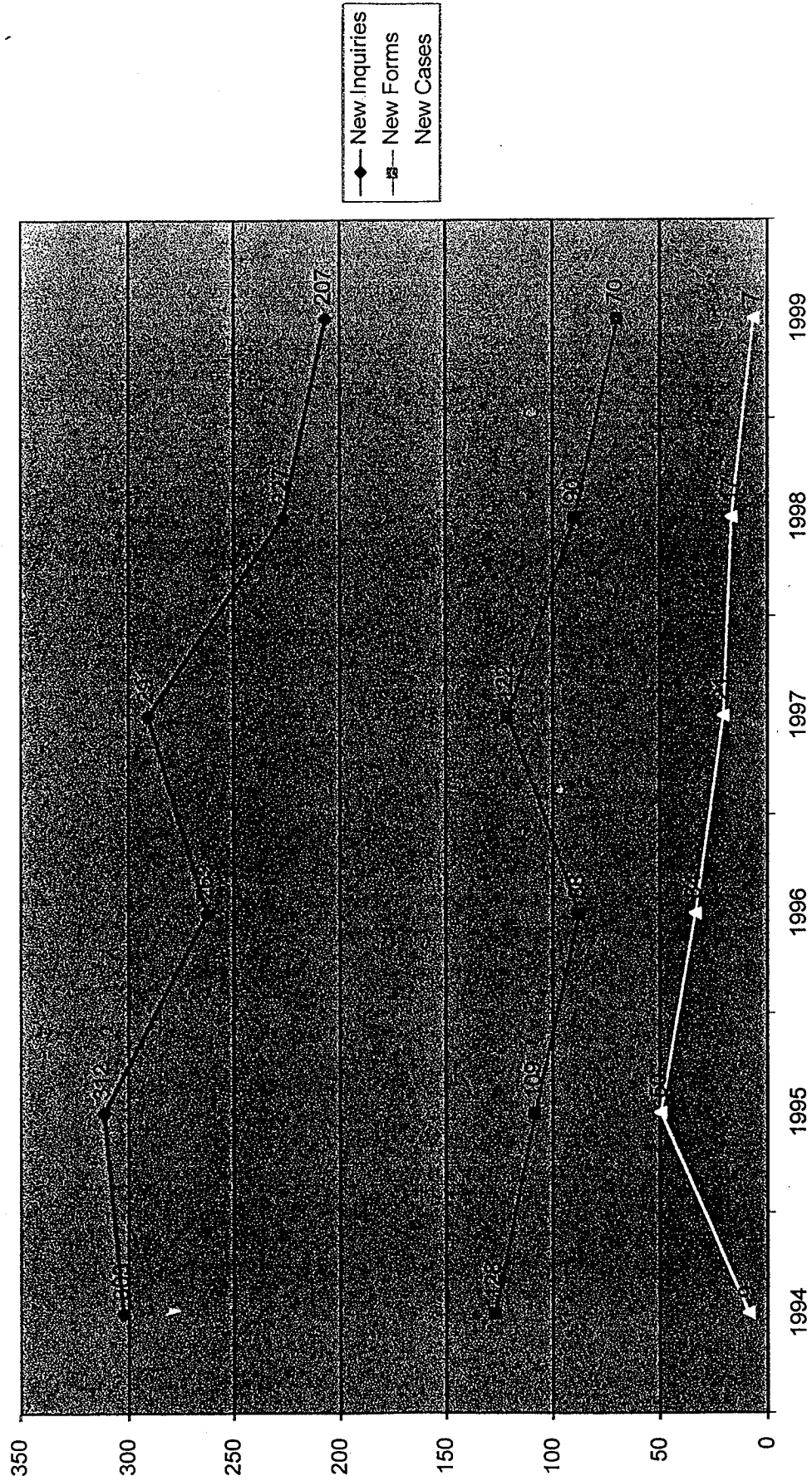
Recommendations in ethics complaints may include suggested corrective actions such as supervision and education and/or may call for sanctions such as notification of employers, regulatory boards, public notification in the chapter and national newsletter. Sanctions may not be put into effect until the Executive Committee of the national Board of Directors has given formal, written approval of the sanctions requested by the chapter.

**Prepared by: Maureen R. McGlone, MSW – NASW Office of Ethics and Professional Review.  
March, 1999**

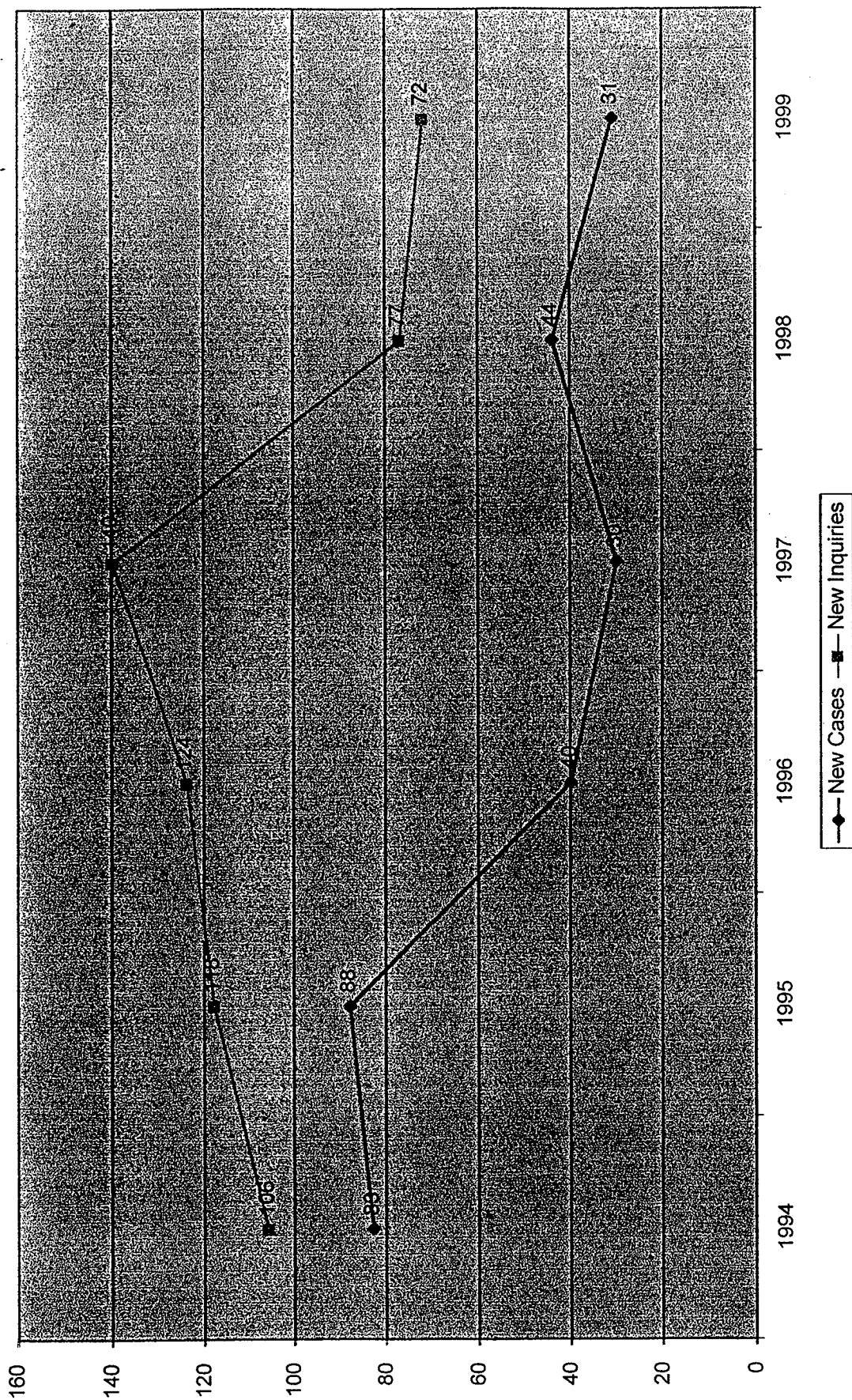


## **Graphs, Ethics Office Statistics, 1994-1999**

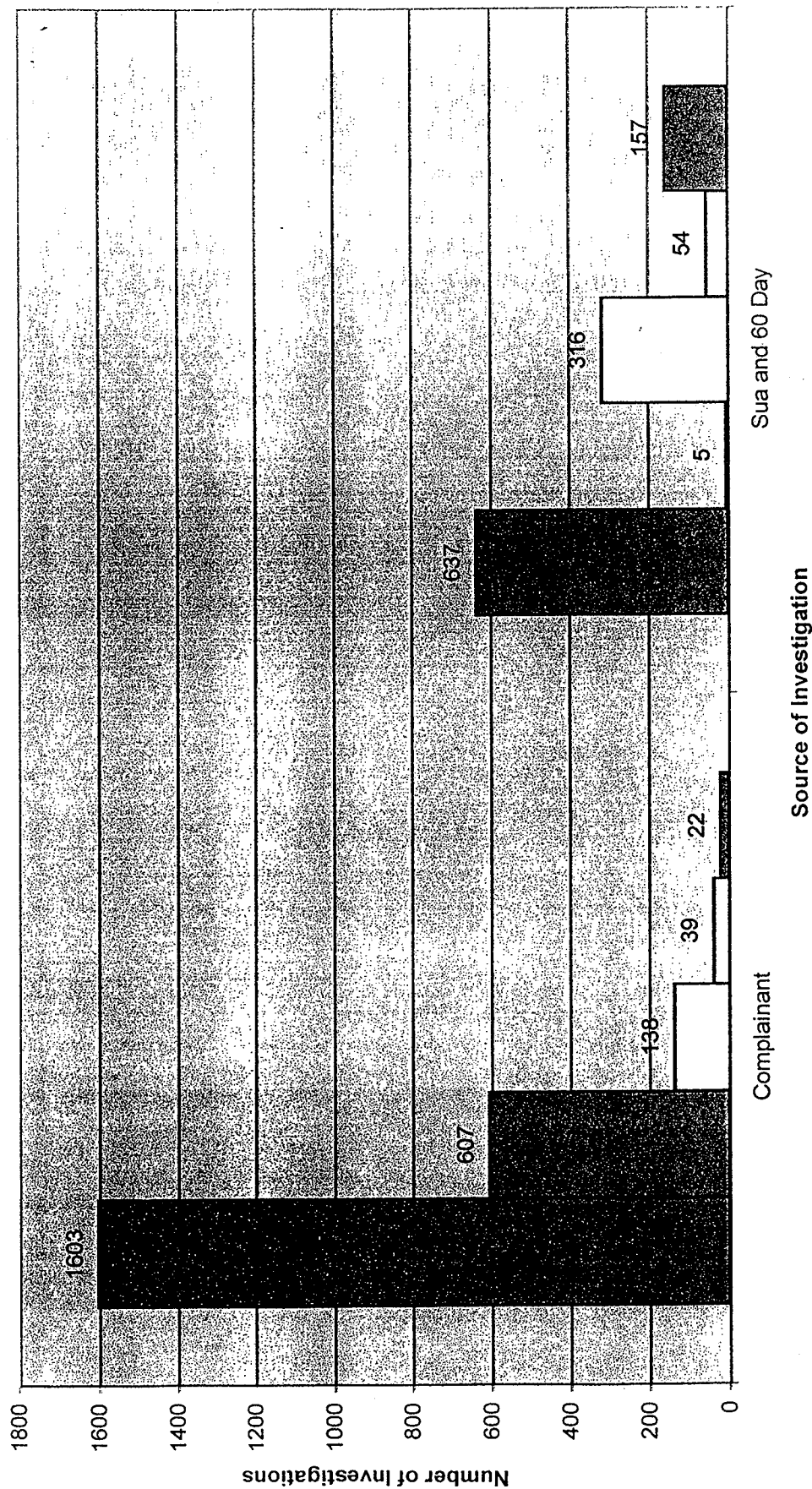
# Complainant Activity Inquiries, Forms Received, and Cases Opened 1994-1999



Sua Sponte and Show Cause Inquiries and New Cases

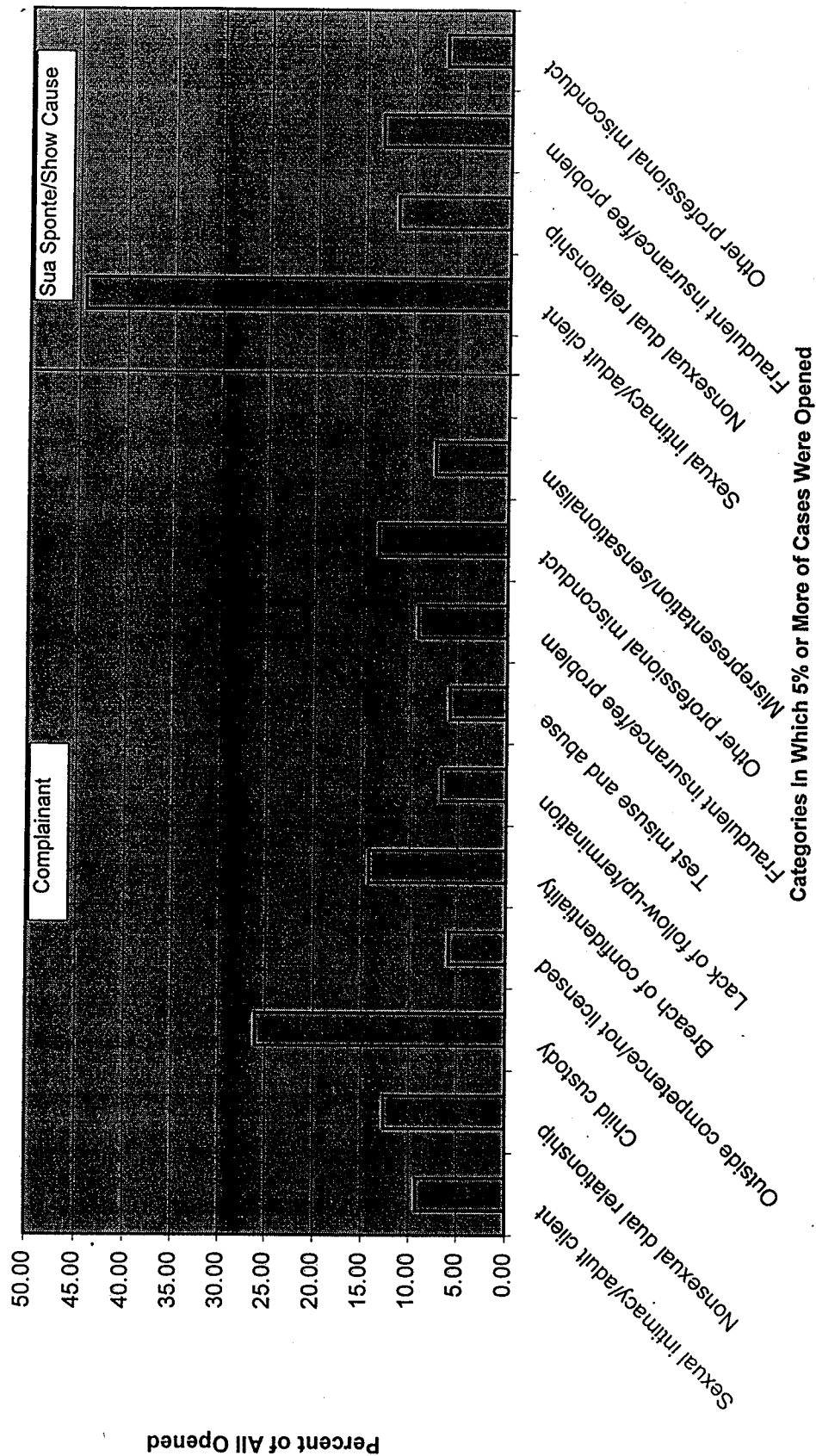


# Outcome of Investigations 1994-1999



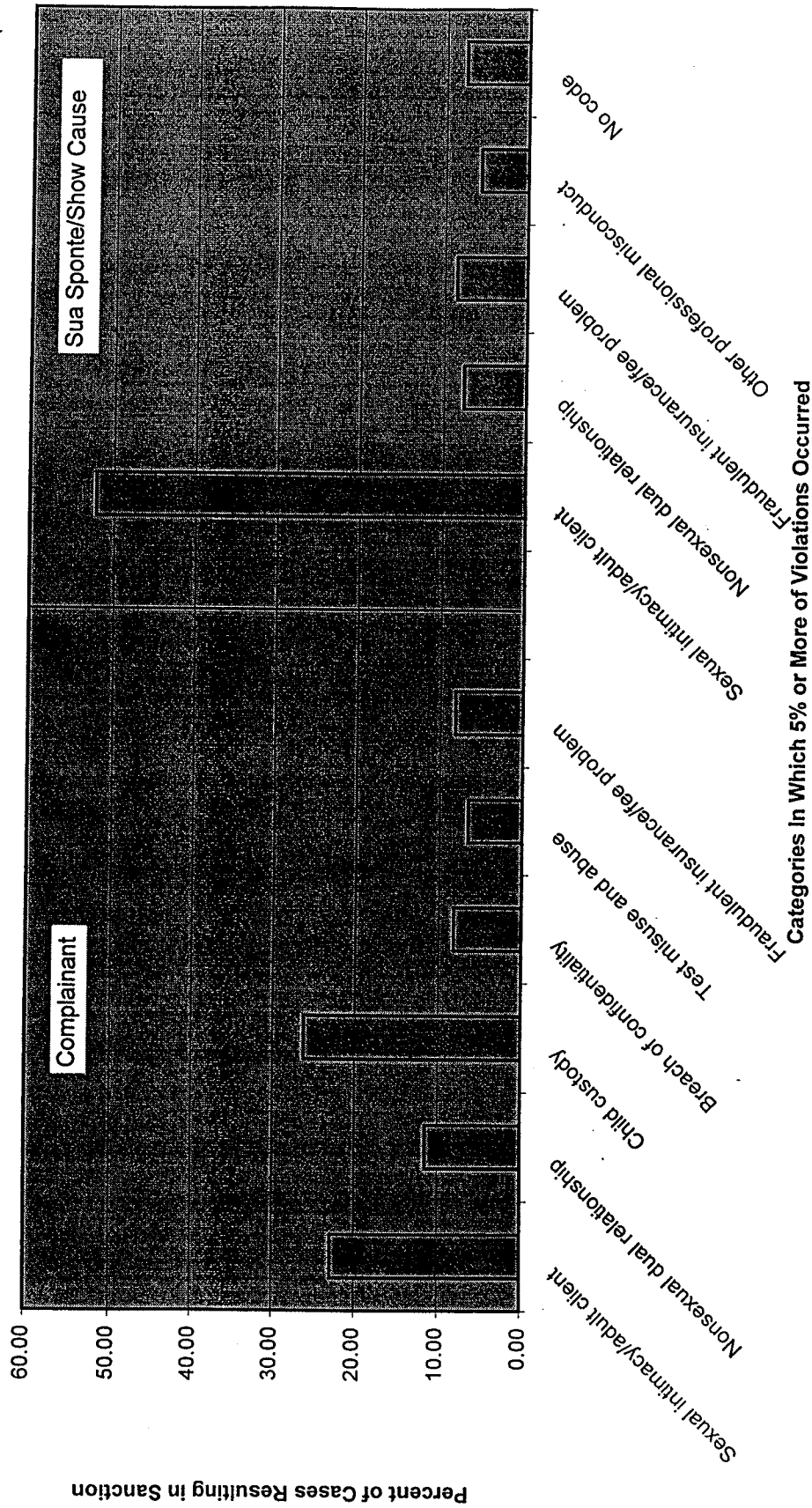
☒ New Inquiries 
 ☒ New Forms 
 ☒ Reprimand/Censure 
 ☒ Loss of Membership

# Category of Investigations Opened as Cases 1994-1999



Note: Complainant category percentages calculated separately from sua sponte/show cause category percentages.

# Category of Violations Found 1994-1999



Note: Complainant category percentages calculated separately from sua sponte/show cause category percentages.

# **Ethics Program Fact Sheet**



### General History

- Informal ethics actions taken since the mid-1930's and continuing Committee formed 1938.
- First formal ethics code published in 1953.
- APA Council will discuss ethics adjudication program at its February 2000 meeting.

### During 1990-1998

- APA spent 9 million dollars on its ethics program.
- Average of 816 complaints (at all stages) active each year, including 227 formal cases.
- Two hundred fifteen members lost membership due to ethics actions, 127 due to sexual misconduct (as the underlying behavior) and 23 due to insurance fraud.
- Since 1985, a total of 281 members lost membership due to ethics actions.

### Current Version of the APA Code

- "Ethical Principles of Psychologists and Code of Conduct."
- Adopted August 16, 1992 and Effective December 1, 1992.

### Next Revision of the APA Code

- Ethics Code Task Force appointed November 1996.
- Comments and critical incident survey during 1997-early 1999.
- Revision drafting began during 1999.
- New Ethics Code projected approximately 2001-2002.

### Features of the 1992 Code

- Differentiated aspirational and enforceable statements.
- Enforceable statements more specific and legally defensible.
- Statements organized in functional groups and limited to single behavior "unitary" concepts.
- Introduction provides information regarding the use and enforcement of the code.
- Unitary concepts improve effectiveness for teaching.
- Philosophical clarity limited.
- Essential guidance similar to previous code, except for major additions.
- New explicit provisions regarding sexual involvement with former clients (4.07) and with certain students (1.19), barter (1.18), informed consent to therapy (4.02), withholding records for non-payment (5.11), and forensic services (7.01-7.06).
- Modified provisions regarding dual relationships (1.17), sexual harassment (1.11), and resolving ethical violations (8.04 and 8.05).
- Modifications acceptable to the FTC of provisions previously rescinded regarding referrals and fees (1.27), testimonials (3.05), and in-person solicitation (3.06).

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## **Current Ethics Committee "Rules and Procedures"**

- Revised and adopted in December 1995.
- Effective June 1, 1996.
- Contains Overview.
- Process included solicitation of public comment regarding selected policy changes.
- Includes many major and minor changes (see below).

## **Selected Changes to Rules**

- Dues notice reporting members who have lost membership will become nonconfidential.
- Ethics Office will inform any person who inquires in writing that a former member has lost membership (under the new Rules) due to unethical behavior.
- Time limits for members filing complaints will be extended to 3 years.
- Student affiliates will be as subject to jurisdiction of the Ethics Committee, limited to review of activities not under the scrutiny of the student's graduate program and of affiliates who join with this understanding.

## **Complaint Procedures**

- Complaint judged by ethics code in effect at time of behavior.
- Two types of investigations: charges of 1) violating the ethics code or 2) having been found guilty of serious misconduct by another body ("show cause" procedures).
- APA's actions independent of affiliated state and provincial psychological association ethics committees.
- Member not allowed to resign membership (directly or by non-payment of dues) while under scrutiny of the Committee as defined by Board policy.
- Conviction of felony and ethical misconduct that leads to loss of license or loss of state association membership are grounds for initiating "show cause" action.
- Complaints may be filed by member or non-member complainant or may be initiated by the committee on its own (sua sponte).
- Time limits for filing are 3 years for members (phased in for the new Rules until 1998) and 5 years for non-members.
- The Chair and Director can waive time limit for serious matters, but no more than 10 years after the alleged events occurred.

## **Consent Order with the Federal Trade Commission**

- Finalized in December 1992; effective until 2002.
- Investigated provisions related primarily to advertising and referral fees in the 1981 ethics code suspended 1986 and rescinded 1989.
- Most provisions actually unnecessary in context of still active rules against misleading or fraudulent public statements.

Prepared by: Stanley E. Jones, Ph.D., Director, Office of Ethics

# **Report of the Ethics Committee, 1999**

# Report of the Ethics Committee, 1999

In accordance with the bylaws of the American Psychological Association (APA), the Ethics Committee reports regularly to the membership regarding the number and types of ethical complaints investigated. In addition to the processing of cases, in 1999 significant action was taken toward the revision of the "Ethical Principles of Psychologists and Code of Conduct," hereinafter also referred to as the Ethics Code (APA Ethics Committee, 1992a).<sup>1</sup>

## Board of Directors and Ethics Committee Review of the Ethics Program

In 1999, a proposed revision of the Ethics Committee's "Rules and Procedures" (APA Ethics Committee, 1996b) was delayed pending further study of the ethics program. For greater detail on the Board of Directors's and Ethics Committee's ongoing review of the ethics program, refer to the "Report of the Ethics Committee, 1996" (APA Ethics Committee, 1997), the "Report of the Ethics Committee, 1997" (APA Ethics Committee, 1998), and the "Report of the Ethics Committee, 1998" (APA Ethics Committee, 1999). More information may also be found in the Board of Directors minutes (Levant, 2000, this issue).

## Ethics Code Task Force (ECTF)

Throughout the year the ECTF continued to work on revising the "Ethical Principles of Psychologists and Code of Conduct" (APA Ethics Committee, 1992a).<sup>1</sup> The ECTF plans to hold two to three meetings per year until completion of the revision task, projected for 2002.

As of December 31, 1999, the members of the ECTF were Celia B. Fisher, PhD, Chair; Bruce E. Bennett, PhD; Jessica Henderson Daniel, PhD; Samuel J. Knapp, EdD; Peter E. Nathan, PhD; Thomas D. Oakland, PhD; Julia M. Ramos-Grenier, PhD; Melba J. T. Vasquez, PhD; Peter C. Appleby, PhD (public member); Gerald P. Koocher, PhD (representing the Board of Directors); Brian L. Wilcox, PhD (representing the Council of Representatives); Elizabeth V. Swenson, PhD, JD (representing the Ethics Committee); and Nabil El-Ghoroury, MA (representing the American Psychological Association of Graduate Students; APAGS).<sup>2</sup>

In 1999, the ECTF met twice and conducted one conference call. At its April 1999 meeting, the task force wrote a first draft of enforceable standards of the Ethics Code. On the basis of feedback following the first draft, the ECTF created a second draft during its October meeting and November conference call. Both drafts were provided to the Council of Representatives, the Board of Directors, and APA boards and committees.

In addition, an article in the July/August 1999 *APA Monitor* ("Revision of Ethics Code," 1999) provided infor-

mation highlighting proposed changes to the Ethics Code. The purpose of the publication was both to inform the membership about work on the revision and to invite commentary. The article appeared shortly before the ECTF's 50-minute discussion session with audience comments at the 1999 APA convention in Boston, and it stimulated numerous comments that contributed to the redrafting of several standards at the ECTF's October meeting.

As part of a continuing effort to ensure that revision of the Ethics Code remains an open and collaborative process, the ECTF presented an update on its work at the plenary session of the Council of Representatives in February 1999. The presentation detailed new areas for revision that had been identified through submitted comments on the Ethics Code, the goals of the revision, and a rough estimate of the anticipated time necessary to complete the revision. Council members were again invited to submit comments to the task force.

Information gathering has remained a significant component of the Ethics Committee's plan for revising the Ethics Code. Throughout the year, the ECTF continued to receive and review new comments on the Ethics Code. The summer article in the *APA Monitor* ("Revision of Ethics Code," 1999) prompted comments on proposed changes as well as existing elements of the 1992 Ethics Code. The ECTF also published the call for comments in the Winter 1999 issue of the *APAGS Newsletter* ("Ethics Code Task Force Seeks," 1999), along with a companion piece ("You Can Make A Difference," 1999) encouraging student participation in the revision. In addition, the chair of the ECTF directly contacted division presidents to request comments on the work of the task force. Information updates provided to all relevant groups reiterated the ECTF's continuing interest in commentary.

The ECTF regularly reviews all comments received on the Ethics Code (APA Ethics Committee, 1992a) to determine if any comment meets the following standard: "An interim revision will be undertaken if the Ethics Com-

<sup>1</sup> For greater detail on activities of the ECTF prior to 1999, refer to previous years' Ethics Committee reports (APA Ethics Committee, 1997, 1998, 1999). For details of Ethics Code revision activities prior to the appointment of the ECTF, refer to the "Report of the Ethics Committee, 1995" (APA Ethics Committee, 1996a).

<sup>2</sup> Laura S. Brown, PhD, resigned from the ECTF in 1999. Representatives of the Ethics Committee, the Board of Directors, the Council of Representatives, and the APAGS are voting members of the ECTF, and the representative positions continue to have terms such that reappointments will occur as needed to ensure current membership of the represented group. In December 1999, Dr. Swenson's term on the Ethics Committee ended, and Abigail B. Sivan, PhD, was appointed the Ethics Committee representative to the ECTF. Marcia J. Moody, MEd, APAGS representative, resigned as past chair of APAGS in 1999, and the APAGS Executive Committee subsequently appointed Nabil El-Ghoroury, MA, APAGS representative to the ECTF.

mittee, Board of Directors, or Council of Representatives determines (a) that there is an urgent concern about the Ethics Code that should not be delayed until the major revision and (b) that there should be an interim revision." In 1999, the ECTF reviewed 78 new comments and found that none met the criteria for an interim revision.

## Ethics Committee Membership

The chair of the 1999 Ethics Committee was Kathleen P. Stafford, PhD. Members included Robert T. Kinscherff, PhD, JD, Vice-Chair; William V. Burlingame, PhD; Janet Hibel, PhD; Abigail B. Sivan, PhD; Elizabeth V. Swenson, PhD, JD; Robert H. Woody, PhD, ScD, JD; and Lisa Callahan, PhD (public member). Nonvoting associates were Richard P. Halgin, PhD; Olivia Moorehead-Slaughter, PhD; Edgar J. Nottingham, IV, PhD; and Walter B. Pryzwansky, EdD. Robert G. Meyer, PhD, and Duncan E. Walton, PhD, completed their terms as associates in March 1999. The liaison from the Board of Directors was Catherine Acuff, PhD.

Members of the Ethics Committee are elected by the same process as are members of other APA committees. APA members are nominated to the committee by the membership. A list of prospective committee members is developed by the Ethics Committee; this list then may be supplemented by the Board of Directors prior to approval by the board. The ballot is submitted to the Council of Representatives. Terms are for three years, with the committee electing a chair and a vice-chair each year. Committee associates are appointed by the committee for two-year terms. The public member is elected by the Council of Representatives after being nominated by the committee and approved by the Board of Directors.

## Ethics Office Staff

At the end of 1999, staff in the Ethics Office were Dolph M. Printz, PhD,<sup>3</sup> acting director; Martha Mihaly, MS, senior ethics investigator; Rhea Jacobson, ethics officer; Stephanie Brasfield, JD, ethics investigative officer; Deborah Carliner, JD, temporary investigator; Jennifer Royster, ethics coordinator; Patricia Dixon, ethics investigator; Emily Laumeier, educative coordinator; Deborah Felder, Ethics Code revision coordinator; Elizabeth Klint, educative assistant; Shafegah Uqdah, investigative assistant; and La-Shan Lee, investigative assistant. Ms. Klint served as investigative assistant prior to her promotion to educative assistant. After resigning in September 1999, Stanley E. Jones, PhD, former director of the Ethics Office, became a consultant to the Ethics Office. At the end of April 1999, Sharmaine St. Rose, ethics receptionist, left the Ethics Office for another position within APA. Temporary staff during 1999 included Valinda F. Clark, temporary investigative assistant, and Kemly Vitale, temporary receptionist.

## Ethics Case Data

Reports of the Ethics Committee published in the *American Psychologist* since 1985 have generally given annual figures for the number of inquiries received, the number of

complaints filed, the number of new formal cases opened, and the total number of cases active during the year. To interpret the data, it is necessary to know the definitions of the following terms as used by the Ethics Committee. An *inquiry* is a letter asking about or indicating the intention to file a complaint. An inquiry can also be a statement from an entity, such as a state licensure board, that action has been taken or charges are pending against a member of APA. *Complaint filed* means the Ethics Office has received an official signed complaint form.<sup>4</sup> A *formal case* is opened only after an office investigator and the chair of the Ethics Committee determine that the complaint might involve a violation of the Ethics Code (APA Ethics Committee, 1992a). When there is not enough information to make that decision, a *preliminary investigation* may be opened, which may lead to closing the investigation or opening a formal case. *Active cases* are all cases active in the current year, both new cases opened and those carried over from the previous years. Data presented in this article represent the most accurate data available, and notes indicate when certain data vary from that provided in last year's report (APA Ethics Committee, 1999).

Processing complaints, the main activity of the Ethics Committee, continued at a high but somewhat reduced level in 1999. The total number of active complaints at all stages (inquiry, preliminary investigation, etc.) during the year was 742. This is the lowest level of activity since 1992. Activity each year for 1990 through 1998, respectively, was reported as 563, 662, 736, 870, 860, 942, 921, 941, and 854 active complaints.

## Inquiries

Table 1 indicates the number of written inquiries against members received during each year. In 1999, 340 inquiries were received. This number was below the average from 1990 to 1999 (377) but was an increase from 1998 (307), which had been the lowest number since 1990.

In 1999, the Membership Office forwarded to the Ethics Office for processing 35 applications and reapplications for membership on which a history of unethical behavior was indicated. Student affiliate applications have been modified following changes in the committee's "Rules and Procedures" (APA Ethics Committee, 1996b), and 28 of the 35 applications referred were student affiliate applications. It was later determined that 6 applicants had checked off the ethics history box in error. Nineteen applicants withdrew their applications or did not respond to letters asking for more information. One application of the 35 referred was a request for readmission from a member who had previously lost membership in APA because of

<sup>3</sup> In April 2000, Dr. Printz resigned as acting director of the Ethics Office. Subsequently, L. Michael Honaker, PhD, Deputy CEO, assumed the role of acting director.

<sup>4</sup> The number of complaint forms filed is estimated to be the number of complaint forms received. This overestimates the number slightly, because some complainants do not complete the filing for various reasons, for example, by not completing all required signatures.

**Table 1**  
*Inquiries Received, 1985–1999*

Year	No. of inquiries received
1985	288
1986	228
1987	337
1988	311
1989	—
1990	279
1991	333
1992	360
1993	488
1994	409
1995	433
1996	390
1997	438 <sup>a</sup>
1998	307 <sup>b</sup>
1999	340

Note. The dash indicates data were not available. All superscripts reflect changes in data from the Ethics Committee report published in the August 1999 *American Psychologist*.

<sup>a</sup> Figure is up by 1.

<sup>b</sup> Figure is up by 4.

disciplinary action. An additional 16 applications and 4 reapplications were pending from 1998.

In 1999, the Ethics Committee reviewed 14 applications for membership (4 member and 10 student affiliate) and recommended admission for 13 (4 member and 9 student affiliate). For 1 student application, the committee recommended denial of membership. The committee reviewed 3 requests for readmission, recommending admission on 2 and denial of admission on the other. Eighteen applications and reapplications were still pending review by the Ethics Committee at the end of 1999.

The Board of Directors makes the final decision when the committee recommends denying an application. The board reviewed three such matters in 1999, upholding the committee's recommendation in one matter and admitting one member and one student affiliate in the other two matters. All three applications had been pending board review at the end of 1998. The Membership Committee makes the final decision regarding Ethics Committee recommendations on readmission requests. The Membership Committee upheld two Ethics Committee recommendations regarding readmission (one admitted, one denied readmission), and one recommendation (to readmit) was pending at the end of 1999.

A total of 70 complaint forms were received in 1999, the smallest number received in the years since an improved method for counting forms had been used. The number of forms returned has varied markedly in the past several years. Numbers for each year from 1993 through 1998, respectively, were 113, 129, 118, 89, 121, and 85.<sup>5</sup> APA members subject to the filing of complaints are fellows, members, associate members, and those student af-

filates who joined during or after fall 1996. Membership was 88,500 for 1999,<sup>6</sup> which means that complaints were filed against approximately 1 member per 1,265. Complaints were filed against approximately 0.08% of the membership in 1999, as compared with 0.19% in 1994, 0.14% in 1995, 0.11% in 1996, 0.14% in 1997, and 0.10% in 1998.

The Ethics Committee does not process complaints against nonmembers or organizations. For example, if an inquiry is submitted regarding a nonmember, the complainant is told that the person is not a member and is referred to the appropriate state licensure board and state or provincial psychological association. During 1999, the Ethics Office received no inquiries concerning filing complaints against student affiliates who joined prior to fall 1996 (and who are thus not subject to the filing of complaints), 116 against nonmembers, and 4 against an organization. The actual total of 1999 inquiries, therefore, was 495, including the 340 complaints against members and the 35 applications and reapplications for membership.

### **Preliminary Investigations**

Table 2 presents data on preliminary investigations from 1982 through 1999. Eleven preliminary investigations were carried into 1999 from 1998, and 44 new preliminary investigations were opened. Seventeen complaints were closed at that stage, and 2 were opened as formal cases. Therefore, 36 preliminary investigations were carried into 2000. (Many of these were resolved early in 2000.) The data continue to indicate that other than the large number opened in 1990, few preliminary investigations have gone on to be opened as formal cases.

### **Formal Cases**

Table 3 presents data for cases opened and closed from 1983 through 1999. For 1999, 42 cases were opened and 57 were closed. The number of active cases was the lowest number since 1987. More cases have been closed than opened in the past four years and in six out of the past eight years, while more were opened than closed in the six years from 1986 to 1991.

The length of time it has taken to process cases has typically been reported in terms of cases closed during the year under report. Accordingly, this figure may include substantial processing time that occurred in previous years, particularly for cases of longer duration. The average processing time for cases closed in 1999 (calculated from opening a matter as a case to final action by the Ethics Committee) was 17.44 months, compared with 14.11,

<sup>5</sup> The number of complaint forms filed was previously estimated for 1993 through 1995 as the number of memos from staff to the Ethics Committee chair recommending action following receipt of complaint forms and was reported for each of these years as 167, 114, and 116, respectively. Beginning with data reported for 1996, the number reported is all complaint forms returned, whether completed or not.

<sup>6</sup> This membership figure does not include student affiliates. In 1999, APA had 64,300 student affiliates, many of whom are likely to have joined during or after fall 1996, thus making them subject to the filing of complaints.

13.07, 11.67, 13.53, 12.65, 20.67, and 15.51 months in 1992 through 1998, respectively. The relatively longer time for cases closed in 1997 related to five cases for which the processing time was between five and six years, in large part because they were stayed for the completion of state licensure board investigations. Only one case closed in 1998 and one case closed in 1999 fell in this range, and only three cases in 1998 and 6 in 1999 had taken over three years.

Primary and multiple categories involved in the investigation of the newly opened cases in 1999 are shown in Table 4. (It is important to note that these are not findings of violation, but allegations.) The multiple issues per case are important because the primary category under "cases adjudicated in other jurisdictions" relates to the basis on which APA is processing the case rather than to the underlying behavior, and a secondary category is always assigned to identify this behavior. For example, a case might be assigned the primary category of "loss of licensure," and the misbehavior underlying the delicensure might be assigned the secondary category of "sexual misconduct." The multiple-categories data identify the sexual misconduct problem in addition to the loss of licensure.

The loss of licensure category continues to be the most frequent primary reason for complaints being processed (57%) because of the large number of cases that are pro-

**Table 3**  
*Cases Opened and Closed, 1983–1999*

Year	Carried in	Opened	Total active	Closed
1983	65	59	124	74
1984	50	55	105	56
1985	49	73	122	75
1986	47	91	138	52
1987	86	91	177	80
1988	97	92	189	72
1989	117	91	208	85
1990	123	94	217	64
1991	153	108	261	100
1992	161	66	227	92
1993	135	67	202	79
1994	123	93	216	85
1995	131	138	269	89
1996	180	74	254	108
1997	146	51 <sup>a</sup>	197 <sup>a</sup>	58
1998	139 <sup>a</sup>	61	200 <sup>a</sup>	65
1999	135 <sup>a</sup>	42	177	57
2000	120			

Note. All superscripts reflect changes in data from the Ethics Committee report published in the August 1999 *American Psychologist*. Changes in Carried in and Total active are adjusted accordingly.

<sup>a</sup> Figure is up by 1.

**Table 2**  
*Preliminary Investigations Opened and Closed, 1982–1999*

Year	Carried in	Opened	Total active	Closed	Opened as case
1982	0	31	31	23	2
1983	6	22	28	14	5
1984	9	19	28	17	4
1985	7	33	40	19	3
1986	18	35	53	34	5
1987	14	21	35	23	4
1988	8	22	30	13	2
1989	15	47	62	22	6
1990	34	36	70	34	15
1991	21	24	45	20	8
1992	16	25	41	33	1
1993	7	16	23	18	2
1994	3	16	19	11	0
1995	8	36	44	25	5
1996	14	48	62	44	4
1997	14	57	71	40	6 <sup>a</sup>
1998	25 <sup>b</sup>	34	59 <sup>b</sup>	44	4
1999	11 <sup>b</sup>	44	55	17	2
2000	36				

Note. Opened as case indicates that the preliminary investigation has ended. Carried in is reduced by the number closed and the number opened as cases. All superscripts reflect changes in data from the Ethics Committee report published in the August 1999 *American Psychologist*.

<sup>a</sup> Figure is up by 1.

<sup>b</sup> Figure is down by 1.

cessed secondary to actions taken by state licensure boards. This compared with percentages of 14%, 10%, 16%, 36%, 61%, 36%, 36%, 24%, and 51%, respectively, in 1990 through 1998. Of the 24 cases opened following a loss of licensure in 1999, sexual misconduct was the underlying behavior in 12 cases (50%).

Using the multiple-categories data, categories that were involved in 10% or more of the complaints were sexual misconduct with adult clients (29%), insurance and fee problems (21%), child custody evaluations (10%), and other professional misconduct (10%).<sup>7</sup> Other areas involved in at least 5% of the complaints were sexual misconduct with minors (7%), nonsexual dual relationships (7%), practicing outside competency (5%), and inappropriate follow-up/termination (5%).

For purposes of data analysis, the category of "dual relationship" is subdivided into four categories: sexual misconduct (with adult vs. minor client specified), sexual harassment, and nonsexual dual relationship. This breakdown is analyzed using the multiple-categories data, inasmuch as it identifies loss of licensure cases by the underlying behavior (see Table 5). Of all cases involving dual relationship, 18% were nonsexual in 1999, compared with percentages of 15%, 40%, 23%, 7%, and 19% in 1994–1998, respectively. The major area of sexual dual-relationship allegations continued to be male psychologist

<sup>7</sup> Forensic issues other than child custody evaluations are not coded as a separate category; therefore, no general forensic data are available.

**Table 4**  
*Primary and Multiple Categories of Cases Opened in 1999*

Category	No. of cases with category as primary factor	No. of cases with category as a factor
Cases adjudicated in other jurisdictions		
Felony conviction	5	5
Loss of licensure	24	24
Expulsion from state association	0	0
Malpractice	0	0
Other	2	2
Dual Relationship		
Sexual misconduct, adult	1	12
Sexual misconduct, minor	0	3
Sexual harassment	0	0
Nonsexual dual relationship	2	3
Inappropriate professional practice		
Child custody	4	4
Hospitalization	0	0
Hypnosis	0	0
Outside competence	1	2
Controlling client	0	1
Inappropriate response to crisis	0	0
Confidentiality	0	1
Inappropriate follow-up/termination	0	2
Test misuse	0	0
Insurance/fee problems	1	9
Inappropriate professional relations	0	0
Other	0	4
Inappropriate research, teaching, or administrative practice		
Authorship controversies/credits	0	0
Improper research techniques	0	0
Plagiarism	1	1
Biasing data	0	0
Grading/violation of student rights	0	0
Termination/supervision	0	1
Absence of timely evaluations	0	0
Discrimination	0	0
Animal research subjects' welfare	0	0
Other	0	1
Inappropriate public statements		
Misuse of media	0	0
False, fraudulent, or misleading	0	0
Did not correct misrepresentation	0	1
Public allegation about colleague	0	0
Other	1	1
Failure to uphold standards of the profession		
Response to ethics committees	0	1
Adherence to standards	0	0
Other	0	0
Total cases	42	42

with adult female client (male-female, 53%). For 1999, there were three allegations of female-male sexual dual relationship and no cases in the female-female and male-male categories of complaints. Three complaints cited sexual involvement with minors, and no complaints cited sexual harassment.

### Adjudication

Only those cases that meet jurisdictional tests (e.g., filed within the time limits) and that the Ethics Committee chair and an investigator determine meet "cause for action" criteria are referred to the full committee for resolution. The Ethics Committee held three meetings in 1999, at which it reviewed 62 cases and handled 12 membership-related actions, 14 case-related confidential agenda items, 35 non-case-related confidential agenda items, and 52 non-confidential agenda items.

The sanctions and directives available to the Ethics Committee are described in the "Rules and Procedures" (APA Ethics Committee, 1996b). Sanctions include reprimand, censure, and recommendation to the Board of Directors that the individual be expelled or allowed to resign, under stipulated conditions, from APA membership. Directives include a cease and desist order; corrective actions (except monetary payments to APA or persons injured by the conduct); supervision, education, and treatment require-

**Table 5**  
*Breakdown of Dual Relationship/Sexual Misconduct, 1999*

Category	No. of cases
Sexual misconduct, adult	
Male-female	9
Male-male	0
Female-male	3
Female-female	0
Sexual misconduct, minor	
Male-female	1
Male-male	1
Female-male	0
Female-female	0
Sexual harassment	
Male-female	0
Male-male	0
Female-male	0
Female-female	0
Nonsexual dual relationship	
Male-female	3
Male-male	0
Female-male	0
Female-female	0
Total	17

*Note.* Numbers are based on multiple categories by year opened. One case, involving sexual misconduct with a minor client, is not included because the gender of the client was not indicated in the case material.

ments; and probation. Table 6 indicates the committee recommendations. Of cases that were reviewed by the committee during 1999, 2% were continued and 13% were dismissed (compared with 28% in 1997 and 7% in 1998). Thirty-one percent resulted in recommendations for reprimands or censures, and 55% received recommendations for loss of membership (compared with 44% in 1997 and 66% in 1998).

For complainant-initiated or *sua sponte* cases, when the committee finds a violation, the member has the right to obtain independent review by an impartial panel. Two types of adjudications occur: Reviews of recommendations of expulsion, which ultimately go to the Board of Directors, are heard in person (formal hearings); reviews of recommendations for reprimand and censure occur on a written record (independent adjudications).<sup>8</sup> Members of the Board of Directors's Standing Hearing Panel hear both types of adjudications.<sup>9</sup> A member requesting an independent review or formal hearing chooses the members of his or her hearing panel from a list of panel members.

Two formal hearings, two independent adjudications in lieu of formal hearings, and seven independent adjudications were completed during 1999. Of the formal hearings and independent adjudications in lieu of formal hearings, the hearing committees and panels upheld recommendations of expulsion in three cases and reduced the sanction to censure and added directives in a fourth case. Of the seven independent adjudications, panels upheld the committee's decision in six cases and dismissed one case (in which the committee recommended censure with directives).

As indicated in the "Report of the Ethics Committee, 1997" (APA Ethics Committee, 1998), committee policy for cases reviewed after October 1997 precludes adjudication panels from reducing or eliminating notifications. The policy provides that notifications are not made if cases are dismissed by adjudication panels and that the committee will reconsider notifications if one or more violations are not upheld or if a sanction of censure is reduced to reprimand. (A committee recommendation of reprimand cannot be reduced if violation is upheld.)

**Table 6**  
Summary of Ethics Committee Recommendations,  
1999

Action	No.	%
Continue investigation	1	2
Dismiss	8	13
Reprimand/censure	19	31
Loss of membership <sup>a</sup>	34	55
Total	62	100

<sup>a</sup> This category was previously called "Recommend drop/expel/stipulated resignation/void."

**Table 7**  
Membership Terminations, 1985-1999

Year	Dropped	Expelled	Stipulated resignations	Total
1985	3	3	0	6
1986	8	5	1	14
1987	0	13	1	14
1988	9	9	1	19
1989	7	6	0	13
1990	4	4	3	11
1991	7	13	4	24
1992	6	4	7	17
1993	7 <sup>a</sup>	4	3	14
1994	7 <sup>a</sup>	13	16	36
1995	2	16	13	31
1996	2	12	14	28
1997	0	15 <sup>a</sup>	7	22
1998	0	22	10	32
1999	0	21	7	28
Total	62	160	87	309

<sup>a</sup> This number includes 1 void membership.

The Board of Directors took action in 36 cases in 1999. Three cases were remanded, one for further review and two for reconsideration. The board upheld recommendations for expelling 20 members, granting 2 members' stipulated resignations, and censuring 5 members. The board reduced the directives in one case of censure. The board rejected the Ethics Committee's recommendation in eight matters, including the two reconsiderations noted above. Of the cases for which the committee recommended expulsion, the board reduced two to censure, dismissed one, and offered a stipulated resignation for another. The board dismissed one recommendation for censure. The board increased one sanction: A committee recommendation for censure in a show cause case was rejected and the member expelled.

In 1999, 28 individuals lost their memberships because of ethics actions. Twenty-one were expelled from APA, and 7 persons accepted stipulated resignations. Four of the stipulated resignations were elections of stipulated resignation with admission of violation, which respondents may opt for in their initial response to a show cause notice. In 1993 through 1998, the committee reported 3, 16, 13, 14, 7, and 10 stipulated resignations, respectively; of those, 2, 9, 9, 5, and 8 were with admission of violation. This is a new provision (Part IV, Section 10.1) of the 1992 "Rules and Procedures" (APA Ethics Committee, 1992b) and is

<sup>8</sup> With the 1996 "Rules and Procedures" (APA Ethics Committee, 1996b), the respondent may opt for an independent adjudication-type process in lieu of a formal hearing.

<sup>9</sup> Panel members are appointed to three-year terms by the APA president. The panel must include a minimum of 30 panelists, at least 5 of whom must be public members. As of December 31, 1999, the panel included 45 members, 8 of whom were public members.



**Table 8**  
*Primary Category of Cases Resulting in Termination, 1999*

Category	No. of cases
Sexual misconduct, adult	17
Sexual misconduct, minor	1
Nonsexual dual relationship	2
Insurance/fee problems	3
Other	5
Total	28

available only in cases brought secondary to actions by another tribunal. The rule allows a member to resign without the explicit approval of the Board of Directors, as long as the member admits to the underlying violation. For example, a member convicted of a felony for insurance fraud must admit to the insurance fraud and not just acknowledge the conviction. Table 7 summarizes membership terminations from 1985 through 1999.

The largest single category of underlying unethical behavior in cases that ended in loss of membership was sexual misconduct, accounting for 56% of terminations in 1999 (see Table 8). This is consistent with 56%, 43%, 58%, 58%, 67%, 57%, and 53% of such cases in 1992 through 1998, respectively. One of the 18 sexual misconduct cases involved sexual involvement with a minor. Of the other categories of behavior, three cases related to insurance and fee problems, accounting for 11% of the total. No other category had more than 2 cases in 1999.

### Case Examples

Case examples based on the 1992 Ethics Code (APA Ethics Committee, 1992a) have been presented in "Report of the Ethics Committee, 1993" (APA Ethics Committee, 1994), "Report of the Ethics Committee, 1994" (APA Ethics Committee, 1995), "Report of the Ethics Committee, 1996"

(APA Ethics Committee, 1997), and "Report of the Ethics Committee, 1997" (APA Ethics Committee, 1998). Although the examples are based on actual cases, information is altered to protect the identity of the complainants and members involved. Table 9 presents a reference index to the case examples as published in *American Psychologist* in the aforementioned Ethics Committee reports.

### Educational Activities and Presentations

Numerous telephone consultations were provided daily by Ethics Office staff in 1999. Educational letters were written by the director in response to a variety of situations in 1999. On request, the Ethics Office furnished to members and nonmembers copies of "Ethical Principles of Psychologists and Code of Conduct" (APA Ethics Committee, 1992a), "Rules and Procedures" (APA Ethics Committee, 1992b, 1996b), and other relevant publications. The Ethics Code, rules, and recently published policy statements are available at the APA World Wide Web site (<http://www.apa.org/ethics>).

In July 1999, state and provincial psychological associations' ethics committees were surveyed concerning their ethics programs. Thirty of 51 associations responded. As in previous years, almost all states that responded to the survey reported that they provide educative information (27 of 30 states reporting on this item). Following the survey, all 51 associations were contacted briefly by phone, and two states (North and South Dakota) reported that they have no ethics committee. The follow-up also indicated that only 14 out of 51 associations (27%) have traditional, full adjudication programs. An additional 8 (16%) have a limited adjudication program, primarily taking action only secondary to state boards. Therefore, a total of 22 (43%) have some kind of adjudication program, and 57% do not. Of 15 states that responded to the survey and indicated they were not conducting investigations, 14 had previous investigation programs, and almost all had discontinued investigations since 1994.

**Table 9**  
*Case Examples as Included in American Psychologist, 1994-1999*

Content area	Outcome	Citation in <i>American Psychologist</i>
Psychological evaluation, Medication	No cause for action	July 1994 (p. 663)
Improper termination, Personal problems affecting therapy	Dismiss	August 1995 (p. 710)
Forensic assessment, Child custody	Censure	August 1995 (p. 711)
Plagiarism	Stipulated resignation	August 1995 (p. 711)
Felony conviction (Insurance fraud)	Expulsion	August 1995 (p. 712)
License suspension (Inappropriate treatment)	Censure with probation	August 1997 (p. 903)
Forensic assessment, Child custody	Censure with directives	August 1997 (p. 903)
Multiple relationships	Censure with directives	August 1997 (p. 904)
Plagiarism	No cause for action	August 1998 (p. 977)
Improper supervision	Censure with directives	August 1998 (p. 978)

**Table 10**  
**Current Published Ethics Committee Policy Statements**

Policy	APA Monitor	American Psychologist
"Take Home" Tests	July 1993 (p. 41)	July 1994 (p. 665)
Advertisements and Canned Columns	September 1993 (p. 51)	July 1994 (p. 664)
Internship Applications and Confidential Materials	September 1993 (p. 51)	July 1994 (p. 664)
Military Psychologists and Confidentiality	September 1993 (p. 51)	July 1994 (p. 665)
Limitation on Teaching (Standard 6.04)	March 1995 (p. 18)	August 1995 (p. 713)
Referrals and Fees (Standard 1.27)	March 1995 (p. 18)	August 1995 (p. 713)
Services by Telephone, Teleconferencing, and Internet <sup>a</sup>	January 1998 (p. 38)	August 1998 (p. 979)
Policy on Barring Resignations During Ethics Investigations <sup>b</sup>	November 1997 (p. 38)	November 1997 (p. 1253) December 1997 (p. 1388)

<sup>a</sup> This statement is currently available through links on the Ethics Office page of the APA Website (<http://www.apa.org/ethics/>). Access to the other statements is soon to be added.

<sup>b</sup> This is a Board of Directors resolution that affects Ethics Committee policy.

In response to telephone or mail requests, the Ethics Office provides telephone numbers and addresses of state and provincial psychological associations, ethics committee chairs, and state and provincial licensure boards. Within APA, the Ethics Office maintains a list of state ethics committee chairs. The Ethics Office also provides support for affiliated state psychological associations' ethics committees and keeps them informed about APA Ethics Committee policy and activities through regular mailings.

The Ethics Committee sponsored five sessions at the 1999 APA Convention. Presentations included mock Ethics Committee deliberations, a symposium by committee members and associates entitled "The Changing Face of Ethical Issues for People of Color" (part of the miniconvention on ethnic minority issues sponsored by 1999 APA President Richard M. Suinn, PhD; see presentation titles and presenters below), and a discussion by the ECTF of the Ethics Code revision process. The committee also held two invitation-only meetings: the customary invitation-only meeting for state and provincial psychological association and APA division ethics committee chairs and members, and an invitation-only meeting of groups with interest in the use of the Ethics Code in disciplinary actions. Invitees for the latter meeting were representatives of the Association of State and Provincial Psychology Boards, the American Board of Professional Psychology, the APA Insurance Trust, the National Register of Health Service Providers in Psychology, and the Canadian Register of Health Service Providers in Psychology.

The Ethics Committee symposium "The Changing Face of Ethical Issues for People of Color" consisted of the following presenters and presentations: Elizabeth V. Swenson, PhD, JD, "Considering Diversity Issues in Revising the Ethics Code"; Duncan E. Walton, PhD, "Beyond the Rhetoric of the Ethical Mandate for Diversity Training";

Julia M. Ramos-Grenier, PhD, "Ethical Issues Involving the Assessment of Linguistically Different Populations"; and Robert T. Kinscherff, PhD, JD, "Ethical Challenges with Minority Youth in Juvenile Court Settings."

### **Policy Statements in *American Psychologist* and the *APA Monitor***

No new Ethics Committee policy statements were published in 1999. Table 10 identifies currently active published Ethics Committee statements.

### **REFERENCES**

- American Psychological Association Ethics Committee. (1992a). Ethical principles of psychologists and code of conduct. *American Psychologist*, 47, 1597-1611.
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- American Psychological Association Ethics Committee. (1996b). Rules and procedures. *American Psychologist*, 51, 529-548.
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- Levant, R. F. (2000). Proceedings of the American Psychological Association, Incorporated, for the legislative year 1999. *American Psychologist*, 55, 832-890.
- Revision of ethics code calls for stronger former client sex rule. (1999, July/August). *APA Monitor*, p. 44.
- You can make a difference: Ethics Code Task Force seeks student input. (1999, Winter). *APAGS Newsletter*, p. 1.

10 DECEMBER 2002

JTF GTMO "SERE" INTERROGATION STANDARD OPERATING PROCEDURE

Subj: GUIDELINES FOR EMPLOYING "SERE" TECHNIQUES DURING DETAINEE  
INTERROGATIONS

Ref: (a) FASO DETACHMENT BRUNSWICK INSTRUCTION 3305.3D

1. Purpose. This SOP document promulgates procedures to be followed by JTF-GTMO personnel engaged in interrogation operations on detained persons. The premise behind this is that the interrogation tactics used at U.S. military SERE schools are appropriate for use in real-world interrogations. These tactics and techniques are used at SERE school to

“break” SERE detainees. The same tactics and techniques can be used to break real detainees during interrogation operations.

The basis for this document is the SOP used at the U.S. Navy SERE (Survival, Evasion, Resistance, and Escape) school in Brunswick, Maine and is defined by reference (a).

Note that all tactics are strictly non-lethal.

STRICT COMPLIANCE WITH THE GUIDELINES  
LAID OUT IN THIS DOCUMENT IS MADATORY!

2. Training. All interrogators will undergo training by certified SERE instructors prior to being approved for use of any of the techniques described in this document.
3. Scope. Applicable to military and civilian interrogators assigned to JTF-GTMO, Cuba.

TED K. MOSS  
LtCol, USAF

## INTERROGATION TACTICS

### 1. GENERAL STATEMENT

- a. This document describes in detail the interrogation tactics authorized for use in detainee interrogation operations at JTF\_GTMO and the safety precautions that must be used to prevent injuries. The tactics are the same as those used in U.S. military SERE schools.
- b. ANY PHYSICAL CONTACT NOT EXPRESSLY AUTHORIZED HEREIN IS PROHIBITED.
- c. INTERROGATION TACTICS FOLLOWED BY: \*\*\*\*\* MAY ONLY BE USED BY THOSE INTERROGATORS DESIGNATED IN WRITING BY THE ICE CHIEF.

### 2. INTERROGATION SAFETY

- a. Approved interrogation tactics are found in Sections 3-6.
- b. Additional safeguards are as follows:
  1. Detainee behavior and reactions are continuously observed and evaluated by the interrogator.
  2. Both the detainee's and the interrogators behavior are monitored by the Watch Officer.
  3. IT IS CRITICAL THAT INTERROGATORS DO "CROSS THE LINE" WHEN UTILIZING THE TACTICS DESCRIBED BELOW. Therefore, verbal coded messages or nonverbal signals will be used by the Watch Officer (or other interrogators) when giving instructions to adjust interrogation procedure. For example, two kicks on the door indicated the interrogator should discontinue the current approach and move on to another approach. The statement, "Stop wasting time with this pig," means to discontinue the current training tactic and take a break.

### 3. DEGRADATION TACTICS

- a. **SHOULDER SLAP.** The shoulder slap is a moderate to hard, glancing blow to the back of the shoulder with an open hand. It is used as an irritant.

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JTF GTMO SERE SOP  
10 DECEMBER 2002

- b. **INSULT SLAP.** \*\*\*\*\*

(1) The insult slap is used to shock and intimidate the detainee. The slap is aimed at the detainee's cheek only. Contact will be made only with the fingers in the open hand position and the fingers will be slightly spread and relaxed. **The slap will be**

**initiated no more than 12-14 inches (or one shoulder width) from the detainee's face.** To ensure this distance is not exceeded and to preclude any tendency to wind up or uppercut, **the slap will be initiated with the slap hand contacting the detainee's body on the top of the shoulder.** The target area is slightly below the cheekbone, away from the eyes and ears. Extreme care must be taken not to strike the lower jaw. **Slaps aimed at the ears, mouth, nose eyes or throat are prohibited.**

(2) Uninterrupted or consecutive slaps are prohibited because the detainee will duck or dodge the slap, creating possibility for an injury. Experience has shown that after a second slap, the effectiveness of the slap tactic is significantly reduced. Interrogators **will cease using the slap if detainee begins ducking.** At this point, a threatened slap with the hand will achieve the same purpose as a slap. Blows with the back of the hand, fists, elbows, feet and knees are prohibited. Insult slaps are only to be used by those interrogators designated in writing by the ICE CHIEF.

**C. STOMACH SLAP. \*\*\*\*\***

(1) As with the insult slap, the stomach slap is used to shock and intimidate the detainee. The tactic is delivered with the back of the bare hand. The slap will be directed towards the center of the abdomen. The detainee will not be struck in the solar plexus, ribs, sides, and kidneys or below the navel. The slap **will not** be performed against the bare skin. Slaps will be initiated with the interrogator's upper arm parallel to his/her body, extending the striking hand in a swinging motion to the target area. Detainees will be either facing or to the side of the interrogator when the slap is administered.

(2) Uninterrupted or consecutive slaps are prohibited. **Blows to the stomach with the palm of the hand fist, knees or elbows are prohibited.**

**D. STRIPPING**

(1) Stripping consists of forceful removal of detainees' clothing. In addition to degradation of the detainee, stripping can be used to demonstrate the omnipotence of the captor or to debilitate the detainee. Interrogator personnel tear clothing from detainees by firmly pulling downward against buttoned buttons and seams. Tearing motions shall be downward to prevent pulling the detainee off balance.

**4. PHYSICAL DEBILITATION TACTICS**

a. STRESS POSITIONS. Stress positions are used to punish detainees. **ALL STRESS POSITIONS ARE RESTRICTED TO A MAXIMUM TIME OF TEN MINUTES AND A LOGBOOK ENTRY IS REQUIRED.** An interrogator/guard will remain with detainees during use of stress positions. The authorized positions are:

(1) Head Rest/Index Finger position - Detainee is placed with forehead or fingers against the wall, then the detainee's legs are backed out to the point that the detainee's leaning weight is brought to bear on fingers or head.

(2) Kneeling position - Administered by placing detainee on knees and having him lean backward on heels and hold hands extended to the sides or front, palms upward. Light weights such as small rocks, may be placed in the detainee's upturned palms. **The detainee will not be placed in a position facing the sun or floodlights.**

(3) Worship-the-Gods - The detainee is placed on knees with head and torso arched back, with arms either folded across the chest or extended to the side or front. **The detainee will not be placed in a position facing the sun or floodlights.**

(4) Sitting Position - the detainee is placed with his back against a wall, tree or post; thighs are horizontal, lower legs are vertical with feet flat on floor or ground as though sitting in a chair. Arms may be extended to sides horizontally, palms up and boots on.

(5) Standing position - While standing, the detainee is required to extend arms either to the sides or front with palms up. Light weights such as small rocks may be placed in upturned palms.

## 5. ISOLATION AND MONOPOLIZATION OF PERCEPTION TACTICS

### a. HOODING

(1) Hoods are lightweight fabric sacks large enough to fit loosely over a detainee's head and permit unrestricted breathing.

(2) Hooding is used to isolate detainees. Individually hooded detainees may be moved provided an interrogator/guard leads the detainee. Detainees may not be left standing alone with the hood on. They must be placed either on their stomachs, kneeling, or sitting. **Detainee medical limitations must be considered.**

## 6. DEMONSTRATED OMNIPOTENCE TACTICS

a. MANHANDLING. Manhandling consists of pulling or pushing a detainee. It is used as an irritant and to direct the detainee to specific locations. Detainees must be handcuffed and must grasp their trousers near mid-thigh with both hands. The interrogator firmly grasps detainee's clothing and then moves the detainee at a walking pace. The interrogator must maintain positive control of the detainee. **The detainee is not released until the interrogator is positive the detainee has regained balance.**

b. WALLING. \*\*\*\*\* Walling consists of placing a detainee forcibly against a specially constructed wall. Walling will only be performed in designated areas where  
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10 DECEMBER 2002

specially constructed walls have been built. Walling is used to physically intimidate a detainee. The interrogator must ensure the wall is smooth, firm, and free of any projections. If conducted outside, footing area must be solid and free of objects that could cause detainee or interrogator to lose their

balance. **A detainee can be taken to the wall a maximum of three times per shift.** Walling is done by firmly grasping the front of the detainee's clothing high on each side of the collar, ensuring the top of the clothing is open. Care should be taken to ensure detainees with long hair do not get their hair tangled into the folds of clothes being grasped by the interrogator. To avoid bruising the detainee, roll hands under folds of clothing material and ensure only the backs of the hands contact detainee's chest. Maintain this grip throughout, never allowing the detainee to be propelled uncontrollably. **Ensure only the broad part of the shoulders contact the surface of the wall. Grip the detainee's clothing firmly enough so the collar acts as a restrictive constraint to preclude the detainee's head from contacting the wall does this. If the detainee's head inadvertently touches the wall, walling will be ceased immediately.** Walling is to be used by those interrogators designated in writing by the ICE CHIEF.

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## June 10th Congressional Briefing on Abu Ghraib

Heather OBeirne Kelly  
APA Science Policy

One of the goals of APAs Public Policy Office is to bring relevant psychological science to bear on issues of national concern. On Thursday, June 10, science policy staff organized an APA Congressional Briefing on Capitol Hill to educate a target audience of congressional staff and federal agency personnel about psychological research related to the recent incidents in the Abu Ghraib prison in Iraq. Two distinguished psychological scientists spoke at the briefing: social psychologist Steve Breckler, PhD (APAs Executive Director for Science) and I-O psychologist **Kevin Murphy**, PhD (head of the Department of Psychology at The Pennsylvania State University).



In his talk, *How can the Science of Human Behavior Help us Understand Abu Ghraib?*, Breckler gave an overview of the social psychological principles relevant to the prisoner abuse situation. Drawing on decades of research on the power of the situation to influence and shape behavior and on the stability of individual personalities, Breckler discussed the relevance of findings on social conformity, compliance, obedience to authority, individual differences, and factors that mitigate responses to social influence.

**Steve Breckler discusses** Murphys presentation, *How can Psychological Research in Military Contexts Help Us Prevent Another Abu Ghraib?*, highlighted the study of organizations, and the military in particular. Murphy

focused on how our knowledge about organizational climate and cultural factors, end-accountability, collective corruption, leadership, training, and whistle-blowing can be effectively transferred into military contexts to impact prevention of further incidents and intervention following such events.



The briefing drew a large crowd, even in the midst of an unusual week in Washington during which former President Reagan lay in state in the U.S. Capitol. Rep. Ted Strickland, a psychologist in the U.S. House of Representatives and a former consultant to a correctional facility, planned to make remarks at the APA briefing but was unable to attend due to changes in the congressional schedule. More information can be found at <http://www.apa.org/ppo/issues/abughraibbrief04.html>.

**Kevin Murphy discusses** relationships between organizational factors and individual behavior.



DEPARTMENT OF THE ARMY  
OFFICE OF THE SURGEON GENERAL  
5109 LEESBURG PIKE  
FALLS CHURCH, VA 22041-3258

REPLY TO  
ATTENTION OF

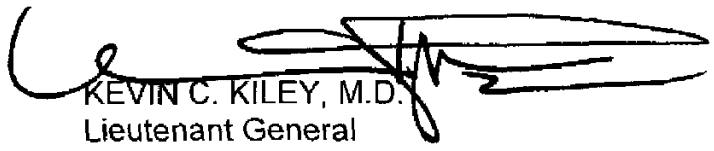
MCJA

MAY 24 2005

## MEMORANDUM FOR RECORD

SUBJECT: Approval of Findings and Recommendations of Functional Assessment Team Concerning Detainee Medical Operations for OEF, GTMO, and OIF

1. I have reviewed the findings and recommendations of the assessment team concerning detainee medical operations for OEF, GTMO, and OIF and the legal review of that report.
2. I hereby approve all the findings and recommendations except the recommendation that psychiatrists/physicians not be used as members of a Behavioral Science Consultation Team (BSCT) and that all detained individuals be treated to the same care standards as U.S. patients in the theater of operation. I direct that these recommendations be further reviewed to determine whether these recommendations should be approved.
3. I also direct the MEDCOM Staff Judge Advocate to make appropriate coordination with the Army Inspector General's Office concerning the alleged misconduct of two senior officers pursuant to paragraph 8-3, AR 20-1.
4. Lastly, I direct that the MEDCOM Staff Judge Advocate coordinate with the appropriate Command/Investigative Organization to determine the final disposition of the other three incidents that were previously referred by the assessment team for appropriate action.

  
KEVIN C. KILEY, M.D.  
Lieutenant General  
The Surgeon General



DEPARTMENT OF THE ARMY  
US ARMY MEDICAL RESEARCH AND MATERIEL COMMAND  
504 SCOTT STREET  
FORT DETRICK, MD 21702-5012

REPLY TO  
ATTENTION OF

MCMR-ZA

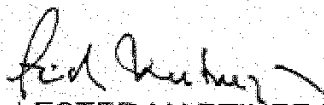
13 April 2005

MEMORANDUM FOR The Army Surgeon General, 5109 Leesburg Pike,  
Falls Church, VA 22041-3258

SUBJECT: Assessment of Detainee Medical Operations for OEF, GTMO, and OIF

1. Reference Memorandum, TSG, Army, Subject: Appointment as Team Leader, Functional Assessment Team, dated 12 November 2004.
2. The attached report documents the assessment of detainee medical operations for the OEF, GTMO, and OIF completed during the period 23 November 2004 to 13 April 2005.
3. The report includes the background and methodology utilized by the Team and addresses each area of interest specified in the appointment memorandum, with findings, discussion and recommendations. The report highlights other key observations pertinent to detainee medical operations, and includes a table of reported incidents and allegations related to medical records, medical practice, interrogation, supplies, staffing, and potential abuse.
4. The team appreciated the courtesies and cooperation provided throughout the visits by all headquarters and staff elements and their personnel, particularly the 30<sup>th</sup> Medical Brigade and European Regional Medical Command which provided outstanding support for our overseas travels. In traveling to more than 22 states and five foreign countries, an extensive logistical effort was required to arrange interviews and provide work space for the interviews. The team was continually impressed by the dedication and devotion of the Soldiers interviewed. Their commitment to providing quality healthcare for detainees as well as U.S. and Coalition Forces was clearly evident.
5. POC for the attached report is COL (b)(6)-2

(b)(6)-2

  
LESTER MARTINEZ-LOPEZ  
Major General, Medical Corps  
Commanding

ENCL

**FINAL REPORT**

**ASSESSMENT OF  
DETAINEE MEDICAL OPERATIONS  
FOR  
OEF, GTMO, AND OIF**

**OFFICE OF THE  
SURGEON GENERAL  
ARMY**

**13 April 2005**

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# **ASSESSMENT OF DETAINEE MEDICAL OPERATIONS FOR OEF, GTMO, AND OIF**

## **OFFICE OF THE SURGEON GENERAL, ARMY**

**13 APRIL 2005**

### **EXECUTIVE SUMMARY**

On 12 November 2004, The Army Surgeon General, LTG Kevin C. Kiley, directed the Commander of the U.S. Army Medical Research and Materiel Command, MG Lester Martinez-Lopez, to lead a multidisciplinary Functional Assessment Team (the Team) to assess detainee medical operations in Operation Enduring Freedom (OEF), Guantanamo Bay, Cuba (GTMO) and Operation Iraqi Freedom (OIF). LTG Kiley specifically directed the team to look at 14 assessment questions with respect to Army active component (AC) and reserve component (RC) medical personnel providing support and/or care to detainees in Afghanistan, Cuba, and Iraq. In formulating the assessment approach, the team reviewed previous assessments related to detainee operations and investigations of detainee abuse, as well as policies, regulations, and field manuals outlining the precepts of detainee operations. The medical assessment focused on aspects related to: (1) detainee medical policies and procedures, (2) medical records management, and (3) the incidence and reporting of alleged detainee abuse by medical personnel; the fourth focus area of training medical personnel for the detainee health care mission was addressed within focus areas (2) and (3).

The Team found a dedicated and committed cadre of medical personnel whose goal and desire were to provide high quality healthcare for each patient they treated, regardless of status. While medical personnel faced numerous challenges in a stress-filled environment, the interviewees continually described the compassionate and dedicated care they provided to detainees. Many medical personnel described the extraordinary measures and efforts put forth to care for and save the lives of detainees. Our medical Soldiers represent the best our country has to offer and they truly gave of themselves to serve our Nation.

#### **Methods**

The Team interviewed medical personnel in maneuver, combat support, and combat service support units in 22 states and 5 countries. The interviewees were preparing to deploy (future), had previously deployed (past), or were currently deployed (present) to OEF, GTMO, or OIF; they included AC and RC (U.S. Army Reserve (USAR) and National Guard (NG)) personnel. For the current interviews, the Team visited the detention medical facilities at Bagram, Afghanistan and Guantanamo Bay, Cuba, and in Iraq, the Team met with the Commander, Task Force (TF) 134 (TF responsible for detainee operations), and interviewed medical personnel supporting detainee operations at Abu Ghraib, Camp Danger, Camp Liberty and Camp Bucca. In Kuwait,

the Team met with the Combined Forces Land Component Command (CFLCC) Deputy Commander and Chief of Staff, as well as the CFLCC Surgeon, to gain a perspective on the planning factors for detainee medical operations. For the past and future interviews, the Team traveled to units in 22 states and Germany. A leadership perspective on the issue of detainee medical operations was gained through interviews with medical personnel from command and control elements at corps, theater, and level I, II and III medical units. For training interviews, the Team visited faculty and students of training programs at the Army Medical Department Center and School (AMEDDC&S), and trainers at the Military Intelligence (MI) School, National Training Center (NTC), Joint Readiness Training Center (JRTC), Continental U.S. Replacement Centers (CRC), and 12 Power Projection Platform (PPP) sites. Additionally, lesson plans and other training materials were reviewed at these training sites.

## **Units**

The identification of each unit, the location in theater, and personnel providing medical support to detainees for OEF and GTMO was more easily discernable than for the OIF theater. In OIF, more than 50,000 detainees have moved from point of capture and collection points, through brigade (Bde) and division internment facilities, to the major prison facilities. Due to the rapidly evolving operational environment, medical personnel served in numerous locales in the OIF theater and provided detainee medical support across the continuum of care, ranging from medical screening to acute trauma management, evacuation, and long-term rehabilitative and chronic disease care.

## **Interviews**

A total of 1,182 personnel were queried, from over 180 military units, in the following categories:

For the past/present/future personnel, 993 interviews (80%AC/8%USAR/12%NG) encompassed 803 (81%) past, 77 (8%) present, and 113 (11%) future deployers to OEF, GTMO or OIF. These interviewees included 705 (71%) males and 288 (29%) females; 522 (52.7%) officers, 3 (0.3%) warrant officers, and 468 (47%) enlisted personnel.

Questionnaires were completed by 166 students at the AMEDDC&S, encompassing 20 91G (Patient Administration Specialist), 74 91W (Health Care Specialist), 17 91WM6 (Health Care Specialist/Licensed Practical Nurse), 15 91X (Mental Health Specialist), and 40 Officer Basic Course (OBC) students.

A total of 12 PPP questionnaires were completed at Ft. Benning (1 MOB, 1 CRC), Ft. Bliss (1 MOB, 1 CRC), Ft. Carson (1 MOB), Ft. Dix (1 MOB), Ft. Drum (1 MOB), Ft. Hood (1 MOB), Ft. Lewis (1 MOB), Ft. Polk (1 MOB), Ft. Riley (1 MOB), and Ft. Sill (1 MOB). Interviews were conducted at the JRTC (Ft. Polk) and NTC (Ft. Irwin).



Interviews were conducted with 11 past (6) and present (5) Behavioral Science Consultation Team (BSCT) members assigned to GTMO (7) and OIF (4).

## **Policy and Guidance**

*Theater-Level Policy and Guidance.* In reviewing policy and guidance, including Operation Orders (OPORDs), Fragmentary Orders (FRAGOs), and Standing Operating Procedures (SOPs), OEF theater-specific detainee medical policies were found dating back to 2004; 47% of past and 60% of present OEF interviewees were aware of the policies. GTMO had well-defined detainee medical policies that have been in place since 2003; 100% of the interviewed personnel were aware of the policies. For OIF, there was no evidence of specific theater-level policies for detainee medical operations until 2004. Only 56% of past OIF interviewees were aware of policies in theater, whereas 88% of current OIF interviewees were aware of policies in theater. This improvement is attributed to the superlative efforts of TF134, combined with the introduction of one field hospital for level III+ detainee health care management across the theater.

*Standard of Care.* In the early stage of OIF, there was confusion among some medical personnel, both leaders and subordinates, regarding the required standard of care for detainees. Medical personnel were unsure if the standard of care for detainees was the same as that for U.S./Coalition Forces in theater, or if it was the standard of care available in the Iraqi health care system. This confusion may be explained by the use of different classifications for detained personnel (Enemy Prisoner of War (EPW), detainees, Retained Personnel (RP), Civilian Internees (CI)) that, under Department of Defense (DoD) and Department of the Army (DA) guidance, receive different levels care. Theater-level guidance was not provided in a timely manner to early-deploying medical units or personnel, and in the absence of guidance many units developed their own policies. As the OIF theater matured and roles and responsibilities were clarified, theater-level policy was developed and promulgated, resolving the early confusion.

*Recommendations.* Although not required by law, DA guidance (DoD level is preferable) should standardize detainee medical operations for all theaters, should clearly establish that all detained individuals are treated to the same care standards as U.S. patients in the theater of operation, and require that all medical personnel are trained on this policy and evaluated for competency.

## **Medical Records**

*Medical Records Training.* Medical records management was a primary area of focus for this assessment. When asking past/present/future personnel from OEF, GTMO, and OIF about their training in detainee medical records management, 4% of AC and 6% of RC interviewees received Military Occupational Specialty (MOS) or other school training. When asked about unit training at home station, 6% of AC and 4% of RC interviewees reported receiving training. During mobilization, 5% of AC and 8% of RC interviewees reported receiving training about detainee medical records. For

past/present personnel from OEF, GTMO, and OIF, 27% of AC and 35% of RC interviewees reported receiving training in theater.

*Medical Records Generation.* There was wide variability in medical records generation at level I and II facilities. In some cases, no records were generated. In others, detainee care was documented in a log book for statistical purposes and unit reports. In other cases, care was documented on Field Medical Cards (FMCs) (Department of Defense Form 1380 (DD1380)) only. Some of the units with log books or FMCs created Standard Form 600 (SF600) (Chronological Record of Medical Care) for detainee patients requiring complex treatment, with chronic medical conditions, and/or for those being evacuated to higher levels of care. Some units used overprinted SF600 to document screenings, and others used completed SF88 (Report of Medical Examination) and SF93 (Report of Medical History). Level III facilities consistently generated detainee medical records in the same manner as records for U.S. and Coalition Forces.

*Access to and Security of Detainee Medical Records at Detention Medical Facilities.* The Team was asked to address access to, and security of, detainee medical records at detention medical facilities. This was accomplished with several specific interview questions as well as direct observations and questions during site visits to the facilities at OEF, GTMO, and OIF. Individual responses to the pertinent questions were generally very consistent within each location, as well as across all locations. In general, the medical records for detainees were managed the same as records for the AC. The security of records and confidentiality of medical information tended to be better at detention facilities that were co-located with medical facilities. Security and confidentiality also generally improved as an individual theater matured. When asked about which “other” personnel could have access to detainee medical records besides the treating medical personnel, the vast majority of answers were: Patient Administration (PAD), Criminal Investigation Division (CID), the International Committee of the Red Cross (ICRC), and medical chain of command. Very few individuals responded that military police (MP) or other detention facility personnel could have access to medical records.

*Medical Screening, Medical Care, and Medical Documentation Associated with Interrogation.* There are inconsistencies in the guidance for pre- and post-interrogation screening. Medical care, including screenings, at or near the time of interrogation, was neither consistently documented nor consistently included in detainee medical records. Some medical personnel were unclear whether interrogations could be continued if a detainee required medical care during the interrogation. Medical personnel at some locations felt empowered to halt interrogations for either medical or safety reasons.

*Storage of Originals and Copies of Medical Records.* The team found that level I and II facilities stored original medical records at detention facilities, detention medical facilities, and medical unit treatment areas. In some cases the records were maintained with interrogation records maintained by MI or MP personnel. At level III facilities, the originals were maintained by PAD. The availability of copy machines was variable;

therefore, when detainees were transferred to other detention facilities or medical facilities, either the original or a copy of the medical record was sent.

*Disposition of Medical Records.* The original detainee medical records and original U.S. Forces medical records at level III facilities are sent to Patient Administration Systems and Biostatistics Activity (PASBA). Within and among all interviewed units providing level I and II medical care, there was extreme variability in the method of documentation, the circumstances influencing the creation of documentation, and the maintenance and final disposition of detainee medical records.

*Recommendations.* DA guidance (DoD level is preferable) should require that detainee medical records at facilities delivering level III and higher care be generated in the same manner as records of U.S. patients in theater. Guidance should address the appropriate location and duration of maintenance as well as the final disposition of detainee medical records at facilities that deliver level III or higher care. Most importantly, guidance is needed to define the appropriate generation, maintenance, storage, and final disposition of detainee medical records at units that deliver level I and II care.

## **Reporting of Detainee Abuse**

*Abuse Reporting Training.* The Team found that 16% of AC and 15% of RC interviewees (past/present/future OEF/GTMO/OIF combined) received MOS or other school training about reporting possible detainee abuse. When asked about training at home station on this topic, 21% of AC and 14% of RC interviewees reported receiving training. During mobilization, 25% of AC and 26% of RC interviewees reported receiving training. For the past/present OEF/GTMO/OIF deployers, 40% of AC and 26% RC interviewees reported receiving this training in theater.

*Abuse Reporting Policies.* Unit policies, SOPs and Tactics, Techniques, and Procedures (TTPs) were most often either absent or not properly disseminated to deployed medical personnel. The Team found no DoD, Army, or theater policies requiring that actual or suspected abuse be documented in a detainee's medical records; however, theater-level guidance specifically requiring medical personnel to report detainee abuse was implemented just within the past year. The Team found that 37.0% (295 of 798) of formerly deployed OEF/GTMO/OIF interviewees were aware of a unit requirement to report suspected detainee abuse; 94.2% (278 of 295) of these interviewees reported their unit followed the policies; 85.5% (65 of 76) of presently deployed OEF/GTMO/OIF interviewees were aware of such policies; and 98.5% (64 of 65) of these interviewees reported their unit followed the policies. Medical personnel with knowledge of existing unit policies/SOPs/TTPs overwhelmingly complied with such guidance (94%) and, over time, awareness of unit level policies requiring reports of detainee abuse has steadily increased.

*Observing and Reporting Suspected Detainee Abuse.* The personnel interviewed during this assessment were vigilant in reporting actual or suspected detainee abuse to their medical supervisor, chain of command, or CID. Only 5% of previously deployed

interviewees directly observed suspected abuse and only 5% had a detainee report abuse to them. Previously deployed interviewees reported the suspected abuse 91% of the time when the suspected abuse was alleged by a detainee and 80% if they directly observed suspected detainee abuse. For those interviewees presently deployed, 25% had a detainee report alleged abuse and 3% directly observed suspected abuse. All presently deployed interviewees reported the alleged or suspected abuse. Only 2 medical personnel failed to properly report actual or suspected detainee abuse that had not previously been conveyed to an appropriate authority. The Team referred these cases to the CID.

### *Recommendations.*

**Medical.** At all levels of professional training, medical personnel should receive instruction on the requirement to detect, document and report actual or suspected detainee abuse. This training should include the definition and signs of suspected detainee abuse. Scenario-based training on detecting detainee abuse should be developed and fielded at non-Army Medical Department (AMEDD) training sites such as JRTC, NTC, PPP, CRC, etc. All deploying medical personnel should receive this training prior to arrival in theater.

**DoD-Wide.** It is important to have clearly written standardized policies for detecting, documenting and reporting actual or suspected detainee abuse at all levels of command. Medical planners at all levels should ensure clearly written standardized guidance is provided to all medical personnel. This guidance should list possible indicators of abuse and contain concise instruction documentation and procedure for reporting actual or suspected abuse.

### **Other Issues**

This assessment addressed several other issues the Team deemed relevant to detainee medical operations that were not specifically directed by the appointing memorandum. The topics include: (1) overview from site visits to Afghanistan, Cuba and Iraq; (2) OIF theater preparation for detainee care; (3) medical screening and sick call at the division internment facilities (DIFs) and prisons; (4) restraints and security; (5) medical personnel interactions with interrogators; (6) medical personnel photographing detainees; (7) the use of behavioral science consultation teams (BSCT) in the interrogation process; (8) stress on medical personnel providing detainee medical care; and (9) interviewee training requests.

*Overview of Site Visits to Afghanistan, Cuba and Iraq.* The overall quality of outpatient and inpatient detainee medical care is extremely high. Detainees are treated with dignity and respect. Detainee rights and patient rights are clearly posted. Medical records are very complete and contain master problem lists. Daily sick call is well organized. Medical personnel know procedures for reporting abuse and follow those procedures. All facilities are staffed with extremely dedicated personnel who take their responsibilities very seriously.

*OIF Theater Preparation for Detainee Care.* In planning for detainee medical operations, there were limited assets allocated to provide support for detainee/EPW medical care. The plan did not encompass medical assets to provide chronic care, definitive care, or rehabilitative care. There was a requirement to deliver medical care to detainees in theater; however, level I, II, and III medical assets were not resourced to care for the special needs presented by this population. Recommend the AMEDD establish an experienced subject matter expert (SME) team to comprehensively define the personnel, equipment, and supply needs to support detainee medical operations, and develop a method to ensure a flexible delivery system for these special resources.

*Medical Screening and Sick Call at the Division Internment Facilities (DIF) and Prisons.* The Team found that detainees have excellent access to daily sick call, outpatient, and inpatient medical care at the DIFs and Prisons. The vast majority of interviewees reported that initial screening medical examinations were performed during in-processing to a DIF or prison. Recommend DA guidance (DoD level is preferable) require initial medical screening examinations shortly after arriving at the detention facility.

*Restraints/Security.* The use of physical restraints for detainees varied widely within and among all interviewed units. The Team found no evidence that medical personnel used medications to restrain detainees. Interviewees reported medical personnel were tasked to perform a variety of detainee security roles. Medical documentation of restraint was neither uniform nor consistent. Some medical units used restraints on all detainees for security reasons, some used them only when detainees were violent or disruptive, and others (specifically level III facilities) used them only for medical indications such as attempts to dislodge medical devices, or for risk of falling. Interviewees expressed concern over the tasking of medical personnel for detainee security purposes. This concern is based on the ethical conflict of both caring for and guarding detainees. Additionally, as medical personnel were tasked to provide security support, it impacted on the ability of the medical unit to provide care to all patients, including U.S. Soldiers. Recommend DA (DoD level is preferable) standardize the use of restraints for detainees in units delivering medical care. The guidance should contain clear rules for security-based restraint versus medically-based restraints. Medical personnel should not be encumbered with duties related to security of detainees.

*Medical Personnel Interactions with Interrogators.* The Team found that medical personnel participation in interrogations was exceedingly rare and was reported only five times, and occurred only in OIF at units providing level I or II care. The evaluation or treatment of detainee patients was rarely delayed for intelligence gathering purposes. Medical personnel were rarely requested to be present during interrogations. Many interviewees reported the existence of policies that addressed the interaction between medical personnel and interrogators; however, dissemination and awareness of these policies were inconsistent. As the OEF and OIF theaters matured, dissemination and awareness of these policies improved for level III facilities. DA guidance (DoD level is preferable) should prohibit all medical personnel from active participation in

interrogations. This includes medical personnel with specialized language skills serving as translators. Empower medical personnel to halt interrogations when a necessary examination or treatment is required.

*Medical Personnel Photographing Detainees.* There are inconsistencies among Army Regulations, individual unit guidance, and usual medical practices regarding photographing detainees. Many medical personnel photographed detainees for a variety of reasons including medical documentation, future teaching material, supporting criminal investigation, and to provide a means for family members to identify a detainee. While AR 190-8, paragraph 1-5d, strictly prohibits photographing enemy prisoners of war, retained persons, and civilian internees “for other than internal internment facility administration or intelligence/counterintelligence purposes,” chapter 34 of the 2004 edition of the text “Emergency War Surgery” advocates units having a digital or other high quality camera for use in medical documentation of EPW injuries. This text also advocates the inclusion of faces in these pictures for accurate, efficient, and complete documentation of patient injuries and surgical interventions. Additionally, AR 40-66, paragraph 2-8b (which is not specific to detainees), permits photographs but requires consent be obtained prior to releasing photographs “of a person or of any exterior portion of his or her body” for the purpose of research. DA guidance (DoD level is preferable) should authorize photographing detainee patients for the exclusive purpose of including these photos in medical records. Informed consent should not be required to use photographs in this manner (consistent with AR 40-66). Additionally, photographs of detainees taken by medical personnel for other reasons, including future educational material, research, or unit logs, should require a detainee's informed consent.

*Behavioral Science Consultation Teams (BSCT).* BSCTs consisted of physicians/psychiatrists and psychologists who directly support detainee interrogation activities. Physicians and psychologists were initially assigned to this duty in 2002 at GTMO and in December 2003 for OIF. Since January 2004 these positions have been staffed by psychologists. This issue has been raised in previous assessments and investigations. There is no doctrine or policy that defines the role of behavioral science personnel in support of interrogation activities. The most complete guidance found by the Team were SOPs that describe the role and responsibilities of personnel serving in BSCT positions. In the purest sense, the mission of the BSCT is to provide forensic psychological expertise and consultation to assist the command in conducting safe, legal, ethical, and effective interrogation and detainee operations. DoD should develop well-defined doctrine and policy for the use of BSCT personnel. A training program for BSCT personnel should be implemented to address the specific duties. The Team recommends that more senior psychologists should serve in this type of position. There is no requirement or need for physicians/psychiatrists to function in this capacity.

*Stress on Medical Personnel Providing Detainee Medical Care.* Medical personnel were not specifically asked to describe their personal deployment experiences; however, during numerous interviews memories of personal experiences re-surfaced. Many of these interviewees noted this was the first time they had the opportunity to

share personal experiences. The issues raised by medical personnel included the ethical dilemma of providing care to insurgents that killed or injured U.S. Soldiers, providing care to Soldiers and Iraqis with limited medical resources, the quantity and severity of the injuries observed, and the stress of a warfare environment. Recommend the U.S. Army Medical Command (MEDCOM) establish an experienced SME team comprised of a psychiatrist, a psychologist, chaplain, and clinical representation from all levels of care, to comprehensively define the training requirements for medical personnel in their pre-deployment preparation. Other initiatives include revising combat stress control doctrine to effectively deliver support to medical personnel in theater, develop an effective system to regularly monitor post deployment stress, and refine leadership competencies to assess, monitor and identify coping strategies of medical personnel in a warfare environment.

*Interviewee Training Requests.* The Team asked interviewees the following question: "If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care?" Many interviewees noted that current training in this area was not sufficient. The most commonly recommended topics were: cultural awareness training (including religious differences, local customs, accepted societal behaviors, diet, etc.); basic medical and conversational language training for the respective area of operation, with emphasis on triaging and treating detainee patients and U.S./Coalition patients in the same manner; and medical Rules of Care. Other key training needs identified by the interviewees were stress management for medical personnel; retraining for sub-specialists utilized in other roles (e.g., primary care, emergency room, or general surgery); how to handle interactions with other government agencies (OGAs), MI personnel, and interpreters; field sanitation issues; preparation for long-term care of detainees; treatment of blast and gunshot injuries; and interest in having more mass casualty (MASCAL) exercises.

## **Conclusion**

The Team was very impressed with current detainee medical operations in OEF, GTMO, and OIF. In the early phases there were definite shortcomings; however, in the ongoing maturing process, policies are being established, training conducted, and resources provided to ensure appropriate standardized detainee medical operations. Indeed, a number of interviewees discussed shortcomings at their arrival, but reported significant improvements during their tour. There are still opportunities for improvement and the Team has provided a comprehensive list of recommendations to assist the process. We have been honored to conduct this assessment; the experience has reinforced our pride as members of the AMEDD.

## Chapter 2 Background

### 2-1. Synopsis

a. With the current hostilities in Afghanistan (OEF) and Iraq (OIF), and the confinement by U.S. military personnel of detainees in Afghanistan (GTMO) and Iraq, concerns regarding the appropriate treatment of detainees, including during interrogation and access to medical care, have arisen. Increased concern arose with revelations of detainee abuse in the Abu Ghraib Detention Facility in Iraq. Additionally, reports in the press have alleged wrongdoing by military medical personnel.

b. A series of investigations have alleged wrongdoings and have recommended reforms, including actions of Army medical personnel. Some of these reports looked at medical issues; however, to date, there has not been a medical specific assessment of detainee operations in OEF, GTMO or OIF.

c. The Army Surgeon General (TSG), LTG Kevin C. Kiley, reviewed the Fay/Jones report (Cit. 25) with the Army's senior leadership, including recommendations that further inquiry was necessary to determine (i) if detainee medical records were properly maintained; and (ii) if medical personnel were aware of detainee abuse and failed to report the abuse.

d. On 12 November 2004, LTG Kiley directed MG Lester Martinez-Lopez, Commander of the U.S. Army Medical Research and Materiel Command, to lead a Functional Assessment Team (the Team) to determine whether detainee medical records were properly maintained; whether medical personnel were aware of detainee abuse and failed to report abuse; and to determine whether medical personnel received and/or are currently receiving appropriate training so that they are fully prepared to perform the mission of caring for detainees.

### 2-2. Chronology of Important Events

Date	Event
7 Oct 01	OEF begins in Afghanistan
11 Nov 01	First detainees secured at Mazar-e-Sharraf
Dec 01	Bagram Holding Area (BHA) and Kandahar Holding Area (KHA) open
Jan 02	ICRC conducts first visit to Bagram detention facility
1 Jan 02	First detainees arrive at GTMO
Jan 02	ICRC conducts first visit to GTMO detention facility
19 Mar 03	Invasion of Iraq begins (OIF)
4 Aug 03	Abu Ghraib prison reopened by the Coalition Provisional Authority (CPA)



Aug 03	MG Miller leads survey team to assess intelligence, interrogation, and detention operations in Iraq ( <i>Miller Report</i> )
24 Oct 03	Date stamp on prison scandal pictures from Abu Ghraib
Oct / Nov 03	MG Ryder: Office of the Provost Marshal General of the Army – “Report on Detention and Corrections Operations in Iraq” ( <i>Ryder Report</i> )
Oct 03	ICRC visits Abu Ghraib
Nov 03 – Mar 04	MG Taguba: “AR 15-6 Investigation of the 800 <sup>th</sup> Military Police Brigade” ( <i>Taguba Report</i> )
Feb 04	ICRC: “Treatment by Coalition Forces of Prisoners of War and Other Protected Persons by the Geneva Conventions in Iraq during Internment and Interrogation” submitted to LTG Sanchez
Feb 04	The Department of the Army Inspector General (DAIG): “Inspection of Detainee Operations Inspections” in OEF, GTMO, and OIF ( <i>DAIG Report</i> )
Feb 04	Task Force (TF) Oasis begins medical care at Abu Ghraib
Mar 04	MG Fay and LTG Jones: “AR 15-6 investigation of Abu Ghraib Prison and the 205 <sup>th</sup> Military Intelligence Brigade” ( <i>Fay/Jones Report</i> [also called the <i>Kern Report</i> ])
May 04	MG Jacoby: “Detention Operations and Facilities in Afghanistan” ( <i>Jacoby Report</i> )
May 04	Vice Admiral Church investigates DoD interrogation operations in OEF, GTMO and OIF ( <i>Church Report</i> )
Aug 04	Schlesinger: “Final Report of the Independent Panel to Review DoD Detention Facilities” ( <i>Schlesinger Report</i> )
Aug 04	115 <sup>th</sup> Field Hospital (FH) arrives at Abu Ghraib
Oct 04	115 <sup>th</sup> FH arrives at Camp Bucca
12 Nov 04	Tasking of the Team

### 2-3. Previous Reports - Summary of Findings and Recommendations Regarding Detainee Medical Care

a. *Ryder Report* (Cit. 39). The Ryder Report contains several observations regarding detainee medical care, health management and medical care.

(1) No clear delineation of the responsibilities of health care existed for the various detainee categories. This resulted in confusion regarding the responsibilities between the U.S. military and CPA health care systems. MG Ryder stated a clear need for published guidance regarding detainee categorization and health care directives.

(2) The expansion of mission responsibilities, to include serving as the Iraqi correctional medical system until it is fully operational, challenged the health care delivery system.

(3) The rapid turnover of MP Bde Surgeons, on a 90-day rotation, creates significant correctional health care management concerns and inefficiencies. Recommended a one-year rotation for Bde Surgeons who are versant in preventive medicine and/or correctional medical operations for continuity and mission oversight.

(4) Mentally ill detainees were receiving no treatment. Mental illness was a grossly neglected area for the health care of Iraqi detainees. Mental health services must be incorporated into the correctional health care model.

b. *Taguba Report* (Cit. 44). The Taguba report contains minimal comments regarding medical care and medical assets at Abu Ghraib. Two medics provided witness statements. Additionally, testimony from non-medical personnel and detainees included both positive and negative comments concerning medical personnel at Abu Ghraib.

c. *DAIG Report* (Cit. 19). This inspection was a comprehensive review of how the Army conducts detainee operations in Afghanistan and Iraq. Medical issues related to detainee care were included in this functional analysis.

(1) Holding detainees for longer timeframes at all locations resulted in increased requirements in facility infrastructure, medical care, preventive medicine, trained personnel, logistics, and security. Organic unit personnel at these locations did not have the required institutional training and were therefore unaware of, or unable to fully comply with, Army policies in areas such as detainee processing, confinement operations, security, preventive medicine, and interrogation.

(2) The DAIG Team inspected four Internment/Resettlement facilities and 12 forward and central collection points. No units fully complied with the Geneva Conventions requirements for medical treatment of detainees, or with the required sanitary conditions for detainee facilities. Not all medical personnel were aware of detainee medical treatment requirements. They also lacked the proper equipment to treat a detainee population. Medical personnel reported no specific training in detainee operations. There was a widespread lack of preventive medicine resources.

d. *Fay/Jones Report* (Cit. 25). This report did not focus on issues of medical care. The report contains references to, and statements by, medical personnel regarding suspicion of, knowledge of, and reporting of detainee abuse. The report also concludes medically related joint doctrine and policy was not always followed.

(1) Specifically, joint doctrine and policy defines a requirement for medical screening of all detainees. This requirement was not being met at Abu Ghraib. Additionally, there was an absence of medical documentation for some detainees, and a general absence of a centralized management system for medical evaluations. The report also concludes that medical personnel are included in the 54 personnel found to have some degree of responsibility or complicity in the abuse that occurred at Abu Ghraib.

(2) This report recommends improved training to all personnel in Geneva Conventions, detainee operations, and the responsibilities of reporting detainee abuse. The report recommends Training and Doctrine Command (TRADOC) address medical record keeping and information sharing requirements.

e. *Church Report* (Cit. 15). Specific medically related findings include:

(1) Medical personnel understood their responsibility to provide humane medical care to detainees in accordance with U.S. military medical doctrine and the Geneva Conventions.

(2) There was inconsistent field level implementation of medical documentation, medical record handling, and medical treatment (for example, medical screenings).

(3) The report described the role of behavioral science personnel who assisted interrogation personnel to include observing interrogation, assessing detainee behavior and motivations, reviewing interrogation techniques, and offering advice to interrogators. Behavioral science personnel were not involved in detainee medical care, nor did they have access to detainee medical records. This report recommended a DoD level policy review to ensure behavioral science teams performed with proper safeguards. The report also recommended the status of medical personnel who do not participate in patient care be clarified.

(4) DoD level policy review was necessary to define intelligence personnel access to detainee medical information. There was a substantial variation in access to medical information in different locations. However, no misuse of this information was identified.

(5) Admiral Church concluded there was no way to know if medical personnel reported abuse as necessary. Medical personnel stated they reported abuses when it was suspected. The report states that it appeared that medical personnel may have attempted to misrepresent the circumstances of three separate detainee deaths, possibly in an effort to disguise detainee abuse.

f. *Schlesinger Report* (Cit. 40). This report contains only one specific medically related recommendation (which originated with the Fay/Jones). At least three of the 14 recommendations are applicable to all medical leadership and personnel engaged in detention operations. The three recommendations are:

(1) The nation needs more specialists for detention/interrogation operations, including linguists, interrogators, human intelligence (HUMINT), counter-intelligence, corrections police and behavioral scientists.

(2) All personnel engaged in detention operations from the point of capture to final disposition, should participate in a professional ethics program that would serve as the moral compass for guidance in situations with conflicting moral obligations.

(3) Several recommendations from the Fay investigation cited the failure of medical personnel to report detainee abuse, shortfalls in training and force structure for field sanitation, preventive medicine and medical treatment requirements for detainees.

g. The Team reviewed two reports that are presently classified - the *Miller Report* and the *Jacoby Report* (Cit. 29).

## Chapter 3

### Methodology

**3-1. Team Members.** In a memo dated 12 November 2004, TSG, LTG Kevin C. Kiley, directed the Team to specifically assess issues related to detainee medical care in the OEF, GTMO, and OIF (Exhibit A, Annex 1). MG Lester Martinez-Lopez, Commanding General, U.S. Army Medical Research and Materiel Command and Fort Detrick, Fort Detrick, MD, led the multi-disciplinary team, which included (see Exhibit B for Team biosketches):

- a. COL (b)(6)-2 MS, Garrison Commander, (b)(6)-2 (b)(6)-2
- b. COL (b)(6)-2 MC, Staff Internist and Intensivist, (b)(6)-2 (b)(6)-2 Internal Medicine Consultant to TSG, (b)(6)-2
- c. COL (b)(6)-2 AN, Deputy Commander for Health Services, (b)(6)-2 (b)(6)-2
- d. LTC (b)(6)-2 JA, Staff Judge Advocate, (b)(6)-2 (b)(6)-2
- e. MAJ (b)(6)-2 MC, Program Director, Internal Medicine Residency Program, (b)(6)-2
- f. MSG (b)(6)-2 91W, Soldier Medic Training Site, Noncommissioned Officer in Charge (NCOIC), (b)(6)-2

**3-2. Assessment Questions.** The appointment memo specifically directed the Team to assess the following with respect to AC and RC Army medical personnel providing medical support and care to detainees in OEF, GTMO and OIF: -

- a. *What units provided medical care to detainees in OEF and OIF and what was the period of service for each unit?*
- b. *At what location did each unit provide medical care (e.g., Medical Treatment Facility (MTF), detainee facility, and interrogation facility)?*
- c. *What Military Occupational Specialty (MOS) and Officer Basic Training (OBC) training or other school training did the medical personnel serving in these units receive regarding the generation, storage and collection of detainee medical records and regarding the medical reporting of detainee abuse?*
- d. *Was there any policy guidance, Operation Order (OPORDER), standard operating procedure (SOP), or other authority establishing criteria for providing detainee medical support and/or care in theater of operation?*

*e. What unit training did the active component (AC) receive prior to deployment regarding the generation, storage and collection of detainee medical records and the medical reporting of detainee abuse?*

*f. What unit training did the RC receive at home station, power projection platforms (PPP) and in-theater regarding the generation, storage and collection of detainee medical records and the medical reporting of detainee abuse?*

*g. Identify OEF and OIF detention medical facilities.*

*h. With respect to the detention medical facilities identified in subparagraph g, determine if the facility generated, stored and collected detainee medical records to include records documenting medical support to any detainee being prepared for interrogation, being interrogated, or needing medical treatment as a result of, or immediately after, interrogation.*

*i. With respect to those detention facilities that kept medical records, did medical personnel properly generate, store and collect appropriate medical records of detainees?*

*j. With respect to those detention facilities that kept detainee medical records, identify the location where the original and any copies of the records are maintained.*

*k. Were any medical personnel aware of, or treat injuries related to, actual or suspected detainee abuse?*

*l. Did any medical personnel aware of, or who treated actual or suspected, detainee abuse properly document the abuse?*

*m. To whom did any medical personnel aware of, or who treated, detainee abuse report such abuse?*

*n. Were there any theater or unit policies or established SOP's/Tactics, Techniques and Procedures (TTP) that specifically required medical personnel to report detainee abuse?*

**3-3. Assessment Focus.** From the assigned Assessment Questions, the Team determined four areas of Assessment Focus:

- a. Training.
- b. Detainee medical policies and procedures.
- c. Medical records management.

- d. Incidence of and reporting of detainee abuse by medical personnel.

### **3-4. Methods**

a. In formulating the assessment approach, the Team reviewed previous assessments related to detainee operations and investigations of detainee abuse as well as theater level and unit policies, Army regulations (AR) and field manuals (FM) outlining the precepts of detainee operations (included in Chapter 27, References). The Team reviewed numerous classified documents. The report purposefully cites only unclassified portions of classified documents. The use of these unclassified portions was coordinated with the Medical Research and Materiel Command Operations Division.

b. Based on the review, the Team identified an additional area of focus: the role of medical personnel in the detainee interrogation process.

c. A questionnaire-based measurement tool was determined to be an efficient and effective methodology for obtaining the desired information. Questionnaires with interview questions were developed based on the fourteen assessment questions and four assessment focus areas.

d. A signed Privacy Act Statement (Exhibit C, Annex 3) and Sworn Statement on DA Form 2823 were obtained from interviewees, as explained below.

- e. The assessment methodology was designed with a three-pronged approach.

#### *(1) Training Questionnaires*

(a) *Student Questionnaire*. Used to assess detainee medical operations training at the AMEDDC&S. Not a Sworn Statement, not individual interviews. (Exhibit C, Annex 8)

(b) *PPP / CRC Questionnaire*. Used to assess detainee medical training conducted at the major PPP and CRC training sites. Not a Sworn Statement, individual interviews. (Exhibit C, Annex 6)

(c) *JRTC and NTC Questionnaire*. Used to conduct interviews at the JRTC and the NTC. Not a Sworn Statement, individual interviews. (Exhibit C, Annex 9)

(2) *Behavioral Science Consultation Team Questionnaire*. Used to interview personnel serving on BSCTs at GTMO and OIF (Abu Ghraib). Sworn Statement with individual interviews. (Exhibit C, Annex 7)

(3) *Past/Present Deploying Medical Personnel Questionnaire and Future Deploying Medical Personnel Questionnaire*. Used to interview medical personnel supporting detainee operations in maneuver, combat support, and combat service

support units preparing to deploy (future), those previously deployed (past) and personnel currently deployed (present) to obtain a wide-ranging perspective on the myriad of issues related to detainee medical operations, including a sampling of echelon level I, II and III care providers. After developing a set of core questions, customized questionnaires were developed for different duty positions working at the three levels of care in the past and present or future (Past/Present and Future Questionnaires). A questionnaire with additional questions was also developed to interview headquarters commanders. Sworn Statement with individual interviews. (Exhibit C, Annex 4 & 5)

f. In preparation for conducting the initial surveys and interviews, detainee medical records and detainee autopsy reports were reviewed. Information gleaned from this review provided a list of potential medical personnel for the Team to interview. The Team identified AC/RC units with past, present or future deployments to OEF, GTMO and OIF. The Team did not interview special operational units or special operations personnel. The Team then scheduled interviews and traveled to the units' locations to interview personnel.

### **3-5. Interviews and Units**

a. The Team interviewed medical personnel in maneuver, combat support, and combat service support units in 22 states and 5 countries. The interviewees were in a past, present or future deployment status for OEF, GTMO, or OIF and included AC and RC personnel. For the current interviews, the Team visited the detention medical facilities in Afghanistan (Baghrum) and Cuba (Guantanamo Bay). In Iraq, the Team met with the Commander, TF 134, and interviewed medical personnel supporting detainee operations at Abu Ghraib, Camp Danger, Camp Liberty and Camp Bucca. In Kuwait, the Team met with the CFLCC Deputy Commander and Chief of Staff, as well as the CFLCC Surgeon, to gain a perspective on the planning factors for detainee medical operations. For the past and future interviews, the Team traveled to units in 22 states and Germany. A leadership perspective on the issue of detainee medical operations was gained through interviews with medical personnel from command and control (C2) elements at corps, theater, and level I, II and III medical units. For training interviews, the Team visited faculty and students of training programs at the AMEDDC&S and the MI School, and trainers at NTC, JRTC, the two CRCs, and 12 PPPs. Additionally, lesson plans and other training materials were reviewed at these training sites.

b. A total of 1,182 questionnaires were completed in the following categories:

(1) *Student Questionnaires.* A total of 166 student questionnaires were completed at the AMEDDC&S, encompassing 20 91G (Patient Administration Specialist), 74 91W (Health Care Specialist), 17 91WM6 (Licensed Practical Nurse), 15 91X (Mental Health Specialist), and 40 OBC students. The findings, discussion, and recommendations are in Chapter 6.

(2) *PPP Questionnaires.* A total of 12 PPP Questionnaires were completed at Ft. Benning (1 Mobilization, 1 CRC), Ft. Bliss (1 MOB, 1 CRC), Ft. Carson (1 MOB), Ft. Dix



(1 MOB), Ft. Drum (1 MOB), Ft. Hood (1 MOB), Ft. Lewis (1 MOB), Ft. Polk (1 MOB), Ft. Riley (1 MOB), and Ft. Sill (1 MOB). The findings, discussion, and recommendations are in Chapters 8, 9 and 18.

(3) *JRTC and NTC*: Interviews were conducted at the JRTC (Ft. Polk) and NTC (Ft. Irwin). The findings, discussion, and recommendations are in Chapter 18.

(4) *BSCT Questionnaires*: Interviews were conducted with 11 past (6) and present (5) BSCT members assigned to GTMO (7) and OIF (4). The findings, discussion, and recommendations are in Chapter 18.

(5) *Past/Present and Future Questionnaires*. The team completed 993 interviews (80%AC/8%USAR/12%NG) with 803 (81%) interviews from units which previously served in OEF, GTMO or OIF (past), 77 (8%) currently serving in OEF, GTMO or OIF (present), and 113 (11%) preparing to mobilize to OEF, GTMO or OIF (future). The interviewees included 705 (71%) males and 288 (29%) females, including 522 (52.7%) officers, 3 (0.3%) warrant officers, and 468 (47%) enlisted personnel, with a mean age of 34.77 years. The findings, discussion, and recommendations are in following chapters of the report.

c. *Units*. A total of 180 units were sampled, as listed in Tables 3-1 through 3-6.

**Table 3-1. OEF Medical Units**

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(b)(2)-2

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**Table 3-2. OEF Non-divisional Non-medical Units**

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**Table 3-3. OEF Divisional Non-medical Units**

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(b)(2)-2

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**Table 3-4. OIF Medical Units**

(b)(2)-2

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**Table 3-5. OIF Non-divisional Non-medical Units**

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(b)(2)-2

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**Table 3-6. OIF Divisional Non-medical Units**

(b)(2)-2

## Chapter 4.

**Question a. What units provided medical care to detainees in OEF and OIF and what was the period of service for each unit?**

**4-1.** Listed below are units who provided detainee care in OEF and OIF. The Team defined “providing detainee care” as any unit assigned medical resources that, at any time, provided care to at least one detainee. Also listed are the units of medical personnel who, at any time while in either theater, individually provided care to at least one detainee.

**4-2.** The list is not all-inclusive. The ability to capture 100% of the units involved in detainee care was a challenge. It was difficult to identify all the “one for one” medical personnel replacements and attachments. Another factor was the mission-required integration of non war-traced units. This included AC/RC medical units that were not previously configured to serve as a cohesive unit. Dates of service given were obtained from interviews and may not represent the exact period of service for the entire unit. The Team is confident that the below list is accurate and represents the scope and breadth of units that provided detainee care.

### *a. Operation Enduring Freedom*

Non-Medical Units	Arrival	Departure
(b)(2)-2		

(b)(2)-2
(b)(2)-2

Medical Units	Arrival	Departure
(b)(2)-2		

b. *Operation Iraqi Freedom*

Non-medical Units	Arrival	Departure
(b)(2)-2		

(b)(2)-2

(b)(2)-2

(b)(2)-2

(b)(2)-2

(b)(2)-2

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(b)(2)-2

(b)(2)-2

**Chapter 5.**

**Question b. At what location did each unit provide medical care (e.g., MTF, detainee facility, and interrogation facility)?**

The answers to this question are found in Chapter 10 (Question g).

## **Chapter 6**

**Question c. What MOS and OBC training or other school training did the medical personnel serving in these units receive regarding the generation, storage and collection of detainee medical records and regarding the medical reporting of detainee abuse?**

### **Section I**

#### **Summary of Findings**

##### **6-1. Summary of Findings and Recommendations**

a. Overall, less than 3% of medical personnel surveyed from the AC and 7% from the RC (past and present) medical personnel reported receiving training on detainee medical records. Refer to Table 6-4 to view AMEDDC&S student responses. A SME team comprised of individuals with exceptional knowledge of the generation, storage and collection (disposition) of detainee medical records should standardize training requirements and develop competency-based training for levels I-III in all theaters.

b. Overall, less than 15% of medical personnel from the AC, USAR, and NG (past and present) reported receiving MOS or other school training about reporting possible detainee abuse. Refer to Table 6-1 to view responses for OEF, GTMO and OIF. MEDCOM should appoint a SME team under the direction of the AMEDDC&S to develop the tasks and framework to build a comprehensive training program to train medical personnel on detention health care including medical reporting of detainee abuse with follow-up assessment of competency to measure effectiveness of training.

### **Section II**

#### **Training Received Regarding Generation, Storage and Collection of Detainee Medical Records**

##### **6-2. Findings**

a. Less than 3% of medical personnel surveyed from the AC and 7% of the RC (past and present) reported receiving training on detainee medical records. Students surveyed in the OBC and four MOS -specific courses do receive training on medical records; however, there is minimal to no evidence that students receive training specific to the generation, storage and collection, and disposition of detainee medical records. See Table 6-4.

b. The majority (97%) of medical personnel surveyed from the AC and 93% from the RC that have served or are serving in OEF, GTMO, and OIF report they did not receive any school training on detainee medical records. See Table 6-1.

c. Of the nine PAD officers (MOS 70E) and ten PAD specialists surveyed, 30% reported receiving school training specific to detainee medical records in their courses.

d. The 70E Program Director offers a “Just-in-Time Deployment Training” course for deploying PAD officers (Cit. 4). The course curriculum mirrors the guidance in the MEDCOM memo entitled “Deployment Medical Documentation Guidance/Reporting Requirements.”

e. The AMEDDC&S published a matrix listing lesson plans (LP) and courses that identify the tasks related to AR 190-8 (Cit. 6); however, AR 190-8 is cited in only one recent LP from the 91W10 course (Cit. 1). The regulation is stated as a reference in one exportable training package (Cit. 3). The most cited training reference in all courses on medical records is AR 40-66.

f. There is no exportable training specific to detainee medical records.

g. PAD officers and administrative specialists assigned to (Table of Organization and Equipment (TOE)) units are not afforded sufficient training opportunities to sustain their Area of Concentration (AOC) or MOS skills. The resulting lack of proficiency affects their capability to correctly maintain detainee records.

### 6-3. Discussion

a. *General Questionnaire.* Question 69. Have you received MOS or other school training about detainee medical records?

(1) The responses for OEF, GTMO and OIF, for past, present and future deployers, in the AC and RC combined, are presented in Table 6-1.

**Table 6-1. Question 69. Have you received MOS or other school training on detainee medical records? [for AC/USAR/NG combined].**

	YES	NO	UNK	N/A
OEF – Past (63)	3 (4.8%)	60 (95.2%)	0 (0%)	0 (0%)
OEF – Present (14)	1 (14.3%)	13 (100%)	0 (0%)	0 (0%)
OEF – Future (26)	1 (4%)	25 (96%)	0 (0%)	0 (0%)
GTMO – Past (2)	2 (100%)	0 (0%)	0 (0%)	0 (0%)
GTMO – Present (7)	1 (14.3%)	6 (85.7%)	0 (0%)	0 (0%)
OIF – Past (729)	24 (3.3%)	698 (95.7%)	3 (0.4%)	4 (0.5%)
OIF – Present (52)	1 (1.9%)	51 (98.1%)	0 (0%)	0 (0%)
OIF – Future (84)	6 (7.1%)	75 (89.3%)	3 (3.6%)	0 (0%)

(2) *AC and RC Response*

(a) *AC*. Overall, 2.9% of 710 interviewees (past and present) and 2.7% of 73 (future) interviewees reported receiving MOS or other school training on detainee medical records.

(b) *RC*. Overall, 7% of 157 interviewees (past and present) and 0% of 37 (future) reported receiving MOS or other school training on detainee medical records.

b. *Student Questionnaire*. A total of 166 student questionnaires were completed at the AMEDDC&S, encompassing the OBC, 91G, 91W, 91WM6, and 91X students, as in Table 6-2. For all courses, the instruction had included training in the Geneva Conventions, the Law of War, and AR 190-8. Questionnaires were not executed for the Career Captains Course (CCC) as they had not received the training during the time period of the assessment. The results for questions pertinent to detainee medical records are presented in Tables 6-2 through 6-5. Students responding “yes” to question 603 (Table 6-3) were asked questions 608 and 611.

**Table 6-2. Students participating in the Student Questionnaire.**

Course	Number of Students	Week in Course
OBC	40	Week 10
91G	20	Week 5
91W	74	Week 15
91WM6	17	Week 6
91X	15	Week 10

**Table 6-3. Question 603. At this point in your current course, has the training included AR 190-8 (Enemy Prisoners of War (EPW), Retained Personnel (RP), Civilian Internees (CI), and other Detainees).**

	YES	NO	UNK	N/A
OBC (40)	33 (83%)	4 (10%)	3 (8%)	0 (0%)
91G (20)	6 (30%)	13 (65%)	1 (5%)	0 (0%)
91W (74)	57 (77%)	12 (16%)	5 (7%)	0 (0%)
91WM6 (17)	11 (65%)	4 (24%)	2 (12%)	0 (0%)
91X (15)	2 (13%)	7 (47%)	5 (33%)	1 (7%)

**Table 6-4. Question 608. Did the training include requirements for medical records keeping for a detainee population?**

	YES	NO	UNK	N/A
OBC (33)	20 (61%)	10 (30%)	3 (9%)	0 (0%)
91G (6)	3 (50%)	3 (50%)	0 (0%)	0 (0%)
91W (57)	12 (21%)	31 (54%)	14 (25%)	0 (0%)
91WM6 (11)	3 (27%)	6 (55%)	2 (18%)	0 (0%)
91X (2)	0 (0%)	1 (50%)	1 (50%)	0 (0%)

**Table 6-5. Question 611. To what extent did the training raise your comfort level with accurately documenting medical records on a detainee?**

	Excellent	Good	Neutral	Fair	Poor	None
OBC (33)	0 (0%)	9 (27%)	9 (27%)	9 (27%)	5 (15%)	1 (3%)
91G (6)	1 (33%)	2 (17%)	3 (50%)	0 (0%)	0 (0%)	0 (0%)
91W (57)	0 (0%)	12 (21%)	15 (26%)	8 (14%)	11 (19%)	11 (19%)
91WM6 (11)	0 (0%)	1 (9%)	5 (45%)	1 (9%)	4 (36%)	0 (0%)
91X (2)	0 (0%)	1 (50%)	0 (0%)	0 (0%)	0 (0%)	1 (50%)

*c. LPs and Course Content (Cit. 6)*

(1) LPs in the following professional development courses and MOS specific courses were reviewed: OBC, CCC, AC/RC Basic Non-commissioned Officer (BNCOC), Advanced Non-commissioned Officer Course (ANCOC), Medical Evacuation Doctrine Course, Flight Medic Course, Combat Casualty Care Course (C4), and Preventive Medicine Courses. None of these courses actually cite AR 190-8 or any DoD detention regulation outside of the DA 40 series regulations. The course content does address tasks related to AR 190-8; for example, General Protection Policy, captivity of EPW/RP, evacuation and care of EPW and RP, operation of EPW internment facilities and management, punitive jurisdiction, transfer of Prisoners of War, and medical care and sanitation. Other specialty courses offer medical ethics, ethical decision making, or ethics theory presentations. Only one LP, the International Humanitarian Law and the Geneva Conventions draft LP (draft dated 30 March 2005), which is taught into the 91W10 course, cites AR 190-8 (Cit. 1).

(2) The AMEDDC&S Doctrine and Training Development's new exportable training package, Medical Ethics of Detainee Care, cites AR 190-8. The exportable training package presentation mentions that documentation on medical records for



detainees is the same as for U.S. Soldiers, citing AR 40-66 as the reference. Although AR 190-8 is stated in the presentation, the tasks required to document medical screening, generation, storage and collection of detainee medical records are not stated. AR 40-66 is also in many of the courses' programs of instruction (POI). It is unknown if the content of MEDCOM memorandum entitled "Deployment Medical Documentation Guidance/Reporting Requirements" (office symbol MCHS-I, undated and unsigned) provides guidance and establishes procedures and responsibilities specific to detainee inpatient and outpatient records (Cit. 32). The content of this memorandum is not taught in any of the courses outside of the "PAD Just-in-Time Deployment Training" course.

d. *PAD Training*

(1) The course director and the assistant course director at the 70E course were interviewed. They provided a draft itinerary of the PAD "Just-in-Time Deployment Training" course (Cit. 4) and a copy of the slides for a course entitled "Medical Documents in Combat and Contingency Operations" (Cit. 5). The objectives of the course are to "(1) identify U.S. Army policies regarding medical records ownership and custody in accordance with (IAW) AR 40-66, (2) identification of the deployment management process of the Adult Preventive and Chronic Care Flow sheets (DA2766) and (3) the purpose and management of field and 'drop' files." Subsequent slides discuss the forms that make up the "field" file, inpatient treatment record, and "drop" file. The course also stressed that, if the Theater/Area of Responsibility (AOR) surgeon considers it impractical, the inpatient treatment record will not be used. Indications for use of Field Medical Card (DD1380) are presented in the course.

(2) PAD officers expressed concerns about maintaining proficiency for TOE 70E and 91G personnel. Skills training and sustainment have not been a unit priority. Other unit duties and responsibilities of these medical personnel have limited their opportunities for training. One officer reported developing a program to ensure her 91G personnel received proficiency training prior to deployment. The resulting lack of proficiency affects their capability to correctly maintain detainee records.

#### **6-4. Recommendations**

a. AMEDDC&S should ensure standardization of training of detainee healthcare documentation and disposition of retired detainee records across the entire healthcare spectrum in all theaters, from the point of capture and collection point to the detention facilities.

b. Establish a team under the direction of the AMEDDC&S comprised of clinicians and PAD expertise with exceptional knowledge of the generation, storage, maintenance and collection (disposition) of detainee medical records from the point of capture, collection point to the detention facilities. The tasks and training content should be developed by this team. The AMEDDC&S should facilitate this process.

(1) The above team should analyze courses' POIs and LPs to determine training gaps in the generation, storage and collection of detainee medical records.

(2) The training should include a crosswalk of Geneva Conventions, DoD and DA regulations and policies pertaining to the generation, storage and collection of detainee medical records. Training content should be regularly revised to reflect changes in the policies.

(3) The training structure should include all levels of care, from point of capture and the collection point to the detention facilities. Training should incorporate AC/RC Table of Distribution and Allowance (TDA) and TOE medical units and medical assets in MP and maneuver units.

c. Create and deploy an exportable training package specific to the generation, storage and collection of detainee medical records for medical personnel in AC/RC TDA and TOE medical units. Medical assets assigned to AC/RC MP and maneuver units should receive the training package.

d. PAD officers and senior PAD specialists should serve as the SMEs and training resource for AC/RC level II and III units. The physician assistant (PA) or senior 91W should serve as the training resource for non-medical units.

e. Incorporate training that is focused on the generation, storage and collection of detainee medical records into the 70E and 91G courses.

f. Expand PAD "Just-in-Time Deployment Training" course to include deploying RC 70E and 91G personnel.

g. Develop sustainment and proficiency training for 70E and 91G personnel in AC/RC units. Training and proficiency data for 70E and 91G personnel should be competency-based and reported regularly as part of the unit's readiness report.

### **Section III**

#### **Training Received Regarding Medical Reporting of Detainee Abuse**

##### **6-5. Findings**

a. 94% or more of medical personnel report familiarization with the Geneva Conventions.

b. 97.5% of OBC Army Nurse officers surveyed reported receiving training on Geneva Conventions and Law of War. See Table 6-10.

(1) Approximately one-quarter of the students enrolled in the 91G course reported receiving Geneva Conventions and one-third reported receiving Law of War training.

(2) Eighty-five percent (85%) of students in the 91W course reported receiving the Geneva Conventions training, although little more than one-half of the students reported receiving Law of War training.

(3) Fifty-nine percent (59%) of 91WM6 students reported receiving Geneva Conventions and less than half reported receiving Law of War training.

(4) Two of the 15 91X students reported receiving Geneva Conventions training and three of the fifteen students reported receiving Law of War training.

e. Less than half of all students reported that training included a process of medical reporting for suspected detainee abuse. Students who reported receiving the training reported that the training raised their comfort level with medical reporting of suspected detainee abuse. Refer to Tables 6-14 and 6-15 to view students' responses.

f. The LPs listed in the AMEDDC&S Review of Institutional Training matrix do not discuss actual or suspected abuse. The plans also do not contain case studies or scenarios requiring students to apply newly learned concepts to situations in which abuse may not be readily apparent. There are no known "approved" scenarios or case studies that role play actual or suspected abuse and the reporting process. LPs do not address the care and the complexity of care and resources at the point of capture, collection point and at detention facilities. AR 190-8 is cited as a reference in LP but cited in only one presentation.

g. There are no pocket training aids to serve as a quick reference training guide for students or deploying medical units that identify medical personnel responsibilities for reporting actual or suspected abuse of detainees.

h. There is no evidence that training content has been developed and or vetted by Service members with exceptional knowledge of detainee care at the point of capture, collection point and detention facilities with representation from a judge advocate, a medical ethicist, and SME serving in the prison health care system.

i. Several LPs have been recently updated. Lectures such as medical ethics have been added.

## **6-6. Discussion:**

a. *General Questionnaire.* Tables 6-6 through 6-15 depict responses to questions pertaining to training received regarding medical reporting of detainee abuse.

(1) Question 51. Have you received MOS or other school training about reporting possible detainee abuse?

(a) For AC/USAR/NG combined, data is presented in Table 6-6.

**Table 6-6. Question 51. Have you received MOS or other school training about reporting possible detainee abuse? [for AC/USAR/NG combined].**

	YES	NO	UNK	N/A
OEF – Past (63)	9 (14%)	52 (83%)	2 (3%)	0 (0%)
OEF – Present (15)	1 (7%)	12 (80%)	2 (15%)	0 (0%)
OEF – Future (25)	4 (16%)	21 (84%)	0 (0%)	0 (0%)
GTMO – Past (2)	1 (50%)	1 (50%)	0 (0%)	0 (0%)
GTMO – Present (7)	2 (29%)	5 (71%)	0 (0%)	0 (0%)
OIF – Past (738)	108 (15%)	613 (83%)	17 (2%)	0 (0%)
OIF – Present (55)	6 (11%)	49 (89%)	0 (0%)	0 (0%)
OIF – Future (85)	27 (32%)	56 (66%)	2 (2%)	0 (0%)

In all categories of personnel, 50% or more had not received this school training.

*(b) AC and RC responses*

*(i) AC.* 14% of 721 surveyed (past and present) and 30% of 72 (future) surveyed reported receiving MOS or other school training about reporting possible detainee abuse.

*(ii) RC.* 13% of 159 surveyed (past and present) and 21% of 38 (future) surveyed reported receiving MOS or other school training about reported possible abuse.

(2) Responses to other questions pertaining to training received regarding medical reporting of detainee abuse are in Tables 6-7 to 6-15.

**Table 6-7. Question 1. Are you familiar with the Geneva Conventions?**

	YES	NO	UNK	N/A
OEF – Past (63)	63 (100%)	0 (0%)	0 (0%)	0 (0%)
OEF – Present (14)	14 (100%)	0 (0%)	0 (0%)	0 (0%)
OEF – Future (25)	26 (100%)	0 (0%)	0 (0%)	0 (0%)
GTMO – Past (2)	2 (100%)	0 (0%)	0 (0%)	0 (0%)
GTMO – Present (7)	7 (100%)	0 (0%)	0 (0%)	0 (0%)
OIF – Past (735)	730 (99.3%)	2 (0.3%)	3 (0.4%)	0 (0%)
OIF – Present (55)	54 (98%)	0 (0%)	1 (2%)	0 (0%)
OIF – Future (88)	83 (94%)	4 (5%)	1 (1%)	0 (0%)

In all categories of personnel, 94% or more were familiar with the Geneva Conventions.

**Table 6-8. Question 2. In preparation for providing detainee care did your unit use case studies?**

	YES	NO	UNK	N/A
OEF – Past (63)	17 (27%)	41 (65%)	5 (8%)	0 (0%)
OEF – Present (13)	2 (15%)	11 (85%)	0 (0%)	0 (0%)
OEF – Future (26)	18 (69%)	5 (19%)	3 (12%)	0 (0%)
GTMO – Past (2)	1 (50%)	1 (50%)	0 (0%)	0 (0%)
GTMO – Present (7)	5 (71%)	2 (29%)	0 (0%)	0 (0%)
OIF – Past (723)	147 (20.3%)	501 (69.2%)	72 (9.9%)	3 (0.4%)
OIF – Present (52)	11 (21%)	37 (71%)	4 (8%)	0 (0%)
OIF – Future (85)	26 (31%)	50 (59%)	8 (9%)	1 (1%)

In all categories, there is an increasing trend of using case studies in this training from past to present to future deploying personnel.

**Table 6-9. Question 3. Did your overall unit training prepare you for addressing human rights issues of detainees?**

	YES	NO	UNK	N/A
OEF – Past (63)	45 (71%)	17 (27%)	1 (2%)	0 (0%)
OEF – Present (14)	6 (43%)	0 (57%)	0 (0%)	0 (0%)
OEF – Future (26)	22 (85%)	3 (12%)	1 (4%)	0 (0%)
GTMO – Past (2)	2 (100%)	0 (0%)	0 (0%)	0 (0%)
GTMO – Present (7)	6 (86%)	1 (14%)	0 (0%)	0 (0%)
OIF – Past (734)	473 (64%)	237 (32%)	24 (3%)	0 (0%)
OIF – Present (55)	33 (60%)	21 (38%)	1 (2%)	0 (0%)
OIF – Future (87)	54 (62%)	28 (32%)	4 (5%)	1 (1%)

Except for present OEF personnel (43%), 60% or more of the personnel felt their unit training prepared them for addressing human rights issues of detainees.

b. *Student Questionnaire.* The results for questions pertinent to training received regarding medical reporting of detainee abuse are presented in Tables 6-10 through 6-15.

**Table 6-10. Question 601. At this point in your current course, has the training included the Geneva Conventions?**

	YES	NO	UNK	N/A
OBC (40)	39 (97.5%)	1 (2.5%)	0 (0%)	0 (0%)
91G (20)	5 (25%)	9 (45%)	6 (30%)	0 (0%)
91W (74)	63 (85%)	8 (11%)	3 (4%)	0 (0%)
91WM6 (17)	10 (59%)	6 (35%)	1 (6%)	0 (0%)
91X (15)	2 (13%)	6 (40%)	6 (40%)	1 (7%)

For 91G and 91X courses, one-quarter or less of the students recalled receiving training on the Geneva Conventions.

**Table 6-11. Question 609. Did the training include the specifics of medical reporting of detainee abuse? Answers for students responding “yes” to Question 601 who answered this question.**

	YES	NO	UNK	N/A
OBC (39)	16 (41%)	19 (49%)	4 (10%)	0 (0%)
91G (4)	2 (50%)	2 (50%)	0 (0%)	0 (0%)
91W (63)	22 (35%)	31 (49%)	10 (16%)	0 (0%)
91WM6 (10)	6 (60%)	3 (30%)	1 (10%)	0 (0%)
91X (2)	0 (0%)	2 (100%)	0 (0%)	0 (0%)

Responses for 91G and 91X are unreliable due to small sample size. For the other courses, except for 91WMG (60%), less than half of the students recalled receiving this training.

**Table 6-12. Question 612. To what extent did the training raise your comfort level with medical reporting of detainee abuse? Answers for students responding “yes” to Question 601 who answered this question.**

	Excellent	Good	Neutral	Fair	Poor	None
OBC (39)	1 (3%)	13 (33%)	11 (28%)	8 (21%)	4 (10%)	2 (5%)
91G (5)	1 (20%)	2 (40%)	2 (40%)	0 (0%)	0 (0%)	0 (0%)
91W (60)	0 (0%)	13 (22%)	17 (28%)	10 (17%)	9 (15%)	11 (18%)
91WM6 (10)	0 (0%)	3 (30%)	4 (40%)	1 (10%)	0 (0%)	2 (20%)
91X (2)	0 (0%)	0 (0%)	0 (0%)	1 (50%)	0 (0%)	1 (50%)

Responses for 91G and 91X are unreliable due to small sample size. Overall, the training did not produce a good or excellent comfort level for reporting detainee abuse.

**Table 6-13. Question 602. At this point in your current course, has the training included the Law of War?**

	YES	NO	UNK	N/A
OBC (40)	40 (100%)	0 (0%)	0 (0%)	0 (0%)
91G (20)	7 (35%)	12 (60%)	1 (5%)	0 (0%)
91W (74)	42 (57%)	14 (19%)	18 (24%)	0 (0%)
91WM6 (17)	7 (41%)	7 (41%)	3 (18%)	0 (0%)
91X (15)	3 (20%)	6 (40%)	5 (33%)	1 (7%)

For 91G and 91X courses, one-third or less of the students recalled receiving training on the Law of War.

**Table 6-14. Question 609. Did the training include the specifics of medical reporting of detainee abuse? Answers for students responding “yes” to Question 602 who answered this question.**

	YES	NO	UNK	N/A
OBC (40)	17 (43%)	19 (48%)	4 (10%)	0 (0%)
91G (6)	3 (50%)	3 (50%)	0 (0%)	0 (0%)
91W (42)	16 (38%)	19 (45%)	7 (17%)	0 (0%)
91WM6 (7)	5 (60%)	2 (71%)	0 (29%)	0 (0%)
91X (3)	1 (33%)	2 (67%)	0 (0%)	0 (0%)

Responses for 91X are unreliable due to small sample size. For the other courses, except for 91WMG (60%), half or less of the students recalled receiving this training.

**Table 6-15. Question 612. To what extent did the training raise your comfort level with medical reporting of detainee abuse? Answers for students responding “yes” to Question 602 who answered this question.**

	Excellent	Good	Neutral	Fair	Poor	None
OBC (40)	1 (3%)	13 (33%)	11 (28%)	9 (21%)	4 (10%)	2 (5%)
91G (7)	2 (29%)	2 (29%)	2 (29%)	0 (0%)	0 (0%)	1 (14%)
91W (41)	0 (0%)	8 (20%)	11 (27%)	9 (22%)	5 (12%)	8 (20%)
91WM6 (7)	1 (11%)	2 (22%)	3 (33%)	1 (11%)	1 (11%)	1 (11%)
91X (2)	0 (0%)	1 (33.3%)	0 (0%)	1 (33.3%)	0 (0%)	1 (33.3%)

Responses for 91X are unreliable due to small sample size. Overall, the training did not produce a good or excellent comfort level for reporting detainee abuse.

(1) *Comments from Surveyed Students.* About half of the OBC and 91W and less than half of the 91WM6 students surveyed requested interactive real world examples through scenario based training. One student requested a pocket reference guide. Another student requested written and on-line references for further research on the subject matter. Many students desired more detail and complexity in the scenarios to provide them the opportunity to discuss the issues in depth. Students particularly wanted to hear the personal stories of the Soldiers and their experiences.

(2) *Program of Instructions/LPs.* Review of the courses’ POIs and LPs indicate that students attending professional development, MOS specific courses, and specialty courses do receive Geneva Conventions and Law of War training. LPs do not address physical and psychological examinations/medical screening for abuse, cultural



considerations and language barriers, use of interpreters and limitations, interrogations and medical personnel's responsibilities, detainee medical record documentation and disposition, emotional aspects in caring for detainees, signing of death certificates, distinguishing between abuse and lawful combat operations, and use of case studies or scenario-play (Table 20).

d. *Other AMEDD Center And School Training Products*

(1) Interviews with staff members at the Department of Training Support, AMEDD C&S, revealed a team dedicated to the Dean's charge to quickly move education and knowledge outside the Academy walls to the AMEDD population worldwide. In January 2005, 200 sets of AMEDD training CDs were distributed to units in Iraq. The training products are provided on request from the field. As of 24 March 2005, Department of Training Support was processing orders from MEDCOM, Forces Command (FORSCOM), and USAR units in addition to Navy active duty units and personnel. The first set was completed in less than four weeks. The next goal is to develop current instructional materials into an exportable distance learning formats. Content will be reviewed yearly or sooner if required by the dynamic environment and needs of the AMEDD personnel (Cit. 3).

(2) The Medical Ethics in Detainee Operations (Cit. 2) provides a cursory overview of the Just War Theory, explanation of the Red Cross/Red Crescent, challenging unlawful orders and war crimes, treatment of detainees under medical roles of care, battlefield triage and evacuation categories. Scenarios presented are easily recognizable as war crimes. The scenarios infer that Soldiers know that the order is unlawful and takes the reader through the steps to challenge the order and contact the chain of command. In contrast, more subtle incidents that present ethical and professional dilemmas such as a 91W fluent in Arabic in which he has been directed to question detainees by his medical Officer in Charge (OIC) to obtain more intelligence information or a medic that initiates intravenous therapy on a dehydrated detainee during an interrogation or a physician which obtains a buccal swab under the direction of the interrogator. The detainee is informed by the interrogator that the swab will link him to terrorist activities. These incidents are examples of incidents which could be incorporated into LPs for further probing and discussion by students and instructors.

## **6-6. Recommendations**

a. Tools should be introduced to assist students in recalling their training; for example, a reference pocket training aid. The tool should display a decision algorithm to assist them in distinguishing actual or suspected abuse from injuries as a result of lawful combat operations.

b. AMEDDC&S, as the proponent for training of medical personnel in detainee healthcare (to include medical reporting of detainee abuse) across the entire healthcare spectrum in theater, from the point of capture and collection point to a detention facility should:

(1) Establish a SME team to develop the tasks and framework to build a comprehensive AMEDD training program. The framework should include all training platforms (Mobilized Unit Inprocessing Centers (MUIC), Reserve Training Sites (RTS), NTC, JRTC, and PPP sites) and methods of instruction (lecture, case studies, scenario, after action review (AAR)). The framework must encompass all levels of care, from point of capture to a detention facility. The framework must serve as an additional resource for TOE medical units and TDA facilities as part of the readiness component.

(2) SME Team membership should include appropriate representation from the RC and should have exceptional knowledge of detainee care at the point of capture, collection point and detention facilities. Additionally, the team should be comprised of a judge advocate, a medical ethicist, and SMEs serving in the prison health care system. The tasks and training content should be standardized particularly in the professional development and MOS specific courses.

(3) MOS-specific schools and professional development courses should incorporate case studies and scenario-based training on current Army operations. Training Centers, such as NTC and JRTC, should be provided with the means to provide realistic level I to level III detainee medical care training.

(4) Consider using regularly scheduled video teleconferences with 91W, 91WM6 students and Soldiers that experienced detainee care from the point of capture, collection point or detention facility to enhance learning followed with a Q and A format.

(5) Revise the existing exportable training package to include all tasks associated with detainee care. Incorporate selected incidents and allegations to serve as case studies or scenario play. The AMEDDC&S should facilitate development of the training package and push the products out.

c. MEDCOM should provide all medical senior leaders (AC/RC) detention care policies, regulations and references which could be accessed through the Army Knowledge Online (AKO) site. MEDCOM should continually update AKO so that evolving guidance, tools and references are current. The following criteria and content (not all inclusive) should be considered:

- (1) Theater accessible.
- (2) Approved for continuing education credit.
- (3) Approved detention care competency tools.
- (4) DoD detention care guidance.
- (5) DA guidance relating to detention care.

(6) “Health Professional’s Guide to Medical and Psychological Evaluation of Torture by Physician for Human Rights” as an example (Cit. 38).

d. DoD-I 1322.24, “Medical Readiness Training” (12 July 2002) (Cit. 21) should include detention care competencies. Competencies should be developed by SMEs possessing exceptional knowledge of detainee care at the point of capture, collection point and detention facilities and the prison health care system.

## **Chapter 7**

**Question d. Was there any policy guidance, OPORDER, SOP, or other authority establishing criteria for providing detainee medical support and/or care in the theater of operation?**

### **7-1. General Findings**

- a. Present DA and DoD guidance regarding the standard of care for detainees has gaps, at times is ambiguous, and is not specific enough.
- b. Many “Yes” respondents were unable to specifically identify policies or regulations, or provide details of the guidance contained therein.
- c. AR 40-400 provides the best statement regarding health care standards.

### **7-2. Operation Enduring Freedom Findings**

- a. The Team found no evidence of **specific** theater-level policies for detainee medical operations in OEF until 2004.
- b. 47% of past and 60% of current OEF personnel answered “Yes” to question (d) above.

### **7-3. Guantanamo Bay Detention Facility Findings**

- a. There have been numerous theater-level/facility policies for detainee medical operations since early 2003 (Cit. 26).
- b. 100% of past and current GTMO personnel answered “Yes” to question (d) above.
- c. All medical personnel interviewed on-site at GTMO were very well-versed in appropriate policies and procedures.

### **7-4. Operation Iraqi Freedom Findings**

- a. The team found no evidence of **specific** theater-level policies for detainee medical operations in OIF until 2004.
- b. 56% of past and 88% of current OIF personnel answered “Yes” to question (d) above.
- c. The current organization of detainee medical operations is under TF 134.
- d. TF 134 has developed broad policy and guidelines for detainee medical care.

## 7-5. Discussion

a. The Team found evidence of confusion among medical personnel, both leaders and subordinates, of the required level of care for detainees. This confusion is explained by the use of different classifications for detained personnel. As discussed in paragraph 7-5d below, the guidance on the standard of care varies for different classifications of detainees.

b. Two Combat Support Hospital (CSH) Commanders (Interviewees # 634 and 715) stated they were instructed by their higher headquarters to provide detainee medical care based on local Iraqi standards. Despite this incorrect guidance, both CSHs provided detainees the correct level of care as stated in paragraph 7-5d(3) below.

c. Theater level guidance was not provided in a timely manner to deploying OEF and OIF medical units or personnel. Some units developed their own policies for providing detainee medical care, including most CSHs and TF Oasis. DoD and DA guidance is outlined below:

### d. *Present DoD and DA Guidance*

(1) Health Affairs (HA) Policy 02-005, Medical Care for Enemy Persons under U.S. Control Detained in Conjunction with Operation Enduring Freedom, dated April 2002 (Cit. 28), states that medical care shall be provided consistent with AR 190-8 to the extent appropriate. The phrase “to the extent appropriate” is ambiguous. The policy also states that care for detainees shall be guided by standards **“similar to those that would be used to evaluate medical issues for US personnel.”** The adoption of a “similar standard” is also ambiguous. HA Policy 02-005 references DoD Directive 2310.1, DoD Program for Enemy Prisoners of War and other Detainees, dated August 1994 (Cit. 22). DoD Directive 2310.1 does not include any specific information related to medical care.

(2) AR 190-8, Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees, dated October 1997 (Cit. 11), presently contains the most detailed guidance on medical care to individuals under U.S. control. However, the vast majority of the brief medical information contained in this AR (Section 6-6) only pertains to CIs. The stated standard is **“The treatment must be as good as that provided for the general population.”** It is not clear if this section is intended to apply to all classes of detained persons. Medical information elsewhere in this AR pertaining to other classes of detainees is inadequate.

(3) AR 40-400, Patient Administration, dated March 2001 (Cit. 10), contains the clearest statement of the Army standard of medical care for detainees. Paragraph 3-38 states: **“Members of the enemy armed forces and other persons captured or detained by U.S. Armed Forces are entitled to medical treatment of the same kind and quality as that provided U.S. Forces in the same area.”** Although misplaced (AR 40-3 and AR 190-8 would be the logical locations), this is a succinct statement that

is easy to comply with and understand. Not one single interviewee, nor any Team member prior to this assessment, knew of the existence of paragraph 3-38.

(4) AR 40-3, Medical, Dental, and Veterinary Care, dated November 2002 (Cit. 8), and AR 40-66, Medical Records Administration and Health Care Administration, dated July 2004 (Cit. 9), contain **no** guidance regarding detainee care.

(5) Secretary of Defense (SECDEF) Memorandum, SUBJECT: Procedures for Investigation into Deaths of Detainees in the Custody of the Armed Forces of the U.S., dated June 2004 (Cit. 41), clearly states the procedures for death investigations for detainees in the custody of the Armed Forces, including the requirement for an autopsy.

(6) Deputy Secretary of Defense Memorandum, SUBJECT: Policy Statement and Guidelines on Body Cavity Searches and Exams for Detainees under DoD Control, dated January 2005 (Cit. 20), provides clear direction on body searches.

*e. Operation Enduring Freedom*

(1) Combined Joint Task Force (CJTF) -76 BHA and KHA Detainee Medical Standard Operating Procedure (SOP), dated August 2004 (Cit. 17), contains some areas of very specific guidance (e.g. tuberculosis screening, sick call procedures, and inprocessing). However, some confusing paragraphs include: "patients with life, limb, or eye emergencies like heart attacks or stroke will be referred to the medic on duty and if the medic decides that the complaint can wait, the PUC will be seen the following day," and one paragraph describing the assessment of detainees prior to interrogation.

(2) Bagram SOP, Annex W-1, dated September 2004 (Cit. 12), contains two pages on specific medical issues, including: in-processing, sick call, monthly exams, GTMO transfer, pharmacy, and preventive medicine. Medical screening and exam forms have been developed.

(3) CJTF-76, Detainee Operations SOP's, Bagram (Secret), dated January 2005, has minimal information on medical care but includes: (U) **"Care will be provided to the same extent provided by CJTF-76 to its own forces."** Other medical issues covered include: sick call, hunger strikes, the taking of photos, and access to medical records.<sup>1</sup>

(4) U.S. Southern Command (USSOUTHCOM) Confidentiality Policy for Interactions between Health Care Providers and Enemy Persons under U.S. Control, Detained in Conjunction with OEF, dated August 2002 (Cit. 42), references AR 190-8 and the Geneva Conventions, but contains vague and potentially ambiguous wording:

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<sup>1</sup> "Only those individuals identified as requiring knowing the detainee's medical condition will have access to the medical records." The SOP does not define the criteria used to determine who has a "need to know."

(a) This policy states “**Medical care is provided under conditions and for purposes similar to those applicable to military correctional facilities,**” without citing any references to support this standard.

(b) The standard in 3(a) above has been supplemented by the USSOUTHCOM Policy on Health Care Delivery to Enemy Persons Under U.S. Control at U.S. Naval Base Guantanamo Bay, Cuba, dated 9 August 2004. Paragraph 10c states: “Medical care and treatment shall be provided whenever necessary.” Paragraph 10g states: “U.S. accepted standards of medical care (current practice guidelines) are used.”

*f. Guantanamo Bay Detention Facility*

(1) USSOUTHCOM Policy on Healthcare Delivery to Enemy Persons under U.S. Control at US Naval Base, Guantanamo Bay, Cuba, dated August 2004 (Cit. 43), includes: “**U.S. accepted standards of medical care are used.**”

(2) There are numerous SOPs from the Detainee Hospital, GTMO, from 2003 and 2004 (Cit. 27). Several specific ones that could be referred to in the future as potential standards in all theaters include: Detainee Weight Management and Nutrition Program, In-Processing Medical Evaluation, Detainee Refusal of Care, and Vaccinations.

*g. Operation Iraqi Freedom*

(1) ANNEX Q (Medical Services) to U.S Army Central Command (USARCENT) Operation Plan (OPLAN) 1003-96 (Secret), dated April, 1997: (U) “**Provide health services for CI’s and EPW’s at established camps as governed by customary and conventional international law.**” It does not specifically reference AR 190-8, nor does it explain what is meant by this statement.

(2) Appendix 7 (Medical) to ANNEX I to V Corps OPLAN 1003 (Secret), dated December, 1998: (U) “**EPWs, CIs, and Detained Persons (DETS) are provided medical treatment on the same basis as US sick and wounded. Medical factors are utilized to determine the priority of treatment.**”

(3) Fragmentary Order (FRAGO) 1206 to CJTF-7 Operation Order (OPORD) 03-036 (Secret), dated December 2003, states: (U) “Establish and staff a 50 bed facility which will provide level I-III care for security detainees IVO Abu Ghraib NLT 15 February 2004.”

(4) FRAGO 20 to FORSCOM Deployment Orders in Support of OIF-2 (Secret), dated May 2004, (U) recognizes and addresses the shortfall of not having a dedicated level III facility specifically for detainee care.

(5) Camp Bucca SOP, dated June 2004, sec. 4-4: “Detainee Medical Procedures” (Cit. 14), covers numerous areas in generalities, including: roles of different medical personnel, in-processing, sick call, medical records (access shall be restricted and

governed IAW AR 340-16 and 340-21), medical evacuation, detainee deaths, preventive medicine operations, and dental care.

(6) Appendix 2 (Medical Care for Detainee Operations) to ANNEX Q (Health Services Support) to Multinational Corps, Iraq (MNC-I) CAMPAIGN PLAN: OIF (Secret), dated August 2004.

(7) ANNEX Q (Health Services Support) to USCENTCOM OPORDER 11 to Multi-National Forces-Iraq (MNF-I) (Secret), dated December, 2004, includes: (U) **“EPWs, CIs, and SDs (Security Detainees) will be provided medical treatment on the same basis as Multinational Forces, Iraq (MNF-I) sick and wounded,** and IAW existing treaties, international law, and the Geneva Convention. Standard military triage protocols will be used to determine the priority of treatment to be administered. To the extent possible, EPWs, CIs, and SDs will be treated in separate wards from MNF-I patients, subject to physical constraints. Detained enemy medical personnel may be used as much as possible in the care of EPW's.”

(8) MNF-I Policy 05-02, “Interrogation Policy” (Secret), encl.1, “Safeguards,” dated January 2005, includes:

(a) (U) “Detainee medical information will be protected in accordance with all applicable laws and regulations. Routine detainee healthcare is separated from interrogation operations. Healthcare providers for detained persons will not be required to verbally provide detainee medical information to intelligence collectors. This applies to all agencies conducting interrogations. Medical personnel shall provide interrogators such information as they believe necessary to protect the health and safety of the detainee or to prevent the commission of a crime.”

(b) (U) “Detained persons selected for interrogation must undergo a medical exam or assessment before the beginning of interrogation. The exam or assessment will record the physical and medical condition of the detainee and ensure the detainee is medically cleared to undergo interrogation.”

(c) (U) “No interrogation of hospitalized detained persons may be conducted without first obtaining the approval of DCGDO/Commander, TF 134, in conjunction with the DCCS at the hospital.”

(d) (U) “Interrogation of wounded personnel will not delay or interfere with the evacuation of wounded personnel to the appropriate level of medical care.”

(9) OIF Theater Detention Healthcare Policy, dated January 2005, with multiple appendixes (Cit. 37); per Commander, Detainee Medical TF, and Commander, TF 44<sup>th</sup> MEDCOM; is very comprehensive and covers the major areas of detainee medical operations.



(10) MNF-I SOP: Detainee Healthcare, dated February 2005 (Cit. 34); mirrors # 9 above.

(11) TF 134 Memorandum, SOP for Ensuring Separation of Detention Operations Functions, dated February 2005 (Cit. 46); reinforces the need to protect detainee medical information.

#### **7-6. Recommendations.**

a. Although not required by law, DA guidance (DoD level is preferable) should standardize detainee medical operations for all theaters, should clearly establish that all detained individuals are treated to the same care standards as U.S. patients in the theater of operation, and require that all medical personnel are trained on this policy and evaluated for competency. Specific areas of guidance should include, but are not limited to:

- (1) Initial and continual screening assessments.
- (2) Medical care equal to standards for U.S. Soldiers in the theater of operation.
- (3) Informed consent.
- (4) Protection of detainee medical information.
- (5) Documentation in and handling of medical records.
- (6) Recognition, documentation, and reporting of suspected abuses.
- (7) Planning factors for medical resources required for detainee care.

b. All medical personnel must be trained on this guidance, with follow-up assessment of competency.

c. Policies concerning detainee medical operations should be declassified to the greatest extent possible to allow for the widest application of recommendation (a) above.

d. Classified policies should be archived on secure command web pages as they are updated or as new ones are added, since this will allow one to evaluate policy implementation timelines.

e. Units having theater-level responsibilities (for example TF 134), should propagate DA or DoD guidance, with particular emphasis on units delivering level I or II care in their AOR.

## Chapter 8

**Question e. What unit training did the active component receive prior to deployment regarding the generation, storage and collection of detainee medical records<sup>1</sup> and the medical reporting of detainee abuse?**

### Section I

#### Operation Enduring Freedom

#### 8-1. Findings

a. *Training on Detainee Medical Records.* Very few past/present OEF interviewees received medical records training prior to deployment; 32% received this training in theater. For future OEF deployers, almost two-thirds of the interviewees received unit training at their home stations.

b. *Training on Detainee Abuse Reporting.* Few past/present OEF interviewees received detainee abuse reporting training prior to deployment; 42% received this training in theater. For future OEF deployers, most of the interviewees received unit training at their home stations.

c. Few interviewees stated they had prior knowledge their deployment would include a detainee medical mission in theater.

#### 8-2. Discussion

a. *Training on Detainee Medical Records.*

(1) 38 AC past/present OEF medical personnel were interviewed.

(a) 5% reported receiving unit training at home station (Question 70).

(b) 5% reported receiving unit training during mobilization (Question 71).

(c) 32% reported receiving unit training in theater (Question 72).

(2) Of 26 AC future OEF-deploying soldiers, 62% stated they received unit training at their home station about detainee medical records (Question 70).

b. *Training on Detainee Abuse Reporting.*

(1) 38 AC past/present medical personnel were interviewed.

(a) 18% reported receiving unit training at home station (Question 52).

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<sup>1</sup> As noted in paragraph 6-2a, 2.8% of 692 AC interviewees surveyed (past and present) and 2.7% of 73 (future) reported receiving MOS or other school training on detainee medical records.

(b) 24% reported receiving unit training during mobilization (Question 53).

(c) 42% reported receiving unit training in theater (Question 54).

(2) Of 26 AC future OEF-deploying soldiers, 92% stated they received unit training at their home station about reporting possible detainee abuse (Question 52). This large improvement over the past/present personnel, according to many future interviewees, is directly attributable to the publicity, and lessons-learned, from Abu Ghraib.

## **Section II**

### **Guantanamo Bay Detention Facility (GTMO)**

#### **8-3. Findings**

a. *Training on Detainee Medical Records.* Very few past/present GTMO interviewees received medical records training prior to deployment; 71% received this training in theater.

b. *Training on Detainee Abuse Reporting.* Over 50% of past/present GTMO interviewees received detainee abuse reporting training prior to deployment; 71% received this training in theater.

c. Interviewees were aware of their detainee mission prior to deploying.

#### **8-4. Discussion**

a. *Training on Detainee Medical Records.*

(1) Seven AC past/present GTMO medical personnel were interviewed:

(a) 14% reported receiving unit training at home station (Question 70).

(b) 0% reported receiving unit training during mobilization (Question 71).

(c) 71% reported receiving unit training in theater (Question 72).

(2) No interviews were conducted on GTMO future deploying individuals.

b. *Training on Detainee Abuse Reporting.* Training on detainee abuse reporting

(1) Seven AC past/present GTMO medical personnel were interviewed:

(a) 57% reported receiving unit training at home station (Question 52).

(b) 71% reported receiving unit training during mobilization (Question 53).

(c) 71% reported receiving unit training in theater (Question 54).

(2) No interviews were conducted on GTMO future deploying individuals.

## **Section IV**

### **Operation Iraqi Freedom**

#### **8-5. Findings**

a. *Training on Detainee Medical Records.* Very few past/present OIF interviewees received medical records training prior to deployment; 27% received this training in theater. For future OIF deployers, 27% of the interviewees received unit training at their home stations.

b. *Training on Detainee Abuse Reporting.* Less than one-quarter of the past/present OIF interviewees received detainee abuse reporting training prior to deployment; 40% received this training in theater. For future OIF deployers, 32% of the interviewees received unit training at their home stations.

c. Most OIF interviewees stated they had no prior knowledge their deployment included a detainee mission in theater. Only one unit knew of a specific detainee mission awaiting them in theater.

#### **8-6. Discussion**

a. *Training on Detainee Medical Records.* Training on detainee medical records:

(1) 644 AC past/present OIF medical personnel were interviewed.

(a) 3% reported receiving unit training at home station (Question 70).

(b) 5% reported receiving unit training during mobilization (Question 71).

(c) 27% reported receiving unit training in theater (Question 72).

(2) Of 47 AC future OIF deploying personnel interviewed, 15% stated they received unit training at their home station about detainee medical records (Question 70).

b. *Training on Detainee Abuse Reporting.* Training on detainee abuse reporting:

(1) 658 AC past/present OIF medical personnel were interviewed.

(a) 18% reported receiving unit training at home station (Question 52).

(b) 24% reported receiving unit training during mobilization (Question 53).

(c) 40% reported receiving unit training in theater (Question 54).

(2) Of 47 AC OEF future deploying soldiers, 32% stated they received unit training at their home station about reporting possible detainee abuse (Question 52).

c. The <sup>(b)(2)-2</sup> personnel knew they were deploying to a specific detainee mission in theater before deploying; however, they did not conduct additional pre-deployment training related to detainee healthcare before departing for Iraq other than their mandatory PPP training. Strong hospital and company-level leadership combined with committed support from the 44<sup>th</sup> MEDCOM has helped offset this training oversight. The unit has helped draft the first comprehensive detainee healthcare operations policies and SOPs in OIF (Cit. 37). According to interviewees, other units not providing their soldiers with additional pre-deployment training have not fared as well in theater.

## **Section VI**

### **Recommendations**

#### **8-7. Overall Recommendations**

a. Leaders at all levels should conduct meaningful training and verify by following up with an assessment via a competency test, regardless of the unit's deployment status. This training should be documented and archived. Training should be pertinent to and specifically address standard of care and the generation, storage and collection of detainee medical records as well as recognizing and reporting detainee abuse.

b. Specific standardized training requirements should be given to all medical units, AC/RC prior to deploying to a theater of operation. Particular attention needs to be given to the training guidance given by the AMEDD to medical personnel assigned to level I and level II medical units.

c. All medical units should assume they will have a detainee healthcare mission when deploying and identify it as a METL-training requirement.

d. Develop pre-designated medical units specifically identified to serve in detention facility roles in future operations. These units can tailor their training, both pre-deployment/pre-mobilization, as well as during deployment/mobilization, to this mission. Training should also focus on security procedures for medical personnel treating detainees and the physical and psychological stresses involved in detainee care.

## Chapter 9

**Question f. What training did reserve component soldiers receive at home station, power projection platforms and in-theater regarding the generation, storage and collection of detainee medical records<sup>1</sup> and the medical reporting of detainee abuse?**

### Section I

## Operation Enduring Freedom

### 9-1. Findings

a. For RC past/present OEF interviewees, no or minimal unit training was conducted on detainee medical records at the home station, during mobilization, or in theater. No future RC OEF deployers were interviewed.

b. For RC past/present OEF interviewees, less than one-quarter received unit training on detainee medical records at the home station, during mobilization, or in theater. No future RC OEF deployers were interviewed.

c. None of the interviewees were aware they were deploying to a detainee mission in theater prior to deployment.

### 9-2. Discussion

#### a. *Training on Detainee Medical Records:*

(1) 37 RC past/present OEF medical personnel were interviewed:

(a) 0% reported receiving unit training at home station (Question 70).

(b) 3% reported receiving unit training during mobilization (Question 71).

(c) 7% reported receiving unit training in theater (Question 72).

(2) No future deploying RC units were interviewed.

#### b. *Training on Detainee Abuse Reporting:*

(1) 38 RC past/present OEF medical personnel were interviewed:

(a) 5% reported receiving unit training at home station (Question 52).

(b) 21% reported receiving unit training during mobilization (Question 53).

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<sup>1</sup> As noted in paragraph 6-2a, 1.2% of 39 RC interviewees surveyed (past and present) and 0% of 37 (future) reported receiving MOS or other school training on detainee medical records.

(c) 16% reported receiving unit training in theater (Question 54).

(2) No future deploying RC units were interviewed.

## **Section II**

### **Guantanamo Bay Detention Facility**

#### **9-3. Findings**

Training on detainee medicals records and reporting detainee abuse was received by the two RC past/present GTMO personnel interviewed. No RC future GTMO personnel were interviewed.

#### **9-4. Discussion**

a. *Training on Detainee Medical Records.* Only two RC past/present GTMO personnel were interviewed. Both received unit training on detainee medical records at home station, during mobilization, and in theater. No RC future GTMO personnel were interviewed.

b. *Training on Detainee Abuse Reporting.* Only two RC past/present GTMO personnel were interviewed. Both received unit training on reporting detainee abuse at home station, during mobilization, and in theater. No RC future GTMO personnel were interviewed.

## **Section III**

### **Operation Iraqi Freedom**

#### **9-5. Findings**

a. For RC past/present OIF interviewees, no or minimal unit training was conducted on detainee medical records at the home station or during mobilization; however, 40% received the training in theater. Only 3% of RC future OIF deployers received the training at their home unit.

b. For RC past/present OIF interviewees, approximately one-quarter received unit training on detainee medical records at the home station, during mobilization, or in theater. Only 13% of RC future OIF deployers received the training at their home unit.

c. No interviewees stated they had prior knowledge of going into theater to perform a detainee-specific mission.

#### **9-6. Discussion**

a. *Training on Detainee Medical Records*

(1) 112 RC past present OIF medical personnel were interviewed:

(a) 4% reported receiving unit training at home station (Question 70).

(b) 7% reported receiving unit training during mobilization (Question 71).

(c) 40% reported receiving unit training in theater (Question 72).

(2) Of 38 RC future OIF deploying personnel interviewed, 3% stated they received unit training at their home station on detainee medical records (Question 70).

*b. Training on Detainee Abuse Reporting:*

(1) 112 RC past present OIF medical personnel were interviewed:

(a) 15% reported receiving unit training at home station (Question 52).

(b) 27% reported receiving unit training during mobilization (Question 53).

(c) 27% reported receiving unit training in theater (Question 54).

(2) Of 39 RC future OIF deploying personnel interviewed, 13% stated they received unit training at their home station on reporting detainee abuse (Question 52).

## **Section IV**

### **Overall Recommendations**

#### **9-7. Overall Recommendations**

a. Leaders at all levels should conduct meaningful training, and verify by following up with an assessment via a competency test, regardless of the unit's deployment status. This training should be documented and archived. Training should be pertinent to and specifically address standard of care and the generation, storage and collection of detainee medical records as well as recognizing and reporting detainee abuse.

b. Specific standardized training requirements should be given to all medical units prior to deploying to a theater of operations. Particular attention needs to be given to the training guidance given by the AMEDD to medical personnel assigned to level I and level II medical units.

c. All medical units should assume they will have a detainee healthcare mission when deployed and identify it as a METL-training requirement.

d. Develop pre-designated medical units specifically identified to serve in detention facility roles in future operations. These units can then tailor their training, both pre-



deployment/pre-mobilizations as well as during deployment/mobilization, to this unique mission. Training should also focus on security procedures for medical personnel treating detainees and the physical and psychological stresses involved in detainee care.

## Chapter 10

### Question g. Identify OEF and OIF Detention Medical Facilities

#### 10-1. Background

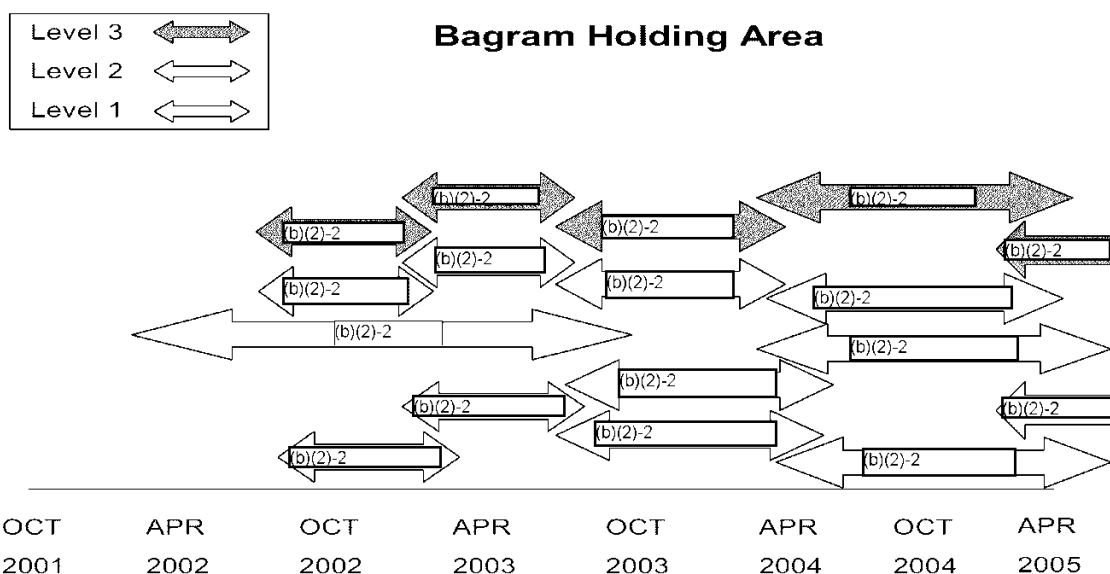
a. In OIF and OEF, nearly all maneuver and MP units of any size participated to some extent in detainee operations. Participation depended on the type and size of the unit and included:

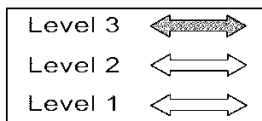
- (1) Point of Capture/Collection Point.
- (2) Brigade Internment Facility (BIF).
- (3) Division Internment Facility (DIF).
- (4) Prison.

b. Medical personnel assigned to these units participated in detainee medical care along a continuum of care ranging from medical screening to acute trauma management and evacuation.

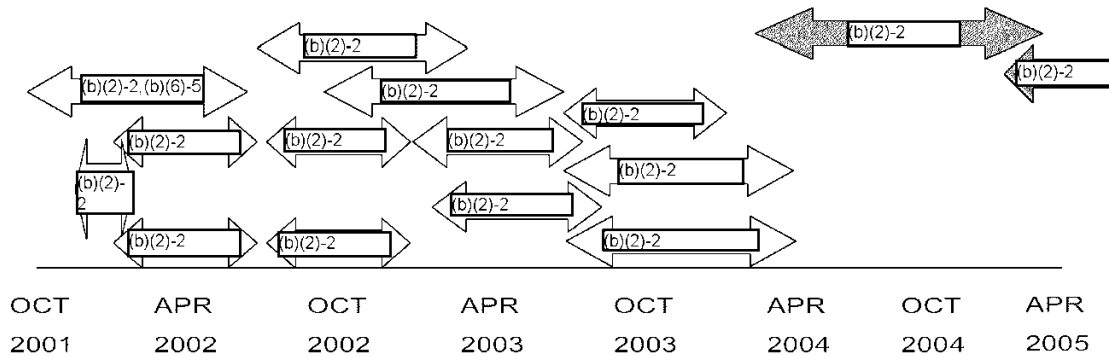
c. At the maneuver Bn and Bde detainee holding facilities the duration of detention ranged from a few hours to several days. The involvement of medical personnel at these locations varied accordingly.

**10-2. Operation Enduring Freedom.** There are two major detention facilities in Afghanistan, one each at Bagram and Kandahar. The diagrams in this chapter include medical and non-medical units that provided or are currently providing level I, II and III medical care for the detainees at these facilities.





## Kandahar Holding Area



**10-3. Guantanamo Bay Detention Facility.** There is a dedicated detainee hospital capable of providing level I, II and III care and a base Naval Hospital. The base hospital has a dedicated large 4-bed room available for detainees, capable of supporting critical care needs. Staffing is Tri-service.

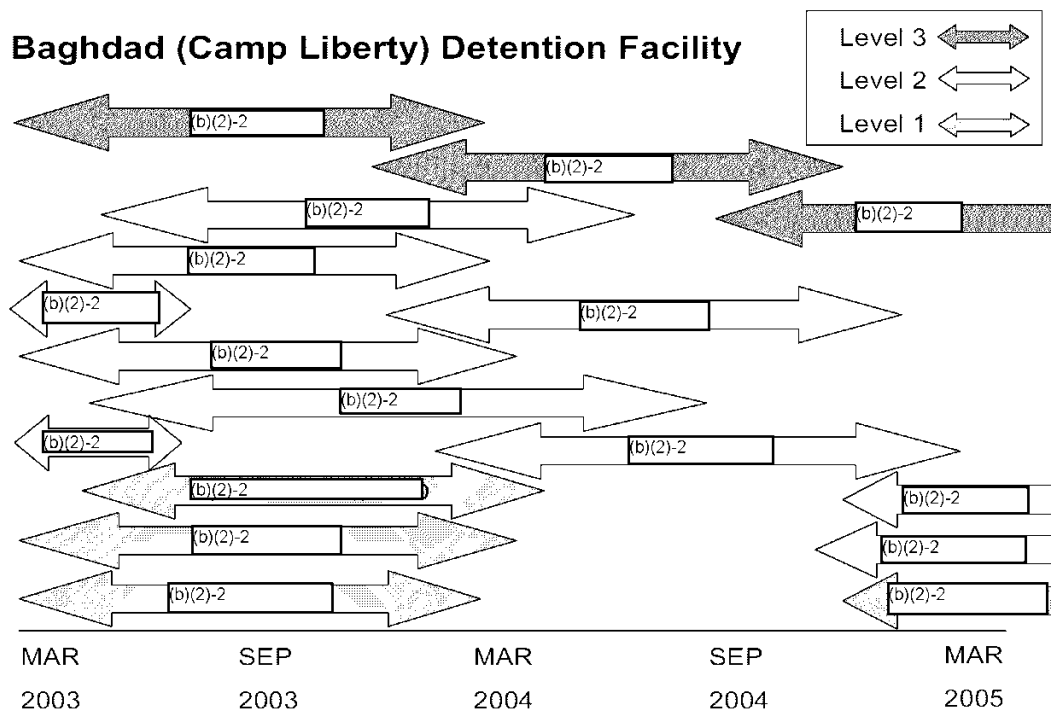
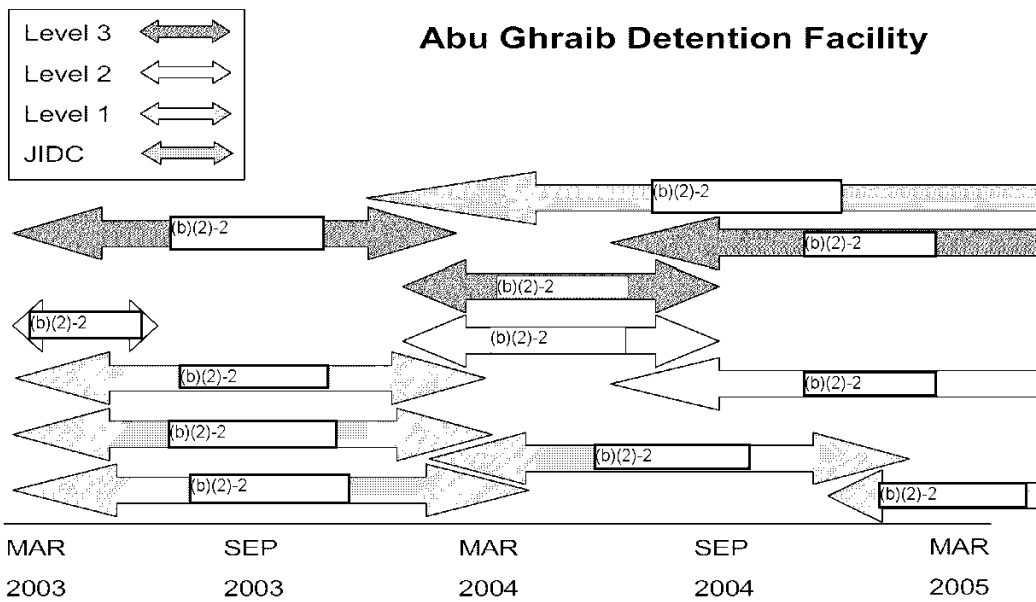
## 10-4. Operation Iraqi Freedom.

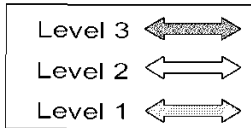
a. There are three prisons in Iraq: Camp Cropper (also known as Baghdad International Airport (BIAP) or High Value Detainee (HVD) detention facility), Abu Ghraib, and Camp Bucca. There are also three division level internment facilities in Iraq at Baghdad, Mosul, and Tikrit. The diagrams in this chapter include medical and non-medical units that provided or are currently providing level I, II and III medical care for the detainees.

b. In January 2004, Med Bde (followed by Med Bde in February 2004) established TF Oasis to provide level II and III medical care for Abu Ghraib. The soldiers comprising this task force were from the following units:

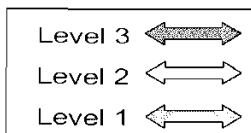
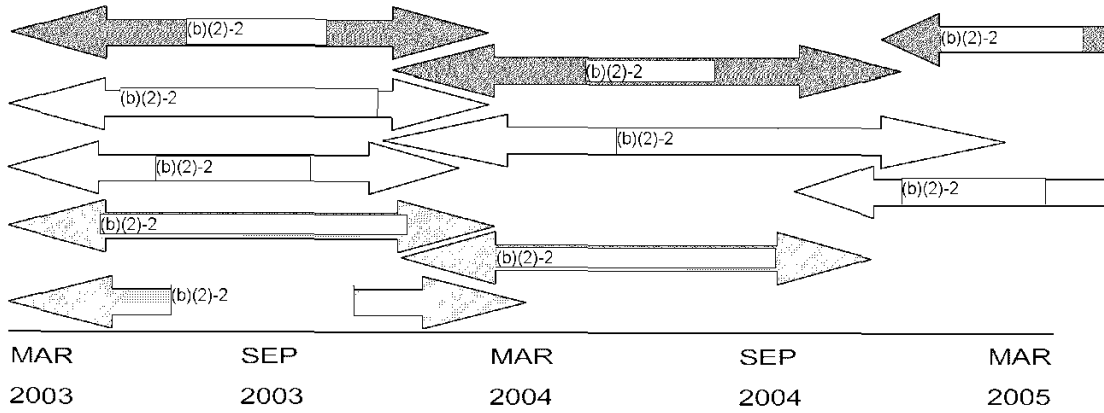
This was the first "detainee-only" hospital built by the Army. It opened for inpatient occupancy on 18 March 2004.

c. In August 2004, deployed to Abu Ghraib to further expand medical capabilities for detainees for level III and ultimately limited rehabilitative medical care. In October 2004, a slice of (including medical personnel from the moved to Camp Bucca to establish level III care at that detention facility.

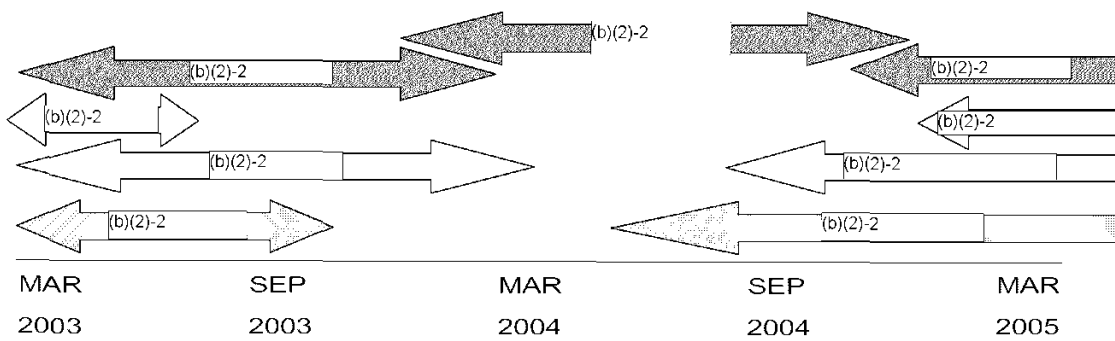


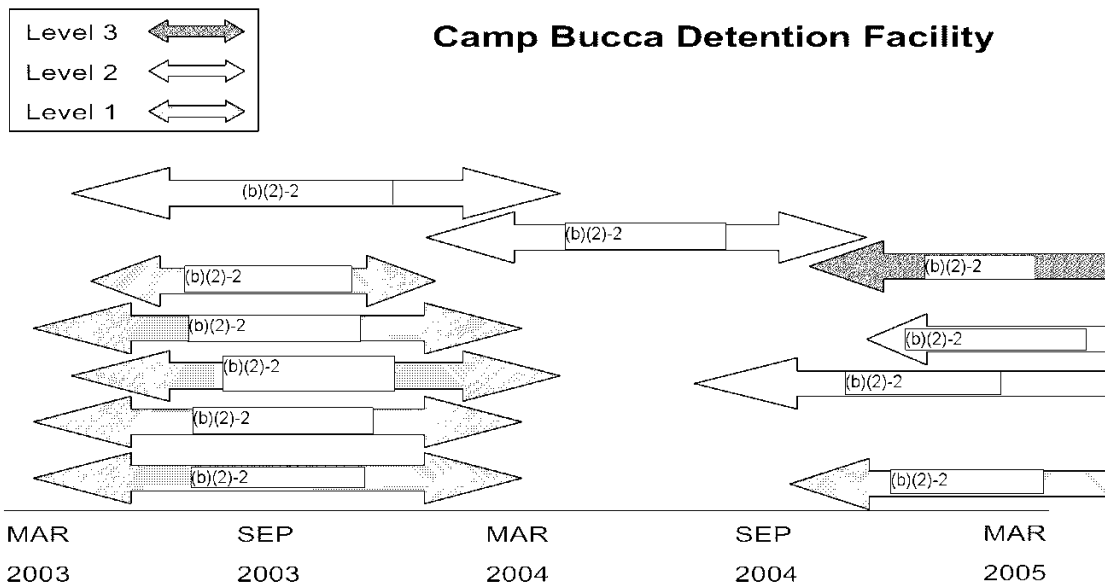
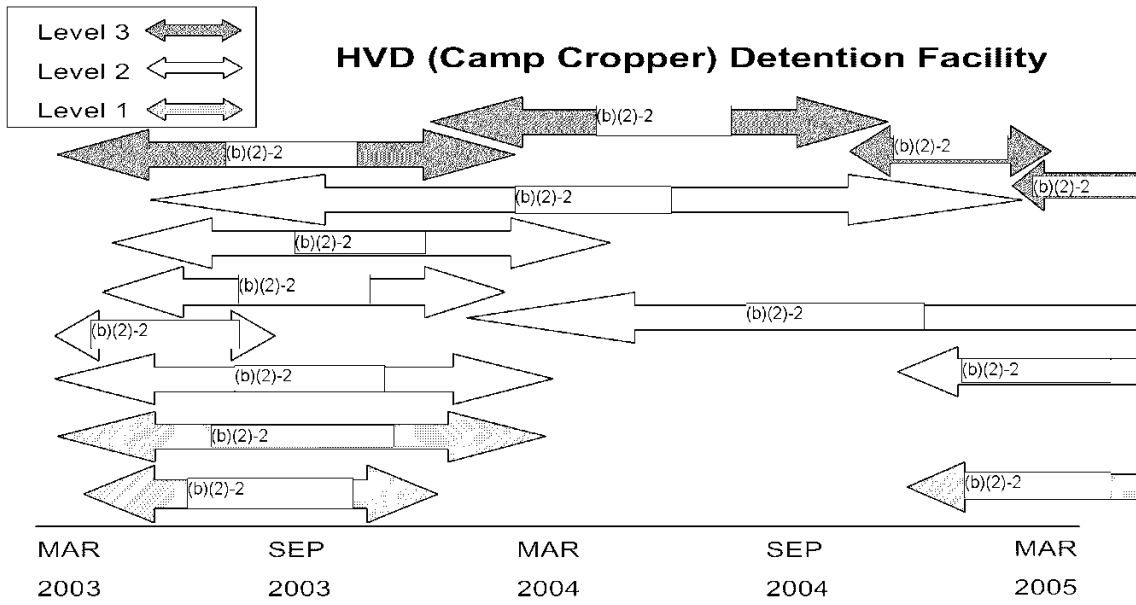


## Mosul Detention Facility



## Tikrit (Camp Danger) Detention Facility





## **Chapter 11**

**Question h. With respect to the detention medical facilities identified in subparagraph g immediately above, determine if the facility generated, stored and collected detainee medical records, to include records documenting medical support to any detainee being prepared for interrogation, being interrogated, or needing medical treatment as a result of, or immediately after, interrogation.**

### **11-1. Findings**

- a. Guidance regarding criteria for pre- and post-interrogation medical screening is inconsistent.
- b. Medical care (including screenings) at or near the time of interrogations was neither consistently documented nor consistently included in detainee medical records.
- c. Some medical personnel were unclear whether interrogations could be continued if a detainee required medical care during the interrogation.
- d. Medical personnel at some locations felt empowered to halt interrogations for either medical or safety reasons.

### **11-2. Discussion**

#### *a. Operation Enduring Freedom*

(1) No interviewees reported being asked to provide medical care during interrogations so that the interrogations could be continued. No interviewees reported being aware of other medical personnel who were asked to do the same.

(2) 38% (3 of 8) of interviewees who served at Bagram reported that pre-interrogation screenings were completed. 25% (2 of 8) reported that post-interrogation screenings were completed. Those giving positive responses agreed that this information was always documented, but was not always included in the medical records.

(3) 33% (3 of 9) of interviewees who served at Kandahar reported that pre-interrogation screenings were completed. 11% (1 of 9) reported that post-interrogation screenings were completed. Those giving positive responses agreed that this information was always documented and was always included in the medical records.

#### *b. Guantanamo Bay Detention Facility*

(1) No interviewees were asked to provide medical care during interrogations so that the interrogations could be continued. No interviewees were aware of other medical personnel who were asked to do the same.

(2) No interviewees reported either pre or post interrogation screenings were completed.

*c. Operation Iraqi Freedom*

(1) 1% (7 of 483) of interviewees were asked to provide medical care to detainees during interrogations so that the interrogations could be continued. These seven individuals represent seven different units, and each individual was requested to do so only once.

(2) All seven reported administering the medical treatment that was required. Examples include (a) intravenous fluid administration for symptoms consistent with or for actual volume depletion and (b) providing food for hypoglycemia. One occurred at Camp Cropper in 2003 and one occurred at Abu Ghraib in 2003, while the other five occurred at short-term holding areas or collection points at various times. (See Interview #s 517, 698, 132, 661, 60, 250, and 505.)

(3) *Abu Ghraib*

(a) Prior to January 2004, very few pre- or post-interrogation screenings were completed at Abu Ghraib. In January 2004, the Air Force Detainee Health Team (DHT) was tasked to support military interrogation operations; the team consisted of one Family Medicine or Internal Medicine physician, one PA, and two medics.

(b) The DHT provided initial medical assessments of detainees to determine preexisting conditions that might affect the interrogation process; it was also tasked with completing pre-, trans-, and post-interrogation medical assessments on an individual basis, at the request of the interrogators. These medical assessments were documented on a SF600 and included in detainee medical records. (See CONOPS for DHT in Support of Military Intelligence Interrogation Operations (Cit. 18).)

(c) All interviewed DHT members denied ever being asked to provide medical care to detainees during interrogations so that the interrogations could continue. If medical care was needed for detainees during an interrogation, the interrogation was stopped, treatment was rendered, and the interrogation did not continue. (See Interview # 734, 788, 817.)

(4) *Camp Bucca*. 12% (3 of 25) of interviewees reported that pre- and post-interrogation screenings were completed. Of these 3, 2 (8% of total) reported that screenings were documented and included in the medical records.

(5) *Camp Cropper*. 49% (19 of 39) of interviewees reported that pre-interrogation screenings were completed. Of these 19, 17 (44% of total) reported screenings were documented, and of these 17 individuals, 9 (23% of total) reported documentation was included in the medical records. 10% (4 of 39) of interviewees reported that post-



interrogation screenings were completed, documented, and included in the medical records.

(6) *Camp Liberty*. 48% (19 of 40) of interviewees reported that pre-interrogation screenings were completed. Of these 19, 18 (45% of total) reported screenings were documented, and of these 18 individuals, 10 (25% of total) reported documentation was included in the medical records. 15% (6 of 40) of interviewees reported that post-interrogation screenings were completed, documented, and included in the medical records.

(7) *Mosul*. 17% (1 of 6) of interviewees reported that pre-interrogation screenings were completed and documented; however, the individual was unsure if documentation was included in the detainee medical records. No interviewees reported that post-interrogation screenings were completed.

(8) *Tikrit*. 14% (1 of 7) of interviewees reported that pre-interrogation screenings were completed, documented, and included in the detainee medical records. No interviewees reported that post-interrogation screenings were completed.

**11-3. Recommendations.** DA guidance (DOD level is preferable) should:

- a. Authorize medical personnel to halt any interrogation or interrogation technique if the detainee's health or welfare is endangered.
- b. Require interrogations to stop immediately if a detainee requires any medical treatment during the interrogation.
- c. Authorize medical personnel to perform pre- and/or post-interrogation medical evaluations at their discretion.
- d. Require pre- and/or post- interrogation medical evaluations be performed upon the request of an interrogator.
- e. Require all pre-, during, and post-interrogation medical care to be documented and included in the detainee medical records.
- f. Describe the process for documenting medical care delivered during or due to an interrogation.
- g. Describe the process to report and document in the medical record suspected abuse.
- h. Require medical personnel to be trained on the above recommendations, with follow-up assessment of competency to measure the effectiveness of training.

## **Chapter 12**

**Question i. With respect to those detention facilities that kept medical records, did medical personnel properly generate, store and collect appropriate medical records of detainees?**

### **Section I**

#### **General Findings**

##### **12-1. General Findings**

- a. Level III facilities consistently generated detainee medical records in the same manner as records for U.S. patients.
- b. The final disposition of original detainee medical records from level III facilities was usually the same as that of “retired” U.S. medical records (sent to PASBA).
- c. Within and among all interviewees from units providing level I and II medical care, there was extreme variability in method of documentation, circumstances influencing the creation of documentation, and the maintenance and final disposition of detainee medical records.
- d. In two separate instances, individuals reported reservations about writing their names on medical records that might eventually be given back to the detainee. One provider in OEF omitted his name entirely, and one provider in OIF intentionally changed the spelling of his last name.

### **Section II**

#### **Operation Enduring Freedom**

##### **12-2. Findings**

- a. The Team interviewed five PAD personnel (MOS 70B, 70E, and 91G) from four hospitals (b)(2)-2 which provided or are currently providing level III detainee care in Bagram and Kandahar. All indicated that detainee medical records were generated and maintained in the same manner as records of U.S. patients in theater. The original medical records were initially maintained by PAD until the records were forwarded to PASBA for storage.
- b. Interviewees from the (b)(2)-2 reported copies of medical records were exclusively made to accompany detainees being transferred to another detention facility (e.g., GTMO). The (b)(2)-2 made no copies of detainee medical records.
- c. At Bagram, 85% (41 of 48) of interviewees reported unit procedures for controlling access to detainee medical records and 78% (36 of 46) reported unit procedures for

maintaining security of these records. None of 46 said that either “anyone” or interrogators could have access to these records.

d. At Kandahar, 73% (11 of 15) of interviewees reported unit procedures for controlling access to detainee medical records and 75% (12 of 16) reported unit procedures for maintaining security of records. None of the 16 said “anyone” could have access to these records and only 6% (1 of 16) said interrogators could have access.

### **Section III**

#### **Guantanamo Bay Detention Facility**

##### **12-3. Findings**

a. No specific PAD personnel were formally interviewed; however, during the site visit, the Team observed that detainee medical records were generated and maintained in the same manner as records of U.S. patients. The original medical records are maintained by PAD.

b. All nine interviewees reported unit procedures for controlling access to detainee medical records and unit procedures for maintaining security of these records. One of nine (11%) reported that “anyone” could have access to these records. (This individual then stated that no interrogators could have access.)

### **Section IV**

#### **Operation Iraqi Freedom**

##### **12-4. Findings**

###### *a. Abu Ghraib and Camp Cropper*

(1) The Team interviewed two PAD personnel (MOS 91G and 70E) from two hospitals (b)(2)-2 that provided or are currently providing level III detainee care at Abu Ghraib and Camp Cropper. Both reported that detainee medical records were generated and maintained in the same manner as records of U.S. patients in theater. The original medical records were initially maintained by PAD until the records were forwarded to PASBA for storage.

(2) The (b)(2)-2 sent copies of discharge summaries to detention medical facilities. The (b)(2)-2 makes copies of detainee medical records only for CID, as needed for evidence in investigations.

(3) At Abu Ghraib, 73% (107 of 147) of interviewees reported unit procedures for controlling access to detainee medical records, and 70% (103 of 147) reported unit procedures for maintaining security of these records. 6% (9 of 147) said “anyone” could have access to these records and 7% (10 of 147) said interrogators could have access.

(4) At Camp Cropper, 69% (124 of 181) of interviewees reported unit procedures for controlling access to detainee medical records and unit procedures for maintaining security of these records. 6% (11 of 181) said “anyone” could have access to records and 7% (12 of 181) said interrogators could have access.

*b. Camp Bucca*

(1) The Team interviewed one 91G from the (b)(2)-2 which is currently providing level III detainee care at Camp Bucca. He reported that detainee medical records are generated and maintained in the same manner as records of U.S. patients in theater. The original medical records are maintained by PAD initially and are then apparently provided to the detainee. Copies of detainee medical records are only made for CID as needed for evidence in investigations.

(2) 63% (24 of 38) reported unit procedures for controlling access to detainee medical records and 58% (22 of 38) reported unit procedures for maintaining security of these records. 3% (1 of 38) said either “anyone” or interrogators could have access to these records.

*c. Camp Liberty*

(1) The Team interviewed three PAD personnel (MOS 91G and 70E) from two hospitals (b)(2)-2 that provided or are currently providing level III care for detainees at the DIF at Camp Liberty. All indicated that detainee medical records were generated and maintained in the same manner as records of U.S. patients in theater. The original medical records in both facilities were initially maintained by PAD and then forwarded to PASBA.

(2) The (b)(2)-2 sent copies of discharge summaries to the detention medical facility. The (b)(2)-2 makes copies of detainee medical records only for CID, as needed for evidence in investigations.

(3) 65% (124 of 190 ) reported unit procedures for controlling access to detainee medical records and 66% (125 of 190) reported unit procedures for maintaining security of these records. 7% (12 of 190) said “anyone” could have access to these records and 9% (16 of 190) said interrogators could have access.

*d. Mosul*

(1) The Team interviewed four PAD personnel (MOS 91G and 70E) from two hospitals (b)(2)-2 which provided level III care for detainees at the DIF in Mosul. All reported that detainee medical records were generated and maintained in the same manner as records for U.S. patients in theater.

(2) At the (b)(2)-2 the original medical records were initially maintained by PAD and then forwarded to PASBA for storage.

(3) The (b)(2)-2 records are being maintained by their PAD permanently. These records have not been forwarded to a repository. Copies of detainee medical records were sent to the detention medical facilities, to civilian hospitals, or other MTFs whenever detainees were transferred to one of these locations.

(4) 78% (60 of 77) reported unit procedures for controlling access to detainee medical records and 77% (59 of 77) reported unit procedures for maintaining security of these records. 4% (3 of 77) said "anyone" or interrogators could have access to these records.

*e. Tikrit*

(1) The Team interviewed one 91G from the (b)(2)-2 which provided level III care for detainees at the DIF in Tikrit. He reported that detainee medical records were generated and maintained in the same manner as records of U.S. patients in theater. The original medical records were initially maintained by PAD and then forwarded to PASBA. Copies of detainee medical records were sent with detainees to the DIF upon discharge.

(2) 79% (45 of 57) reported unit procedures for controlling access to detainee medical records and 81% (46 of 57) reported unit procedures for maintaining security of these records. 5% (3 of 57) said "anyone" could have access to these records and 4% (2 of 57) said interrogators could have access.

## **Section V**

### **General Discussion**

#### **12-5. Methods of documentation for level I and II care include the following practices**

- a. Completing an initial detainee medical evaluation on a Field Medical Card (FMC) (Department of Defense Form 1380 (DD1380)) only, but then no subsequent documentation of any detainee care.
- b. Documenting detainee care in a log book for statistical purposes and unit reports.
- c. Documenting detainee care on Standard Form 600 (SF600) (Chronological Record of Medical Care) only for detainees with chronic medical conditions (with no documentation for others).
- d. Documenting all detainee care on SF600's, but not documenting the initial screenings.

- e. Documenting initial screenings for all detainees on overprinted SF600's.
- f. Documenting a complete history and physical examination on some or all detainees using the SF88 (Report of Medical Examination) and SF93 (Report of Medical History).

**12-6. Locations where original detainee medical documents were stored for level I and II care include the following:**

- a. Detention facilities.
- b. Detention medical facilities.
- c. Medical unit treatment areas.
- d. Interrogation records maintained by MI/MP personnel.

**12-7. Copy machines.** Copy machine availability was variable; therefore, when detainees were transferred to other detention facilities or medical facilities, they were accompanied by original medical records, copies of records, or sometimes no records at all.

**12-8. Access to and Security of Detainee Medical Records.** The Team addressed access to and security of detainee medical records with several specific interview questions in addition to direct observations and questions during site visits to OEF, GTMO, and OIF. Individual responses to the pertinent questions were generally very consistent within each location, as well as across OEF, GTMO, and OIF.

- a. Security of records and confidentiality of medical information tended to be better at detention facilities that were co-located with medical facilities. Security and confidentiality also generally improved as an individual theater matured.

- b. When asked about which "other" personnel could have access to detainee medical records besides the treating medical personnel, the vast majority of answers were: PAD, CID, ICRC, and medical chain of command. A few individuals included MPs or other detention facility personnel.

## **Section VI**

### **General Recommendations**

**12-9. DA guidance (DoD level is preferable) should:**

- a. Require that detainee medical records at facilities that deliver level III and higher care be generated in the same manner as records of U.S. patients in theater.

b. Address the appropriate location and duration of maintenance as well as the final disposition of detainee medical records at facilities that deliver level III or higher care.

c. Define appropriate generation, maintenance, storage, and final disposition of detainee medical records at units that deliver level I and II care.

d. Address the need for uniform documentation, to include accurate identification of all individuals entering information into all detainee medical records.

e. Clearly outline the rules for access to detainee medical records and provision of medical information to non-health care providers. The guidance should only permit release of detainee medical information to interrogators when needed to ensure the health and welfare of the detainee.

**12-10. Training of medical personnel.** All medical personnel should be trained on the above and evaluated for competency.

**12-11. DA guidance (DoD level is preferable) should:**

a. Define who has access to detainee medical information and under what circumstances.

b. Require that all military personnel are trained on this policy and evaluated for competency.

## **Chapter 13**

**Question j. With respect to those detention facilities that kept detainee medical records, identify the location where the original and any copies of the records are maintained.**

See Chapter 12 (Question i).



## **Chapter 14**

**Question k. Were any medical personnel aware of, or treat injuries related to, actual or suspected detainee abuse?**

### **14-1. General Findings**

- a. Medical personnel were aware of, and treated injuries related to, actual and suspected detainee abuse.
- b. 5.0% (30 of 596) of past OEF/GTMO/OEF interviewees directly observed actual or suspected detainee abuse.
- c. 3.1% (2 of 64) of present OEF/GTMO/OIF interviewees directly observed actual or suspected detainee abuse.
- d. 5.4% (43 of 798) of past OEF/GTMO/OEF interviewees had a detainee directly report alleged abuse to them.
- e. 26.3% (20 of 76) of present OEF/GTMO/OIF interviewees had a detainee directly report alleged abuse to them.

### **14-2. Findings - Operation Enduring Freedom**

- a. No (0 of 60) past OEF interviewees directly observed actual or suspected detainee abuse.
- b. No (0 of 11) present OEF deployed interviewees directly observed actual or suspected detainee abuse.
- c. 1.6% (1 of 63) of past OEF interviewees had a detainee directly report alleged abuse to them.
- d. No (0 of 14) present OEF interviewees had a detainee directly report alleged abuse to them.

### **14-3. Findings - Guantanamo Bay Detention Facility**

- a. No (0 of 2) past GTMO Interviewees directly observed actual or suspected detainee abuse.
- b. No (0 of 7) of present GTMO interviewees directly observed actual or suspected detainee abuse.
- c. No (0 of 2) of past GTMO interviewees had a detainee directly report alleged abuse to them.

d. 28.6% (2 of 7) of present GTMO interviewees had a detainee directly report alleged abuse to them.

#### **14-4. Findings - Operation Iraqi Freedom**

a. 5.0% (30 of 596) of past OIF interviewees directly observed actual or suspected detainee abuse.

b. 3.1% (2 of 64) of present OIF interviewees directly observed actual or suspected detainee abuse.

c. 5.4% (42 of 733) of past OIF interviewees had a detainee directly report alleged abuse to them.

d. 32.7% (18 of 55) of present OIF interviewees had a detainee directly report alleged abuse to them.

#### **14-5. General Discussion**

a. The above findings are based on responses to two questions:

(1) *Question 141* – Did any detainee report abuse directly to you?

(2) *Question 145* - Did you directly (or personally) observe detainee abuse?

b. Medical personnel are often in a position to observe the physical evidence of actual or suspected abuse. Alleged abuse can also be revealed when obtaining a detainee's medical history. Not all acts of abuse are evidenced by physical injuries.

c. Two important assumptions overlay the above findings.

(1) Injuries potentially consistent with abuse can occur as a result of lawful combat operations (including the forcible capture of enemy combatants).

(2) Lawful physical force is sometimes required to maintain good order and discipline in a detention setting.

f. Acts of torture are clearly detainee abuse; however, other acts below the internationally recognized threshold of torture violate the standards of AR 190-8. The language of AR 190-8 sets a high standard of care and concern for all detainees:

(1) Paragraph 1-5a(1): "All persons captured, detained, interned, or otherwise held in U.S. Armed Forces custody during the course of conflict will be given humanitarian care and treatment from the moment they fall into the hands of U.S. forces until final release or repatriation."

(2) Paragraph 1-5a(2): “As a matter of policy, all detainees will be treated in accordance with the principles applicable to enemy prisoners of war unless and until a more precise legal status and accordant treatment is determined appropriate by competent authority.”

(3) Paragraph 1-5b: “The following acts are prohibited: murder, torture, corporal punishment, mutilation, the taking of hostages, sensory deprivation, collective punishments, execution without trial by proper authority, and all cruel and degrading treatment.”

(4) Paragraph 1-5c: “All persons will be respected as human beings. They will be protected against all acts of violence to include rape, forced prostitution, assault and theft, insults, public curiosity, bodily injury, and reprisals of any kind. This list is not exclusive. EPW/RP are to be protected from all threats or acts of violence.”

#### 14-6. General Recommendations

a. A DA definition of detainee abuse should be adopted (a DoD definition is preferable).<sup>1</sup>

b. At all levels of professional training medical personnel should receive instruction on the definition of detainee abuse and the requirement to document and report actual or suspected detainee abuse.

c. Pocket cards be developed and distributed to all deploying medical personnel with “Medical Rules of Engagement” on the front and a training aid on detainee abuse on the back.<sup>2</sup>

<sup>1</sup> The prohibitions of Paragraphs 1-5a through 1-5c of AR 190-8 should be considered when developing a definition for “detainee abuse.”

<sup>2</sup> Two suggested recommendations are below:

	<u><b>The ABCs of Detainee Abuse</b></u>		<u><b>Be a Medic</b></u>
<b>A</b>	Abuse is always wrong	<b>M</b>	Medically asses all detainees
<b>B</b>	Be aware of the signs of abuse	<b>E</b>	Examine detainees for signs of abuse
<b>C</b>	Convey suspected abuse to your chain of command	<b>D</b>	Document your findings
		<b>I</b>	Inform your chain of command of suspected abuse
		<b>C</b>	Chart your actions

## **Chapter 15**

### **Question I. Did any medical personnel aware of, or who treated actual or suspected detainee abuse, properly document the abuse?**

#### **15-1. Findings**

a. Although the majority of medical personnel aware of actual or suspected abuse reported the abuse to proper authorities, they did not consistently nor uniformly document such abuse in the medical record.

b. The documentation of abuse in detainee medical records by medical personnel falls into three categories:

(1) Medical personnel who routinely documented actual or suspected abuse and noted they had reported the abuse.

(2) Medical personnel who routinely documented actual or suspected abuse but failed to note in the medical record if they had reported the abuse.

(3) Medical personnel who failed to document actual or suspected abuse (medical evidence of abuse but no further notations in the medical record or lack of medical record).

c. The Team discovered no DoD, Army, or theater policies requiring that actual or suspected abuse be documented in a detainee's medical records.

#### **15-2. Discussion**

a. Team members reviewed 463 detainee CSH medical records from OEF, GTMO, and OIF. Thirty-four (7.3%) of the reviewed records contained medical evidence of suspected abuse or notations of alleged abuse. Twenty-four of the 34 (70.6%) records do not state what action was taken concerning the suspected or alleged abuse.

b. The first opportunity for medical personnel to document alleged or suspected abuse is often during a detainee's initial medical screening. There is no standardized detainee medical screening form.<sup>1</sup> The Team reviewed several field medical screening forms. All were different.

c. Effective communication to subordinate units remains especially challenging in a deployed theater. One example highlights this point. The Commander, (b)(2)-2 distributed AR 190-8 via e-mail to subordinate units. Some units providing detainee care reported never receiving this information. Many interviewees across the spectrum

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<sup>1</sup> DA Form 4237-R (Detainee Personnel Record), found at page 81 in AR 190-8, contains one section (paragraph 44) entitled "Medical Record." The Team considers the required information in this section to be inadequate.

of units the Team visited (including at least one Division Surgeon) were unaware of the medical guidance contained in AR 190-8.

### **15-3. Recommendations**

a. A DA definition of detainee abuse be adopted (a DoD level definition is preferable).

b. A DA standard requiring actual, alleged or suspected abuse be documented in a detainee's medical record (a DoD level standard is preferable). The standard should require:

(1) Documentation of actual, alleged or suspected abuse in the detainee's medical record.

(2) The medical provider's opinion if the medical evidence supports actual, alleged or suspected abuse; and

(3) The action taken by medical personnel:

(a) If the medical evidence fails to support the alleged abuse this fact should be noted in the detainee's medical record.

(b) If the medical evidence is consistent with abuse, or is inconclusive, medical personnel must report the alleged or suspected abuse to the hospital/MTF commander (MEDCOM SJA Information Paper - Health Care Professional Detainee Abuse Reporting Requirements - 8 Sep 04) (Cit. 31).

(c) A notation in the detainee's medical record that a report was made, when, and to whom.

c. A DA standard detainee medical screening form should be developed and fielded (a DoD level standard is preferable).

## Chapter 16

### Question m. To whom did any medical personnel aware of, or who treated, detainee abuse report such abuse?

#### 16-1. General Findings

a. Medical personnel aggressively reported actual and suspected detainee abuse to the proper authorities.<sup>1</sup>

b. Medical personnel typically reported actual or suspected detainee abuse to one (or more) of three channels:

- (1) Medical supervisor.
- (2) Chain of command.
- (3) Criminal investigators (CID).

c. 73 previously deployed medical personnel were personally aware of actual or suspected abuse.<sup>2</sup> 87.6% (64 of 73) reported the actual or suspected abuse.<sup>3</sup>

d. 22 presently deployed medical personnel were personally aware of actual or suspected abuse.<sup>4</sup> 100% (22 of 22) reported the actual or suspected abuse.

e. Only 2 interviewees failed to properly report actual or suspected detainee abuse which had not otherwise been conveyed to an appropriate authority.<sup>5</sup>

#### 16-2. Findings - Operation Enduring Freedom

a. 1 previously deployed OEF medical provider was personally aware of actual or suspected abuse. This provider reported the actual or suspected abuse.

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<sup>1</sup> An incident of abuse may have been observed and/or reported by more than one interviewee.

<sup>2</sup> 5.4% (43 of 798) of past OEF/GTMO/OIF interviewees responded "yes" to question 141 (Did any detainees report abuse directly to you?). 5.0% (30 of 596) of past OEF/GTMO/OIF interviewees responded "yes" to question 145 (Did you directly observe possible abuse?).

<sup>3</sup> There were 4 "no report made" answers to question 142 by previously deployed personnel. One was not reported for lack of specific information (Interview 140). Three were deemed to lack credibility (Interviews 415, 454 and 945). There were 5 "no report made" responses to question 146. In three cases the interviewees reported action was taken (Interviews 465, 717 and 729).

<sup>4</sup> 26.3% (20 of 76) of present OEF/GTMO/OIF interviewees responded "yes" to question 141 (Did any detainees report abuse directly to you?). 3.1% (2 of 64) of present OEF/GTMO/OIF interviewees responded "yes" to question 145 (Did you directly observe possible abuse?).

<sup>5</sup> The Team referred one of these cases to CID (Interview 72) and one to the chain of command after conferring with the CID Staff Judge Advocate (Interview 33). One additional case, in which previous administrative action was taken, was also referred by the Team to CID (See Chapter 20, Incident and Allegations Table #72).

b. No presently deployed OEF medical personnel stated they were personally aware of actual or suspected abuse.

### **16-3. Findings - Guantanamo Bay Detention Facility**

a. No previously deployed GTMO medical personnel were personally aware of actual or suspected abuse.

b. 2 presently deployed GTMO medical personnel were personally aware of actual or suspected abuse. Both stated they reported the actual or suspected abuse.

### **16-4. Findings - Operation Iraqi Freedom**

a. 72 previously deployed OIF medical personnel were personally aware of actual or suspected abuse. 85.5% (63 of 72) reported the actual or suspected abuse (See footnote #3).

b. 18 presently deployed OIF medical personnel were personally aware of actual or suspected abuse. 100% (18 of 18) reported the actual or suspected abuse.

### **16-5. General Discussion**

a. Recent media articles have focused on the alleged torture and abuse of detainees by U.S. military members. DoD guidance clearly requires reporting alleged or suspected torture.<sup>6</sup>

b. Present MEDCOM guidance requires medical personnel to report detainee abuse.<sup>7</sup>

c. The above findings are based on responses to four questions:

(1) *Question 141:* Did any detainee report abuse directly to you?

(2) *Question 142:* (If yes) Did you report this?

(3) *Question 145:* Did you directly (or personally) observe detainee abuse?

(4) *Question 146:* (If yes) Did you report this?

d. By any measure, medical personnel were exceptionally vigilant in reporting actual or suspected detainee abuse. It is especially encouraging that all observed or reported suspicion of detainee abuse was reported by presently deployed medical personnel.

<sup>6</sup> Paragraph 4b, CJCSI 3290.01A, 15 October 2000, Program for Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detained Personnel (EPW/Detainee Policy) (Cit. 16). Paragraphs 4.3 and 4.4, DoD Dir. 5100.77, DoD Law of War Program (9 December 1998) (Cit. 23).

<sup>7</sup> Health Care Professional Detainee Abuse Reporting Requirements, dated 8 September 2004 (Cit. 31).

## **16-6. General Recommendations**

- a. At all levels of professional training, medical personnel should receive instruction on the requirement to document and report actual or suspected detainee abuse. This training should include the definition and signs of actual or suspected detainee abuse.
- b. Scenario-based training on detecting detainee abuse should be developed and fielded at all PPPs, MUICs, and reserve medical training sites. All deploying medical personnel should receive this training prior to arrival in theater.
- c. All deploying medical personnel, prior to arrival in theater, should receive refresher training on the requirements and procedures to document and report actual or suspected detainee abuse.
- d. All individual and collective training for medical personnel (such as NTC, JRTC, Warfighters, and field training exercises (FTXs)) should include reinforcing training on recognizing and reporting actual or suspected detainee abuse.
- e. Follow-on competency evaluations should be incorporated into all training guidance and plans.



## **Chapter 17**

**Question n. Were there any theater or unit policies or established SOPs/TTPs that specifically required medical personnel to report detainee abuse?**

### **17-1. General Findings**

a. Theater level guidance specifically requiring medical personnel to report detainee abuse was implemented within the past year.

b. Unit policies and SOPs/TTPs were sometimes absent and/or not properly disseminated to deployed medical personnel.

c. Medical personnel with knowledge of existing unit policies/SOPs/TTPs overwhelmingly complied with such guidance.

(1) 37.0% (295 of 798) of formerly deployed OEF/GTMO/OIF interviewees were aware of a unit requirement to report suspected detainee abuse. 94.2% (278 of 295) of these interviewees reported their unit followed the policies.

(2) 85.5% (65 of 76) of presently deployed OEF/GTMO/OIF interviewees were aware of such policies. 98.5% (64 of 65) of these interviewees reported their unit followed the policies.

d. The awareness of unit level policies requiring reports of detainee abuse has steadily increased.

### **17-2. Findings - Operation Enduring Freedom**

a. The Team did not discover a theater level policy specifically requiring medical personnel to report detainee abuse.<sup>1</sup>

b. 39.7% (25 of 63) of formerly deployed OEF interviewees were aware of a unit requirement to report suspected detainee abuse. 88% (22 of 25) of these interviewees reported their unit followed the policies.

c. 71.4% (10 of 14) of presently deployed OEF interviewees were aware of such policies. All ten reported their unit followed the policies.

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<sup>1</sup> There is presently a theater specific requirement to report alleged or suspected detainee abuse to the chain of command. CJTF-76, Detainee Operations SOP (S), paragraph 5b (U), dated 21 January 2005.

### 17-3. Findings - Guantanamo Bay Detention Facility

a. The earliest discovered theater policy specifically requiring medical personnel to report detainee abuse is dated 9 August 2004.<sup>2</sup>

b. 100% (2 of 2) of formerly assigned GTMO interviewees were aware of such policies. Both reported their unit followed the policies.

c. 71.4% (5 of 7) of presently assigned GTMO interviewees were aware of such policies. All five reported their unit followed the policies.

### 17-4. Findings - Operation Iraqi Freedom

a. The earliest discovered theater policy specifically requiring medical personnel to report detainee abuse is dated 12 July 2004.<sup>3</sup> The medical unit presently responsible for Abu Ghraib, (b)(2)-2 has also published a requirement to report alleged or suspected detainee abuse.<sup>4</sup>

b. The OIF Theater Detention Healthcare Policy, paragraph 3B, dated January 2005 (Cit. 37), requires medical personnel to be trained to recognize the signs and symptoms of detainee maltreatment and abuse and to report any reported or suspected abuse.<sup>5</sup>

c. The Team did not discover a theater policy specifically requiring medical personnel to report detainee abuse.<sup>6</sup>

d. 34.7% (268 of 773) of formerly deployed OIF interviewees were aware of a unit requirement to report suspected detainee abuse. 94.8% (254 of 268) of these interviewees reported their unit followed the policies.

e. 90.9% (50 of 55) of presently deployed OIF interviewees were aware of such policies. 98% (49 of 50) reported their unit followed the policies.

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<sup>2</sup> USSOUTHCOM Policy on Health Care Delivery to Enemy Persons Under U.S. Control at US Naval Base Guantanamo Bay, Cuba, 9 August 2004. Paragraph 10a states "Medical personnel who gain knowledge of physical or mental ill-treatment of detainees will report this ill-treatment to the appropriate military authority." (Cit. 43).

<sup>3</sup> FRAGO 329, Detention Operations to MNC-I OPOD 04-01 (S), 12 July 2004, Annex C (unnumbered paragraph), *Medical Authority Responsibilities* (U), states (original bolded) "**Any sign of mistreatment will be reported to the Commanding General.**"

<sup>4</sup> Paragraph 5 of The Tenets of Detention Healthcare, dated March 2005 (Cit. 45), states "All allegations or possible signs/symptoms of abuse, torture or maltreatment must be immediately reported to CID and the Detention Ops and medical chains of command regardless of whom or when it occurred."

<sup>5</sup> This paragraph also states "Healthcare providers must be trained in the tenets of the Geneva Conventions, the law of war, standards of medical care, AR 190-8, and other regulations and principles of detainee care." This policy does not identify when the required training should occur, nor who is responsible to provide the training. The policy also does not define what personnel are considered to be "healthcare providers."

<sup>6</sup> There is presently a theater specific requirement to report alleged or suspected detainee abuse to the chain of command. CJTF-76, Detainee Operations SOP (S), paragraph 5b (U), dated 21 January 2005.

## **17-5. General Discussion**

a. Many unit policies were verbally briefed to personnel but never formalized in writing.

b. Commanders and leaders at all levels should present a unified position that detainee abuse is wrong, and that alleged or suspected abuse must be promptly documented, reported, and properly investigated.

c. Despite the small GTMO interview sample, the Team is confident the results are accurate. Policies governing detainee procedures at GTMO were extensive, and based on the Team's personal observations, strictly adhered to.

d. Carefully planned post-training competency assessments are critical to ensure training is effectively equipping medical personnel to successfully recognize, document, and report actual or suspected detainee abuse.

## **17-6. General Recommendations**

a. Clearly written standardized policies for documenting and reporting actual or suspected detainee abuse should exist at all levels of command (DoD, Army, Combatant Command, theater, and individual subordinate units). These policies must then receive command emphasis on a continuing basis.

b. Medical planners at all levels should ensure clearly written standardized guidance is provided to medical personnel. This guidance should list possible indicators of abuse and contain concise instruction on how, and to whom medical personnel should document and report actual or suspected abuse.

c. Develop DA level guidance (DoD level is preferable) on the procedures for processing allegations of abuse not supported by medical evidence. This guidance should contain clear instructions on how medical personnel should properly document allegations of abuse that are not further reported based on lack of medical evidence.

## **Chapter 18**

### **Other Issues**

#### **Section I**

#### **Overview of Site Visits to Afghanistan (OEF), Cuba (GTMO), and Iraq (OIF)**

##### **18-1. Operation Enduring Freedom**

- a. The overall level of outpatient and inpatient detainee medical care is extremely high.
- b. Living conditions are very good and detainees are treated respectfully.
- c. During a walk-through of the (b)(2)-2 the Team reviewed the care of a detainee in the Intermediate Care Ward (ICW). Some entries in his record were not signed by an attending physician. Although this was apparently not a common practice at the hospital, others were also hesitant to put their names on entries, as these documents might eventually be given to detainees upon their release from the facility.
- d. The Bagram/Kandahar (BHA/KHA) SOP, dated 8 March 2005 (S), states that medical records will be destroyed after three years from the time of any detainee's release. This does not specifically follow the provisions of AR 40-400, paragraphs 15-2 and 15-8, which require fixed and deployed MTFs to transmit/provide PASBA with the medical records and workload reports. Additionally, PASBA has been designated the interim inpatient record holding/processing facility for records from the deployed level III MTFs, memorandum dated 12 Mar 2004, unsigned (Cit. 32).
- e. Policies and procedures were often hard to obtain prior to a unit's arrival in theater. Mobilizing units should have access to these well in advance of arrival.
- f. Medical care and initial screening procedures at BHA were streamlined and well-conceived.

##### **18-2. Guantanamo Bay Detention Facility**

- a. The overall level of outpatient and inpatient detainee medical care is extremely high. Staff has the ability to utilize four beds at the Naval Hospital for detainees as well, which can include Intensive Care Unit (ICU) care. According to the Hospital's Commander the GTMO Naval Hospital recently received full Joint Commission Accreditation for Healthcare Organizations (JCAHO) with no findings.
- b. Detainee medical records are extremely complete, and mirror U.S. medical records. Outpatient records examined had complete master problem lists. Inpatient discharge summaries are also translated into native languages for those patients being sent home.

c. Detainee living conditions overall appeared very good.

d. All interrogations are videotaped. Medics randomly observe interrogations and have the ability to halt an interrogation at any point they deem necessary.

### **18-3. Operation Iraqi Freedom**

a. (b)(2)-2 and Camp Bucca

(1) Overall the level of medical care was felt to be exceptional.

(2) Entire staff takes responsibilities seriously; mottos include: "Restoring America's Honor," and "Detention Healthcare is a Globally Visible, Strategic-level Mission."

(3) Initial intake assessments are very comprehensive and are appropriately recorded. This includes history and physical, dental, nutritional, chest x-ray, immunizations, and retinal scanning. Master problem lists are very complete. Comprehensive care is also available for more complicated chronic diseases, including a multi-disciplinary team for diabetic patients, prosthesis clinic with physical therapy/occupational therapy, and 24 hour in-patient and out-patient psychiatric care.

(4) Daily sick call is well-organized (average up to 10% of the population on any given day) and ranges from on-site in the camp to the emergency room.

(5) Records security is excellent. The staff is well-versed on keeping medical information separate from MI personnel.

(6) Living conditions appeared very good; all detainees were treated respectfully. Detainee rights and patient rights are clearly posted. All staff are directed to report even minimally-suspected abuses.

(7) BSCT staff is appropriately utilized with carefully-defined roles. They do not provide any clinical care.

(8) There is comprehensive development of policies and medical forms, with generally widespread dissemination and education of all staff. Hospital committees are well-organized, including: executive, credentials, pharmacy and therapeutics, and bioethics.

(9) Strong recommendations from the staff to the Team were to widen detention medical training, e.g., incorporate at JRTC, etc.

b. *DIF Visits at Tikrit and Baghdad*

(1) Medical documentation very good; detainees remain at these locations generally days-to-weeks.

(2) Initial intakes are less comprehensive, but still good, and are documented in records.

(3) Some medics were not well-versed in their understanding of the separation of medical information from MI staff, and it was not clear that access to medical information was as secure as possible.

(4) Some translators used during medical intakes and other clinic visits were also used by MI staff during interrogations, also representing a potential breach in security of medical information. The Team discussed this on-site with the staff, as well as with the (b)(2)-2 Commander as a suggested area for improvement.

(5) Shortages of translators existed for a variety of reasons, including: a lack of qualified personnel who have been cleared to work for Coalition Forces, others would terminate their services because of potential danger to themselves from insurgents, and priority often went to interrogation staffing needs.

(6) There were some concerns over the staffing at the DIFs. Medical assets, in particular 91Ws, were provided no flexibility when assigned to these areas. A loss of one person, for any reason, could hamper their ability to provide adequate care.

#### **18-4. Recommendations**

a. CFLCC guidance, regulations, and standards in relation to detainee healthcare, to OEF and OIF theaters, should be standard across the AOR, consistent with DoD guidance, and disseminated to the lowest levels.

b. Prior to the onset of operations, combat or humanitarian, dedicated translators must be embedded within level III healthcare units, for use by medical assets only.

c. OIF medical commanders should ensure medical assets are in place, and have a viable system to replenish them when necessary, at level I or II facilities that have significant detainee contact.

d. To ensure that medical information is protected, translators assisting medical personnel with detainee care should not assist interrogators who question the same detainees.

## **Section II**

### **OIF Theater Preparation for Detainee Medical Care**

#### **18-5. Findings**

a. In planning for detainee medical operations there were limited assets allocated to provide support for detainee/EPW medical care. The plan did not encompass medical assets to provide chronic care, definitive care, or rehabilitative care in theater. (FRAGO 1206 to CJTF-7 OPOD 03-036 (Secret) and FRAGO 20 to FORSCOM Deployment Orders in Support of OIF-2 (Secret).)

b. There was a requirement to deliver medical care to detainees in theater.

c. Level I, II, and III medical assets were not resourced to deliver the special needs presented by this population.

## **18-6. Discussion**

### *a. Planning / Transfer / Evacuation*

(1) Theater medical asset needs were planned using an expected patient population of injured military and non-hostile civilians.

(2) The robust system for medical evacuation allowed military patients to receive treatment at Landstuhl Regional Medical Center (LRMC) and, if needed, in CONUS in a very rapid fashion. In many cases the time from injury to arrival at LRMC was as short as 36 hours.

(3) For injured non-hostile civilians, transfer to Iraqi civilian medical treatment facilities was limited by the level of care available at those facilities (but not by security and intelligence requirements).

(4) Transfer of detainees out of theater, or to other than U.S. military treatment facilities, was not possible due to international agreements and security and intelligence reasons.

### *b. Issues Identified with Detainee Care*

(1) Iraqi civilian and detainee populations have special care needs that are not commonly found in our deployed Soldier population; for example, obstetrics, pediatric and neonatal intensive care, dialysis, airborne communicable diseases, and complex chronic medical conditions. Level III MTFs are not routinely equipped with the personnel, supplies, infrastructure, or medications required to properly care for patients with such conditions.

(2) Interviewees reported shortfalls in a number of areas. Some examples are listed below.

(a) *Capacity.* The extended stays in level II holding areas, combined with prolonged hospital stays of the detainee population, resulted in limited availability of beds and constrained surge capability.

i. Interviewees reported that detainees with external fixators needed to remain in a level III MTF ICW until the external fixator was no longer required, resulting in a need to expand the inpatient bed capability.

ii. Definitive and rehabilitative burn care requires extremely long hospitalization when burn center transfer is not available.

*(b) Medications.* Units providing level I and II medical care didn't routinely stock medications needed to treat chronic medical and psychiatric problems.

i. Anti-hypertensive, cardiac, anti-tuberculous, anti-psychotic, and anti-depressive medications were not part of the authorized packing list in a MP company or battalion medical section.

ii. Long-acting insulins were not part of the medical equipment sets (MES) packing list for medical companies in a maneuver unit.

iii. Oxygen (or oxygen concentrating equipment) was not available in sufficient quantity to provide continuous oxygen therapy to detainees that were held for prolonged times in medical company holding areas or aid stations.

#### *c. Facility Infrastructure*

(1) Negative pressure isolation was not available for holding patients with contagious illnesses.

(2) Level III facilities housed detainees in a variety of ways that impacted the location of medical and security resources. Detainees required both ICU- and ICW-level care within a hospital; these separate wards required two different sets of security resources.

#### *d. Medical Supplies and Equipment*

(1) Level III facilities did not initially stock pedicle screws for spine surgery. The inability to conduct definitive spine surgery increased the hospital length of stay as patients with spinal injuries faced complicated healing and rehabilitative requirements.

(2) MP medics were not supplied with glucometers.

(3) Medical companies stocked a limited supply of glucose test strips and glucometers. These supplies were insufficient to adequately monitor multiple patients for months at a time.

(4) Initially Level III facilities did not have the required plates and screws to definitively treat maxillofacial injuries.



#### *e. Mental Health and Psychiatric Care Resources*

(1) This is a broad ranging area that includes suboptimal resourcing at all levels of care. Shortfalls existed in medications, isolation capabilities (infrastructure), psychiatric expertise (anti-psychotic and anti-depressive medication management), and counseling expertise (both the mental health professional and the necessary interpreter).

(2) The detainee population became a hotbed for mental health and psychiatric care needs for several reasons:

(a) Individuals were often taken into custody without their personal medication supply.

(b) Mood disorders are often exacerbated in a detention environment.

#### **18-7. Recommendations.**

a. The AMEDD should establish an experienced SME team to:

(1) Comprehensively define the personnel, equipment and supply needs for detainee operations.

(2) Develop a method to ensure a flexible delivery system for these special resources to the appropriate levels of care and for the entire timeline of future military operations.

b. Military planners need to assume that there is a high likelihood for detainee operations in all future conflicts and must allocate resources for detainee medical care in the planning process.

### **Section III**

#### **Medical Screening and Sick Call at the DIFs and Prisons**

#### **18-8. Findings**

a. Detainees have had excellent access to daily sick call, outpatient, and inpatient medical care.

b. The vast majority of interviewees reported that initial screening medical examinations were performed during in-processing to a DIF or prison.

#### **18-9. Discussion**

a. *Operation Enduring Freedom*

(1) Bagram

(a) 71% (5 of 7) interviewees reported that detainees receive initial screening medical examinations. Two interviewees were uncertain (they did not work in the detainee intake area).

(b) All interviewees reported detainee access to daily sick call.

(c) The Team visited Bagram in March 2005. Detainees receive initial screening medical examinations, have access to daily sick call, and 24 hours access to an on-call medic.

(2) Kandahar

(a) All interviewees (10) reported that medical personnel completed initial screening medical examinations on detainees.

(b) 90% (9 of 10) interviewees reported detainee access to daily sick call. One interviewee, deployed in theater between August 2003 and May 2004, reported that detainee sick call was not available.

(c) The Team reviewed the KHA SOP (Cit. 17). The SOP requires that all detainees receive an initial screening examination, have access to daily sick call, and 24 hour access to an on-call medic.

b. *GTMO*. The Team visited GTMO in January 2005. Detainees receive initial screening medical examinations, have access to daily sick call, and 24 hour access to an on-call medic.

c. *Operation Iraqi Freedom*

(1) Abu Ghraib

(a) 95% (42 of 44) interviewees reported that detainees receive initial screening medical examinations. Two interviewees were uncertain (they did not work in the detainee intake area).

(b) All interviewees reported detainee access to daily sick call.

(c) The Team visited Abu Ghraib in March 2005. Detainees receive initial screening medical examinations, have access to daily sick call, and 24 hour access to an on-call medic.

(2) Camp Bucca

(a) 76% (16 of 21) interviewees reported that detainees receive initial screening medical examinations. One interviewee, deployed in theater from April 2003 to April 2004, stated detainees did not receive initial medical screenings. Four interviewees were uncertain (they did not work in the detainee intake area).

(b) All interviewees reported detainee access to daily sick call.

(c) The Team visited Camp Bucca in March 2005. Detainees receive initial screening examinations, have access to daily sick call, and access to an on-call medic continuously.

(3) Camp Cropper:

(a) 86% (31 of 36) interviewees reported that detainees receive initial screening medical examinations. One interviewee, deployed in theater from April 2003 to April 2004, stated detainees did not receive initial medical screenings. Four interviewees were uncertain (they did not work in the detainee intake area).

(b) All but one interviewee reported that detainees had access to daily sick call. One medic, deployed in theater between April 2003 and April 2004, reported that sick call was not available.

(4) Camp Liberty

(a) 97% (34 of 35) interviewees reported that detainees receive initial screening medical examinations. One interviewee was uncertain (he did not work in the detainee intake area).

(b) 94% (33 of 35) interviewees reported detainee access to daily sick call. One interviewee, deployed in theater between February 2003 and February 2004, stated sick call was not available, one interviewee was uncertain.

(c) The Team visited Camp Liberty in March 2005. Detainees receive initial screening medical examinations, have access to daily sick call, and 24 hour access to an on-call medic.

(5) Mosul

(a) 88% (7 of 8) interviewees reported detainees receive initial screening medical examinations. The other interviewee was uncertain.

(b) 88% (7 of 8) interviewees reported detainees had access to daily sick call. One interviewee, who was in theater between February 2003 and June 2003, reported that sick call was not available. It is unclear what dates he worked at the detention facility itself.

(6) Tikrit

(a) All five interviewees reported that detainees receive initial screening medical examinations. Detainees presently have access to daily sick call.

(b) The Team visited the facility in Tikrit in March 2005. Detainees receive initial screening examinations, have access to daily sick call, and 24 hour access to an on-call medic.

#### **18-10. Recommendations**

a. DA guidance (DoD level is preferable) should require:

(1) Initial medical screening examinations upon inprocessing to a detention facility.

(2) Daily access to medical care for all detainees.

b. All military personnel must be trained on the above policy and demonstrate competency.

#### **Section IV Restraints/Security**

#### **18-11. Findings**

a. The use of physical restraints for detainees varied widely within and among all interviewed units.

b. The Team found no evidence that medical personnel used medications to restrain detainees.

c. Interviewees reported medical personnel were tasked to perform a variety of detainee security roles.

d. Medical documentation of restraint was neither uniform nor consistent.

#### **18-12. Discussion**

a. The Team found little consistency in the use of restraints for detainees. Some medical units used restraints on all detainees for security reasons, some used them only when detainees were violent or disruptive, and others, specifically level III facilities, used them only for medical indications such as attempts to dislodge medical devices, or for risk of falling.

b. The following factors influenced the decision to restrain detainees.

- (1) The availability of MPs.
- (2) The availability of unit medical staff for security purposes.
- (3) Unit policies and directives.

c. Interviewees expressed concern about tasking of medical personnel for detainee security purposes. The rationale for the concern was the ethical conflict of both caring for and guarding detainees. Additionally, as medical personnel were tasked to provide security support, it impacted on the ability of the unit to provide care to all patients, including U.S. Soldiers.

d. 28% (196 of 728) interviewees reported good or excellent medical documentation related to the use of restraints. The Team found that many medical personnel may not have viewed this as a high priority. Detainee inpatient documentation on the use of restraints was not consistent with restraint documentation standards found in most U.S. hospitals.

### **18-13. Recommendations**

a. DA guidance (DoD level is preferable) should standardize the use of restraints for detainees in units delivering medical care. The guidance should contain clear rules for security-based restraint versus medically-based restraint. Medical personnel must be trained on this guidance, with follow-up competency evaluations.

b. Use of restraints on any patient should be appropriately documented in the medical record.

c. All facilities providing level II or III care should be appropriately supplemented with MPs dedicated to provide detainee security.

## **Section V**

### **Medical Personnel Photographing Detainees**

### **18-14. Findings**

a. There are inconsistencies among ARs, individual unit guidance, and usual medical practices regarding photographing detainees.

b. Many medical personnel photographed detainees for a variety of reasons, including: medical documentation, future teaching material, possible criminal investigation documentation, and future identification for detainee family members.

### **18-15. Discussion**

a. Of the 520 individuals asked, 73% (379 ) said photographs of detainees were taken in their units with either a personal or unit-owned camera. When pictures were used for documentation, they were included in the detainee medical record(s), included in an investigation record, or obtained post-mortem for future identification, i.e., when no family members were available at the time of death. More often, pictures were taken by medical personnel for their future teaching material, or for unit case logs. Of the 379 that reported detainees being photographed, 42% (159) reported that these included faces. Of these 159, 32% (51) explained this was only in the case of facial injuries or other medical findings involving the face. Of the 159, 7% (11) explained this was only with permission by the detainee to include the face, and 3% (4) explained this was for the post-mortem or investigation documentation described above.

b. Many of the individuals who reported that pictures were not taken of detainees explained that this was specified (i.e., not allowed) in either a unit policy or an AR.

c. A few individuals reported personal concern that the use of photography in their unit made them uncomfortable, even when it was done as part of medical documentation or future personal teaching material. One individual reported that when she made these concerns known to other members of her unit, she was socially isolated from her co-workers (Interview # 543).

d. While AR 190-8, paragraph 1-5*d*, strictly prohibits photographing EPWs, RPs and CIs “for other than internal internment facility administration or intelligence/ counterintelligence purposes,” the 2004 edition of the Emergency War Surgery text (Chapter 34) advocates units having a digital or other high quality camera for use in medical documentation of EPW injuries. This text also advocates the inclusion of faces in these pictures for accurate, efficient, and complete documentation of patient injuries and surgical interventions. In addition, AR 40-66 (which is not specific to detainees), paragraph 3-1*b*, allows photographs to be “mounted on authorized forms and filed in medical and dental records.” Paragraph 2-8*b*(8)(*b*) further requires that consent must be obtained to release photographs “of a person or of any exterior portion of his or her body” for the purpose of research.

## **18-16. Recommendations**

a. DA guidance (DoD level is preferable) should:

(1) Authorize photographing detainee patients for the exclusive purpose of including these photos in medical records, and not require informed consent for photographs used in this manner (consistent with AR 40-66).

(2) Mandate that photographs of detainees taken by medical personnel for other reasons, including future personal education material, research, or unit logs, must first have informed consent from the detainee.

b. Guidance for the above should be included in AR 190-8, which is currently under revision.

## **Section VI**

### **The Use of Behavioral Science Consultation Teams (BSCT) in the Interrogation Process**

#### **18-17. General Findings**

- a. BSCT personnel are not serving in a health care provider role.
- b. There is no indication that BSCT personnel participated in abusive interrogation practices.
- c. BSCT personnel presently do not have access to detainee medical records.
- d. The BSCTs provide forensic psychological expertise to ensure the interrogation process is conducted in a safe, legal and ethical manner.

#### **18-18. Findings - Operation Enduring Freedom**

There was no use of BSCTs in Afghanistan; however, the Team was informed that a BSCT was in route to support interrogation activities.

#### **18-19. Findings - Guantanamo Bay Detention Facility**

- a. The Team interviewed seven AC psychiatrists, psychologists, and a behavioral science technician providing direct support to the Joint Interrogation Group (JIG) at GTMO (three presently serving and four served previously at GTMO). They were assigned to CSCs with duty at GTMO.
- b. There is no doctrine or policy that defines the role of behavioral science personnel in support of interrogation activities; however, there are SOPs which describe the role and responsibilities of personnel serving in a BSCT role (Cit. 13). The rating chains for these personnel were not in medical channels. BSCT personnel are rated by the JIG Commander and senior rated by the Commanding General or Chief of Staff of the Joint Task Force (JTF) GTMO.
- c. Personnel serving in a BSCT role at GTMO provided behavioral science consultation to the JIG and JTF command group. Physicians/psychiatrists and psychologists were initially assigned to this duty in 2002. Since mid year 2003, the positions have been filled by psychologists. The duties of the BSCT include:
  - (1) Reviewing detainee information.
  - (2) Providing opinion on character and personality of detainee.

(3) Assessing how dangerous a detainee might be (ref. release and potential future combat role).

(4) Providing opinion on behavioral science aspects of the camp and camp organization and procedures.

(5) Consulting on interrogation plan and approach.

(6) Providing feedback on interrogation technique.

(7) Teaching behavioral science topics to interrogators.

d. The BSCT personnel observed interrogations but were not active participants in the interrogation process.

e. The BSCT personnel were not medically credentialed at GTMO and did not provide any medical services in the medical treatment facility. Several BSCT personnel did have access to the detainee medical records. In June 2004, BSCT were no longer permitted to directly review detainee medical records. The BSCT personnel did not document the medical condition of detainees in the medical record but did keep a restricted database which provided medical information on detainees. BSCT personnel never provided psychological services for detainees but on two occasions consulted with interrogators who were experiencing non-work related stress.

f. Two of the seven personnel interviewed did feel conflicted while serving in the BSCT role. The conflict centered on the lack of SOPs, policy and guidance on how to function in this role. In both instances, the conflict was resolved through refinement of procedures and establishment of SOPs. Every interviewee felt that medical personnel should serve in a BSCT position for interrogation activities, but recommended using psychologists, not physicians/psychiatrists, in this role.

g. In the realm of training, all BSCT personnel were familiar with the Geneva Conventions but only four out of seven felt their training prepared them for addressing the human rights issues of detainees. The psychologists did go through limited training at Fort Bragg Resistance Training Laboratory prior to taking on the BSCT role at GTMO.

h. There was one incidence where a BSCT member was aware of potential abuse as he was present when the Federal Bureau of Investigation (FBI) reported the incident to the JIG Commander. Apparently the abuse involved an interrogator pulling on the thumbs of a detainee. Another BSCT member reported a questionable incident where a female interrogator took off her battle-dress uniform (BDU) jacket, rubbed her breasts against the body of the detainee being interrogated, sat on his lap and whispered in his ear. The interrogation was stopped and the individual was reported for her inappropriate behavior to the chain of command.



## 18-20. Findings - Operation Iraqi Freedom.

a. The Team interviewed four psychiatrists and psychologists (two presently assigned and two previously assigned) who provided direct support to the Joint Interrogation and Debriefing Center (JIDC) at the Abu Ghraib detention facility. These officers were assigned to this task through various methods. One was assigned to the General Staff of (b)(2)-2; 4 interviewees were listed on paper as part of a CSC with duty at the JIDC. The rating chain and technical reporting chains at this time are through the JIDC commander with senior rating by the Commander of (b)(2)-2

b. There is no overarching DoD or DA policy or doctrine for employment of medical personnel in a BSCT role. The first Abu Ghraib BSCT member, a physician, was assigned in the January 2004 timeframe and only remained onsite for 33 days. The officer developed a proposed job description that he could ethically execute; the duties included providing assessments for the psychological fitness of detainees to be interrogated. In June 04, a psychologist was assigned to the (b)(2)-2 staff. As a BSCT member, he served as a consultant and special staff officer. He did not wear the Medical Service Corps branch insignia but wore the General Staff insignia on his uniform. His BSCT role was to ensure interrogations were safe and ethical. He observed interrogations, consulted with interrogators concerning techniques, suggested wording and questions that the interrogator could use, and reviewed all interrogation plans.

c. The BSCT personnel at Abu Ghraib did not provide medical services to the detainees. They did not have access to the medical records of detainees; however, they did have knowledge of detainee medical conditions. In recent months this has changed – they no longer have knowledge of medical conditions. The medical staff provides information regarding medically-related limitations for a detainee undergoing interrogation; however, the specifics of the medical condition(s) is not revealed.

d. The medical condition of detainees is not documented by BSCT personnel except in extreme examples. One BSCT member completed a psychological referral request for a detainee and, in another instance, informed the medical personnel when a detainee had a Post Traumatic Syndrome Disorder (PTSD) reaction during interrogation and was referred for mental health care. The BSCT personnel did not maintain medical records on detainees.

e. Three of the four personnel serving as a BSCT at Abu Ghraib felt conflicted while working in that position. The conflict was based on three issues: (1) the BSCT personnel did not want detainees to view them as health care providers; (2) the BSCT role is an isolated position, an advocacy duty which can get lonely; and (3) concern about the lack of mental health services for detainees, especially the children (this was in January 2004 and is now rectified). The conflicts were resolved by seeking advice from trusted colleagues with more experience and establishing services to support the mental health needs of the detainees.

f. All of the BSCT members thought that medical personnel should serve in a BSCT role for interrogation activities. One BSCT articulated that he did not think physicians/psychiatrists should serve in this role since no medications are provided and it is not a health care provider position.

g. In the training realm, all BSCT personnel were familiar with the Geneva Conventions and three of the four felt their training prepared them for addressing the human rights issues of detainees.

h. At Abu Ghraib, no BSCT personnel observed possible detainee abuse in the interrogation setting. No cases of potential abuse have surfaced when a BSCT member was involved with interrogation.

## **18-21. General Discussion**

a. In the purest sense, the mission of the BSCT is to provide forensic psychological expertise and consultation in order to assist the command in conducting safe, legal, ethical, and effective interrogation and detainee operations. Several of the psychologists and physicians described the position as a “safety officer” for the interrogation process. While serving in this role the objective is to:

(1) Provide psychological expertise in order to maximize the effectiveness of the legal interrogation process.

(2) Provide psychological expertise to assist the command in ensuring that the interrogation process is conducted in a safe, legal, and ethical manner.

(3) Promote the overall effectiveness of detainee operations.

b. The BSCT provides checks and balances in the interrogation process. Initially, BSCT personnel struggled with their role in this arena; the lack of doctrine and policy contributed to their “discomfort.” The initial lack of an information firewall between the BSCT personnel and the medical records of the detainees provided a tenuous situation that was later alleviated by prohibiting BSCT personnel from having access to medical records.

c. Those serving in a BSCT role did not feel the assignment of physicians in this capacity was the best utilization of their skills; they could be used more effectively in the patient care arena. In fact, physicians in this role only confused the situation since BSCT personnel provided no direct medical care or services. Psychologists have served in similar roles in Special Forces units, as well as in civilian forensic settings, and their background and training provides a foundation for duty as a BSCT member.

d. The issue of “dual agency” for medical professionals serving in the BSCT role has been raised. Medical personnel serving in BSCTs understood their role and clearly understood they were not permitted to provide health care services. Recent published

articles suggest that “physicians and other medical professionals breached their professional ethics and the laws of war by participating in abusive interrogation practices.” There is no indication that any medical personnel participated in abusive interrogation practices; in fact, there is clear evidence that BSCT personnel took appropriate action and reported any questionable activities when observed.

e. BSCT personnel served as protectors, much like a safety officers to ensure the health and welfare of the detainee under interrogation. In reviewing interrogation plans with the ability to halt interrogations at any time, BSCT personnel provide the oversight and checks and balances in the interrogation process.

## **18-22. General Recommendations**

- a. DoD develop well-defined doctrine and policy for the use of BSCT.
- b. DA (preferably DoD) policy should permit only BSCT personnel to participate in interrogation planning.
- c. Psychiatrists/physicians should not be used in a BSCT role.
- d. All psychologists and behavioral health technicians serving in BSCT positions should receive structured training on the roles and responsibilities while functioning in this capacity.
- e. MI personnel should clearly understand the defined roles, responsibilities and limitations of behavioral health personnel serving in a BSCT position.
- f. All psychologists utilized as BSCT members should be senior, experienced personnel.

## **Section VII<sup>1</sup>**

### **Medical Personnel Interactions with Interrogators<sup>2</sup>**

## **18-23. General Findings**

- a. Medical personnel participation in interrogations was exceedingly rare (five instances), occurred only in OIF, and occurred exclusively at units providing level I or II care.
- b. Evaluation or treatment of detainee patients was rarely (2.3%) delayed for intelligence gathering purposes.

<sup>1</sup> Note: Question sets were tailored by the Team for particular MOS/job duties. Therefore, all questions were not asked of all interviewees. This accounts for the differing numbers of interviewees responding to particular questions.

<sup>2</sup> This observation does not include information relating to BSCT personnel.

c. Medical personnel were rarely (5%) requested to be present during interrogations.

d. Many interviewees reported that policies addressed the interaction between medical personnel and interrogators. However, dissemination and awareness of these policies was inconsistent.

e. In OEF and OIF, dissemination and awareness of these policies improved for level III care personnel as the theaters matured.

## 18-24. Discussion - Operation Enduring Freedom

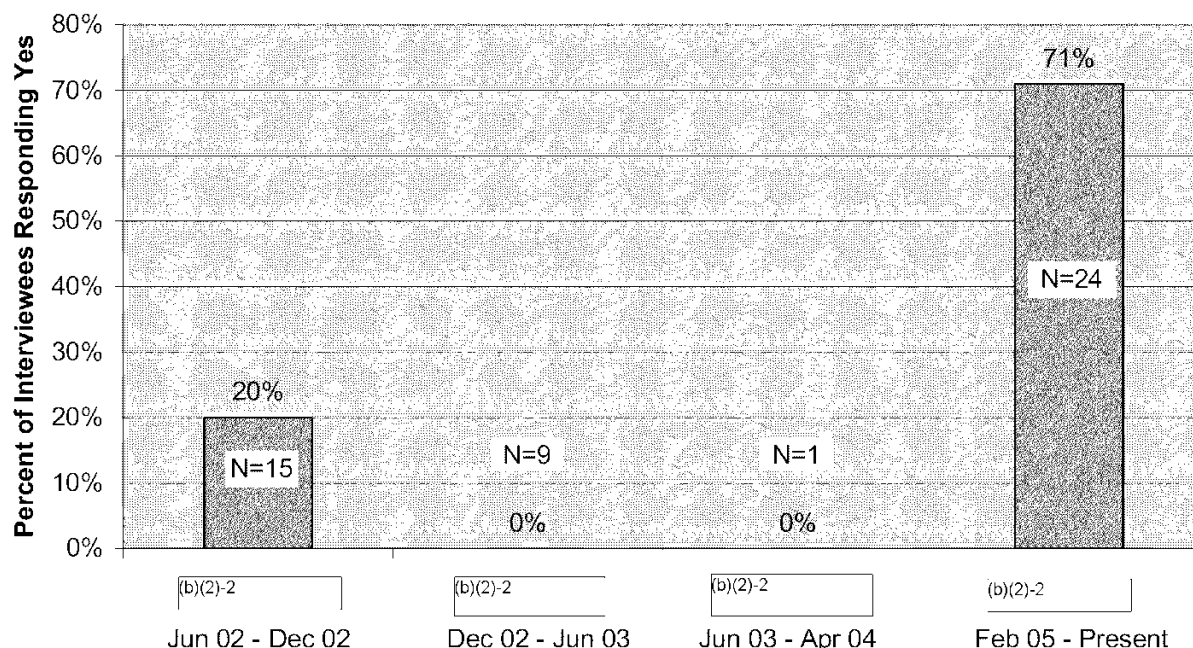
### a. Interrogation Policies

(1) 92 interviewees were asked if there was either a policy on interrogators, or a policy on conducting interrogations in their medical facility (Questions 62 and 63).

(2) 43 interviewees provided level I and II medical care to detainees. 51% (22 of 43) reported the existence of a written or verbal unit policy.

(3) 49 interviewees provided level III care to detainees. The chart below details the percentage of "Yes" respondents at all level III facilities in the theater. "N" is the total number of respondents per MTF. Approximate MTF dates of service are included.

**OEF Level III MTFs: "Was there either: 1) a policy on interrogators, or 2) a policy on conducting interrogations in their medical facility?"**



*b. Delay of Initial Medical Exams*

(1) No interviewees were ever asked to delay an initial detainee medical examination until after an interrogation, and none delayed an initial detainee medical examination until after interrogation (Questions 128 and 129).

(2) No interviewees were aware of others being asked to delay an initial detainee medical examination until after an interrogation, and none were aware of others who delayed a initial detainee medical examination until after interrogation (Questions 130 and 131).

*c. Medical Personnel Presence During Interrogations*

(1) The Team interviewed sixty-six (66) individuals and asked:

(a) Had they ever been asked to be present during interrogations? (Question 65);

(b) Had they ever been present during interrogations? (Question 66);

(c) Were they aware of other medical personnel being asked to be present during interrogations? (Question 67); or

(d) Were they aware of other medical personnel being present during interrogations? (Question 68).

(2) 41 interviewees provided level I or II detainee medical care.

(a) 7% (3 of 41) were asked to be present during interrogations;

(b) 17% (7 of 41) were present during an interrogation;

(c) 5% (2 of 41) were aware of others being asked to be present during interrogations, and

(d) 15% (6 of 41) were aware of others being present during an interrogation.

(3) 25 interviewees provided level III care. All answered "no" to all four questions.

*d. Medical Personnel Participation In Interrogations*

(1) 78 interviewees were asked if medical personnel were ever asked to participate in interrogations (Question 57).

(2) All answered "no."

## **18-25. Discussion - Guantanamo Bay Detention Facility**

a. *Interrogation Policies.* 9 interviewees were asked if there was either a policy on interrogators, or a policy on conducting interrogations in their medical facility. Three responded yes, three responded no and three reported being uncertain.

### *b. Delay of Initial Medical Exam*

(1) No interviewees were ever asked to delay an initial detainee medical examination until after interrogation, and none delayed an initial detainee medical examination until after interrogation.

(2) No interviewees were aware of others who were ever asked to delay an initial medical examination until after interrogation, and none were aware of others who delayed an initial detainee medical examination until after interrogation.

c. *Medical Personnel Presence During Interrogations.* No interviewees were asked to be present during interrogations, were ever present during interrogations, were aware of others being asked to be present during interrogations, or were aware of others ever being present during interrogations.

d. *Medical Personnel Participation In Interrogations.* No interviewee was ever asked or aware of medical personnel being asked to participate in an interrogation.

## **18-26. Discussion - Operation Iraqi Freedom**

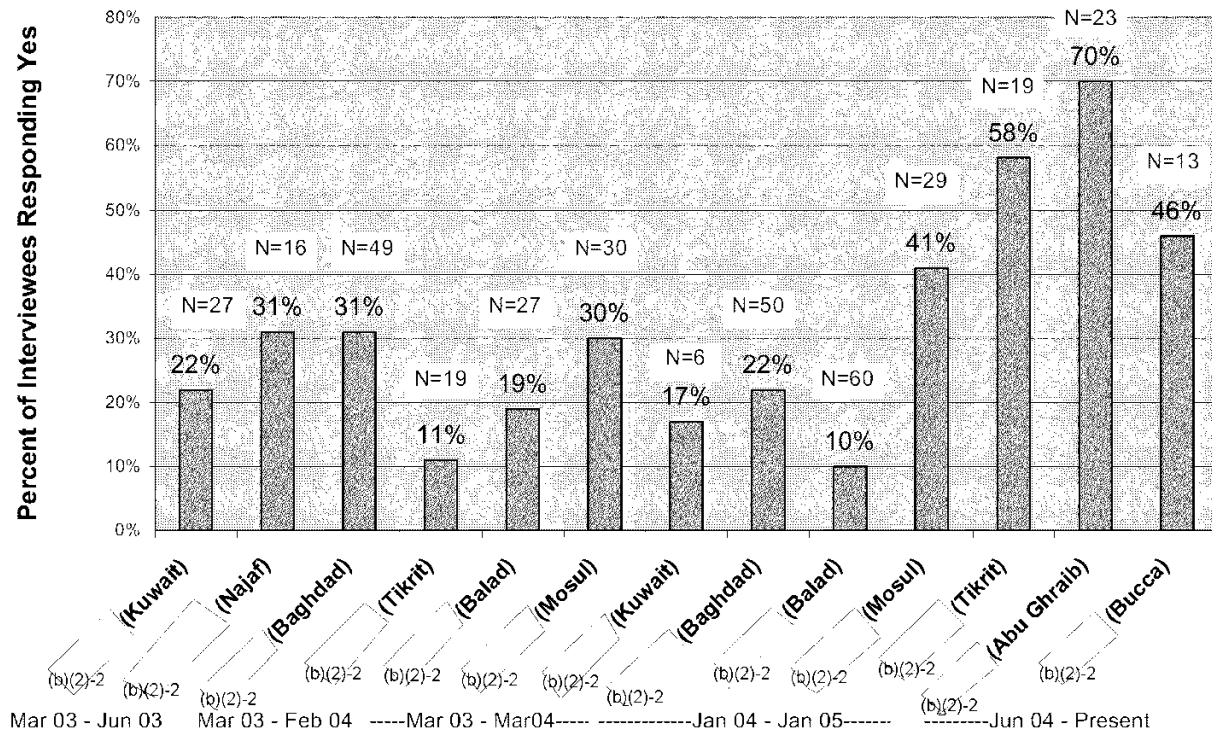
### *a. Interrogation Policies*

(1) 883 interviewees were asked if there was either a policy on interrogators, or a policy on conducting interrogations in their medical facility (Questions 62 and 63).

(2) 507 interviewees provided level I and II medical care to detainees. 27% (136 of 507) reported the existence of a written or verbal unit policy.

(3) 376 interviewees provided level III care to detainees. The chart below details the percentage of "Yes" respondents at all level III facilities in the theater. "N" is the total number of respondents per MTF. Approximate MTF dates of service are included. Many MTFs performed split operations and facility locations are annotated in parentheses.

**OIF Level III MTFs: "Was there either: 1) a policy on interrogators, or 2) a policy on conducting interrogations in their medical facility?"**



**b. Delay of Initial Medical Exams**

(1) 4% (17 of 436) of interviewees had been asked to delay an initial medical examination until after an interrogation.

(a) 1.4% (6 of 436) refused.

(b) 2.5% (11 of 436) delayed initial medical exams.

(2) 3.2% (14 of 435) of interviewees were aware of others being asked to delay an initial medical examination until after interrogation.

(a) 1.4% (6 of 435) refused.

(b) 1.8% (8 of 435) delayed initial medical exams.

**c. Medical Personnel Presence During Interrogations**

(1) The Team interviewed 777 individuals and asked:

- (a) Had they ever been asked to be present during interrogations? (Question 65);
- (b) Had they ever been present during interrogations? (Question 66);
- (c) Were they aware of other medical personnel being asked to be present during interrogations? (Question 67); or
- (d) Were they aware of other medical personnel being present during interrogations? (Question 68).

(2) 495 interviewees provided level I or II detainee medical care.

- (a) 6% (32 of 495) were asked to be present during interrogations;
- (b) 10% (48 of 495) were present during an interrogation;
- (c) 8% (39 of 495) were aware of others being asked to be present during interrogations, and
- (d) 12% (57 of 495) were aware of others being present during an interrogation.

(3) 282 interviewees provided level III care.

- (a) 2% (7 of 282) were asked to be present during interrogations,
- (b) 9% (26 of 282) were present during an interrogation,
- (c) 6% (17 of 282) were aware of others being asked to be present during interrogations, and
- (d) 13% (37 of 282) were aware of others being present during an interrogation.

d. *Medical Personnel Participation In Interrogations*

- (1) 793 interviewees were asked if medical personnel were asked to participate in interrogations (Question 57).
- (2) 99.4% (788 of 793) answered "no."
- (3) 6% (5 of 793) participated in interrogations. Descriptions are below:
  - (a) Two interviewees fluent in Arabic served as translators for interrogations.



(b) One interviewee fluent in Arabic was asked to gather intelligence for interrogators.<sup>3</sup>

(c) One physician was asked to feign evaluations and treatment on detainees by (i) doing a DNA test from a hair sample, (ii) doing a DNA test from a buccal swab, or (iii) providing cough syrup but informing the detainee it was truth serum. The physician complied with the first two requests, but refused to comply with the third. He thereafter refused any further involvement by himself or any of his medical personnel.

(4) One medic agreed to gather intelligence upon developing a rapport with detainees.

## **18-27. General Recommendations**

a. DA guidance (DoD level is preferable) should:

(1) Prohibit all medical personnel from participating in interrogations.<sup>4</sup> This includes medical personnel with specialized language skills serving as translators.

(2) Empower medical personnel to halt interrogations when any examination or treatment is required.

b. All military personnel should be trained on the above recommendations.

c. Scenario training is highly recommended.

d. Follow-on competency evaluations should be incorporated into all training guidance and plans.

## **Section VIII**

### **Stress on Medical Personnel Providing Detainee Medical Care**

## **18-28. Findings**

a. 5% (41 of 803) of the interviewees (past) volunteered to discuss their personal experiences in providing care to patients in theater. No question asked medical personnel to volunteer their experiences and to describe the emotional impact of their

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<sup>3</sup> The medic (interview #979) felt this role was inappropriate as he was unable to provide detainee medical care while serving as a translator.

<sup>4</sup> For purposes of this recommendation the term "participating in interrogations" refers to the active participation by medical personnel during an interrogation. For example, asking questions would be active participation. Medical personnel who assist in developing the plan of interrogation are not deemed to be "participating in an interrogation." Likewise, actual presence in the interrogation room may not constitute "participating in an interrogation." For example, personal observation by medical personnel to ensure the health and welfare of the detainee is not deemed to be "participation in the interrogation."

experiences. If the question had been asked, the actual numbers of responses might be higher.

b. 3.7% (30 of 803) of the interviewees reported that training should be required to prepare medical personnel for the ethical challenges and stressors associated with the theater environment, trauma care, detainee care, and the challenges of providing care with limited resources.

## **18-29. Discussion**

a. 5% (41 of 803) of the interviewees (past) described their own personal experiences in providing care to patients in theater. No question asked medical personnel to volunteer their experiences and to describe the emotional impact of their experiences. If the question had been asked, the actual numbers of responses might be higher. Responses fell into the following categories:

(1) Ethical dilemma of providing care to insurgents that killed or injured U.S. Soldiers.

(2) Providing care to U.S. Soldiers and Iraqis with limited medical resources.

(3) Quantity and severity of the injuries.

(4) Stress of a warfare environment.

b. "If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care?" was asked. The majority of past interviewees answered the question (Q6-803 respondents and Q8-800 respondents). Thirty interviewees reported that training should be required to prepare medical personnel for the ethical challenges and stress associated with the theater environment, trauma care, detainee care and the challenges of providing care with limited resources.

c. Some medical personnel reported that our interviews re-surfaced memories of their experiences. Several Soldiers identified the interview as the first opportunity to share personal experiences.

d. Some medical personnel did previously discuss their deployment experiences because they had provided care to detainees. They felt that providing detainee care devalued their deployment experience. A hospital executive officer emphasized "the enormous difficulty of being on a ward 24/7 with 20 detainees that just came off the battlefield from trying to kill American soldiers. There is no training scenario in the Army that prepares you for that" (Interview #234). The commander of a hospital described the extremely difficult work environment of the nursing staff providing detainee care. He then commented that he was very proud of their commitment to provide quality care. Several nurses assigned to a CSH talked about detainees hissing, spitting, defecating

and urinating on the floors of the ward, despite the interpreters informing detainee patients this was unacceptable. Another interviewee commented that she was a mid-deployment replacement and that she received no pre-deployment training. She adds that medical personnel must be prepared for the psychological aspects of providing detainee care.

e. Sixteen interviewees described the emotional aspects of caring for detainees. More specifically, five related their personal challenges in providing care to insurgents that killed or injured U.S. Soldiers. One nurse commented that “the detainee health care mission was very difficult and that there was much stress involved when dealing with detainees day-to-day and that sometimes personal attitudes changed, particularly if the detainees tell you that once they are released they will come back and kill you” (Interview #781). A physician characterized the “stress as unique in dealing with detainees; for example, the emotional aspect of dealing with those who were killing U.S. Soldiers and the responsibility in caring for them. Very difficult for the young medics to work through the ethics conflict” (Interview #400). A nurse simply conveys “preparing for the psychological effect of taking care of one who has tried to harm your fellow Soldier” (Interview #316).

f. Although many interviewees commented on trauma training, only a few statements captured personal experiences relating to trauma care. For example, a nurse anesthetist describes “spending resources on Iraqis no differently than American soldiers. One thing that sticks in my mind is that we expended hardware, blood, medications, supplies on an insurgent who shot an American Soldier and then had to call for blood drives at night for the next Soldier because we had expended resources on Iraqis” (Interview #159). Another nurse anesthetist assigned to another CSH commented that training should be focused on the ethical dilemmas of caring for detainees since it was a struggle; for example, “a detainee was severely wounded and we gave him the required blood, knowing that we might not have the blood for our injured soldiers. This is something that we dealt with everyday” (Interview #685). A company commander commented: “It was very challenging to deal with massive trauma. There is no place to get away from it. The reality of war is tough” (Interview #212). Finally, a CSH Chief Nurse stated: “there’s never a break, trauma everyday 24/7” (Interview #680).

g. When asked “How comfortable did you feel discussing ethical issues related to detainee care with your immediate supervisor?” 934 of 993 (94%) (past, present and future) interviewees responded with “very comfortable” and “comfortable.” Some commented that it was discussed regularly and others commented that it was not an issue; therefore, it was not discussed. Two medical treatment facilities reported convening an ethics meeting regularly (interviews #274 and #612). A few interviewees raised concerns and addressed them through the chain of command.

h. 28% (43 of 152) past/present respondents at level I in OIF graded availability of medications as either poor, fair or neutral and 26% (39 of 152) graded medical supplies as poor, fair or neutral. Interviewees commented that medical materiel sets and the

initial medical supply system did not provide for chronic illnesses, definitive and rehabilitative care necessary for detainee care; for example, a physician and two 91Ws, all from different units, commented that, initially, they were not resourced to treat medical conditions such as diabetes and hypertension (Interview #s 693, 132, and 512). Many interviewees commented that the availability and use of supplies was the same for both U.S. Soldiers and Iraqis and there was no difference in who received the resources. A 91W assigned to a MP unit commented "I used all of the resources I had for our Soldiers on the detainees and sometimes we didn't have enough" (Interview #95).

### **18-30. Recommendations**

a. MEDCOM should establish an experienced SME Team comprised of a psychiatrist, a psychologist, clinical representation from all levels of care, and include representation from a Chaplain. The team should:

(1) Comprehensively define the training requirements for medical personnel for inclusion into their pre-deployment preparation.

(2) Consider revising CSC doctrine to effectively deliver support to medical personnel in theater.

(3) Develop an effective system to regularly monitor post deployment stress.

(4) Refine leadership competencies to assess, monitor and identify coping strategies of medical personnel in a warfare environment.

b. AMEDDC&S should develop the training content defined by the above team. The above team should approve the content. The training (not all inclusive) should include ethical dilemmas medical personnel face and the emotional aspects in providing care to insurgents and detainees.

c. MEDCOM should assure post deployment mental health assessment of medical personnel and provide follow-up care.

## **Section IX**

### **Interviewee Training Requests**

### **18-31. Training Questions**

a. The Team asked the following of interviewees: "If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? Format? How often? When?"

b. The following provides responses from past/present OIF/GTMO/OIF interviewees.

### **18-32. Operation Enduring Freedom**

a. Exceedingly few interviewees felt that current training was sufficient, and nearly all felt strongly that training in general needed significant upgrading. The most commonly recommended topics were: pre-deployment: cultural awareness training (including religious differences, local customs, accepted societal behaviors, diet, etc.), basic medical and conversational language training for the respective area of operation, emphasis on triaging and treating detainee patients and U.S./Coalition patients in the same manner, and Medical Rules of Care (ROC).

b. Responses concerning the desired frequency of training were quite varied, including: annually, semi-annually, quarterly, and monthly for deploying units; during annual training (AT); and at all training locations with follow-up given at regular intervals. Responses were also varied concerning when the training should occur, to include: unit training at home station upon receipt of warning orders (varying from 30-365 days in advance of deployment) with increased training as mobilization approaches; just before mobilization with refresher in theater; and only in theater.

c. For comparison purposes in some training areas, responses were grouped by officer and enlisted personnel. Officers (physicians, nurses, and PAs) generally stated a learning preference towards a PowerPoint lecture format (with topics including local endemic diseases), while enlisted personnel generally favored scenario-based and hands-on training (with topics including staff safety and the securing of detainees).

### **18-33. Guantanamo Bay Detention Facility**

a. Responses were centered specifically on the provision of medical care while deployed to GTMO, including the security of detainees and universal precautions.

b. Responses concerning the desired frequency of training were as similarly varied as the OEF responses. Nearly all stated that while training should occur before deployment, some form of refresher training should occur after arrival in theater.

### **18-34. Operation Iraqi Freedom**

a. Training content suggestions were similar to those voiced in OEF, but also included: stress management for medical personnel; retraining for subspecialists utilized in other roles (e.g., primary care, ER, or general surgery); interactions with OGAs, MI personnel, and interpreters; field sanitation issues; preparation for long-term care of detainees; treatment of blast and gunshot injuries; and interest in having more MASCAL exercises. Of note, when Geneva Convention training was mentioned, only one interviewee recommended AR 190-8 training, reflecting a widespread lack of familiarity with this AR. Additionally, the number of responses that included desired training related to security of detainees was strikingly higher than those received in the other two theaters.

b. Responses concerning both the desired frequency and the timeframe of training were also similar to those voiced in OEF, although some interviewees also wanted detainee training added to annual common task training (CTT) requirements. It was repeatedly recommended that refresher training in theater was universally desired regardless of when or where original training took place. It was also suggested that JRTC and NTC be made prime training locations for detainee operations.

c. Desired training methods (lectures vs. scenarios) were also similar to those voiced in OEF.

## **Chapter 19**

### **Non-AMEDD Training Sites**

#### **Section I**

##### **Overview of Non-AMEDD Training Sites**

The Team visited numerous non-AMEDD training sites to glean a perspective on training initiatives relative to the detainee health care mission. The visits provided critical insights into the types of training, and the time allocated for tasks pertinent to detainee medical operations. The Team interviewed personnel at JRTC, NTC, the PPPs and CRCs, and the MI school.

#### **Section II**

##### **Joint Readiness Training Center (JRTC)**

##### **19-1. Findings**

a. The Iraq theater is replicated at the JRTC platform. Two hundred to four hundred Iraqis are hired to play various roles to include the four to five terrorist groups. The majority of scenario play is trauma. The detainee center is located next to the hospital.

b. The medical scenarios address detainee care from the point of injury to level III. When asked if simulated care was documented, the response was that it was very difficult to do the documentation in the limited amount of time provided to complete the task.

c. It was reiterated that the observer controllers (OC) do not evaluate training, but observe the training. Therefore, OCs observe but do not evaluate medical ethics training, Law of War training and Geneva Conventions training.

d. Medical ethics training as it relates to medical care is not annotated in the written AAR.

##### **19-2. Discussion**

a. OCs request tactical unit SOPs for review prior to start of exercise (STARTEX). If SOPs are missing, then the OC will coach them through to completion prior to STARTEX.

b. There were no formal checklists, rather the OCs draw from their personal experiences.

c. Scenarios are tailored to the needs of the unit's mission in theater and dynamic to reflect the changing picture in theater.

d. OCs expressed concerns that there were no selection criteria to serve as an OC and it impacts on the quality of the training. It was mentioned that AC and USAR personnel often arrive with no deployment experience to serve as an OC.

e. OCs stated their future plans are to develop scenarios to improve the quality of training. In order to improve the quality of training, they seek input from units in theater or from units that have recently returned.

### **19-3. Recommendations**

a. Establish a SME team comprised of expertise from clinicians to develop the tasks and framework to formalize the training program. The framework should encompass all levels of care, from point of capture to care in the detention facility.

b. The above team should assess the current training, specifically the scenarios to determine training deficiencies and determine the best practices in improving the quality of training as it relates to detainee medical care.

c. Since AMEDD personnel must be prepared to provide care across the entire healthcare spectrum in theater, from the point of capture and collection point to the prison facilities, the training content should be developed by medical personnel with exceptional knowledge of detainee care. Additionally, the team should be comprised of representation from JAG, a medical ethicist, and subject matter experts serving in the prison health care system. The team members should develop the content and the JRTC medical OCs should facilitate.

d. Team membership should include representation from the NG and USAR personnel that served in these facilities as well as the active component.

e. The training should include a crosswalk of DoD and DA regulations and policies pertaining to detainee medical care. Training content should be revised regularly to reflect changes in the policies.

f. Define competencies for observer controllers. Ensure OCs are from every component.

### **Section III National Training Center (NTC)**

#### **19-4. Findings**

a. The NTC scenario has evolved to mirror the Iraqi theater.

b. The NTC Rules of Engagement (ROE) have evolved to include detainee operations including medical care.



## 19-5. Discussion

a. In 1999, the NTC scenarios first incorporated Civilians on the Battlefield (COB) training. This was not medical training per se and there was no casualty play or casualty evacuation of COBs at that time. Since the start of OIF, the scenario for NTC changed significantly and on a large scale. No longer was the linear battlefield and high intensity conflict the focus of the training scenarios. Specifically, the scenario changed so that the cantonment area simulates the experience of Kuwait in the deployment process. In the box, the scenarios are focused on Iraq with a large amount of realism. There are now Forward Operating Bases (FOBs) established at the battalion level for the scenario training. Also there are Iraqi cities in the box with Iraqi nationals hired as contractors from the Titan Corporation. They speak Arabic and interact with the training soldiers in as realistic manner as possible.

b. In 2002 to 2003 the NTC ROE changed. Prior to this, Opposing Forces (ORFOR) automatically became killed in action (KIA) if captured and there was no scenario play for detainment operations or detainee care and support (including medical). Detainee Operations are now part of the standard scenario training and the medical ROE is a big part of the planning including treatment, evacuation, and care. In the Leader Training Plan (LTP) "pre-course," the medical ROE is briefed to include information on entitlement and treatment. Medical leaders are provided with references in the form of the 8 and 4 series FMs as well as access to the Tarantula AKO shared site which has the actual medical ROE for OIF, FMs, and example tactical SOPs (TACSOP). Access to this AKO shared sight is for all who request subscription on the AKO site at: AKO → Files → US Army Organizations → FORSCOM → Irwin → NTC Operations Group → Tarantula Team → Tarantula 2/4 → Rotational folders.

c. Resources available to deploying units include the JTF-7 Smart Card with non-medically related translation phrases. Units are informed of this resource and of the Palm Phrasalator software that is used by some in the field to do translations for medical and non-medical purposes.

**19-6. Recommendations.** The Team endorses the following specific recommendations from the NTC trainers:

a. Add a detainee medical operations specific task to the Expert Field Medical Badge (EFMB) task list.

b. Add detainee medical operations into combat lifesaver (CLS) training – the true first interface between the fighting force medical provider and the detainee.

c. Commanders need to incorporate detainee medical operations into the METL.

## **Section IV**

### **Power Projection Platforms (PPPs)**

#### **19-7. Findings**

- a. PPPs do not offer classes on the generation, collection and storage of detainee medical records or on specifically reporting detainee abuse.
- b. Training at the PPP is directed from 1<sup>st</sup> Army or 5<sup>th</sup> Army. It is undetermined if enough time could be allocated at these facilities to conduct training specifically geared to prepare medical units for a detainee care mission in theater.
- c. PPPs offer generic Law of War and Geneva Convention classes to soldiers deploying to OEF, GTMO, OIF. The training is not unit or theater-specific.

#### **19-8. Discussion**

- a. PPPs provide training for deploying soldiers, including a Geneva Convention/Law of War class, often provided by the local legal office. This training is not sufficient to educate medical personnel deploying to a detainee healthcare mission in theater.
- b. No training is provided on the generation, storage and collection of detainee medical records or for recognizing and reporting detainee abuse. Medics are often employed at the PPPs to cover ranges or to teach CLS courses.
- c. Few PPPs offer theater-specific training.
- d. Guidance for mandatory training leaves little time to incorporate additional, necessary, training into the schedule.
- e. Training, while meeting the guidelines from higher headquarters (HQ), is widely varied across the PPPs. Detainee Operations training is very detailed for deploying MP units, but not medical units.
- f. FTX training at the PPP does allow for unit-specific METL training.

#### **19-9. Recommendations**

- a. PPPs need to ensure medical personnel deploying are able to use their time at the training site to prepare for their upcoming mission. They should not be tasked with non-training missions (such as providing routine medical care) unless a quantifiable training effect can be assessed from such medical care.

b. PPPs need to make their training “theater-specific” to ensure Soldiers processing through are adequately informed of any unique theater challenges or dangers.

c. Geneva Convention/Law of War training needs to be improved upon by reflecting current rules of engagement and ethical challenges facing Soldiers. Emphasis needs to be placed on reporting suspected or actual abuse.

d. Units should still bear the responsibility of training soldiers on detainee medical records.

## **Section V**

### **CONUS Replacement Centers (CRC)**

#### **19-10. Findings**

a. CRCs do not provide classes on the generation, collection and storage of detainee medical records or on reporting detainee abuse.

b. It is undetermined if time can be allocated at these facilities specifically to prepare medical personnel who are deploying to a detainee care mission.

c. CRCs offer Law of War and Geneva Convention classes to deploying individuals. Ft Bliss’ CRC does make these classes theater-specific.

d. Ft Bliss’ CRC provides a detailed detainee operations class, “Process Enemy Prisoners of War/Civilian Internees (EPWs/Cis) at a Collection Point or Holding Area” (Cit. 48), geared more toward MP and combat arms Soldiers.

#### **19-11. Discussion**

a. The training provided on Geneva Convention/Law of War is lecture only and provides no scenario based exercises.

b. The time constraints on personnel processing through CRCs significantly limits increased training opportunities.

c. Personnel qualified to instruct detainee medical care classes are currently not available.

#### **19-12. Recommendations**

a. CRCs need to look at opportunities to expand current detainee operations training to include more comprehensive teachings on reporting suspected or actual detainee abuse.

b. Geneva Convention/Law of War training needs to be improved upon by reflecting current rules of engagement and ethical challenges facing Soldiers and use a scenario based component to enhance learning modalities. It needs to emphasize reporting suspected or actual abuse

c. Units should still bear the responsibility of training soldiers on detainee medical records.

## **Section VI**

### **Military Intelligence Training**

#### **19-13. Findings**

The Enhanced Analysis and Interrogation Training (EAIT) advanced individual training (AIT) course includes specific training on interacting with BSCT members.

a. 97E AIT includes instruction that interrogations should be postponed or interrupted if a detainee requires any medical evaluation or treatment.

b. The EAIT course includes specific training on interacting with BSCT members.

#### **19-14. Discussion**

a. Personnel with the 97E MOS receive a Law of War briefing from the MI JAG office. The only training in the 97E AIT which focuses on interacting with medical personnel emphasizes that any ill or injured detainee is to have an interrogation delayed or interrupted so that medical care can be administered promptly. In the FTX portion of 97E AIT none of the scenarios include moulaged or injured detainees; however, current scenarios do cover the need to report all suspected abuses inflicted by any other interrogators.

b. New interrogation training doctrine is being developed at the current time. There was a plan to include the interfacing of students with medical personnel, with the goal of increasing sources of general intelligence about detainees. This training is not specifically included in the 97E AIT, since this not described within current training doctrine. However, when current students ask trainers about using medical personnel as sources of general intelligence, this is not discouraged.

d. The EAIT was established as an advanced course for Human Intelligence Collectors and Intelligence Analysts who would be working at the GTMO detention facility. The curriculum for the EAIT course is very dynamic, and rather than being driven by doctrine, as is the 97E training, it appears to be driven by

the leadership needs at GTMO for their ever-changing personnel staffing needs/desires. However, even though this course was in fact originally established with a focus on GTMO, many current and future students will be assigned to other theaters of operation.

e. The EAIT course emphasizes the need for students to interact with medical personnel, in particular the BSCT staff; in theaters of operation this interaction is intended to occur 2-3 times per week at a minimum. Students are trained about the roles of the BSCT staff, which include: checking the medical history of detainees with a focus on depression, delusional behaviors, manifestations of stress, and “what are their buttons.” Students are also trained that BSCT staff will greatly assist them with: obtaining more accurate intelligence information, knowing how to gain better rapport with detainees, and also knowing when to push or not push harder in the pursuit of intelligence information.

f. During the EAIT course, trainee competency is evaluated during their planning phase for interrogation and analysis, and failure to interact with the BSCT staff is a “NO-GO” in this process.

#### **19-15. Recommendation**

DA, or preferably DoD, should exercise oversight in the revision of current interrogation training doctrine to ensure compatibility with the Geneva Conventions, the Law of War, and all policies that apply to medical personnel.

## **Chapter 20**

### **Incidents and Allegations**

**20-1.** This Incidents and Allegations Table (IAT) groups events by theater. Based on the number of OIF entries that theater is further subdivided into the following categories:

- a. Medical records
- b. Medical practice/behavior
- c. Interrogations
- d. Staffing shortages
- e. Reuse of supplies
- f. Supply shortages
- g. Detainee environment
- h. Potential abuses by US/Coalition Forces
- i. Potential abuses by Iraqis

**20-2.** The Team identified numerous examples of medical personnel reporting suspected abuse (to medical supervisors, the chain of command or CID). Medical personnel also made on-the-spot corrections and added or changed policies and procedures to prevent reoccurrences.

**20-3.** The Team referred 3 cases for further investigation (two to CID and one to the chain of command).

- a. Procedure performed on a dead Iraqi. This had been investigated in theater and the Soldier received a letter of reprimand. Referred to CID (IAT #72).

- b. Medical personnel providing sedatives to a detainee potentially for interrogation purposes; observed by 1 interviewee, but not confirmed by additional interviews. Referred to chain of command (IAT #41).

- c. Medical personnel failed to report detainees restrained in excessive heat without adequate water. Referred to CID (IAT #93).

**20-4.** Many of the listed allegations are either unsubstantiated or disputed by other interviewees.

**20-5.** The Team found conflicting interview results concerning the possible reuse of certain medical supplies.

**20-6.** The initial level of staffing and resourcing of supplies, combined with excessive lengths of stay for detainee patients at some level III facilities, at times limited the ability of these facilities to readily accept transfer detainee patients.

**20-7.** Allegations discussed by media reports and published articles often involved inaccurate facts. Several medical personnel who were interviewed for media stories or other publications state they were misquoted.

a. Close in time suspicious detainee deaths. Both deaths were ultimately determined to be homicides. The first death was not originally classified as a homicide. The changing of the death certificates are unfairly mischaracterized as an attempted cover-up (IAT #2).

b. Intravenous Infusion (IV) placed into a deceased Iraqi. CID had been notified (Investigation later concluded that detainee death was abuse-related). An IV was placed in the body prior to transport to make detainee appear to be alive. The purpose of the unneeded IV was to reduce the risk of a riot by detainees. Mischaracterized as an attempt to cover-up cause of death (IAT #9).

c. Internists and other nonphysicians carrying out amputations and other procedures performed by surgeons. Provider treated a detainee with a nearly severed limb. Interviewee claims he was misquoted (IAT #14).

d. Dentist performing open heart surgery. No evidence found to support this allegation (IAT #15).

e. MP suturing a detainee. Incident was investigated fully by CID. Confirmed (IAT #16).

f. Inadequate mental health assets for detainee care. Individual claims he was misquoted. He did not perform the duties of a psychologist in theater but as a medical platoon leader (IAT #17).

g. Physicians designed interrogation techniques. This statement is misleading. Medical BSCT members did monitor interrogation techniques to ensure the welfare and safety of detainee interviewees. Medical personnel were empowered to immediately stop any interrogation being conducted within Abu Ghraib based on health or safety concerns (IAT #37).

h. Reviving a detainee for continued interrogation. No evidence found to verify or disprove the allegation. Undetermined (IAT #38).

i. Reuse of medical supplies. Conflicting statements by various interviewees. Undetermined (IAT #48).

j. Medical supply shortages. Confirmed (IAT #57).

k. Use of a leash for a detainee. Interview statements provide explanation for limited use as a restraint tool on a single mentally unstable detainee. Explanation is not fully stated in article (IAT #73).

**20-8.** The Incidents and Allegations Table summarizes in one location the events deemed by the Team to be significant. The Team made a good faith effort to interview all known medical personnel involved in the listed incidents and allegations.



# INCIDENTS AND ALLEGATIONS TABLE

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
<b>OEF</b>				
1. Suspicious detainee death	Interview #314	Dec-02	Bagram	Did not observe abuse but was aware of two detainees brought in for post mortem examination who died under suspicious circumstances. The deaths were investigated by CID.
2. Suspicious detainee deaths	Interview #899, NEJM 29 July 04 (Lifton) (Cit. 35)	Dec-02	Bagram	A detainee death was initially thought to be secondary to a pulmonary embolus, and not related to any abuse. The interviewed TF Commander requested an Armed Forces Institute of Pathology (AFIP) autopsy thru CENTCOM and arranged for international physicians (German and Jordanian) to attend. After a second detainee died shortly thereafter, the AFIP forensic pathologist returned with a Jordanian and Korean physician in attendance for that next autopsy, and the first death was evaluated again. This time the cause of death was determined to be homicide. A 15-6 was directed by CJTF-180 commander. CID did a complete investigation. The Team reviewed the final autopsy reports and confirmed that both deaths were concluded to be homicides.
3. Allegation of photos documenting multiple Afghan detainee physical abuses	E-mail from PROFIS Surgeon	Unknown	Kandahar	The surgeon reporting this incident stated it was unclear if the photos were real or fake. Allegation referred to CID by Ft Benning MTF Commander for investigation.
4. Uzbek detainee in Afghanistan captured and at next level reported prior physical abuse	Interview #378	B/T Jul 03- Apr 04	Shkin	Sent to CID for investigation; no fault found.
<b>GTMO</b>				
5. Inappropriate interrogator techniques	BSCT #6	B/T Jun 02 -- Dec 02	GTMO	There was one incident where a BSCT member was aware of potential abuse as he was present when the FBI discussed the incident with the JIG Commander. Apparently the abuse involved an interrogator pulling on the thumbs of a detainee.
6. Inappropriate interrogator techniques	BSCT #5	B/T Dec 02- May 03	GTMO	BSCT member reported a questionable incident where a female interrogator took off her BDU jacket, rubbed her breasts against the body of the detainee being interrogated, sat on his lap, and whispered in his ear. The interrogation was stopped and the individual was reported for her inappropriate behavior.
<b>OIF</b>				
<b>OIF - MEDICAL RECORDS ISSUES</b>				
7. Burning of medical records	Interview #431/#271	B/T Jan-Mar 04	Balad	Interviewee #431 stated: (b)(2)-2 mentioned that the records were burned after discharge." Interview #271, assigned to (b)(2)-2 claims records were maintained by the CSH. Unconfirmed on both accounts.
8. Burning of medical records	Interview #435/#681	B/T Jan-Nov 04	Mosul/ Balad	Admitted that as S-3/S-2 he would burn records of those detainees not transferred. Interviewee #681 claims records were maintained by the (b)(2)-2 and copies were given to MPs going to "Area 51" with a detainee, then contradicts by saying they have no idea what happened to the original records after going to "Area 51".

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
9. Death of a detainee/place-ment of IV and packed in ice	NEJM 29 July 04 (Cit. 35) Time Mag 07 Feb 05 (Cit. 47). Interview #970/#917/ #698	B/T Jul 03- Mar 04	Abu Ghraib	The medics and #917 were contacted to evaluate a detainee who was found to be dead upon their arrival. He had a sandbag by his head, a cut over his eye, chest contusions, his knees were "scuffed up," and he exhibited raccoon eyes. #970 documented his findings (physical), but he did not sign a death certificate. #970 was called to pronounce the detainee dead (he has a report in his possession because he did not know how to file this report on an unidentified person). He stated that the detainee had already been pronounced dead by the Iraqi physician on call. This detainee had no prison number, had apparently just been captured, and was not a prisoner of the U.S. military, but of an OGA. Autopsy was recommended. #698 stated that he was called down with #917 and another medic. The medic was instructed to place the IV by the JIDC Director (with OGA personnel present). The IV was placed to prevent the other detainees from rioting (confirmed when investigated by CID). The body was packed in ice and transported to an unknown destination. According to #705, the JDIC Director ordered them not to discuss the incident to anyone, including the B Co Commander, (b)(2)-2 #705 was unaware of incident until interviewed by CID. Also investigated by CIA.
10. Possibility of falsifying detainee death certificate	Interview #415	B/T Jul 03- Mar 04	Undeter- mined	Stated that while working with (b)(2)-2 on two separate occasions, he was pressured by OGA personnel into filling out death certificates on Iraqi Detainees. Stated he was not given the opportunity to examine the dead. Causes of death were later found to be inaccurate. CID investigated.
11. Misrepresenta- tion in med records	Interview #595	B/T May-Jul 04	Baghdad	Interviewee stated: "Changed the spelling of my last name on detainee records; I was told the paperwork would be given to detainees upon release." Was attached to the (b)(2)-2 at the time.
<b>OIF - MEDICAL PRACTICE/BEHAVIOR ISSUES</b>				
12. Physician refusing to treat a detainee.	Fay/Jones report/ Interview #897/#904/ E-mail correspon- dence to Team (Cit. 24)	Dec-03	Abu Ghraib	An MI soldier, in her testimony for the Fay /Jones report, stated that she found a detainee in his cell with a Foley catheter in place but without a collection bag attached. She states that she contacted the physician on duty that night and he refused to see the patient or attend to her concerns. The Team contacted the MI Soldier to get more information about who this physician was. She did not remember his name, nor remember if he was an LTC or a COL, but stated that she could identify him in a picture if given one. The Team spoke to many medics and the few physicians that were working in Abu Ghraib around the time of this incident. The Team was not able to identify this physician. #970 does not meet the description and #706 re-deployed November 03 per email msg dated 25 Mar 05 to Team member.
13. Failure to provide detainee care	Public admission/ Interview by Team member	May-04	Kufa	Started an interview on this medic who informed the Team member he had been interviewed about six times by CID concerning an incident where a Company Commander had shot a wounded Iraqi. He said the subject had "half his head blown off" and it was the worst head wound he had ever seen. He told me that he did not treat the patient because he was "expectant." He did not report the incident because an unmanned drone caught it on film. The case was brought to light by the media during the Company Commander's court-martial.
14. "Internists and other nonphysicians carrying out amputations and other procedures performed by surgeons".	Time Mag 07 Feb 05 (Cit. 47) / NY Times 04 Feb 05 (Cit. 36). Interview #916/e-mail correspond ence to Team from #818	B/T Jul 03- Mar 04	Abu Ghraib	There were approximately 130 casualties, including some with open chest wounds and traumatic amputations. #916 stated that he thought the Time Magazine interview was about staffing shortages and a shortage of supplies. During the interview, he mentioned that he cared for amputees. Several of the casualties sustained traumatic limb amputations in which the limb was not salvageable, but had skin attaching it to the body. #915 did not perform any amputations. In cases where the limb was salvageable, the extremity was wrapped and the patient was evacuated. Interviewee stated he felt misrepresented by the article. A patient was admitted to the hospital with Diabetic Foot Ulcer. The patient did not respond to the antibiotic therapy. The orthopedic surgeon performed the toe amputation in the OR.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
15. Dentist allegedly doing heart surgery	NY Times 04 Feb 05 (Cit. 36)/ Interview # 904/#705	B/T Mar 03-Apr 04	Abu Ghraib	#904 stated there was no dentist assigned to Abu Ghraib during Mar 03 to Jan 04. #705 stated that a dentist may have assisted with the insertion of chest tube during a mortar attack, but did not perform open heart surgery. It is unclear when this allegation could have occurred.
16. Two detainees' depositions describe an incident where a medic allowed a medically untrained guard to suture a prisoner's laceration	Incident #21 in Fay-Jones. Lancet (Miles) (Cit 30)/ Interview # 698 (2nd visit to the unit)	Late 2003	Abu Ghraib	#698 (combat medic (b)(2)-2) was asked by MP if he could place a suture. The MP informed #698 that he was a trained Combat Life Saver. #698 monitored the placement of the suture and subsequently monitored the detainee for signs of infection. The wound healed without difficulty. The detainee statement in the Fay/Jones report states that "a doctor" allowed one of the guards to do the suturing. This is not accurate. Interview #705 (physician, (b)(2)-2) was not aware of the incident until CID notified him in Theater. #705 questioned #698 about the incident and verbally counseled him that a PA or physician needs to review and concur with plan of care before suturing in the future. Incident was investigated by CID.
17. Inadequate mental health assets for detainee care	NY Times 14 Feb 05 (Cit. 36)/ Interview #974/#705	B/T Apr 03-Mar 04	Abu Ghraib	#974 (70B, Platoon Leader, (b)(2)-2) was contacted by (b)(6)-2 (bioethicist) for a telephonic interview for the NEJM. It was #974's understanding that (b)(6)-2 sought information to improve care. He asked #974 about mental health issues, knowing that #974 was a professor of psychology and counseling. #974 informed him that about "5% of the detainees suffered from mental illness." #705 is quoted in the article as follows "for long periods, there was no one to treat mental-health problems among inmates, no doctor qualified to prescribe antipsychotic drugs and other drugs that could have calmed mentally ill detainees." #974 stated that (b)(6)-2 inferred that #974 was performing mental health services. #974 stated that he did not perform mental health services and explained that to (b)(6)-2 as well. He said that (b)(6)-2 asked him about BSCTs and he informed him that he had never heard of that term. #974 stated he was misrepresented in the Times article. The NEJM 06 Jan 05 (b)(6)-2 does discuss BSCTs but does not does not mention #974's comment. The Times article does mention #974's comment, but quotes #705.
18. Line medic given the authority to not treat patients	Interview #545	B/T May 03-Jul 04	Baghdad/ Najaf	#545 stated that he was given the authority by the platoon leader to not treat detainees at point of capture who were considered "too far gone." Once told by Platoon Leader of (b)(2)-2 that he had the option of providing medical care to detainees or not. Was also told by a Medical NCO in Sadr City that he, the Medical NCO, did not always treat detainees at point of capture. Said he treated US personnel first and then detainees if there were enough medical supplies. Team could not locate these two individuals.
19. Contract Iraqi physicians secretly taking medications prescribed to detainees to sell on the black market	interview #246	Spring 2003	Baghdad	Reported through chain of command; responsible individuals fired from contract positions.
20. Abuse of a detainee by a nurse	Interview #717	Early 2004	Balad	The nurse interviewed from the ICU reported that he felt that a nurse from the ICW was abusing detainees. He didn't report it, but counseled the nurse himself and obtained a rights warning card from the MPs. He then threatened to bring the nurse up on charges if his treatment of the detainees did not improve. No additional incidents noted.
21. Abuse of detainee by nurse at (b)(2)-2	Interview #430/#431/ #937	B/T Jan 04-Nov 04	Balad	Nurse struck detainee after he grabbed her. COC notified, administrative action taken. Confirmed by interview #166. The 91WM6 was reprimanded in writing for attempting to defend herself when a detainee grabbed her. #937 believes she tried to choke him or push him away. For corrective training, she provided classes on Law of War and the Geneva Conventions with respect to detainee care.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
22. Death of a restrained detainee who fell due to the restraint	Interview #711	2004	Baghdad	The (b)(2)-2 commander interviewed describes an incident where a detainee died from a subdural hematoma. At the time of the fall, the detainee was restrained to his bed by one wrist and one ankle restraint. The commander determined that the fall was caused by the method of restraint (root cause analysis) and the hospital restraint policy was changed.
23. Observed junior Anesthesiologist drop a litter with a detainee patient hard on purpose three times	Interview #12	B/T Mar-Oct 03	Baghdad	Confronted individual, assigned to the (b)(2)-2 on the spot; reported to OR head nurse. No further incidents.
24. Staff nurses appeared to hold pain medications on detainees to absolute time limit of med order	Interview #582	B/T Aug 03-Feb 04	Balad	Reported to Nursing chain of command at the (b)(2)-2 practice stopped.
25. Staff possibly feeding detainees MREs with pork products on purpose	Interview #582	B/T Aug 03-Feb 04	Balad	Reported to Nursing chain of command at the (b)(2)-2 practice stopped.
26. Alleged directive to withhold pain medications from detainees	Interview #398/#463/#459	2004	Northwest Iraq	#398 reported that medical personnel were not allowed to give detainees any pain medications, even Tylenol, Motrin, or aspirin, by order of the detention facility commander for (b)(2)-2. The Team determined that he was actually talking about (b)(2)-2. He brought his concerns to the PA and Bn surgeon. Two other medical personnel were interviewed from (b)(2)-2. The BN Surgeon, #459, stated that all detainee medical resources were good, including medication resources, and that all the resources were the same and not separated. Interview #463 was asked specifically if there were directions from his command about limiting resources for detainees and he stated "no."
27. Delay in care of critically injured detainee	Interview #239	Spring 2003	Kuwait	The first time detainee casualties from Iraq landed at the landing zone (LZ) for the (b)(2)-2 in Kuwait, there was an argument among the (b)(2)-2 leadership about providing detainee care in Kuwait. The casualties waited on the LZ without care for two hours. This resulted in significant patient care delay without changing patient outcome. The (b)(2)-2 later received approval to treat such detainee emergencies in Kuwait.
28. Quality of care for a detainee	Interview #729	Summer 2003	Bucca	#729 describes watching a medic from another unit attempt to put an IV in a detainee multiple times. The medic placing the IV was "not very good at placing IVs, was yelling at the detainee to cooperate with her, and told the interpreter that she wouldn't care for the detainee if he didn't start to cooperate." The interviewee intervened and placed the IV herself and counseled the medic on the spot.
29. Quality of care for detainees	Interview #444	Late 2003	Abu Ghraib	When influenza vaccines were available, the unit administered them to detainees. #444 and other medics were counseled from the MP higher HQ for administering flu shots to detainees. Regardless, #444 established a protocol to administer flu shots first to detainees with chronic illnesses, and then to the other detainees.
30. Refusing to accept detainee patients	Interview #172	Spring 2003	Baghdad	The interviewed physician from Camp Cropper (BIAP) recounted a significant problem with detainees having advanced stage TB. #172 reports one child hemorrhaging from his cavitary TB and dying. After that happened he developed a four-drug therapy protocol for TB. He reports that one of his detainee patients was desaturating due to his TB and that the (b)(2)-2 refused to accept this patient in transfer even though there were not the appropriate medical resources at BIAP to treat him. He states that ultimately he stopped calling ahead to the (b)(2)-2 to let them know he was transferring detainee patients to ensure that he would not have these patients blocked for transfer. He was concerned that when he called to report on a critically injured patient he was transferring, the first question he was always asked was "is this a US soldier or a detainee?" He was concerned that this conveyed a bias against accepting detainee patients.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
31. Refusing to accept detainee patients	Interview #444/#904	B/T Apr 03-Apr04	Baghdad	This medic at Abu Ghraib reports that the medical evacuation resources for detainees were poor and felt this was due to the (b)(2)-2 refusing to accept patients in transfer. Two patients that were particularly memorable were a patient with a base of the skull fracture and a patient with partial hand amputation. Ultimately, the fracture patient was accepted in transfer to the (b)(2)-2 which then transferred him to the (b)(2)-2 for level III care. (Interview # 444) His NCOIC (also a medic) reports contacting his Bn command who in turn would contact the BDE command who in turn would contact the (b)(2)-2 who would contact the (b)(2)-2 to transfer these patients. Neither of these medics spoke directly to anyone at the (b)(2)-2. They did report that once they found the (b)(2)-2 they stopped trying to send any patients to the (b)(2)-2 and never had a problem having a detainee patient accepted for transfer the (b)(2)-2.
32. Appropriate support of level II medical unit by the (b)(2)-2	Interview #172/#695	B/T May-Oct 03	Baghdad	#172 (board certified Family Practice physician) reports that he would send detainees from the BIAP/HVD detention facility to the (b)(2)-2 for subspecialty consultation. They would be seen by a PA or an NP doing acute care and sent back with the consultation completed by that person, instead of the specialist. He felt this was inappropriate. #695 learned that PAs were running the screening clinics and were not prepared to manage complex medical illnesses. #695 met with the (b)(2)-2 DCCS to discuss his concern. No change in this practice occurred; therefore, he stopped sending these patients and treated them himself at the (b)(2)-2 15 bed Aid Station.
33. Appropriate support of level II medical unit by the (b)(2)-2	Interview #172	B/T Mar-May 03	Baghdad	This physician states that early on in the war (Mar 2003 - May 2003), detainees were being sent back to the HVD detention facility with external fixators in place. He felt this was inappropriate because they were sleeping in the dirt and had a very high risk of infection from their environment. He complained about this to the (b)(2)-2 command and ultimately, by June 2003, the (b)(2)-2 sent a delegation of command staff to the HVD detention facility to see what the environment was for the detainees. After they saw the conditions, they stopped sending patients back that couldn't safely receive their post-operative care at the detention facility.
34. Appropriate care of detainees by the (b)(2)-2	Interview #172	B/T Mar-Aug 03	Baghdad	#172 recalls a conversation he had with the OMF surgeon from the (b)(2)-2 that concerned him. #172 had sent a patient with an open facial fracture involving the maxillary sinus from the BIAP to the (b)(2)-2. He asked the OMF surgeon how this patient was doing when he next saw the OMF surgeon and #172 reports that the OMF surgeon told him that she didn't remember the patient. #172 reports that the OMF surgeon then asked if the patient was a US soldier or a detainee and when #172 stated this was a detainee, #172 reports that the OMF surgeon stated that she didn't always get called on the detainee patients.

## OIF - INTERROGATION ISSUES

35. Simultaneous treatment and interrogation of a detainee	Interview #398/#68/#452/#453/#454/#456/#460	2004	Mosul	Detainee with a gunshot wound simultaneously interrogated in aid station, according to #398. Others interviewed did not mention this or other similar episodes. Soldiers assigned to (b)(2)-2
36. Simultaneous treatment and interrogation of a detainee	Interview #398/#68/#452/#453/#454/#456/#460	2004	Mosul	Detainee with a gunshot wound simultaneously interrogated in aid station, according to #398. Others interviewed did not mention this or other similar episodes. Soldiers assigned to (b)(2)-2
37. "Army officials stated that a physician and a psychiatrist helped design, approve, and monitor interrogations at Abu Ghraib."	Lancet article (Miles); Interview #734, #BSCT 9	B/T Jan -Feb 04	Abu Ghraib	#734 is the "physician" referred to in this article. #734 reported that he and his EMEDS Commander wrote the CONOPS for the JIDC DHT. As the DHT physician, he helped to monitor interrogation techniques, not monitor interrogations directly. Also, he did not develop interrogation techniques. He did not approve techniques, but rather had the authority to stop any technique used anywhere in Abu-Ghraiab on the spot and without approval of the BDE FOB Commander. # 734 felt that the Lancet article misrepresents his actual duties at the JIDC.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
38. "In one example of a compromised medically monitored interrogation, a detainee collapsed and was apparently unconscious after a beating, medical staff revived the detainee and left, and the abuse continued."	Lancet (Miles)		Abu Ghraib	The Team found no evidence to verify or disprove this allegation.
39. Physician was asked to participate in interrogations three times	Interview #848	B/T Sep 03-Aug 04	Baghdad	Three requested episodes: 1) to pretend to collect DNA with a hair sample; 2) to pretend to collect DNA sample with buccal swab; 3) to provide cough syrup as a "truth drug". He refused #3, and prohibited medical personnel inclusion in any subsequent interrogations. Practice stopped.
40. Medical personnel involved with interrogations	Interview #398/#979	B/T Sep03-Sep04	Northwest Iraq	#398 reports that he was used as an interpreter for interrogations under the direction of the S-2 because he is fluent in Arabic. #398 never acted as a medic during any interrogations, only acted as an interpreter. #979 (combat medic, (b)(2)-2) who is fluent in Arabic, reports that he served as interpreter for intelligence gathering. #979 asked his supervisor to limit the use of his language skills to care for detainees. Despite repeated requests, #979 was told by his medical OIC that he would continue to assist in intelligence gathering.
41. Medical personnel providing sedatives to a detainee so he would talk more during interrogation	Interview #33/#36/#139/#138/#137/#32/#136/#63/#62	B/T Mar 03-Mar 04	Kirkuk	#33, an LPN from (b)(2)-2 reported that he saw sedatives (ativan, diazepam, etc.) being used by medical personnel to calm a detainee so that the detainee would talk more. #33 did not think it was appropriate. #33 reports that he was asked to do this, but he did not do it himself. Several others in the unit (#36, 139, 138, 137, 32, 136, 63, and 62) were interviewed and none of them reported similar requests or observations. None of them reported administering any medications to assist in the interrogation process. The Team referred this incident to the chain of command after conferring with the CID Staff Judge Advocate.
42. Interrogation on ICW ward	Interview #164	B/T Mar 03-Feb 04	Balad	Interview #164 stated that "if the detainee or EPW was not picked up or claimed by the unit that brought them to us (could be MP or maneuver unit) at the time of discharge, the S-3 cell under the authorization of the Commander released them. Interrogators came to the ward to ask questions of detainees. I don't know who the interrogators were (MPs, MI, etc.). The detainees were taken to the end of the ICW to be questioned. There was a process in which the interrogator had to go to the S-3 shop first. S-3 escorted the interrogator to the ward. I did receive verbal instructions on the procedure for interrogators entering our facility (my ward)."
<b>OIF - STAFFING SHORTAGES</b>				
43. Interrogators used as interpreters	Interview #866/Visit to DIF	Jan-05	Camp Liberty	Interrogators assigned to (b)(2)-2 were used as interpreters for the medical staff during the initial screening of detainees, giving some interrogators access to all of the detainee's medical information. Discussed on-site by Team.
44. Access to detainee medical information	Interview #644	B/T Mar-Aug 04	Baghdad	The translators with the (b)(2)-2 often worked with the interrogators in addition to serving as translators for medical care. It could create a set of conditions for distrust between providers and detainees.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
45. Inadequate personnel resources -- interpreters	Interview #631/#261/#36/#726/#259/#237/#178	2003-2005	Various Locations	Individual medical personnel from the units listed reported that the supply of interpreters strictly for medical purposes was inadequate. One individual reported that the interpreters used for medical purposes were the same as the ones used for interrogation (#36 - (b)(2)-2 (Kirkuk)). One individual reported that they had to rely on other detainees to be interpreters (#726 - (b)(2)-2 (Bucca)). One individual reported that they had to use the interrogators as interpreters because they were the only ones available to be interpreters (#259 - (b)(2)-2). One individual reported concerns about the quality of the interpreters with concerns that one interpreter was found to be inappropriately touching patients and was fired and another was found to be sending intelligence to Kuwait for retaliation against the Iraqis (#261 - (b)(2)-2 Baghdad). Another individual felt that having Kuwaiti interpreters was inappropriate as they often talked down to the Iraqi patients and were culturally insensitive (#240 - (b)(2)-2 (Baghdad)). One individual had concerns that the interpreter provided to them was not accurate in what he was conveying (#631 - (b)(2)-2 Kuwait)). Two other individuals noted a general lack of availability of interpreters (#237 - (b)(2)-2 #178 - (b)(2)-2 (Mosul)). Founded.
46. Inadequate personnel resources	Interview #917	B/T Jul 03-Mar 04	Abu Ghraib	(b)(2)-2: The (b)(2)-2 medical section was tasked to support (b)(2)-2 with an ambulance and medical resupply support. (b)(2)-2 mission was to supplement staffing at Abu Ghraib. #917 reported that initially the (b)(2)-2 senior medic assisted the unit, but within a very short period of time the MP medics were not available to assist with sick call. Physicians rotated every 90 days, making it extremely difficult to provide any continuity in leadership. #917 relates that one rotating MP Bn surgeon spent his entire deployment traveling to accomplish the task of establishing a hospital.
47. Inadequate personnel resources -- medical personnel doing guard duty	Interview #240/#173/#176/#716/#198	B/T 2003-2004	Baghdad, Mosul, Balad hospitals	These five individuals, assigned to CSHs, reported a concern that nurses and enlisted medical personnel were required to guard individual detainee patients or wards of detainee patients. Their concerns were for inappropriate use of medical resources and a possible conflict of interest, respectively.
<b>OIF - RE-USE OF SUPPLIES</b>				
48. Re-use of chest tubes	NY Times 04 Feb 05 (Cit. 36)/ Time Mag 07 Feb 05 (Cit. 47). Interview #916/#771	B/T Mar-Jul 04	Abu Ghraib	(b)(2)-2 Regarding the scarcity of supplies, #916 stated that the medical chests had only 6.5 and 9 ET tubes and that they were missing sizes 7, 7.5 and 8. During the MASCAL, there were no sterile chest tubes left. He said he was offered what appeared to be a bloody chest tube; it was rinsed in normal saline and used immediately. He also states that the article misrepresents the care provided to detainees and that top quality care was delivered given the limited resources. #771 states disposable medical supplies were never re-used and he never observed a chest tube being pulled out of one patient and put in another patient.
49. Re-use of expendable medical supplies	Interview #169	B/T Mar 03-Feb 04	Baghdad	#169 reported that resources were available but observed sharing of needles and sharing of drugs for all Iraqi patients. There was fear that medical supplies would be depleted. Assigned to (b)(2)-2
50. Re-use of supplies	Interview #634	B/T Mar 03-Feb 04	Baghdad/ Tikrit	"Did not have policy on re-use of expendable medical supplies, but had direction that scope of care in Iraq would permit that, and policy from higher HQ was to care for Iraqis based on local scope of care. Did Commander's Inquiry concerning the re-use of medical supplies and found the allegation was not substantiated." Assigned to (b)(2)-2
51. Re-use of supplies	Interview #197	B/T Nov 03-Jan 04	Baghdad	"Had limited resources. Shared resources equally. Many disposable supplies reused." Because US and coalition forces were evacuated quickly the reuse was mainly limited to the detainees. There was no policy on reuse for Iraqi patients, it was just done because of a shortage of supplies. Assigned to (b)(2)-2
52. Re-use of supplies	Interview #124	B/T May 03-Jul 04	Baghdad	While assigned to the (b)(2)-2 reused syringes with a new needle for Iraqi personnel and detainees.
53. Limited resources/re-use of supplies	Interview #316	B/T Mar 03-Feb 04	Baghdad	"Initially short on supplies. Reused gloves, needles, and syringes on detainees only because of shortage. Always reused on same patient. Did this for three months. As more supplies arrived, stopped the practice."
54. Limited resources/ re-use of supplies	Interview #198	B/T Jan-Jun 03	Tallil	Nurses issued one needle, one syringe, and one pair of gloves per day for mixing drugs, not for patient care. Assigned to (b)(2)-2
55. Re-use of expendable medical supplies	Interview #511	B/T Mar-Jun 03	Tallil Air Base	Reuse of expendable medical supplies for all patients. "We were only allowed to use one pair of gloves per day so we wouldn't run out." Attached to (b)(2)-2

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
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## OIF - SUPPLY SHORTAGES

56. Med resources for detainees	Interview #775	B/T Jan 04-Jan 05	Mosul, Tikrit, TF OASIS	# 775 (Commander (b)(2)-2) stated that she "went to (b)(2)-2 for staff and resources, told to provide local scope of care for Iraqis, and to not call them EPWs because detainees did not have to receive the same care per Geneva Conventions."
57. Shortage of medical supplies	NY Times 04 Feb05 (Cit. 36)/ Time Mag 07 Feb 05 (Cit. 47). Interviews #917/#705/ #916/#700	B/T Jul 03-Jul 04	Abu Ghraib	#917 reported a three month lag from ordering to acquiring supplies. There were not enough test strips to monitor blood glucose levels adequately. As a result, the therapeutic goal was limited to keeping blood glucoses in the 200-300 mg/dl range. #705 reported that he did not have adequate supplies and personnel to manage detainee care.  (b)(2)-2 01 Mar 04-July 04: #916 commented that (b)(2)-2 should have been better resourced. He stressed that 130 patients were treated in six hours with the staff and supplies available during a MASCAL.
58. Shortage of medical supplies	Interview #139, 137	B/T Mar 03-Mar 04	Kirkuk	#139 and #137 reported that the maneuver unit Bde Commander required one patient to stay at the FST for 3 weeks for intelligence reasons. The patient had significant injuries requiring a great deal of personnel and supply resources. #139 and #137 felt that this was an inappropriate use of FST resources, which were depleted due to holding patients at the FST longer than doctrinally described. #139 and #137 reported that a surgeon from the FST voiced his concerns directly with the Bde commander and the detainee was transferred to a CSH.
59. Shortage of medical supplies	Interview #172	B/T Mar-May 03	BIAP (HVD facility)	#172 reported that initially the facility did not have any clothing for the detainees. #172 reported that he deployed with adequate supplies, but ran out quickly and re-supply was not adequate until about June 2003. #172 reports getting into arguments with the ASMC Commander about the detainee population and that he ultimately threatened involving the ICRC to get the Company Commander to respond to his requests for the needed supplies.
60. Shortage of medical supplies	Interview #95	B/T Apr-Nov 03	Bucca	#95 (combat medic (b)(2)-2) reported that the MTOE for his unit's medical supplies was inadequate. #95 reported that the only medical supplies he was allowed to deploy with were those on the MTOE and included only his aid bag and no medications (not even Tylenol). #95 felt the packing list for the aid bag was inadequate. #95 reported that he and the other medic in his unit were told by their company that they would always be with a hospital and have medical supplies provided to them in theater. #95 stated that he used all of the resources he had on the detainees and did not have enough for US soldiers at times. Before Dec 2003, #95 had to drive to Kuwait to pick up supplies for US soldiers and detainees.
61. Shortage of medical supplies	Interview #713	B/T Mar 03-Jul 04	Balad	#713 rated detainee medical supplies as poor to none. He received directives to use resources on US soldiers first and only use what was left over for detainees. He formally requested a separate source of supplies for detainees. He felt that as medics, they were put in an unfair position because they weren't given enough to care for both US soldiers and the detainees, and yet they were held accountable to the ICRC for the care given to the detainees.
62. Shortage of medical supplies	Interview #683	B/T Jan-Jun 04	Baghdad	#683, assigned to (b)(2)-2 reported making specific requests to (b)(2)-2 including specialized orthopedic and neurosurgical supplies, that would result in more definitive surgical results and shorter length of stay for detainees. (US soldiers with these surgical requirements were evacuated out of theater, which is why the CSH didn't deploy with these items initially.) He felt the (b)(2)-2 really did want to help, but that they possibly didn't know how to accomplish these special requests. Ultimately, these supplies were made available to them after a more experienced MSC Logistician was provided to the (b)(2)-2
63. Inadequate instrumentation to treat maxillofacial injuries	Interview #692	2003		#692 reported there were detainees with maxillofacial injuries that required plates and screws that were not available. #692 attempted to procure the items prior to and during deployment without success. However, the unit that followed did receive these items.
64. Shortage of medical supplies	Interviews #261/708	B/T Mar-Jun 03	Baghdad, Kuwait	#261 (b)(2)-2 and #708 (b)(2)-2 reported that the medical re-supply system in theater was not adequate because the supply routes would "go down."
65. Shortage of medical supplies	Interview #770	B/T Feb-May 03	Objective RAMS	Ethics committee of (b)(2)-2 met to discuss if the unit should hold back supplies for US soldiers. The ethics committee decided all patients would get the same treatment and have equal access to resources.



Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
66. Inadequate resources for detainee care	Interview #773	B/T Feb 03-Feb 04	Baghdad	#773 (medical planner, (b)(2)-2 office) reported that he received no guidance from CFLCC or CENTCOM that addressed detainee medical care. Planning at (b)(2)-2 level began in Apr 02. There was discussion and planning for detainee medical care but the terminology used was "displaced civilians" or "EPW," and never the term "detainees." In going to the compressed deployment, #773 stated there was no time to get additional hospitals in theater. #773 reported that the (b)(2)-2 intent was to evacuate the displaced civilians or EPWs back to Kuwait for medical care. #773 reported that, during the planning stages, it was not known that Iraqis would not be able to be taken out of Iraq.
67. Inadequate medication supply for detainees	Interview #512	B/T Apr 03-Apr 04	Camp Scania	#512 (b)(2)-2 reported they had a shortage of medication for all of their patients, including azithromycin and cold medications, and some medications specifically needed for detainees, including insulin and cardiac meds.
68. Shortage of medical supplies	Interview #293	B/T Apr 03-Mar 04	Baghdad	#293 (b)(2)-2 stated that "some medical supplies were limited at our level. I trained my Soldiers to treat US Soldiers first. If supplies were available, then we treated all the same."
69. Shortage of medical supplies	Interview #978	B/T Apr 03-Apr 04	BIAP	#978 (b)(2)-2 stated that medication supplies for diabetic and insulin-dependent diabetic patients was limited. #978 felt that the supporting MP units could not procure the necessary medications through logistic channels.

## OIF - DETAINEE ENVIRONMENT

70. Inadequate detainee environment	Interview #511	B/T Mar-Jun 03	Tallil Air Base	#511 (b)(2)-2 reported that there were not enough blankets for the detainees at night in the ICW and that it was very cold there. #511 was not supplied with extra blankets despite requests. #511 suggested to "his COL" that he was going to build a fire in the middle of the ICW to keep the patients warmer. He was told not to build a fire and blankets were then provided.
71. Inadequate detainee environment	Interview #444	B/T Apr 03-Apr 04	Abu Ghraib	#444 (combat medic (b)(2)-2 reported that Abu Ghraib sanitation was poor and that, in addition, the food supply for the detainees was horrible. He found cockroaches in the food that was available for the detainees and he dumped it out himself so it could not be served to them and they were given MREs instead. He stated that he reported his concerns directly to the (b)(2)-2 Bde Commander and complained about this constantly, but it never got better while he was there. He also reported having policies briefed to him about not giving medical care or appropriate food or sanitation to the detainees. He stated that he and the other medic from his unit did not follow these policies and that he was formally reprimanded at least five times as a result. He reported issue to (b)(2)-2 Bde Commander directly; no actions taken.

## OIF - POTENTIAL ABUSES-BY US/COALITION FORCES

72. Performing medical procedure on dead Iraqi soldier	Interviews #2/#704/#701/#249/#642 and Team member telecon with CDR, (b)(2)-2 (b)(2)-2 18 Mar 05	Sep-03	Camp Ramadi	A dead Iraqi was brought to the (b)(2)-2 aid station. He was placed in a body bag and removed from the aid station. A physician went out to view the body and performed a cricothyroidotomy, inserted a tube, and instructed medics on how to perform the procedure. 15-6 was done. The physician received a GO letter of reprimand. This incident was referred by the Team to CID.
73. Criminal detainee on a leash	NY Times 04 Feb 05 (Cit. 36)/Time Mag 07 Feb 05 (Cit. 47). /Interview #705/#917/#974	B/T Jul 03-Mar 04	Abu Ghraib	#705 (b)(2)-2 stated he never directed the MPs to use a leash. #705 felt that he ran out of options to control a mentally unstable criminal detainee. He pursued transfer to the (b)(2)-2 and to a civilian Iraqi hospital with mental health services, but both refused. #705 determined that the only remaining option was to apply a belt around his abdomen as a temporary measure. The belt ended up around his neck. #705 does not how this happened. The detainee was being restrained for throwing feces and self-mutilation. #705 worked with the NCOIC of (b)(2)-2 to order a harness, but could not locate one in the automated supply system. #917 stated restraint was applied only to one other detainee for the purpose of administering IV fluids. #917 reported that the MPs did not use restraints because it required additional personnel to monitor. #705 stated that he was misrepresented in the New York Times article.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
74. Beating of an Iraqi born American by Special Forces when he stood in the way to prevent the rape of a local Iraqi girl.	Interview #695	B/T Jul-Oct 03	BIAP	#695 recalls an incident that was described to him by an Iraqi-born American citizen on a mission with the Special Forces. He stated the Special Forces attempted to rape a local Iraqi girl. When the Iraqi-born American citizen stood in the way, he was beaten and presented to #695 for treatment. #695 reported this incident to CID for investigation.
75. Abuse of a detainee by MP	Interview #695	B/T Jul-Oct 03	BIAP	A material witness, kept as a detainee for his own protection, was used as an interpreter. He was handcuffed and dragged to a transportation vehicle by an MP. When another interpreter appeared, the MP denied the abuse. The interviewee reported the incident to CID for investigation.
76. Detainee with burns	Interview #734	B/T Jan-Mar 04	Abu Ghraib	#734 documented injuries consistent with abuse (cigarette burns) during initial screening of a detainee. As he had early access to the detainee upon arrival to the facility, #734 felt the abuse must have been done by the capturing unit. #734 submitted photographs and sworn statements to the Abu Ghraib CID. #734 was told by Abu Ghraib CID that if incidents occurred outside of Abu Ghraib it was not in their jurisdiction and the reports would be passed on to a higher level of CID whenever that other CID unit passed thru Abu Ghraib. #734 felt this was inadequate and went to the FOB Commander for guidance. The FOB Commander and #734 decided to turn these reports over to CID, ICRC, and the Coalition Provisional Authority to ensure they would be investigated fully.
77. Detainee death	Interview #475	B/T Jun 03-Mar 04	Balad/ Mosul	#475 had to report a potential detainee abuse case to CID three times before it was fully investigated. Ultimately, a soldier was arrested for the abuse incident
78. Detainee abuse	Interview #458	B/T Jun-Oct 04	Balad	#458 reported that an "MP on ward was found guilty of abuse and demoted."
79. Detainees with burns	Interview # 172/#206/# 209/# 634 and (b)(2)-2 Medical Record Review (Detainee register # 0013753, #0015835)	B/T Mar-Aug 03	Camp Cropper	#172 saw many injuries that he suspected were from abuse. He reported each of these, officially, to CID and to the Warrant Officer who was designated to receive abuse allegations. The reports he submitted included two patients with burns on their buttocks from being transported in a High Mobility Multi-Wheeled Vehicle (HMMWV) while seated on a hot surface. In reviewing the medical records from the (b)(2)-2, #172 documented his findings, his concern for abuse, and his contacting CID (register # (b)(7)(C)-4) and in his interview he states he reported register # (b)(7)(C)-4 (as well).
80. Abuse of a detainee by US soldiers	Interview #80	Jul-04	Bucca	#80 stated that a detainee reported he was dragged by chains around the compound by a HMMWV. #80 involved his supervising physician, who documented a history and physical exam and took a sworn statement. #80 reported that this physician reported the incident up the chain of command.
81. Detainee abuse	Interview #221	B/T Aug 03-Apr 04	Fallujah.	#221 recalled an incident that occurred after the hospital was bombed and two health care providers were killed. #221 reported that a medic got angry and hit a detainee. This was handled by the medic's unit (b)(2)-2 with formal counseling of the medic.
82. Detainee with multiple bruises	Interview #385/#386	B/T Aug 03-Apr 04	Fallujah	Detainee had repeatedly attempted escape, had multiple bruises; 15-6 done, and charges unsubstantiated.
83. Possible detainee abuse	Interview #765	B/T Jan -Oct 04	Baghdad	#765 reported that a soldier was transporting a detainee when a improvised explosive device exploded, injuring personnel in the HMMWV. The soldier got mad, went to the back of the convoy and hit a detainee. This was reported to, and investigated by, CID.
84. Detainee found unresponsive	Interview #246	Spring 03	Baghdad	Patient in ketoacidosis, but MPs approached as if he were merely faking. Reported up chain of command and investigated; patient treated successfully for critical illness.
85. Detainee "kidnapped" from FST by MI	Interview #246	Spring 03	Baghdad	Event reported up chain of command and investigated; patient returned and treated appropriately.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
86. Detainee beaten by MPs excessively after attempted escape from holding facility	Interview #246	Spring 03	Baghdad	Event reported up chain of command and investigated; patient hospitalized and treated.
87. Detainees with suspicious injuries	Interview #209	B/T Mar 03-Feb 04	Baghdad	One patient with bruises, another with burns. Chain of command/CID notified.
88. Detainees with burns	Interview #206	B/T Mar 03-Feb 04	Baghdad	Reported for investigation; confirmed with other interview and med records review.
89. Possible detainee abuse	Interview #634	B/T Mar 03-Feb 04	Baghdad/ Tikrit	At the (b)(2)-2 a detainee was brought in with suspected abuse; gentleman came with abrasions to his lower legs, feet and ankles, consistent with being drug around. It was reported by doctor, to DCCS, to med CINC meeting (detainee camps and special ops, directing medical assets) at Mosul.
90. Detainee DOA with multiple bruises	Interview #206	B/T Mar 03-Feb 04	Baghdad	Not clear if bruises related to point of capture, but reported thru chain of command for investigation.
91. Detainee with multiple bruises including boot print to axilla	Interview #581	B/T May 03-Jul 04	Baghdad	Reported thru chain of command to CID.
92. Detainee abuse	Interview #775	B/T Jan 04-Jan 05	Mosul, Tikrit, TF OASIS	#775 referred three cases to CID. "I met with CID Commander and was informed that all the cases had been investigated."
93. Detainees forced to stand bound on blacktop all day. They went hours without water. At least two fainted.	Interview #72	B/T Jan-Aug 03	In vicinity of aid station.	Not reported by soldier, who was assigned to (b)(2)-2 Team referred incident to CID.
94. Detainee handcuffed to a vehicle steering wheel	Interview #545	B/T May-Jun 03	Baghdad/ Najef	Reported to COC. A Platoon Leader, assigned to (b)(2)-2 left the detainee handcuffed for at least five hours in an awkward position; detainee became ill. Platoon Leader was subsequently reprimanded and apologized to the patrol.
95. Detainee abuse	Interview #470	B/T Jan-Jun 03	Camp Bucca	Psychotic detainees were being held in Connexes in 130 degree temperatures, lying in own urine and feces. Reported to Camp Bucca Leadership; conditions corrected.
96. Detainee Abuse	Interview #492	B/T May-Sep 03	Camp Victory	Guards reported that MI personnel had placed handcuffed detainees outside in 120+ degree temperatures for nine hours. Two detainees treated for heat injuries. Interviewee confronted MI First Sergeant, reported to (b)(2)-2 and sent written report to MP Battalion Commander.
97. Possible detainee abuse	Interview #715	B/T Mar 03-Feb 04	Mosul	Detainee with injuries not consistent with falling (guard's story), but with assault. Referred to CID.
98. Detainee abuse	Interview #625	B/T Jan 04-Jan 05	Unknown	US Soldier injured in convoy ambush hit a detainee. Reported and investigated.
99. Possible detainee abuse	Interview #96	B/T Jan-Jun 03	Tallil	Detainee had been very combative, and had attempted multiple escapes. Reported to chain of command; formal investigations done, and not substantiated.
100. Possible detainee abuse	Interview #380	B/T Apr 03-May 04	Fallujah	Detainee complained of abuse frequently; referred for investigation, and unsubstantiated.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
101. Possible abuse of Iraqi firefighter	Interview #380	B/T Apr 03-May 04	Fallujah	Report of a Company Commander physically abusing an Iraqi firefighter; CID notified and investigated.
102. Detainee abuse	Interview #38	B/T May 03-Mar 04	Baghdad	Detainee reported abuse, investigated. "Commander relieved, appropriate action taken."
103a. Possible detainee abuse	Interview #200	B/T Mar 03-Feb 04	Mosul	One detainee brought in with broken jaw. Detainee said he was pushed, MP said he fell. This occurred as detainees were made to exercise, doing squats while wearing hoods. Once guidance was changed concerning detainee operations, stopped using loud music and prolonged standing activities.
103b. Detainee death	Interview #200	B/T Mar 03-Feb 04	Mosul	A detainee with diabetes and hypertension died. Did not do an autopsy. Death was investigated by CID. Interviewee reported the investigation did not "show anything."
104. Possible detainee abuse	Interview #549	B/T Dec 03-Jul 04	Baghdad	Detainee reported abuse, did full exam and x-rays; investigated; abuse unfounded.
105. Detainee abuse	Interview #572	B/T May 03-Aug 04	Baghdad	Individual physically abused a detainee and he was chaptered out of the Army.
106. Possible detainee abuse	Interview #788	B/T Jan-Mar 05	Abu Ghraib	Detainee alleged abuse during interrogation; post-interrogation record did not reflect abuse reported at that time. Detainee brought to ER, CID notified; detainee retracted allegation.
107. Documentation of pre-interrogation screening in detainee record; detainees presenting with old injuries; MPs yelling at detainees	Interview #978	B/T Apr 03-Apr 04	BIAP	Assigned at BIAP and worked at the DIF; prisoners would show up at (b)(2)-2 with MP without coordination; felt that some of the MPs yelled at detainees and did not have a good understanding of cultural considerations; language barrier exacerbated the event. A number of detainees came in with injuries (approximately five days old); wounds were infected. #978 brought this up to the physicians. Physicians and medics would clarify the nature of the injuries through the interpreter (assigned w/ MP). On two occasions, #978 questioned the nature of the injury to the MP. MP said facial injuries occurred from another Iraqi civilian.
108. Two cases of possible detainee abuse observed	Interview #132/#133	B/T Apr-Dec 03	BIAP	Documented in medical record, took pictures, and forwarded through chain of command for investigation.
109. Detainees placed in metal guard shack	Interview #599	B/T May 03-May 04	Baghdad	Observed detainees placed in guard shack that was very hot, handcuffed, with sandbag over the head. No injuries sustained by detainees.
110. Rumor of a soldier using a tazor on a detainee	Interview #850	B/T May 03-Jul 04	Baghdad	Reported as a rumor only; not mentioned in 61 other interviews with individuals from (b)(2)-2
111. Physician refusing to treat a detainee.	Fay/Jones report/ Interview #897/#904/ e-mail correspondence to Team	Dec-03	Abu Ghraib	An MI soldier, in her testimony for the Fay /Jones report, stated that she found a detainee in his cell with a Foley catheter in place but without a collection bag attached. She stated that she contacted the physician on duty that night and he refused to see the patient or attend to her concerns. The Team contacted the MI Soldier to get more information about who this physician was. She did not remember his name, nor remember if he was a LTC or a COL, but stated that she could identify him in a picture if given one. The Team spoke to many medics and the few physicians that were working in Abu Ghraib around the time of this incident. The Team was not able to identify this physician. #970 does not meet the description and #706 re-deployed November 03, per email msg dated 25 Mar 05 to Team member.
112. Detainees held in inappropriate environment	Interview #574	B/T Jul 03-Jul 04	Baghdad	The detainees were held in a large pen without cover, hands were bound, and 90% of the time they had sandbags over their heads. The detainees were not treated with dignity and respect. Sometimes made to stand for two hours at a time.

Incidents/ Allegations	Source	Date of Incident/ Allegation	Location in Theater	Summary
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## OIF - POTENTIAL ABUSES-BY IRAQIS/IRAQI POLICE

113. Sexual assault of a possible child detainee (age unknown) by another prisoner	Interview #970	B/T Oct 03-Mar 04	Abu Ghraib	An interpreter reported to #970, assigned to (b)(2)-2 that a detainee, believed to be a child detainee, had been sexually assaulted by another prisoner. #970 reported it to the (b)(2)-2 Commander, who investigated. #970 believes the criminal detainee was disciplined through the Iraqi court system. Afterwards, no children were sent to Abu Ghraib.
114. Possible sexual abuse of detainees	Interview #711	B/T Jan 04-Jan 05	Baghdad	#711, assigned to (b)(2)-2 reported that the unit received assistance in the investigation of two episodes of alleged sodomy on detainees. In both instances, the MP physician made the initial reports at the detention facility. This was reported to (b)(2)-2 and they contacted the (b)(2)-2 to accept the patients in transfer for further evaluation. Both had colonoscopies done to evaluate for physical findings that supported this allegation. CID was involved immediately to collect statements and medical records and investigate this further. In a third episode, #711 was concerned about abuse and when he reported it, CID came three weeks later to the (b)(2)-2 to gather information for their investigation.
115. Abuse of detainees by Iraqi police.	Interview #37	B/T Apr-Oct 04	Northwest Iraq	This physician reported that, at his BAS, they treated numerous detainees that had been physically abused by the Iraqi police. In order to prevent this further, the US MPs took custody of the detainees after their medical treatment.
116. Detainee with bruises	Interview #385	B/T Aug 03-Apr 04	Fallujah	Investigated and found to be from other Iraqis.
117. Detainee abused by other Iraqis--SQ injections with gasoline	Interview #804/#775	B/T Jan 04-Jan 05	Mosul	CID notified; no adverse clinical outcome.
118. Physical abuse of a detainee by Iraqi Army at a detention facility	Interview #816	Early 2005	Baghdad	Chain of command notified; practice stopped.
119. Sexual assault of a young detainee	Interview #915	B/T Mar-Jun 03	Balad	Young detainee gang-raped twice in holding facility, second time after being returned to same area. MPs had no guards assigned directly within the facility. Unclear if any actions taken.

## Chapter 21

### Citations in the Report

1.	AMEDDC&S 91W10 Lesson Plan - International Humanitarian Law and the Geneva Conventions (DRAFT) - 30 Mar 2005.
2.	AMEDDC&S Exportable Training Package – Ethics and Detainee Operations - 2005.
3.	AMEDDC&S Email - Exportable Training Package – 24 Mar 2005.
4.	AMEDDC&S PAD - Just-in-Time Deployment Training – 10 Apr 2004.
5.	AMEDDC&S PAD - Medical Documents in Combat and Contingency Operations – 10 Apr 2004.
6.	AMEDDC&S - Review of Institutional Training – 15 Feb 2005 and AMEDDC&S Courses.
7.	AMEDDC&S Training Materials.
8.	AR 40-3 - Medical, Dental, and Veterinary Care – 12 Nov 2002.
9.	AR 40-66 - Medical Record Administration and Health Care Administration – 20 Jul 2004.
10.	AR 40-400 - Patient Administration – 12 Mar 2001.
11.	AR 190-8 - Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detainees – 1 Oct 1997.
12.	Bagram SOP, Annex W-1 - Sep 2004.
13.	Behavioral Science Consultation Team Joint Intelligence Group, Joint Task Force-GTMO Standard Operating Procedures – 28 Mar 2005.
14.	Bucca SOP, sec. 4-4: Detainee Medical Procedures - Jun 2004.
15.	Church – Comprehensive Review of Department of Defense (DoD) Interrogation Operations – date unknown.
16.	CJCSI 3290.01A - Program for Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detained Personnel (EPW/Detainee Policy) -15 Oct 2000.
17.	CJTF-76 BHA and KHA Detainee Medical Standard Operating Procedure (SOP) - August 2004.
18.	CONOPS for DHT in Support of Military Intelligence Interrogation Operations.
19.	DAIG – Detainee Operations Inspection Report – 21 Jul 2004.

20.	Deputy Secretary of Defense Memorandum, Policy Statement and Guidelines on Body Cavity Searches and Exams for Detainees under DoD Control – Jan 2005.
21.	DoD Instruction 1322.24 - Medical Readiness Training – 12 Jul 2002.
22.	DoD Directive 2310.1 - DoD Program for Enemy Prisoners of War and other Detainees – 12 Aug 1994.
23.	DoD Directive 5100.77 - DoD Law of War Program - 9 Dec 1998.
24.	Email – (b)(6)-2 – More Questions About the Catheter - 28 Mar 2005.
25.	Fay/Jones – Article 15-6 Investigation of the Abu Ghraib Prison and 205th Military Intelligence Brigade – Feb 2004.
26.	GTMO - Numerous theater-level/facility policies for detainee medical operations since early 2003.
27.	GTMO - Numerous SOPs from the Detainee Hospital, GTMO, from 2003 and 2004.
28.	Health Affairs Policy 02-005: DoD Medical Care for Enemy Persons Under U.S. Control Detained in Conjunction with Operation Enduring Freedom, 10 Apr 2002.
29.	Jacoby - Review of Detainee Operations and Facilities in Afghanistan – 26 Jul 2004.
30.	Lancet (Miles) - The Legacy of Abu Ghraib – 21 Aug 2004.
31.	MEDCOM SJA Information Paper - Health Care Professional Detainee Abuse Reporting Requirements - 8 Sep 2004.
32.	MEDCOM - Deployment Medical Documentation Guidance-Reporting Requirements – 12 Mar 2004.
33.	MEDCOM SJA - Health Care Professional Detainee Abuse Reporting Requirements – 8 Sep 2004.
34.	MNF-I SOP: Detainee Healthcare – Feb 2005.
35.	NEJM (Lifton) - Human Rights - Doctors and Torture – 29 Jul 2004.
36.	New York Times (Bloche & Marks) - Triage at Abu Ghraib – 4 Feb 2004.
37.	OIF Theater Detention Healthcare Policy – Jan 2005, with multiple appendices.
38.	Physicians for Human Rights – Examining Asylum Seekers.
39.	Ryder – Assessment of Detention and Corrections Operations in Iraq – 6 Nov 2003.

40.	Schlesinger – DoD Detention Operations Final Report – Aug 2004.
41.	Secretary of Defense Memorandum: Procedures for Investigation into Deaths of Detainees in the Custody of the Armed Forces of the U.S., 9 Jun 2004.
42.	SOUTHCOM Confidentiality Policy for Interactions between Health Care Providers and Enemy Persons under U.S. Control, Detained in Conjunction with OEF – August 2002.
43.	SOUTHCOM Policy on Healthcare Delivery to Enemy Persons under U.S. Control at US Naval Base, Guantanamo Bay, Cuba – Aug 2004.
44.	Taguba – Administrative Investigation of Alleged Detainee Abuse by the 800th Military Police Brigade – 24 Jan to 9 Mar 2004.
45.	Task Force Medical 115 Poster and Soldier Cards: “Tenets of Detention Healthcare” – Mar 2005.
46.	Task Force 134 Memorandum, SOP for Ensuring Separation of Detention Operations Functions – Feb 2005.
47.	Time Magazine (Zagorin) - The Abu Ghraib Scandal You Don't Know – 7 Feb 2005.
48.	104 DIV PPT - Process EPW/CI at a Collection Point or Holding Area – date unknown.



## Chapter 22

### Glossary of Terms

ABBREVIATIONS	TERM
AAR	After Action Review
AC	Active Component
AIT	Advanced Individual Training
AKO	Army Knowledge On-Line
AMEDD	Army Medical Department
AMEDD C&S	Army Medical Department Center and School
AOC	Area of Concentration
AOR	Area of Responsibility
AR	Army Regulation
ASMB	Area Support Medical Battalion
ASMC	Area Support Medical Company
AT	Annual Training
BAS	Battalion Aid Station
BDE/Bde	Brigade
BIAP	Baghdad International Airport
BIF	Brigade Internment Facility
BN/Bn	Battalion
BSCT	Behavioral Science Consultation Team
CENTCOM	Central Command
CF	Coalition Forces
CFLCC	Combined Forces Land Component Command
CI	Civilian Internee
CID	Criminal Investigation Division
CJTF	Combined Joint Task Force
CLS	Combat Lifesaver
COB	Civilians on the Battlefield
COD	Cause of Death
CONOPS	Concept of Operations
CONUS	Continental United States
CPA	Coalition Provisional Authority
CRC	CONUS Replacement Center
CSA	Chief of Staff-Army
CSC	Combat Stress Control
CSH	Combat Support Hospital
CSS	Combat Service Support
CTT	Common Task Training
C2	Command and Control
DA	Department of the Army
DAIG	Department of the Army Inspector General
DHT	Detainee Health Team
DIF	Division Internment Facility

DoD	Department of Defense
EFMB	Expert Field Medical Badge
EPW	Enemy Prisoner of War
EMEDS	Expeditionary Medical Support
EXSUM	Executive Summary
FH	Field Hospital
Fm	Field Manual
FOB	Forward Operating Base
FORSCOM	Forces Command
FRAGO	Fragmentary Order
FSB	Forward Support Battalion
FST	Forward Surgical Team
FTX	Field Training Exercise
GH	General Hospital
GO	General Officer
GTMO	Guantanamo Bay
HA	Health Affairs
HQ	Headquarters
HVD	High Value Detainee
IAT	Incidents and Allegations Table
IAW	In Accordance With
ICRC	International Committee of the Red Cross
ICW	Intermediate Care Ward
IED	Improvised Explosive Device
I/R	Internment/Resettlement
ITO	Iraqi Theater of Operations
JAG	Judge Advocate General Officer
JIDC	Joint Interrogation and Debriefing Center
JIG	Joint Interrogation Group
JRTC	Joint Readiness Training Center
JTF	Joint Task Force
KIA	Killed in Action
LP	Lesson Plan
LRMC	Landstuhl Regional Medical Center
LTP	Leader Training Plan
LZ	Landing Zone
MASCAL	Mass Casualty
MED/Med	Medical
MEDCOM	Medical Command
METL	Mission Essential Task List
MEU	Marine Expeditionary Unit
MI	Military Intelligence
MNC-I	Multi-National Corps-Iraq
MNF-I	Multi-National Forces-Iraq
MOB	Mobilization

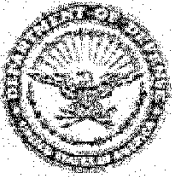
MOS	Military Occupational Specialty
MP	Military Police
MRE	Meals Ready to Eat
MSC	Medical Service Corp
MTF	Medical Treatment Facility
MUIC	Mobilized Unit In-Processing Center
NCOIC	Noncommissioned Officer in Charge
NG	National Guard
NTC	National Training Center
OBC	Officer Basic Course
OC	Observer-Controller
OEF	Operation Enduring Freedom
OGA	Other Government Agency (can refer to CIA, FBI, etc)
OIC	Officer in Charge
OIF	Operation Iraqi Freedom
OPFOR	Opposing Forces
OPORDER	Operation Order
OTC	Over the counter
PA	Physician Assistant
PAD	Patient Administration Division
PASBA	Patient Administration Systems and Biostatistics Activity
POI	Program of Instruction
PPP	Power Projection Platform
PUC	Person Under Control
RC	Reserve Component (Army Reserve or National Guard)
RIP	Relief in Place
ROC	Rules of Care
ROE	Rules of Engagement
RP	Retained Personnel
SD	Security Detainee
SDARNG	South Dakota Army National Guard
SECDEF	Secretary of Defense
SME	Subject Matter Expert
SOC	Special Operations Command (can refer to SF, Delta Force, etc)
SOP	Standard Operating Procedure
SOUTHCOM	Southern Command
STARTEX	Start of Exercise
TACSOP	Tactical Standard Operating Procedure
TB	Tuberculosis
TDA	Table of Distribution and Allowances
TF	Task Force
TIF	Theater Internment Facility
TOA	Transfer of Authority
TOE	Table of Organization and Equipment
TSG	The Surgeon General (refers to the Army Surgeon General)

TTP	Tactics, Techniques and Procedures
USARCENT	US Army Central Command
USARSO	US Army South
VTC	Video Training Conference
XO	Executive Officer

PHRASES	TERM
Abu Ghraib	Detention facility located near Baghdad. Site of abuse scandal involving MP and MI personnel. Currently houses a Level III detention medical facility. Has a large detainee population. There is variety in the spelling of this location in the documents cited. The Team, for uniformity purposes, has decided on the spelling listed.
Abuse	Fay/Jones EXSUM page 3 – Treatment of detainees that violated U.S. criminal law or international law that was inhumane or coercive without lawful justification.
AMEDD Center and School	Headquartered at Ft Sam Houston, TX, it is the location where the vast majority of medical training in the Army takes place. It is responsible for Career Management Field 91 (Health Services) schools. It is the site of advanced training for Medical Officers and Medical NCOs. Also trains many members from the other services.
AR 190-8	Army Regulation titled <u>Enemy Prisoners of War, Retained Personnel, Civilian Internees and Other Internees</u> , dated 1 October 1997.
Bagram Holding Area	Largest holding area in the OEF theater. It is located at Bagram Air Base. For the purpose of this report it is considered a detention facility.
Brigade Detention Facility	Detention facility run by a Brigade-level unit that serves as a staging point for detainees before release or transfer to a DIF. Length of stay is very minimal. There are numerous BIFs in the OIF theater.
Camp Bucca	Largest of detention facilities. Houses a Level III detention medical facility.
Camp Cropper	Detention Facility located at BIAP. Houses a Level II detention medical facility.
Career Captains Course	Course designed for commissioned officers with a medical AOC at the 1LT-CPT level. Formally called the Officer Advanced Course.
Chain of Command	Succession of leadership from squad leader to President of the United States.
Combat Life Saver	Non-medical personnel trained to perform basic life saving procedures in emergency situations,
CONUS Replacement Centers (CRC)	Specific locations designed to prepare, assess and give final approval to individuals headed to units in a theater of operations. The two stateside CRCs are located at Ft Bliss and Ft Benning.

Detainee	Term used for any person under US/Coalition control in the three theaters highlighted in this report. Includes enemy prisoners of war, civilian internees, retained personnel, high value detainees, security detainees and persons under control.
Detainee Care	Medical care given to any persons under US/Coalition custody.
Detainee Caregiver	Any medical personnel who provided medical care to at least one detainee during their tour in theater (OEF, GTMO, OIF).
Detainee Medical Records	Medical documentation of inpatient and outpatient treatment and care given to personnel under US/Coalition control.
Detention Facility	Refers to any area where a detainee is maintained, processed, interrogated or all of the above. This report focuses on division-level detention facilities and above.
Division Internment Facility	Detention facility located in theater that serves as a staging point for detainees before release or transfer to a fixed prison facility. Time of stay for detainees is up to 21 days, 28 days with GO approval.
15-6 Investigation	Official investigation started at the direction of the unit, or higher, command.
High Value Detainee	Any detainee who may hold significant information on enemy operations in the OIF/OEF theater. Also refers to prominent members of the former Iraqi Regime.
Home Station	Military installation where a military member is stationed before mobilizing for deployment.
Kandahar Holding Area	Holding area located at Kandahar Air Base in the OEF theater. For the purpose of this report it is considered a detention facility.
Levels of Medical Care	Refers to the capabilities a medical unit has to perform medical services. Level I includes self-aid, buddy-aid, Combat Life Savers, Line Unit 91Ws (Medical Specialists) and Battalion Aid Stations. Level II includes Forward Surgical Teams and Area Support Medical Battalions. Level III refers to Mobile Surgical Hospitals, Combat Support Hospitals, General Hospitals and Field Hospitals. Note that the levels of care of some units in the OEF and OIF theater significantly changed as resources and personnel were or were not available.
Line Medic	Medical Personnel assigned to a combat arms unit. These medical personnel accompany the combat arms soldiers on all missions in order to be able to perform emergency medicine.
Maneuver Unit	Combatant Unit/Combat Arms Unit
Medical Personnel Mobilization	Refers to all personnel who hold a medical MOS or AOC. Occurs in phases, and refers to the actions taken to prepare and deploy a unit.
MP Medic 91G	Medical personnel, usually a 91W, assigned to an MP unit. Army Medical Records Specialist
91W	Army Healthcare Specialist. Commonly referred to as a combat medic.
91WM6	Army Licensed Practical Nurse

91X	Army Mental Health Specialist
Officer Basic Course	Initial training for commissioned officers with a medical AOC at the 2LT-CPT level.
Operation Enduring Freedom	Refers to actions in the Afghanistan region that began in December of 2001 and is currently ongoing.
Operation Iraqi Freedom	Refers to actions in the Iraq/Kuwait region that began in March 2003 and is currently ongoing.
PASBA	Designated as the repository for all detainee medical records from the OIF and OEF theater.
Period of Service	The time frame a unit or individual was deployed to a Theater of Operations.
Point of Capture	Initial place that a detainee is taken into US/Coalition custody. Normally accomplished by a combat arms unit
Power Projection Platform (PPP)	Specific locations designed to prepare, assess and give final approval to the deployability of units heading into the different theaters.
Rules of Care	Specific guidelines that detail the actions that medical personnel need to take in treating non-US/Coalition troops in that theater. Often referred to as Medical Rules of Engagement (MROE).
Southern Command	Headquarters, located in Florida, that has command and control over Guantanamo Bay.
S-2	The Security and Intelligence Cell of individual units.
S-3	The Plans and Operations Cell of individual units.
70E	Refers to the AOC given to a Patient Administration Division officer.
Task Force	A grouping of units, or parts of units, brought together to perform a specific mission.
Team (the)	Refers to the Functional Assessment Team, the authors of this report.
Theater	An area of major operations by the US military. This report deals with the Afghanistan, Iraq/Kuwait and Guantanamo Bay theaters. Can also be referred to as a Theater of Operations.
Training Centers	Can refer to a number of military institutions involved in training soldiers. In CONUS, most commonly used to refer to the National Training Center and the Joint Readiness Training Center.
USARSO	The Army Service Component of the US Southern Command, headquartered in San Antonio, TX.



DEPARTMENT OF THE ARMY  
OFFICE OF THE SURGEON GENERAL  
5109 LEEBSBURG PIKE  
FALLS CHURCH, VA 22041-3258

REPLY TO  
ATTENTION OF

MCJA

12 November 2004

MEMORANDUM FOR Major General Lester Martinez-Lopez, Commanding General,  
U.S. Army Medical Research and Materiel Command, 504 Scott Street, Ft. Detrick,  
Maryland 21702

SUBJECT: Appointment as Team Leader, Functional Assessment Team

1. You are hereby appointed as Team Leader of a Medical Training, Operations and Treatment Functional Assessment Team. In this capacity, you will lead the team identified at Enclosure 1 to assess whether Army medical personnel serving in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) properly generated, stored and collected medical records. You will assess the adequacy of all law of war training for all medical personnel from accession to deployment into the theater of operations in OEF and OIF. In conjunction with your assessment, you should also determine whether any medical personnel observed or became aware of improper treatment of detainees which could be abuse and, if so, whether they properly documented and reported the abuse. Additionally, with respect to medically documenting and reporting detainee abuse, you will also assess both the adequacy of MOS/OBC/other school training, unit training, pre- and post-deployment medical training and the adequacy of medical operations doctrine. You will specifically determine whether the training covered the procedures and policies for maintaining medical records and for providing medical treatment to POWs and other detainees.

2. Specifically, you will assess the following with respect to Army medical personnel, both reserve component and active duty, providing medical support and/or care to detainees in OEF (including Guantanamo Bay) and OIF:

a. What units provided medical care to detainees in OEF and OIF and what was the period of service for each unit?

b. At what location did each unit provide medical care (e.g., MTF, detainee facility, and interrogation facility)?

c. What MOS and OBC training or other school training did the medical personnel serving in these units receive regarding the generation, storage and collection of detainee medical records and regarding the medical reporting of detainee abuse?

MCJA

SUBJECT: Appointment as Team Leader, Functional Assessment Team

d. Was there any policy guidance, OPORDER, SOP, or other authority establishing criteria for providing detainee medical support and/or care in the theater of operation?

e. What unit training did the active component receive prior to deployment regarding the generation, storage and collection of detainee medical records and the medical reporting of detainee abuse?

f. What training did reserve component soldiers receive at home station, power projection platforms and in-theater regarding the generation, storage and collection of detainee medical records and the medical reporting of detainee abuse?

g. Identify OEF and OIF detention medical facilities.

h. With respect to the detention medical facilities identified in subparagraph 2g immediately above, determine if the facility generated, stored and collected detainee medical records, to include records documenting medical support to any detainee being prepared for interrogation, being interrogated, or needing medical treatment as a result of, or immediately after, interrogation.

i. With respect to those detention facilities that kept medical records, did medical personnel properly generate, store and collect appropriate medical records of detainees?

j. With respect to those detention facilities that kept detainee medical records, identify the location where the original and any copies of the records are maintained.

k. Were any medical personnel aware of, or treat injuries related to, actual or suspected detainee abuse?

l. Did any medical personnel aware of, or who treated actual or suspected detainee abuse properly document the abuse?

m. To who did any medical personnel aware of, or who treated, detainee abuse report such abuse?

n. Were there any theater or unit policies or established SOPs/TTPs that specifically required medical personnel to report detainee abuse?

3. Prior to commencing your functional assessment, you and each team member will:

a. Become familiar with the findings and recommendations of existing investigations into detainee abuse (e.g., Schlesinger, Taguba, Fay, Ryder, Miller, Jacoby and Church).



SUBJECT: Appointment as Team Leader, Functional Assessment Team

Rules of Instruction for Functional Assessment Team (Enclosure 2).

- d. Law of war requirements for medical support and/or care to POWs and other detainees.
  - e. Published media articles (newspaper, Internet, periodicals) specifically commenting on medical aspects of detainee abuse (e.g., The Legacy of Abu Ghraib, Wash Post, 21 Aug 04; Doctors and Torture, New England Journal of Medicine, 29 Jul 04; US Complicit in Prison Abuse?, CBSNEWS.com, 27 Oct 04).
  - f. Army Chief of Staff Memorandum, SUBJECT: Army Detainee Operations and Detainee-Interrogation Operations Integration Plan, dated 17 Sep 04.
  - g. Army Detainee Operation Synchronization Matrix, Version 2.0 dated 7 Oct 04.
  - h. Textbook of Military Medicine.
  - i. Textbook of Emergency War Surgery.
  - j. Briefing by COL (b)(6)-2 OTSG, to the Senate Armed Services Committee regarding medical treatment to detainees.
  - k. House Government Reform Committee brief on medical ethics by COL (b)(6)-2 (b)(6)-2 Medical Ethics Consultant and Chief of Medicine (b)(6)-2
  - l. Integrated Process Team findings on Policy and Procedures for Medical Detail Operations, charted by MG Farmer, previous DSG, and presented to MG Webb.
4. In drafting your assessment, you should identify the standard (e.g., regulation, policy, field manual, SOP, TTP, OPORDER) used in making your assessment and determine whether medical personnel complied with the standard. You will make recommendations to remediate any deficiencies. If in the course of your assessment you come to suspect that certain people may have committed criminal offenses under the UCMJ or applicable Federal Statute, you must consult the Rules of Instruction for Functional Assessment Team and follow the instructions set forth therein.
5. Your assessment is not an investigation. Rather you are chartered under the authority of The Surgeon General of the Army to review matters listed in this appointment memorandum and make recommendations. Accordingly, you are not bound by the requirements of the procedures set forth in AR 15-6, rather, you are governed by the Rules of Instruction for Functional Assessment Team.

MCJA

SUBJECT: Appointment as Team Leader, Functional Assessment Team

6. This assessment takes precedence over all other normal duties, TDY, leave or other activities. Prior to commencing your duties, you should consult with COL (b)(6)-2

(b)(6)-2 MEDCOM Staff Judge Advocate who may be reached at (b)(6)-2

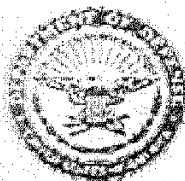
(b)(6)-2 Once you have commenced your assessment, your legal advisor is LTC (b)(6)-2 who can be contacted at (b)(6)-2

(b)(6)-2 You will regularly consult LTC (b)(6)-2 and you will provide COL (b)(6)-2 a weekly update on the progress of your assessment through LTC (b)(6)-2

7. Once you have concluded your assessment, you will consult with COL (b)(6)-2 before you prepare your report. You will submit your assessment through LTC (b)(6)-2 through COL (b)(6)-2 to me, with appropriate copies, not later than 120 days from the date of this memorandum. If you cannot meet the suspense date, you must request an extension through LTC (b)(6)-2 and COL (b)(6)-2 to me.

2 Encls

  
KEVIN C. KILEY, M.D.  
Lieutenant General  
The Surgeon General



DEPARTMENT OF THE ARMY  
OFFICE OF THE SURGEON GENERAL  
1101 LEEBURG PIKE  
FALLS CHURCH, VA 22041-3258

BEAL N TO  
ATTENTION OF

MCJA

30 November 2004

MEMORANDUM FOR Functional Assessment Team Appointees

SUBJECT: Appointment of Members to Functional Assessment Team

1. The following are hereby appointed as members to the Medical Training, Operations and Treatment Functional Assessment Team:

a. Team Leader: MG Lester Martinez-Lopez, MRMC

b. Legal Advisor: LTC (b)(6)-2 JA, (b)(6)-2

c. COL (b)(6)-2 MS, (b)(6)-2

d. COL (b)(6)-2 MC, (b)(6)-2

e. COL (b)(6)-2 AN, (b)(6)-2


f. MAJ (b)(6)-2 MC, (b)(6)-2

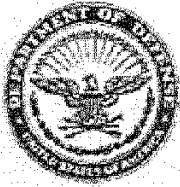
g. SFC (b)(6)-2 91W, (b)(6)-2

2. The team leader exercises authority over your activities as a team member. Your duty as a team member takes precedence over all normal duties, TDY, leave, or other activities.

3. Team members are subject to the limitations set forth in the Rules of Instruction for Functional Assessment Team, which will be distributed by the team leader.

4. Point of contact for this action is COL (b)(6)-2 Staff Judge Advocate, (b)(6)-2  
(b)(6)-2

  
KEVIN C. KILEY, M.D.  
Lieutenant General  
The Surgeon General



DEPARTMENT OF THE ARMY  
HEADQUARTERS  
U.S. ARMY MEDICAL RESEARCH AND MATERIEL COMMAND  
AND FORT DETRICK  
504 SCOTT STREET  
FORT DETRICK, MD 21702

REPLY TO:  
ATTENTION OF:

MCMR-Z

14 December 2004

MEMORANDUM FOR Medical Training, Operations and Treatment Functional  
Assessment Team

SUBJECT: Appointment as Acting Adjutants

1. Pursuant to paragraph 3-3e of Army Regulation 614-100, the commissioned officers listed in paragraph 2 below are appointed as acting adjutants. This appointment is made for the specific purpose of empowering these officers to administer oaths pursuant to 10 U.S.C. 936(a)(3). This appointment is valid for all actions taken pursuant to their duties as members of the above Functional Assessment Team.

2. The following officers are appointed as acting adjutants:

- a. COL (b)(6)-2 MS, (b)(6)-2
- b. COL (b)(6)-2 MC, (b)(6)-2
- c. COL (b)(6)-2 AN, (b)(6)-2
- d. MAJ (b)(6)-2 MC, (b)(6)-2

LESTER MARTINEZ-LOPEZ  
Major General, MC  
Team Leader

**Chapter 24 - Exhibit B**  
**Functional Assessment Team Biosketches**

<b>Rank</b>	MG	
<b>Name</b>	Lester Martinez-Lopez	
<b>Branch/MOS</b>	MC	
<b>Current Duty Assignment</b>	USA Medical Research and Materiel Command, Ft Detrick, MD	
<b>Brief History of Previous Assignments</b>	Mar 2002 – Present	Commanding General, USAMRMC, FT Detrick, MD
	Jan 2000 – Mar 2002	Commanding General, USACHPPM, Aberdeen, MD
	Jun 1999 – Jan 2000	Command Surgeon, HQ USA FORSCOM, FT McPherson, GA
	May1998 – Jun 1999	Commander, USA MEDDAC, FT Benning, GA
	Jun 1996 – May 1998	Commander, USA MEDDAC, FT Campbell, KY
	Jul 1994 - Jun1996	Commander, Combat Support Hospital FT Campbell, KY
	Jul 1990 – Jul 1994	Chief of Family Practice Service, USA MEDDAC FT Benning, GA
	Jun 1988 – Jul 1990	Division Surgeon, Infantry Division, FT Carson, CO
	Jul 1985 – Jun 1988	Dispensary Commander, MD DET GEN DISP CP Walker, KS
	Jul 1983 – Jul 1985	Aerospace Medical Resident, STU DET AHS FT Sam Houston, TX
	Oct 1981 – Jul 1983	Flight Surgeon, Family Practice, USA HLTH CLN FT Belvoir, VA
	Jul 1979 – Oct 1981	Family Practice Resident, USA MEDDAC FT Bragg, NC
	Jun 1978 – Jul 1979	Family Practice Intern, FT Bragg, NC

Exhibit B  
Functional Assessment Team Biosketches

<b>Rank</b>	Colonel	
<b>Name</b>	(b)(6)-2	
<b>Branch/MOS</b>	Medical Service Corps / 72C	
<b>Current Duty Assignment</b>	Garrison Commander, (b)(6)-2	
<b>Brief History of Previous Assignments</b>	Aug 03 – Present	Garrison Commander, (b)(6)-2
	Jul 00 – Aug 03	Deputy Commander, U.S. Army Medical Research and Materiel Command, Fort Detrick, Frederick, MD 21702
	Aug 97 – Jul 00	Chief of Staff, U.S. Army Medical Research and Materiel Command, Fort Detrick, Frederick, MD 21702
	Jul 96 – Aug 97	Executive Officer, Walter Reed Army Institute of Research, Walter Reed Army Medical Center, Washington, DC 20307
	May 93 – Jul 96	Secretary of the General Staff, U.S. Army Medical Research and Development Command, Fort Detrick, Frederick, MD 21702
	Jun 90 – Jun 92	Assistant Director, Army Audiology and Speech Center, Walter Reed Army Medical Center, Washington, DC 20307
	Jul 85 – Jun 90	Chief Audiology and Speech Pathology, Tripler Army Medical Center, Honolulu, HI
	Jun 82 – Jul 85	Chief Audiology Section, Fitzsimons Army Medical Center, Denver, Colorado
	Jan 81 – Dec 81	Audiology Consultant US Army Medical Command Korea, Yong San Korea
	Jan 78 – Dec 80	Audiologist, Madigan Army Medical Center, Tacoma, Washington

Exhibit B  
Functional Assessment Team Biosketches

<b>Rank</b>	Colonel	
<b>Name</b>	(b)(6)-2	
<b>Branch/MOS</b>	Medical Corps / 61F9A	
<b>Current Duty Assignment</b>	Staff Internist and Intensivist, (b)(6)-2 Internal Medicine Consultant to the Army Surgeon General Governor, Army Chapter, American College of Physicians (b)(6)-2	
<b>Brief History of Previous Assignments</b>	2001-present	Staff Internist, (b)(6)-2
	2001-present	Army ACP Chapter Governor
	1997-present	OTSG Internal Medicine Consultant
	1996-1997	Director of Medical Education, Womack Army Medical Center
	1993-2001	Chief, Dept of Medicine, Womack Army MEDCEN
	1990-1993	Chief, Dept of Medicine, US Army Hospital, Heidelberg
	1986-1990	Chief, Internal Medicine Service, Dewitt Army Community Hospital, Ft Belvoir, VA
	1982-1986	Staff Internist, Frankfurt Army Regional MEDCEN
	1982	Advanced Course in Critical Care Medicine, LAMC
	1979-1982	Internship and Residency in Internal Medicine, BAMC

Exhibit B  
Functional Assessment Team Biosketches

<b>Rank</b>	Colonel	
<b>Name</b>	(b)(6)-2	
<b>Branch/MOS</b>	Army Nurse Corps / 66H/66E	
<b>Current Duty Assignment</b>	Deputy Commander for Health Services, (b)(6)-2	
<b>Brief History of Previous Assignments</b>	2002-2004	Chief, Medical-Surgical Nursing Section, Brooke Army Medical Center, San Antonio, TX
	1999-2002	Chief, Medical Support Branch, Joint Readiness Clinical Advisory Board, Fort Detrick, MD
	1997-1999	Chief Nurse, 10 <sup>th</sup> Combat Support Hospital; deployed to Bosnia-Hergovina, Task Force Medical Eagle in support of Operation Joint Forge
	1995-1997	Chief, Perioperative Nursing Services, Fort Leonard Wood, MO
	1993-1995	Advisor to the Officer Advanced Course, AMEDD Center and School, Fort Sam Houston, TX
	1991-1992	Perioperative Nursing Educator and floor coordinator at Madigan Army Medical Center; assigned as FORSCOM nurse to the 47 <sup>th</sup> Combat Support Hospital, Fort Lewis, WA
	1990-1991	Deployed as staff nurse and as an infection control officer with the 47 <sup>th</sup> Combat Support Hospital; provided care to soldiers during Operation Desert Shield; unit reconfigured as a 24 bed hospital and followed the 24 <sup>th</sup> Infantry Division into Iraq
	1989-1990	Head Nurse, Ambulatory Surgery Center, Madigan Army Medical Center; assigned as FORSCOM nurse to the 47 <sup>th</sup> Combat Support Hospital, Fort Lewis, WA
	1985-1988	Operating Room Staff Nurse/Infection Control Officer, Berlin, MEDDAC Berlin, West Germany
	1982-1985	Operating Room Staff Nurse, Madigan Army Medical Center



Exhibit B  
Functional Assessment Team Biosketches

<b>Rank</b>	LTC	
<b>Name</b>	(b)(6)-2	
<b>Branch/MOS</b>	JAG/27A	
<b>Current Duty Assignment</b>	Staff Judge Advocate (b)(6)-2	
<b>Brief History of Previous Assignments</b>	Jul 02 - Jun 03	Deputy Staff Judge Advocate, III Corps & Fort Hood, TX
	Jul 00 – Jun 02	Chief, Administrative & Civil Law III Corps & Fort Hood, TX
	Jul 98 – Jun 00	Executive Officer & Chief, Criminal Law U.S. Forces Korea & 8 <sup>th</sup> Army
	Jul 96 – Jun 98	Instructor Air Force Judge Advocate School Maxwell AFB, AL
	Jun 95 – Jun 96	Chief, Criminal Law Fort Sill, OK
	Jul 94 – May 95	JAG Graduate Course Charlottesville, VA
	Jul 94 – Jun 95	Senior Defense Counsel Fort Sill, OK
	Apr 91 – Jun 93	Chief, Legal Assistance, Trial Counsel, & Administrative Law Attorney 101 <sup>st</sup> & Fort Campbell, KY
	Sep 90 – Mar 91	Brigade Legal Advisor Desert Shield / Desert Storm
	Jan 88 – Aug 90	Chief, Claims, Legal Assistance Attorney Fort McClellan, AL

Exhibit B  
Functional Assessment Team Biosketches

<b>Rank</b>	Major
<b>Name</b>	(b)(6)-2 USAR
<b>Branch/MOS</b>	Medical Corps / 61F
<b>Current Duty Assignment</b>	Program Director, Internal Medicine Residency Program, (b)(6)-2
<b>Brief History of Previous Assignments</b>	<p>2003 Chief, Internal Medicine Service, Womack Army Medical Center</p> <p>2002 -- 2003 Staff Internist, Womack Army Medical Center</p> <p>2001 -- 2002 Clinical Assistant Professor of Medicine, University of Washington Medical School, Seattle, WA</p> <p>1998 -- 2002 Staff Internist, Adult Primary Care Clinic, Department of Medicine, Madigan Army Medical Center</p> <p>2000 -- 2002 Director, Intern Training and Assistant Program Director, Transitional Residency Program, Madigan Army Medical Center</p> <p>1999 -- 2000 PROFIS Field Surgeon, 296 FSB, Fort Lewis, WA</p> <p>1998 -- 1999 Chief, Medical Residents, Madigan Army Medical Center</p> <p>1995 -- 1998 Intern and Resident in Internal Medicine, Madigan Army Medical Center</p>

Exhibit B  
Functional Assessment Team Biosketches

<b>Rank</b>	Master Sergeant
<b>Name</b>	(b)(6)-2
<b>Branch/MOS</b>	91W5H
<b>Current Duty Assignment</b>	Soldier Medic Training Site NCOIC, (b)(6)-2
<b>Brief History of Previous Assignments</b>	<div>Jan 04 – Present      Current Assignment</div> <div>Feb 03 – Dec 03      115<sup>th</sup> FH, Fort Polk, LA, Platoon Sergeant//EMT NCOIC (Deployed to OIF: March 03 – Jun 03 Camp Arifijan, Kuwait)</div> <div>Nov 01 – Jan 03      565<sup>th</sup> Ground Ambulance Co, Ft Polk, LA Platoon Sergeant</div> <div>Sep 01 – Oct 01      ANCOC, Ft Sam Houston, TX</div> <div>Nov 98 – Aug 01      USAREC: Cary, NC Recruiting Station and Barstow, CA Recruiting Station Detailed Recruiter</div> <div>Nov 96 – Oct 98      1/11<sup>th</sup> ACR, Ft Irwin, CA Medical Evacuation Section Sergeant</div> <div>Oct 95 – Oct 96      United Nations Command Security Battalion, Joint Security Area, Camp Bonifas, Korea Medical Evacuation Section Sergeant</div> <div>May 95 – Sept 95      BNCOC, Ft Sam Houston, TX</div> <div>Jul 94 – May 95      5<sup>th</sup> Engineer BN (C)(M) FLW, MO Medical Section Sergeant</div> <div>Jan 92 – Jun 94      93<sup>rd</sup> Evacuation Hospital, Ft. Leonard Wood, MO Medical Specialist in MCW</div> <div>Dec 90 – Dec 91      296<sup>th</sup> FSB, Camp Edwards, Korea Aidman in Treatment section</div> <div>Jun 90 – Nov 90      IET and AIT</div>

## **Chapter 25 - Exhibit C, Annex 1**

### **Interview Script**

I have been appointed by The Surgeon General of the Army as a member of a medical assessment team. We have been tasked to look at medical operations in a deployed theater, pre-deployment training, in theater training, post-deployment training, and detainee medical care and documentation. This is an assessment/evaluation, not an investigation. We are seeking input to improve future training and medical capabilities, as well as evaluating medical personnel's understanding of their obligations under Army regulations and international law.

[If requested, show interviewee a copy of the **team** appointment letter]

Although this is not an investigation, we are required to document the information obtained from our one-on-one interviews as official, sworn statements.

I will be asking you to complete two documents. The first is a Privacy Act Statement. The second will be your official statement. The Privacy Act Statement explains the various uses for the information you provide me. Your statement will consist of answers to a standard set of questions and any additional information, not covered by the standard questions, that you provide me. We will also complete a questionnaire cover sheet. The cover sheet provides background information about your duty history and information about your unit. It is important that you provide me complete, honest answers to all questions. I again want to emphasize that this is an assessment, not an investigation.

Prior to beginning the interview I will ask you to respond to some scenario questions.

After completing the scenario questions ask -

Do you have any questions before we begin the interview?

### **INTERVIEW PROCEDURE**

1. Complete Privacy Act Statement.
2. Complete background cover sheet.
3. Complete questionnaire, ensure each page is reviewed and initialed.
4. Ensure you have completed the information on the top of each page.
5. Read the Affidavit portion on the last page word for word to the interviewee.
6. Have the interviewee acknowledge that they understand the Affidavit.
7. Have the interviewee sign the statement.
8. Complete the date and location of the statement.
9. Sign and print your name.
10. Your authority to administer oaths is "**Acting Adjutant.**"

### **DA Form 3881 (If needed)**

On first line of Section A cross out "with the United States Army" and write in "a member of a medical assessment team."

LTC <sup>(b)(6)-2</sup>

**Chapter 25 - Exhibit C, Annex 2**  
**Questionnaire Cover Sheet**

**Record #** (office entry)

<b>Date of Interview</b>	DD-MMM-YR	<b>Location of Interview</b>	
<b>Interviewer</b>		<b>Rank of Interviewer</b>	MG COL LTC MAJ MSG

<b>INTERVIEWEE</b>	<b>First Name</b>	<b>MI</b>	<b>Last Name</b>	
<b>Rank</b>	<b>MOS/AOC</b>	<b>Gender</b>	Male Female	<b>Age</b>
<b>Years of Active Military Service</b>	<b>Years of USAR/NG Service</b>	<b>Component</b>	AC RC NG	

**PRESENT UNIT:**

<b>Unit Name</b>	<b>Address</b>	<b>State</b>	<b>Zip</b>	<b>Yrs Assigned</b>
<b>City/Post</b>				
<b>Phone No.</b>	<b>Unit Email</b>			
<b>Unit Commander</b>				

**DEPLOYMENT HISTORY:**

<b>Deployment Status</b>	Past Present Future N/A	<b>Level</b>	1 2 3	<b>Theater</b>	GTMO OEF OIF
<b>Name of Unit Deployed With:</b>					
<b>Specific Location of Unit in Theater</b>					
<b>Theater Date of Arrival</b>	DD-MMM-YR	<b>Theater Date of Departure</b>	DD-MMM-YR		
<b>Name of Medical OIC</b>					

<b>Reassigned in Theater?</b>	Y N	<b>If YES, Name of Unit Attached to</b>	
<b>Level</b>	1 2 3	<b>Name of Medical OIC</b>	
<b>Did you receive additional training at the new unit?</b>	YES NO		
<b>Explain:</b>			

<b>Did your unit provide detainee medical care in theatre?</b>	YES NO
<b>If YES, which unit?</b>	(use this unit for the assessment)
<b>Did you provide detainee medical care in theatre?</b>	YES NO

**MEDICAL DUTY:**

1	MP Medic	9	CSH DCCS	17	ASMC PA
2	Maneuver Medic	10	CSH DCA	18	ASMC Doctor
3	ASMC Medic	11	CSH Chief Nurse	19	Medical Co CO
4	CSH 91W	12	CSH Senior Clinical NCO	20	DIV Surgeon
5	CSH 91WM6	13	Maneuver PA	21	BDE Surgeon
6	Nurse	14	Maneuver Doctor	22	BN Surgeon
7	CSH Doctor	15	MP PA	23	Dentist/Oral Surgeon
8	CSH Cdr	16	MP Doc	24	Administrative
26	Other:			25	Non-medical Leader

**COMMENTS:**

**Chapter 25 - Exhibit C, Annex 3**  
**Privacy Act Statement**

SUBJECT: Privacy Act Statement

1. **AUTHORITY:** The authority for the collection of personal information during the conduct of this assessment is Title 10, United States Code, Section 3012 (10 USC 3012).

2. **PRINCIPAL PURPOSE:** The purpose for soliciting this information is to assist The Surgeon General in assessing Medical Training, Operations and Treatment in OEF and OIF.

3. **ROUTINE USES:** Any information you provide is disclosable to members of the Department of Defense (DoD) who have a need for the information in the performance of their duties. In addition, the information may be disclosed to government agencies outside of the DoD as follows:

a. To members of the U.S. Department of Justice when necessary in the defense of litigation brought against the DoD, or against members of that department as a result of actions taken in their official capacity.

b. To members of the U.S. Department of Justice when necessary for the further investigation of criminal misconduct.

4. **DISCLOSURE MANDATORY; THE EFFECT OF NOT PROVIDING INFORMATION:**

a. For individuals warned of their rights under Article 31, UCMJ, or the Fifth Amendment to the U.S. Constitution:

"Providing the information is voluntary. There will be no adverse effect on you for not furnishing the information other than essential information which might not otherwise be available to the commander for his decision(s) in this matter."

b. For individuals who may be ordered to testify:

"Providing the information is mandatory. Failure to provide information could result in disciplinary or other adverse action against you under the UCMJ, Army Regulations, or Office of Personnel Management Regulations."

Date:\_\_\_\_\_ Name:\_\_\_\_\_ Signature: \_\_\_\_\_

Chapter 25 - Exhibit C, Annex 4  
Past/Present Questionnaire

Printed on DA FORM 2823, DEC 1998 - SWORN STATEMENT

MEDICAL DUTY CATEGORIES TO ANSWER	TQ num	KQ let	QUESTIONS	RESPONSES
ALL	1	cef	Are you familiar with the Geneva Conventions?	Y N U NA
1-24 inclusive, 26	2	ef	In preparation for providing detainee care did your unit use case studies?	Y N U NA
ALL	3	ef	Did your overall unit training prepare you for addressing human rights issues of detainees?	Y N U NA
1-24 inclusive, 26	4	ef	Did your training prepare you for providing medical care to detainees?	Y N U NA
1-24 inclusive, 26	5	ef	How would you rate your training to prepare you for detainee care?	E G N F P
ALL	6	cef	If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? <i>Format?</i>	
ALL	7	cef	If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? <i>How Often?</i>	
ALL	8	cef	If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? <i>When?</i>	
26	150	d	What orders did you get from higher HQ regarding the provision of detainee medical care? (If written, please provide a copy of the orders.)	
26	151	d	What was your understanding of the policy regarding detainee medical care?	
26	152	d	Were you involved in the planning of detainee care?	Y N U NA
26	153	d	What was your planning sequence? (Please provide the plan and orders.)	



26	154	d	What was your understanding of the requirements of running a detainee medical facility?						
26	155	d	What was your understanding of the special concerns for this population, i.e., chain of custody for medical records, interrogators in the facility, etc?						
26	156	d	What resources did you request to accomplish this mission?						
26	157	d	Who did you ask for these resources?						
26	158	d	Were these resources provided to you?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,20,21,22,23	9	cef	Were you provided with instructions about the procedure to document medical screening of detainees?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,20,21,22,23	10	d	Is there a detainee daily sick call?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,20,21,22,23	11	dl	Was there/is there an initial assessment at the detention facility of detainees to assess their physical condition?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,20,21,22,23	12	dk	How do you rate detainee facility sanitation?	E	G	N	F	P	
1,2,3,13,14,15,16,17,18,19,20,21,22,23	13	dk	How do you rate detainee temperature environment?	E	G	N	F	P	
1,2,3,13,14,15,16,17,18,19,20,21,22,23	14	dk	How do your rate detainee bedding?	E	G	N	F	P	
1,2,3,13,14,15,16,17,18,19,20,21,22,23	15	dk	How do you rate detainee clothing?	E	G	N	F	P	
1,2,3,13,14,15,16,17,18,19,20,21,22	16	cdef	Are monthly medical screens performed?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,20,21,22	17	cdef	Are monthly weights recorded?	Y	N	U	NA		

ALL	18	d	Were there detained women?	Y	N	U	NA		
ALL	19	d	Were there any policies for detained women?	Y	N	U	NA		
ALL	20	d	Did your unit follow these policies?	Y	N	U	NA		
ALL	21	d	Were there detained children (16 years and younger) ?	Y	N	U	NA		
ALL	22	d	Were there any policies for detained children (16 years and younger)?	Y	N	U	NA		
ALL	23	d	Did your unit follow these policies?	Y	N	U	NA		
ALL	24	d	Were there detainees with contagious illnesses?	Y	N	U	NA		
ALL	25	d	Were there any policies for detainees with contagious illnesses?	Y	N	U	NA		
ALL	26	d	Did your unit follow these policies?	Y	N	U	NA		
ALL	27	d	Were there detainees with mental illnesses?	Y	N	U	NA		
ALL	28	d	Were there any policies for detainees with mental illnesses?	Y	N	U	NA		
ALL	29	d	Did your unit follow these policies?	Y	N	U	NA		
4,5,6,7,8,9,10,11,12,23,24,26	30	di	Was informed consent obtained from detainees when indicated? (same standard as for other patients)	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,20,21,22	31	d	Is there a policy for immunizing detainees?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,20,21,22	32	d	Did your unit follow these policies?	Y	N	U	NA		
9,10,11,12,19,20,21,24,25	33	d	Is a detainee's medical condition made available to family members? (if entered into a system = yes)	Y	N	U	NA		
1-23, 25, 26	34	dk	Were detainees restrained in your facility?	Y	N	U	NA		
1-23, 25, 26	35	dk	Restrained for inability to comprehend or follow instructions?	Y	N	U	NA		
1-23, 25, 26	36	dk	Restrained for punishment?	Y	N	U	NA		
1-23, 25, 26	37	dk	Restrained for attempt to dislodge medical device?	Y	N	U	NA		
1-23, 25, 26	38	dk	Restrained for risk for falling?	Y	N	U	NA		
1-23, 25, 26	39	dk	Restrained for violent or disruptive behavior?	Y	N	U	NA		
1-23 inclusive, 26	40	di	How would you rate the quality of documentation re: restraining detainees in your facility?	E	G	N	F	P	0

ALL	41	dk	How do you rate detainee medical resources?	E	G	N	F	P	0
ALL	42	dk	How do you rate detainee medication resources?	E	G	N	F	P	0
ALL	43	dk	How do you rate detainee medical supplies?	E	G	N	F	P	0
ALL	44	dk	How do you rate detainee medical personnel resources?	E	G	N	F	P	0
ALL	45	dk	How do you rate detainee medical evacuation resources?	E	G	N	F	P	0
1,2,3,13,14,15,16,17,18,19,21,22,23,25	46	def	Are you familiar with the procedures to send detainees to higher levels of care?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,21,22,23,25	47	d	Did your unit follow these procedures?	Y	N	U	NA		
1,15,16,17,18,19,25	48	dh	Does your unit have BSCTs?	Y	N	U	NA		
1,15,16,17,18,19,25	49	dh	Did any member of the BSCT provide medical care to US Soldiers?	Y	N	U	NA		
1,15,16,17,18,19,25	50	dhi	Did any member of the BSCT provide medical care to detainees?	Y	N	U	NA		
ALL	51	c	Have you received MOS or other school training about reporting possible detainee abuse? (non-unit level/related)	Y	N	U	NA		
ALL	52	ef	Have you received unit training at your home station about reporting possible detainee abuse?	Y	N	U	NA		
ALL	53	ef	Have you received unit training during mobilization about reporting possible detainee abuse?	Y	N	U	NA		
ALL	54	ef	Have you received unit training in theater about reporting possible detainee abuse?	Y	N	U	NA		
ALL	55	n	Are there unit-level policies that require reporting suspected abuse?	Y	N	U	NA		
ALL	56	n	Did your unit follow these policies?	Y	N	U	NA		
1-23,25, 26	57	h	Were medical personnel ever asked to participate in interrogations?	Y	N	U	NA		
1-23,25, 26	58	h	In what way?						
4,5,6,7,8,9,10,11,12,23,24, 26	59	cdhi	Did/does your unit have a digital or other high quality camera for use in documentation of patient injuries?	Y	N	U	NA		
4,5,6,7,8,9,10,11,12,23,24, 26	60	cdhi	Did your unit photograph patient injuries?	Y	N	U	NA		
4,5,6,7,8,9,10,11,12,23,24, 26	61	cdhi	Did pictures include faces?	Y	N	U	NA		

1-19,21,22,23,26	62	dh	Was there a policy on interrogators in your medical facility?	Y	N	U	NA		
1-19,21,22,23,26	63	dh	Was there a policy on conducting interrogations in your medical facility?	Y	N	U	NA		
1-19,21,22,23,26	64	defh	Did you ever get instruction on that policy?	Y	N	U	NA		
1-18,21,22,23,26	65	hk	Were you ever asked to be present during interrogations?	Y	N	U	NA		
1-18,21,22,23,26	66	hk	Were you aware of any medical personnel being asked to be present during interrogations?	Y	N	U	NA		
1-18,21,22,23,26	67	hk	Were you aware of any medical personnel being present during interrogations?	Y	N	U	NA		
1-18,21,22,23,26	68	hk	Were you ever present during interrogations?	Y	N	U	NA		
1-24 inclusive, 26	69	c	Have you received MOS or other school training about detainee medical records? (non unit related)	Y	N	U	NA		
1-24 inclusive, 26	70	ef	Have you received unit training at your home station about detainee medical records?	Y	N	U	NA		
1-24 inclusive, 26	71	ef	Have you received unit training during mobilization about detainee medical records?	Y	N	U	NA		
1-24 inclusive, 26	72	ef	Have you received unit training in theater about detainee medical records?	Y	N	U	NA		
1-24 inclusive, 26	73	d	Are there theater policies regarding detainee medical records?	Y	N	U	NA		
1-24 inclusive, 26	74	d	Did your unit follow these policies?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,21,22,24,25	75	hi	Were medical screenings completed in pre-interrogations?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,21,22,24,25	76	hi	Were medical screenings completed in post-interrogation?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,21,22,24,25	77	hi	Was there medical documentation in pre-interrogation?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,21,22,24,25	78	hi	Was there medical documentation in post-interrogation?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,21,22,24,25	79	hi	Was the medical documentation included in the detainee medical record?	Y	N	U	NA		
1-24 inclusive, 26	80	j	Where are original detainee medical records maintained?	Y	N	U	NA		
1-24 inclusive, 26	81	j	none maintained	Y	N	U	NA		
1-24 inclusive, 26	82	j	in detention facility	Y	N	U	NA		
1-24 inclusive, 26	83	j	in detention medical facility	Y	N	U	NA		
1-24 inclusive, 26	84	j	in interrogation record/facility	Y	N	U	NA		
1-24 inclusive, 26	85	j	sent to level 3 facility	Y	N	U	NA		
1-24 inclusive, 26	86	j	transferred with the detainee to next detainee facility	Y	N	U	NA		
1-24 inclusive, 26	87	j	in a log book only	Y	N	U	NA		
1-24 inclusive, 26	87	j	don't know	Y	N	U	NA		
1-24 inclusive, 26	88	j	Other:	Y	N	U	NA		

1-24 inclusive, 26	89	j	Were copies ever made of detainee medical records? If yes,	Y	N	U	NA		
1-24 inclusive, 26	90	j	Where are the copies of detainee medical records maintained? none maintained	Y	N	U	NA		
1-24 inclusive, 26	91	j	in detention facility	Y	N	U	NA		
1-24 inclusive, 26	92	j	in detention medical facility	Y	N	U	NA		
1-24 inclusive, 26	93	j	in interrogation record/facility	Y	N	U	NA		
1-24 inclusive, 26	94	j	sent to level 3 facility	Y	N	U	NA		
1-24 inclusive, 26	95	j	transferred with the detainee to next detainee facility	Y	N	U	NA		
1-24 inclusive, 26	96	j	in a log book only	Y	N	U	NA		
1-24 inclusive, 26	97	j	don't know	Y	N	U	NA		
1-24 inclusive, 26	98	j	Other:	Y	N	U	NA		
ALL	99	di	Were there procedures for controlling access to medical records of detainees?	Y	N	U	NA		
ALL	100	di	Were these procedures followed?	Y	N	U	NA		
ALL	101	di	Were there procedures for maintaining security of detainee records within your treatment area?	Y	N	U	NA		
ALL	102	di	Were these procedures followed?	Y	N	U	NA		
ALL	103	hi	Besides the treating medical personnel, who else was granted access to information in the detainee medical records? Anyone	Y	N	U	NA		
ALL	104	hi	BSCT	Y	N	U	NA		
ALL	105	hi	No one	Y	N	U	NA		
ALL	106	hi	Interrogators	Y	N	U	NA		
ALL	107	hi	My chain of command	Y	N	U	NA		
ALL	108	hi	Other:	Y	N	U	NA		
4-12, 23, 24, 26	109	j	What happened to the detainee records upon discharge from the hospital? Given to patient	Y	N	U	NA		
4-12, 23, 24, 26	110	j	Given to MP	Y	N	U	NA		
4-12, 23, 24, 26	111	j	Destroyed	Y	N	U	NA		
4-12, 23, 24, 26	112	j	I don't know	Y	N	U	NA		
4-12, 23, 24, 26	113	j	Transferred to the lower level medical facility	Y	N	U	NA		
4-12, 23, 24, 26	114	j	Maintained by the hospital	Y	N	U	NA		
4-12, 23, 24, 26	115	j	Forwarded to a repository	Y	N	U	NA		
ALL	116	k	How comfortable did you feel discussing ethical issues related to detainee care with your immediate supervisor?	V	C	N	U	V	U

ALL	117	d	Are there policies, OPORDERS, or SOPs establishing criteria for detainee medical care and support?	Y	N	U	NA		
ALL	118	d	Are these policies briefed and discussed with unit personnel?	Y	N	U	NA		
ALL	119	d	Did you observe non-medical personnel providing medical care?	Y	N	U	NA		
ALL	120	kim	Are you aware of retribution against someone who reported abuse?	Y	N	U	NA		
ALL	121	k	Are you aware of any detainee reporting abuse to any other US Soldier?	Y	N	U	NA		
ALL	122	fm	Do you know if action was taken?	Y	N	U	NA		
ALL	123	m	What happened?						
1-15,21,22,23,26	124	hk	Were you ever asked to participate in interrogation by administering assistive medications? (e.g. paralytics, sympathomimetics, sedative/hypnotics, etc.)	Y	N	U	NA		
1-18,21,22,23,26	125	hk	Were you aware of any medical personnel being asked to participate in interrogations by administering assistive medications?	Y	N	U	NA		
1-18,21,22,23,26	126	hk	Were you aware of any medical personnel participating in interrogations by administering medications?	Y	N	U	NA		
1-18,21,22,23,26	127	hk	Did you ever participate in interrogation by administering assistive medications?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22,23	128	hk	Were you ever asked to delay an initial examination until after interrogation?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22,23	129	hk	Did you ever delay an initial examination until after interrogation?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22,23	130	hk	Were you aware of any medical personnel being asked to delay initial examination until after interrogation?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22,23	131	hk	Were you aware of any medical personnel delaying initial examination until after interrogation?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22,23	132	hk	Were you ever asked to treat a patient to return him/her to an improved physical state so that he/she could continue in the interrogation process?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22,23	133	hk	Do you know anyone ever asked treat a patient to return him/her to an improved physical state so that he/she could continue in the interrogation process?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22,23	134	hk	Do you know anyone who treated a patient to return him/her to an improved physical state so that he/she could continue in the interrogation process?	Y	N	U	NA		
1,2,3,4,7,13,14,15,16,17,18,21,22,23	135	hk	Did you ever treat a patient to return him/her to an improved physical state so that he/she could continue in the interrogation process?	Y	N	U	NA		

1-24 inclusive, 26	136	hi	Do you know if anyone was ever asked to change detainee medical documentation?	Y	N	U	NA		
1-24 inclusive, 26	137	hi	Do you know if anyone was ever asked to inaccurately document medical information in a detainee record?	Y	N	U	NA		
1-24 inclusive, 26	138	hi	Were you ever asked to change detainee medical documentation?	Y	N	U	NA		
1-24 inclusive, 26	139	hi	Were you ever asked to inaccurately document medical information in a detainee record?	Y	N	U	NA		
1-24 inclusive, 26	140	hi	Did you ever change detainee medical documentation?	Y	N	U	NA		
ALL	141	k	Did any detainees report abuse directly to you?	Y	N	U	NA		
ALL	142	m	Did you report this?	Y	N	U	NA		
ALL	143	lm	How did you report?						
ALL	145	k	Did you directly observe possible detainee abuse?	Y	N	U	NA		
ALL	146	m	Did you report this?	Y	N	U	NA		
ALL	147	lm	How did you report?						
ALL	144		Is there anything I should have asked but didn't?	Y	N	U	NA		

## **MEDICAL DUTY CATEGORIES**

ALL All categories below

- 1 MP Medic
- 2 Maneuver Medic
- 3 ASMC Medic
- 4 CSH 91W
- 5 CSH 91WM6
- 6 Nurse
- 7 CSH Physician
- 8 CSH Cdr
- 9 CSH DCCS
- 10 CSH I - 27 Other:
- 11 CSH Chief Nurse
- 12 CSH Senior Clinical NCO
- 13 Maneuver PA
- 14 Maneuver Physician
- 15 MP PA
- 16 MP Physician
- 17 ASMC PA
- 18 ASMC Physician
- 19 Medical Co CO
- 20 DIV Surgeon
- 21 BDE Surgeon
- 22 BN Surgeon
- 23 Dentist/Oral Surgeon
- 24 Administrative
- 25 Non-medical Leader
- 26 Other: MEDBDE & Hospital Cdr. BSCT, etc.

## **TQ and KQ**

TQ Nom Team Question Number - Numbers established by Assessment Team

KQ Let Kiley Question Letter - from Appointment Memo

## **KEY TO RESPONSES**

- Y YES
- N NO
- U Unknown
- NA Not Applicable
- E Excellent
- G Good
- N Neutral
- F Fair
- P Poor
- O None
- VC Very Comfortable
- C Comfortable
- N Neutral
- U Uncomfortable
- VU Very Uncomfortable



Chapter 25 - Exhibit C, Annex 5  
Future Questionnaire

Printed on DA FORM 2823, DEC 1998 - SWORN STATEMENT

MEDICAL DUTY CATEGORIES TO ANSWER	TQ num	KQ let	QUESTIONS	RESPONSES
ALL	1	cef	Are you familiar with the Geneva Conventions?	Y N U NA
1-24 inclusive, 26	2	ef	In preparation for providing detainee care does your unit use case studies?	Y N U NA
ALL	3	ef	Does your overall unit training prepare you for addressing human rights issues of detainees?	Y N U NA
1-24 inclusive, 26	4	ef	Does your training prepare you for providing medical care to detainees?	Y N U NA
1-24 inclusive, 26	5	ef	How would you rate your training to prepare you for detainee care?	E G N F P
ALL	6	cef	If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? Format?	
ALL	7	cef	If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? How Often?	
ALL	8	cef	If you were responsible for the training of medical personnel prior to deployment, what aspects of training would you focus on with regard to detainee care? When?	
26	150	d	What orders did you get from higher HQ regarding the provision of detainee medical care? (if written, please provide a copy of the orders)	
26	151	d	What was your understanding of the policy regarding detainee medical care?	
26	152	d	Were you involved in the planning of detainee care?	Y N U NA
26	153	d	What was your planning sequence? (please provide the plan and orders)	

26	154	d	What was your understanding of the requirements of running a detainee medical facility?						
26	155	d	What was your understanding of the special concerns for this population, i.e. chain of custody for medical records, interrogators in the facility, etc?						
26	156	d	What resources did you request to accomplish this mission?						
26	157	d	Who did you ask for these resources?						
26	158	d	Were these resources provided to you?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,20,21,22, 23	9	ccf	Were you provided with instructions about the procedure to document medical screening of detainees?	Y	N	U	NA		
ALL	19	d	Are there any policies for detained women?	Y	N	U	NA		
ALL	22	d	Are there any policies for detained children (16 years and younger)?	Y	N	U	NA		
ALL	25	d	Are there any policies for detainees with contagious illnesses?	Y	N	U	NA		
ALL	28	d	Are there any policies for detainees with mental illnesses?	Y	N	U	NA		

1,2,3,13,14,15,16,17,18,19,20,21,22	31	d	Is there a policy for immunizing detainees?	Y	N	U	NA		
1,2,3,13,14,15,16,17,18,19,21,22,23,25	46	def	Are you familiar with the procedures to send detainees to higher levels of care?	Y	N	U	NA		
1,15,16,17,18,19,25	48	dh	Does your unit have BSCTs?	Y	N	U	NA		
ALL	51	c	Have you received MOS or other school training about reporting possible detainee abuse? (non-unit level/related)	Y	N	U	NA		
ALL	52	ef	Have you received unit training at your home station about reporting possible detainee abuse?	Y	N	U	NA		
ALL	53	ef	Have you received unit training during mobilization about reporting possible detainee abuse?	Y	N	U	NA		
ALL	55	n	Are there unit-level policies that require reporting suspected abuse?	Y	N	U	NA		
4,5,6,7,8,9,10,11,12,23,24,26	59	edhi	Did/does your unit have a digital or other high quality camera for use in documentation of patient injuries?	Y	N	U	NA		
1-19,21,22,23,26	62	dh	Is there a policy on interrogators in your medical facility?	Y	N	U	NA		
1-19,21,22,23,26	63	dh	Is there a policy on conducting interrogations in your medical facility?	Y	N	U	NA		
1-19,21,22,23,26	64	dehi	Did you ever get instruction on that policy?	Y	N	U	NA		
1-24 inclusive, 26	69	c	Have you received MOS or other school training about detainee medical records? (non unit related)	Y	N	U	NA		
1-24 inclusive, 26	70	ef	Have you received unit training at your home station about detainee medical records?	Y	N	U	NA		
1-24 inclusive, 26	71	ef	Have you received unit training during mobilization about detainee medical records?	Y	N	U	NA		

1-24 inclusive, 26	80	i	Where are original detainee medical records maintained?	none	Y	N	U	NA		
1-24 inclusive, 26	81	j	in detention facility		Y	N	U	NA		
1-24 inclusive, 26	82	j	in detention medical facility		Y	N	U	NA		
1-24 inclusive, 26	83	j	in interrogation record/facility		Y	N	U	NA		
1-24 inclusive, 26	84	j	sent to level 3 facility		Y	N	U	NA		
1-24 inclusive, 26	85	j	transferred with the detainee to next detainee facility		Y	N	U	NA		
1-24 inclusive, 26	86	j	in a log book only		Y	N	U	NA		
1-24 inclusive, 26	87	j	don't know		Y	N	U	NA		
1-24 inclusive, 26	88	j	Other:		Y	N	U	NA		
ALL	99	di	Are there procedures for controlling access to medical records of detainees?		Y	N	U	NA		
ALL	101	di	Are there procedures for maintaining security of detainee records within your treatment area?		Y	N	U	NA		
4-12, 23, 24, 26	109	j	What happens to the detainee records upon discharge from the hospital?		Y	N	U	NA		
4-12, 23, 24, 26	110	j	Given to patient		Y	N	U	NA		
4-12, 23, 24, 26	111	j	Given to MP		Y	N	U	NA		
4-12, 23, 24, 26	111	j	Destroyed		Y	N	U	NA		
4-12, 23, 24, 26	112	j	I don't know		Y	N	U	NA		
4-12, 23, 24, 26	113	j	Transferred to the lower level medical facility		Y	N	U	NA		
4-12, 23, 24, 26	114	j	Maintained by the hospital		Y	N	U	NA		
4-12, 23, 24, 26	115	j	Forwarded to a repository		Y	N	U	NA		
ALL	116	k	How comfortable do you feel discussing ethical issues related to detainee care with your immediate supervisor?		Y	C	N	U	V	U
ALL	117	d	Are there policies, OPORDERS, or SOPs establishing criteria for detainee medical care and support?		Y	N	U	NA		
ALL	118	d	Are these policies briefed and discussed with unit personnel?		Y	N	U	NA		
ALL	120	klm	Are you aware of retribution against someone who reported abuse?		Y	N	U	NA		

ALL	144	Is there anything I should have asked but didn't?	Y	N	U	NA

#### MEDICAL DUTY CATEGORIES

ALL All categories below

- 1 MP Medic
- 2 Maneuver Medic
- 3 ASMC Medic
- 4 CSH 91W
- 5 CSH 91WM6
- 6 Nurse
- 7 CSH Physician
- 8 CSH Cdr
- 9 CSH DCCS
- 10 CSH 27 Other:
- 11 CSH Chief Nurse
- 12 CSH Senior Clinical NCO
- 13 Maneuver PA
- 14 Maneuver Physician
- 15 MP PA
- 16 MP Physician
- 17 ASMC PA
- 18 ASMC Physician
- 19 Medical Co CO
- 20 DIV Surgeon
- 21 BDE Surgeon
- 22 BN Surgeon
- 23 Dentist/Oral Surgeon
- 24 Administrative
- 25 Non-medical Leader
- 26 Other: MEDBDE & Hospital Cdr, BSCT, etc.

#### TQ and KQ

TQ Num Team Question Number - Numbers established by Assessment Team

KQ Let Kiley Question Letter - from Appointment Memo

#### KEY TO RESPONSES

- Y YES
- N NO
- U Unknown
- NA Not Applicable
- E Excellent
- G Good
- N Neutral
- F Fair
- P Poor
- O None
- VC Very Comfortable
- C Comfortable
- N Neutral
- U Uncomfortable
- VU Very Uncomfortable

Chapter 25 - Exhibit C, Annex 6

Power Projection Platform / CONUS Replacement Center Questionnaire

Date:

POC Name:

POC Duty Position:

POC Telephone #:

POC Email:

Platform Location: Benning, Bliss, Bragg, Campbell, Carson, Dix, Drum, Eustis, Hood, Lewis, McCoy,  
Polk, Riley, Sill, Stewart (circle one)

TQ Num	Question				
300	Were you at a <b>MOB Training Site</b> or a <b>CRC Training Site</b> ? (circle one)				
301	What drives the training you provide to units at this Power Projection Platform?				NA
302	Have you ever compared the training produced here with training produced at other Power Projection Platforms?	Y	N	U	NA
303	Do you provide training for detainee operations?	Y	N	U	NA
304	If Yes to #303, how many hours?				NA
305	If Yes to #303, what is the nature of this training? (Please provide a copy of training materials.)				NA
306	Do you cover medical operations for the detainee population?	Y	N	U	NA
307	Do you provide medical ethics training?	Y	N	U	NA
308	If Yes to # 307, how many hours?				NA
309	If Yes to # 307, who conducts this training? (unit, rank, MOS)				NA

310	If Yes to # 307, is it UNIT-SPECIFIC or GENERIC? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
311	If Yes to # 307, is it THEATER-SPECIFIC OR GENERIC? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
312	Do you provide Law of War Training?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
313	If Yes to # 312, how many hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
314	If Yes to # 312, who conducts this training? (unit, rank, MOS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
315	If Yes to # 312, is it UNIT-SPECIFIC or GENERIC? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
316	If Yes to # 312, is it THEATER-SPECIFIC OR GENERIC? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
317	Do you provide Geneva Convention Training?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
318	If Yes to # 317, how many hours?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
319	If Yes to # 317, who conducts this training? (unit, rank, MOS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
320	If Yes to # 317, is it UNIT-SPECIFIC or GENERIC? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
321	If Yes to # 317, is it THEATER-SPECIFIC OR GENERIC? (circle one)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
322	Do you use scenario training for any portion of the pre-deployment training?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA
323	If Yes, to # 322, for what areas of training is this used?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	NA

Chapter 25 - Exhibit C, Annex 7  
BSCT Questionnaire

**BSCT QUESTIONNAIRE**

Printed on DA FORM 2823, DEC 1998 - SWORN STATEMENT

TQ num	KQ let	QUESTION	RESPONSE
401	d	When assigned to duty on the BSCT (or equivalent duty) did you have Written or Verbal orders? (Circle one)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
402	d	If written orders were provided to you, who wrote them? (please supply a copy of the orders)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
403	d	What was your rating chain? (please supply a copy of the OER and OER support form for the time of this duty)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
404	d	What was your technical chain of command?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
405	d	What doctrine or policy outlines your deployment in a BSCT role?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
406	hi	Define your scope of duties while serving in a BSCT position?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
407	hij	Define your duty limitations while in a BST position?	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
408	d	Did you provide clinical services to detainees, interrogators, assigned personnel or referred personnel while assigned in a BSCT role?	Y N U NA
409	d	Were you credentialed by the medical facility?	Y N U NA



410	h	Did you participate in the interrogation of detainees?	Y	N	U	NA
411		Did the detainees seek your services as a psychologist / psychiatrist / behavioral health specialist / medical provider in any role?	Y	N	U	NA
412	h	How did you interact with the interrogators?	Y	N	U	NA
413	ij	Did you have knowledge of the detainees medical conditions?	Y	N	U	NA
414	ij	Did you have access to the detainee medical records?	Y	N	U	NA
415	ij	Did you have access to any information in the medical records? (eg through discussion with other medical personnel)	Y	N	U	NA
416	ij	If Yes, what types of medical information?	Y	N	U	NA
417	hiI	Did you document the medical condition of the detainee?	Y	N	U	NA
418	ijI	Where did you store those records?				
419		Did you ever feel conflicted in your position?	Y	N	U	NA
420		Describe the nature of the conflict?				

421		How did you resolve the conflict?				
422		Do you think medical personnel should serve in a BSCT role for interrogation activities?	Y	N	U	NA
423	cef	Are you familiar with the Geneva Conventions?	Y	N	U	NA
424	ef	Did your overall unit training prepare you for addressing human rights issues of detainees?	Y	N	U	NA
425	k	Were you aware of anyone else observing or involved with possible abuse?	Y	N	U	NA
426	m	Do you know if this possible abuse was reported?	Y	N	U	NA
427	k	Did you observe any possible abuse of detainees?	Y	N	U	NA
428	m	Did you report the possible abuse?	Y	N	U	NA
429	m	To whom did you report the possible abuse?				
430		Is there anything else I need to know?	Y	N	U	NA

Chapter 25 - Exhibit C, Annex 8  
Student Questionnaire

## STUDENT QUESTIONNAIRE

Date: \_\_\_\_\_ Rank: \_\_\_\_\_ Years Active Military Service: \_\_\_\_\_ Years USAR/NG Service: \_\_\_\_\_

Current course (circle one): OBC, OAC, PLDC, BNOC, ANOC, 91W, 91WM6, Other: \_\_\_\_\_

Duration of current course in weeks: \_\_\_\_\_ In what week are you currently enrolled? \_\_\_\_\_

TQ Num	Questions	Answers					
601	At this point in your current course, has the training included the Geneva Conventions?	Y	N	Unk	NA		
602	At this point in your current course, has the training included the Law of War?	Y	N	Unk	NA		
603	At this point in your current course, has the training included AR 190-8 (Enemy Prisoners of War, Retained Personnel, Civilian Internees, and other Detainees)	Y	N	Unk	NA		
<b>The following questions apply to the training in questions 601, 602 and 603:</b>							
604	How many hours did the training in involve (total)?	≤ 1	1 to 2	2 to 3	3 to 4	> 5	
605	Was the training scenario based?	Y	N	Unk	NA		
606	Was there group discussion involved in the training?	Y	N	Unk	NA		
607	Did the training include the specifics of detainee treatment and medical care?	Y	N	Unk	NA		
608	Did the training include requirements for medical records keeping for a detainee	Y	N	Unk	NA		
609	Did the training include the specifics of medical reporting of detainee abuse?	Y	N	Unk	NA		
610	To what extent did the training raise your comfort level in being able to provide medical care for a detainee in a combat theater of operations?	excellent	good	neutral	fair	poor	none
611	To what extent did the training raise your comfort level with accurately documenting medical records on a detainee?	excellent	good	neutral	fair	poor	none
612	To what extent did the training raise your comfort level with medical reporting of detainee abuse?	excellent	good	neutral	fair	poor	none
613	Did the training you received conflict with any previous ethical or Law of War training you received?	Y	N	Unk	NA		
614	If Yes to # 613, how did it conflict?						
615	What would you suggest to make the training better?						

Chapter 25 - Exhibit C, Annex 9  
JRTC Questionnaire

JRTC QUESTIONNAIRE

Date:

POC Name:

POC Duty Position:

POC Telephone #:

POC Email:

TQ Num	Question				
501	Are the units provided scenarios pertaining to the medical needs of detainees?	Y	N	U	NA
	At what level do the medical scenarios address detainee care (circle all that apply)?				
502	Level 1 (e.g., MP units, medical companies)	Y	N	U	NA
503	Level 2 (e.g., medical support battalions, FSTs, CSC units)	Y	N	U	NA
504	Level 3 (e.g., combat support hospitals)	Y	N	U	NA
505	Do you evaluate medical ethics training as it relates to the care of detainees?	Y	N	U	NA
506	If Yes to #506, at the theater policy level?	Y	N	U	NA
507	If Yes, to #506, at the unit policy level?	Y	N	U	NA
508	If Yes, to #506, at the unit compliance level?	Y	N	U	NA
509	Do you evaluate Law of War as it relates to medical care of detainees?	Y	N	U	NA
510	If Yes to #510, at the theater policy level?	Y	N	U	NA
511	If Yes, to #510, at the unit policy level?	Y	N	U	NA
512	If Yes, to #510, at the unit compliance level?	Y	N	U	NA

513	Do you evaluate Geneva Convention Training?	Y	N	U	NA
514	If Yes to # 514, at the theater policy level?	Y	N	U	NA
515	If Yes, to # 514, at the unit policy level?	Y	N	U	NA
516	If Yes, to # 514 , at the unit compliance level?	Y	N	U	NA
517	Is the evaluation of medical training to detainees annotated in the AAR?	Y	N	U	NA
518	Is the evaluation of medical ethics training, as it relates to medical care, annotated in the AAR?	Y	N	U	NA
519	Is the evaluation of Geneva Conventions training, as it relates to medical care, annotated in the AAR?	Y	N	U	NA
520	Is there anything else you wish to tell me?				

## **Chapter 26 – Exhibit D**

### **Summary of Recommendations**

The purpose of this Exhibit is to list all of the recommendations offered in this report. Some recommendations may be similar to others; however, all recommendations are included here.

#### **26-1. Question a. What units provided medical care to detainees in OEF and OIF and what was the period of service for each unit?**

None

#### **26-2. Question b. At what location did each unit provide medical care (e.g., MTF, detainee facility, and interrogation facility)?**

None

#### **26-3. Question c. What MOS and OBC training or other school training did the medical personnel serving in these units receive regarding the generation, storage and collection of detainee medical records and regarding the medical reporting of detainee abuse?**

##### *a. Medical Records Training*

(1) AMEDDC&S should ensure standardization of training of detainee healthcare documentation and disposition of retired detainee records across the entire healthcare spectrum in all theaters, from the point of capture and collection point to the detention facilities.

(2) Establish a team under the direction of the AMEDDC&S comprised of clinicians and PAD expertise with exceptional knowledge of the generation, storage, maintenance and collection (disposition) of detainee medical records from the point of capture and collection point to the detention facilities. The tasks and training content should be developed by this team. The AMEDDC&S should facilitate this process.

(a) The above team should analyze courses' POIs and LPs to determine training gaps in the generation, storage and collection of detainee medical records.

(b) The training should include a crosswalk of Geneva Conventions, DoD and DA regulations and policies pertaining to the generation, storage and collection of detainee medical records. Training content should be regularly revised to reflect changes in the policies.

(c) The training structure should include all levels of care, from point of capture and collection point to the detention facilities. Training should incorporate AC/RC TDA and TOE medical units and medical assets in MP and maneuver units.

(3) Create and deploy an exportable training package specific to the generation, storage and collection of detainee medical records for medical personnel in AC/RC TDA and TOE medical units. Medical assets assigned to AC/RC MP and maneuver units should receive the training package.

(4) PAD officers and senior PAD specialists should serve as the subject matter experts and training resource for AC/RC level II and III units. The PA or senior 91W should serve as the training resource for non-medical units.

(5) Incorporate training that is focused on the generation, storage and collection of detainee medical records into the 70E and 91G courses.

(6) Expand PAD “Just-in-Time Deployment Training” course to include deploying RC 70E and 91G personnel.

(7) Develop sustainment and proficiency training for 70E and 91G personnel in AC/RC units. Training and proficiency data for 70E and 91G personnel should be competency-based and reported regularly as part of the unit’s readiness report.

*b. Detainee Abuse Training*

(1) Tools should be introduced to assist students in recalling their training; for example, a reference pocket training aid. The tool should display a decision algorithm to assist them in distinguishing actual or suspected abuse from injuries as a result of lawful combat operations.

(2) AMEDDC&S, as the proponent for training of medical personnel in detainee healthcare care (to include medical reporting of detainee abuse) across the entire healthcare spectrum in theater, from the point of capture and collection point to a detention facility should:

(a) Establish a SME team to develop the tasks and framework to build a comprehensive AMEDD training program. The framework should include all training platforms (MUIC, RTS, NTC, JRTC, and PPP) and methods of instruction (lecture, case studies, scenario, and AAR). The framework must encompass all levels of care, from point of capture to a detention facility. The framework must serve as an additional resource for TOE medical units and TDA facilities as part of the readiness component.

(b) SME Team membership should include appropriate representation from the RC and should have exceptional knowledge of detainee care at the point of capture, collection point and detention facilities. Additionally, the team should be comprised of a judge advocate, a medical ethicist, and SMEs serving in the prison health care system. The tasks and training content should be standardized particularly in the professional development and MOS specific courses.

(c) MOS-specific schools and professional development courses should incorporate case studies and scenario-based training on current Army operations. Training Centers, such as NTC and JRTC, should be provided with the means to provide realistic level I to level III detainee medical care training.

(d) Consider using regularly scheduled video teleconferences with 91W, 91WM6 students and Soldiers that experienced detainee care from the point of capture, collection point or detention facility to enhance learning followed with a Q and A format.

(e) Revise the existing exportable training package to include all tasks associated with detainee care. Incorporate selected incidents and allegations to serve as case studies or scenario play. The AMEDDC&S should facilitate development of the training package and push the products out.

(3) MEDCOM should provide all medical senior leaders (AC/RC) detention care policies, regulations and references which could be accessed through the AKO site. MEDCOM should continually update AKO so that evolving guidance, tools and references are current. The following criteria and content (not all inclusive) should be considered:

(a) Theater accessible.

(b) Approved for continuing education credit.

(c) Approved detention care competency tools.

(d) DoD detention care guidance.

(e) DA guidance relating to detention care.

(f) "Health Professional's Guide to Medical and Psychological Evaluation of Torture by Physician for Human Rights" as an example (Cit. 38).

(4) DoD-I 1322.24, Medical Readiness Training, 12 July 2002, (Cit. 21) should include detention care competencies. Competencies should be developed by SMEs possessing exceptional knowledge of detainee care at the point of capture, collection point and detention facilities and the prison health care system.



**26-4. Question d. Was there any policy guidance, OPORDER, SOP, or other authority establishing criteria for providing detainee medical support and/or care in the theater of operation?**

a. Although not required by law, DA guidance (DoD level is preferable) should standardize detainee medical operations for all theaters, should clearly establish that all detained individuals are treated to the same care standards as U.S. patients in the theater of operation, and require that all medical personnel are trained on this policy and evaluated for competency. Specific areas of guidance should include, but are not limited to:

- (1) Initial and continual screening assessments
- (2) Medical care equal to standards for U.S. Soldiers in the theater of operation
- (3) Informed consent
- (4) Protection of detainee medical information
- (5) Documentation in and handling of medical records
- (6) Recognition, documentation, and reporting of suspected abuses
- (7) Planning factors for medical resources required for detainee care

b. All medical personnel must be trained on this guidance, with follow-up assessment of competency.

c. Policies concerning detainee medical operations should be declassified to the greatest extent possible to allow for the widest application of recommendation (a) above.

d. Classified policies should be archived on secure command web pages as they are updated or as new ones are added, since this will allow one to evaluate policy implementation timelines.

e. Units having theater-level responsibilities (for example (b)(2)-2), should propagate DA or DoD guidance, with particular emphasis on units delivering level I or II care in their AOR.

**26-5. Question e. What unit training did the active component receive prior to deployment regarding the generation, storage and collection of detainee medical records and the medical reporting of detainee abuse?**

a. Leaders at all levels should conduct meaningful training and verify by following up with an assessment via a competency test, regardless of the unit's deployment status.

This training should be documented and archived. Training should be pertinent to and specifically address standard of care and the generation, storage and collection of detainee medical records as well as recognizing and reporting detainee abuse.

b. Specific standardized training requirements should be given to all medical units, AC/RC prior to deploying to a theater of operation. Particular attention needs to be given to the training guidance given by the AMEDD to medical personnel assigned to level I and level II medical units.

c. All medical units should assume they will have a detainee healthcare mission when deploying and identify it as a METL-training requirement.

d. Develop pre-designated medical units specifically identified to serve in detention facility roles in future operations. These units can tailor their training, both pre-deployment/pre-mobilization, as well as during deployment/mobilization, to this mission. Training should also focus on security procedures for medical personnel treating detainees and the physical and psychological stresses involved in detainee care.

**26-6. Question f. What training did reserve component soldiers receive at home station, power projection platforms and in-theater regarding the generation, storage and collection of detainee medical records and the medical reporting of detainee abuse?**

Same as 26-5 (Question e).

**22-7. Question g. Identify OEF and OIF detention medical facilities.**

None

**26-8. Question h. With respect to the detention medical facilities identified in subparagraph 2g immediately above, determine if the facility generated, stored and collected detainee medical records, to include records documenting medical support to any detainee being prepared for interrogation, being interrogated, or needing medical treatment as a result of, or immediately after, interrogation.**

a. Authorize medical personnel to halt any interrogation or interrogation technique if the detainee's health or welfare is endangered.

b. Require interrogations to stop immediately if a detainee requires any medical treatment during the interrogation.

c. Authorize medical personnel to perform pre- and/or post-interrogation medical evaluations at their discretion.

d. Require pre- and/or post- interrogation medical evaluations be performed upon the request of an interrogator.

e. Require all pre-, during, and post-interrogation medical care to be documented and included in the detainee medical records.

f. Describe the process for documenting medical care delivered during or due to an interrogation.

g. Describe the process to report and document in the medical record suspected abuse.

h. Require medical personnel to be trained on the above recommendations, with follow-up assessment of competency to measure the effectiveness of training.

**26-9. Question i. With respect to those detention facilities that kept medical records, did medical personnel properly generate, store and collect appropriate medical records of detainees?**

a. *DA guidance (DoD level is preferable) should:*

(1) Require that detainee medical records at facilities that deliver level III and higher care be generated in the same manner as records of U.S. patients in theater.

(2) Address the appropriate location and duration of maintenance as well as the final disposition of detainee medical records at facilities that deliver level III or higher care.

(3) Define appropriate generation, maintenance, storage, and final disposition of detainee medical records at units that deliver level I and II care.

(4) Address the need for uniform documentation, to include accurate identification of all individuals entering information into all detainee medical records.

(5) Clearly outline the rules for access to detainee medical records and provision of medical information to non-health care providers. The guidance should only permit release of detainee medical information to interrogators when needed to ensure the health and welfare of the detainee.

(6) Training of medical personnel. All medical personnel should be trained on the above and evaluated for competency.

b. *DA guidance (DoD level is preferable) should:*

(1) Define who has access to detainee medical information and under what circumstances.

(2) Require that all military personnel are trained on this policy and evaluated for competency.

**26-10. Question j. With respect to those detention facilities that kept detainee medical records, identify the location where the original and any copies of the records are maintained.**

See 26-9 (Question i).

**26-11. Question k. Were any medical personnel aware of, or treat injuries related to, actual or suspected detainee abuse?**

a. A DA definition of detainee abuse should be adopted (a DoD definition is preferable).

b. At all levels of professional training medical personnel should receive instruction on the definition of detainee abuse and the requirement to document and report actual or suspected detainee abuse.

c. Pocket cards be developed and distributed to all deploying medical personnel with "Medical Rules of Engagement" on the front and a training aid on detainee abuse on the back.

**26-12. Question l. Did any medical personnel aware of, or who treated actual or suspected detainee abuse properly document the abuse?**

a. A DA definition of detainee abuse be adopted (a DoD level definition is preferable).

b. A DA standard requiring actual, alleged or suspected abuse be documented in a detainee's medical record (a DoD level standard is preferable). The standard should require:

(1) Documentation of actual, alleged or suspected abuse in the detainee's medical record.

(2) The medical provider's opinion if the medical evidence supports actual, alleged or suspected abuse; and

(3) The action taken by medical personnel:

(a) If the medical evidence fails to support the alleged abuse this fact should be noted in the detainee's medical record.

(b) If the medical evidence is consistent with abuse, or is inconclusive, medical personnel must report the alleged or suspected abuse to the hospital/MTF commander

(MEDCOM SJA Information Paper-Health Care Professional Detainee Reporting Requirements-8 Sep 04) (Cit. 31).

(c) A notation in the detainee's medical record that a report was made, when, and to whom.

c. A DA standard detainee medical screening form should be developed and fielded (a DoD level standard is preferable).

**26-13. Question m. To whom did any medical personnel aware of, or who treated, detainee abuse, report such abuse?**

a. At all levels of professional training, medical personnel should receive instruction on the requirement to document and report actual or suspected detainee abuse. This training should include the definition and signs of actual or suspected detainee abuse.

b. Scenario-based training on detecting detainee abuse should be developed and fielded at all PPPs, MUICs, and reserve medical training sites. All deploying medical personnel should receive this training prior to arrival in theater.

c. All deploying medical personnel, prior to arrival in theater, should receive refresher training on the requirements and procedures to document and report actual or suspected detainee abuse.

d. All individual and collective training for medical personnel (such as NTC, JRTC, Warfighters, and FTXs) should include reinforcing training on recognizing and reporting actual or suspected detainee abuse.

e. Follow-on competency evaluations should be incorporated into all training guidance and plans.

**26-14. Question n. Were there any theater or unit policies or established SOPs/TTPs that specifically required medical personnel to report detainee abuse?**

a. Clearly written standardized policies for documenting and reporting actual or suspected detainee abuse should exist at all levels of command (DoD, Army, Combatant Command, theater, and individual subordinate units). These policies must then receive command emphasis on a continuing basis.

b. Medical planners at all levels should ensure clearly written standardized guidance is provided to medical personnel. This guidance should list possible indicators of abuse and contain concise instruction on how, and to whom medical personnel should document and report actual or suspected abuse.

c. Develop DA level guidance (DoD level is preferable) on the procedures for processing allegations of abuse not supported by medical evidence. This guidance should contain clear instructions on how medical personnel should properly document allegations of abuse that are not further reported based on lack of medical evidence.

## **26-15. Other Issues**

### *a. Overview of Site Visits to Afghanistan (OEF), Cuba (GTMO), and Iraq (OIF)*

(1) CFLCC guidance, regulations, and standards in relation to detainee healthcare, to OEF and OIF theaters, should be standard across the AOR, consistent with DoD guidance, and disseminated to the lowest levels.

(2) Prior to the onset of operations, combat or humanitarian, dedicated translators must be embedded within level III healthcare units, for use by medical assets only.

(3) OIF medical commanders should ensure medical assets are in place, and have a viable system to replenish them when necessary, at level I or II facilities that have significant detainee contact.

(4) To ensure that medical information is protected, translators assisting medical personnel with detainee care should not assist interrogators who question the same detainees.

### *b. OIF Theater Preparation for Detainee Care*

(1) The AMEDD should establish an experienced SME team to:

(a) Comprehensively define the personnel, equipment and supply needs for detainee operations.

(b) Develop a method to ensure a flexible delivery system for these special resources to the appropriate levels of care and for the entire timeline of future military operations.

(2) Military planners need to assume that there is a high likelihood for detainee operations in all future conflicts and must allocate resources for detainee medical care in the planning process.

### *c. Medical Screening and Sick Call at the DIFs and Prisons*

(1) DA guidance (DoD level is preferable) should require:

(a) Initial medical screening examinations upon inprocessing to a detention facility.

(b) Daily access to medical care for all detainees.

(2) All military personnel must be trained on the above policy and demonstrate competency.

d. *Restraints/Security*

(1) DA (DoD level is preferable) should standardize the use of restraints for detainees in units delivering medical care. The guidance should contain clear rules for security-based restraint versus medically-based restraint. Medical personnel must be trained on this guidance, with follow-up competency evaluations.

(2) Use of restraints on any patient should be appropriately documented in the medical record.

(3) All facilities providing level II or III care should be appropriately supplemented with MPs dedicated to provide detainee security.

e. *Medical Personnel Interactions with Interrogators*

(1) DA guidance (DoD level is preferable) should:

(a) Prohibit all medical personnel from participating in interrogations.<sup>1</sup> This includes medical personnel with specialized language skills serving as translators.

(b) Empower medical personnel to halt interrogations when any examination or treatment is required.

(2) All military personnel should be trained on the above recommendations.

(3) Scenario training is highly recommended.

(4) Follow-on competency evaluations should be incorporated into all training guidance and plans.

e. *Medical Personnel Photographing Detainees*

(1) DA guidance (DoD level is preferable) should:

<sup>1</sup> For purposes of this recommendation the term "participating in interrogations" refers to the active participation by medical personnel during an interrogation. For example, asking questions would be active participation. Medical personnel who assist in developing the plan of interrogation are not deemed to be "participating in an interrogation." Likewise, actual presence in the interrogation room may not constitute "participating in an interrogation." For example, personal observation by medical personnel to ensure the health and welfare of the detainee is not deemed to be "participation in the interrogation."

(a) Authorize photographing detainee patients for the exclusive purpose of including these photos in medical records, and not require informed consent for photographs used in this manner (consistent with AR 40-66).

(b) Mandate that photographs of detainees taken by medical personnel for other reasons, including future personal education material, research, or unit logs, must first have informed consent from the detainee.

(2) Guidance for the above should be included in AR 190-8, which is currently under revision.

*e. The Use of Behavioral Science Consultation Teams (BSCT) in the Interrogation Process*

(1) DoD develop well-defined doctrine and policy for the use of BSCT.

(2) DA, (preferably DoD) policy should permit only BSCT personnel to participate in interrogation planning.

(3) Psychiatrists/physicians should not be used in a BSCT role.

(4) All psychologists and behavioral health technicians serving in BSCT positions should receive structured training on the roles and responsibilities while functioning in this capacity.

(5) MI personnel should clearly understand the defined roles, responsibilities and limitations of behavioral health personnel serving in a BSCT position.

(6) All psychologists utilized as BSCT members should be senior, experienced personnel.

*g. Stress on Medical Personnel Providing Detainee Medical Care*

(1) MEDCOM should establish an experienced SME Team comprised of a psychiatrist, a psychologist, clinical representation from all levels of care and include representation from a Chaplain. The team should:

(a) Comprehensively define the training requirements for medical personnel for inclusion into their pre-deployment preparation.

(b) Consider revising CSC doctrine to effectively deliver support to medical personnel in theater.

(c) Develop an effective system to regularly monitor post deployment stress.



(d) Refine leadership competencies to assess, monitor and identify coping strategies of medical personnel in a warfare environment.

(2) AMEDDC&S should develop the training content defined by the above team. The above team should approve the content. The training (not all inclusive) should include ethical dilemmas medical personnel face and the emotional aspects in providing care to insurgents and detainees.

(3) MEDCOM should assure post deployment mental health assessment of medical personnel and provide follow-up care.

## **26-16. Non-AMEDD Training**

a. *Joint Readiness Training Center (JRTC)* (recommendations offered by JRTC personnel, not the Team)

(1) Establish a SME team comprised of expertise from clinicians to develop the tasks and framework to formalize the training program. The framework should encompass all levels of care, from point of capture to care in the detention facility.

(2) The above team should assess the current training, specifically the scenarios to determine training deficiencies and determine the best practices in improving the quality of training as it relates to detainee medical care.

(3) Since AMEDD personnel must be prepared to provide care across the entire healthcare spectrum in theater, from the point of capture and collection point to the prison facilities, the training content should be developed by medical personnel with exceptional knowledge of detainee care. Additionally, the team should be comprised of representation from JAG, a medical ethicist, and subject matter experts serving in the prison health care system. The team members should develop the content and the JRTC medical OCs should facilitate.

(4) Team membership should include representation from the NG and USAR personnel that served in these facilities as well as the active component.

(5) The training should include a crosswalk of DoD and DA regulations and policies pertaining to detainee medical care. Training content should be revised regularly to reflect changes in the policies.

(6) Define competencies for OCs. Ensure OCs are from every component.

b. *National Training Center (NTC)* (recommendations offered by NTC personnel, not the Team)

(1) Add a detainee medical operations specific task to the EFMB task list.

(2) Add detainee medical operations into CLS training – the true first interface between the fighting force medical provider and the detainee.

(3) Commanders need to incorporate detainee medical operations into the METL.

*c. Power Projection Platforms (PPPs)*

(1) PPPs need to ensure medical personnel deploying are able to use their time at the training site to prepare for their upcoming mission. They should not be tasked with non-training missions (such as providing routine medical care) unless a quantifiable training effect can be assessed from such medical care.

(2) PPPs need to make their training “theater-specific” to ensure Soldiers processing through are adequately informed of any unique theater challenges or dangers.

(3) Geneva Convention/Law of War training needs to be improved upon by reflecting current rules of engagement and ethical challenges facing Soldiers. Emphasis needs to be placed on reporting suspected or actual abuse.

(4) Units should still bear the responsibility of training Soldiers on detainee medical records.

*d. CONUS Replacement Centers (CRC)*

(1) CRCs need to look at opportunities to expand current detainee operations training to include more comprehensive teachings on reporting suspected or actual detainee abuse.

(2) Geneva Convention/Law of War training needs to be improved upon by reflecting current rules of engagement and ethical challenges facing Soldiers and use a scenario based component to enhance learning modalities. It needs to emphasize reporting suspected or actual abuse

(3) Units should still bear the responsibility of training Soldiers on detainee medical records.

*e. Military Intelligence*

DA, or preferably DoD, should exercise oversight in the revision of current interrogation training doctrine to ensure compatibility with the Geneva Conventions, the Law of War, and all policies that apply to medical personnel.

## Chapter 27 – Exhibit E

### References Reviewed by the Medical Functional Assessment Team

Reference
<b>ACLU DOCUMENTS</b>
CID Responsive Documents to ACLU Request
CID ACLU DOC Index Spreadsheet
CSD ACLU DOC Index Spreadsheet
MEDCOM Consolidated ACLU DOC Index Spreadsheet
PASBA ACLU DOC Index Spreadsheet (OEF_OIF Internees)
Proponency Office ACLU DOC Index Spreadsheet
<b>POLICY &amp; REGULATORY</b>
AFI 41-210 Patient Administration
AR 40-3 Medical, Dental, and Veterinary Care – 12 Nov 02
AR 40-5 Preventive Medicine – 15 Oct 90
AR 40-66 Medical Record Administration and Health Care Documentation – 20 Jul 04
AR 40-400 Patient Administration – 12 Mar 01
AR 190-8 Enemy Prisoner of War, Retained Personnel, Civilian Internees, and other Detainees – 1 Oct 97
AR 190-47 The Army Corrections System – 5 Apr 04
AR 350-1 Army Training & Education – 9 Apr 03
CJCSI 3290.01A Program for Enemy Prisoners of War, Retained Personnel, Civilian Internees, and Other Detained Personnel – 15 Oct 00
CJCSI 5810.01B Implementation of the DoD Law of War Program – 25 Mar 02
DA PAM 27-1 Treaties Governing Land Warfare – 7 Dec 56
DA PAM 27-24 Selected International Agreements, Volume II – 1 Dec 76
DoD Directive 2310.1 DoD Enemy POW Detainee Program – 18 Aug 94
DoD Directive 5100.77 DoD Law of War Program – 9 Dec 98
DoD Instruction 1322.24 Medical Readiness Training – 12 Jul 02
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FM 3-19.1 (FM 19-1) Military Police Operations – 22 Mar 01
FM 3-19.40 (FM 19-40) Military Police Internment Resettlement Operations – 1 Aug 01
FM 4-02 (FM 8-10) Force Health Protection in a Global Environment – 13 Feb 03
FM 4-02.4 (FM 8-10-4) Medical Platoon Leaders' Handbook – 24 Aug 01
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Protocol (Protocol 1), Additional to the Geneva Conventions of 12 August 49, and relating to the Protection of Victims of International Armed Conflicts - Adopted 8 Jun 77
Hague Convention, Convention Respecting the Laws and Customs of War on Land – 18 Oct 1907
JP 3 Doctrine for Joint Operations – 10 Sep 01
JP 3-63 Joint Doctrine for Detainee Operations - Final Coordination Draft – 23 Mar 05
JP 4-06 Joint Tactics, Techniques, and Procedures for Mortuary Affairs in Joint Operations – 28 Aug 96
NAVMED P-117 Manual of the Medical Department, 23 Nov 94 – Reprinted 96
18 U.S.C. § 2441. War Crimes Act of 1996 (As Amended)
<b>PUBLIC DOMAIN</b>
American Medical Association's <u>Code of Medical Ethics</u> - 2002/2003 version
Borden Institutes' Books <u>Military Medical Ethics</u> - Volumes I & 2 - 2003
Vice Adm. Church's Comprehensive Review of Department of Defense (DoD) Interrogation Operations (Complete Report and Executive Summary)
Department of the Army Inspector General's (DAIG) Detainee Operations Inspection Report - 21 Jul 04
DoD Book <u>Emergency War Surgery</u> , 3rd Ed, 2004
MG Fay and LTG Jones Article 15-6 Investigation of the Abu Ghraib Prison and 205th Military Intelligence Brigade – Feb 04
International Committee of the Red Cross (ICRC) Report 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 - Feb 04
International Corrections and Prisons Association's (ICPA) Book <u>Practical Guidelines For the Establishment of Correctional Services Within United Nations Peace Operations</u> - 01
BG Jacoby's Review of Detainee Operations and Facilities in Afghanistan – 26 July 04
Judge Advocate General's School Operational Law Handbook - 02
Judge Advocate General's School Law of War Workshop Deskbook - 00
MG Ryder's Assessment of Detention and Corrections Operations in Iraq – 6 Nov 03
Mr. Schlesinger's DoD Detention Operations Final Report – Aug 04
MG Taguba's Administrative Investigation of Alleged Detainee Abuse by the 800th Military Police Brigade, 24 JAN -9 Mar 04.
MEDCOM [Patient Administration Systems & Biostatistics Activity's (PASBA)] Memorandum "Deployment Medical Documentation Guidance/Reporting Requirements" – 12 Mar 04
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Physician's for Human Rights' 2002 Publication of "Dual Loyalty & Human Rights In Health Professional Practice; Proposed Guidelines & Institutional Mechanisms"
United Nations Publication of "Standard Minimum Rules for the Treatment of Prisoners' 13 May 77
United Nations Publication of "Principles of Medical Ethics Relevant to the Role of Healthcare Personnel, Particularly Physicians, in the Protection of Prisoners and Detainees Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment" – 18 Dec 82

United Nations Publication of "Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment" – 9 Dec 88
United Nations High Commissioner for Human Rights' Publication of "The Istanbul Protocol - Manual on the Effective Investigation and Documentation of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment" - 9 Aug 99
White House Press Release "President Issues Military Order – Detention, Treatment, and Trial of Certain Non-Citizens in the War Against Terrorism" – 13 Nov 01
White House Presidential Order Number 499 "Humane Treatment of Al Qaeda and Taliban Detainees" – 7 Feb 02
World Medical Association's (WMA) "Resolution on the Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel or Inhuman or Degrading Treatment of Which They Are Aware" – Sep 03
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Miami Herald (Dodds) "Sexual Tactics Debased Detainees, Translator Says" - 28 Jan 05
NEJM (Lifton) "Human Rights -Doctors and Torture" – 29 Jul 04
NEJM (Comments to Editor – including DoD response) RE: "Doctors and Torture" – 7 Oct 04
NEJM (Gawande) "Casualties of War - Military Care for the Wounded from Iraq and Afghanistan" – 9 Dec 04
NEJM (Peoples, Jezior, Shriver) "Caring for the Wounded in Iraq – A Photo Essay" – 9 Dec 04
NEJM (Bloche & Marks) "When Doctors Go to War" – 6 Jan 05
New York Times (Zernike) "Only a Few Spoke Up on Abuse as Many Soldiers Stayed Silent" – 22 May 04
New York Times (Lewis) "Red Cross Finds Detainee Abuse In Guantanamo" – 30 Nov 04

New York Times (Bloche & Marks) "Triage At Abu Ghraib" – 4 Feb 05
New York Times (Schmitt) "New Interrogation Rules Set For Detainees In Iraq" 10 Mar 05
OSD PAO Transcript of Church Briefing on Detention Operations and Interrogation Techniques – 10 Mar 05
Seattle P.I. (AP) "Red Cross Sees Problems at Guantanamo" - 30 Nov 04
Stars and Stripes (Coon) "Task Force Oasis brings medicine to Abu Ghraib" – 6 Jun 04
Time Magazine (Zagorin) "The Abu Ghraib Scandal You Don't Know" – 14 Feb 05
USA Today (Squitieri & Moniz) "U.S. Army re-examines deaths of Iraqi prisoners" – 28 Jun 04
Washington Post (Slevin) "Detainees Medical Files Shared: Guantanamo Interrogators Access Criticized" -10 Jun 04
Washington Post (Eggen & Smith) "FBI Agents Allege Abuse of Detainees at Guantanamo" - 21 Dec 04
Washington Post (Smith & Eggen) "Justice Expands 'Torture' Definition" - 31 Dec 04
Washington Post (Reuters Report) "CIA is Ordered to Release Detainee Abuse Files" – 3 Feb 05
Washington Post (Xenakis) Letter to Editor "From Medics, Unhealthy Silence"- 6 Feb 05
Washington Post (Kiley) Response to Xenakis "A Healthy Silence" 10 Feb 05
Washington Post (Leonnig & Priest) "Detainees Accuse Female Interrogators" – 10 Feb 05
Washington Post (Graham) "Prisoner Uprising In Iraq Exposes New Risk for U.S." - 21 Feb 05
Washington Post (Smith & White) "Soldier Who Reported Abuse Was Sent to Psychiatrist" – 5 Mar 05
Washington Post (White & Smith) "Low-Level Leaders and Confusion Blamed" – 10 Mar 05
Washington Post (White & Graham) "Senators Question Absence of Blame in Abuse Report" – 11 Mar 05
Washington Post (Web Post) "Conditions at Guantanamo Bay: Defense Dept. Documents Detail Red Cross Comments on Detainee Treatment and Actions Taken in Response" – 18 Jun 04
Washington Post "A Guantanamo Timeline" – 4 Jan 05
Weekly Standard (MacDonald) "Torturing The Evidence The truth about the doctors at Guantanamo" – 24 Jan 05
World Socialist Web Site (Randall) "Bush's 'Torture Inc.' at Guantanamo" – 2 Dec 04
<b>TESTIMONY</b>
HASC Hearing on Iraqi Prisoner Abuse – 7 May 04
SASC Hearing on Iraqi Prisoner Abuse –7 May 04
SASC Hearing on Iraqi Prisoner Abuse – Morning of 11 May 04
SASC Hearing on Iraqi Prisoner Abuse – Afternoon 11 May 04
SASC Hearing on Iraqi Prisoner Abuse –19 May 04
<b>TEAM RELATED</b>
Appointment as Team Leader, Functional Assessment Team – 12 Nov 2004
Appointment of Members to Functional Assessment Team – 30 Nov 2004
CO[ <sup>(b)(6)</sup> -2] Email Traffic "Mission and Objectives of the Behavioral Science Consultation

Team (BSCT)" With COL (b)(6)-2	- 21 Dec 04
COL (b)(6)-2	Email Traffic "Notes from Meeting with (b)(6)-2 – 3 Feb 05
COL (b)(6)-2	Email Traffic "Followup Phone Call" From COL (b)(6)-2 4 Apr 05
COL (b)(6)-2	Email Traffic "Requested Lesson Plans" from Mr. (b)(6)-2 (AMEDD C&S) – 16 Dec 04
COL (b)(6)-2	Email Traffic "Exportable Training Package" to Col (b)(6)-2 (AMEDD C&S, C, Dept of Training Support) – 24 Mar 05
MAJ (b)(6)-2	Email Traffic "More Questions about the Catheter" to (b)(6)-2 – 25 Mar 05
MCJA MFR (Assessment Team Guidance) – 12 Nov 04	
MCJA Rules of Instruction for Functional Assessment Team - Undated	
Medical Legal Reference Matrix – Developed by Team 7 Apr 05	
Team Summary of 28 <sup>th</sup> CSH Medical Record Review – 29 Dec 04	
Team Summary of Autopsy Case Reviews -	
<b>NOT READILY AVAILABLE</b>	
(b)(2)-2	Detainee Handling and Detention Facility SOP - 12 Mar 04
(b)(2)-2	Detainee Packet Checklist (blank)
(b)(2)-2	Detention Facility Assessment Form (Blank)
(b)(2)-2	Post OIF Operational AAR (Undated)
(b)(2)-2	Intensive Care Unit (ICU) SOP "Care of Detainees/EPW/Non-Combatant Civilians – 30 May 03
(b)(2)-2	Memorandum " Operation Iraqi Freedom: Surgical Experience of the (b)(2)-2 20 Oct 04
(b)(2)-2	"OIF Lessons Learned" Briefing – 26 Feb 05
(b)(2)-2	Memorandum (EPW Holding Facility Monthly Inspections) - 21 Sep 04
(b)(2)-2	"Medical Rules of Eligibility" Briefing – 17Feb 05
(b)(2)-2	EPW Legal References
(b)(6)-2	JAO Information Paper (Nutritional requirements for Iraqi enemy prisoners of war) – 10 Feb 03
(b)(2)-2	JAO Information Paper (Authority to use public vehicles for transportation of EPWs) – 15 Feb 03
(b)(2)-2	JAO Information Paper (Care of dead EPWs and civilian internees) – 20 Feb 03
(b)(2)-2	JAO Information Paper (Use of Riot Control Agents against Enemy Prisoners of War) - 22 Feb 03
(b)(2)-2	JAO Information Paper (Use of Enemy Prisoners of War for Labor and Services) – 24 Feb 03
(b)(2)-2	Guidance (Use of Force for EPW Guards) (Undated)
(b)(2)-2	Enclosure 1 (Training Requirements for OIF) to FRAGO 559 (Consolidated Deployment Training Guidance) to (b)(2)-2 OPORD 03-02 (Phantom Victory)
(b)(2)-2	91WM6 Training Requirements (Undated)
(b)(2)-2	Tab G Clinical Training to (b)(2)-2 FY 05 Annual training Guidance (Undated)

(b)(2)-2	Baghdad Central Correctional Facility (BCCF) Memorandum "Standards of Conduct (Policy Letter 1)" – 3 Jun 04
(b)(2)-2	Baghdad Central Correctional Facility (BCCF) SOP 8 "SOP Scheduled Sick Call (Bison 1-4)" 3 Jun 04
(b)(2)-2	Baghdad Central Correctional Facility (BCCF) SOP 21 "SOP Scheduled Sick Call (Cougar 1-2)" 3 Jun 04
(b)(2)-2	Baghdad Central Correctional Facility (BCCF) SOP 32 "SOP Scheduled Sick Call (Cougar 3)" 3 Jun 04
(b)(2)-2	Baghdad Central Correctional Facility (BCCF) Memorandum "Policy/Procedures Exceptions in Observance of Ramadan" – 5 Oct 04
(b)(2)-2	Detention Cell SOP - 1 Oct 99
(b)(2)-2	Memorandum "Interrogation Tactics and Treatment of Detainees" (Undated)
(b)(2)-2	Attachment (Detainee Medical Screening Sheet) to (b)(2)-2
(b)(2)-2	Memorandum "Interrogation Tactics and Treatment of Detainees" (Undated)
(b)(2)-2	"Elective Surgical Case Protocol for (b)(2)-2 - 12 May 04
(b)(2)-2	Commander Memorandum "Lessons Learned: (b)(2)-2 Prison Hospital, ABG, Iraq, Feb-Jul 04" 9 Mar 05
(b)(2)-2	Commander Memorandum "Accomplishments of (b)(2)-2 Baghdad Central Detention Facility Hospital, ABG, Iraq, OIF 2" - 9 Mar 05
(b)(2)-2	Commander Memorandum "Requirements for level I Healthcare at an Army- Run Detention Facility, Formulated to Comply with AR 190-8 and the Recommendations of ICRC Visits" – 9 Mar 05
(b)(2)-2	Annex Q (Medical Services) to (b)(2)-2 (EPW/CI) TACSOP (Undated)
	AMEDD IPT Detainee Medical Care/Information Process Charter – 17 Jun 04
	AMEDD IPT Detainee Medical Care Final Report to Deputy Surgeon General of the Army – 21 Jul 04
	AMEDD IPT Detainee Medical Care Dissenting email from Mr (b)(6)-2 - 14 Jul 04
	AMEDD IPT Detainee Medical Care Dissenting email from COL (b)(6)-2 (b)(6)-2 20 Jul 04
	AMEDD IPT Detainee Medical Care Draft OTSG/MEDCOM Policy Memo xx-xxx – "Medical care of detainees, prisoners of war, internees, and retained personnel" – XX Jul 04
	AMEDD IPT Detainee Medical Care Briefing 22 Oct 04 Version 2
	Baghdad Central Correctional Facility (b)(2)-2 Detainee Suicide Prevention Plan (Undated)
	Baghdad Central Detention Facility Point Paper "Military Health Support to a Military Detention Facility" – 25 Jan 04
	Baghdad Central Detention Facility Hospital "Internee Health Care" – 27 Jan 04
	Baghdad Central Detention Facility Hospital "Medical Processing Briefing" (Undated)
	Baghdad Central Detention Facility Hospital Layout and Task organization (Undated)
	Baghdad Central Detention Facility Hospital Memorandum "Restraints" - Feb 04



	Baghdad Central Detention Facility Hospital Memorandum "Care of Detainees" - Feb 04
	Baghdad Central Detention Facility Hospital Memorandum "Management and Evaluation of Suspected Sexual Assault Victims" - Mar 04
	Baghdad Central Detention Facility Hospital Memorandum "Suspected / Alleged Assault or Abuse" - Apr 04/Rev/Jun 04
	Baghdad Central Detention Facility Hospital Memorandum " Family Visitation & Detainee Mail" - 13 Jun 04
	Baghdad Central Detention Facility Hospital Memorandum "Patient Death" (Ver 1 - Apr 04)
	Baghdad Central Detention Facility Hospital Memorandum "Patient Death" (Ver 2 Rev/Jun 04)
	Camp Bucca, Iraq SOP (b)(2)-2 (EPW/CI)) - 1 Jun 04
	Camp Bucca Internment Facility Dental Clinic SOP (b)(2)-2 - Mar 05
	Central Air Force Command's "Concept of Operations for Detainee Health Team in Support of Military Intelligence Interrogation Operations" – 23 Jan 04
	CFLCC Medical Rules Of Care - 12 Jan 03
(b)(2)-2	Policy Memorandum #12 – Medical Rules of Eligibility" Detainee Operations (Undated)
(b)(2)-2	CG Policy Memorandum 18 – Proper Conduct During Combat Operations – 4 Mar 04
(b)(2)-2	JA Information Paper - Scope of Medical Care Required for Security Detainees - 2 May 04
(b)(2)-2	JA Information Paper - Minimum Standards of Treatment Applied to Security Internees - 7 May 04
(b)(2)-2	Prisoner Health Patient Records
(b)(2)-2	Bagram Holding Area (BHA) and Kandahar Holding Area (KHA) Detainee Medical Standing Operating Procedure (SOP) MFR - 14 Aug 04
(b)(2)-2	Bagram Holding Area SOP - 29 Sep 04
	Annex W-1 (Medical) to (b)(2)-2 Bagram Holding Area SOP
	Annex W-2 (Medical) – Guarding and Transferring PUCs Under the Care of The BHA Physician to (b)(2)-2 Bagram Holding Area SOP
	CSA Correspondence - Army Detainee Operations & Detainee-Interrogation Operations Integration - 17 Sep 04
	CSA Correspondence – Appendices to Annex B Army Detainee Operations & Detainee-Interrogation Operations Integration Plan(Synch Matrix) v2.0 7 Oct 04
	DoD Policy Memorandum on Medical Care for Enemy Persons Under U.S. Control Detained in Conjunction with Operation Enduring Freedom - 10 Apr 02
	DoD Policy Memorandum on Procedures for Investigation into Deaths of Detainees in the Custody of the Armed Forces of the United States - 9 Jun 04
	DOJ (FOUO) Memorandum on the Legal Standards Applicable under 18 United States Code, Statutes 2340-2340A (Standards of Conduct for Interrogation) – 30 Dec 04
	GTMO - Behavioral Science Consultation Team Joint Intelligence Group, (b)(2)-2
(b)(2)-2	SOP - 28 Mar 05 – Redacted Document
	GTMO Memorandum "Operational Policy Memorandum 14 "Behavioral Science Consultation Team" – 10 Dec 04

	GTMO Detainee Hospital SOP 010 - Medication Dispensing Policy - 18 Jan 04
	GTMO Detainee Hospital SOP 011 Out-Processing Procedures - 21 Mar 03
	GTMO Detainee Hospital SOP 014 Detainee Weight Management and Nutrition Program - 21 Mar 03
	GTMO Detainee Hospital SOP 015 Mental Health Services to Detainees - 1 Feb 04
	GTMO Detainee Hospital SOP 017 Detainee Medical Transports - 9 Mar 04
	GTMO Detainee Hospital SOP 021 Infection Control (Undated)
	GTMO Detainee Hospital SOP 029 Nursing - 3 Oct 03
	GTMO Detainee Hospital SOP 034 Medical department Training (Undated)
	GTMO Detainee Hospital SOP 035 Guidelines for Role of Independent Duty Corpsmen - 4 Mar 03
	GTMO Detainee Hospital SOP 036 Guidelines for Role of Physician Assistants - 4 Mar 03
	GTMO Detainee Hospital SOP 050 Detainee refusal of Care - 7 Aug 03
	GTMO Detainee Hospital SOP 060 Cardiac Arrest Procedures at Camp Delta - Apr 04
	GTMO Detainee Hospital SOP 061 Block Nurse (Undated)
	GTMO Detainee Hospital SOP 068 Emergency Medical Treatment SOP - May 04
	Joint Interrogation & Debriefing Center (JDIC) Briefing " Abu Ghayb, Iraq" (Undated)
	OSD-DA (FOUO) Detainee Medical Policy Briefing - Nov 04
	OSD (FOUO) Memorandum Addressing the DOJ Memorandum on the US Statute Implementing the Convention Against Torture - 27 Jan 05
	SECDEF DEPUTY Policy Statement and Guidelines on Body Cavity Searches and Exams for Detainees Under DoD Control - 12 Jan 05
	SECDEF Policy Memorandum on Handling of Reports from the International Committee of the Red Cross - 14 Jul 04
	MEDCOM SJA Information Paper - Health Care Professional Detainee Abuse Reporting Requirements - 8 Sep 04
	MNC-I Completed Technical Assist Visit Inspection of CP BIAP (Undated)
	MNC-I Completed Technical Assist Visit Inspection of CP Victory - 10 Sep 04
	MNC-I Completed Technical Assist Visit Inspection of CP Grey Wolf - 12 Sep 04
	MNC-I Completed Technical Assist Visit Inspection of CP Curevo - 17 Sep 04
	MNC-I Completed Technical Assist Visit Inspection of CP Renegade - 6 Oct 04
	MNC-I Completed Technical Assist Visit Inspection of CP Caldwell - 7 Oct 04
	MNC-IJA Information Paper "Scope of Medical Care for Security Detainees"- 29 Sep 04
	MNF-I Surgeon's Information Brief (Mar-Apr 05
	MNF-I (FOUO) Policy XX-YY (Detention Operations) - - 24 Jan 05
	MNF-I Policy (Provision of Healthcare to Detainees) - 17 Feb 05
	MNF-I SOP (Detainee Healthcare) - 21 Feb 05
	MNF-I SOP (Tuberculosis Policy and Procedures) - 25 Feb 05
	MNF-I SOP for Ensuring Separation of Detention Operations Functions (Healthcare, Interrogation Operations, and Custody and Control) - 12 Feb 05
	MNF-I & MNC-I (FOUO) Detention Center Technical Assistance Visit Checklist (blank)
	MNF-I Surgeon's 30 Day Assessment (Medical) for Feb 05 - 23 Feb 05
(b)(2)-2	Policy (Care of Iraqi Civilians at (b)(2)-2 FOB Abu Ghraib) - 25 Oct 04
(b)(2)-2	Mental Health Evaluations Policy - 1 Sep 04

(b)(2)-2	Mental Health Appraisal Policy – 1 Sep 04
(b)(2)-2	Mental Health Screening Policy – 15 Jan 05
(b)(2)-2	Detainee Mental Health Screening Checklist (English & Arabic)
(b)(2)-2	OIF Theater Detention Healthcare Policy - plus appendices - Jan 05
	Appendix 1(Theater Policy Regarding the Physical Examination of Detainees) to OIF Theater Detention Healthcare Policy
	Appendix 2 (Patient Right's, Rules, and Responsibilities – English and Arabic) to OIF Theater Detainee Healthcare Policy
	Appendix 3 (b)(2)-2 Detainee Operations "Standard Operating Procedures for Ensuring Separation of Detention Operation Functions (Healthcare, Interrogation Operations, and Custody and Control)" - 12 Feb 05
	Appendix 4 (Medical In-Processing of Security Detainees) to OIF Theater Detention Healthcare Policy
	Enclosure - DETAINEE HEALTH AND MEDICAL RECORD OF quality assurance screen (SF600 overprint , ver 1.1, IAW AR 190-8) to Appendix 4 (Medical In-Processing of Security Detainees) to OIF Theater Detention Healthcare Policy
	Enclosure - DETAINEE HEALTH AND MEDICAL RECORD OF SCREENING EXAMINATION (SF600 overprint, ver 1.4, IAW AR 190-8 to Appendix 4 (Medical In-Processing of Security Detainees) to OIF Theater Detention Healthcare Policy
	Appendix [Number not indicated] (Theater Policy Regarding the Dental In-Processing of Detainees) to the OIF Theater Detainee Healthcare Policy
	Appendix 5 (Theater Detention Facility TB SOP) to OIF Theater Detention Healthcare Policy
	Appendix 6 (Theater Policy for Detainee Patient Identification) to OIF Theater Detention Healthcare Policy
	Appendix 7 (Theater Detainee Dispensary Services) to the OIF Theater Detention Healthcare Policy
	Appendix 8 (Detainee Medication Administration Procedures) to OIF Theater Detainee Healthcare Policy
	Appendix 11 (b)(2)-2 Standing Operating Procedure - Early Release of Detainee Due to Medical Circumstances – aka Compassionate Release SOP) to OIF Theater Detainee Healthcare Policy – 7 Nov 04
	Appendix [Number not indicated] (Detainee Assault or Abuse Reporting) to OIF Theater Detention Healthcare Policy)
	Appendix [Number not indicated] (Detainee Death Standard Operating Procedure) to the OIF Theater Detention Healthcare Policy
	Appendix [Number not indicated] (Detainee Outpatient Wound Care) to OIF Theater Detention Healthcare Policy
(b)(2)-2	Mission Essential Task List (Undated)
(b)(2)-2	Poster "Tenets of Detention Healthcare" – Mar 05
(b)(2)-2	Soldier Cards "Tenets of Detention Healthcare" – Mar 05
(b)(2)-2	Detainee Operations Standard Operating Procedures for Detainee Healthcare and Medical Support to Interrogation Operations - 27 Sep 04
	USSOUTHCOM Regulation 1-20 (Human Rights Policy and Procedures) - 8 Apr 02
	USSOUTHCOM Confidentiality Policy for Interactions Between Health Care Providers

	and Enemy Persons Under U.S. Control, Detained in Conjunction with Operation Enduring Freedom - 6 Aug 02
	USSOUTHCOM Policy on Health Care Delivery to Enemy Persons Under U.S. Control at US Naval Base Guantanamo Bay, Cuba - 9 Aug 04
USSOUTHCOM (b)(2)-2	SJA Memorandum on "Initial Observations from ICRC Concerning Treatment of Detainees" – 21 Jan 02
USSOUTHCOM (b)(2)-2	SJA Memorandum on "Concerns Voiced by the International Committee for the Red Cross (ICRC) on Behalf of Detainees" – 24 Jan 02
USSOUTHCOM (b)(2)-2	SJA Minutes of ICRC Meeting – 2 Feb 04
USSOUTHCOM (b)(2)-2	SJA Memorandum for Record of ICRC Meeting Minutes – 9 Oct 03
<b>TRAINING RELATED</b>	
(b)(2)-2	"Process Enemy Prisoners of War/Civilian Internees (EPWs/CIs) at a Collection Point or Holding Area" Briefing (Undated)
(b)(2)-2	, Office of Staff Judge Advocate "Law of War" Briefing (Undated)
	HQ V United States Army FRAGO 7, Annex T (Revised Training Guidance for Forces Deploying ISO of Operation Iraqi Freedom after September 20, 2004) – 30 Sep 04.
	HQ V United States Army Appendix 1 to Annex T (Revised Training Guidance for Forces Deploying ISO of Operation Iraqi Freedom after September 20, 2004) – 30 Sep 04.
	HQ V United States Army Matrix (Individual and Collective training IAW OIF Change 3 MSG) (Undated)
(b)(2)-2	"Deployment Stress Management" Briefing (Undated)
	Air Force Judge Advocate General School's Training Session on "The Law of Armed Conflict" (Undated)
	Army Medical Department "Medical Ethics Training" Briefing (Undated)
	AMEDD Center & School, Military Law Branch "Medical Care of EPW's, Detainees, and Civilian Internees" Briefing – 4 Aug 04
	AMEDD Center & School, Patient Administration Branch "Medical Documents in Combat & Contingency Operations" Briefing – 14 Oct 04
	AMEDD Center & School Review of Institutional Training In Accordance With AR 190-8 (Undated Excel Spreadsheet)
	AMEDD Center & School (Dept of Healthcare Operations) Program of Instruction for 513-91G10 Patient Administration Specialist – 24 Apr 02
	AMEDD Center & School (Dept of Combat Medic Training) Program of Instruction for 300-91W10 Healthcare Specialist – 16 Jul 03
	AMEDD Center & School (Dept of Preventive Health Services) Program of Instruction for 302-91X10 Mental Health Specialist – 19 May 04
	AMEDD Center & School (Dept of Health Services Administration) Program of Instruction for 513-91G10 Patient Administration Specialist – 30 Nov 04
	AMEDD Center & School (Dept of Combat Medic Training) 91W PROPONENCY Pre-mobilizing Medical Refresher Training Matrix for USAR and NG units – 8 Dec 04
	Consultant to the Surgeon General for Medical Ethics' "Medical Ethics in the Combat Zone" Briefing – 17 Nov 04
	Lesson Plan - AMEDD BNCOC - Applied Ethics[WVBN039B / Version 1] 23 Jan 03

Lesson Plan - AMEDD BNCOC/Dental BNCOC - Dental Personnel in Alternate Wartime Roles [DPBN32Q0 / Version 1] - 05 Jan 04
Lesson Plan - AMEDD BNCOC - Manage Casualties (RTD, EVAC, DOW, POW) [WVBN014B / Version 5] - 08 May 02
Lesson Plan - AMEDD Captains Career & Warrant Officer Advanced (WOAC) - Laws of War and Operations Other Than War [FE1A1001 / Version 1] - 16 Sep 04
Lesson Plan - AMEDD Center & School - Effects of Geneva Conventions on Medical Evacuation [C191W034 / Version 1] - 27 Sep 00
Lesson Plan - AMEDD Center & School - Enemy Prisoner of War Procedures [JRC40570 / Version 1] - 01 Jun 04
Lesson Plan - AMEDD Center & School - FIELD TRAINING EXERCISE (EQB) [PEOS003A / Version 1.1] - 10 Sep 03
Lesson Plan - AMEDD Center & School - Geneva Convention on the Wounded and Sick [JRC4A220 / Version 1] - 01 Jun 04
Lesson Plan - AMEDD Center & School - Healthcare Jurisprudence [HLPADTOR / Version 1] - 09 Apr 01
Lesson Plan - AMEDD Center & School - Internally Displaced Persons (IDP) / Refugee Camp Assessments [PES00030 / Version 1] - 16 Dec 02
Lesson Plan [DRAFT] - AMEDD Center & School (91W10)- International Humanitarian Law and the Geneva Conventions – [30 Mar 05]
Lesson Plan - AMEDD Center & School - Law of War [WVBN042B / Version 1] - 04 May 01
Lesson Plan - AMEDD Center & School - Law of War [WVBN042B / Version 3] - 09 Nov 04
Lesson Plan - AMEDD Center & School - Law of War [HLOBCLOW / Version 04] - 03 Sep 04
Lesson Plan - AMEDD Center & School - Legal Aspects of Preventive Medicine [HLPREVMMA / Version 03F] - 21 Mar 03
Lesson Plan - AMEDD Center & School (Medical Evacuation Doctrine & Flight Medics) - Geneva Convention [UE2C1302 / Version 1] - 18 Aug 03
Lesson Plan - AMEDD Center & School - Medical Legal Issues in Military Healthcare [HLOBCMED / Version 1.1] - 20 Sep 04
Lesson Plan - AMEDD Center & School - Military Justice [HLOBMJ00 / Version 0698] - 15 Sep 04
Lesson Plan - AMEDD NCO Advanced (NCOES) - Enemy Prisoner of War (EPW) Casualties [WYAN006B / Version 1] - 17 Apr 03
Lesson Plan - AMEDD NCO Advanced (NCOES) Law of War [WYAN039B / Version 1] 15 Dec 04
Medical Paper (Murray, Roop, & Hospenthal) “Medical Problems of Detainees after the Conclusion of Major Ground Combat During Operation Iraqi Freedom” (Undated)
Power Projection Platform (Ft Bliss) Required Training List for All Individuals Processing Through the CONUS Replacement Center (CRC)” – 29 Nov 04
Power Projection Platform (Ft Bragg) Standard Training Package – “Coordinate Internee Hospitalization (191-384-4409) (Undated)
Power Projection Platform (Ft Bragg) Standard Training Package – “Issue Medication to Internees” (191-381-1338) – Oct 03

Power Projection Platform (Ft Bragg) Standard Training Package – “Supervise Administrative and Disciplinary Measures in an Internment Facility” (191-383-3396) – Oct 03
Power Projection Platform (Ft Bragg) Standard Training Package – “Supervise Work Activities Within an Internment Facility” (191-382-2352) - Oct 03
Power Projection Platform (Ft Bragg) Training Task – “Conduct Security Operations for Hospitalized Internees” (19-2-3510) – Jan 05
Power Projection Platform (Ft Bragg) Training Task – “Supervise Work Project Operations for Enemy Prisoners of War (EPWs) and Civilian Internees (CIs)” (19-2-3610) – Jan 05
Power Projection Platform (Ft Bragg) Training Task – “Supervise Work Project Operations for United States (US) Military Internees (19-2-3204) – Jan 05
Power Projection Platform (Ft Carson) – “7 <sup>th</sup> Infantry Division & Ft Carson Detainee Training Guidance , 2 <sup>nd</sup> Quarter, Fiscal Year (FY) 05” (Undated)
Power Projection Platform (Ft Hood) “Mandatory Briefings and Force Protection Lane Training” – 12 Jan 05
Power Projection Platform (Ft Lewis) “GTMO 6.0 Detainee Operations Brief” (Undated)
Power Projection Platform (Ft Riley) “Theater Specific Requirements for Operation Iraqi Freedom 05-07 – Version 1 CS/CSS (With FORSCOM 4 Guidance)” – 22 Feb 04
Power Projection Platform (Ft Stewart) “Medical Training Matrix for Mobilizing RC Combat Units” – 9 Jan 05
Training Support Package (TSP) to AR 190-8 for Medical Personnel who Handle, Treat, Monitor and or Evacuate Enemy Prisoners of War (EPW), Retained Personnel (RP), Civilian Internees (CI) and Other Detainees (Undated)
<b>CLASSIFIED</b>
(S) Treatment of Enemy Combatants Detained at Naval Station Guantanamo Bay, Cuba, and Naval Consolidated Brig Charleston (dated 11 May 04)
(S) ANNEX Q to USARCENT OPLAN 1003-96 (Dated 1 April 1997)
(S) APPENDIX 7 (MEDICAL) to ANNEX I to V CORPS OPLAN 1003 (Dated 1 December 1998)
(S) MNF-I ANNEX Q to MNF-I Framework OIPORD (U) - 22 Mar 05
(S) MNF-I ANNEX Q (Health Service Support) - 7 Dec 04
(S) MNF-I SOP (Intra-Theater Military Airlift for Security Detainees – DRAFT) - 1 Mar 05
(S) MNF-I Policy 05-02 (Interrogation Policy) - 27 Jan 05)
MNF-I Surgeon’s 30 Day Assessment (Medical) for Jan 05 (Secret) - 25 Jan 05
MNF-I Surgeon’s 30 Day Assessment (Medical) for Mar 05 (Secret) - 23 Mar 05
(S) MNC-I ANNEX Q (Health Service Support) TO MNC-I Campaign Plan: Operation Iraqi Freedom - 22 Aug 04
(S) MNC-I ANNEX Q TO MNC-I FRAMEWORK OPLAN (Medical Services) - 20 Mar 05 (Draft)
(S) FORSCOM FRAGO 20 to FORSCOM Deployment Order ISO Operation Iraqi Freedom Rotation 2 ((b)(2)-2) DEPOD - Recognizes detainee HC shortfall) - 29 May 04
(S) Detainee Operations Responsibilities – 21 Jan 05
(S) V CORPS FRAGO 006M [Detention of Civilians] to V CORPS OPORD 0303-343 - 19 Mar 03

(S) V CORPS FRAGO 010M [V CORPS EPW Operations] to V CORPS OPORD 0303-343 - 19 Mar 03
(S) V CORPS FRAGO 018M [Obligations to Children Under Age 18 in U.S. Custody] to V CORPS OPORD 0303-343 - 24 Mar 03
(S) V CORPS FRAGO 037M [Change to FRAGO 010M: V CORPS EPW Operations] to V CORPS OPORD 0303-343 - 20 Mar 03
(S) V CORPS FRAGO 038M [Establishment of Class VIII Accounts] to V CORPS OPORD 0303-343 - 21 Mar 03
(S) V CORPS FRAGO 329M [Transition to Stability Operations in Baghdad Secured Zones] to V CORPS OPORD 0303-343 - 11 Apr 03
(S) V CORPS FRAGO 349M [Seizure of Iraqi Prisons] to V CORPS OPORD 0303-343 - 13 Apr 03
(S) (b)(2)-2 FRAGO 244 [Medical Supply Support Activity (SSA) Ordering and Inventory Management Requirements] to (b)(2)-2 OPORD 03-036 - 1 Jul 03
(S) (b)(2)-2 FRAGO 344 [Armed Security for Enemy Prisoners of War and Detained Individuals in (b)(2)-2 and (b)(2)-2] to (b)(2)-2 OPORD 03-036 - 8 July 03
(S) (b)(2)-2 FRAGO 520 [Medical Support for Abu Ghurayb] to (b)(2)-2 OPORD 03-036 - 27 Jul 03
(S) MNC-I FRAGO 1206 (10DEC03 DTU) to (b)(2)-2 OPORD 03-036 - 11 Dec 03
(S) MNC-I FRAGO 494 (Security for Detainees While in Medical Treatment Facilities) to (b)(2)-2 OPORD 04-01 - 25 Mar 04
(S) (b)(2)-2 FRAGO 014 (Task Organization Change) (b)(2)-2 TACON over MP medical Personnel - 16 Oct 04
(S) MNC-I FRAGO 016 (Health and Sanitation Inspections in Support of MNC-I Detention Facilities) to MNC-I OPORD 04-01 TO be Published {TBP} - 17 Apr 04
(S) MNC-I FRAGO 018 (Medical Record Documentation and Filing System for U.S. Detainee Operations in Iraq AO) to MNC-I OPORD 04-01 (TBP) - 17 May 04
(S) MNC-I FRAGO 260 (Investigating and Reporting Detainee Deaths) to MNC-I OPORD 04-01 - 29 Jun 04
(S) MNC-I FRAGO 329 (Detention Operations) to MNC-I OPORD 04-01 - 12 Jul 04
(S) MNC-I FRAGO 955 (b)(2)-2 to Move Medical Equipment Sets to Bucca ISO (b)(2)-2 to MNC-I OPORD 04-01 - 3 Nov 04
(S) MNC-I FRAGO 1029 (Attach 40 Bed Patient Hold Capability to (b)(2)-2 to MNC-I OPORD 04-01 - 13 Nov 04
(S) MNC-I FRAGO 1043 (Detainee Acceptance) to MNC-I OPORD 04-01 - 15 Nov 04
(S) MNC-I FRAGO 1173 (Detention Operations) to MNC-I OPORD 04-01 - 2 Nov 04
(S) (b)(2)-2 FRAGO 330 [Medical Coverage for MND-CS] to (b)(2)-2 OPORD Final Thrust - 10 Aug 03
(S) (b)(2)-2 FRAGO 341 [Medical Coverage for The Abu Ghraib Prison] to (b)(2)-2 OPORD Final Thrust - 14 Aug 03
(S) (b)(2)-2 FRAGO 468 [Medical Equipment to Abu Ghraib Prison] to OPORD Final Thrust - 9 Nov 03
(S) (b)(2)-2 OPLAN 04-02 (Iraqi Freedom) - 1 Mar 04
(S) (b)(2)-2 Annex EE [Baghdad Central Detention Facility (BCDF) to (b)(2)-2 BDE OPLAN 04-02 (Iraqi Freedom) - 1 Mar 04

(S) (b)(2)-2 Jun 02	FRAGO 6 (Detainee Operations Guidance) to Operations Order 02-01 - 4
(S) (b)(2)-2	FRAGO 274 (Detainee Handling, Movement, and Temporary Transfer Guidance) - 26 Feb 04
(b)(2)-2	Questioning and Interrogation Approaches SOP - 15 Jan 05
(S) (b)(2)-2	Detainee Operations Standard Operating Procedures - 21 Jan 05
(S) (b)(2)-2	Standard Operating Procedures for Detainee Medical Care - 8 Mar 05
(S)	CDR USSOUTHCOM EXORD for Detainee Movement Operation 45 - 25 Feb 05
(S) (b)(2)-2 11 Nov 02	Behavioral Science Consultation Team Standard Operating Procedures -





## PRESIDENT'S COLUMN

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# Speaking against torture

**AAPA member who participates in torture or degrading treatment of people, or who enables use of information gleaned in health or mental health-care relationships to the detriment of a person's safety and well-being, stands in violation of our ethics code.**

By Dr. Gerald P. Koocher, APA President  
February 2006, Vol 37, No. 2  
Print version: page 5

In early July, the Task Force on Psychological Ethics and National Security (PENS), appointed a few months earlier by then-APA President Ron Levant, released a thorough and thoughtful report detailing the ethical constraints on psychologists who serve in or consult to military and security agencies of our government. The task force included a broad range of psychologists with career interests in ethics, government service, peace and negotiation studies, and the victims of torture. The task force took as its starting point APA's strong historic stand against the use of torture, as well as the ethical foundation that unlawful acts against others also constitute ethical misconduct.

The group became aware of several incidents in which psychologists serving in the military had intervened, putting their own careers at some risk by taking strong stands against abusive actions toward people held in detention both in Iraq and at Guantanamo Naval Base. For example, an APA member has been credited with alerting his superiors as early as 2002 about questionable interrogation of detainees at Guantanamo. The task force members had a keen awareness of reports in the news media of alleged ethical misconduct by mental health professionals involved in the interrogation of such detainees, predicated chiefly on rumor and speculation regarding a confidential report by the Red Cross, which has never become public.

The task force members drafted a thoughtful, detailed report and sent it on to the APA Ethics Committee for study. The Ethics Committee, the only body of APA authorized by our Bylaws to interpret our ethics code, reviewed the report, made some edits and confirmed that the guidance offered by the PENS task force conformed fully to the Ethical Principles of Psychology and Code of Conduct. The report then went to the APA Board of Directors for review and approval for its public release on July 5, 2005.

A number of opportunistic commentators masquerading as scholars have continued to report on alleged abuses by mental health professionals. However, when solicited in person to provide APA with names and circumstances in support of such claims, no data have been forthcoming from these same critics and no APA members have been linked to unprofessional behaviors. The traditional journalistic dictum of reporting who, what, where and when seems notably absent.

The PENS report makes clear that any APA member who participates in torture or the cruel, inhuman or degrading treatment of people, or who enables use of information gleaned in health or mental health-care relationships to the detriment of a person's safety and well-being, stands in violation of our ethics code. The task force declined to use the words "coercive" or "harmful" in describing ethical misconduct, because many legitimate professional roles of psychologists could prove problematic in that regard. The psychologist who acts as a mandated reporter of abusive behavior toward children or dependent persons may cause harm to the perpetrator, while acting to protect the more vulnerable party. Clinicians who conduct custody evaluations, criminal competency assessments or independent disability evaluations will often evaluate people who feel coerced to cooperate by the legal system. We undertake such assignments with appropriate disclosure to the parties and a solid commitment to promoting a world where our scientific and clinical skills benefit society as a whole, and its most vulnerable citizens in particular.

Sadly, many people, including some public luminaries, some of our own members and some of our psychiatric colleagues have leaped to find fault with the PENS report. Ironically, many appear to have offered their critical commentary without carefully reading the report or by selectively ignoring key elements. Many of our psychiatric colleagues have offered interpretive criticism, although their professional association has yet to agree on an official

position. One proposed draft before the psychiatric association includes an itemization of specific prohibited tactics they deem as torture. When carefully scrutinized, their draft bears a remarkable resemblance to our position, although no journalist has yet commented on this point. Likewise, no journalist-including those critical of the PENS report-has commented upon an interesting irony: Despite psychiatrists' opposition to prescription privileges for psychologists, the psychiatric association's list of forbidden coercive techniques omits any mention of the use of drugs, implicitly allowing such practices.

Many APA members oppose current government war policies, strongly support victims of torture or want to proudly uphold our strong tradition of advocacy for social justice. All our members can take pride in the work of the PENS task force and the strong ethical positions held by APA.

If you have not yet done so, I encourage you to read the full report. It can be found at PENS Task Force (/pubs/info/reports/pens.pdf) (PDF, 534KB).

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**Find this article at:**

<http://www.apa.org/monitor/feb06/pc.aspx>

**APA Resignation**  
**Why I Resigned from the**  
**American Psychological Association**

**Kenneth S. Pope, Ph.D. , ABPP (<http://kspope.com/kpope/index.php>)**

The following letter was sent to APA President Alan Kazdin via FedEx on February 6, 2008, and to members of the APA Council of Representatives via the Council listserv Thursday morning, February 7:

Alan E. Kazdin, Ph.D.  
President,  
American Psychological Association  
750 First Street, NE  
Washington, DC 20002-4242

Dear Alan,

With sadness I write to resign from the American Psychological Association. My respect and affection for the members, along with my 29 year history with APA, make this a hard and reluctant step. Chairing the Ethics Committee, holding fellow status in 9 divisions, and receiving the APA Award for Distinguished Contributions to Public Service, the Division 12 Award for Distinguished Professional Contributions to Clinical Psychology, and the Division 42 Award for Mentoring reflect **a few chapters in my APA history** (<http://kspope.com/kpope/index.php>) .

I respectfully disagree with decisive changes that APA has made in its ethical stance during the past 6+ years. These changes moved APA far from its ethical foundation, historic traditions, and basic values, and beyond what I can in good conscience support with my membership.

I would like to note two examples of disagreement. First, the years since 9-11 brought concern over psychologists' work that affects detainees. APA has stressed psychologists' "vital role" regarding "the use of ethical interrogations to safeguard the welfare of detainees" and ways that psychologists "help advance the cause of detainee welfare and humane treatment." Yet in its ethics code, APA chose not to recognize any humane treatment requirements governing psychologists' work with detainees as enforceable standards.

Historically, when concerns arose about the impact of psychologists' behavior on groups at risk, APA moved decisively to create specific requirements and limitations in the ethics code's enforceable standards. These groups included persons "for whom testing is mandated by law or governmental regulations," "persons with a questionable capacity to consent," research participants, "subordinates," clients, students, supervisees, and employees. Facing concerns about the impact of psychologists' behavior on research animals, for example, APA created an enforceable standard supporting the "humane treatment" of laboratory animals. But for detainees, APA chose not to adopt any enforceable standards in the ethics code mandating humane treatment.

The code's numbered ethical standards "set forth enforceable rules of conduct." The code emphasizes that although other code sections should be given consideration, even the code's "Preamble and General Principles are not themselves enforceable rules..." APA's decision to adopt an enforceable standard regarding "humane treatment" of animals but not to adopt an enforceable standard regarding "humane treatment" of detainees turns APA away from its ethical foundation, historic traditions, and basic values that should endure even in the midst of post-9-11 risks and realities.

My second area of disagreement concerns the ethics code that Council adopted August 21, 2002 (which took effect June 1, 2003). The 2002 code echoes the earlier code in setting forth the following enforceable standard: "If psychologists' ethical responsibilities conflict with law, regulations, or other governing legal authority, psychologists make known their commitment to the Ethics Code and take steps to resolve the conflict." But the 2002 code created a new enforceable standard: "If the conflict is unresolvable via such means, psychologists may adhere to the requirements of the law, regulations, or other governing legal authority" (Standard 1.02).

This new enforceable standard, in my opinion, contradicts one of the essential ethical values voiced in the Nuremberg trials. Even in light of the post-9-11 historical context and challenges, I believe we can never abandon the fundamental ethical value affirmed at Nuremberg.

An attempt to modify Standard 1.02 was placed only in the nonenforceable section. In the 5 years since creating this new enforceable ethical standard in a sharp break with the past, APA chose to make no qualifications, restrictions, or other modifications to Standard 1.02 in the code's enforceable section.

The code's 89 enforceable standards identify diverse ethical responsibilities, some representing the profession's deepest values. The code recognizes that these ethical values

can stand in stark, irreconcilable conflict (no matter what steps the psychologist takes to resolve the conflict) with a regulation, a law, or governing legal authority. APA's creation of an enforceable standard allowing psychologists to violate these fundamental ethical responsibilities in favor of following a regulation, a law, or a governing legal authority clashes with its ethical foundation, historic traditions, and basic values.

Such changes in APA's approach to its enforceable ethical standards over the past 6+ years embrace issues of enormous complexity and conflicting values. I've tried during these years to read as widely and carefully as possible in these diverse areas, comparing secondary sources to primary sources and evaluating claims in light of evidence. On one narrow topic, for example, I've read and maintained an archive of citations of over 220 published works (including those from APA) that specifically address the controversy over physicians and psychologists participating in the planning and implementation of detainee interrogations. (The archive is at :

<<http://kspope.com/interrogation/index.php>>).

Over the decades I've written articles and books examining APA's earliest discussions about ethical responsibilities and accountability, the choice to create an ethics code, the innovative methods used to create a unique code, the revisions and controversies over the years, and APA members' ethical views, dilemmas, and behavior. During the code's distinguished history, it has set forth APA's essential ethics and the standards to which members agree to hold themselves accountable through the Ethics Committee's formal enforcement. For me, the two examples above represent defining issues for APA. Steps that APA has taken or avoided since 9-11 mark a sharp shift in values and direction.

I respectfully disagree with these changes; I am skeptical that they will work as intended; and I believe that they may lead to far-reaching unintended consequences.

These changes take APA so far away from its ethical foundation, historic traditions, and basic values, and from my own personal and professional view of our responsibilities, that I cannot support them with my membership. In light of my respectful disagreement with APA about these fundamental changes, it is with great sadness and regret that I resign my membership.

Sincerely,

Ken

Kenneth S. Pope, Ph.D., ABPP

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Dr. Sharon Stephens Brehm  
President  
American Psychological Association

Dear Dr. Brehm,

I am writing in response to a listserv post regarding APA's Task Force on Psychological Ethics and National Security (PENS) that is composed of writings by Amy Goodman, host of the program "Democracy Now," and Dr. Jean Maria Arrigo, who was a member of the PENS Task Force. While I have not spoken outside of APA venues in my role as chair of the PENS Task Force, the Goodman/Arrigo post presents such a gross distortion of the PENS process—a process that concluded over two years ago—that silence no longer seems reasonable or prudent. Please distribute this letter as you deem appropriate.

First, I want to be clear: I have never worked in any capacity for the CIA, the FBI, or the Department of Defense. I am a psychologist for a nursery through 9<sup>th</sup> grade private school. I also serve on the training faculty for a university-based, multicultural center. I have served as chair of the APA Ethics Committee and chair of my state's psychology licensing board. I am currently a member of the APA Board for the Advancement of Psychology in the Public Interest (BAPPI). Like hundreds of other APA members, I have volunteered my time for APA activities. I have never received monies or compensation of any nature from APA for my time. While my employers have allowed flexibility in my work schedules to attend meetings, APA activities have never been counted toward my professional advancement. When I was asked to chair the PENS Task Force, I accepted. At no point was there any mention of compensation, reward, benefit, or other inducement for serving in this role or for coming to a particular position on the substantive issues. Any other suggestion is, quite frankly, an insult to my integrity.

Second, the Goodman/Arrigo post implies that virtually everyone in the room when the PENS Task Force met, other than Dr. Arrigo, was either covertly providing information to the military or had significant conflicts of interest that would predetermine a position. The APA staff present, many of whom are long-standing APA members, have been unspeakably poised and gracious in not publicly responding to the implication that their own integrity was compromised. A cursory review of APA activities reveals that APA has taken positions at significant odds with the United States government. The most recent example is the 2007 resolution on interrogations itself. The Washington Post calls APA's 2007 resolution "a rebuke of the Bush administration's anti-terrorism policies."

Third, the names and biographical statements of the Task Force members were provided to the APA Council of Representatives and posted on an APA division website weeks before the Task Force met with no restrictions whatsoever on how this information could be disseminated. This information was readily available through the Internet for interested members of the public. On the night the PENS Task Force began its work in Washington, a journalist contacted the director of the Ethics Office and asked for hotel information for specific members of the Task Force, by name. The notion that either the names of Task Force members or their biographical descriptions were not publicly available until a year after the Task Force met is completely false.

Fourth, as PENS Task Force Chair, I responded immediately when Dr. Arrigo raised allegations of “irregularities” in the PENS process. I believed strongly that the individuals directly involved should have the first opportunity to hear and respond to any such allegations. Nonetheless, despite numerous entreaties over several weeks, Dr. Arrigo refused to provide any substantive response to my requests that she explain what she viewed as Task Force irregularities. What are finally raised in the Goodman/Arrigo post as examples are, in fact, not irregularities at all. Other APA task forces have had multiple observers. In regard to the question of an investigation, the president-elect of APA pointed out to Dr. Arrigo that APA has neither subpoena power nor the necessary security clearances, so an “investigation” would be pointless—and would serve to demonstrate only that APA did not understand what a competent investigation would require. The Goodman/Arrigo post states “No task force member was permitted to speak about the PENS report.” In fact, Dr. Arrigo has spoken a great deal about the PENS report. At no point has APA taken any action to discourage Dr. Arrigo from doing so. Much to the contrary, Dr. Arrigo spoke most recently at an APA Convention program on ethics and interrogations, the planning for which was funded by the APA Board of Directors.

Fifth, in discussing the composition of the PENS Task Force, the Goodman/Arrigo post fails to address how several of the Task Force members have been described in publicly available documents as taking central roles in fighting detainee abuse. Dr. Mike Gelles has been hailed for a successful protest of prisoner abuse in Guantanamo Bay. The work of Dr. Larry James in implementing procedures to prevent further abuses at Abu Ghraib has been described in a recent book by a former APA president. Dr. Robert Fein, chair of the Intelligence Science Board study on educating information, is demonstrating that research does not support the effectiveness of harsh interrogation techniques in eliciting accurate and reliable information; his work has been discussed in the *New York Times*. Dr. Morgan Banks has been described by Jane Mayer in the *New Yorker* magazine as taking an unequivocal position against “reverse-engineering” of SERE techniques; Dr. Banks has repeatedly stated that “reverse SERE engineering” is both unethical and ineffective. Dr. Scott Shumate is portrayed in a recent *Vanity Fair* article as “disgusted” in reaction to detainee abuse. The Goodman/Arrigo post states “Six of the ten members were highly placed in the Department of Defense” (an inaccurate statement), and then goes on to ignore entirely the publicly available information about what these individuals have done to fight the abuse of detainees. The post likewise ignores how Mike Gelles has since left government service and remains a strong and vocal supporter of the PENS Task Force conclusions. Neither Amy Goodman nor Dr. Arrigo saw fit in their post so much as even to acknowledge the position of these PENS Task Force members or their actions to fight against detainee abuse.

Sixth, immediately following the PENS Task Force meeting after Task Force members had left Washington, a final draft of the report was distributed for their approval. Dr. Arrigo’s response reads in its entirety:

The depth, scope, and wisdom of this document are indeed impressive, and I approve it as a Task Force member. Also, I appreciate its literary grace (owing to Steve). As mentioned previously, I have felt uneasy with some elements, primarily omissions. Fulfillment of the Task Force recommendations would relieve my concerns, and I hope for an opportunity for further participation. Thanks to the APA ethics committee, board, and staff members who have mobilized for swift review and dissemination of the PENS report. Jean Maria Arrigo



(Given that Dr. Arrigo has now provided this information to multiple individuals and entities, including an investigative journalist, I will assume that she has waived any expectation of her own privacy regarding these materials). The year following release of the PENS report, a majority of PENS Task Force members determined that the APA Ethics Committee was the appropriate body to write a casebook/commentary on the PENS report. Dr. Arrigo dissented vigorously and argued that the PENS Task Force should continue its involvement in PENS-related work.

Seventh and finally, I note with dismay that nowhere on the Democracy Now website was I able to find any material from the many voices at Convention and on APA Council who spoke strongly in support of APA's position and eloquently against a limitation of psychologists' roles in detention centers. In contrast, APA leadership ensured that all voices and perspectives would be heard at our annual meeting.

In response to continued member interest in this issue, the APA Board of Directors funded a group to plan an extensive program on ethics and interrogations at the 2007 Convention in San Francisco. The program consisted of nine, two-hour sessions. The majority of members on the program planning group were affiliated with the Divisions for Social Justice. Some of the harshest critics of APA's position (including Dr. Arrigo) spoke at the Convention program—with APA leadership's knowledge and full support. Democracy Now filmed at several of the sessions, including the Town Hall meeting, again with APA leadership's knowledge and support. The Board of Directors was entirely committed to ensuring that a proposal limiting the roles of APA members in detention facilities would be discussed and debated at the Council of Representatives meeting. The discussion took place on the final day of Council's meeting, as requested by the chair of the Divisions for Social Justice. The resolution adopted by Council was the result of an intense, open and inclusive collaboration between Council representatives from numerous and diverse APA groups.

I appreciate that our membership has passionate differences of opinion on this complex issue. APA's current position is the result of intelligent, informed, and thoughtful debate that has been ongoing for over two years. We have explored every aspect of this issue in challenging and sometimes painful discourse, and we have reached a considered position. For those truly interested in a democratic process, APA leadership provided an excellent example in San Francisco of democracy in action.

Sincerely,

Olivia Moorehead-Slaughter, PhD  
Chair, PENS Task Force



# UNIVERSITY OF MARYLAND

COLLEGE OF EDUCATION  
COUNSELING AND PERSONNEL SERVICES

468

OCT 30 2001

College Park, Maryland 20742  
PRIVACY REDACTION

October 26, 2001

Jonathan Tin  
APA Ethics Office  
750 First St., N.E.  
Washington, DC 20002

Dear Mr. Tin,

Enclosed, please find comments on Draft 5 of the proposed revisions to the APA Ethics Code compiled by my professional seminar on ethics and legal issues. I suspect that it may be too late for Draft 5, but many of these comments would likely apply to Draft 6 as well.

Thank you for your consideration of these comments.

Sincerely,

A handwritten signature in dark ink, appearing to read "W. Strein".

William Strein  
Associate Professor

# Comments on Draft 5 of APA Proposed Revisions to Ethics Code

Submitted by

Members of the University of Maryland

School Psychology Seminar on Ethics and Legal Issues

William Strein, Instructor

October 9, 2001

We would like to preface our comments on Draft 5 by commending the Committee on its work on a vital, but very difficult task. We are impressed by the thoughtfulness with which the proposed revisions to our Ethics Code have been drafted. Reviewing Draft 5, and the changes that have occurred between Draft 5 and the earlier draft, has been a valuable learning experience for us. We thank the Committee for making the information so readily available and on being so proactive in seeking input. Our comments follow.

Section and Page No. <sup>1</sup>	Comments
Introduction and Applicability, p. 3(top) and Standard 1.02, p. 8	We are concerned that the phrase "...may adhere to the requirements of the law..." might be interpreted by some as condoning not following laws, legal rulings, or precedents. Given the sentences preceding and following the sentences containing this phrase, we believe that simply eliminating the sentence containing the "may adhere to" phrase will reduce the possibility of misinterpretation, and will still leave room for the psychologist to understand that following all laws, even if unjust, is not absolutely required by the Ethics Code. <u>If</u> the Ethics Committee's intent in using the word "may" was to indicate that following the law blindly is not, per se, an ethical violation, then some phrase such as, "Adhering to the requirements of the law when such are in apparent conflict with the Ethics Code is not, per se, an ethical violation."
Principle D: Justice (p. 7)	We believe that the wording in the February, 2001, draft, especially in sentence 1 of that statement, is a stronger statement about psychologists' commitment to social justice. We recommend keeping the February, 2001, statement rather than the modifications made in the June 24 <sup>th</sup> draft.
Principle E, (p. 8)	Next to last sentence: In our judgment, this sentence would have a better tone if written as "...and consider these factors in the delivery of professional services when working with persons of such diverse backgrounds." In the last sentence, we recommend maintaining parallel word use by the phrase, "...of others based upon such biases."
Principles, Generally	We are disappointed to see that the obligation to engage in "pro bono" work that is in the current (1992) Principle F: "They [psychologists] are encouraged to contribute a portion of their professional time for little or no personal advantage" seems to have disappeared altogether. We recommend re-instating some similar phrase.
1.04 (p. 9)	Given that many psychologists work in institutional environments

<sup>1</sup> Page numbers refer to the Committee Document "Comparison of February, 2001 Published Draft and Draft 5, June 24, 2001" distributed at the 2001 APA Conference. All references are to the June 24, 2001 draft (Draft 5).

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	where they function as staff employees, we recommend adding as an example of in the "Such actions might include..." section, a statement such as, "...conferring with the administrative supervisor of the unit providing the services in question..."
Page 10 and elsewhere	The document repeatedly refers to "scientific or professional knowledge". What does "professional knowledge" mean – this term needs to be defined. Is this a reference to something like "accepted professional practice" or "standard of care" or what?
2.02(b) (p. 11)	In our opinion, this section would be made clearer by adding an illustrative example, such as "...for whom appropriate mental health services are not available (e.g., underserved populations and/or geographic locations) and for which..."
2.03 (p. 11)	We recommend phrasing "maintaining competence" to more clearly indicate the need to stay abreast of advancing knowledge. One such phrasing might be, "...maintain competence in the skills they use by keeping abreast of current developments in the advancing scientific and professional knowledge in areas relevant to their areas of expertise or practice."
2.06(a) (p.12)	We believe that this point would be more clear by referring to "...engaging in specific professional activities..." rather than, "...undertaking an activity..."
3.06 (p. 14)	Re-phrasing this statement from "...when prior personal..." to "...when prior and/or current personal..." would make it clear that avoiding both prior and current conflicts is the goal.
3.10 (p. 15)	We suggest either replacing the phrase in the first sentence "...psychotherapy, counseling..." with "...psychological interventions...", or adding "...or other psychological interventions..." after the "...psychotherapy, counseling..." phrase. The current wording is not broad enough to include such interventions as behavior modification programs or skill development groups that might not be thought of as "counseling" or "psychotherapy".
4.03 (p. 17)	We believe that this statement would be clearer and stronger if stated similarly as follows: "Before recording the voice or image of individuals to whom they provide services, psychologists obtain permission from all such persons or their legal representatives."
7.02(b) (p.23)	Because students frequently register for course prior to having a syllabus for it, we recommend adding a phrase as follows: "...to ensure that course syllabi and publicly available course descriptions are accurate..."

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## Visit to the U.S. Joint Task Force Station at Guantanamo Bay: A First-Person Account

Ronald F. Levant  
*2005 APA President*

In this article, I describe my trip to the U.S. Joint Task Force Station at Guantanamo Bay, Cuba, on October 19, 2005. I participated as the 2005 President of the American Psychological Association and was part of a group of leaders from several national health and mental health organizations and United States and Department of Defense Officials. My purpose in participating was to inform the participants and other individuals of the American Psychological Association's (APA) position against torture and cruel, inhuman, or degrading treatment. The trip afforded a unique opportunity to speak with people directly about APA's work in this area and to clarify questions about APA's position. The trip had no "fact-finding" component.

I was one of a group of leaders from several national health and mental health organizations that visited the U.S. Joint Task Force Station at Guantanamo Bay (GTMO), Cuba on October 19, 2005. I was invited in my capacity as the 2005 President of the American Psychological Association (APA).

The invitation came from the Assistant Secretary of Defense for Health Affairs, Dr. William Winkenwerder, Jr. The purpose of the visit was to learn more about the work of physicians and psychologists currently serving as part of the Joint Task Force–Guantanamo and to enter into a dialogue with U.S. Department of Defense (DoD) officials and the rest of the visiting group about appropriate and effective roles for health and mental health professionals in detainee operations. APA has a strong interest in the role that psychologists are playing in national security investigations as part of the Joint Task Force and wishes to continue to help advise our

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Ronald F. Levant is Dean and Professor of Psychology at the Buchtel College of Arts and Sciences, The University of Akron.

Correspondence should be addressed to Ronald F. Levant, Buchtel College of Arts and Science, The University of Akron, Akron, OH 44325–1901. E-mail: [PRIVACY REDACTION](#)

members and DoD to ensure that such work by psychologists is safe, legal, ethical, and effective.

The visitors included Dr. Susan Okie, Contributing Editor, *New England Journal of Medicine*; Dr. Nancy Sherman, medical ethicist at Georgetown University; Dr. Audiey Kao, Vice President for Ethics, American Medical Association (AMA), Dr. Priscilla Ray, Chair, AMA Council on Ethical and Judicial Affairs; Dr. Larry Mohr, Board of Regents, Uniformed Services University for the Health Sciences; and Dr. Steven Sharfstein, President, American Psychiatric Association (ApA). Accompanying us was the U.S. Surgeon General, Dr. Richard Carmona; The Surgeon General of the Army, Dr. Kevin Kiley; the Joint Staff Surgeon, Dr. Joseph Kelly; and several other Department of Defense officials.

I accepted this invitation to visit Guantanamo because I saw it as an important opportunity for the Association to provide input on the question of how psychologists can play an appropriate and ethical role in national security investigations. APA's position concerning the role of psychologists in national security investigations is very clear. As stated in the Report of the American Psychological Association Presidential Task Force on Psychological Ethics and National Security (PENS; APA, 2005), APA believes that there is an appropriate role for psychologists in such investigations as bounded by our ethics code and a strict prohibition against torture or cruel, inhuman or degrading treatment.

It is important to note that APA's position on this matter was repeatedly mischaracterized by a group of medical reporters and journalists throughout 2005. As I wrote in my APA Presidential address (Levant, 2006 p. 386):

Despite the clear statements in the PENS report, and the affirmation of the report by the Ethics Committee, Board of Directors and Council, commentators have seriously mischaracterized APA's position on these matters in well-respected journals such as *Lancet*, where an editorial stated that according to APA, psychologists have no ethical obligations whatsoever when acting outside traditional health care provider roles (Wilks, 2005). APA holds precisely the opposite position as the editorial claimed. The entire point of the PENS report is to set forth the ethical obligations of psychologists in a non-traditional setting. Recognizing this error, *Lancet* provided APA space for a correction, but to the best of my knowledge the author of the editorial has never retracted this statement, which has been repeated in other venues of equal stature.

We made vigorous efforts to correct the record on APA's position, as evidenced by multiple attempts to publish Letters to the Editor in leading newspapers and medical journals like the *New York Times*, *Los Angeles Times*, *Boston Globe*, *Washington Post*, and *Lancet*, a number of which did get published.

The purpose of the trip was *not* to evaluate the detention camps. We did not visit the detention camps, and we were not permitted to see any detainees, although at least one of the visitors was able to catch some glimpses (Okie, 2005).

My goal in this visit was to create opportunities for APA to advise the DoD in setting up rules and procedures that allow psychologists to work in the national security arena and do so in ways that are legal and ethical and that protect the safety of all participants.

In preparation for this extraordinary trip I read the critical reports in the regular and medical media and several of the military investigations of allegations of abuse and torture, plus I had briefings with several military psychologists and APA staff members.

I flew into Reagan National Airport and was driven by private car to Andrews Air Force Base (AAFB) the evening before the trip. On Wednesday 10/19/05, at 07:20, we gathered at the AAFB airport to have breakfast and receive a preliminary briefing. We took off at 08:30, flying in a Gulf Stream C-20. Apart from members of Congress, the Red Cross, and the national media, we were the first civilians to visit GTMO.

The first thing that one must understand about visiting GTMO in 1 day is that you will spend most of the day in transit, which in this case created opportunities for multiple conversations while enroute. The flight is approximately 3 to 3½ hr. Ours was a bit on the long and bumpy side because Hurricane Wilma was in the general vicinity. After we arrived, there is a 20-min boat ride over to the other side to Guantanamo Bay, and then a 10-min bus ride to headquarters. All told, we spent about 8 hr in transit and about 4 hr at GTMO. We also had a dinner meeting that went fairly late into the evening.

When we arrived at Camp Delta, we saw what I had imagined we would see: A very scary looking place, with guard towers and dark green canvas covering the chain link fence, which was topped by concertina wire.

We went directly to the Headquarters Building, where we met for lunch in a large but tightly packed conference room. The luncheon briefing took over 2 hr. It was led by General Jay Hood, who presented a power point slide show, which covered overall detainee operations, including the history of the detention facilities beginning with Camp X-Ray, and then the building of Camp Delta. We were told that the camps range from maximum security to open and communal, and that detainees gain access to the better units by cooperating with the Joint Task Force. General Hood also discussed the Behavioral Science Consultation team (or BSCT, pronounced "biscuit"), threat assessment, and medical care at the facility.

General Hood stated emphatically that there will be no torture under his watch, and said that they rely on building rapport as the principle method of interrogation. I was impressed by his confidence and clarity. He also seemed quite transparent.

General Hood informed us that under their policies a psychologist cannot be both a clinician (part of the Medical Corps) and be involved in interrogation (a member of the BSCT), as these roles are clearly separated. This sharp demarcation of roles is consistent with the PENS report and would serve to prevent the alleged practice of BSCTs providing information on detainees' vulnerabilities, such as



phobias, that could be exploited by interrogators. We also discussed the fact that BSCT members are considered “combatants,” unlike psychologists who serve in the medical corps.

The use of civilian contractors as interrogators generated some discussion. Some asked if contractors would be more likely to engage in abusive practices because they are not subject to Uniform Military Code. In response it was pointed out that contractors are subject to civilian criminal penalties.

Survival, Evasion, Resistance, and Escape (SERE) training for BSCTs was discussed. SERE training has been provided to BSCTs so that they can learn the perspective of persons in captivity. General Hood stated that the purpose was not so that they would learn how to use SERE techniques in interrogation.

Two BSCTs, both psychologists, were present in the luncheon meeting, and one accompanied us for the rest of our visit. I had discussions with both of them. I learned that BSCTs observe interrogations from video monitors, consult to and advise interrogations on such matters as how to establish or improve rapport and ask questions more effectively. BSCTs help interrogators who get frustrated and angry when the detainees do not provide the information they want by offering instruction in self-control and self-management techniques. BSCTs monitor interactions between interrogators and detainees to guard against the kind of behavioral drift that can become abusive. They use techniques from Industrial/Organizational psychology in this regard. The BSCTs report to General Hood.

One of the BSCTs who had been at GTMO only a short time told me that she had been reluctant to take the assignment because of news reports that BSCTs were engaging in unethical practices. She told that, since being there for a couple of months, she has had a change of attitude and stated unequivocally “I am not doing unethical things.”

We next went to the medical facility for the base personnel. We learned that this facility is JCAHO-accredited, but that the medical facility for detainees is not. Due to threats made by detainees, medical personnel cover up their name badges while on the wards, and go by their initial (e.g., one whom we talked with was “Dr. O”).

We discussed the hunger strike. There were 20 to 30 hunger strikers at that time. General Hood believes that the hunger strike is being orchestrated. He sees it as a combat tactic to defeat the “Global War on Terror,” and asserted that “we will not allow them to die.” The hunger strikers are being force-fed. We were told that forced feeding takes place after missing nine meals. General Hood stated that almost all the hunger strikers cooperate with the forced feeding. Lawyers for the hunger strikes have complained about unsanitary conditions, size and length of tubes, and reuse of tubes. General Hood disputed these allegations, asserting that they provide appropriate medical care and practice. At the time of our visit we were told that one hunger striker was in six-point restraints. This hunger striker was reported to have hit a nurse in the mouth on the previous night, and she clearly had a bruised and swollen lip on the day of our visit.



We next visited the brand new psychiatric wing, which has both inpatient and outpatient services. I had a very unusual experience as we were standing at the nursing station, receiving a briefing from the psychiatrist. Behind me a voice asked “Dean Levant? Is that you?” That was the last thing I expected to hear at GTMO! I turned to see a former doctoral student in clinical psychology from Nova Southeastern University (NSU), who is now a military psychologist. I thought to myself, “NSU’s graduates sure have done a good job of getting out into the world!”

We discussed the fact that many of psychiatric personnel are women who wear Western clothes, which are considered too revealing by many Muslims. A psychiatric nurse commented that “we uglify ourselves” as a way of deflecting these concerns.

During our trip back, we had more one-on-one conversations, which provided great opportunities to advance psychology’s agenda. For example, I had an hour conversation with U.S. Surgeon General Carmona on the rationale for integrating psychological health care into medical care. We then had dinner at AAFB, followed by a lengthy meeting led by Assistant Secretary of Defense for Health Affairs, Dr. William Winkenwerder, Jr. We had more discussion regarding DoD’s new policies on reporting and investigating abuse and about the forced feeding of hunger strikers.

We spent a lot of time discussing the differences between the position of APA as stated in the PENS report (APA, 2005) versus the apparent position of the American Psychiatric Association (ApA). ApA President Steven Sharfstein distributed copies of the position taken by their Board of Directors, which stated,

Psychiatrists should not participate in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere. Nor should they provide information or advice to military or civilian investigative or law enforcement authorities military regarding the likely consequences of specific techniques of interrogation that is any way particularized in its application to an individual detainee. (ApA, 2005 p. 1)

He indicated that this had been approved by their Board and would soon be approved by their Assembly of Delegates, and would then become ApA policy. In fact, the ApA Assembly of Delegates did not at first approve this restrictive statement but rather approved a position that is similar in many ways to APA’s position. It is important to note that none of ApA’s positions condemn the use of psychiatric drugs in interrogation.

Given these seeming differences between the two national mental health associations, it was only natural that we would get into a discussion of the respective ethics codes. One DoD official stated that he does not see how this activity can be ethical for one group and not for the other. One MD participant responded by suggesting that the “do no harm” part of the Hippocratic oath indicated that

medical ethics were more stringent than that of psychologists, which I easily addressed by pointing out that Principle A in the Ethics code, Beneficence and Nonmaleficence, begins "Psychologists strive to benefit those with whom they work and take care to do no harm." I also noted that the APA Ethics Committee affirmed that the APA ethics code provides adequate guidance to psychologists involved in national security investigations.

We discussed the concept of coercion. The president of the American Psychiatric Association stated that the interrogations were "coerced," and therefore unethical. As a result, he said, psychiatrists cannot get involved. I pointed out that this position does not seem to recognize the ethically appropriate public interest-oriented roles in which psychologists routinely interview people who may feel more or less coerced. Such well-established roles include independent psychological evaluations for disability insurers, employee screening for sensitive positions, and evaluations for the legal system (such as the assessment of criminal responsibility, competence to stand trial, or child-custody evaluations). Psychologists also train others (e.g., police authorities, attorneys, and hostage negotiators) in psychologically effective interrogation techniques. This argument seemed persuasive to many of the attendees.

I should note that on May 22, 2006, the American Psychiatric Association released its final position statement (ApA, 2006) and accompanying press release, with the headline "APA passes position statement barring psychiatric participation in interrogation of detainees." On the very same day, the president of ApA was quoted in the media as stating the position is not an ethical rule and that no military psychiatrist following orders will get into trouble with the psychiatric association for participating in a military interrogation. Thus, the President of the psychiatric association exempted the people to whom the policy statement is most likely to apply on the very day the policy statement was issued!

On the other hand the American Medical Association Council on Ethical and Judicial Affairs report (AMA, 2006) asserted that there needs to be a balance between obligation to individuals and to society (i.e., protecting third parties and the public or national security). A careful review of the AMA report indicates that the report *nowhere* precludes a physician from acting as a consultant or advisor to a noncoercive interrogation, if the physician is not a caregiver. This is exactly the role envisioned by the PENS report.

It would not be right to end this short article without addressing the \$64,000 question: Did any military psychologist act unethically? I do not know. I am not in position that would enable me to fully evaluate this question. However, I do know the following:

1. In all of the investigations conducted to date, there has been only one documented account of abuse in which a psychologist was named. In this case the psychologist was reported to have observed an abusive incident involving a dog

(U.S. Army, 2005). There are also press accounts that a psychologist (Maj. John Leso) “helped breakdown the psyche” of the so-called 20th hijacker, Mohammed al-Khatani (Benjamin, 2006).

2. There has been at least one instance in which a military psychologist and PENS Task Force member has blown the whistle on abuse, as reported in the *New Yorker*, Dr. Michael Gelles (Mayer, 2006). Miles (2006), wrote:

Guantanamo is notable for a successful medical protest of prisoner abuse. In 2002, Dr. Michael Gelles, the chief psychologist of the Navy Criminal Investigative Service, complained about “abusive techniques” to the Navy’s general counsel, Alberta Mora. Mora took the matter to the highest level of the Pentagon, asserting that the techniques were “unlawful and unworthy of the military services.” Senior Navy officials were so upset by Gelles’ reports that they considered pulling out of the Guantanamo interrogations. Secretary of Defense Rumsfeld responded by revoking his initial list of approved interrogation techniques; he issued a more tempered list in April 2003. (p. 126)

3. I believe that the two BSCTs that I spoke with at length are doing exactly what they say they are doing, and are operating ethically.

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G7MO

MO of 12, 1/2 DOO 1/2 MO  
1st Curb.

Nature of G7MO

What it was

Why it was it

Role of engage as Affected

Curbs may - not BSCTB

Not to MO - Rhyth

role now. for -  
interrogation process

Stanger Status for study + report

PEAS

C/R

M-Coin M-Id

OCAP

Gambes Quiet Her . Be careful not to copy

Exams TF Feb

2 carting notes -

① range of medical - psychiatric community

② & mental - Hypocrite OATs

Dr Ireland - front, Psychiatry - no plan / psychiatry, by  
external psychiatrist

AF does not embrace Behav Sci Consultation

OPSEC = Operational Security = confidentiality. let  
Classified Security the year  
Principle - what you can talk about

med  
used

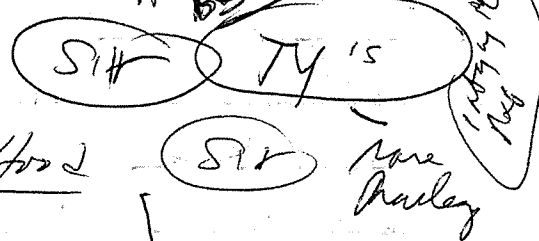
The exercise: To ensure safety of detainee - <sup>is</sup> ~~the~~ person

Asks as a challenge to an organization -

Army SG 35th

Allie Lt Col Kiley - Model

25th general - ~~may~~ may ever T Good  
I would be col equivalent



During time of long delegat  
Malt the of's ~~hangar~~  
Then coming down every week  
Terror Against The Law

(Lt Col 00)

Argu-S - ~~Chap~~  
Argu-B - ~~Alone~~

Debra - It was  
a family to some of the  
really an inspired leader  
Leaders was initially inspired,  
did a lot to empower BSC's  
being possibly up to the level  
consultants

Mr Steve Reid requires - Antist - Rob / Debs  
Intellgen. Ob Col-level of milit. - Debs  
Direct Boss - Direct of JT Intellge group -  
JIG Army

There are 2 yrs - Brilliant inspired leader,  
desire to be a part of it

SOP std of procedure:

BSC do not have access to rec records

2 days of all intellg collected

High value to exist looking of each other 15 years

He has helped move to another phase of project

Major Captain Edmondson

Command Surge of JT TF. High job

Surgeon Ob equivalent

Worked during of established conflict even when there was  
none actually.

Worked out how to share of, contribute to a project by  
formal battle medicine unit

Army  
Psychology - BSCT - Just present Lt Col

Penney Hoffman

took over of Des

Appointed <sup>Army</sup> Doberman

WCL Salomon: say Hello of Des

Combat of the combat team - Order

Edmundson :

Beha Host Source -

Ostergaard - off - (Hans) Detel Host  
all of Host Can

Heather Kelley : Parahut - PPO

Defers Anthony, bill - 40 yrs -  
and give brief, Maxon

What SOB's

What are Psychologists like to it

In here to see what guy is

2 Probly, DOD - to counter health record,

(Polygraph, next gen polygraph -  
John hats)

Mike - Chief of Naval Investigation Sec  
calls to Navy after Ensign's about at  
Gimo.

Morgan : Com Lt Gen Kiles  
3 general ~~the~~ convers

(1) Flight Down -

(2) Dine

2 key

(1) Lt Gen Kiles - Army SO - 3 star



Very low level Command of IT TP Operations  
Mostly Army but some brass  
- Biggs

JFF GIM

PRIVACY REDACTION

Morgan  
Hick

3 Substractive losses.

① Less impact - Where we not pay attention  
Should have a role. try diff  
Pay attention not funds approval

Case book summary

✓ Covered and used on a word - so many ways  
that is not helpful. Open behavior not  
~~that~~ is not in,

✓  
② The SEC = training. Training / skills  
is that they be SEC qualified. More reverse  
engineering. - Supply product  
by law

③ Whole key - Our partner - key phrases -  
Safe legal ethical + efforts SEC  
2018

① Help Ann's fees + safe - At 2018 look the  
look of how easily people can be led to change  
things. More of more where I hope  
properly.

② By the knowledge of individual behavior they make in  
more efforts



(2)

Phrase: The phrase is not whether who  
may play the role  
The Q is how who may  
play it ~~aggressively~~  
Pers TF is the guide

Torture of any cruel, inhuman &  
degrading tx

If we believe it we have a duty to  
report it

Military legally culpable to report it

Natasha, Phoebe, Heather Kelly, Russ,  
Mike H.

Psychologists role in ensuring that it's  
safe legal ethical + effective

John Deane to add I can interpret how

conditions under which the basic that it is approved

Proctor - not as blanket endorsement of the role -  
highlighting the limits + value of it

Not looked at any individual behavior

If any alleged wrong doing we start with  
investigate

John Cross  
Andy Ryan  
Reson  
Doo psychology (SL)  
Direct access

JAG = Judge Advocate General = military lawyer  
Defense / Prosecution

Deliberable - What is the expected

Fitzhigh Miller & House Officer — white coats, closed fist  
 Stho, mchth  
 Union Collective ←  
 Andrew Thomas  
 Henry Kahn  
 Peter Schmalz  
 Mike Smith

↳ Sheehan — Country Psylos — My

Sad with Sharpsten <sup>on phone</sup> — arguing against BSCT team

- ① legal limits status of detainees → loss of hope, hunger strike
- ② inf for images of detainees alleging torture by BSCT team
- ③ moral issue of humanity — something that is immoral regardless of the
- ④ subtext: military — divided on BSCT — Warden Warden not sure. AF of army against, Army for it

Coming from inquiry — purpose of us to see what it's like + tell our constituents. lots of M to report out the

Com of SG: In favor of bands, need for MH in security, understands individual care, will speak

My role: Sharpsten — role of evidence. BSCT

7:00 g then  
 8:30 dep  
 2:15

N bus, Bank, bus to go to med for

Chris Decker — Chris X-ray

# Briefing + lunch

(2)

Brown garden Hays  
Steve Adreys

JTF Mission

Defender — JD ops 98  
Ninth — J Intel 98  
JTF rel 98

Delta 1, 2, 3, 4 / Cong sh, Cong T  
= Defeat for US  
Cong Mexico — f JTF

Cong 4 — open Communist Cong — line during the 1-2-3

Cong T max sent 1000 <sup>months for</sup> Miami, Indiana

Cong Echo — f those efforts of potential war time  
reason to believe these  
reg by military + Arden Council

Nm Cong

Cong 3 2

14 6 51 51

1 ↑ ↑

Mixture  
Duffell  
Dargy  
Cong

Philly  
Robert

way station  
going to Congress  
out 7

Ind Cong

Cong

1, 4 — open Communist  
Congress

41% 36 6

1st Intel  
Interest



200 Detachment sent home - most depend on Corp 4

N = 505

Concert stop 1/02

only 10 bright June J. Howard took hold

Fish birds - McCaid - 1/1/88

Gen Miller comm'd @ GIRM tracks had Myap 6  
ABU Ghraib

Quatani - "20<sup>th</sup> HighTower"

My taking away <sup>approval</sup> ~~of~~ = 1000  
rest of Army Field Manual 34-5 on interrogations  
constant direct pressure  
Coercive ~~type~~

JTG - Task 10  
216 ml 83 - C175

✓ Fusion Analysis section

✓ Determine Access Branch - Eval pit threat of his ~~last~~  
Infl. Vals

of the f Adm val of enemy combatants - Or the  
see to designs of the

~~off~~

BSCT's do the observation.

IT Determine Info mgtsys - DATA BUS (G)

Interrogation Control Element 1 C5

↳ Cable Bus

↳ Buff State

↳ N. of the ~~enemy~~ Enemy

↳ Sidel Airbrn

BSCT Jenny + Bone

Collect mty + D/Dramt

IT Infl TF Com bth forms

Drummer Explodes

over 100 High Value Detainees

35% Generally y. cooperative - willing to talk

65% UNCOOP - mid level operators of AQ Qaeda

✓ City is not intel still important

✓ Can not AQ Qaeda

Importantly cell

recruitment

financing

✓ Can not people who may have been to fill gaps left with

20 off of many unknown ~~not~~ ~~concerned~~ not included in category above.

High Value Detainees in 24 different countries -

Afghanistan, Saudi Arabia, Algeria, Yemen = 60% of

high value detainees

Mid-range interrogator of the majority of detainee population

240 have left NO ORDA.

Intell gaps

• Signal to combat ops - Afghanistan

• Signal to allies

• Terrorist explosive threats -

• Weapons found

• Signal to FBI / homeland security

• Detainees returning to the fight - Mistake.

N = 20

NO US capture here



## BSC

Mission - to provide advice command a rule to ignore safe, legal, ethical + effective definition of interrogator spent JTF = 6th

Tasks

- ① Command of intelligence staff - with McAdams
- Monitor interrogator
- 14 Behavior trends
- Provide story of intelligence + defendant story
- Assist - Dev of defend finally before my team
- Consult with JTF Command

Watch of monitoring room

Do you conduct interrogation & up steps -  
 No - we don't do that  
 report buddy + report best way to  
 do here kind of thing  
 Planning Interrogation:

Soft issues be aware of all times

No access to medical information

Learn & re. staff.

- BSC - person or not can provide
- interaction in M.H. + medical services command
- BSC is liaison between intel staff + medical staff
- That med go address BSC of know medical condition or



. no fees & reduce needs

much have occurred, when have been  
sent as

Best up - lengthy period of Report -

Interrogation - so: are involved. Since F

Dave Becker

SECE -

Adheres to

Unif Code of Military Justice

General Comments

Public Roles & Engagements

It would go ~~for~~

(1,20) The same 1/02

George State No Affair.  
feels internally.

26 strikes. What was reported by Mr. Chris Afford Staff  
Titled just by report. Tony said could not talk as FCR  
10 French Popoff → largest 16

check his  
material

(5)

Chalky grey  
Green traces  
faint green canvas.  
Clean on outside

Comp 4 - reading 3rd -  
~~the~~ literature  
✓ Pashtu - Afghan

Mary Martin

38m

~~at~~ visit to no hospital

21 BIAS

100 all total

P-T area

Dr Ostergaard

100% car

in room

9 Hengzhu Arkes

Shapkin notes AGA approx DSC

Culic is mostly tainted - ethnic of Wilkes Arke - Moss  
stan

He is hands, like feels

only 1 in 4 at rest - need rest

in 100% rest

## 500 Defenses

2000 got Center for Mass

Last no 4X

last can 4 4X

former wife to tell the 6 day long bus

33, m then 1 man cost 3/4 yr

have brother for 1 year

Study defense known this to not state

Hang state 1 by state - Protect ~~the~~ Center Defense

Sr members act as contract of regens

eq 3 long long hall

lots of people between sr members & guards

1st of Dec. Dr Kinzler

~ 1000 as from 100

Ben Bunch 100. 1000

few less 500

# 1 Dec

Wait 60 min

3hr flyh + 1/2 hr boot ride rail way = 7'

530 — 730 pm = 11 hrs — 7 hrs 4 hr

2 1/2 taken up by lunch only food (Hawd)  
heat to me) area — of Arch unit.

Adverts

Fellow field man

My taking = 101 L

Seg of chre give + BSC roles

They know paper but have been stopped / regulated  
lead out

Before given system of units of reference /  
composition

Dec

① Good way to work over the characteristics of  
the free fully reg  
~~they have~~ M.A. line etc

② BSC # 2 — (Canned), not use to go, but  
has come around ANN Orb merge

DEB Sep 12 to end

WB completed by HWS — Sep 12  
there is very close to emergency steps

helping us in this regard not party  
needs further assistance,  
felt he had no way to

1.  $\frac{1}{2}$  of the total amount of the loan is to be repaid in 10 years.  
 2. The remaining  $\frac{1}{2}$  of the loan is to be repaid in 20 years.  
 3. The interest rate is 10% per annum.  
 4. The loan is to be repaid in 10 years.  
 5. The loan is to be repaid in 20 years.

550

*[Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.]*

1. What is the main purpose of the document?  
 The main purpose of the document is to provide a detailed description of the project's objectives, scope, and timeline.

Concentration of inhibitor (mole/l)	Rate of polymerization (mole/l·hr)
0	0.001
0.0001	0.0008
0.0002	0.0006
0.0004	0.0004
0.0006	0.0003
0.0008	0.0002
0.001	0.0001

1. *Chlorophyll a* (green)  
 2. *Chlorophyll b* (yellow-green)  
 3. *Carotenoids* (orange/yellow)  
 4. *Xanthophylls* (yellow)  
 5. *Lutein* (yellow)  
 6. *Anthocyanins* (red/purple)  
 7. *Flavonoids* (various colors)

Shafie

Eve Dharman

Reynolds

- ✓ Gen / Hqs confidence
- ✓ transparency

NA  
LNO

Therapeutic separation of states

Ed in a Party of fellow dms

Re-evaluate ltr the detainees have been categorized

Direct Address - hard report - if 1 work, if  
Naher not differ if it is - Edits / photos

Recovery to POW → elim hang state  
elim habeas corpus loc  
planning is - work

May

DoD is in charge

DoJ info POTUS who defends

Army Name

Captain 900 name

Army but administration

Very diff regime that under Miller

BSCT - Washington phenomenon

When will non value detainees be let go

What is target?

WEJD

More info, impression is

Gen/Hqs clear all states, not to rest concerns

Did not talk to any detainees or where detainees are kept

~~NA~~

Most info necessary up was on BSCT forms

Not directly - George Lake + New feed

< med supply had - media; gender issues; not the US & US >  
L - command



Or Amy: implies that you are asking the questions  
2 issues

- ① Portrayal of Alpin in interrogations practices —  
The more we would be closer if we knew they followed the 508 ~~orders~~ <sup>outline</sup>
- ② Hunger strike. Anorexia. Combat tactics. Pure protest  
on the <sup>in the</sup> ~~in the~~ <sup>and</sup> —  
③ Does make to lose the shoe They ~~pull out~~ <sup>pull out</sup> the shoe  
④ Why it's done is good  
⑤ ~~Point~~ - if genuine hunger strikes = complete to  
make the decision, understanding the weight  
that it is unknown to find for  
not an automatic decision

①  
Winkler: is there anything that really bothers you that you'd  
I should know.

~~Winkler~~

future addition of

BSCT " " who seems to interrogate

much ~~more~~ <sup>who seems to interrogate</sup> to UCMJ guidelines but not

the punishment. Accountability + oversight

presentable under civilian law

②  
General comment

More clarity on the reporting of abuse.

More: ~~BSCT~~ BSCT are combatants & — is not mix the role

Key: either it is or it is not — suffer legal + ethical + effects  
differs like Edict + Psychology. I may ~~pull out~~ <sup>pull out</sup> of psychology  
what is heavy w/ interrogations

I pointed out diff betw A, A + ABA as one of  
lasts neg ver of the ethics

Ch 14 - history - Coercion - Torture

It may be politically expedient to demand  
the way the two ver this is very different





The New York Times

U.S.

# Fresh Details Emerge on Harsh Methods at Guantánamo

By NEIL A. LEWIS JAN. 1, 2005

WASHINGTON, Dec. 31 - Sometime after Mohamed al-Kahtani was imprisoned at Guantánamo around the beginning of 2003, military officials believed they had a prize on their hands -- someone who was perhaps intended to have been a hijacker in the Sept. 11 plot.

But his interrogation was not yielding much, so they decided in the middle of 2003 to try a new tactic. Mr. Kahtani, a Saudi, was given a tranquilizer, put in sensory deprivation garb with blackened goggles, and hustled aboard a plane that was supposedly taking him to the Middle East.

After hours in the air, the plane landed back at the United States naval base at Guantánamo Bay, Cuba, where he was not returned to the regular prison compound but put in an isolation cell in the base's brig. There, he was subjected to harsh interrogation procedures that he was encouraged to believe were being conducted by Egyptian national security operatives.

The account of Mr. Kahtani's treatment given to The New York Times recently by military intelligence officials and interrogators is the latest of several developments that have severely damaged the military's longstanding public version of how the detention and interrogation center at Guantánamo operated.

Interviews with former intelligence officers and interrogators provided new details and confirmed earlier accounts of inmates being shackled for

hours and left to soil themselves while exposed to blaring music or the insistent meowing of a cat-food commercial. In addition, some may have been forcibly given enemas as punishment.

While all the detainees were threatened with harsh tactics if they did not cooperate, about one in six were eventually subjected to those procedures, one former interrogator estimated. The interrogator said that when new interrogators arrived they were told they had great flexibility in extracting information from detainees because the Geneva Conventions did not apply at the base.

Military officials have gone to great lengths to portray Guantánamo as a largely humane facility for several hundred prisoners, where the harshest sanctioned punishments consisted of isolation or taking away items like blankets, toothpaste, dessert or reading material. Maj. Gen. Geoffrey D. Miller, who was the commander of the Guantánamo operation from November 2002 to March 2004, regularly told visiting members of Congress and journalists that the approach was designed to build trust between the detainee and his questioner.

"We are detaining these enemy combatants in a humane manner," General Miller told reporters in March 2004. "Should our men or women be held in similar circumstances, I would hope they would be treated in this manner."

His successor, Brig. Gen. Jay W. Hood, told reporters in November that he was "satisfied that the detainees here have not been abused, they've not been mistreated, they've not been tortured in any way."

Journalists who were permitted to view an interview session from behind a glass wall during General Hood's tenure were shown an interrogator and detainee sharing a milkshake and fries from the base's McDonald's and appearing to chat amiably. It became apparent to reporters comparing notes in August, however, that the tableau of the interrogator and prisoner sharing a McDonald's meal was presented to at least three sets of journalists.

In addition to the account of Mr. Kahtani's treatment, the new interviews provide details and confirm some of the accounts in other recent disclosures

about procedures at Guantánamo: the November report in which the International Committee of the Red Cross complained privately last summer to the United States government that the procedures at Guantánamo were "tantamount to torture"; memorandums from F.B.I. officials, most of which were released in December as part of a lawsuit brought by the American Civil Liberties Union; and another set of interviews with The Times in October in which other former Guantánamo officials described coercive and abusive techniques regularly employed there.

The information from the various sources frequently matched, providing corroboration of the use of specific procedures, which included prolonged sleep deprivation and shackling prisoners in uncomfortable positions for many hours. One F.B.I. agent wrote his superiors that he saw such restraining techniques several times. In the most gruesome of the bureau memorandums, he recounted observing a detainee who had been shackled overnight in a hot cell, soiled himself and pulled out tufts of hair in misery.

Military officials who participated in the practices said in October that prisoners had been tormented by being chained to a low chair for hours with bright flashing lights in their eyes and audio tapes played loudly next to their ears, including songs by Lil' Kim and Rage Against the Machine and rap performances by Eminem.

In a recent interview, another former official added new details, saying that many interrogators used a different audio tape on prisoners, a mix of babies crying and the television commercial for Meow Mix in which the jingle consists of repetition of the word "meow."

The people who spoke about what they saw or whose duties made them aware of what was occurring said they had different reasons for granting interviews. Some said they objected to the methods, others said they objected to what they regarded as a chaotic and badly run system, while others offered no reason. They all declined to be identified by name, some saying they feared retaliation.

Lt. Col. Leon H. Sumpter, the spokesman for the military command at Guantánamo, said in a statement that officials would not comment on

accusations about the treatment of any individual detainee including Mr. Kahtani, who was captured in Afghanistan.

"We do not discuss specific interrogation techniques nor do we identify any specific detainee," Colonel Sumpter said in a statement. "All detainees are safeguarded and are assured food, drink, clothing, shelter, health care and basic rights, all in accordance with the Geneva Convention. The U.S. does not permit, tolerate or condone torture by any of its personnel or employees."

Colonel Sumpter said that the interrogation regimen at Guantánamo had produced useful intelligence "based on trust and not out of fear or duress."

The intelligence officials who spoke with The Times said that the interrogation personnel and their assigned prisoners were divided into five groups. Four were geographically based -- one for Saudi Arabia, one for the Gulf States, another for Pakistan and Afghanistan and the last for Asia, Europe and the Americas. The fifth, termed "special projects," included Mr. Kahtani.

There was a high confidence among military intelligence officials that Mr. Kahtani was a dangerous operative of Al Qaeda. The federal commission investigating the Sept. 11 attacks concluded in its June report that he was denied entry into the United States on Aug. 4, 2001, at the Orlando airport, the same day that Mohamed Atta, the plot's ringleader, was there and most likely intended to meet him.

The officials who spoke about the detainees' treatment said, however, that very few of the other prisoners had much value. "So much of the questioning was about Afghanistan," one intelligence official said. "Most of it was dated. Information about facilitators and recruiters was useful only in style, not in facts."

The clearest indication that senior commanders at Guantánamo were aware of and supported what was occurring may be in some F.B.I. memorandums. One, dated May 10, 2003, and written by an unidentified agent, describes a sharp exchange between bureau officials and General Miller and Maj. Gen. Michael Dunlavey, who was in charge of the intelligence operations at Guantánamo then.

"Both sides agreed that the bureau has its way of doing things and the

D.O.D. has their marching orders from SecDef," the memorandum said, using abbreviations for the Department of Defense and the secretary of defense. "Although the two techniques differed drastically, both generals believed they had a job to do."

The frustration caused by Mr. Kahtani's refusal to cooperate set off a high-level review of allowable interrogation techniques, according to documents released earlier by the Pentagon. After officials at Guantánamo asked for more leeway in dealing with Mr. Kahtani, Defense Secretary Donald H. Rumsfeld in December 2002 approved a list of 16 techniques for use there in addition to the 17 methods in the Army Field Manual. He suspended those approvals the next month after some Navy lawyers complained that they were excessive and possibly illegal. But after a review, Mr. Rumsfeld issued a final policy in April 2003, approving 24 techniques, some of which needed his permission to be used.

None of the approved techniques, however, covered some of what people have now said occurred. Mr. Kahtani was, for example, forcibly given an enema, officials said, which was used because it was uncomfortable and degrading.

Pentagon spokesmen said the procedure was medically necessary because Mr. Kahtani was dehydrated after an especially difficult interrogation session. Another official, told of the use of the enema, said, however, "I bet they said he was dehydrated," adding that that was the justification whenever an enema was used as a coercive technique, as it had been on several detainees.

In order to carry on the charade that he was not at Guantánamo, the military arranged it so Mr. Kahtani was not visited by the Red Cross on a few of its regular visits, creating a window of several months, said a person who dealt with him at Guantánamo. Officials at the Washington office of the Red Cross, which makes periodic visits to each of the Guantánamo detainees, said they would not discuss their meetings with any prisoners as part of their agreement with the United States government.

Two interrogators confirmed several of the complaints in the Red Cross report, including the notion that interrogators were able to obtain prisoners'

medical records easily, which human rights groups say could discourage inmates from seeking medical care. The interrogators also discussed another factor in the Red Cross report, the use of a Behavioral Science Consultation Team, known as Biscuit, comprising a psychologist or psychiatrist and psychiatric workers. The team was used to suggest ways to make prisoners more cooperative in interrogations.

"They were supposed to help us break them down," one said.

The same former interrogator said the Red Cross report was correct in asserting that some female interrogators used sexual taunts to harass the detainees.

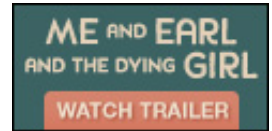
It is unclear whether the Justice Department's new, broader definition of torture, posted on the department's Web site late Thursday, would have affected operations at Guantánamo.

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June 24, 2005

# INTERROGATORS CITE DOCTORS' AID AT GUANTANAMO

By NEIL A. LEWIS

Military doctors at Guantanamo Bay, Cuba, have aided interrogators in conducting and refining coercive interrogations of detainees, including providing advice on how to increase stress levels and exploit fears, according to new, detailed accounts given by former interrogators.

The accounts, in interviews with The New York Times, come as mental health professionals are debating whether psychiatrists and psychologists at the prison camp have violated professional ethics codes. The Pentagon and mental health professionals have been examining the ethical issues involved.

The former interrogators said the military doctors' role was to advise them and their fellow interrogators on ways of increasing psychological duress on detainees, sometimes by exploiting their fears, in the hopes of making them more cooperative and willing to provide information. In one example, interrogators were told that a detainee's medical files showed he had a severe phobia of the dark and suggested ways in which that could be manipulated to induce him to cooperate.

In addition, the authors of an article published by The New England Journal of Medicine this week said their interviews with doctors who helped devise and supervise the interrogation regimen at Guantanamo showed that the program was explicitly designed to increase fear and distress among detainees as a means to obtaining intelligence.

The accounts shed light on how interrogations were conducted and raise new questions about the boundaries of medical ethics in the nation's fight against terrorism.

Bryan Whitman, a senior Pentagon spokesman, declined to address the specifics in the accounts. But he suggested that the doctors advising interrogators were not covered by ethics strictures because they were not treating patients but rather were acting as behavioral scientists.

He said that while some health care personnel are responsible for "humane treatment of detainees," some medical professionals "may have other roles," like serving as behavioral scientists assessing the character of interrogation subjects.

The military refused to give The Times permission to interview medical personnel at the isolated

Guantanamo camp about their practices, and the medical journal, in an article that criticized the program, did not name the officials interviewed by its authors. The handful of former interrogators who spoke to The Times about the practices at Guantanamo spoke on condition of anonymity; some said they had welcomed the doctors' help.

Pentagon officials said in interviews that the practices at Guantanamo violated no ethics guidelines, and they disputed the conclusions of the medical journal's article, which was posted on the journal's Web site on Wednesday.

Several ethics experts outside the military said there were serious questions involving the conduct of the doctors, especially those in units known as Behavioral Science Consultation Teams, BSCT, colloquially referred to as "biscuit" teams, which advise interrogators.

"Their purpose was to help us break them," one former interrogator told The Times earlier this year.

The interrogator said in a more recent interview that a biscuit team doctor, having read the medical file of a detainee, suggested that the inmate's longing for his mother could be exploited to persuade him to cooperate.

Dr. Stephen Xenakis, a psychiatrist and former Army brigadier general in the medical corps, said in an interview that "this behavior is not consistent with our medical responsibility or any of the codes that guide our conduct as doctors."

The use of psychologists and psychiatrists in interrogations prompted the Pentagon to issue a policy statement last week that officials said was supposed to ensure that doctors did not participate in unethical behavior.

While the American Psychiatric Association has guidelines that specifically prohibit the kinds of behaviors described by the former interrogators for their members who are medical doctors, the rules for psychologists are less clear.

Dr. Spencer Eth, a professor of psychiatry at New York Medical College and chairman of the ethics committee of the American Psychiatric Association, said in an interview that there was no way that psychiatrists at Guantanamo could ethically counsel interrogators on ways to increase distress on detainees.

But in a statement issued in December, the American Psychological Association said the issue of involvement of its members in "national security endeavors" was new.

Dr. Stephen Behnke, who heads the group's ethics division, said in an interview this week that a committee of 10 members, including some from the military, was meeting in Washington this weekend to discuss the issue.

Dr. Behnke emphasized that the codes did not necessarily allow participation by psychologists in



such roles, but rather that the issue had not been dealt with directly before.

"A question has arisen that we in the profession have to address and that is where we are now: is it ethical or is it not ethical?" he said.

Dr. William Winkenwerder Jr., assistant secretary of defense for health matters, said the new Pentagon guidelines made clear that doctors might not engage in unethical conduct. But in a briefing for reporters last week, he declined to say whether the guidelines would prohibit some of the activities described by former interrogators and others. He said the medical personnel "were not driving the interrogations" but were there as consultants.

The guidelines include prohibitions against doctors' participating in abusive treatment, but they all make an exception for "lawful" interrogations. As the military maintains that its interrogations are lawful and that prisoners at Guantanamo are not covered by the Geneva Conventions, those provisions would seem to allow the behavior described by interrogators and the medical journal. The article in the medical journal, by two researchers who interviewed doctors who worked on the biscuit program, says, "Since late 2002, psychiatrists and psychologists have been part of a strategy that employs extreme stress, combined with behavior-shaping rewards, to extract actionable intelligence."

The article was written by Dr. M. Gregg Bloche, who teaches at Georgetown University Law School and is a fellow at the Brookings Institution, and Jonathan H. Marks, a British lawyer who is a fellow in bioethics at Georgetown and Johns Hopkins Universities.

Dr. Bloche said in an interview that the use of health professionals in devising abusive interrogation strategies was unethical and led to their involvement in violations of international law. Dr. Winkenwerder said on Thursday that the article was "an outrageous distortion" of the medical situation at Guantanamo, according to Reuters news agency.

The article also challenges assertions of military authorities that they have generally maintained the confidentiality of medical records.

The Winkenwerder guidelines make it clear that detainees should have no expectation of privacy, but that medical records may be shared with people who are not in a medical provider relationship with the detainee only under strict circumstances.

Dr. Bloche said such an assertion was contrary to what he had discovered in his research. It is also in conflict with accounts of former interrogators who previously told The Times that they were free to examine any detainee's medical files. After April 2003, when Defense Secretary Donald H. Rumsfeld tightened rules on detainee treatment, one interrogator said the records had to be obtained through biscuit team doctors who always obliged.

The former interrogator said the biscuit team doctors usually observed interrogations from behind a one-way mirror, but sometimes were also in the room with the detainee and interrogator.

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U.N. Inquiry on Guantanamo

(By The New York Times) UNITED NATIONS, June 23 -- A four-member team of United Nations human rights experts accused the United States on Thursday of stalling on requests over the past three years to visit detainees at Guantanamo and said it would begin its own investigation without American assistance.

"Such requests were based on information from reliable sources of serious allegations of torture, cruel, inhuman and degrading treatment of detainees, arbitrary detention, violations of their right to health and their due process rights," the four, all independent authorities who serve the United Nations as fact-finders on rights abuses, said in a statement.

Pierre-Richard Prosper, the United States ambassador for war crimes, said the United States had been unable to meet the fact-finders' deadline to answer its request but intended to keep the matter open.

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Stephen Behnke, director of ethics for the organization, said psychologists knew not to participate in activities that harmed detainees. But Dr. Behnke also said the group believed that helping military interrogators made a valuable contribution because it was part of an effort to prevent terrorism.

Former military interrogators at Guantánamo told The New York Times last year that some psychiatrists and psychologists had advised them on how to "break" detainees to make them more cooperative. The former interrogators said they had been counseled on how to use a detainee's fears and longings to increase distress. One example was their taking advantage of a prisoner's fear of the dark, known from his medical records.

Dr. Winkenwerder, the Pentagon official, disputed those assertions Tuesday, saying he did not believe that such counseling had occurred. He said the biscuit teams gave interrogators advice only on how to establish a positive rapport with detainees.

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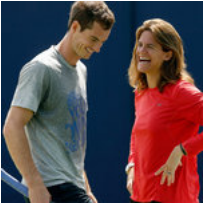


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**The New York Times**

November 30, 2004

# Red Cross Finds Detainee Abuse in Guantánamo

!

## Correction Appended

WASHINGTON, Nov. 29 - The International Committee of the Red Cross has charged in confidential reports to the United States government that the American military has intentionally used psychological and sometimes physical coercion "tantamount to torture" on prisoners at Guantánamo Bay, Cuba.

The finding that the handling of prisoners detained and interrogated at Guantánamo amounted to torture came after a visit by a Red Cross inspection team that spent most of last June in Guantánamo.

The team of humanitarian workers, which included experienced medical personnel, also asserted that some doctors and other medical workers at Guantánamo were participating in planning for interrogations, in what the report called "a flagrant violation of medical ethics."

Doctors and medical personnel conveyed information about prisoners' mental health and vulnerabilities to interrogators, the report said, sometimes directly, but usually through a group called the Behavioral Science Consultation Team, or B.S.C.T. The team, known informally as Biscuit, is composed of psychologists and psychological workers who advise the interrogators, the report said.

The United States government, which received the report in July, sharply rejected its charges, administration and military officials said.

The report was distributed to lawyers at the White House, Pentagon and State Department and to the commander of the detention facility at Guantánamo, Gen. Jay W. Hood. The New York Times recently obtained a memorandum, based on the report, that quotes from it in detail and lists its major findings.

It was the first time that the Red Cross, which has been conducting visits to Guantánamo since January 2002, asserted in such strong terms that the treatment of detainees, both physical and psychological, amounted to torture. The report said that another confidential



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2003, which has never been disclosed, raised questions of whether "psychological torture" was taking place.

The Red Cross said publicly 13 months ago that the system of keeping detainees indefinitely without allowing them to know their fates was unacceptable and would lead to mental health problems.

The report of the June visit said investigators had found a system devised to break the will of the prisoners at Guantánamo, who now number about 550, and make them wholly dependent on their interrogators through "humiliating acts, solitary confinement, temperature extremes, use of forced positions." Investigators said that the methods used were increasingly "more refined and repressive" than learned about on previous visits.

"The construction of such a system, whose stated purpose is the production of intelligence, cannot be considered other than an intentional system of cruel, unusual and degrading treatment and a form of torture," the report said. It said that in addition to the exposure to loud and persistent noise and music and to prolonged cold, detainees were subjected to "some beatings." The report did not say how many of the detainees were subjected to such treatment.

Asked about the accusations in the report, a Pentagon spokesman provided a statement saying, "The United States operates a safe, humane and professional detention operation at Guantánamo that is providing valuable information in the war on terrorism."

It continued that personnel assigned to Guantánamo "go through extensive professional and sensitivity training to ensure they understand the procedures for protecting the rights and dignity of detainees."

The conclusions by the inspection team, especially the findings involving alleged complicity in mistreatment by medical professionals, have provoked a stormy debate within the Red Cross committee. Some officials have argued that it should make its concerns public or at least aggressively confront the Bush administration.

The International Committee of the Red Cross, which is based in Geneva and is separate from the American Red Cross, was founded in 1863 as an independent, neutral organization intended to provide humanitarian protection and assistance for victims of war.

Its officials are able to visit prisoners at Guantánamo under the kind of arrangement the committee has made with governments for decades. In exchange for exclusive access to the prison camp and meetings with detainees, the committee has agreed to keep its findings confidential. The findings are shared only with the government that is detaining people.

Beatrice Mégevand-Roggo, a senior Red Cross official, said in an interview that she could not say anything about information relayed to the United States government because "we do not comment in any way on the substance of the reports we submit to the authorities."

Ms. Mégevand-Roggo, the committee's delegate-general for Europe and the Americas, acknowledged that the issue of confidentiality was a chronic and vexing one for the organization. "Many people do not understand why we have these bilateral agreements about confidentiality," she said. "People are led to believe that we are a fig leaf or worse, that we are complicit with the detaining authorities."

She added, "It's a daily dilemma for us to put in the balance the positive effects our visits have for detainees against the confidentiality."

Antonella Notari, a veteran Red Cross official and spokeswoman, said that the organization frequently complained to the Pentagon and other arms of the American government when government officials cite the Red Cross visits to suggest that there is no abuse at Guantánamo. Most statements from the Pentagon in response to queries about mistreatment at Guantánamo do, in fact, include mention of the visits.

In a recent interview with reporters, General Hood, the commander of the detention and interrogation facility at Guantánamo, also cited the committee's visits in response to questions about treatment of detainees. "We take everything the Red Cross gives us and study it very carefully to look for ways to do our job better," he said in his Guantánamo headquarters, adding that he agrees "with some things and not others."

"I'm satisfied that the detainees here have not been abused, they've not been mistreated, they've not been tortured in any way," he said.

Scott Horton, a New York lawyer, who is familiar with some of the Red Cross's views, said the issue of medical ethics at Guantánamo had produced "a tremendous controversy in the committee." He said that some Red Cross officials believed it was important to maintain confidentiality while others believed the United States government was misrepresenting the inspections and using them to counter criticisms.

Mr. Horton, who heads the human rights committee of the Bar Association of the City of New York, said the Red Cross committee was considering whether to bring more senior officials to Washington and whether to make public its criticisms.

The report from the June visit said the Red Cross team found a far greater incidence of mental illness produced by stress than did American medical authorities, much of it caused by

prolonged solitary confinement. It said the medical files of detainees were "literally open" to interrogators.

The report said the Biscuit team met regularly with the medical staff to discuss the medical situations of detainees. At other times, interrogators sometimes went directly to members of the medical staff to learn about detainees' conditions, it said.

The report said that such "apparent integration of access to medical care within the system of coercion" meant that inmates were not cooperating with doctors. Inmates learn from their interrogators that they have knowledge of their medical histories and the result is that the prisoners no longer trust the doctors.

Asked for a response, the Pentagon issued a statement saying, "The allegation that detainee medical files were used to harm detainees is false." The statement said that the detainees were "enemy combatants who were fighting against U.S. and coalition forces."

"It's important to understand that when enemy combatants were first detained on the battlefield, they did not have any medical records in their possession," the statement continued. "The detainees had a wide range of pre-existing health issues including battlefield injuries."

The Pentagon also said the medical care given detainees was first-rate. Although the Red Cross criticized the lack of confidentiality, it agreed in the report that the medical care was of high quality.

Leonard S. Rubenstein, the executive director of Physicians for Human Rights, was asked to comment on the account of the Red Cross report, and said, "The use of medical personnel to facilitate abusive interrogations places them in an untenable position and violates international ethical standards."

Mr. Rubenstein added, "We need to know more about these practices, including whether health professionals engaged in calibrating levels of pain inflicted on detainees."

The issue of whether torture at Guantánamo was condoned or encouraged has been a problem before for the Bush administration.

In February 2002, President Bush ordered that the prisoners at Guantánamo be treated "humanely and, to the extent appropriate with military necessity, in a manner consistent with" the Geneva Conventions. That statement masked a roiling legal discussion within the administration as government lawyers wrote a series of memorandums, many of which seemed to justify harsh and coercive treatment.



A month after Mr. Bush's public statement, a team of administration lawyers accepted a view first advocated by the Justice Department that the president had wide powers in authorizing coercive treatment of detainees. The legal team in a memorandum concluded that Mr. Bush was not bound by either the international Convention Against Torture or a federal antitorture statute because he had the authority to protect the nation from terrorism.

That document provides tightly constructed definitions of torture. For example, if an interrogator "knows that severe pain will result from his actions, if causing such harm is not his objective, he lacks the requisite specific intent even though the defendant did not act in good faith," it said. "Instead, a defendant is guilty of torture only if he acts with the express purpose of inflicting severe pain or suffering on a person within his control."

When some administration memorandums about coercive treatment or torture were disclosed, the White House said they were only advisory.

Last month, military guards, intelligence agents and others described in interviews with The Times a range of procedures that they said were highly abusive occurring over a long period, as well as rewards for prisoners who cooperated with interrogators. The people who worked at Camp Delta, the main prison facility, said that one regular procedure was making uncooperative prisoners strip to their underwear, having them sit in a chair while shackled hand and foot to a bolt in the floor, and forcing them to endure strobe lights and loud rock and rap music played through two close loudspeakers, while the air-conditioning was turned up to maximum levels.

Some accounts of techniques at Guantánamo have been easy to dismiss because they seemed so implausible. The most striking of the accusations, which have come mainly from a group of detainees released to their native Britain, has been that the military used prostitutes who made coarse comments and come-ons to taunt some prisoners who are Muslims.

But the Red Cross report hints strongly at an explanation of some of those accusations by stating that there were frequent complaints by prisoners in 2003 that some of the female interrogators baited their subjects with sexual overtures.

Gen. Geoffrey Miller, who commanded the detention and intelligence operation at Guantánamo until April, when he took over prison operations in Iraq, said in an interview early this year about general interrogation procedures that the female interrogators had proved to be among the most effective. General Miller's observation matches common wisdom among experienced intelligence officers that women may be effective as interrogators when seen by their subjects as mothers or sisters. Sexual taunting does not, however, comport with what is often referred to as the "mother-sister syndrome."

But the Red Cross report said that complaints about the practice of sexual taunting stopped in the last year. Guantánamo officials have acknowledged that they have improved their techniques and that some earlier methods they tried proved to be ineffective, raising the possibility that the sexual taunting was an experiment that was abandoned.

**EMAIL MESSAGES FROM THE LISTSERV OF THE AMERICAN PSYCHOLOGICAL  
ASSOCIATION'S PRESIDENTIAL TASK FORCE ON PSYCHOLOGICAL ETHICS AND  
NATIONAL SECURITY: APRIL 22, 2005 – JUNE 26, 2006**

*Editor's note: Email addresses, physical addresses and phone numbers have been deleted.*

**From:** "Behnke, Stephen" < >

**Date:** April 22, 2005 10:56:04 AM PDT

**Subject:** Welcome

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Dear Task Force Members,

By this message, I am welcoming you to the Psychological Ethics and National Security (PENS) listserve. To send a message to the list, please use this address: PENS@

This listserve is "hidden," which means that, unlike other APA listserves, it does not show up on the webportion of the server, which provides this listserve an extra layer of security. Only members of this Task Force, the APA President and Board liaisons, and relevant APA staff will have access or be able to send messages to or retrieve messages from the list.

Below you will find the welcome letter, which provides information about certain commands.

Task Force members, please send a message to the listserve by Monday COB, simply to let us know that you all have received this message and are able to send a message to the list.

Thanks so much,

Steve

Dear Colleague,

Congratulations and welcome to the PENS list.

If you are getting this message, you have been successfully subscribed to this list.

The resources (hardware, software, and technical assistance) for this effort are provided without charge by the American Psychological Association as a public service.

There are very few rules as a member of this list/forum. Few restrictions, we have found, result in the greatest number of innovative contributions. However, these rules are critically important.

If you are subscribed to this forum and especially if you send messages to the forum, you are agreeing to these rules. These rules, by the way, apply to members of nearly any Internet news or interest group. Please read the accompanying Subscription Notice Email for these rules, and/or go to this web page:

<http://listserve. /cgi-bin/wa.exe?SHOWTPL=GUIDE>

Some day you may wish to unsubscribe from the Forum. If so, please send me a message. However, if you can remember, simply send a message to:

listserv@

Use no subject line. Your message should say only:

signoff PENS

To contact the owner of the list address your message to:

PENS-request@

**From:** "Banks, Louie M. COL" <>

**Date:** April 22, 2005 11:04:03 AM PDT

**Subject:** Establish Communications

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Steve,

I received your email, and if you get this, I am on the list server.

Morgan Banks

**COL L. Morgan Banks**  
**Director, Psychological Applications Directorate**  
**US Army Special Operations Command**  
**DSN COM**  
**Cell**  
**banks!@ /louie.morgan.banks@**

**From:** Jean Maria Arrigo < >

**Date:** April 22, 2005 11:15:42 AM PDT

**Subject:** Fwd: [PRESIDENTIAL] Welcome

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Thank you. I have received the PENS listserve information and am checking in as requested.

Jean Maria Arrigo

---

Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From:** "Gerald P. Koocher, Ph.D." < >

**Date:** April 22, 2005 12:17:50 PM PDT

**Subject:** Establish Communications

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

I'm on.  
Gerry

Gerald P. Koocher, Ph.D. ABPP  
Professor and Dean  
School for Health Studies  
Simmons College

**From:** Robert Fein < >

**Date:** April 22, 2005 6:28:42 PM PDT

**Subject:** Re: Welcome

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Checking in.

Robert Fein

**From:** Nina Thomas < >

**Date:** April 22, 2005 6:53:29 PM PDT

**Subject:** Re: Welcome

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Glad to be participating,

Nina Thomas

**From:** "R. Scott Shumate" <>

**Date:** April 22, 2005 7:40:02 PM PDT

**Subject:** Checking in

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Checking in

**From:** "Col. Larry C. James PhD" < >

**Date:** April 22, 2005 11:02:28 PM PDT

**Subject:** Re: Welcome

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

yeap, I got the message Steve,

Larry James

**From:** anton < >

**Date:** April 23, 2005 6:58:06 AM PDT

**Subject:** Re: Welcome

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Steve:

I'm on.

Barry

Barry S. Anton, Ph.D., ABPP

Department of Psychology

University of Puget Sound

**From:** "Gelles, Mike" < >

**Date:** April 23, 2005 8:10:10 AM PDT

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

I received the message

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Sent from my BlackBerry Wireless Handheld

**From:** "Gelles, Mike" < >

**Date:** April 23, 2005 8:22:52 AM PDT

**Subject:** Fw: Presidential Task Force

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

nt from my BlackBerry Wireless Handheld

-----Original Message-----

**From:** Behnke, Stephen < >

**To:** Gelles, Mike < >

**Sent:** Wed Apr 20 22:01:35 2005

**Subject:** RE: Presidential Task Force

Mike--thanks, excellent thoughts & observations. If you'd be willing, please put them on the listserve (that you'll receive information about shortly). I'd like the others to read. It's extremely helpful having people like yourself with so close to the ground.

Steve

-----Original Message-----

**From:** Gelles, Mike [mailto: ]

**Sent:** Wednesday, April 20, 2005 8:38 AM

**To:** Behnke, Stephen

**Subject:** Re: Presidential Task Force



Steve as we move forward and based on the composition of the group DOD is trying to update current policy on interrogation. Interesting in that it initially tried to incorporate behavioral consultant into the policy. My and others position was that "behavioral consultant" should not be included in a general policy statement but more clearly defined as a resource and then further defined as who what etc that resource is and does. I think based on the GTMO experience putting mental health care professionals in the role of having to consult on interrogations when their training and role is to treat patients puts them in an untenable position. They do not have the training as it relates to being a consultant to interrogations and an awareness of where the lanes in the road are interrogation is a law enforcement and intelligence function. While we may serve as consultants to the interrogator there are areas which we need to know not to go. I mentioned to DOD that APA was looking at the role of psychologists.

Mike

-----

Sent from my BlackBerry Wireless Handheld

**From:** "LeFever, Bryce E. (CDR)" < >

**Date:** April 25, 2005 6:36:30 AM PDT

**Subject:** Re: Welcome

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Received.

Bryce Lefever

**From:** Olivia Moorehead-Slaughter < >

**Date:** April 27, 2005 1:45:03 PM PDT

**Subject:** Welcome to All

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Hello Everyone,

This is a message to welcome you to the Presidential Task Force on Psychological Ethics and National Security. I am looking forward to meeting each of you in Washington in June and know that we will be fully engaged in our discussions around this important topic in the weeks leading to that time. Thank you for your interest in coming together to contribute your time and talents towards grappling with the myriad of ethical issues within our profession in relation to national

security. Your expertise will be invaluable as we think, discuss, and ultimately document our collective response. It is both a pleasure and an honor to chair this committee and I look forward to working with all of you.

Sincerely,

Olivia Moorehead-Slaughter

**From:** "Col. Larry C. James PhD" < >

**Date:** April 27, 2005 7:42:38 PM PDT

**Subject:** Re: Welcome to All

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Same here, I look forward to meeting you and working with you.

Larry James

**From:** Olivia Moorehead-Slaughter < >

**Date:** May 2, 2005 11:41:10 AM PDT

**Subject:** Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Hello Everyone,

I suspect that all of you have been perusing the rather thick book of readings as have I. I took Steve Behnke's suggestion in terms of where to start and I find myself thoroughly engrossed by what I have been reading. The issues related to ethics, individual versus social concerns, harm, and the role of the psychologist, to name a few, deserve much consideration.

Mike, I began my reading with your article which I found quite compelling. To get the discourse started, would you be willing to comment on your article, particularly noting whether it is an accurate representation of your current thinking? If not, how has your thinking changed and what might be some of your current commentation on this subject? (There are also two newspaper articles in which Mike is mentioned under Tabs 17 and 26.)

As this dialogue begins, I am sure that the core and salient issues which this Task Force has been charged to address will emerge and I will do my best to capture these along the way. It is my hope that by our June meeting, all of us will feel meaningfully engaged in discussion around these issues as a group and poised to think about and to talk about the document that we will draft.

Many thanks.

Olivia

**From:** "Gelles, Mike" < >

**Date:** May 3, 2005 4:59:38 AM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@. >

Olivia,

The article was written a couple of years ago. It was an attempt to put out in the professional arena issues that were ethical challenges for those of us who practice outside of the conventional world of psychology and who were held accountable to standards that did not fit what we did or the challenges we faced.

Perhaps most importantly, the article was meant to be provocative, to get others to think about what the challenges were and for the profession to move forward in considering how to adapt and interpret the ethical guidelines to a changing role of psychology that was beyond the treatment room and classroom. As psychologists broadened their role and became "more visible" in the government, law enforcement and intelligence community there were new demands placed upon us, serving our client the "organization". As Chuck Ewing has said on many an occasion when we were writing this article, the Agency is entitled to consultation just as an individual. This not to suggest that this had not been occurring it just became more visible. In the Squillicote case referenced in the article, and to some extent my experience with the King case, a new demand to re-think how the profession was going to hold psychologists in practice accountable in contexts outside of the clinical and academic arena's was becoming more evident. Psychology as a profession had begun it's own struggle in finding a comfortable place with the "new" and more visible role of psychology in national safety and security. Psychology now had to

provide some guidance to psychologist to exercise their best judgment when asked to consult in situations of national safety and security.

My thinking at best has continued to evolve since the article was written based on the new challenges I have had to confront in the GWOT as a psychologist directly involved in operational consultation and responsible for the oversight of other psychologist doing the same. There are several tenets that I have begun to adhere to in my practice.

1. Recognize who is the client. The client is the organization; Agency, Government etc. Adhere to what is sound judgment and not be unduly influence by the organization or the emotionality of it's leadership who is often under pressure from higher up who may have a political agenda and been relatively uninformed of ground level operations.

2. Provide a disciplined consultation, remain strict in adherence to role and function and stay in your lane. Don't try to assume responsibilities or functions of the roles of others to be helpful. For example, in an interrogation consultation, be a psychological consultant, not an interrogator. Based on what is available today in regard to sources of behavior in which to conduct an indirect assessment, there is no need to go into a room with a subject. If in fact the psychologist is well trained in the area of consultation, indirect assessment and interrogation he or she can be effective without having to comprise their role. In the area of source assessment is easier today to identify yourself as a psychologist and move away from a more clandestine role.

3. Being an organizational consultant requires being responsible for staying in your lane and being accountable for what you suggest and what you do. What we see in less experienced and untrained psychologists (in this arena) is the tendency to want to be helpful and try to be everything to everyone in the service of national safety and security. It is exciting to be in the game and with those who have minimal experience in the context of operational psychology they subsequently step over the boundaries into other professional roles that both compromise their effectiveness and the value of a psychological consultation. It puts them and psychology in an ethical dilemma. We must think about what we are being asked, be responsible when we are asked to do something that is inappropriate and have a channel or chain of command in which to report such.

4. Each consultation requires careful thought and consideration. Models and templates are not effectively applied across subjects. The contexts in which interrogations and assessments are conducted are variable and in some cases change over time. Subject's change over time impact by incarceration etc as well as the value of what they know may erode with time. People who may work for the government are impacted by events and time. It is important for psychologists not to get caught up in the agenda that others hold. Be focused on what is safe, what is effective and what may be moral and ethical.

5. The GWOT and the threat to the US is ambiguous and ever changing. It is a problem that requires a multidisciplinary response. There is no on profession that can offer a specific solution, rather the whole in this case is greater than the sum of the parts. For example, it is important to have some knowledge of the contexts in which you are consulting. There are other professionals such as intelligence analysts who have expertise in different contexts who in partnership with the psychologist can provide the necessary background and foundation from which behavior can be assessed and interpreted. This include, culture, ethnic issues, geographic, etc. In all case that are related to law enforcement and the intelligence community psychologists are not strategic decision makers. Their role is to inform and advise the strategic decision

maker. The goal is to offer insight into the adversary that will help the decision maker in optimizing his actions and maximizing his resources to accomplish the mission.

6. Keep operational consultants separate from health care providers. The field has broadened enough so that we should not expect the psychologist who is operating as a care giver to without sufficient training, experience and supervision to go from the treatment room to the interrogation compound. In general a clinician does not do well operationally, without the appropriate training, mindset and supervision. This is not to say we do not use clinical skills, they are adapted to the operational context and environment so that they are useful to the client.

7. Do no harm. Competence is a critical issue. This includes not just the appropriate training but the appropriate level of experience and oversight. Talking with other professionals regarding the complex nature of consulting on national security and national safety issues is critical. In some cases, doing nothing can also do harm. Understand the context in which you are operating and use other professionals not just other psychologists. Develop as set of competencies and operate within them.

The role of the psychologist quite obviously goes well beyond just interrogation. it is incorporated into source assessment, risk assessment and other related consultations. It is important in my mind that in times of anxiety and worry in the face of an ambiguous threat that we provide psychologists some guide posts to help them remain in their lanes when conducting highly valuable consultations in the service of national safety and security. What we bring to the table in regard to translating behavior for strategic decision makers is at times invaluable and should continue to develop as it has over the years prior to 9/11. Today which just have to recognize that it is all a lot more visible.

Hope that helps.

Michael G. Gelles, Psy.D.

Chief Psychologist

Naval Criminal Investigative Service

Phone: Fax:

**From:** Olivia Moorehead-Slaughter < >

**Date:** May 6, 2005 7:05:09 AM PDT

**Subject:** Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >



Mike has provided an excellent response which is rich in content, poses excellent points for our consideration around ethical practice, and definitely moves us forward in terms of thinking critically about ethical guidelines. One of our goals will be to examine the Ethics Code in light of our discussions and conclusions, to determine whether or not the Ethics

code adequately speaks to these issues. There are several key issues highlighted in Mike's message that provide a good starting point for this discussion.

In his seven points, Mike touches upon several concepts that are in the Ethics Code. For example, he begins by saying "Recognize who is the client," (Point #1) which is the concept found in several ethical standards, e.g., ethical standards 3.07 and 3.11. He then says "Stay in your lane," (Point #32) which I take to mean stay in your role, and he elaborates on this idea by saying that the roles of operational consultants and health care providers are decidedly different and should be kept separate. Clarity about role is another concept found throughout the Ethics Code (see standards 3.07 and 3.11). Mike also ties together the concepts of "Do no harm" (Point #7; Principle A in the Ethics Code) with competence (Section 2 in the Code), and he provides a compelling description of the pull to go beyond one's competence, especially for younger psychologists and perhaps those who find themselves interested in branching out into this very intriguing area of practice.

Mike, you have noted that we need to help psychologists apply the Ethics Code to situations of national safety and security. Is our challenge to think through how the Ethics Code applies--something that we, as a profession, do not have a great deal of experience doing--or is the challenge that the Ethics Code does not adequately speak to the roles and tasks that psychologists working in this area are asked to take? If the Ethics Code does not adequately speak to these roles and tasks, do we have examples of where it falls short?

I look forward to hearing from Mike and others who may want to join in the discussion of these issues and to raise others that emerge as you are pondering what is before us.

Many thanks.

Olivia

**From:** Gerry Koocher < >

**Date:** May 6, 2005 7:21:27 AM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Olivia Moorehead-Slaughter wrote:

Mike has provided an excellent response which is rich in content....In his seven points, Mike touches upon several concepts that are in the Ethics Code. For example, he begins by saying "Recognize who is the client,"

You are quite right about this excellent analysis. I believe that when we start talking in person the question of "who is the client" will come up in multi-layered fashion. For example, the school psychologist has professional obligations to the child s/he evaluates, the parents or guardian, the school superintendent, the school board, etc. In such cases, I have generally argued that the psychologist must hold paramount the welfare of the most vulnerable party (i.e., usually the child).

The government-employed psychologist has a similar chain of responsibility and accountability. In many of the circumstances we will discuss when we meet the psychologist's role may bear on people who are not "clients" in the traditional sense. Example, the psychologist employed by the CIA, Secret Service, FBI, etc., who helps formulate profiles for risk prevention, negotiation strategy, destabilization, etc., or the psychologist asked to assist interrogators in eliciting data or detecting dissimulation with the intent of preventing harm to many other people. In this case the client is the agency, government, and ultimately the people of the nation (at risk). The goal of such psychologists' work will ultimately be the protection of others (i.e., innocents) by contributing to the incarceration, debilitation, or even death of the potential perpetrator, who will often remain unaware of the psychologists' involvement.

This will require some thought about how to offer reasoned guidance to professionals involved in such critical national security roles.

Regards,

Gerry

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Gerald P. Koocher, Ph.D., ABPP  
Professor and Dean  
School for Health Studies

email:

[www.ethicsresearch.com](http://www.ethicsresearch.com)

President-elect, American Psychological Association

**From:** Olivia Moorehead-Slaughter < >

**Date:** May 10, 2005 12:42:19 PM PDT

**Subject: Re: Discussion**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Thanks Gerry for encouraging us to further ponder the question of "who is the client" and for raising the broader issue of whether we might have ethical obligations even to individuals or entities who are not our clients. In looking at the APA Ethics Code (Tab 4), consider the section which states that "in their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons..."

Who are the "other affected persons" in the context of our Task Force?

Gerry, you begin your note by using as an example a school psychologist, and you state "I have generally argued that the psychologist must hold paramount the welfare of the the most vulnerable party (i.e., usually the child)," even though the child may not be identified as the psychologist's client. How do you think this notion of "most vulnerable party" translates from the school context to our (national security) context?

Gerry and others, please feel free to join in with responses to this and other issues that are of interest to you as you think about the tangle of issues before us.

Many thanks.

Olivia

**From:** "Gerald P. Koocher, Ph.D." < >

**Date:** May 10, 2005 4:58:43 PM PDT

**Subject: Re: Discussion**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Dear Olivia (and colleagues):

In using that example (school) I sought to peel the ethical artichoke with an obvious "most vulnerable party." We clearly have a duty to the child in such contexts, even though we may be retained by others, since the referral is "all about the child." However, in the national security context it is easily plausible that the focus of the psychologist's professional efforts may be someone who seeks to harm others or who might be influenced to help prevent harm from befalling others. I do not think that such thoughts were ever directly discussed by the task force, although there was a military psychologist in the group. We tended to focus on notification regarding limits of confidentiality and limits on autonomy related to some practice domains



(e.g., active duty military, prisoners, disability examinees, etc.). I think this is a challenge the PENS task force will need to think through.

Regards,

Gerry

**From:** Olivia Moorehead-Slaughter < >

**Date:** May 11, 2005 1:59:09 PM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Hello to All,

Gerry's reference to the "ethical artichoke" is an apt one. Identifying the layers and providing some guidance to psychologists around how to proceed in cases where they must consider their ethical responsibility to more than one entity will likely be key. There may yet be parts of the Code that do address some of these issues and where possible, we should likely take our guidance from this document. However, some of this is clearly (on unclearly) uncharted territory. How can the psychologist ethically respond when there are seemingly conflicting interests involved?

Back to the questions asked by Mike and Gerry: 1) Who is the client? 2) To whom do we have ethical obligations? It is notable that the answers to these 2 questions may not be the same. Morgan, given your background with the Army Inspector General's team and your involvement in training, how do you address these issues in your training?

As always, all thoughts and comments are welcome.

Thanks!

Olivia

**From:** "Banks, Louie M. COL" < >

**Date:** May 11, 2005 3:11:05 PM PDT

**Subject:** Thoughts for the Presidential Task Force

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

To all,

I must say that the conversation so far has been extremely thought provoking, and I am looking forward to sitting down with all of you. Although I am involved in a number of areas that the TF may study, it seems that the area of psychology support to detainee and interrogation operations is the one of greatest controversy.

I strongly concur with most of Dr. Gelles's comments, especially concerning the need for guidance to psychologists providing this type of support. In my opinion, there is a great paucity of training generally available to psychologists in this area. My main interest is in psychology support to DoD organizations, and in providing clear guidance to the Army psychologists that I train and to whom I provide oversight. Because of that, I have attached a document that is critical to DoD psychologists supporting any type of detainee operation. It is the regulation that governs how all DoD personnel must treat detainees. It is binding on all DoD personnel, not just Army personnel. Although it is published by the Army, each of the services uses the same document. (I probably should have been more proactive and gotten it into the packet we were given--my poor planning.)

[See: ARMY-MP Detainee-regs]

I believe that understanding what the legal requirements are for the treatment of detainees is a critical first step as we develop our thoughts on the ethical standards. I am not saying that there may not be conflict between the two, but I believe it is important to understand the legal requirements first.

Many of the articles we were provided, (and many others in the press,) allege psychologists have been involved in the abuse of detainees. I think it is valuable to break that possible abuse into at least two categories. The first category would be behavior that is illegal. The abuse of detainees due to the social and psychological factors inherent in warfare certainly has occurred. The abuses I am discussing here are those that are illegal under both U.S. and international law. I would expect that there would be general agreement that any psychologist participating in, or condoning such acts should be investigated in accordance with applicable laws. It may also be appropriate to address ethical violations in such cases, but I would expect limited disagreement if such illegal acts were substantiated.

The bigger challenge for us would be the second category of abuse, or potential abuse. That would be behavior that is legal under U.S. law, but that may violate the APA ethical standards, or perhaps would include behavior that is not covered under the ethics code. If I understand correctly, this is the crux of the question that Dr. Moorehead-Slaughter brought up a couple of emails back. I guess that I am simply saying, in a very longwinded way, that a psychologist who participates in the illegal abuse of detainees is already violating U.S. law, regardless of the justification. If a DoD psychologist is aware of the illegal abuse of detainees, and does not attempt to prevent or stop it, he or she is culpable, and should be charged, at least, with dereliction of duty. The challenge that I see is that of investigating what legal behavior is ethical, and then deciding how to establish standards for that behavior.

I expect that this not so shy group may disagree with some or all of my comments, so I await your thoughts.

Very respectfully,

Morgan Banks

**COL L. Morgan Banks**  
**Director, Psychological Applications Directorate**

**US Army Special Operations Command**  
**DSN COM**

**From:** "Banks, Louie M. COL" <>

**Date:** May 11, 2005 3:43:53 PM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Olivia,

(I think our emails crossed, sorry.) The DAIG team addressed the legal and regulatory aspects of detainee operations, to include interrogation. By definition, they were not charged with looking into ethical issues, unless they crossed legal boundaries. We did, however, look deeply into the factors that increased the likelihood of abuse. Although psychology, per se, was not a topic, the leadership lapses that increased or decreased the likelihood of abuse were investigated. This is often where psychology can have a very powerful impact. But back to your questions.

1. For us, the client is clearly the organization. The following (all in quotations) are quotes from the written instructions I give to my psychologists.

"While performing the duties related to interrogation the psychologist functions as a Command Psychologist. The client is the command and the U.S. government."

and

"Except under very unusual circumstances, the psychologist consulting for interrogation operations does not conduct mental health evaluations or provide mental health treatment to detainees. All medical treatment, to include mental health evaluation and treatment, for detainees is provided by a designated medical element not involved in interrogation support. The psychologist will take all reasonable steps to ensure that he or she is not perceived as a healthcare provider for detainees."

I can go into more detail, but the bottom line is that the Command (an army term meaning the unit and its leadership) is the client. (This does not mean that

the psychologist is working only for the individual commander. It actually has a broader meaning, to include a duty to the entire chain of command, and ultimately to the constitution.)

2. This is harder for me to answer. Some ethical obligations exist completely separate from the client. For example,

"The Code of Ethics (3.10(b)) also states, "When consent by a legally authorized person is not permitted or required by law, psychologists take reasonable steps to protect the individual's rights and welfare.""

"Any psychologist, whether supporting interrogations or not, has a duty to ensure the humane treatment of all detainees."

This would be a case of the ethics code obligation existing independent of the client. On the other hand, assuming that the psychologist has not directly interacted with a detainee (consistent with Mike Gelles' comments) and there is no implication of a psychologist-patient relationship (in fact, the detainee should not even know of the existence of the psychologist) then there would be no expectation of confidentiality. Hence, no ethical obligation to the detainee of confidentiality.

Finally, psychologists supporting interrogations have as one of their objectives:

"To provide psychological expertise to assist the command in ensuring that the interrogation process is conducted in a safe, legal, and ethical manner."

In this case, the client is not simply the individual unit or commander, but the command in the broader sense that I discussed above.

I do not feel I have addressed your question very well, and will need to think about it in more detail.

Morgan

COL L. Morgan Banks

Director, Psychological Applications Directorate

US Army Special Operations Command

DSN COM

From: Jean Maria Arrigo <>



**Date:** May 11, 2005 9:29:00 PM PDT

**Subject:** PENS -Squillacote Case

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

PENS Colleagues:

The PENS papers related to the Squillacote espionage case (Tab 49) lay out the moral parameters of psychologists' participation in spycatching. The most interesting to me is Philip Candilis' contrast between work in the open society and work in the secret society, with his implicit standard that they be governed by the same set of rules (5th article at Tab 49, end of p. 455). An FBI psychologist had designed a successful entrapment scheme based on Squillacote's severe vulnerabilities. Even if we agree with Special Agent John Schafer that the FBI psychologist acted ethically in balancing national interests against Squillacote's interests (2nd article at Tab 49), the question remains whether the psychologist's identity should have been withheld during the prosecution of Squillacote.

In the 1977 Senate investigation of the infamous CIA behavioral modification project MKULTRA, DCI Stansfield Turner argued against revealing the identities of scientists and clinicians. At least 144 universities, hospitals, and research institutes had participated. Turner said, "I believe we all have a moral obligation to these researchers and institutions to protect them from any unjustified embarrassment or damage to their reputations which revelation of their identities might bring." And the U.S. Supreme Court later ruled to keep secret the names of the 185 MKULTRA researchers and their institutions. But how do we know the embarrassment or damage to their reputations was "unjustified," as opposed to justified but inconvenient? Covering their identities, of course, left them in place for similar national security projects, whether justified or unjustified.

Societal response is a natural check on the behavior of professionals, if they acknowledge the work for which they accept money and privileges. But then we run into another problem. Intelligence agencies often deceive scientists about the meaning of their work or provide plausible deniability. Ultimately, to demand that psychologists take responsibility for their contributions to national security projects is to demand that their superiors inform them about the meaning of their work. This is impossible though in a field where secrecy and compartmentalization of information are crucial to its utility and where uncertainty is high. In many domains of national security, psychologists cannot both be effective employees AND be subject to independent ethics review. Yet without independent ethics review, there is no way to distinguish between (a) justifiable moral trade-offs for national security gains and (b) deluded, incompetent, or self-interested behavior. It is a truism of organizational theory that problems heap up where accountability is lacking

(as in the childhood sex abuse scandal of the Catholic Church). I think a foundational question for PENS is whether outside accountability CAN be designed into the national security positions of psychologists whose effectiveness depends on secrecy.

Jean Maria Arrigo

**From:** Gerry Koocher <\_>

**Date:** May 12, 2005 7:18:44 AM PDT

**Subject:** Re: PENS -Squillacote Case

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

**Jean Maria's thoughtful comments prompted some reactions, inserted in blue (below).**

**Gerry**

Jean Maria Arrigo wrote:

PENS Colleagues:

The PENS papers related to the Squillacote espionage case (Tab 49) lay out the moral parameters of psychologists' participation in spycatching. The most interesting to me is Philip Candilis' contrast between work in the open society and work in the secret society, with his implicit standard that they be governed by the same set of rules (5th article at Tab 49, end of p. 455). An FBI psychologist had designed a successful entrapment scheme based on Squillacote's severe vulnerabilities. Even if we agree with Special Agent John Schafer that the FBI psychologist acted ethically in balancing national interests against Squillacote's interests (2nd article at Tab 49), the question remains whether the psychologist's identity should have been withheld during the prosecution of Squillacote.

**The "question" is actually MANY questions. It seems clear that the legal question has been resolved, and in so doing the dispute resolution mechanism of our society (i.e., the courts) have done some balancing and rendered an answer. The ethical questions accompanying the withholding of the psychologist's identity are inextricably bound up with value ethics.**

In the 1977 Senate investigation of the infamous CIA behavioral modification project MKULTRA, DCI Stansfield Turner argued against revealing the identities of scientists and clinicians. At least 144 universities, hospitals, and research institutes had participated. Turner said, "I believe we all have a moral obligation to these researchers and institutions to protect them from any unjustified embarrassment or damage to their reputations which revelation of their identities might bring." And the U.S. Supreme Court later ruled to keep secret the names of the 185 MKULTRA researchers and their institutions. But how do we know the embarrassment or damage to their reputations was "unjustified," as opposed to justified but inconvenient? Covering their identities, of course, left them in place for similar national security projects, whether justified or unjustified.

**At least one ethics complaint against an APA member psychologist resulted from MKULTRA activities during my service on the Ethics Committee (1976-79).**

Societal response is a natural check on the behavior of professionals,

**I am not certain this is true, and reject it as a foundational premise. "Society" is a very slippery concept in the heterogeneity of America. Too often, we face societal decisions based essentially on the lowest common denominator or on "spun" news and manipulated communications. Intensely held views on the gay marriage issue, for example, juxtaposed with psychologists offering "conversion" therapies aimed at making gay people "go straight" are couched in moral and ethical values by some. Does "societal response" mean a vote of the majority; respect for minority viewpoints; the muckraking of the American press; the viewpoint of red sate fundamentalists; etc.? I think "societal response" is an illusory concept of little pragmatic utility in the long run.**

**From:** "Col. Larry C. James PhD" <>

**Date:** May 12, 2005 10:12:11 AM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Hi Olivia, I thought That I should add an update for everyone in regards how I dealth with "who is the client" while I was assigned to Abu Ghraib.

As Morgan knows, after the work of the IG team was done, Morgan sent me to Abu Ghraib to put procedures into place so that this terrible tragedy would never happen again.

1. most often, the psychologist is in a very difficult situation because she/he is rated by (works for and reports to) the MI (Military Intelligence) Brigade Commander or Battalion Commander. So this begs the question? what does the psychologist do if he disagrees with the brigade commander (his/her boss)?

Based on a recommendation from Morgan, when I went to Abu Ghraib, I requested 2 very important things:

1) I worked directly for the commanding general (a 2 star general). Thus no one at Abu Ghraib had the legal nor military authority to tell me what to do.

Now Olivia what came out of this was that the commanding general also put me in the "IG" role, thus, I had oversight over everything.

2). the second thing I requested was to have legal authority to STOP any interrogations/interviews when I thought something was inappropriate. Meaning, a psychologist (me) had veto authority to stop anything that I thought was harmful, dangerous, unethical, illegal, etc. The general easily concurred with this request. It allowed me to work for the military client, but also ethically look out for the welfare for the detainees as well.

3) a third function evolved out of this, I brought in a lawyer to review everything to make sure we were in compliance with the Geneva convention and a medical team to do physical examinations on all detainees before and after all interrogations. I organized all of us under a behavioral science directorate which did not fall under the MI commander but rather the general. That way, no one at Abu Ghraib could pressure any of us in doing anything we thought to be medically wrong under the concept of "do no harm," legally wrong or unethical.

By the way the MI community hated me for this :) needless to say, since June of 2004 we have not had any new abuse allegation at Abu Ghraib.

Morgan, did I leave out anything?

thanks,

Larry James



**From:** Gerry Koocher <\_>

**Date:** May 12, 2005 10:28:42 AM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

Col. Larry C. James PhD wrote:

Based on a recommendation from Morgan, when I went to Abu Ghraib, I requested 2 very important things:

**Larry (and all),**

**This is a wonderful account of your your psychological and military command structure enabled you to know what you needed. I suspect that you got what you asked for, both because the upper echelons of command recognized the same issues you did AND because of public embarrassment of the prior abuses.**

**We'll need to think of two other scenario types:**

**#1 - What happens when a more junior of less empowered psychologist finds him/herself in an ethically challenging situation?**

**#2 - What happens when the powers that be determine that an emergency exists? [My wife has me addicted to a "24" ---watch it Monday night --- in which non-psychologist terrorist hunter Jack Bauer routinely inflicts painful injury on suspects as he attempts to stop a terrorist caused nuclear disaster.]**

**Regards,**

**Gerry**

**From:** "Gelles, Mike" <\_>

**Date:** May 13, 2005 7:36:22 AM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

Larry's position an ability to negotiate an ethical challenge is not only admirable but laudable. From discussions with Morgan I know that the challenges in the military as a whole are enourmous as psychologists with an expert resource have to negotiate chains of commands and be placed in positions where their carrers and future as military officers can be directly impacted.

When we recognized what was occuring in GTMO and used the chain of command as civilians we were at much less risk.

Having a personal history as a military officer and psychologist and my current view and anticipation of the psychologists role evolving ands providing a variety of supports to Combatant Commnders that will go well beyond interrogation. The definition of role and function and guide posts that help those in the military negotiate very difficult positions should be discussed by our group. Perhaps a set of recomendations offered to DOD to inform senior leadership not just the value psychologists bring to the table but the limits that they must impose on themselves as professional psychologists.

In the law enforcement realm we are very involved in the interrogation process however, do not exercise any decision making or direction on the process but only provide advisement to the stratyegic decion maker. We recognize and acknowledge that interogations are a law enforcemnt function which we have a narrowly defined role and are adjunct resources and not decision makers.

Again , I look forard to discussions with Larry and Morgan from the perspective of how the process unfolded and how we can learn from those challenges and hopefully come up with a set of recommendations that can meet the needs of all psychologists in all contexts and avoid making the military psychologist any more unique or vulnerable than she or he has to be.

Mike

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Sent from my BlackBerry Wireless Handheld

**From:** "Gerald P. Koocher, Ph.D." <>

**Date:** May 13, 2005 2:10:42 PM PDT

**Subject:** Re: Thoughts for the Presidential Task Force

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Banks, Louie M. COL wrote:

The bigger challenge for us would be the second category of abuse, or potential abuse. That would be behavior that is legal under U.S. law, but that may violate the APA ethical standards, or perhaps would include behavior that is not covered under the ethics code. If I understand correctly, this is the crux of the question that Dr. Moorehead-Slaughter brought up a couple of emails back. I guess that I am simply saying, in a very longwinded way, that a psychologist who participates in the illegal abuse of detainees is already violating U.S. law, regardless of the justification. If a DoD psychologist is aware of the illegal abuse of detainees, and does not attempt to prevent or stop it, he or she is culpable, and should be charged, at least, with dereliction of duty. The challenge that I see is that of investigating what legal behavior is ethical, and then deciding how to establish standards for that behavior.

This is the crux of the matter!

Gerry

**From:** "Banks, Louie M. COL" <>

**Date:** May 13, 2005 3:05:03 PM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

My thoughts on Gerry's questions are inserted below.

Morgan

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**From:** Presidential Task Force on Psychological Ethics and National Security  
[mailto:PENS@ ] **On Behalf Of** Gerry Koocher  
**Sent:** Thursday, May 12, 2005 1:29 PM  
**To:** PENS@  
**Subject:** Re: [PRESIDENTIAL] Discussion

Col. Larry C. James PhD wrote:

Based on a recommendation from Morgan, when I went to Abu Ghraib, I requested 2 very important things:

Larry (and all),

**This is a wonderful account of your your psychological and military command structure enabled you to know what you needed. I suspect that you got what you asked for, both because the upper echelons of command recognized the same issues you did AND because of public embarrassment of the prior abuses.**

**We'll need to think of two other scenario types:**

**#1 - What happens when a more junior of less empowered psychologist finds him/herself in an ethically challenging situation?**

[Banks, Louie M. COL] This is, of course, a risk for anyone in a structured, hierarchical organization. I believe that the best answer lies in proper training, which requires that we help establish standards of conduct/ethical guidelines for our psychologists, and then make sure that these standards are promulgated throughout any organization that utilizes psychologists in these roles. In other words, we make sure the psychologist understands clearly the ethical standards, and then make sure that his or her supervisor also understands the standards. Additionally, we can work to establish various control processes that prevent the type of behavioral drift that can occur in stressful situations.

**#2 - What happens when the powers that be determine that an emergency exists? [My wife has me addicted to a "24" ---watch it Monday night --- in which non-psychologist terrorist hunter Jack Bauer routinely inflicts painful injury on suspects as he attempts to stop a terrorist caused nuclear disaster.][Banks, Louie M. COL] To me, this is simply a case of raising the pressure to act unethically or more likely, illegally, to a higher level. Technically, no one has the authority to tell a soldier to commit an illegal act. Now, that certainly sounds naive, and I do not mean to say that it will not happen -- history is replete with examples. I just believe that ethical standards should be written to include "emergencies." (One man's emergency is another man's opportunity...)**

Regards,

Gerry

From: Nina Thomas <\_>

Date: May 13, 2005 7:09:21 PM PDT

Subject: Discussion

Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

This discussion has been rich and fascinating. I want to jump in at this point with several thoughts. In particular I don't want to lose the thread Mike Gelles started regarding his injunction to psychologists to "stay in lane" and resist the excitement of being "in the game." Certainly I have seen similar tendencies to "leap into the fray" amongst those involved in responding to acute traumatic situations. The pull to such potential boundary violations arises not only for the inexperienced psychologist (though it may be most pronounced for such professionals) but also because of the atypical context of the work being done. That said, particular consideration to the steps that would enable the professional to avoid such pulls seems like an important piece of the guidance we can provide.

In addition, I would add a consideration to the discussion of the psychologist's participation in interrogation practices in "emergency" situations. There have been several references to legal limitations on such practices as directed, for example, by the Geneva Conventions, etc. But, as we all know, there is an obvious problem created when the operant law is in question. Clearly law and ethics are not necessarily congruent but when they are *incongruent*, where then does that put the psychologist? And, what can we offer to help guide the professional through such an eventuality?

In some respects I am "bookmarking" here but I didn't want to lose track of these several thoughts.

Nina Thomas

**From:** "Gerald P. Koocher, Ph.D." <>

**Date:** May 14, 2005 1:03:39 PM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Nina Thomas wrote:

This discussion has been rich and fascinating. I want to jump in at this point with several thoughts. In particular I don't want to lose the thread Mike Gelles started regarding his injunction to psychologists to "stay in lane" and resist the excitement of being "in the game." Certainly I have seen similar tendencies to "leap into the fray" amongst those involved in responding to acute traumatic situations.

**Good point! This also occurs in child custody and child sexual abuse work from time to time (e.g., extremely vulnerable people under extreme pressures).**

In addition, I would add a consideration to the discussion of the psychologist's participation in interrogation practices in "emergency" situations. There have been several references to legal limitations on

such practices as directed, for example, by the Geneva Conventions, etc. But, as we all know, there is an obvious problem created when the operant law is in question. Clearly law and ethics are not necessarily congruent but when they are *incongruent*, where then does that put the psychologist?

**Another great point; especially in the context of the various White House Counsel/Department of Justice memoranda that circulated on a range of issues including what constitutes "torture" or "enemy combatant." This may be a unique period in U.S. history, post-civil war, in terms of defining "enemy," not to mention whether an opinion given to the President by counsel will ultimately lead to trickle down chain of command crises in determining what constitutes a "legal" versus "illegal" order.**

Gerry

**From:** Olivia Moorehead-Slaughter <>

**Date:** May 17, 2005 2:09:19 PM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Hello to All,

I am thoroughly impressed with the thoughtful discourse which is underway regarding some very difficult issues related to legal vs. illegal actions, the role of the military psychologist involved in interrogation activities with detainees, Command as client, and the evolving role of psychologists in the military who may be asked to provide more than assistance around interrogation. I don't have deep wisdom to shed on these topics, but I think that we are beginning to hone in on some areas that will need particular focus in our discussions and in our final document. Morgan, I'd like to ask you a bit more about a couple of issues that you raised in your responses. You noted that "there is a paucity of training generally available to psychologists in this area", i.e. support to detainee and interrogation operations. What do you believe constitutes good ethical training in this area? Also, could you perhaps give some examples of behaviors that are legal but not ethical, or legal but not covered by the Ethics Code? Mike, I agree that one of the outcomes of this Task Force should be guidance/recommendations for military psychologists who can easily find themselves between a rock and a hard place when performing in their roles within the military environment as advisors versus decision makers. No small undertaking.....



Thanks to everyone for your continuing discussion.

Olivia

**From:** "Gelles, Mike" <>

**Date:** May 18, 2005 6:15:24 AM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

I wanted to offer a brief comment to Dr. Koochers reference to "most vulnerable party". I believe it is important to recognize that detainees in any circumstance whether that may be GTMO, Afghanistan, Iraq or many other places in the world where psychologists may offer consultation to interrogation are vulnerable when they are captured. However the "detainee" is for the most part a detainee based on a set of circumstances that put him in direct contact with US forces or allies in the GWOT. The context in which he has been detained perhaps is a critical set of circumstances to discern to assess vulnerability. While there are examples and regrettably too many where individuals have been captured and detained because they were in the wrong place at the wrong time, many detainees are of an extremist mindset and have a strong desire to cause harm to other and to the safety and security of the US. I think as psychologists we may with the appropriate training and experience help discern who may be a greater or lesser risk but based on my experience there is often too little information initially to make a comfortable recommendation. Therefore, when we are forced to make an assessment of "most vulnerable" available information may lead us to quickly default to US safety and security as the most vulnerable.

Relying on the old saying all behavior occurs in a context many of us will agree that the context of war and asymmetrical war where the threat is ambiguous is a context that has to date not been systematically defined or replicable in models of research or anecdotal studies that offer a model for comparison. Having visited and worked in many of these environments as have some of my distinguished colleagues on this panel it is a frightening and psychologically challenging environment that breeds fear, hate and reactions that provoke a desire to help, make it more predictable and less frightening. We are in uncharted areas that don't compare to other situations and perhaps should not be compared.

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Sent from my BlackBerry Wireless Handheld

**From:** "Gelles, Mike" <>

**Date:** May 18, 2005 6:15:27 AM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Follow n thought

It is not surprsing in conditions of ambiguity and fear the organizations that we consult to ask for our help. I do not think we will find a clear and definitive answer to either what this current situation compares to or can be modeled after. The laws addressing these iissues remain unclear and open to a wide range of interpretations. Perhaps the Geneva Convention is a good place to start. One guideline I have used is keeping n mind what would be acceptable in a US court as it relates to interrogation, consultation and assessment in the most egregious violent crimes or c espionage and guide my consultations accordingly. Psychologists are never nor should they be the stategic decision makers in any operation or interrogation. As adjunct experts we advise hopefully we can establish that precedence throughout the government and military an experts who inform and not make decisions.

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Sent from my BlackBerry Wireless Handheld

**From:** "Col. Larry C. James PhD" <>

**Date:** May 18, 2005 9:12:12 AM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>



Although I agree with Mike in theory and principal (a psychologist should not guide nor "Never" be strategic decision makers) I don't think I would agree Mike with the word "Never."

let me try to explain why.

what about if the interrogators are 18 & 19 year old kids right out of high school. And, the only training he/she has is the school house training recieved in A school or AIT? He has never done a real world interrogation!!

No, I don't think the psychologist should do the interrogation, but on the other hand, this is a dangerous situation allowing a 19 year old with no experience to strategically shape the interrogation and determine what to do and where to go with the interrogation. all too often at Abu Ghraib the 19 year olds supervisor was a 25 year old reservist who never did a real world interrogation either, would be the stragetig decision maker. AND, the warrant officer section chief, (Wo2) most often would have no experience either. amazing!

Mike as you know there are no easy answers for this one.

thanks,

Larry

**From:** Robert Fein <>

**Date:** May 18, 2005 9:18:45 AM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Like others, I have been impressed and informed by the comments posed so far. In this note, I want to try to extend or broaden the discussion to include psychologists who are working for national security organizations that are not part of military or law enforcement organizations.

Here is a hypothetical:

Psychologist A works for a non-military, non-law enforcement organization in the intelligence community. Psychologist A receives information in the course of his/her work that Psychologist B, also working for the organization, is involved in

activities that Psychologist A thinks may be on the other side of the ethical line. Not knowing the facts and wanting to clarify things, Psychologist A approaches Psychologist B to inquire. Psychologist B says that he/she both cannot (for security reasons) and will not talk about the work in question. No supervisors in either chain (for Psychologist A or B) are psychologists, and there is no supervisory psychologist structure in the organization.

In such a hypothetical situation, what, if anything, should Psychologist A do?

Robert Fein

**From:** Gerry Koocher <>

**Date:** May 18, 2005 10:28:15 AM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Gelles, Mike wrote:

when we are forced to make an assessment of "most vulnerable" available information may lead us to quickly default to US safety and security as the most vulnerable.

Excellent point. Could compare directly to psychologist acting a negotiator for SWAT team in a domestic urban violence situation with hostages and others at risk.

Gerry

**From:** Gerry Koocher <>

**Date:** May 18, 2005 10:35:48 AM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Col. Larry C. James PhD wrote:

Although I agree with Mike in theory and principal (a psychologist should not guide nor "Never" be strategic decision makers) I don't think I would agree Mike with the word "Never."

Also...when we are in positions of authority, can we every really shed our psychological knowledge at the door? As an academic dean, I use my human assessment and intervention skills daily, although not calearly in a "psychologist" role. Still, I am accountable to the APA ethics code for what I do in my administrator job.

Gerry

**From:** Gerry Koocher < >

**Date:** May 18, 2005 10:49:46 AM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Great question!!!!

If I were A, I'd say to B. I understand and appreciate your position. I also know that I do not have and will not have complete information. Therefore please take this communication only as my colleague to colleague expression of concern and give it whatever professional consideration you think it deserves. The critical issue is the degree of amplitude of the potential infraction. If A deems the problem VERY serious or potentially critical, I would suggest A go to his/her own superior in the agency chain of command to express concern based on limited knowledge (documenting in a confidential personal file) that the contact had occurred.

Regards,

Gerry

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**From:** Jean Maria Arrigo < >

**Date:** May 18, 2005 3:40:12 PM PDT

**Subject:** PENS- Task Force in DC

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Dear Olivia,

Could you clarify our task in the DC meeting? What are we supposed to produce in the 3 - 1/2 days allotted to us?

Here are some issues I find daunting.

#### COMPLEXITY OF NATIONAL SECURITY SYSTEM

The readings and discussion have impressed me with the complexity of relevant factors. Thanks to Louie Banks for Army Regulation 190-8, demonstrating the complexity of detaining even noncombatants under routine conditions. In Bloche's LA TIMES editorial (Tab 8, last page) I was surprised to learn that some U.S. military doctors believe the Hippocratic Oath does simply not apply to them in their roles as consultants to interrogators—dual-role theory. (In NAZI DOCTORS, Lifton also found that the doctors functioned by means of "doubling" in their professional roles.) Dual-role theory could put the APA Ethics Code in the trash bin.

#### DIFFICULTY OF IMPLEMENTING ETHICAL GUIDELINES

My oral history interviews with intelligence professionals have alerted me to the near impossibility of implementing unwelcome guidelines in settings shielded by secrecy. Several interviewees have described the military practice of silencing subordinates who have inconvenient moral concerns by referring the subordinates for psychological examination. It is hard to imagine a countermeasure to this practice. If we are to produce guidelines that can actually be implemented, we will have to be organizational theorists as well as psychologists.

#### OVERLAP OF PSYCHOLOGY WITH OTHER PROFESSIONS

It appears that our main theme is ethical guidelines for the behavior of card-carrying psychologists in various national security settings and roles. But if we are concerned with the use of psychological knowledge or instruments, we will have to coordinate with other professional organizations whose members use psychological knowledge or instruments, e.g., psychiatrists, psychiatric nurses, mental health counsellors, chaplains, personnel directors. I wonder whether there are any military roles uniquely and necessarily performed by psychologists, as brain and eye surgery, for example, are performed by physicians without substitutes. If so, it might be helpful to take a special look at these roles.

Jean Maria

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Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From:** "Banks, Louie M. COL" <>

**Date:** May 18, 2005 5:44:14 PM PDT

**Subject:** Re: Discussion

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

This is a fantastic question, and one that I hope the Task Force can address. I see several possible solutions. Gerry's is probably the most appropriate, but it may be that we need a series of options. Obviously, the first would be to address it with psychologist B. Next, if that does not resolve the issue, Psychologist A should address it with his or her supervisor. If that did not resolve the issue, then perhaps Psychologist A could address it with the organization's Inspector General. Theoretically, by the time the issue was at this level, security concerns would no longer be an impediment. Having said that, I still think this is exactly the type of issue for us to address.

Morgan

COL L. Morgan Banks

Director, Psychological Applications Directorate

US Army Special Operations Command

DSN COM

**From:** Olivia Moorehead-Slaughter <\_>

**Date:** May 18, 2005 6:10:28 PM PDT

**Subject:** Fwd: NEJM: Unspeakably Cruel - Torture, Medical Ethics, & the Law

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

FYI-- This article was sent to me by Steve. Thought you all might want to review this. Olivia

**(Doctors and Interrogators at Guantanamo Bay: Mounting Evidence of Torture. New England Journal of Medicine (May 19, vol. 352, #20, pages 2127-2132)**

[See Article 0 - Doctors and Interrogators -- NEJM]

**From:** Olivia Moorehead-Slaughter <\_>

**Date:** May 18, 2005 6:05:07 PM PDT

**Subject:** Re: PENS- Task Force in DC

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

Hi Jean Maria,

The issues that you described as "daunting" in your response are excellent examples of the complexity and enormity of the task before us. In many areas, we seem to be swimming in very murky water. Clearly, there is a need to begin to set some parameters for ourselves around what this Task Force can be reasonably expected to produce from the June meeting. We will need to be focused so that we make productive use of the limited time that we will have to meet together. I do not have a neat and tidy answer to your question and would encourage Task Force members to weigh in on this issue. I am all for finding some ways to make this feel more focused and manageable before the June meeting.

Additionally, I am attaching the agenda item as submitted to the Board of Directors for your review. This may assist you in your thinking about all of this.

Thanks to all of you.

Olivia

**From:** "Banks, Louie M. COL" <>

**Date:** May 18, 2005 6:42:31 PM PDT

**Subject:** Re: PENS- Task Force in DC

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Jean Marie,

I believe that you have identified some very important issues. I have attached some thoughts under each of your topics.

**COL L. Morgan Banks**  
**Director, Psychological Applications Directorate**  
**US Army Special Operations Command**  
**DSN COM**



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**From:** Presidential Task Force on Psychological Ethics and National Security [mailto:PENS@ ] **On**  
**Behalf Of** Jean Maria Arrigo  
**Sent:** Wednesday, May 18, 2005 6:40 PM  
**To:** PENS@  
**Subject:** [PRESIDENTIAL] PENS- Task Force in DC

Dear Olivia,

Could you clarify our task in the DC meeting? What are we supposed to produce in the 3 - 1/2 days allotted to us?

Here are some issues I find daunting.

#### COMPLEXITY OF NATIONAL SECURITY SYSTEM

The readings and discussion have impressed me with the complexity of relevant factors. Thanks to Louie Banks for Army Regulation 190-8, demonstrating the complexity of detaining even noncombatants under routine conditions. In Bloche's LA TIMES editorial (Tab 8, last page) I was surprised to learn that some U.S. military doctors believe the Hippocratic Oath does simply not apply to them in their roles as consultants to interrogators-dual-role theory. (In NAZI DOCTORS, Lifton also found that the doctors functioned by means of "doubling" in their professional roles.) Dual-role theory could put the APA Ethics Code in the trash bin.

[Banks, Louie M. COL] To me, the dual role issue is both critical, and one that can be addressed in a fairly straightforward manner. I should start by saying that I believe that some dual role issues will always exist in the military. A psychologist is both a sworn officer and a care provider. There will always be challenges inherent in that. Having made my biases clear, though, I think that proper training, establishing the boundaries of the psychologist's role, can limit potential conflicts. For example, psychologists providing interrogation support at GTMO and Abu Ghraib are very clear in that they are NOT providing mental health care, thereby preventing "doubling" of their roles.

#### DIFFICULTY OF IMPLEMENTING ETHICAL GUIDELINES

My oral history interviews with intelligence professionals have alerted me to the near impossibility of implementing unwelcome guidelines in settings shielded by secrecy. Several interviewees have described the military practice of silencing subordinates who have inconvenient moral concerns by referring the subordinates for psychological examination. It is hard to imagine a countermeasure to this practice. If we are to produce guidelines that can actually be implemented, we will have to be organizational theorists as well as psychologists.

[Banks, Louie M. COL] This is another very good point. In 1992 Congress passed law (National Defense Authorization Act for Fiscal Year 1993) that established protection for servicemembers for this type of inappropriate referral. Although I may be guilty of being overly rule-bound on this, I have attached the two DoD Instructions that explain the rules for commanders and psychologists on this topic. I will be the first



to admit that just because it is against the law, that does not mean it does not happen, but it does provide some significant penalties if commanders do attempt to silence subordinates in this manner.

## OVERLAP OF PSYCHOLOGY WITH OTHER PROFESSIONS

It appears that our main theme is ethical guidelines for the behavior of card-carrying psychologists in various national security settings and roles. But if we are concerned with the use of psychological knowledge or instruments, we will have to coordinate with other professional organizations whose members use psychological knowledge or instruments, e.g., psychiatrists, psychiatric nurses, mental health counsellors, chaplains, personnel directors. I wonder whether there are any military roles uniquely and necessarily performed by psychologists, as brain and eye surgery, for example, are performed by physicians without substitutes. If so, it might be helpful to take a special look at these roles.

[Banks, Louie M. COL] There are several areas that I am involved in that are the exclusive purview of psychologists. They include:

1. Survival, Evasion, Resistance, and Escape (SERE) Psychologists. These psychologists are responsible for assisting in the repatriation of Americans who have been returned to US custody following a captivity event. They assist in setting the conditions for successful recovery from the captivity experience. In DOD, only psychologists perform this function, and I am aware of no other professionals within the US government who perform this function. They are also responsible for providing psychological oversight of SERE training (the training that DOD provides to prepare servicemembers to survive captivity).

2. Interrogation support. To my knowledge, at the present time, within DOD, only psychologists perform this function. The Army's Psychiatry Consultant has stated that she is opposed to psychiatrists performing this function.

3. Psychological Selection and Assessment. Within DOD, only psychologists perform this function. They provide this service for a number of specialized units. This usually requires the use of written psychological instruments, thereby limiting it to psychologists.

4. Leader development utilizing psychological instruments. Within the Army, we utilize both 360 assessment instruments and various performance enhancement and other psychological instruments to help our leaders in their professional development. Although there are many people in the Army who also assist in leader development, only psychologists use these instruments. (There is some overlap, for example, with Chaplains who often use the MBTI for workshops, and conceivably for leader development, but they will not use more sophisticated instruments.)

Jean Maria

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Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From:** Gerry Koocher <>

**Date:** May 19, 2005 6:28:49 AM PDT

**Subject:** New NEJM article of interest

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

The new issue of \*New England Journal of Medicine\* scheduled to be released tomorrow (May 19, vol. 352, #20) includes an article: "Unspeakably Cruel - Torture, Medical Ethics, and the Law" (pages 2127-2132).

The article is by George J. Annas, J.D., M.P.H.

Here's the article:

[See - Article 1 "Unspeakably Cruel"]

**From:** "Gelles, Mike" <>

**Date:** May 19, 2005 3:00:40 PM PDT

**Subject:** Re: New NEJM article of interest

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Perhaps this very sobering article articulates what it is that can be accomplished in a weekend meeting and that as noted at the end of this articles recommends clarification of roles.

What is the role of the psychologist when consulting on interrogations?

When should a psychologist refuse?

In being flexible with Larry in his disagreement with my point of the psychologist "never" being the strategic decision maker. Under what conditions should psychologists assume that role?

I think it is going to be difficult to set conditions for when it is convenient to be a psychologist and when it is not. I believe that we must define our role and have it as applicable to as many contexts as possible while retaining our professional responsibilities. We can not let the context define those responsibilities.

The legal and Congressional debates will continue or sometime defining our role ahead of time may help us to adapting our function later.

With all due respect, investigations and operations have and will continue to proceed and succeed without our involvement. Perhaps a final provocative thought is that we may be too involved as it is ?

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Sent from my BlackBerry Wireless Handheld

**From:** "Banks, Louie M. COL" <>

**Date:** May 19, 2005 3:32:51 PM PDT

**Subject:** Re: New NEJM article of interest

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Some very provocative thoughts indeed, from Mike.

Taking the questions in order, I believe that the first question is one that we can at least begin to get our arms around during the weekend. As I sent earlier, my thoughts are that the psychologist assists the command in ensuring that interrogation and detainee operations are safe, legal, ethical, and effective. This includes both the role of oversight (and obviously requires that the psychologist not become involved as an interrogator), and the role of assisting the interrogator in making the questioning process more effective.

A psychologist should refuse when he or she is asked to perform an illegal or unethical act. The illegal part should be easy (open to some discussion, however); it is the unethical part that brings us together as a Task Force. I believe we need to uncover and address the legal but unethical areas of behavior for a psychologist. (I realize this is a statement of the obvious, but I have a simple brain.)

Although a psychologist is always a psychologist, he or she is not always a mental health provider. In the Army, psychologists can assume command of units (including non medical units), and we currently have a senior psychologist selected for command of a hospital. I believe we should focus on the ethical left and right limits of particular types of psychology support, e.g., interrogation support.

It is my opinion that when psychologists are involved in supporting interrogation and detainee operations, these operations are much more likely to be safe, legal, ethical, and effective. I base this on DoD's experience over the last four years. Certainly these operations can be conducted without psychologists, but in my opinion there will be a significant increase in the likelihood of abuse. I am very confident that my psychologists provide a very effective safety mechanism during these operations. I also believe that we provide a significant assist in making the process more productive, based on our knowledge of human behavior.

Morgan

COL L. Morgan Banks

Director, Psychological Applications Directorate

US Army Special Operations Command

DSN COM

**From:** Robert Fein <>

**Date:** May 21, 2005 5:55:40 PM PDT

**Subject:** disturbing, perhaps relevant article

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Given that there has been some discussion about the possible roles psychologists might/should play or not play in consulting to, advising, and/or participating in interrogation-related activities, I wanted to put the disturbing article below on the listserve. I assume that many/most of you have seen it, but just in case...

Robert Fein

> The New York Times May 20, 2005 In U.S. Report, Brutal Details of 2  
Afghan Inmates' Deaths By TIM GOLDEN

[See Article 2 - Brutal Details - The New York Times]

**From:** Jean Maria Arrigo <>

**Date:** May 22, 2005 10:52:02 PM PDT

**Subject:** PENS-A sample agenda

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

PENS Colleagues:

I owe Louie Banks a response to his rich commentary (5/18/05) on my previous letter, but I will respond in a separate message.

Here I am concerned with the agenda for our upcoming 2-1/2 day meeting. It appears to me that our central issue is the conduct of psychologists with respect to coercive interrogation of suspected enemies in national security settings. As a step towards formulating an agenda, I very tentatively propose the four items below and look forward to your suggestions. I must acknowledge two anonymous colleagues—a seasoned peace psychologist and a former army counterintelligence officer—who advised me in drawing up this list but did not review it.

1a. Should the APA declare the contribution of psychologists to coercive interrogation incompatible with the ethical obligations of the profession? This declaration would apply also to contributions by the subordinates of psychologists, such as Behavioral Science Specialists, Psychiatric Specialists, and Mental Health Specialists.

1b. Should the APA exclude from membership psychologists who intentionally or negligently contribute to coercive interrogation?

2. Should the APA offer support to psychologists employed in national security settings who undertake "acts of conscience" contrary to command?

The support might take the form of witness to legal proceedings, administrative legal assistance, or legal aid.

3. Should the APA recommend that psychologists be legally mandated to report to their superiors all instances of coercive interrogation or degradation of detainees, as (a) disclosed by detainees, (b) observed by themselves, or (c) observed by their subordinates? The reporting requirement would cover all instances, whether deemed appropriate or inappropriate in the national security context.

4. Should the APA recommend that national security agencies archive at a central facility all copies of documents concerning treatment of detainees that are signed by psychologists or their subordinates? The documents would be archived for sanitization and release at some future date.

The rationale here is that the APA has a need to know the nature of professional activities of psychologists. We may not be able to make well informed recommendations concerning psychological ethics and national security at this time, but we can attempt to initiate collection of data for clearer consideration later.

I appreciate your time in reviewing this list. I hope that our combined perspectives will lead us to wisdom.

Jean Maria

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Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From:** Gerry Koocher <>

**Date:** May 23, 2005 6:04:19 AM PDT

**Subject:** Re: PENS-A sample agenda

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

**I think Jean Maria suggests some good points, but the perspective is a bit narrow and potentially unrealistic.**

**My comments are inserted below in blue for easy recognition.**

**Gerry**

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Jean Maria Arrigo wrote:

1a. Should the APA declare the contribution of psychologists to coercive interrogation incompatible with the ethical obligations of the profession? This declaration would apply also to contributions by the subordinates of psychologists, such as Behavioral Science Specialists, Psychiatric Specialists, and Mental Health Specialists.



**I believe the issues of concern extend well beyond any role psychologists or psychological research plays in "coercive interrogation."**

**The overarching issue is the degree to which our ethics code applies to certain behaviors of APA members who work in national security (or parallel law enforcement) positions. Subordinate questions might include, but should not be limited to:**

- 1. What general statements does APA wish to make about the use of behavioral science or psychological techniques in the service of national security or criminal investigations?**
- 2. What obligations apply to balancing tests when normative ethics and utilitarian ethics (e.g., absolutist values versus greatest good for the greatest number of people) go head to head?**
- 3. What principles should guide behavioral scientists and mental health practitioners asked or ordered to become a party to ethically problematic activities (e.g., coercive interrogation, application of psychological techniques in espionage, use of psychology to undermine or promote political agenda, etc.)?**
- 4. What principles should guide or obligate APA members when they find themselves asked to engage in ethically problematic behaviors while functioning within an organization or unit of government where they have other competing directives (e.g., sworn military or law enforcement officers, obligated by security regulations, etc.).**
- 5. What principles should guide psychologists in interactions with vulnerable parties who are not traditional or actual "clients" (e.g., detainees, enemy combatants, criminal suspects, persons posing potential security threats, etc.).**
  - 1b. Should the APA exclude from membership psychologists who intentionally or negligently contribute to coercive interrogation?**

**This question seems naive since APA will likely never know about such conduct, nor be in a position to investigate it.**

- 2. Should the APA offer support to psychologists employed in national security settings who undertake "acts of conscience" contrary to command?**

**This question again seems naive since APA will likely only know about cases that become public and may not be in a position to investigate the veracity of claims on either side. I suppose we could consider amicus briefs on the ethical issues should such cases lead to litigation, but we need to be realistic about what cases will come to us, in what fashion, and with what data.**

The support might take the form of witness to legal proceedings, administrative legal assistance, or legal aid.

**We already have a Psychology Defense Fund, but have never provided services as "witness to legal proceedings or administrative legal assistance." Why would APA want to take on such new roles?**

3. Should the APA recommend that psychologists be legally mandated to report to their superiors all instances of coercive interrogation or degradation of detainees, as (a) disclosed by detainees, (b) observed by themselves, or (c) observed by their subordinates? The reporting requirement would cover all instances, whether deemed appropriate or inappropriate in the national security context.

**Are you suggesting here that APA recommend new Federal legislation (i.e., "legal mandate")? If so, it seems wise first to determine what legal mandates already exist.**

4. Should the APA recommend that national security agencies archive at a central facility all copies of documents concerning treatment of detainees that are signed by psychologists or their subordinates? The documents would be archived for sanitization and release at some future date.

The rationale here is that the APA has a need to know the nature of professional activities of psychologists. We may not be able to make well informed recommendations concerning psychological ethics and national security at this time, but we can attempt to initiate collection of data for clearer consideration later.

**What archiving practices now exist?**

**What archiving practices best serve the nation?**

**What is the basis of APA's presumed "need to know?"**

**Why should government care about the wishes of a private professional association?**

**Why should APA's voice carry weight apart from NASW, ACA, ApA, etc.?**

**I do not pretend to have the answers, but I think we need to take a much broader view than initially suggested.**

**Best regards,  
Gerry**



**From:** "Col. Larry C. James PhD" <>

**Date:** May 23, 2005 10:45:37 AM PDT

**Subject:** Re: PENS-A sample agenda

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Question 1a "should the APA declare the contribution of psychologists to coercive interrogation incompatible with the ethical obligations of the profession?"

This question is worded in the affirmative that DOD/Military psychologists have done something illegal, morally wrong and/or unethical.

Like Morgan Banks, I am very proud of the fact, it was psychologists who fixed the problems and not caused it. **This is a factual statement!** the fact of the matter is that since Jan 2003, where ever we have had psychologists no abuses have been reported.

Question 1b. any psychologist who engages in unethical behavior can be removed from membership so why must we develop a document to single out DOD/military psychologist? I disagree with this one.

Question 2. "legally mandated to report..." Jean, this is not necessary. Let me explain, military psychologists as military officers are bound by the Geneva convention, APA ethics code **AND the UCMJ (uniformed code of military justice)**. A military officer found guilty of violating the UCMJ Jean may very well get an all expenses paid trip to Leavenworth federal prison. As a military officer, If I observe a violation and I do not act I may be subject to prosecution under the UCMJ.

Question 3. Jean I'm going to phrase your question a little different. Should APA have access to classified information (archived data)? I really don't think this is going to happen, I agree with the issues Gerry raised about this question, but the bottom line here is that it will never happen.

Thanks,

Larry

**From:** Olivia Moorehead-Slaughter <>

**Date:** May 23, 2005 8:12:40 AM PDT

**Subject: Re: disturbing, perhaps relevant article**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@ >**

Hi Robert,

Thank you for circulating this article. I had not seen it and like you, found it very disturbing and daunting in that there is some reference early in the article to "what is generally accepted as interrogation techniques." I trust that most of what is described in this article does not fall into that category. Am I being terribly naive here?

Olivia

**From: Nina Thomas < >**

**Date: May 23, 2005 3:23:46 PM PDT**

**Subject: Re: disturbing, perhaps relevant article**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@ >**

There was a further article by Tim Golden on the same subject, focusing on the military's investigation in yesterday's Times. I can't seem to find it at present but worth a look.

Nina Thomas

**From: Jean Maria Arrigo < >**

**Date: May 23, 2005 3:38:25 PM PDT**

**Subject: PENS - Reply to Banks on "Complexity," etc.**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@ >**

Louie,

Thanks so much for your very informative comments. I have responded interlinearly at lines preceded by dashes.

Jean Maria

On May 18, 2005, at 6:42 PM, Banks, Louie M. COL wrote:

Jean Marie,

I believe that you have identified some very important issues. I have attached some thoughts under each of your topics.

**COL L. Morgan Banks**

**Director, Psychological Applications Directorate**

**US Army Special Operations Command**

**DSN COM**

#### **COMPLEXITY OF NATIONAL SECURITY SYSTEM**

The readings and discussion have impressed me with the complexity of relevant factors. Thanks to Louie Banks for Army Regulation 190-8, demonstrating the complexity of detaining even noncombatants under routine conditions. In Bloche's LA TIMES editorial (Tab 8, last page) I was surprised to learn that some U.S. military doctors believe the Hippocratic Oath does simply not apply to them in their roles as consultants to interrogators-dual-role theory. (In NAZI DOCTORS, Lifton also found that the doctors functioned by means of "doubling" in their professional roles.) Dual-role theory could put the APA Ethics Code in the trash bin.

[Banks, Louie M. COL] To me, the dual role issue is both critical, and one that can be addressed in a fairly straightforward manner. I should start by saying that I believe that some dual role issues will always exist in the military. A psychologist is both a sworn officer and a care provider. There will always be challenges inherent in that. Having made my biases clear, though, I think that proper training, establishing the boundaries of the psychologist's role, can limit potential conflicts. For example, psychologists providing interrogation support at GTMO and Abu Ghraib are very clear in that they are NOT providing mental health care, thereby preventing "doubling" of their roles.

—Whether or not a particular profession can tolerate conflicting role behaviors seems to vary. The military legal code, for instance, in "Conduct Unbecoming an Officer") treats some legal "sins" (e.g., adultery) as cause for court martial. The rationale, I have heard, is that fairness, trust, morale, and cohesion can be matters of life and death in a military unit. After a long history of controversy, the chaplaincy finally decided that chaplains cannot bear arms, even under military necessity (I think). The question is not whether the professionals themselves are clear which role they are performing situation but whether the relevant

community will separate the roles. When there are strong conflicts at a symbolic level, the person may simply have to choose one role or the other.

## DIFFICULTY OF IMPLEMENTING ETHICAL GUIDELINES

My oral history interviews with intelligence professionals have alerted me to the near impossibility of implementing unwelcome guidelines in settings shielded by secrecy. Several interviewees have described the military practice of silencing subordinates who have inconvenient moral concerns by referring the subordinates for psychological examination. It is hard to imagine a countermeasure to this practice. If we are to produce guidelines that can actually be implemented, we will have to be organizational theorists as well as psychologists.

[Banks, Louie M. COL] This is another very good point. In 1992 Congress passed law (National Defense Authorization Act for Fiscal Year 1993) that established protection for servicemembers for this type of inappropriate referral. Although I may be guilty of being overly rule-bound on this, I have attached the two DoD instructions that explain the rules for commanders and psychologists on this topic. I will be the first to admit that just because it is against the law, that does not mean it does not happen, but it does provide some significant penalties if commanders do attempt to silence subordinates in this manner.

—I really appreciated the opportunity to see the DoD instructions. The rule against manipulating subordinates with psychological referrals is excellent in itself. But to have any force in politicized contexts, independent reviewers would be required, whereas reviewers in the same chain of command are typically used. There are numerous publicized cases of inappropriate use of psychological/psychiatric examinations. (Perhaps you know the 1994 case of Lawrence Rockwood in Haiti.) Grievance procedures often have built into them the method for circumventing the true application of the procedure, for example, through selection of reviewers who are beholden to the more powerful party.

## OVERLAP OF PSYCHOLOGY WITH OTHER PROFESSIONS

It appears that our main theme is ethical guidelines for the behavior of card-carrying psychologists in various national security settings and roles. But if we are concerned with the use of psychological knowledge or instruments, we will have to coordinate with other professional organizations whose members use psychological knowledge or instruments, e.g., psychiatrists, psychiatric nurses, mental health counsellors, chaplains, personnel directors. I wonder whether there are any military roles uniquely and necessarily performed by psychologists, as brain and eye surgery, for example, are performed by physicians without substitutes. If so, it might be helpful to take a special look at these roles.

[Banks, Louie M. COL] There are several areas that I am involved in that are the exclusive purview of psychologists. They include:

1. Survival, Evasion, Resistance, and Escape (SERE) Psychologists. These psychologists are responsible for assisting in the repatriation of Americans who have been returned to US custody following a captivity event. They assist in setting the conditions for successful recovery from the captivity experience. In DOD, only psychologists perform this function, and I am aware of no other professionals within the US government who perform this function. They are also responsible for providing psychological oversight of SERE training (the training that DOD provides to prepare servicemembers to survive captivity).

—A CI officer suggested to me that there is a natural crossover from SERE training to coercive interrogation. Obviously the defensive and offensive uses of techniques require similar expertise. What is your opinion about the crossover?

2. Interrogation support. To my knowledge, at the present time, within DOD, only psychologists perform this function. The Army's Psychiatry Consultant has stated that she is opposed to psychiatrists performing this function.

—This is remarkable. I did not know one person would have that power. I wonder whether there is an Army Psychology Consultant.

— It seems unlikely to me that the Navy's Psychiatry Consultant (if there is a corresponding office) agrees with the Army's. The former Navy Chief of Neuropsychiatry at Guantanamo Bay, William Henry Anderson, wrote a strong article in the Ass'n of Former Intel Officers journal proposing that the U.S. simply kill the 100,000 or so intractable terrorists with defective brains. The AFIO published my letter (attached as an rtf file) in the Winter/Spring 2005 issue of THE INTELLIGENCER. Dr. Anderson replied and stood his ground. I have hoped for another perspective by navy authorities.

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3. Psychological Selection and Assessment. Within DOD, only psychologists perform this function. They provide this service for a number of specialized units. This usually requires the use of written psychological instruments, thereby limiting it to psychologists.

4. Leader development utilizing psychological instruments. Within the Army, we utilize both 360 assessment instruments and various performance enhancement and other psychological instruments to help our leaders in their professional development. Although there are many people in the Army who also assist in leader development, only psychologists use these instruments. (There is some overlap, for example, with Chaplains who often use the MBTI for workshops, and conceivably for leader development, but they will not use more sophisticated instruments.)

—Very interesting. Thank you for this education. Is it the statistics that separates the psychologists from the psychiatrists, chaplains, and personnel officers?

Jean Maria

Jean Mar a Arr go, PhD

Project on Ethics and Art n Test mony

<i64904p.pdf><d64901p.pdf>

From: Nina Thomas <>

**Date:** May 23, 2005 7:19:06 PM PDT

**Subject:** Re: PENS - Reply to Banks on "Complexity," etc.

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

was there an attachment sent in a message from Jean Maria? I received an e with one but am wary of opening attachments without knowing what to expect in advance.

Thanks,

Nina

**From:** Jean Maria Arrigo < >

**Date:** May 23, 2005 7:42:11 PM PDT

**Subject:** Re: PENS - Reply to Banks on "Complexity," etc.

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Nia,

Yes, I had sent an rtf file with my letter to the Editors of THE INTELLIGENCER concerning Dr. Anderson's article. I have copied it below. Thanks for your interest.

Jean Maria

**Date:** Tue, 01 Jun 2004 09:28:08 -0700

**From:** Jean Maria Arrigo < >

**Reply-To:**

**Organization:** Project on Ethics and Art in Testimony

**To:** [afio@](mailto:afio@), [dsanders@](mailto:dsanders@), [JosephG8954@](mailto:JosephG8954@),

[bkcollector@](mailto:bkcollector@), [venona@](mailto:venona@)

**Subject:** Comment on Wm. Anderson's "Terrorism"

To the Editor and Contributing Editors of *The Intelligencer*.

[See: Article 3 -Arrigo on Anderson]

**From:** "Banks, Louie M. COL" <>

**Date:** May 23, 2005 8:55:54 PM PDT

**Subject:** Re: PENS - Reply to Banks on "Complexity," etc.

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Jean Maria,

I have responded with a few very brief comments; I am traveling away from home, and am using a very slow dial-up connection.

Morgan

**COL L. Morgan Banks**  
**Director, Psychological Applications Directorate**  
**US Army Special Operations Command**  
**DSN COM**

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**From:** Presidential Task Force on Psychological Ethics and National Security  
[mailto:PENS@ ] **On Behalf Of** Jean Maria Arrigo  
**Sent:** Monday, May 23, 2005 6:38 PM  
**To:** PENS@  
**Subject:** [PRESIDENTIAL] PENS - Reply to Banks on "Complexity," etc.

Louie,

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**COL L. Morgan Banks**

**Director, Psychological Applications Directorate**

**US Army Special Operations Command**

**DSN COM**

## **COMPLEXITY OF NATIONAL SECURITY SYSTEM**

The readings and discussion have impressed me with the complexity of relevant factors. Thanks to Louie Banks for Army Regulation 190-8, demonstrating the complexity of detaining even noncombatants under routine conditions. In Bloche's LA TIMES editorial (Tab 8, last page) I was surprised to learn that some U.S. military doctors believe the Hippocratic Oath does simply not apply to them in their roles as consultants to interrogators-dual-role theory. (In NAZI DOCTORS, Lifton also found that the doctors functioned by means of "doubling" in their professional roles.) Dual-role theory could put the APA Ethics Code in the trash bin.

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[Banks, Louie M. COL] I am not sure I understand completely; perhaps this will need to be more fully discussed when we meet. I believe that clarity of roles is critical in ethically functioning in any environment. This would apply to both the individual and the organization, and if relevant, any other effected persons.



## DIFFICULTY OF IMPLEMENTING ETHICAL GUIDELINES

My oral history interviews with intelligence professionals have alerted me to the near impossibility of implementing unwelcome guidelines in settings shielded by secrecy. Several interviewees have described the military practice of silencing subordinates who have inconvenient moral concerns by referring the subordinates for psychological examination. It is hard to imagine a countermeasure to this practice. If we are to produce guidelines that can actually be implemented, we will have to be organizational theorists as well as psychologists.

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-I really appreciated the opportunity to see the DoD instructions. The rule against manipulating subordinates with psychological referrals is excellent in itself. But to have any force in politicized contexts, independent reviewers would be required, whereas reviewers in the same chain of command are typically used. There are numerous publicized cases of inappropriate use of psychological/psychiatric examinations. (Perhaps you know the 1994 case of Lawrence Rockwood in Haiti.) Grievance procedures often have built into them the method for circumventing the true application of the procedure, for example, through selection of reviewers who are beholden to the more powerful party.

[Banks, Louie M. COL] We may end up fundamentally disagreeing on this point. Within DoD, Inspectors General are given the task of independently investigating violations that cannot be fairly reviewed by the Chain of Command. In fact, every servicemember has a right to address grievances with the IG. General Officers are routinely investigated by the IG, and not uncommonly found to have acted wrongly. (Obviously, this applies to non-criminal behavior. Criminal behavior is investigated by the various Criminal Investigative Commands, who are structured independently of all but the highest Chain of Command.) However, the point can be made that everyone in DoD is ultimately working for the President and the Secretary of Defense. In my opinion, there are sufficient checks and balances within the system to insure that any abuse by leaders is eventually discovered and corrected, although it may take some time to occur. (One example of this is the current abuse cases that have been alleged to occur in Bagram in 2002.)

## OVERLAP OF PSYCHOLOGY WITH OTHER PROFESSIONS

It appears that our main theme is ethical guidelines for the behavior of card-carrying psychologists in various national security settings and roles. But if we are concerned with the use of psychological knowledge or instruments, we will have to coordinate with other professional organizations whose members use psychological knowledge or instruments, e.g., psychiatrists, psychiatric nurses, mental health counsellors, chaplains, personnel directors. I wonder whether there are any military roles uniquely and necessarily performed by psychologists, as

brain and eye surgery, for example, are performed by physicians without substitutes. If so, it might be helpful to take a special look at these roles.

[Banks, Louie M. COL] There are several areas that I am involved in that are the exclusive purview of psychologists. They include:

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-A CI officer suggested to me that there is a natural crossover from SERE training to coercive interrogation. Obviously the defensive and offensive uses of techniques require similar expertise. What is your opinion about the crossover?

[Banks, Louie M. COL] Great question. This is a point I spend a lot of time discussing. The purpose of SERE training is to teach individuals to resist interrogation. The conditions in this training often simulate the behavior that is used against us by our captors. However, the structure and use of "coercive" techniques is intended (quite successfully) to strengthen our soldiers' determination to resist successfully. The purpose of interrogation, at least by the US, is to gain reliable, valid information. These two goals are diametrically opposed. At the Army's SERE school, the point is made very clearly and formally, that the techniques used in training are not to be used in US interrogations, are illegal for use by our forces, and are in fact, counter productive to the production of valid, reliable information. (Unless the purpose of our interrogations is to teach detainees how to resist us.)

2. Interrogation support. To my knowledge, at the present time, within DOD, only psychologists perform this function. The Army's Psychiatry Consultant has stated that she is opposed to psychiatrists performing this function.

-This is remarkable. I did not know one person would have that power. I wonder whether there is an Army Psychology Consultant.

[Banks, Louie M. COL] I should have been more specific. The Army Psychiatry Consultant can only speak for **Army** psychiatrists on policy matters. Her position is as I stated. There is an Army Psychology Consultant, and he and I are in frequent contact on this and other matters.

- It seems unlikely to me that the Navy's Psychiatry Consultant (if there is a corresponding office) agrees with the Army's. The former Navy Chief of Neuropsychiatry at Guantanamo Bay, William Henry Anderson, wrote a strong article in the Ass'n of Former Intel Officers journal proposing that the U.S. simply kill the 100,000 or so intractable terrorists with defective brains. The AFIO published my letter (attached as an rtf file) in the Winter/Spring 2005 issue of THE INTELLIGENCER. Dr. Anderson replied and stood his ground. I have hoped for another perspective by navy authorities:

[Banks, Louie M. COL] I cannot speak to the Navy's position on this. To the best of my knowledge, there are no Navy Psychiatrists involved in interrogation support. They are certainly

not involved at Guantanamo. Although I have not read Dr. Anderson's article, I agree with your comments in rebuttle.

**From:** "Gelles, Mike" < >

**Date:** May 24, 2005 4:43:41 AM PDT

**Subject:** Re: PENS - Reply to Banks on "Complexity," etc.

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

I would like to add a couple of brief comments related to the discussion and the issues that we might address as proposed by committee members.

First of all, I believe Dr. James made some very important and clear points regarding the idea that classified information may be made accessible to APA. I do not think that access to classified information is going to help in clarifying any of the issues we are confronting. The guidelines will hopefully help those who also work in areas where there are ethical challenges in the unclassified arena and in particular in the law enforcement arena where national security and national safety has a growing role. Counter terrorism being the example, where law enforcement has a critical role and conducts investigations and operations with the assistance of police psychologists who do not have access to classified information or the appropriate guidance offered by a chain of command.

Dr. James also has offered along with Dr. Banks in his communications the very clear guidance given to military officers who are psychologists. I have always found that military psychology has provided extensive guidance to their psychologists with perhaps the Army being the best. However, there are many civilian psychologists who are working in government who offer consultation in a variety of contexts. They do not have the same valuable guidance provided by the military. They do look to APA as a professional organization that represents psychology. However, see themselves as very different from other psychologists, not understood, under the scrutiny of academic rigor and in some cases fearful that their roles in supporting national security and safety could compromise their professional future. In some cases some choose not join APA or surrender their membership. As the role of psychology in national security evolves without appropriate guidance for this specialty we could end up both alienating psychologists as well as fragmenting a significant group away from APA. I would hope we want to avoid APA might taking a position of excommunicating those who end up in areas where the guidelines have not been defined and the challenges that confront them are great. I think it is important that as we discuss potential guidelines, goals and issues that we don't end up tipping the balance for those who are already ambivalent about what they are doing and fearful of the potential consequences for practicing in this area. I suspect that we may inevitably suggest that a set of Specialty Guidelines be developed for psychologist in national security as was done with forensic psychology.

I personally am willing to share if determined appropriate some of my own personal feelings about a national security case that I worked on, that although came under rigorous scrutiny highlighted for me the importance of remaining with APA as a

psychologist and thinking about our methods of practice our role and function and how we can remain a unified group living in harmony amongst academics and clinicians.

As I have said a number of times here, the work done in national security occurs in a different context with different challenges.

I think that as we define these goals and issues we should keep an important theme in mind and that is unity in the profession. We all have embraced the evolution of psychology over the decades, this in my mind is another successful evolution and we must keep those in practice close to the profession and develop the guidelines and protections for them to enable them to serve the community.

**Michael G. Gelles, Psy.D.**  
Chief Psychologist  
Naval Criminal Investigative Service

**From:** Gerry Koocher <>

**Date:** May 24, 2005 6:14:51 AM PDT

**Subject:** Intelligencer ?

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

What is: THE INTELLIGENCER ?

I attempted to find it with Google to assess what type of publication it is and had some difficulty locating which "intelligencer" you are citing.

Gerry

**From:** Jean Maria Arrigo <>

**Date:** May 24, 2005 8:55:31 AM PDT

**Subject:** Re: Intelligencer ?

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

Gerry,

THE INTELLIGENCER: JOURNAL OF U.S. INTELLIGENCE STUDIES, published by the Association of Former Intelligence Officers (AFIO), [www.afio.com](http://www.afio.com). The website announces that the journal is available only to members, as I not see, not available online. If you would like to see Dr. Anderson's article and his reply to my commentary in advance of the Task Force meeting, I will gladly mail you a photocopy. Just send me a mailing address.

Jean Maria

**From:** Gerry Koocher <>

**Date:** May 24, 2005 11:54:52 AM PDT

**Subject:** Re: Intelligencer ?

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

Why don't you bring a copy to the meetings. People can look at it and decide if they need a copy.

Thanks,

Gerry

**From:** Nina Thomas <>

**Date:** May 25, 2005 2:21:41 PM PDT

**Subject:** Fwd: [PRESIDENTIAL] disturbing, perhaps relevant article

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

Geoff Mumford kindly found this article. It was what I had referred to in my earlier email. (May 22, 2005. Army Faltered in Investigating Detainee Abuse. By TIM GOLDEN

[See "Article 4 - Army Faltering"]

FYI,



nina

-----Original Message-----

From: Mumford, Geoffrey <\_\_>

To:

Sent: Tue, 24 May 2005 07:49:42 -0400

Subject: FW: [PRESIDENTIAL] disturbing, perhaps relevant article

Hi Nina,

Is this the article you were referring too...if so you may want to forward it to the list?

Best,

-geoff

Geoff Mumford, PhD

Director of Science Policy

American Psychological Association

**From:** Olivia Moorehead-Slaughter <\_\_>

**Date:** May 25, 2005 4:01:05 PM PDT

**Subject:** message to all

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

Dear Task Force Members,

I hope you are well and looking forward to a restful Holiday weekend. I am very pleased with our listserve discussion and look forward to further postings in preparation for our June meeting.

As I was reflecting on our work, it occurred to me that while we have all been identified to the APA Membership as members of the PENS Task Force, as a

group we have not yet discussed how to present ourselves when we may be involved with issues related psychological ethics and national security.

I think it best that, for the time being, should we identify ourselves or be identified as PENS Task Force members, we make clear that we are speaking in our individual capacities, and not speaking or acting on behalf of the Task Force or in our roles as members of the Task Force. While this issue may not arise for anyone before our June meeting, and my sense is that all of you would react this way instinctively, given the interest in our work I thought it best to anticipate such a situation and make sure that we all had the same understanding.

Thank you, and please let me know if you have any thoughts or questions about this or any other Task Force matters,

Olivia

**From:** Nina Thomas <\_>

**Date:** May 25, 2005 8:11:56 PM PDT

**Subject:** Re: PENS - Reply to Banks on "Complexity," etc.

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@\_>

I appreciate the thoughtful and rigorous comments from all participants in this discussion. I fear that I have several times come into a discussion mid thread, however, so i am especially grateful that people copy the comments they are responding to.

I do want to "bookmark" for consideration somewhere in our process something we have not thus far noted. That is, that we consider the issue of ethnicity as it plays out in the instances of abuse of power and role that we are considering. It has, thus far been the case, that the instances of detainee abuse in various locations have most often (I have yet to see a contrary example) of white interrogators against detainees who are people of color. Tht opic does not conveniently fit into any of the matters we have considered to this point. That said, it seems important that we not lose sight of it.

Regards,

Nina Thomas

**From:** Jean Maria Arrigo <\_>

**Date:** May 25, 2005 11:24:38 PM PDT

**Subject:** PENS-Postponed replies

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

PENS Colleagues,

Thank you for responses to my proposals and perplexities. I will be back on-line with PENS on Sunday and send replies. Meanwhile, I am praying that we will arrive at a wise and manageable agenda before our June meeting, while there is still time to gather information.

Jean Maria

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Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From:** Gerry Koocher <>

**Date:** May 26, 2005 5:34:05 AM PDT

**Subject:** Re: PENS-Postponed replies

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**Jean Maria Arrigo wrote:**

**Meanwhile, I am praying.**

**With due respect, let's keep our work secular. :-)**  
**Gerry**



**From:** Jean Maria Arrigo <\_>

**Date:** June 2, 2005 11:18:45 AM PDT

**Subject:** PENS-Sample Agenda #2

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

PENS Colleagues

I am appealing again for an advance agenda. Our meeting in Washington is short, we have no research staff, our backgrounds and professional commitments are diverse, and our topic is highly politicized. With an advance agenda, we could muster our individual resources to the specific topics and seek critical information ahead of time.

Here are some major objections to my sample agenda of 5/23:

*scope of discussion*—the relationship of psychology to many kinds of military operations is of importance, not only interrogation of terrorist suspects;

*idealism versus realism*—realistically, the APA cannot know or influence secret, high-stakes activities in military settings;

*dual loyalties/dual roles*—psychologists may legitimately be patriots or military officers first.

Here is a new sample agenda:

1. Should the APA make a public statement opposing psychologists' assistance in coercive interrogation to maintain or establish our moral identity?

This is a narrow topic but the one that current events have thrown up to us. There is a wide public following on this issue. The specter of "Nazi doctors" haunts all health professions.

Definitions of "assistance" and "coercive interrogation" are not needed. Coercive interrogation does not even have to be condemned but only specified as incompatible with the professional ideals of APA psychologists. By analogy, military chaplains do not condemn all killing in war; however, they themselves do not carry weapons and do not serve as warfighters so as to preserve a crucial moral identity for their profession.

With homeland security and possible future domestic terrorist attacks, the interrogation situation could turn much worse. Later public statements by the APA, after a period of "bystander apathy," would be more costly.

A public statement would enable Psychologists for Social Responsibility or other activist groups to support "psychologists of conscience."

2. Should APA make a public statement promoting specified positive actions by psychologists in interrogation or detention settings?

Larry James (PENS msg 5/23/05 10:45 AM) stated that psychologists have fixed the problems, not caused them. "Wherever we have had psychologists, no abuses have been reported." Can we specify the effective actions?

A problem that comes to my mind is the access of psychologists to settings where abuses occur. In a related matter, my inquiries among atomic veterans, military chaplains, historians of the chaplaincy, and History-of-War listserve readers turned up no chaplains—zero— at the Pacific or Nevada nuclear test sites.

3. Should APA sponsor (or otherwise initiate) a study to address the dual-role problem for psychologists in national security work?

At least two articles in the PENS readings (Tabs 7 and 29) address the dual-role problem for psychologists with both clinical and forensic roles. A good proposal with respect to national security work in general would probably require even more data collection and assessment. Louie Banks' list of military tasks exclusively performed by psychologists (PENS msg May 18, 2005 6:42 PM) offers a starting point.

It is unlikely we could formulate a useful, comprehensive policy during our June meeting in Washington.

4. Should APA initiate a historical program to record the testimony of psychologists involved in high-stakes national security?

For reasoning about Psychological Ethics in National Security, APA has little reliable information and little expectation of access from official sources. (Even Kurt Lewin's OSS work has not been made public.) We can create an information base ourselves for future psychologists. Psychologists who are willing to share relevant experiences (as Mike Gelles offered in his 5/25/05 4:43 AM PENS msg) could contribute to a Psychological Ethics in National Security Collection. The Director of the American Archive of the History of Psychology, David Baker, would be glad to archive such a collection. (See our correspondence below.) Likewise, Brad Bauer, archivist for collection development, at the Hoover Institution on War, Revolution, and Peace at Stanford, would accept the collection. Hoover has cataloguers with military clearances and capacity to restrict materials from access for specified periods.

Thank you for reading this far. I welcome corrections and alternatives.

Jean Maria

From:

Subject: RE: AHAP - classified materials

Date: May 23, 2005 1:32:01 PM PDT

To:

Cc:

Hi Jean,

This is certainly material worthy of the historic record. First offering probably should be made to Wade Pickren, the APA archivist and historian. He can be reached at APA Central Office. If not, we would be happy to have it here. Our cataloguer does not have any type of military clearance as it has never come up. If it did come to us, I recommend it come sealed with instructions on length of restriction. We would place it in a locked document case in the stacks. Our stacks are restricted and there are only five individuals with keys.

I will be at APA and we can talk more if you would like.

Best,

David

David B. Baker, Ph.D.

Interim Dean-University Libraries

Director-Archives of the History of American Psychology

Bierce Library

The University of Akron

—Original Message—

From: Jean Maria Arrigo [mailto: ]

Sent: Saturday, May 21, 2005 4:25 PM

To: Baker,David B

Subject: AHAP - classified materials

Dear Dr. Baker:

I am writing to you as a member of the APA President's Task Force on Psychological Ethics and National Security (PENS). The Task Force will

meet June 23-26 in Washington, DC, to make recommendations concerning psychologists' participation in detention, interrogation, and other military settings. I propose that PENS recommend collecting and archiving memoirs, interviews, and publications of psychologists who are currently serving in such settings. Some of these materials would have to be restricted for a period of time. Might the AHAP be willing to archive such a collection? Does AHAP have a cataloguer with military clearance and a locked area for restricted materials?

Thank you for attending to my inquiry.

Cordially,

Jean Maria Arrigo

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Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From:** Jean Maria Arrigo <\_\_>

**Date:** June 2, 2005 11:40:35 AM PDT

**Subject:** Background data

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

Dear Olivia,

Does PENS have any means of obtaining demographic data about psychologists in national security roles? If so, approximate answers to the questions below would give us civilians a much better picture of the scope of our task.

Jean Maria

=====

How many psychologists are currently working in national security settings? According to degree (B.A., M.A., Ph.D., Psy.D.)? According to speciality? According to rank?

What percent are reservists?

What percent have potential financial obligations due to national security scholarships?

What percent are members of the APA?

What percent are involved with interrogation or detention of suspected enemies?

What is the overlap between psychologists involved in counterinterrogation training of U.S. personnel and those involved in interrogation of suspected enemies?

How many enlisted personnel are in psychological specialties?

How many academic psychologists have national security affiliations, e.g., as consultants, reservists, funded researchers? Are these relationships open or concealed?

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Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From:** Olivia Moorehead-Slaughter <>

**Date:** June 3, 2005 10:29:50 AM PDT

**Subject:** Observers

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

**Dear Task Force Members,**

**Thank you for your continued postings on the PENS listserve, which are very helpful in shaping our meeting agenda. I think we've done some very good work in crystallizing the issues and questions that we will address.**

**Our meeting will take place in the APA Boardroom, on APA's sixth floor. The Board room does have enough space for observers, and I would like to ask whether there are individuals we would like to see included, or groups represented, whose work is particularly relevant to our discussions and/or who would potentially have a unique contribution to make. We don't have unlimited space, of course, but certainly do have room for a few more people. Including others would have the added benefit of conveying an open and more inclusive process.**

**If anyone has names to suggest, please post them on our listserve.**

**Thanks very much,**

**Olivia**

**From:** Barry Anton <\_>

**Date:** June 3, 2005 10:51:06 AM PDT

**Subject:** Re: Observers

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**Colleagues:**

**I'd like to recommend Dr. Russ Newman, Executive Director of the APA Practice Directorate. This TF has direct implications for practice. I believe he is acquainted with many members of the TF.**

**Best,**

**Barry**

**Barry S. Anton, Ph.D., ABPP**

**Professor of Psychology**  
**University of Puget Sound**

**From:** "Banks, Louie M. COL" <>

**Date:** June 3, 2005 11:01:28 AM PDT

**Subject:** Re: Observers

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

**I will think about other potential observers, and make recommendations as I do, but I wanted to second Barry's recommendation of Russ. I think he could provide significant value added.**

**Morgan**

**COL L. Morgan Banks**

**Director, Psychological Applications Directorate**

**US Army Special Operations Command**

**DSN COM**

**From:** Olivia Moorehead-Slaughter <>

**Date:** June 3, 2005 12:26:22 PM PDT

**Subject:** Obsevers

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

**Hello Everyone,**

**It sounds like Russ Newman would be a great invite as an observer to our meeting. As for other APA staff to include, I think its best to leave this to the discretion of the Ethics Office and Science Directorate staff who are coordinating this effort. In the meantime, please do continue to share your suggestions about non-APA staff to include as I think that an inclusive and open process is good for what we are trying to accomplish.**

**Your input about this and all other issues related to the Task Force's work continue to be appreciated and welcome.**

**Have an enjoyable weekend.**

**Olivia**

**From: "Col. Larry C. James PhD" < >**

**Date: June 3, 2005 12:56:03 PM PDT**

**Subject: Re: Obsevers**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >**

**Olivia, I agree completely that openness is ideal and the best way to go. But I have to say that I was a little uncomfortable when I read your recommendation to to have an open meeting. I think it would be great having Russ there, I don't have any concerns about Russ.**

**Here are my concerns:**

**1). Olivia, some of what we have to say and discuss may not be classified INTEL information but nevertheless may be sensitive information, suppose a member of the press shows for this meeting if it is an open meeting. Will this person be allowed to stay if it is an "open" meeting? Having the board room filled with people may adversely affect discussion by task force members.**



**2). my second concern is one of safety. Several of us on the task force have worked with some very dangerous, hard core, terrorist who enjoy killing people (particularly americans) frankly speaking.**

**So I would want to know who will attend, why, which group he/she will represent before anyone else attends. Allowing this to be an open forum to anyone who wants to attend make me uncomfortable.**

**From: "Gelles, Mike" < >**

**Date: June 3, 2005 1:21:07 PM PDT**

**Subject: Re: Obsevers**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >**

**I would like very much to concur with Dr. James' comments**

**Michael G. Gelles, Psy.D.**

**Chief Psychologist**

**Naval Criminal Investigative Service**

**From: "Gerald P. Koocher, Ph.D." < >**

**Date: June 3, 2005 1:50:47 PM PDT**

**Subject: Re: Obsevers**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >**

**In light of Larry's comments I suggest that we limit observers to APA members we might choose to invite because of expertise, etc. NOT members of the public or press.**

**Gerry**

**From:** Olivia Moorehead-Slaughter <\_>

**Date:** June 3, 2005 2:30:39 PM PDT

**Subject:** Re: Obsevers

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

**Larry and Gerry,**

**Your comments are very well taken. I actually did not mean to imply open" in its broadest sense. My intention was to convey that I think that we should consider including observers, that is, individuals who are not members of the Task Force but who would have an interest in this matter as well as some possible contribution to make to our deliberations.**

**I absolutely agree that the press should not be a part of these meetings.**

**Additionally, the parties in the room will be "known entities" who have been approved to be there. I, like you, believe that it is imperative that our discussions proceed in an environment of safety and collegiality.**

**As always, thanks for your feedback.**

**Olivia**

**From:** Jean Maria Arrigo <\_>

**Date:** June 6, 2005 12:01:14 PM PDT

**Subject: PENS-Observers**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security**  
**<PENS@ >**

Olivia,

I support the concerns of our PENS military colleagues. I also have information relevant to our task, given me to me in confidence, that I am not prepared to broadcast to people who are not formally accountable to PENS.

Because of my oral histories of atomic veterans, I looked closely at the FINAL REPORT of the 1993-1995 President's Advisory Committee on Human Radiation Experiments. The absence of military and intelligence committee members or advisors is one of the main reasons, in my opinion, that the Advisory Committee was unable to grapple with tough moral issues raised by atomic veterans. It is a good sign that PENS has so much military expertise. I hope we will be able to conduct proceedings so as to encourage further military collaboration.

It would be very helpful, I think, if certain experts were available for telephone consultation during our meeting, especially a military attorney, an APA attorney, and an AMA ethics representative. For the latter, Matt Wynia, Director of the AMA Institute of Ethics, is willing to consult by telephone.

Jean Maria

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Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From: "Gelles, Mike" < >**

**Date: June 6, 2005 1:39:38 PM PDT**

**Subject: Re: Observers**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security**  
**<PENS@ >**

**Dr. Mel Gravitz**

**Michael G. Gelles, Psy.D.**

**Chief Psychologist**

**Naval Criminal Investigative Service**

**From:** Olivia Moorehead-Slaughter <>

**Date:** June 7, 2005 6:42:49 AM PDT

**Subject:** Re: Observers

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**Hi Mike,**

**Could you say more about Dr. Mel Gravitz for those of us who may not be as familiar with him? Thanks.**

**Olivia**

**From:** Olivia Moorehead-Slaughter <>

**Date:** June 7, 2005 7:07:36 AM PDT

**Subject:** Re: PENS-Observers

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**Hi Jean Marie,**

**Thanks for sharing your concerns about who will be present during the upcoming meeting. You listed several sources of expert counsel that the Task Force may want to access through telephone consultation. Certainly, the APA Office of General Counsel has**

**assured us of their availability in whatever way the Task Force would find helpful.**

**Please be assured that all observers would be individuals who are there for professional reasons and no one would be present that I, as Chair, and the two Board liasons have not approved. Even so, if anyone in the room had strong objections to a particular observer, this would be taken into serious consideration. I remain committed to assuring that the Task Force meetings take place in an environment of safety and collegiality.**

**Again, thanks for your response.**

**Olivia**

**From:** Jean Maria Arrigo <\_>

**Date:** June 7, 2005 11:16:40 AM PDT

**Subject:** Re: PENS-Observers

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@\_>

Olivia, I couldn't imagine objecting to any particular person. The weekend availability of the APA General Counsel is very encouraging. I worry that we will not be able to come to any meaningful resolutions for lack of information. — Jean Maria

Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From:** "Gelles, Mike" <\_>

**Date:** June 7, 2005 3:56:42 PM PDT

**Subject:** Re: Observers

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**Dr Gravitz is affectionately referred to as the father of operational psychology. He was the first psychologist at NSA and then spent. A short career with the Navy. Mel consults to several government agencies and has been very involved in a number of issues confronting psychologists in government and ethics. I am uncertain as to how much time he may have available but is is very grounded in the issues that confront psychology in the national security arena**

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**Sent from my BlackBerry Wireless Handheld**

**From:** "Gerald P. Koocher, Ph.D." <>

**Date:** June 7, 2005 4:37:24 PM PDT

**Subject:** Re: Observers

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**During the 1970s-80s Mel worked for the State Department assessing candidates for consular appointments.**

**Gerry**

**From:** Olivia Moorehead-Slaughter <>

**Date:** June 8, 2005 6:16:48 AM PDT

**Subject:** Re: Observers

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**Dr. Gravitz sounds ideal and I have asked Steve Behnke to extend an invitation to him to attend our meeting. Thanks for the info.**

**Olivia**

**From:** Jean Maria Arrigo <\_\_>

**Date:** June 10, 2005 9:50:12 AM PDT

**Subject:** PENS-APA Ethics Code procedures

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@\_>

Dear Olivia,

I am rereading the PENS description for the APA Board of Director, which you sent on May 18:

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The overarching purpose of the task force will be to examine whether our current Ethics Code adequately addresses such activities, whether the APA provides adequate ethical guidance to psychologists involved in these endeavors, and whether APA should develop policy to address the role of psychologists and psychology in investigations related to national security.

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Now I understand we are to serve as preliminary advisors for possibly a very long process. I'm sorry I didn't have the time span in focus at the outset. As an organization, how does APA develop policy or augment the Ethics Code? Could you or some APA authority direct us to a source for these procedures? PENS recommendations will probably be more useful if they take into account the organizational procedures that follow.

Jean Maria

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Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From:** Robert Fein <\_\_>

**Date:** June 12, 2005 2:01:17 PM PDT

**Subject:** NY Times Mag article

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**Dear Colleagues,**

**I apologize for burdening you with a long article, knowing that only a small part of our task deals with interrogation questions. But Joseph Lelyveld (former executive editor of the NYT) is one of the country's most respected journalists, and his essay is, I think, thoughtful and sobering.**

**Sincerely,**

**Robert Fein**

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**New York Times Magazine, June 12, 2005,**

**Interrogating Ourselves**

**By JOSEPH LELYVELD**

**[See 'Article 5 - Interrogating Ourselves']**

**From:** Barry Anton <\_\_>

**Date:** June 13, 2005 7:57:29 AM PDT

**Subject:** Re: NY Times Mag article



**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**TF members:**

**I too read the article in the NY Times Magazine yesterday and suggested this morning to Steve that we might want to compile a glossary so that we all understand terminology in a consistent manner.**

**See you soon.**

**Barry**

--

**Barry S. Anton, Ph.D., ABPP  
Professor of Psychology  
University of Puget Sound**

**From:** Olivia Moorehead-Slaughter <>

**Date:** June 16, 2005 5:57:52 PM PDT

**Subject:** Our Meeting

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**Dear Colleagues,**

**In anticipation of our meeting next week, I wanted to share with you some thoughts regarding our agenda. A number of you have shared your thinking about how best to approach our work; I'd like to note especially Jean Maria's encouraging us to form a plan.**

**Put in the broadest (perhaps most simplistic) way, we'll want to consider where we want to be by meeting's end, and how we're going to get there.**

**In terms of where we want to be, the two "big ticket" items are: what sort of product do we want to issue, and to whom will it be made available. In terms of how we will get there, we'll want to lay out a process for addressing the issues we want our final product to contain.**

**I would very strongly encourage us to plan on having by meeting's end a report that we feel we can sign off on as a Task Force. As Jean Maria has cautioned us, I think that we do not need to feel as if our product needs to answer, or even touch upon, each of the many complicated issues. I think we should aim to identify whatever "bottom line" positions we can all agree upon, and then develop a way for psychologists (and other mental health professionals working in this arena) to analyze or approach the ethical challenges that arise in cases of uncertainty and ambiguity. I think we will especially want to offer as much guidance as we can to psychologists, particularly young psychologists, both in ethically ambiguous situations and in situations where it appears that other psychologists may be acting unethically. Robert has offered a very illuminating vignette to help us focus here.**

**In terms of analytic frameworks, very early on Morgan offered the legal/illegal, ethical/unethical distinctions, which I have found very helpful in my own thinking about how to approach these questions. Both Morgan and Mike used terms such as "safe, effective, legal, and ethical," which could provide another good way of anchoring ourselves in the "bottom line" questions we need to address.**

**Jean Maria poses the very important question of what public statements APA ought to make; these will be an important part of our discussions on what the final product should look like. Nina has raised issues of ethnicity, and I believe it will be very important for us to discuss the ethnic/cultural dimensions of this issue. A number of people have raised the dual role question, which will clearly be front and center in our discussions; I find myself mindful of Mike's very evocative language "Stay in your lane." Mike and Larry then offered an exchange concerning whether psychologists should ever be "strategic decision-makers," which raises the issues of both role and competency. Larry has provided his thoughts on how he dealt with another question that will be central to our thinking:**

**Who is the client? Part of our task will be to examine how these distinct but related questions and issues fit together.**

**Please let me know your thoughts. I look forward to meeting you all in person, and to a challenging and productive weekend.**

**Warmly,**

**Olivia**

**From:** Nina Thomas <\_>

**Date:** June 16, 2005 8:35:36 PM PDT

**Subject:** Re: Our Meeting

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@\_>

**Dear All -**

I want to add to Olivia's extremely well framed detail of our agenda for the meetings this weekend, particularly on the subject of the work product we come up with. Although a policy position would require the approval of Council, I suggest that we formulate a proposed public statement that articulates APA's position. Although Olivia, you had suggested that we leave to staff the decision of whom to include (from staff) in our meetings, I would not want to overlook Rhea Farberman as someone who should be included as we consider the issues involved in a much needed public statement.

**Nina K. Thomas, Ph.D., ABPP**

**From:** Nina Thomas <\_>

**Date:** June 17, 2005 7:44:57 AM PDT

**Subject:** Michael Ignatieff

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@\_>

In reading and thinking about the Lleyveld article I remembered a piece Ignatieff wrote some while ago for the magazine section of the NY Times about terrorism, torture and interrogations. I think it was called "The Terrorist as Auteur" from the Nov. 11, 2004 Magazine Section. Might, if people have a chance (I couldnt access the whole article), be worth a read as an additional viewpoint on the complexities involved of balancing security with liberty.

See you Thursday.

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** "LeFever, Bryce E. (CAPT)" <\_>

**Date:** June 20, 2005 6:26:11 AM PDT

**Subject:** Re: Establish Communications

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@\_>

Morgan,

How are you? I am excited to participate with you on this project. I have, unfortunately, been screened from the entire listserve dialog. If you have kept any of it, I would appreciate seeing the significant portions. I have several immediate questions:

1. Are we wearing uniforms--or, what is the dress code?
2. Are you, or anyone, traveling with your wife? Are wives permitted at the dinners or are they working dinners?
3. Has a format for discussion been established?
4. Have I missed any obvious questions?

I look forward to seeing you,

Take care,

Bryce

Bryce Lefever, Ph.D. ABPP  
CAPT MSC USN  
Department Head  
Substance Abuse Rehabilitation Program  
Naval Medical Center Portsmouth, Virginia

**From:** Olivia Moorehead-Slaughter <\_>

**Date:** June 20, 2005 8:27:50 AM PDT

**Subject:** Re: Our Meeting

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

**Hi Nina and Everyone,**

**Sorry for the delayed response to your excellent suggestion of Rhea as someone to consult regarding any proposed public statement. I agree that we should do this.**

**Looking forward to seeing everyone later this week.**

**Olivia**

**From:** Olivia Moorehead-Slaughter <\_>

**Date:** June 20, 2005 1:57:21 PM PDT

**Subject:** Logistics

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

**Hello Everyone,**

**There are a few logistics that all of you may find of interest as we close in on Thursday and that some of you have asked about. They are as follows:**

- 1. Dress:** From my perspective, you should dress so that you can comfortably work. There may be those of you for whom protocol would dictate differently and I would leave that to your discretion.
- 2. Dinner:** Dinner will be at 7:30 P.M. on Thursday evening to accommodate the various travel schedules. There has been a suggestion that dinner on Friday and Saturday be moved to either 6:00 or 6:30 and I will ask APA staff to explore this possibility. If

anyone has strong objections to an earlier dinnertime on these two nights, please do let me know.

**3. Listserv discourse:** If you have missed any messages during the listserv discussions, they can be accessed through the following link::

**<http://listserv. /archives/pens.html>**

**4. Other Assistance:** If you need other assistance with logistics, please do not hesitate to be in contact with Rhea at APA who will be pleased to help you out.

Thanks to all of you for the hard work that you have already done in preparation for this meeting. Your time, interest, and expertise is already appreciated. Travel safely everyone! I'm looking forward to seeing all of you.

My best,

Olivia

**From:** "Gerald P. Koocher, Ph.D." <>

**Date:** June 20, 2005 5:27:25 PM PDT

**Subject:** Re: Logistics

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

**Olivia Moorehead-Slaughter wrote:**

**2. Dinner:** Dinner will be at 7:30 P.M. on Thursday evening to accommodate the various travel schedules. There has been a suggestion that dinner on Friday and Saturday be moved to either 6:00 or 6:30 and I will ask APA staff to explore this possibility. If anyone has strong objections to an earlier dinnertime on these two nights, please do let me know.

**As an early riser, I am an enthusiastic supporter of early dinners 6 or 6:30 p.m.**

**Gerry**

**From: "R. Scott Shumate" <>**

**Date: June 20, 2005 7:09:12 PM PDT**

**Subject: Re: Our Meeting**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >**

**Fellow Members:**

**I have been reading the various comments that have been posted over the past many weeks. I look forward to the discussions that are going to commence on Thursday and continue through the weekend. The undertaking that we are about to embark on has many benefits as well as possible pitfalls. The early discussions in particular appeared to me to be an attempt to persuade others that their views were most sensible and that ultimately through the power of the debate a correction in thinking was likely.**

**There will likely be much common ground that will be the basis for policy guidance on ethical standards for psychologists involved in national security. All sides of the dialogue have important points to be made and considered in the final suggestions. Having been involved on a personal level in the protection of this country in foreign lands I have over the years gained a greater appreciation that the doves need the hawks and the hawks need the doves. The balance that is achieved is vastly superior to anyone leaning and that the openness of the debate is the foundation of our strength as a society. I hope I can speak for my colleagues in the Department of Defense that we embrace the discussions and various viewpoints that will be represented at the table during the next four days. I look forward to sorting out the ethical guidance that we will recommend to the APA while also being vigilant that we are not there to debate nor confront the past, present nor future policies of the Administration or the Department. I believe that we can do what is right for psychology while holding reserve on those aspects that we have neither the authority nor the charge to address. I am sure that others may feel differently about what boundaries we must remain within and the discussion may yield interesting dilemmas for us to tease out.**



**I applaud the APA in this undertaking and the APA's willingness to explore the ethical dilemmas that we in the national security arena have confronted throughout our career. Lets have fun, lets be productive and lets be inclusive. Scott Shumate**

**From:** Nina Thomas <>

**Date:** June 20, 2005 9:15:01 PM PDT

**Subject:** Re: Logistics

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**Not to put too fine a point on it but if we are working til 5:00-ish, I would welcome the opportunity to throw some water on my face before dinner so a 6:30 dinner would be more to my taste allowing some amount of time to get from one place to another and still throw water on my face (no smart retorts please Gerry)**

**Nina**

**Nina K. Thomas, Ph.D., ABPP**

**From:** anton <>

**Date:** June 20, 2005 9:52:40 PM PDT

**Subject:** Logistics

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**TF Colleagues**

**I would agree with Nina that a slightly later dinner time would give us a little time to perhaps exercise or check email, whatever your pleasure. However, later dinners put a burden on staff who may want to get home for the evening. Perhaps ending at 4:30 (with a half-hour lunch to preserve work time) would achieve the same break needs before dinner and keep the start time the same. For those of us from the west coast, a 6:30 dinner is essentially a (very) late lunch:)**

**See you soon.**



**Barry**

**Barry S. Anton, Ph.D., ABPP**

**Department of Psychology**

**University of Puget Sound**

**From:** Olivia Moorehead-Slaughter <>

**Date:** June 22, 2005 11:01:49 AM PDT

**Subject:** Re: Logistics

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**Hello Everyone,**

**Hope the email from Rhea represents a workable compromise in terms of our dinners for everyone. Nina, thanks for the levity!**

**Safe travels to all.**

**Warmly,**

**Olivia**

**From:**

**Date:** June 22, 2005 7:30:45 PM PDT

**Subject:** Re: Logistics

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@>

**On the side of the earlier dinners.--Jean Maria**

**From:** Olivia Moorehead-Slaughter <\_>

**Date:** June 26, 2005 6:15:56 PM PDT

**Subject:** Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

Hello Everyone,

I trust that everyone has arrived home safely. Once again, I thank you for your fabulous participation on the Task Force this weekend and in all of the weeks leading up to the meeting. We met our goal by producing a document which I believe represents all of us and APA very well. As promised, Steve has produced a final draft for our review which represents his best efforts to incorporate everyone's best thinking into a coherent document. I have no doubts that he has succeeded.

Although I expressed my appreciation for all of Steve's hard work at other points during the weekend, I unfortunately neglected to do so during my parting remarks to all of you. I have had the good fortune to have Steve's wise counsel and tireless support during this entire process. I simply could not have asked for better guidance and assistance at every turn. The production of this document in its present form and in such a timely manner is testament to Steve's exquisite work. Steve, APA is truly fortunate to have you and the profession of psychology is enriched by all that you do. I truly and sincerely thank you. By the way, I still don't know WHEN you sleep! :)

Everyone, please review the document and post any suggestions or recommendations on the listserve by noon on Monday. The report will be forwarded to the Board of Directors at 1:00 P.M. tomorrow. Thanks to all of you for your continued hard work towards this effort.

My best.

Olivia

[Please see PENS Final Draft #4]

**From:** Nina Thomas <\_>

**Date:** June 26, 2005 7:06:25 PM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Beyond impressive, beyond complete. To my eye the report incorporates all our last minute changes, suggestions, etc. It certainly has my ok. Steve, you are incomparable.

I appreciate the opportunity to have served with each of you.

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** Robert Fein <\_>

**Date:** June 27, 2005 4:34:59 AM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Dear PENS Colleagues,

I think the draft final report is comprehensive, thoughtful, sensitive, and nuanced. I think it can serve as a map that directs us, APA, and others toward work in the future that prevents violence and keeps people safe.

It was an honor and privilege for me to spend time with you all, including wonderful APA staff, this weekend. I learned much and emerge from our discussions less ignorant and more hopeful than when we began.

Thank you very much.

Robert

P.S. I heard/am floating a rumor that Olivia and Steve might be convinced to offer their gracious chairpersoning and unbelievable wordsmithing services to government agencies in need, at steep discount from what they might command in the real world.

**From:** "LeFever, Bryce E. (CAPT)" <>

**Date:** June 27, 2005 6:17:34 AM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Olivia,  
The report is very good. It has my endorsement.  
Yours truly,  
Bryce

-----Original Message-----

From: Olivia Moorehead-Slaughter [mailto: ]

Sent: Sunday, June 26, 2005 9:16 PM

To: PENS@

Subject: [PRESIDENTIAL] Final draft of TF document

**From:** Mike Wessells <>

**Date:** June 27, 2005 7:13:37 AM PDT

**Subject: Re: Final draft of TF document**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@>**

Many thanks for sending this excellent revision, the quality of which owes extensively to Steve's careful work.

One very small but important suggested change is that yesterday, we had agreed to include under the fourth point reference (in two places) to both the Geneva Conventions and the Convention Against Torture (which applies to detainees who are not Prisoners of War). An easy "fix" is in each place in point four where reference is made to the Geneva Conventions, add "and the 1987 Convention Against Torture." The latter could have a footnote that includes the full title, "Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment" and the original text (see U. N. Doc. A/RES/39/46).

It has been an honor to serve on this Task Force

Mike W.

---

**From: Jean Maria Arrigo <\_>**

**Date: June 27, 2005 8:33:58 AM PDT**

**Subject: Re: Final draft of TF document**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@>**

My three comments on the 6-27-05 draft follow below.

I think the appropriate acknowledgment for Steve is a Pullitzer Prize in the new genre of committee reports. Thanks to all, especially the military psychologists, for an enriching and heartening experience of democratic process. I am grateful for the opportunity to participate in this process.

Jean Maria

=====

P. 1, para 4, p. 2 title, p. 3 title: "Nonetheless, the Task Force was unambiguous that psychologists DO NOT engage in...."

Returning to a point of language addressed on Sunday, I am concerned that readers unfamiliar with the location of the APA Ethics Code may give this an ordinary language interpretation as a statement of fact. Suggested rewording, "...psychologists MUST NOT engage in...." Similarly, on the next page, "II. Task Force STATEMENTS" might be clarified as "Task Force RESOLUTIONS" or some similar word to indicate intent rather than fact. Following through, the p. 3 title would be "II. Introduction and Commentary on the Twelve Task Force RESOLUTIONS," of the similar word.

P.2 #8 and P. 6 Eighth: "Psychologists who consult on interrogation techniques ARE MINDFUL THAT the individual being interrogated may not have engaged in untoward behavior and may not have information of interest to the interrogator." This is much weaker than our original notion of a litmus test for suitability of interrogation techniques. Suggested rewording: "In consultation on interrogation techniques, psychologists recommend and condone only techniques that are appropriate whether or not the individual being interrogated is later determined to have engaged in untoward behavior or to have information of interest to the interrogator."

P. 3 , para 3. "Many association members work for the U.S. government as employees or consultants in national security-related positions. It is the responsibility of APA to think through and provide guidance on the complex ethical challenges that face these psychologists, WHO APPLY THEIR TRAINING, SKILLS, AND EXPERTISE IN OUR NATION'S SERVICE." In deference to APA members who are not U.S. citizens, and to emphasize political neutrality, I suggest omitting the last clause. The intent of the paragraph is still maintained.

---

Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From:** Gerry Koocher <>

**Date:** June 27, 2005 9:19:34 AM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Jean Maria Arrigo wrote:

My three comments on the 6-27-05 draft follow below. P. 1, para 4, p. 2 title, p. 3 title: "Nonetheless, the Task Force was unambiguous that psychologists DO NOT engage in...."

Returning to a point of language addressed on Sunday, I am concerned that readers unfamiliar with the locution of the APA Ethics Code may give this an ordinary language interpretation as a statement of fact. Suggested rewording, "...psychologists MUST NOT engage in...." Similarly, on the next page, "II. Task Force STATEMENTS" might be clarified as "Task Force RESOLUTIONS" or some similar word to indicate intent rather than fact. Following through, the p. 3 title would be "II. Introduction and Commentary on the Twelve Task Force RESOLUTIONS," of the similar word.

**I support the original draft report language.**

P.2 #8 and P. 6 Eighth: "Psychologists who consult on interrogation techniques ARE MINDFUL THAT the individual being interrogated may not have engaged in untoward behavior and may not have information of interest to the interrogator." This is much weaker than our original notion of a litmus test for suitability of interrogation techniques. Suggested rewording: "In consultation on interrogation techniques, psychologists recommend and condone only techniques that are appropriate whether or not the individual being interrogated is later determined to have engaged in untoward behavior or to have information of interest to the interrogator."

**I support the original draft report language, as the proposed substitution has confusing post hoc reasoning.**

P. 3, para 3. "Many association members work for the U.S. government as employees or consultants in national security-related positions. It is the responsibility of APA to think through and provide guidance on the complex ethical challenges that face these psychologists, WHO APPLY THEIR TRAINING, SKILLS, AND EXPERTISE IN OUR NATION'S SERVICE." In deference to APA members who are not U.S. citizens, and to emphasize political neutrality, I suggest omitting the last clause. The intent of the paragraph is still maintained.

**I support the original draft report language, and am not concerned about the sensibilities of non-citizen APA members. Non-citizen members are unlikely to be asked to engage in national service to the United States.**

**Gerry**

**From:** "R. Scott Shumate" <>

**Date:** June 27, 2005 9:34:12 AM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <[PENS@](#)>

Although, late, I have no problems with the final draft. Scott shumate

R. Scott Shumate

**From:** Jean Maria Arrigo <>

**Date:** June 27, 2005 2:10:17 PM PDT

**Subject:** Intelligence & Ethics 2006

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <[PENS@](#)>

PENS Colleagues:



Below is the announcement for the Intelligence & Ethics 2006 meeting, as I promised to some of you. Updated information will appear at <http://eli.sdsu.edu/ethint>. My principal co-organizer is Prof. Jan Goldman at the Joint Military Intelligence College ([Jan.Goldman@](mailto:Jan.Goldman@)), whom you may also contact for information. Of course, I would be delighted to see any of you there.

Jean Maria

=====

## INTELLIGENCE AND ETHICS 2006 — CALL FOR PAPERS

[See Call for Papers INTELLIGENCE AND ETHICS 2006]

**From:** "Banks, Louie M. COL" <>

**Date:** June 27, 2005 2:52:55 PM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <[PENS@](mailto:PENS@)>

To all,

I am honored to have met and worked with you all, and truly amazed at the clarity and comprehensiveness of the document. I thank you all for the hard work and time you devoted to educating me. I hope to continue our friendship and collaboration, especially with those of you who do not work within DoD. The document has my full endorsement.

Very respectfully,

Morgan

COL L. Morgan Banks

Director, Psychological Applications Directorate

US Army Special Operations Command

DSN COM

**From:** "R. Scott Shumate" <>

**Date:** June 27, 2005 5:41:32 PM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Fellow APA PENS and APA Staff:

Now that my day has finally brought me home I thought I would take a few moments to express my feelings about this past weekend. I want to thank each and everyone of you for working so hard, expressing your views and remaining open as well as inclusive in your dealings and decisions. It has been an honor and privilege to have worked with you and I believe we have penned a document that will be the basis for additional discourse and thought over many years. To the APA staff your professionalism and dedication to this endeavor as well as your investment in the process created an atmosphere where we were able to be productive and successful.

A special thanks to Steve, you did a wonderful job and ensured the process was well thought-out, as Einstein use to say, "the advantage goes to the prepared."

Scott Shumate

**From:** "Col. Larry C. James PhD" <>

**Date:** June 27, 2005 10:24:01 PM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

the document has my full support,

Larry

**From:** "Gerald P. Koocher, Ph.D." <>

**Date:** June 28, 2005 4:29:28 AM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

R. Scott Shumate wrote:

Fellow APA PENS and APA Staff:

Now that my day has finally brought me home I thought I would take a few moments to express my feelings about this past weekend.

Hi Scott,

I had meant to ask you last weekend: are you related to [*personal information deleted*]

Regards,  
Gerry Koocher

**From:** Nina Thomas <>

**Date:** June 28, 2005 6:50:08 AM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

In a message dated 6/27/2005 7:24:06 AM Pacific Daylight Time, \_\_ writes:

One very small but important suggested change is that yesterday, we had agreed to include under the fourth point reference (in two places) to both the Geneva Conventions and the Convention Against Torture (which applies to detainees who are not Prisoners of War

I've been having email trouble so am not fully caught up on yesterday's flock. My reading had references to both in a first footnote under whatever number when it first appears. No? Or are you referring to spelling it out in both iterations?

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** Olivia Moorehead-Slaughter <\_>

**Date:** June 28, 2005 8:35:02 AM PDT

**Subject:** Update on Task Force report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Hello Everyone,

Thanks to everyone for your timely review of the our report. I thought that you might want a bit of an update around how it has been distributed. The report has been forwarded to the Board of Directors as well as the Ethics Committee. I expect that the Board will act upon this Report in an expeditious manner, but we must await their direction before any of us can distribute this document. I do recall that on Sunday some of you noted that you wanted to have access to the Report as soon as possible, but I ask for your patience as it is reviewed by the appropriate APA constituencies. Although this may seem like a lengthy process, I am told that by APA standards this is actually all happening with exceptional speed. It's pretty remarkable that we had nothing written on Thursday and a full report prepared and sent to the Board of Directors by Monday! This could not have been done without all of you and again, I thank you.

Warmly,

Olivia

**From:** "Gelles, Mike" <\_>

**Date:** June 28, 2005 8:43:59 AM PDT

**Subject:** Re: Update on Task Force report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Thanks Olivia

Michael G. Gelles, Psy.D.

Chief Psychologist

Naval Criminal Investigative Service

**From:** Nina Thomas <>

**Date:** June 28, 2005 9:43:05 AM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

\_ writes:

I thank you all for the hard work and time you devoted to educating me. Quite frankly it felt much as tho you guys were doing the heavy lifting as far as the educative role goes, at least I experienced the greatest benefit of learning from you all.

I hope to continue our friendship and collaboration, I endorse the sentiment. I hope there will be opportunity for both - continued friendship and collaboration. Larry and I discovered that in fact we had presented on a panel together several years ago (it was Chicago, Larry, at least I think it was, but I cant remember what year). My wish would be that our contacts remain vital.

Warm wishes for a good summer and much good effect from our work.

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** Olivia Moorehead-Slaughter <>

**Date:** June 28, 2005 11:08:02 AM PDT

**Subject:** For your review

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

I'm sending you the link for accessing the statement released by the American Psychiatric Association. I think that when you read it, you will be even more proud of what we have produced as there is quite a contrast. I'd like to think that we've done well by our profession.

Olivia

[http://www.psych.org/news\\_room/press\\_releases/05-40psychpracticeguantanamo.pdf](http://www.psych.org/news_room/press_releases/05-40psychpracticeguantanamo.pdf)

[See : Article 8 – psychpracticeguantanamo]

**From:** Nina Thomas <>

**Date:** June 28, 2005 12:19:52 PM PDT

**Subject:** Re: For your review

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

I appreciate receiving the link to the ApA's response (tho they claim it as the APA's). I do think we were in a good position to have produced a response that is much more thorough and comprehensive. The fortune of timing was with us.

N

Nina K. Thomas, Ph.D., ABPP

**From:** "R. Scott Shumate" <>

**Date:** June 28, 2005 12:41:49 PM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Gerald: I am undoubtedly related to [personal information deleted]. How closely related I am not sure since this is the first time that I have heard of him. Maybe I will give him a call and see if we can trace the tree back. Thanks. Scott Shumate

R. Scott Shumate

**From:** "Col. Larry C. James PhD" <>

**Date:** June 28, 2005 1:44:42 PM PDT

**Subject:** Re: Final draft of TF document

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Nina I'll have to go back and check the ole APA convention proceedings, now you've got me curious.

take care,

Larry

**From:** Olivia Moorehead-Slaughter <>

**Date:** June 29, 2005 7:51:37 AM PDT

**Subject:** Update on process

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Dear Colleagues,

Just a brief message to let you know where our Report is in the process. Steve sent the Report to the Board of Directors and to the Ethics Committee. The Ethics Committee is reviewing the Report this afternoon, for the purpose of determining whether our twelve statements are "appropriate interpretations and applications" of the APA Ethics Code. The Ethics Committee will convey the results of its determination to the Board, at which point

the Board will indicate whether it is satisfied with the Report or whether it believes the Report requires additional work.

If the Board is satisfied with the Report, I will ask Steve to send the Report to the Board with the words "Final Draft" removed, so that what is sent is the "Report of the Task Force on Psychological Ethics and National Security." I have asked Steve to copy the Report and to review the report for consistency in style, correctness of grammar and usage, etc., by this afternoon, so that the Report will be available as soon as the Board requests it. I have also authorized Steve to add any citations to the Ethics Code that the Ethics Committee, during its conference call, believes are relevant to one of our twelve statements and that we may have overlooked.

I will provide you an update when I have more information.

Warmly,

Olivia

**From:** Nina Thomas <\_>

**Date:** June 29, 2005 11:15:03 AM PDT

**Subject:** Re: Update on process

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

thanks for the update Olivia...looking forward to the further report on the progress.

N

**From:** Olivia Moorehead-Slaughter <\_>

**Date:** June 29, 2005 2:43:54 PM PDT

**Subject:** Update on Report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>



Hello Everyone:

The Ethics Committee met by Conference Call this afternoon and thoroughly discussed the Report of the Task Force. They were very appreciative of the hard work and depth of consideration demonstrated in this document. A slightly amended version of the Report will be sent out to you for review later this evening. Please review this document at your very earliest convenience and respond on the listserve with your feedback around the changes. Thanks so much.

Olivia

**From:** "Banks, Louie M. COL" <>

**Date:** June 29, 2005 3:06:29 PM PDT

**Subject:** Re: Update on Report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

If it is possible, I would appreciate having the changes annotated, helping with the review. Thanks.

Morgan

COL L. Morgan Banks

Director, Psychological Applications Directorate

US Army Special Operations Command

DSN COM

**From:** Nina Thomas <>

**Date:** June 29, 2005 6:15:41 PM PDT

**Subject:** Re: Update on Report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

In a message dated 6/29/2005 3:05:39 PM Pacific Daylight Time, \_ writes:

I would appreciate having the changes annotated, helping with the review.

ditto, Nina

Nina K. Thomas, Ph.D., ABPP

**From:** "Gerald P. Koocher, Ph.D." <>

**Date:** June 29, 2005 6:26:01 PM PDT

**Subject:** Re: Update on Report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Olivia Moorehead-Slaughter wrote:

A slightly amended version of the Report will be sent out to you for review later this evening.

I am amazed at the turn-around time on this!

Will Steve be providing both English and Latin versions?

Gerry

**From:** anton <>

**Date:** June 29, 2005 6:28:48 PM PDT

**Subject:** Re: Update on Report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

I think we would all agree: Watching Steve work is beauty in motion.

Cheers,

Barry

Barry S. Anton, Ph.D., ABPP

Distinguished Professor

Department of Psychology

University of Puget Sound

**From:** "Behnke, Stephen" <>

**Date:** June 29, 2005 6:45:14 PM PDT

**Subject:** Re: Update on Report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Si vobis placet, agam.

**From:** Olivia Moorehead-Slaughter <>

**Date:** June 29, 2005 7:09:19 PM PDT

**Subject: Almost there! (Please respond)**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@

>

Hi Everyone,

I share your sentiments about Steve. He is a wonder!

Attached please find the Task Force Report, that has gone through the copyediting process and has been reviewed by the Ethics Committee. (At the end of this message, please find the Ethics Committee's action. The Committee was impressed.) I think you will find the Report a very clear statement of our positions.

At your very earliest convenience, please indicate whether you approve of the Report being sent in this form to the APA Board of Directors. (Note that, until the Board indicates their satisfaction with the Report, the word "Draft" will be included in the title).

In addition to the copying editing changes, and changes to ensure conformity in style, these four other changes have been made:

1) The concept of the Ethics Code applying whenever psychologists are engaged in professional activities has been included in the Overview to the Report. The Ethics Committee saw this concept as centrally important and believed it should have a more prominent role.

2) The Ethics Committee recommended adding the words "from an individual's medical record" to statement three, which now reads: "Psychologists who serve in the role of supporting an interrogation do not use health care related information from an individual's medical record to the detriment of the individual's safety and well-being. While information from a medical record may be helpful or necessary to ensure that an interrogation process remains safe, psychologists do not use such information to the detriment of an individual's safety and well-being. (Ethical Standards 3.04, Avoiding Harm and 3.08, Exploitative Relationships)"

The Ethics Committee felt that this addition clarified the statement. I agree, and think that this addition improves statement three.

3) Also in regard to statement three, the Committee recommended moving the sentence: "Regardless of their role, psychologists who are aware of an individual in need of health or mental health treatment may seek consultation regarding how to ensure that the individual receives needed care. (Principle A, Beneficence and Nonmaleficence)" from under statement 3 to statement 5, which is more on point. I think this move makes good sense.

4) Recommendation #2 has been deleted as superfluous. The recommendation concerned adopting the statements or having the Ethics Committee determine whether the statements are appropriate interpretations and applications of the Ethics Code. Since the

Ethics Committee has now made that determination, recommendation 2 is no longer needed. (Note that there are still 10 recommendations, since recommendation 8 was actually two recommendations, and so has been split into two)

Finally, for conformity of style, the phrase "have an ethical obligation to" has been removed from statement 12, since the statement "have an ethical obligation to" is implied in all the statements.

The Ethics Committee reviewed in detail the PENS Task Force Report and unanimously passed the following motion:

That the Ethics Committee affirms that the 12 statements in the Report of the Task Force on Psychological Ethics and National Security are appropriate interpretations and applications of the American Psychological Association Ethical Principles of Psychologists and Code of Conduct (2002).

The Ethics Committee expresses its appreciation to the Task Force for its hard and thoughtful work.

Thanks everyone for the quick turn-around.

Olivia

[See PENSTFFinaldraft #6]

**From:** Nina Thomas <>

**Date:** June 29, 2005 7:12:42 PM PDT

**Subject:** Re: Almost there! (Please respond)

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

no attachment appeared with your latest message of the ethics committee's recommendations, Olivia, only your description of their suggested changes.

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** Olivia Moorehead-Slaughter <>

**Date:** June 29, 2005 7:16:50 PM PDT

**Subject: Really Almost there! (please respond)**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Ooops! Sorry about that! :)

**From:** Nina Thomas <>

**Date:** June 29, 2005 7:41:44 PM PDT

**Subject: Re: Really Almost there! (please respond)**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

The changes as I can see them are acceptable to me. I am glad that the specific references to the Geneva conventions were added in the text in Item #4. I gather that was what Mike Wessell was referring to that I had not previously "gotten."

I am not clear about what happened to the "Executive Summary" listing the 12 statements absent explanatory material. When you have a minute, I would appreciate knowing why it was decided to delete that from the introduction as we had originally discussed.

Thanks,

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** Jean Maria Arrigo <>

**Date:** June 29, 2005 7:52:36 PM PDT

**Subject: Approval of 6/29/05 draft**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

The depth, scope, and wisdom of this document are indeed impressive, and I approve it as a Task Force member. Also, I appreciate its literary grace (owing to Steve).

As mentioned previously, I have felt uneasy with some elements, primarily omissions. Fulfillment of the Task Force recommendations would relieve my concerns, and I hope for an opportunity for further participation.

Thanks to the APA ethics committee, board, and staff members who have mobilized for swift review and dissemination of the PENS report.

Jean Maria Arrigo

Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From:** Nina Thomas <\_>

**Date:** June 29, 2005 8:25:19 PM PDT

**Subject:** FYI: Answers to questions

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Steve responded to my question about the change in the Executive Summary with the following, if others are interested:

Rhea Farberman felt that the twelve statements, separated from their commentary, might be misleading to the public. Rhea therefore suggested that we number the statements, and place each in bold, in order to ensure that they would be read along with their commentary. Also, the expanded overview was more like an executive summary than what we had before.

Nina K. Thomas, Ph.D., ABPP

**From:** "Col. Larry C. James PhD" <\_>

**Date:** June 29, 2005 10:16:53 PM PDT

**Subject:** Re: Really Almost there! (please respond)

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Wow, it is impressive. I support and concur with the document.

It was a pleasure and honor working with all of you.

Thanks,

Larry James

**From:** "R. Scott Shumate" <>

**Date:** June 29, 2005 10:32:02 PM PDT

**Subject:** Re: Really Almost there! (please respond)

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

I concur with the revised document.

Scott Shumate

**From:** "Gelles, Mike" <>

**Date:** June 30, 2005 2:59:34 AM PDT

**Subject:** Re: Really Almost there! (please respond)

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

I concur with the document as revised. It has been a privilege to work with all of you.  
Thanks

Mike Gelles



**From:** Robert Fein <>

**Date:** June 30, 2005 3:00:25 AM PDT

**Subject:** Re: Really Almost there! (please respond)

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

I hope/believe that this impressive document will inform and improve the discussion of these complicated and important issues, certainly among psychologists, and perhaps among others also. I concur. Thank you.

Robert Fein

**From:** "Banks, Louie M. COL" <>

**Date:** June 30, 2005 4:08:10 AM PDT

**Subject:** Re: Really Almost there! (please respond)

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

The revised document has my full endorsement. I concur, and hope to work with you all again.

Morgan

COL L. Morgan Banks

Director, Psychological Applications Directorate

US Army Special Operations Command

DSN COM

**From:** "LeFever, Bryce E. (CAPT)" < >

**Date:** June 30, 2005 6:01:56 AM PDT

**Subject:** Re: Really Almost there! (please respond)

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Olivia,

You and Steve have been amazing indeed. It is a superb statement. It has my approval and the Task Force has my admiration and gratitude.

Take care,

Bryce

**From:** Mike Wessells < >

**Date:** June 30, 2005 8:50:07 AM PDT

**Subject:** Re: Really Almost there! (please respond)

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

This document looks good even in Tbilisi and has my support.

Thanks,

Mike

**From:** Olivia Moorehead-Slaughter <>

**Date:** July 1, 2005 9:14:31 AM PDT

**Subject:** Thank You

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Hello Everyone,

This is just a quick note of thanks for your rapid review and response to the Task Force Report. Steve and I will continue to update all of you as things develop. In the meantime, please know that I appreciate your ongoing commitment to the work that we all care about so much. Your input has been invaluable.

My best.

Olivia

**From:** "Banks, Louie M. COL" <>

**Date:** July 1, 2005 2:01:37 PM PDT

**Subject:** Re: Thank You

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Olivia,

Do we have a projected time-line for release? I just want to make sure than when asked, I have the best possible answer to the question.

Morgan

COL L. Morgan Banks

Director, Psychological Applications

Directorate US Army Special Operations

Command DSN COM

**From:** Olivia Moorehead-Slaughter <>

**Date:** July 1, 2005 3:16:26 PM PDT

**Subject:** Report Release Update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Dear Task Force Members,

I know you are all eager to have the Report. Below, please find the schedule for release. We will receive the Report on Monday evening, but must keep the Report confidential until Tuesday at 11 am.

I am eager to see how our Report is recieved. Have a wonderful weekend.

Warmly,

Olivia

Monday evening: APA Council and PENS Task Force  
(Embargoed until Tuesday 11am)

Tuesday 9 am: APA Division and State listserves, APA  
Governance Committees

Tuesday 10 am: Courtesy copies to Capitol Hill, White  
House, DoD Contacts

Tuesday 11 am: Media and posted to the APA Website

**From:** Nina Thomas <>

**Date:** July 1, 2005 5:13:15 PM PDT

**Subject: Re: Report Release Update**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@

>

I hope we can be confident that the "embargo" on the release of the report after its being sent to Council will be honored. I am not so sure. Perhaps we can include a statement that emphasizes the importance of respecting the process and the necessity of such an embargo. Will a schedule of the report's release go with the report when it is sent to Council. My suggestion is that one accompany the report. Even so, I fear there will be leaks tho I hope that since it is July 4th, people will be too busy watching fireworks and eating hot dogs to read their e-mail. We can all live in hope.

Regards,

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** "R. Scott Shumate" <>

**Date:** July 1, 2005 7:21:50 PM PDT

**Subject: Re: Report Release Update**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@

>

I echo Nina's reservations, to have the maximum impact to seniors in the various branches of Government, having lead time will serve their receptive attitude.

Scott Shumate

**From:** "Gerald P. Koocher, Ph.D." <>

**Date:** July 2, 2005 5:20:18 AM PDT

**Subject: Re: Report Release Update**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@

>

I agree with Nina and Scott.

I want to leave this in the hands of our PR folks, but I am mindful of Benjamin Franklin's famous quote: "Two may keep a secret, if one of them is dead."

My preference would be to send the "embargoed" version to Council and our friends in government simultaneously, with copy to state psychological associations, divisions, and the press a few hours later. Why, it will start to leak almost immediately that the people we most want to feel "in on the process" need to know before leakage starts. In addition, APA has very good relationships with a number of members of Congress and we do want them to feel well inside the loop.

I'll be giving an invited talk on ethics at the European Congress of Psychology in Madrid on July 5th and would love to highlight this report to our European colleagues, if it is "out" on the 5th.

Regards,

Gerry

**From:** "Banks, Louie M. COL" <>

**Date:** July 2, 2005 6:16:50 AM PDT

**Subject:** Re: Report Release Update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <[PENS@](mailto:PENS@)>

Olivia,

Thanks very much for the time-line. This is GREAT news.

Morgan

COL L. Morgan Banks

Director, Psychological Applications Directorate

US Army Special Operations Command

DSN COM

**From:** Olivia Moorehead-Slaughter <\_>

**Date:** July 2, 2005 4:09:14 PM PDT

**Subject:** Washington Post editorial

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Dear Colleagues,

An editorial in yesterday's Washington Post, "The Stain of Torture," by Burton J. Lee, III, contains the paragraph immediately below (the entire editorial is posted at the end of the message). Could people comment on what Burton Lee may be referring to when he states "These new guidelines distort traditional ethics rules beyond recognition to serve the interests of interrogators, not doctors and detainees"? I think it's likely that questions about this editorial will come up when our Report is released. On the whole, I think our Report fits well with the editorial, but I would be very interested in comments on this particular statement, and/or how this statement fits with our Report.

Olivia

"Now that comfort is shattered. Reports of torture by U.S. forces have been accompanied by evidence that military medical personnel have played a role in this abuse and by new military ethical guidelines that in effect authorize complicity by health professionals in ill-treatment of detainees. These new guidelines distort traditional ethical rules beyond recognition to serve the interests of interrogators, not doctors and detainees."

The Stain of Torture

By Burton J. Lee III

Friday, July 1, 2005; Page A25

[See Article 9 – Stain of Torture]

**From:** Olivia Moorehead-Slaughter <\_>

**Date:** July 2, 2005 4:24:26 PM PDT

**Subject:** Release of Report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Hi Everyone,

Some of you have expressed concerns that the Report will not go to the parties designated in the orderly fashion that has been orchestrated. Steve is very well aware of this concern. He will be in touch with the appropriate APA staff who are coordinating the release of the Report and reinforce this message. Like Nina, I too hope that some of them are too busy celebrating to read their email in a timely manner.

My best.

Olivia

**From:** Nina Thomas <>

**Date:** July 2, 2005 4:36:38 PM PDT

**Subject:** Re: Washington Post editorial

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

I share your concern Olivia. I have already had a significant number of e-mails from colleagues and listservs encouraging my signing on to a petition sponsored by PHR in condemnation of torture but have relied on Larry's remarks as persuasive. Yet there is this swirl around us. I don't think we can afford to ignore it.

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** "Col. Larry C. James PhD" <>

**Date:** July 2, 2005 5:51:09 PM PDT

**Subject:** Re: Washington Post editorial



**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

he must be referring to the recent guidelines from the Surgeon General of the Army. I happen to know these guidelines well and he simply has his head in the sand, the new guidelines in no way say that torture by health care professionals is perfectly o.k.

Larry

**From:** Nina Thomas <>

**Date:** July 2, 2005 6:11:03 PM PDT

**Subject:** Washington Post Editorial

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Thanks for that response Larry. I think we have to be prepared to be able to quote chapter and verse to be able to respond to internal as well as external reactions that appear to know otherwise. I imagine that both Steve and Rhea Farberman would benefit from knowing the page in the hymnal from which to quote.

I hope one of us gets to enjoy a bang up fourth.

Best,

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** "Banks, Louie M. COL" <>

**Date:** July 3, 2005 5:49:01 AM PDT

**Subject:** Re: Washington Post editorial

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Olivia,

My opinion is that the crux of the issue is that many people, to include Dr. Lee (and certainly to include Dr. Bloche) do not believe that interrogation can be conducted in a safe, legal, and ethical manner. Dr. Lee assumes that interrogation is synonymous with abuse. If that were so, I would agree with his conclusion. (The idea that we can prevent abuse does not seem to have occurred to him.) I think that the Task Force Report addresses his concerns clearly, although he may not like all of the statements. My personal recommendation is that we focus on what we agree on, i.e., that abuse of detainees is unethical (in addition to being illegal).

On a side note, I am aware of no guidelines, new or old, that allow complicity of anyone in the abuse of detainees.

Morgan

COL L. Morgan Banks

Director, Psychological Applications Directorate

US Army Special Operations Command

DSN COM

**From:** Olivia Moorehead-Slaughter <\_>

**Date:** July 4, 2005 4:52:30 PM PDT

**Subject:** Update on Report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Hello Everyone, I'm sending along the message sent to me today by Ron Levant in its entirety. Hope you're all having a festive Fourth!

Olivia

Olivia: For your information and that of PENS. Please note embargo.

Best,

Ron

Ronald F. Levant, Ed.D., M.B.A., ABPP

Professor

Center for Psychological Studies

Nova Southeastern University

President, American Psychological Association, 2005

"Making Psychology a Household Word"

From: Council of Representatives [<mailto:COR@>] On Behalf Of

Ronald F. Levant, Ed.D., M.B.A., ABPP

Sent: Monday, July 04, 2005 4:08 PM

To: [COR@](mailto:COR@)

Subject: [COR] Report of the APA Presidential Task Force on Psychological

Ethics and National Security

Sensitivity: Confidential

Date: Monday, July 4, 2005

To: APA Council of Representatives

From: Ronald F. Levant, EdD, ABPP, APA President

The Report of the APA Presidential Task Force on Psychological Ethics and National Security is being distributed to Council, today, in advance of its wider distribution to the APA membership and the news media tomorrow. This is for Council's information only at this time. The document is embargoed until Tuesday, July 5, at 11 am. It is vitally important that you do not send this to anyone until tomorrow, Tuesday, July 5, at 11 am. You are free to share the report

with all interested parties beginning tomorrow, Tuesday, July 5 at 11 am. Here is the release schedule FYI:

Monday evening: APA Council and PENS Task Force (Embargoed until Tuesday 11am)

Tuesday 9 am: APA Division and State listserves, APA Boards and Committees

Tuesday 10 am: Courtesy copies to Capitol Hill, White House, DoD Contacts

Tuesday 11 am: Media and posted to the APA Website

You will recall that the Council received information regarding the Board's approval, at its February 16 & 17, 2005 meeting, to establish a Task Force to Explore the Ethical Aspects of Psychologists' Involvement and the Use of Psychology in National Security-Related Investigations (later thankfully re-named the APA Presidential Task Force on Psychological Ethics and National). The charge before the Task Force was to examine whether the current APA Ethics Code adequately addressed the ethical dimensions of psychologists' involvement in national security-related activities, whether APA provides adequate ethical guidance to psychologists involved in these endeavors, and whether APA should develop policy to address the role of psychology and psychologists in investigations related to national security.

Its charge did not include an investigative or adjudicatory role, nor was the Task Force asked to render any judgment concerning events that may or may not have happened in national-security related settings. The purpose of the report and the Task Force findings is to give guidance to our members about work in this important national security arena.

Because of the overwhelming interest in the report and APA's position on these issues from the media, U.S. government, and other sources, and in order to respond in a timely manner to these very pressing events, the Board (in keeping with its role as stated in the APA Bylaws) voted to "declare an emergency" and passed the following motion:

"Affirming the determination by the American Psychological Association (APA) Ethics Committee that the twelve statements included in the Report of the Presidential Task Force on Psychological Ethics and National Security are appropriate interpretations and applications of the APA Ethics Code, the APA Board of Directors adopts the task force report as APA policy. The Board of Directors plans to review the recommendations provided in Section IV of the report at its August 2005 meeting and upon completion of its review, will forward the recommendations to the Council of Representatives for consideration. In addition, the Board requests that the Report of the Presidential Task Force on Psychological Ethics and National Security be provided to APA governance for their information, posted on the APA website and provided to the public as appropriate."

I have pasted below the note that will go out to correspondents and have attached the full report.

## Report of the APA Presidential Task Force on Psychological Ethics and National Security

### Note to Correspondents

(Washington, DC) –The American Psychological Association today released the report of its Presidential Task Force on Psychological Ethics and National Security which affirms the adequacy of the current APA Ethics Code in addressing the ethical dimensions of psychologists' involvement in national security-related activities and affirms APA's continuing central role and commitment to developing policies that address the role of psychology and psychologists in investigations related to national security. The Task Force report also called for APA to develop further its resources to provide ethics consultation to psychologists who work with classified information in national security-related settings.

The major findings of the Task Force include:

- It is consistent with the APA Code of Ethics for psychologists to serve in consultative roles to interrogation- or information-gathering processes for national security-related purposes. 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.
- The APA states emphatically that whenever psychologists serve in any position by virtue of their training, experience and expertise the APA ethics code always applies to their work.
- Psychologists who serve in the role of supporting an interrogation do not use health care related information to the detriment of an individual's safety and well-being.
- The Task Force furthermore endorsed and reaffirmed the APA's 1986 Resolution against Torture, which states that psychologists do not engage in, direct, support, facilitate or offer training in torture or other cruel, inhuman, or degrading treatment.
- The Task Force also finds that psychologists have an ethical obligation to be alert to and report any acts of torture or cruel or inhuman treatment to appropriate authorities.

"I formed this Task Force because of the number of critical questions that arose during the past year about the proper role of psychologists working in investigations related to national security. The purpose of the Task Force report is to provide guidance to APA members about the ethics of work in this important national security arena," states APA President, Ronald Levant, EdD.



The Task Force was established earlier this year. Its charge did not include an investigative or adjudicatory role, nor does the Task Force render any judgment concerning events that may or may not have happened in national-security related settings.

Full text of the report is attached.

The American Psychological Association (APA), in Washington, DC, is the largest scientific and professional organization representing psychology in the United States and is the world's largest association of psychologists. APA's membership includes more than 150,000 researchers, educators, clinicians, consultants and students. Through its divisions in 53 subfields of psychology and affiliations with 60 state, territorial and Canadian provincial associations, APA works to advance psychology as a science, as a profession and as a means of promoting health, education and human welfare.

Ronald F. Levant, Ed.D., M.B.A., ABPP

Professor

Center for Psychological Studies

Nova Southeastern University

President, American Psychological Association, 2005

"Making Psychology a Household Word"

[See PENSTaskForceReportFinal]

**From:** Gerald Koocher <>

**Date:** July 5, 2005 9:48:24 AM PDT

**Subject:** Reactions to report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

See below:

I have just finished a first reading of the Report. While a few questions occurred to me that seem not to have been fully answered in the document, the overall content and recommendations are of such high quality and comprehensiveness that I am moved to say without reservation that I am

very very proud of the work of this task force and manner in which this report reflects the highest standards of the science and profession of psychology.

The process anticipated by the recommendations, both in terms of research and ethical consultation, will give substance to psychologists' ability to contribute to national defense while upholding their commitment to ethics and human rights. Congratulations and gratitude are due to President Levant and the Task Force for their superb work.

James A. Mulick, Ph.D.

Division 33 COR Member

Professor, Pediatrics & Psychology

The Ohio State University

**From:** Nina Thomas <>

**Date:** July 5, 2005 9:56:29 AM PDT

**Subject:** Re: Reactions to report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

thanks for sending James Mulick's reactions...glad to see someone appreciates fine thinking and work.

Hope you all had a good 4th.

N

Nina K. Thomas, Ph.D., ABPP

**From:** Olivia Moorehead-Slaughter <>

**Date:** July 6, 2005 9:24:18 AM PDT

**Subject: New York Times article**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@>**

Hello Everyone: I've enclosed for your information the letter sent by Ron Levant to the New York Times in response to today's article about the Task Force Report. Thought you'd want to see this.... Olivia

Letter from Ron Levant to the New York Times, regarding today's article:

In focusing on perceived shortcomings of an American Psychological Association Task Force report, (Psychologists See Ethics Risks at Guantanamo, July 6), Neil Lewis failed to report on the strict ethical boundaries the APA sets forth when its members are involved in national security activities, and thus overlooked a critical point: Professional codes of ethics are more than simple laundry lists. Lewis' example--using a phobia to inflict severe psychological distress--is clearly prohibited by the Task Force report. The report makes clear that psychologists never: engage in, direct, support, or facilitate torture or cruel, inhuman, or degrading treatment; use information from a medical record to the detriment of an individual's safety and well-being; mix treatment and consultant roles. Psychologists have an ethical obligation to report such behaviors and are bound by the APA Ethics Code in all their professional activities, regardless of whether they identify themselves as "behavioral scientists" or some other term.

**From: Nina Thomas <>**

**Date: July 6, 2005 12:12:02 PM PDT**

**Subject: Re: New York Times article**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@>**

thanks for sending this on Olivia...



Nina

**From:** Olivia Moorehead-Slaughter <>

**Date:** July 7, 2005 2:06:26 PM PDT

**Subject:** Media

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Dear Colleagues,

As I am sure you are aware, there is great interest in our work and some members of the media have contacted you individually. From what I can gather, some of these contacts have been persistent and aggressive, to the point of harassing. All of you have shared your time and expertise for the benefit of APA and psychology, and I feel strongly that you should not have to contribute additional time to explaining our work to the media--APA has very well-established channels to communicate with the media and the public.

Given that, as a Task Force, we agreed to let our Report speak for us, and that we would not share the substance of our discussions further than what the Report contains, I ask that we all refer any questions from the media concerning the Task Force to Steve and Rhea, even if we're asked to speak off the record or "on background."

Thank you,

Olivia

**From:** Nina Thomas <>

**Date:** July 7, 2005 9:06:50 PM PDT

**Subject:** Talking about the report

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@ >**

I am on several listservs that have responded either to our report or to Neil Lewis' article in response. There is considerable feeling about the report (only some have actually read it and I have advised that it is to my mind incumbent on psychologists, presumably thoughtful and reflective people, to actually be *informed* before they take positions on issues). How much latitude do I have in responding to/informing the discussions that will arise on these listservs (APA listservs for the most part) with respect to what was discussed in our deliberations? I want to respect our decision not to discuss the process outside our TF but it is very difficult to sit by watching a discussion without weighing in to correct some misinformation. e.g., the report is "political" and "" that it could be used to give cover for American psychologists to participate in coercive interrogations" and "on the other hand, it is a political document formed by consensus among different interests, including military psychologists and others who may be supportive of, or involved in policies many of us deplore. In that, there is a great deal of vagueness, what Steven calls grayness, about the role of psychologists assisting interrogations."

I am not so experienced as some of our TF members at sitting quietly by while statements that I know to be misinformed are bandied around as "truths."

Thoughts? Reactions? Suggestions? Bite my tongue is not an acceptable response.

Nina

Nina K. Thomas, Ph.D., ABPP

**From: "Col. Larry C. James PhD" < >**

**Date: July 7, 2005 10:00:40 PM PDT**

**Subject: Re: Talking about the report**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@ >**

Hi Nina, I tend to encourage fellow psychologists to avoid the assumption of evil. I think this is mostly prevalent in the media, when they don't completely know all the facts they tend to assume that the doctors wearing the uniform are somehow automatically evil in some way, rather than the safety shield.

The Army surgeon General held a press conference today at 4:30 p.m, EST on CSPAN, I recorded it on VHS. I Will see if I can get copies made if anyone would

like a copy. This was a briefing on the results of a 5 month long investigation into many of the allegations you all have heard/read in the press.

He provided detailed information on the results of over 200 medical personnel being interviewed at Cuba, Abu G and Af. There were 3 clear findings: 1). There is no documented evidence that Psychologists at either Abu G or Cuba colluded in torture. 2) there is no documented evidence that any medical professional (including psychologists) gave medical information to interrogators for the purpose of torture. And 3), psychologists at these facilities worked to protect the welfare and safety of the detainees.

Larry

**From:** Nina Thomas <>

**Date:** July 8, 2005 4:30:42 AM PDT

**Subject:** Re: Talking about the report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Dear Larry -

Thanks for the response...I for one would welcome having access to that press conference.

N

Nina K. Thomas, Ph.D., ABPP

**From:** "Banks, Louie M. COL" <>

**Date:** July 8, 2005 5:16:38 AM PDT

**Subject:** Re: Talking about the report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

The press conference is available on C-Span, and in total is about 30 minutes. The Surgeon General specifically

mentioned the TF Report. I highly recommend reviewing it.

Morgan

**COL L. Morgan Banks**  
**Director, Psychological Applications Directorate**  
**US Army Special Operations Command**  
**DSN COM**

**From:** "Mumford, Geoffrey" < >

**Date:** July 8, 2005 5:06:45 AM PDT

**Subject:** Re: New York Times article

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

In case you hadn't seen this, Ron's letter was published in the NYT yesterday as follows:

To the Editor:

In focusing on perceived shortcomings of an American Psychological Association Task Force report, "Psychologists Warned on Role in Detentions" (news article, July 6) does not highlight the strict ethical boundaries that our organization sets forth when its members are involved in national security activities, thus overlooking a critical point: professional codes of ethics are more than simple laundry lists. For example, using a phobia to inflict severe psychological distress is clearly prohibited by the task force report.

The report makes clear that psychologists never engage in, direct, support or facilitate torture or cruel, inhuman or degrading treatment; use information from a medical record to the detriment of an individual's safety and well-being; and mix treatment and consultant roles.

Psychologists have an ethical obligation to report such behaviors and are bound by our association's ethics code in all their professional activities, regardless of whether they identify themselves as "behavioral scientists" or some other term.

Ronald F. Levant

President, American

Psychological Association

Plantation, Fla., July 6, 2005

**From:** Nina Thomas <\_>

**Date:** July 8, 2005 9:39:39 AM PDT

**Subject:** Re: Talking about the report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

Morgan - Help a techniphobe out here. I have tried searchnig the C-Span website for the surgeon general's press conference and cant find it....how is it titled or how can I search it?

Thanks,

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** "Banks, Louie M. COL" <>

**Date:** July 8, 2005 9:58:47 AM PDT

**Subject:** Re: Talking about the report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

Nina,

Try this website, about half-way down the page. If this doesn't work, look on the middle right section of the C-Span home page, clic on defense-security, and you should see a press conference by LTG Kiley.

[http://www.c-span.org/VideoArchives.asp?z1=&PopupMenu\\_Name=Defense/Security&CatCodePairs=Issue,DESE;](http://www.c-span.org/VideoArchives.asp?z1=&PopupMenu_Name=Defense/Security&CatCodePairs=Issue,DESE;)

Morgan

**COL L. Morgan Banks**  
**Director, Psychological Applications Directorate**  
**US Army Special Operations Command**  
**DSN COM**

**From:** Nina Thomas < >

**Date:** July 8, 2005 10:41:20 AM PDT

**Subject:** Re: Talking about the report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Morgan, thanks for the link...worked fine and listened to most of it...

Have a good weekend,

N

Nina K. Thomas, Ph.D., ABPP

**From:** Olivia Moorehead-Slaughter < >

**Date:** July 8, 2005 10:50:22 AM PDT

**Subject:** Re: Talking about the report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

I will look for this press conference as well. Thanks for sharing this information.

Olivia

**From:** Olivia Moorehead-Slaughter <\_>

**Date:** July 8, 2005 10:56:40 AM PDT

**Subject:** Response to Inquiries

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

Dear Colleagues,

In reflecting on how to respond to listserve and other traffic, I do believe that there are several important points to make that are in keeping with our agreement not to discuss the substance of our discussions. As examples (that people should feel free to use, as seems right in a given situation):

- 1) Impress upon people the value of actually reading the Report. Ask people to discuss the merits of the document itself, not a newspaper's account of the document. (Also, it's fine to mention that Steve provided the author of the New York Times article several quotations which the article did not use.)
- 2) Point out the Task Force was comprised of individuals from very different backgrounds and experiences, who brought considerably different perspectives to the process, and who worked in good faith to struggle with complicated ethical issues. The Report states explicitly that the twelve statements were "agreed upon," and indicates areas of disagreement. Where the Report indicates agreement, there was genuine agreement among the 10 very diverse task force members.
- 3) Note that the Report--like a good ethics code--is not a laundry list of prohibited activities. The Report gives very clear guidance on a number of issues--and certainly prohibits the use of a phobia to inflict severe emotional distress, which is the example that people seem intent upon bringing up with the misimpression that APA's stance is vague or ambiguous on this question.
- 4) Ask that people compare the Task Force report with the statement of the American Psychiatric Association on this issue (at [http://www.psych.org/news\\_room/press\\_releases/05-40psychpracticeguantanamo.pdf](http://www.psych.org/news_room/press_releases/05-40psychpracticeguantanamo.pdf)). The difference between the two statements is stark and compelling.
- 5) Point out that the Task Force decided to keep the substance of its discussions private, to allow for full and frank debates (note that this was the subject of disagreement, as the Report itself notes). Thus, any listserve

messages suggesting first-hand knowledge of what was discussed during the meeting are not based on the facts, and any speculation about what occurred is just that--speculation.

6) Note that the Task Force Report was not intended as APA's final and definitive action on these issues, but rather as the beginning of a process, as the Report's tenth recommendation makes very clear:

That APA: View the work of this Task Force as an initial step in addressing the very complicated and challenging ethical dilemmas that confront psychologists working in national security-related activities. Viewed as an initial step in a continuing process, this report will ideally assist APA to engage in thoughtful reflection of complex ethical considerations in an area of psychological practice that is likely to expand significantly in coming years.

Rhea indicates that so far, the NYTimes article seems out of step with other coverage, which appears more well disposed to our Report.

Warmly,

Olivia

**From:** "Col. Larry C. James PhD" <\_>

**Date:** July 8, 2005 2:34:11 PM PDT

**Subject:** Re: Talking about the report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

Nina, I'll get some copies made and send one to you

-----Original Message-----

**From:** Nina Thomas <\_>

**Date:** July 8, 2005 3:23:20 PM PDT



**Subject: Re: Talking about the report**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@ >**

Hi all - I did finally get to see the Army Surgeon general's press conference. I guess it is all in the eye of the beholder. I heard him reference the task force report but it sounded as though he did not actually have much at his fingertips to reference in it saying just some equivalent of the APA task force report said it was ok for psychologists to be involved in interrogations. Although yes, he did say there was no evidence of psychologist involvement in abuse, etc.

APA members who have been in touch with me have expressed major disappointment, however, that the report did not go further and found some of the wording to be too vague offering what many referred to as: "too much wiggle room." For example, from one listserv:

"Especially disturbing for me was paragraph #4 at the top of p. 4, ...  
"Psychologists involved in national security-related activities follow all applicable rules and regulations that govern their roles. Over the course of the recent U.S. military presence in locations such as Afghanistan, Iraq, and Cuba, such rules and regulations have been significantly developed and refined." The text goes on to urge that psychologists have an ethical responsibility to be informed of and follow the most recent applicable regulations and rules. Given the controversy even in the corporate media around the practices in these sites and how high up the chain of command the responsibility goes for the violation of human rights and the Geneva Convention, it is really disturbing to see the uncritical call for psychologists to know and adhere to these new "developments and refinements." All in all, there is much wiggle room in the document as a guide for ethical action for psychologists to do whatever they see as indicated by concerns of national security."

This week's New Yorker article by Jane Meyer only further fuels the concerns for something on the order of: "how come there are all these reports by both former insiders and outsiders (lawyers, e.g.) of alleged abuses - al Ghatani as one - in which psychologists have reportedly been involved in interrogations that sound like torture?" (Both Michael Gelles and Morgan are quoted and referenced in the article.) It is a troubling article to read and I find it difficult to dismiss as exaggerations, misrepresentations, or some such. I am sure there will be further calls to address these issues from Council and the membership.

Nina

Nina K. Thomas, Ph.D., ABPP

**From: "Behnke, Stephen" <>**

**Date: July 8, 2005 7:01:39 PM PDT**

**Subject: Re: Talking about the report**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@ >**

In reflecting on Nina's message, I had a few thoughts I'd like to share. The first is how struck I am with how much of yourselves you've put into this process...it's hugely impressive and speaks volumes about your commitment to your work and to the field of psychology. It's clear that all of you care deeply about these issues and about doing the right thing.

Second, regarding the issue of "wiggle room" or vagueness, I'd like to offer a note of significant caution. I spend a great deal of time reviewing professional codes of ethics (as I know many of you do as well), and note a defining characteristic of these codes: they leave ample room for professional judgement and discretion--that's what defines them as codes of ethics belonging to a *profession*. Outside of the most egregious cases (such as sexual involvement with a current client), ethics codes almost never identify specific acts as prohibited--it's not the way the codes are written, and there is a significant downside to naming specific acts, since a code could never be exhaustive in that way. Consider what the APA Ethics Code says about multiple relationships, standard 3.05. People could say--and I would agree--that it would be a clear violation of standard 3.05 for a psychologist in a busy private practice to hire a current client as an accountant (to do all the psychologist's billing, contact clients who had not paid, pursue collection when necessary, discuss ways of minimizing tax liability, etc.) Yet the standard says nothing whatsoever about hiring a client as an account; rather, it says:

"A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists."

The expectation is that the psychologist will apply standard 3.05, and conclude--as any reasonable psychologist would--that hiring a current client as an accountant would violate the standard. The Ethics Code is not problematic, insofar as it does not say "It is unethical for a psychologist to hire a current client as an accountant." The issue is rather one of applying the Code in a proper and reasonable manner. The proper touchstone, it seems, is therefore: How would a reasonable psychologist apply the Task Force report? Which brings me to my third and (thankfully) final point.

As a Task Force, you demonstrated a great deal of humility in approaching your task, encouraging APA to see your Report as the beginning of a process of thinking through these complicated and challenging issues. In Recommendation #10, for example, you write: "Viewed as an initial step in

a continuing process, this report will ideally assist APA to engage in thoughtful reflection of complex ethical considerations in an area of psychological practice that is likely to expand significantly in coming years." Two critical phrases in that sentence are "initial step" and "continuing process"--these are enormously complicated issues, that will be considered, reflected upon, and written about for many years to come. Your Report explicitly recognizes and allows room for APA further developing its thinking in this area. Recommendation #2 seems especially pertinent at the moment; you recommend that APA "Develop a document that will serve as a companion to the 12 statements contained in this report, for the purpose of providing illustrative examples and commentary." It seems to me that there is a great deal of speculation about how the Report does not go far enough; a way to reframe this point is that *we don't yet have a document that demonstrates how to apply the Report*. You saw the need for such a document and recommended that it be written. You've written a Report that is thorough, sound, balanced, and comprehensive. You may be quite right that work remains to be done--to show what the Report means when the rubber hits the road--but that speaks to the nature of ethics guidelines and ethics codes, not to the quality of your Report.

Be well,

Steve

**From:**

**Date:** July 9, 2005 9:00:30 AM PDT

**Subject:** Re: Response to Inquiries

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Dear Olivia,

I particularly agree with your suggestions that critics actually READ the report and compare our substantial attention to situation with the meager attention of related ethics codes.

But emphasis on the diversity of the 10-member Task Force and on the report's acknowledgment of our areas of disagreement could well invite criticism. A look at participant backgrounds from the bios shows six military psychologists and two non-military psychologists with some knowledge of military operations, no Middle Eastern names, etc. I myself am uneasy that the list of areas of disagreement is so short.

Four unmentioned areas of disagreement on my part are: (1) the utilization of Behavior Specialists, mental health counsellors, and other military personnel trained in psychology; (2) interrogation outside of premises controlled by the U.S. military, where interrogators and consultants have to maneuver gingerly with foreign counterterrorist police and military units; (3) the importance of historical examples and institutional arrangements, because opportunities and procedures persist in large bureaucracies; and (4) the relevance of basic demographic information, such as, the number of military psychologists, their areas of deployment, and possible financial pressures on them. (Regarding the third point, a positive response to my presentation of Dr. Wm. Henry Anderson's paper would have been a commitment to finding out when and why he was at Guantanamo Bay rather than a statement that the opinions of retirees are irrelevant.)

I am proud of the work of the Task Force and grateful for the opportunity to have participated. Yet I understand our report to apply to a narrower domain than it professes to address. The situations considered by the Task Force did not include situations in which confidantes have told me of problematic involvement of physicians and psychologists/psychiatrists in interrogation.

Recognizing that we could not do everything at once, followup on the recommendations of the Task Force is crucial in my view.

Jean Maria

**From:** Olivia Moorehead-Slaughter < >

**Date:** July 9, 2005 6:48:46 PM PDT

**Subject:** Re: Response to Inquiries

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Hello to All,

I appreciate all of your continued interest and passion around the work which we began some weeks ago and that culminated (for now at least) in the production of the Task Force report. In some ways, now that the report is open to public scrutiny, the most difficult part of the task has likely begun. As anticipated, all of the feedback has not been positive.

This is difficult to hear but I do not think that we should now begin to second-guess ourselves. The issue covered in the report were addressed in a well-reasoned and careful manner and I think that our deliberations took into account the wording of the statements that we put forth. We were well-aware that this document was not about specificity so much as guidance for psychologists who are in positions where they must make judgments about their actions. We should not be surprised at the level of intensity with which some are responding to this report and we should not allow the intensity of these responses to minimize the import of the document which all of you produced. This is the beginning of a process.

My best as all of this continues to unfold.

Olivia

**From:** "R. Scott Shumate" <>

**Date:** July 9, 2005 7:26:08 PM PDT

**Subject:** Re: Response to Inquiries

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Well said!

Scott Shumate

**From:** "Gerald P. Koocher, Ph.D." <>

**Date:** July 10, 2005 7:19:01 AM PDT

**Subject:** Re: Response to Inquiries

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Dear Jean Marie,

**With due respect, I cannot allow your comments (below) to pass without response. I could simply ignore them and allow the matter to pass, but that is not my nature. In addition, allowing your comments to pass un rebutted does a disservice to all of those participating in the project. Please note my comments in blue below.**

**Gerry Koocher**

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\_ wrote:

But emphasis on the diversity of the 10-member Task Force and on thereport's acknowledgment of our areas of disagreement could well invite criticism. A look at participant backgrounds from the bios shows six military psychologists and two non-military psychologists with some knowledge of military operations, no Middle Eastern names, etc.

**In addition to the ten official members and liaisons there were a number of observers who added enriching comments to the deliberations of the group. Your citation of 6+2 above is inaccurate an misleading in that regard. Your reference to a lack of "Middle-Eastern names" promotes stereotyping in a potentially offensive manner. The middle-east is not populated with homogeneous peoples of like mind and the implication of your statement are unclear. There were no people of Asian, Native American, South Pacific, etc. heritage, yet every area of the world has faced terrorism and torture allegations. The committee was composed from among nearly 100 highly expert nominees, and your hint that diversity was an issue leading to lack if disagreement is unfounded and potentially misleading.**

I myself am uneasy that the list of areas of disagreement is so short. Four unmentioned areas of disagreement on my part are: (1) the utilization of Behavior Specialists, mental health counsellors, and other military personnel trained in psychology; (2) interrogation outside of premises controlled by the U.S. military, where interrogators and consultants have to maneuver ginergerly with foreign counterterrorist police and military units; (3) the importance of historical examples and institutional arrangements, because opportunities and procedures persist in large bureaucracies; and (4) the relevance of basic demographic information, such as, the number of military psychologists, their areas of deployment, and possible financial pressures on them. (Regarding the third point, a positive response to my presentation of Dr. Wm. Henry Anderson's paper would have been a commitment to finding out when and why he was at Guantanamo



Bay rather than a statement that the opinions of retirees are irrelevant.)

**I do understand your personal concerns, especially in the context of your own family and life experiences, as shared during the meeting. Nonetheless, some of your comments above go well beyond the scope of the assigned task force mission (e.g., interrogation outside of premises controlled by the military, historical examples...and procedures in large bureaucracies, and demographics of military personnel). If you were dissatisfied with the scope of work defined for the task force, you could have chosen not to serve. However, it is grossly inappropriate (in my opinion) to criticize the product or the group for staying within its assigned parameters.**

I am proud of the work of the Task Force and grateful for the opportunity to have participated. Yet I understand our report to apply to a narrower domain than it professes to address. The situations considered by the Task Force did not include situations in which confidantes have told me of problematic involvement of physicians and psychologists/psychiatrists in interrogation. Recognizing that we could not do everything at once, followup on the recommendations of the Task Force is crucial in my view.

**I too am proud of the task force's efforts and product. I also concur with the importance of follow through and expect that APA will respond in a timely and appropriate manner to any and all allegations that lead to investigatable complaints regarding identifiable individuals who have the opportunity to defend themselves and events that can be factually corroborated. I also hope that we will find ways to cooperate with physicians across specialty areas in additional initiatives.**

Regards,

Gerry

From:

Date: July 11, 2005 9:48:22 AM PDT

Subject: Re: Scope of the PENS report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Dear Gerry,

I think the constitution of the Task Force was very fine and also appropriate. It could be favorably compared to the 1993-1995 President's Advisory Committee on Human Radiation Experiments, for example, which did not include any military or intelligence expertise on the Committee or staff. Nevertheless, answering our critics by citing Task Force diversity could draw more fire.

The focus of the Task Force on credentialed military psychologists working in facilities completely under military control is surely the right first step-- and all we could manage to address in one weekend. Insofar as the Task Force report was intended to address public concerns though, I think we would do better to acknowledge the limited scope of the report. It is difficult for the one report to serve both purposes: (1) to make recommendations for applying the APA ethics code to military psychologists in consultation with interrogators and (2) to respond to public concerns from non-psychologists.

My specific further concerns about psychological ethics and national security arise from many oral histories and other communications with military and intelligence professionals and with those affected by them. These concerns may not lie within the province of the APA. Perhaps a member of the APA ethics committee will attend the Jan 27-28 Intelligence & Ethics conference (in DC) so as to help sort out the matter in conversation with intelligence practitioners.

Jean Maria

**From:** "Banks, Louie M. COL" <>

**Date:** July 11, 2005 10:55:09 AM PDT

**Subject:** Re: Talking about the report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

I, as you might imagine, read the New Yorker magazine article with more than a little concern. I was totally misquoted twice. (I never said, "We did this when we learned people were flipping it,"; and I certainly didn't say



that psychologists could support interrogations, "as long as they don't break the law." [p. 67]) I have pretty good familiarity with most aspects of DOD's use of psychologists in this role, and where she got the idea that there is some kind of experiment going on has me dumbfounded. She mentions the research on corticosteroids, and, in my opinion, appears to have completely missed the purpose of the research, which is to understand how soldiers respond to stress, and how to prevent it. In particular, how to prevent and treat PTSD. (It is certainly not to "understand what inspires maximum anxiety in trainees." [p. 64] I have included as attachments some of the research she is discussing.) I only bring all this up because this article, using unnamed sources, followed by several interviews the author gave, has very little factual basis. I apologize for going on like this, but to have such grossly inaccurate information presented as fact is very disturbing.

The accuracy in the article lies in the fact that some people have certainly acted inappropriately, and sometimes illegally. Most of the individuals that I am aware of, who conducted themselves in this manner, are being prosecuted. I, like the Surgeon General, am aware of no psychologists within the Army who have acted improperly. (I only limit it to the Army because that is what I have intensely looked into.)

Morgan

**COL L. Morgan Banks**  
**Director, Psychological Applications Directorate**  
**US Army Special Operations Command**  
**DSN COM**

[See Article 10 - eyewitnessSERE-Morganresearch; Article 11 - hormonesSERE-Morganresearch; Article 12 - npyrepSERE-Morganresearch; Article 13 - npysere-Morganresearch. It is noteworthy that the PENS Report tacitly approves research using detainees as subjects.]

**From:** Nina Thomas <\_>

**Date:** July 16, 2005 8:17:39 AM PDT

**Subject:** FYI - NE Jnl.

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security

<PENS@\_>

I am attaching Bloche and Marx latest article. Tho it makes no reference to APA it does make a number of serious allegations. How do we square this with what you have described, Larry, as policy at Guantanamo?

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** "Col. Larry C. James PhD" <>

**Date:** July 16, 2005 8:11:12 PM PDT

**Subject:** Re: FYI - NE Jnl.

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Nina, this is an easy one. Nina, remember one of the things I emphasized is the major safety role we (psychologists) have. The psychologist, in order to protect the welfare of the detainee, needs to know if the detainee has a major medical condition. Because AF and Iraq are third world countries, seeing detainees with untreated heart disease, uncontrolled/untreated diabetes, positive TB test or Hep A, B or C, etc., are all too common in these populations. The psychologist would use the information to prevent any interrogation technique that would be medically contra indicated.

The belief that I would steal information out of a Detainee (or a patient's) medical record to use it to craft an interrogation or worse, harm another human being is nuts.

The statement in the article that since 2003 interrogators there have had wholesale access to medical records is simply a lie--it is simply not true. "How we square it" is easy. Nina, the medical records, the entire physical space of the hospital and even for an interrogator to discuss a case with medical personnel is strictly off limits. In fact we now have an Army regulation prohibiting any of what he is claiming in this article. Thus, any interrogator or any medical personnel doing what the author (and I'm using this term here loosely) is in violation of the Army Medical Department Policy.

Much of what this person is claiming happened in 2002. Nina, this is old stuff and it has been fixed, just because one soldier (or doctor for that matter) does something stupid does not mean that it is common practice.

Larry

**From:** Olivia Moorehead-Slaughter <>

**Date:** July 18, 2005 9:08:17 AM PDT

**Subject:** Re: FYI - NE Jnl.

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Hi Nina,

Thanks for sending this article. Unfortunately, I was unable to view it on my computer.

Olivia

**From:** Nina Thomas <>

**Date:** July 18, 2005 12:14:07 PM PDT

**Subject:** Re: FYI - NE Jnl.

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Olivia - Do you want me to send it again?

Nina

**From:** "Banks, Louie M. COL" <>

**Date:** July 18, 2005 1:23:30 PM PDT

**Subject: Request from the American Psychiatric Association**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@ >**

Olivia,

I have been asked by a friend and co-worker, Lieutenant Colonel Dave Benedek, to speak at the American Psychiatric Association's Fall Institute in San Diego, CA, October 5-9, 2005. They are very interested in discussing the ethical issues that we have worked on, and I would like to support them: (Dave is the Army's Forensic Psychiatry Consultant.) Unfortunately, I cannot, given the present circumstances, get up in an open forum and expose my command to potential press inquiries, or run the risk of being misquoted (again) in a way that might reflect poorly on the Army. I explained this to Dave, and he wondered if any of the other members of the Task Force would be willing to take part in a forum on this topic. (San Diego in October....) What do you think?

Morgan

**COL L. Morgan Banks  
Director, Psychological Applications Directorate  
US Army Special Operations Command**

**From: "Gerald P. Koocher, Ph.D." <>**

**Date: July 18, 2005 4:45:47 PM PDT**

**Subject: Re: Request from the American Psychiatric Association**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security <PENS@ >**

**I would recommend sending Steve Behnke to represent the TF, if he is available**

**Regards,**

**Gerry**

**From:**

**Date:** July 18, 2005 6:19:29 PM PDT

**Subject:** Examples

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

Steve & Olivia,

At the DC Task Force meeting, we spoke of providing some examples of the appropriate contributions of military psychologists to the interrogation of terrorist suspects. Such examples would do more to aid public understanding than denials of wrongdoing. Are there any plans to provide positive examples to accompany our report?

Jean Maria

**From:** Nina Thomas <\_>

**Date:** July 19, 2005 5:42:15 PM PDT

**Subject:** Re: FYI - NE Jnl.

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_>

Larry -

May I refer to the information you note in your email to me, viz:

The statement in the article that since 2003 interrogators there have had wholesale access to medical records is simply a lie—it is simply not true. "How we square it" is easy. Nina, the medical records, the entire physical space of the hospital and even for an interrogator to discuss a case with medical personnel is strictly off limits. Army regulation prohibits any of what is claimed in this article. Thus, any interrogator or any medical personnel doing what the author asserts is in violation of the Army Medical Department Policy.

Much of what this person is claiming happened in 2002. Nina, this is old stuff and it has been fixed, just because one soldier (or doctor for that matter) does something stupid does not mean that it is common practice.

I am only interested in conveying the essence of what you are saying obviously without any reference beyond this specific content. I ask because the listserv discussion is quite intense and I am being expressly asked for information a portion of which questions I would like to respond to.

Thanks,

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** "Col. Larry C. James PhD" <>

**Date:** July 19, 2005 7:20:18 PM PDT

**Subject:** Re: FYI - NE Jnl.

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Nina, I would only ask that you do not include my name and where I work/and live.

thanks,

Larry j

**From:** "Banks, Louie M. COL" <>

**Date:** July 20, 2005 7:51:17 AM PDT

**Subject:** Re: Request from the American Psychiatric Association

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Steve? Any interest? Or others?

Morgan

COL L. Morgan Banks  
Director, Psychological Applications Directorate

US Army Special Operations Command  
DSN COM

**From:** Nina Thomas <\_>

**Date:** July 20, 2005 10:59:10 AM PDT

**Subject:** Re: FYI - NE Jnl.

**Reply-To:** Presidential Task Force on Psychological Ethics and National  
Security <PENS@\_>

In response to your concern Larry, absolutely I would say nothing other than the content of what you've communicated - no names, no aliases, no addresses, nunca. Without question!!!

N

**From:** "Behnke, Stephen" <\_>

**Date:** July 20, 2005 5:19:15 PM PDT

**Subject:** Re: Request from the American Psychiatric Association

**Reply-To:** Presidential Task Force on Psychological Ethics and National  
Security <PENS@\_>

I have only limited access to email right at the moment, but I would be very happy to attend (although I could hardly take your place, Morgan). I will need to check whether I have another commitment that weekend, but I will confirm when I return to DC on Monday. In the meanwhile, there may be others with an interest as well.

Steve

**From:** "Banks, Louie M. COL" <>

**Date:** July 21, 2005 3:57:51 AM PDT

**Subject:** Re: Request from the American Psychiatric Association

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Thanks much, Steve. If I am available, I may try to attend also, but only from the audience.

Morgan

COL L. Morgan Banks

Director, Psychological Applications Directorate

US Army Special Operations Command

DSN COM

**From:** Mike Wessells <>

**Date:** July 21, 2005 1:09:25 PM PDT

**Subject:** Re: Request from the American Psychiatric Association

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@>

Steve, you're in the best position to do this. I'll be at the meeting, on the weekend at least. I'd be more interested in discussing less the professional code issues than wider ethics issues and long-term implications associated with use of highly coercive methods.

Mike



**From:** Nina Thomas <\_\_>

**Date:** July 21, 2005 1:30:41 PM PDT

**Subject:** Re: Request from the American Psychiatric Association

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_\_>

In a message dated 7/21/2005 1:09:29 PM Pacific Daylight Time, \_\_ writes:

I'd be more interested in discussing less the professional code issues than wider ethics issues and long-term implications associated with use of highly coercive methods.

Can we assume there will also be some discussion of the international human rights norms as a measure against which interrogation methods are weighed?

N

Nina K. Thomas, Ph.D., ABPP

**From:** Mike Wessells <\_\_>

**Date:** July 21, 2005 1:41:13 PM PDT

**Subject:** Re: Request from the American Psychiatric Association

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@\_\_>

Definitely--international human rights standards are a key part of the global ethics discourse and provide key norms and benchmarks.

Thanks,

mike

**From:** "Behnke, Stephen" < >  
**Date:** July 21, 2005 4:00:21 PM PDT  
**Subject:** Re: Request from the American Psychiatric Association  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Could we get a head count of how many of us will be at the meetings? Morgan and Mike, it seems you both will be there, if your schedules allow...Nina? Others?

**From:** "Col. Larry C. James PhD" < >  
**Date:** July 21, 2005 4:23:01 PM PDT  
**Subject:** Re: Request from the American Psychiatric Association  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Steve, I won't be there,  
Larry

**From:** Nina Thomas < >  
**Date:** July 21, 2005 7:44:26 PM PDT  
**Subject:** Re: Request from the American Psychiatric Association  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Nope, I don't expect I will be there...  
Nina

**From:** "Gelles, Mike" < >  
**Date:** July 22, 2005 3:48:40 AM PDT  
**Subject:** Re: Request from the American Psychiatric Association  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

When and where is the meeting?

Michael G. Gelles, Psy.D.  
Chief Psychologist  
Naval Criminal Investigative Service

**From:** Olivia Moorehead-Slaughter < >  
**Date:** July 22, 2005 7:27:47 AM PDT

**Subject: Re: FYI - NE Jnl.**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Hi Nina,

Sorry for the long delay in responding. Our internet has been malfunctioning and was repaired yesterday. Thanks for offering to resend the article. I think the problem had to do with the format in which it was sent which you may have no way of altering. In any case, I'll try again when you resend it. Thanks.

Olivia

**From:** Jean Maria Arrigo < >

**Date:** July 22, 2005 1:42:18 PM PDT

**Subject: Re: Request from the American Psychiatric Association**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

I can attend for a day at least.

The meeting announcement is posted at <http://www.psych.org/edu/annmtgs/ips/05/index.cfm>. It isn't clear to me from the preliminary program which sessions or which days are relevant to Task Force members. Please advise.

Jean Maria

Jean Maria Arrigo, PhD  
Project on Ethics and Art in Testimony

**From:** Olivia Moorehead-Slaughter < >

**Date:** July 25, 2005 7:41:08 AM PDT

**Subject: commentary recommendation**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Hi Jean Maria and Everyone,

Sorry for such a delayed response to your message, Jean Maria. I have had brutal internet difficulties over the past week and hope that all of that is finally resolved. In response to your message regarding examples, I think that the Task Force Report addresses this nicely in the second recommendation where we suggest a commentary with illustrative examples. I think that we are in agreement with your position that having these examples will be enormously helpful, but it was not possible to make all of this happen in the initial report.

My best to all of you.

Olivia

**From:** Olivia Moorehead-Slaughter < >  
**Date:** July 25, 2005 8:07:36 AM PDT  
**Subject:** **Re: Request from the American Psychiatric Association**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Hi Morgan,

Sorry for the delay in responding to your email. My internet connection has been malfunctioning for the past week so I've been cut-off from this form of communication. I'll try again this morning to get this message out to you. I concur with the recommendation to ask Steve to do this presentation if he is able. Sounds like an important one. Again, sorry for the long time-lapse!

Olivia

**From:** Olivia Moorehead-Slaughter < >  
**Date:** July 25, 2005 11:03:41 AM PDT  
**Subject:** **Re: Request from the American Psychiatric Association**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >  
Hi Steve,

I am not planning to be there.

Olivia

**From:** "Mumford, Geoffrey" < >  
**Date:** July 27, 2005 5:41:51 AM PDT  
**Subject:** **Detainee legislation**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Colleagues,

FYI, below I've copied part of a news item from this mornings Congressional Quarterly. Many of you have probably seen bits and pieces of this on-going story in the popular press. I think it would be very helpful for those considering these legislative initiatives to know that work on the commentary and illustrative examples (recommended by the Task Force report) is moving forward as it would likely inform all sides in the debate.

Regards,  
-geoff

CQ TODAY

July 26, 2005 1:31 p.m.

GOP Clash Over Detainees Sidetracks Defense Bill

[SEE Article 14 - CQ TODAY 07-26-05]

**From:** Nina Thomas < >

**Date:** July 29, 2005 10:16:40 AM PDT

**Subject:** More on our report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Yesterday's NY Times had an article by Neil Lewis (p. A21) headlined: "Military's opposition to harsh interrogation is outlined" in which he reports on the highest military lawyers' opposition to the methods used in interrogating detainees, citing international human rights standards as the measure against which the U.S. will be judged. Reading it made me all the more sad that Mike Wessells, Jean Maria and I were not more successful at arguing our case for a more stringent standard for holding psychologists to account. Whether that was then and this is now or not, whether we were limited in the scope of our activity to addressing the ethics code's provision for psychologists activities in this regard or not, I do think that APA needs to have a clearly articulated direction for the next steps in its approach to addressing the concerns that underlie these issues. Case examples and directions for research are not likely to cut it with other members of APA governance, nor with the public.

I can't continue to read the popular press and feel sanguine about our work as having adequately addressed the concerns of our members (or my own for that matter). It does not take much of a stretch in interpretation to believe that, as the Lewis article details, our military and (more hopefully) are liable to severe ill treatment and Rumsfeld to arrest in Spain, Belgium or perhaps a dozen other countries whose citizens have been caught up in the net that dumps them in Guantanamo. I hope that one at least has the *cujomes* to do so.

Nina

Nina K. Thomas, Ph.D., ABPP

**From:** Nina Thomas < >

**Date:** July 29, 2005 10:21:15 AM PDT

**Subject:** Correction

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

I did not screen an edit that I made in writing the prior e-mail thus I did not catch how the wording had made it liable to misinterpretation. When I said: *It does not take much*



*of a stretch in interpretation to believe that, as the Lewis article details, our military and (more hopefully) are liable to severe ill treatment and Rumsfeld to arrest. I did not mean I hoped our military would be treated badly. Rather, I meant that I am hopeful that Rumsfeld might be arrested.*

Nina K. Thomas, Ph.D., ABPP

**From:** Olivia Moorehead-Slaughter < >

**Date:** July 29, 2005 7:25:00 PM PDT

**Subject:** regarding our report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Nina and colleagues,

Thank you for your--as always--very thoughtful message. In reflecting on your concerns, it seems to me that we should keep two points in mind. First, we discussed the role of human rights standards for the document, and it seems that our colleagues from the military were clear that including such standards in the document would likely (perhaps definitely) put the document at odds with United States law and military regulations. The effect of such a conflict, it seems to me, would be that the military would simply have ignored the document--thus, the community that we would most want to reach would have been prevented from using the report. Of course the document is a compromise--but it's a compromise that has ensured that our voice is present to and heard by the psychologists doing the work and their superiors.

Second, and what seems more important, is what actual activities does the report permit and prohibit? There has been much speculation by the media (not much of it terribly well informed, in my opinion), and I continue to return to Jean's point concerning the value of illustrative examples. I see the commentary as enormously important, because it will describe where the rubber hits the road; I think we should establish a process for writing the commentary, whereby we invite groups both within and outside of APA to submit their comments, questions, and uncertainties about what the report means, and we can use the commentary to address these issues. (Of course, the process governing the commentary is up to the Board of Directors) It seems to me that, far more important than how one characterizes what law governs, is what actual behaviors are deemed acceptable and not acceptable--that, ultimately, is what we are all concerned about.

Finally, most of what's been in the media has come from a particular perspective. My sense is that there are other perspectives as well, and I am certain that over time those voices will emerge.

Again, I thank everyone for giving so much of yourselves to the process. I continue to believe that we have made an important contribution, but realize we have more work to do. I have complete confidence in our ability, as a group, to address the issues that need to be addressed.

Sincerely,

Olivia

**From:** Nina Thomas < >  
**Date:** July 29, 2005 8:43:12 PM PDT  
**Subject:** Re: regarding our report  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Olivia:

I appreciate your response and regret being technologically enfeebled from being able to include an electronic copy of the article I am referncing. But re: your comment below:

including such standards in the document would likely (perhaps definitely) put the document at odds with United States law and military regulations.

you see it is exactly that issue that Lewis' article addresses pointing out that it has been the military's own lawyers, indeed their highest ranking lawyers who have argued for the importance of using international human rights standards as the benchmark. The suggestion was made that it was that argument that at least persuaded Rumsfeld to drop his approval of the harshest interrogation methods.  
Nina K. Thomas, Ph.D., ABPP

**From:** "Col. Larry C. James PhD" < >  
**Date:** July 29, 2005 8:50:45 PM PDT  
**Subject:** Re: regarding our report  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Maybe its just me, but I must say I am a little confused. I read the New York Times article and it didn't seem to have anything to do with Psychologists?

I am proud of the document we developed and more so, I feel better in my heart about the work that psychologists did at GITMO and Abu Ghraib. It really wasn't the high ranking military attorneys(as the article refers to) who got things under control, it was 2 psychologists. Because of the work(and sometimes them harassing the system:) Mike Gelles and an Army Psychologist did at GITMO, the harsh procedures were in fact outlawed. Mike Gelles Fought up through the Navy and DOD chain of command and the Army Psychologist worked to develop policy for the General in charge at GITMO and the SECDEF.

The Army Psychologist(ironically the gentleman who was blasted in the NEJM article) was the one who actually developed a memorandum for the secretary of defense that laid out the outlawed procedures. As a result, by the time I arrived at GITMO in January 2003 this memorandum was on official DOD letterhead, signed by the secretary of defense. And now clearly defines what can and cannot be done. We are just well past this.

People keep writing articles about 2002 as if it were today and the process and procedures have been tremendously improved. I want to emphasize the positive. Again, thanks to psychologists, procedures are in place to prevent these things from

happening again at GITMO and Abu G. I think our charter was to tackle the tough roll(s) of the psychologist lane and I think we did this.

Larry

**From:** Nina Thomas < >  
**Date:** July 30, 2005 7:56:06 AM PDT  
**Subject:** Fwd: FYI  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Geoff Mumford was kind enough to provide the article I was referring to for everyone's delectation.

N

Nina K. Thomas, Ph.D., ABPP

**From:** "Mumford, Geoffrey" < >  
**Date:** July 29, 2005 9:22:33 PM PDT  
**To:** "Nina Thomas" < >  
**Subject:** FW: [PRESIDENTIAL] regarding our report

Nina,

Is this the article (in case you'd like to post to the list)?

-geoff

NYT - July 28, 2005

## **Military's Opposition to Harsh Interrogation Is Outlined**

By NEIL A. LEWIS

[See: Article 15 - NYT 07-28-05 -- Military's Opposition to Harsh techniques]

**From:** Nina Thomas < >  
**Date:** July 30, 2005 8:13:23 AM PDT  
**Subject:** Article  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Apparently the article I tried to send did not get forwarded so here it is posted below.



N

## **Military's Opposition to Harsh Interrogation Is Outlined**

(Repeat of article 15: NYT 07-28-05 -- Military's Opposition to Harsh techniques)

Nina K. Thomas, Ph.D., ABPP

**From:** Olivia Moorehead-Slaughter < >

**Date:** July 30, 2005 9:17:05 AM PDT

**Subject:** regarding our report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Nina,

As I read the article, though, the issue was both United States and international law.  
From the article:

"Despite the military lawyers' warnings, the task force (an administration legal task force) concluded that military interrogators and their commanders would be immune from prosecution for torture under federal and international law..."

"The documents include one written by the deputy judge advocate general of the Air Force, Maj. Gen. Jack L. Rives, advising the task force that several of the 'more extreme interrogation techniques, on their face, amount to violations of domestic criminal law' as well as military law."

"The Bybee memorandum defined torture extremely narrowly and said Mr. Bush could ignore domestic and international prohibitions against it in the name of national security."

The article focuses on immunity from prosecution for violations of domestic and international law--but I think we as a Task Force are in complete agreement that psychologists do NOT violate any United States law.

**From:** "Gerald P. Koocher, Ph.D." < >

**Date:** July 30, 2005 10:50:42 AM PDT

**Subject:** Re: regarding our report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Olivia Moorehead-Slaughter wrote:

As I read the article, though, the issue was both United States and international law.

I have long had a sense of frustration with "international law." In particular, many nations have shown a preoccupation to promulgate grand statements of human rights principles, with no teeth, no financial support, and contradictory actions. Please recall that the Bush administration cited "international law" on WMD as a reason for invading Iraq in the first place.

I have zero interest in entangling APA with the nebulous, toothless, contradictory, and obfuscatory treaties that comprise "international law." Rather, I prefer to see APA take principled stands on policy issues where psychology has some scientific basis for doing so.

Gerry

**From:** Jean Maria Arrigo < >  
**Date:** August 2, 2005 8:56:04 AM PDT  
**Subject:** Dr. Daniel Jordan's critique of PENS report  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

**From PENS Colleagues:**

Perhaps I missed a round of conversation and you have already addressed the letter below from Dr. Daniel Jordan. To my mind, at minimum his letter calls into question the wisdom of our using the Ethics Code language, "Psychologists do not do , " so mean "Psychologists should not do , " in a public report where it sounds like an assertion of historical fact. Please consider a revision of our public report so as to use the common meaning of words.

Jean Maria

=====

: Dan Jordan <drdanj@>

**Date:** July 8, 2005 7:39:53 AM PDT  
**To:** [ippn@](#), [Psysr-disc@](#)  
**Subject:** [ippn] APA Response to Torture  
**Reply-To:** [ippn@](#)

To: [ethics@](#)

APA, and Dr Levant's NY Times commentary are sadly pathetic responses to the

question of whether psychologists engaged in torture, and APA's responsibility to investigate allegations of ethical standards by members of its profession.

Dr Levant also lied in his Letter to the Editor. He states:

"The report makes clear that psychologists never engage in, direct, support or facilitate torture or cruel, inhuman or degrading treatment; use information from a medical record to the detriment of an individual's safety and well-being; and mix treatment and consultant roles."

That statement is wholly unsubstantiated. How can he possibly claim the "psychologists never. . ."? And just what does "mix treatment and consultant roles" mean? One obvious reading is that so long as psychologists are just acting as consultants, then facilitating torture might be okay. Did Dr Levant mean that? I have no idea. But because he used this wording, he clearly leaves the door open for a subsequent defense that psychologists can do such things so long as they only act as consultants.

APA sidestepped the issue of whether psychologists engaged in torture. APA sidestepped the opportunity to investigate the question, as clearly defined in the work group's mission. Those of us who called for an investigation did not call for APA to examine its own navel and decide whether ethical standards were clear enough. We called upon APA to investigate specific claims. APA chose not to do that, and instead has engaged in an effort to whitewash its image.

APA could have looked directly into the heart of the matter, and behaved honorably. Had it found substantiating information, it could have taken the psychologists to task. Had it found the allegations unsubstantiated, APA could have cleared its name and the name of the profession. APA chose not to do that.

When politicians and pundits wonder "why do they hate us?" I am sad to say that we can now add APA as part of the answer.

Daniel Jordan, PhD

[Non-text portions of this message have been removed]

**From:** "Behnke, Stephen" < >

**Date:** August 2, 2005 9:22:32 AM PDT

**Subject:** Re: Dr. Daniel Jordan's critique of PENS report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Jean Maria and Colleagues,

While I normally prefer to remain silent and so benefit from everyone's good and wise thinking on this listserve, I simply cannot allow this letter to stand without a more immediate response. To say that Ron Levant "lied" in his letter to the New Yorker is (here I'll be as generous as I am able) irresponsible. To say that the Report allows psychologists to facilitate torture under any circumstances ignores the Report's plain and forceful language. The Task Force took pains to emphasize that the twelve statements apply whenever

psychologists are using their background, training, and expertise as psychologists, regardless of whether the term "psychologist" or "consultant" is applied. Finally, the APA Ethics Committee--and not the PENS Task Force--is charged with investigating ethics complaints, and the Ethics Committee can only do so when it has credible evidence that an APA member has violated the Ethics Code. To date I am aware of no such evidence.

The language of the Report was written in the form of the APA Ethics Code, e.g., "Psychologists do not do x, y, or z." The Ethics Code does not use "should" when it intends to convey an absolute ethical obligation or prohibition, because "should" can be interpreted as tempering what is intended to be absolute. It would be ironic indeed for the Task Force to have felt as strongly as it did about these positions, and to have relied upon language (i.e., "should") which could then be argued to cast the statements in an aspirational rather than enforceable light.

Steve

**From:** Jean Maria Arrigo < >

**Date:** August 3, 2005 12:55:12 PM PDT

**Subject:** Re: Dr. Daniel Jordan's critique of PENS report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Steve and Task Force Colleagues:

I contacted Dr. Jordan by telephone last night to try to understand the source of his vehemence, and he explained the history of his PENS concerns.

In the past I have had arguments with philosophers about whether representing one's ethical position requires sincere attempts to communicate with the opposition. My 2004 "Utilitarian Argument against Torture Interrogation of Terrorists" (SCI & ENGINEERING ETHICS, 10 (3)) brought severe criticism from Kantians. They accused me of potentially justifying torture because I ran a utilitarian argument against torture, which opens the possibility that benefits might later overshadow costs. My position was that in order to communicate with military personnel I had to start from their institutional premises (and, of course, I felt sure the benefits would never outweigh the costs). As a PENS Task Force member, I similarly want to try to understand the perspectives of our critics. Unanimous agreement by the Task Force members and APA Board support do not necessarily validate our work.

Dr. Jordan sent me a file of PsySR and Div. 48 listserve correspondence, which showed his early and forceful role in calling for an APA investigation of psychologists' roles in interrogation, and his communication with the Div. 48 representative to the Board, Coran Orkordudu. What Dr. Jordan and some others wanted was an APA investigation of news reports of psychologists' involvement in interrogation, not just an extension of APA ethics code. For example, they wanted APA inquiries through Amnesty International and other organizations that made the reports.

Our Report did not discuss the reasons the APA did not undertake such an investigation. Many reasons, both good and bad, can be imagined. Without addressing the reasons, our report could not respond to those who believed an APA investigation to be imperative, so I think we

will have to live with their dissatisfaction.

The Ethics Code language of the Report e.g, "psychologists do not do x, y, or z" was carried into the press, where it is subject to reasonable interpretation as an historical assertion. (I am not suggesting changing the APA Ethics Code language.) So I think we have to accept the consequences of misinterpretation, too.

I realize that some of you may have had prior contact with Dr. Jordan or others of similar view. You may wish to add to my account.

Jean Maria

**From:** Olivia Moorehead-Slaughter < >

**Date:** August 5, 2005 6:38:23 PM PDT

**Subject:** latest updates

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Task Force Colleagues:

Attached please find an editorial in the journal Lancet that will be published next week and a response from APA. The editorial, by Michael Wilks, egregiously misrepresents the position of the Task Force. Lancet editors have admitted the error, but informed us that the issue was already in press when it came to their attention. Lancet has offered to post our response on their website and/or publish the response in their next issue. (Immediately below are juxtaposed texts from the editorial and our Task Force report, as an example of how Wilks mischaracterizes our position)

Posted below the attachments is an editorial on Medscape by Mildred Solomon, an ethicist at Harvard Medical School. Please see her positive comments regarding the PENS Task Force Report under the heading "For those of us outside the military."

From Michael Wilks' Lancet editorial:

"This report [The APA Presidential Task Force report] rehearses conventional ethical principles about care of individual patients, but then does an about-face when it comes to sanctioning input from psychologists and advice on techniques to be used in interrogation. In effect, it becomes acceptable for a health professional to dispense with any ethical responsibilities when their training and expertise is used outside a strictly therapeutic context."

From the PENS Task Force Report (Overview and Introduction sections):

"As a context for its statements, the Task Force affirmed that when psychologists serve in any position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies. The Task Force thus rejected the contention that when acting in roles outside traditional health-service provider relationships psychologists are not acting in a professional capacity as psychologists

and are therefore not bound by the APA Ethics Code."

"The Task Force addressed the argument that when psychologists act in certain roles outside traditional health-service provider relationships, for example as consultants to interrogations, they are not acting in a professional capacity as psychologists and are therefore not bound by the APA Ethical Principles of Psychologists and Code of Conduct (hereinafter the Ethics Code). The Task Force rejected this contention. The Task Force believes that when psychologists serve in a position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies. Thus in any such circumstance, psychologists are bound by the APA Ethics Code."

<<Ethics.pdf>> <<Response to Lancet.doc>>

Mildred Z. Solomon, EdD  
Medscape General Medicine. 2005;7(3) 2005 Medscape  
Posted 08/04/2005 [Image]

(SEE: Editorial - General Medicine Solomon)

**From:** Olivia Moorehead-Slaughter < >  
**Date:** August 5, 2005 6:46:59 PM PDT  
**Subject:** **Two Commentaries on our Report: Message from Steve**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Task Force Colleagues (same message with attachments!):

**From:** Gerry Koocher < >  
**Date:** August 11, 2005 11:16:43 AM PDT  
**Subject:** **Confidential- Today's broadcast**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

**Dear colleagues,**  
**I want to share with you (in confidence) my response to a colleague**  
**regarding this morning's web-cast. I served as a defense witness for Dr. Z**  
**in a licensing board case.**  
**Regards,**  
**Gerry**  
-----

Dear Z.,



We have very different points of view on this.

My only regret is that Steve did not slam the other two participants by pointing out that their claims that the "facts are in" are totally bogus and inflammatory. If I were there, I would have said, "Okay, give me credible factual reports of the names and dates and we'll act right now." All that exists are rumors and "unconfirmed reports" by people and agencies who provide no hard actionable data. Their behavior amounted to defamation military psychology in general (i.e., they're pronounced guilty before specifics are made public and adjudicated). Given your licensing board experience, would you want APA to act on unfounded allegations?

Do not mistake Steve's care, thoughtfulness, and precision for shiftiness. He was much more appropriate than the other two, who made significant conceptual leaps and a multitude of over generalizations.

In addition, lots of "interrogation" by psychologists themselves in many forms and venues takes place every day and does not, "damage people's minds." Psychologists often do things that "harm" one person for an appropriate societal purpose (e.g., rigorous cross examination of a rape victim at a trial; interviewing convicted defendants for pre sentencing reports, interviewing sex offenders or parole candidates to determine whether their incarceration should persist; involuntary civil commitment hearings, mandated reporting of dependent person abuse, conducting independent evaluations of people claiming medical disability, profiling suspected criminals to aid in their apprehension, etc.). None of these involve the military; all involve coercive or less than fully voluntary interrogation that society values and that fall well within the legal system and ethical psychological practice.

Let's not allow our anger about Bush policies to spill over into unjust criticism of military personnel. Let's not repeat the errors of the Vietnam era. Prosecute Lt. Calley, but don't disrespect the military who do their job appropriately and ethically.

Regards,

Gerry

-----  
Dr Z wrote:

Dear Gerry,

I have just watched a debate on DemocracyNow! in which Stephen Behnke participated, attempting to defend the position the APA task force has taken on the role of psychologists in interrogations and torture.

Gerry, it was disturbingly shameful; embarrassing. (You can view the debate, which also included Wilks and Lifton, on their website; the archiving is excellent, with multiple choices for downloading and viewing: [www.democracynow.org](http://www.democracynow.org))

Behnke was labored in his delivery, insecure in his footing, and downright shifty in his presentation. He seemed to be looking around the studio where he was located to find someone to cue him for answers when he was not attempting to justify (read sell) this heinous decree.

The one position he took that was simply illogical to my mind was that the task force decided psychologists must adhere to a higher good and that we must also adhere to law. There is a clear disconnect here, one that the task force should have addressed firmly and unequivocally. Behnke tried to assert that the higher good might be in the interests of national security, when the only true higher good is to do no harm. Period. The oath may well conflict with laws in many cases as it appears is the case in this administration's determination to distort the law to its own sadistic ends to torture but that oath has always been, and always should be, the ONLY higher good we ever look to as professionals. I was frankly disgusted and ashamed. And even more so to discover that members of the military were involved in the task force decision process.

But somehow it was altogether too consistent with my experience of the general trend of the profession's understanding and application of ethical principles, too predictable.

When I placed this decision within the context of Bush's intent to have every child tested for mental disorder so that they can be medicated, I became even more curious about the minutes of those discussions. There is so much to be gained by losing sight of our ethical obligations.

Lifton is right; this is a slippery slope in which we are setting ourselves up for complicity in atrocities. I will have none of it, and I hope that your tenure will address this problem head on. What can we be doing now within the organization to thwart these notions? The show today spoke of a debate raging within the APA, but I've heard nothing about it within professional channels, and cannot find anything about it on the website.

I hope this finds you in good health and enjoying your summer. Thank you for being there, for this inquiry, as for all my other questions in the past.

Best,  
Z

**From:** "R. Scott Shumate" <>

**Date:** August 11, 2005 8:35:34 PM PDT

**Subject:** Re: Confidential- Today's broadcast

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security



<PENS@ >

Gerry and Stephen:

As a psychologist I find, in principle, a debate over the complexities of the ethical issues to be an essential function of a profession. Yet, Dr. Z appears to rely on emotion and misinformation to make an argument about a highly complex and difficult topic area. I have heard similar illogical arguments by individuals who were encouraging a no bars approach to gathering essential intelligence. The argument was that anyone who opposes a no limit approach to interrogation was willing to allow the city of New York to be destroyed by a nuclear detonation. This form of argument advances little and attempts to confuse the complexity of the issues by instilling a visceral reaction that is aimed at suspending more sophisticated critical thinking.

The measured and well throughout arguments that both of you articulated attest to the soundness of a profession that has taken a serious and mindful approach to dealing with the issues. There will no doubt be counter claims that you unabashedly support the military psychologists, yet I believe that what you are truly supporting is the profession and the psychologists that adhere to the ethical guidelines that are at the basis of our profession. We in the Department of Defense applaud your support of the profession and in turn us. Scott Shumate

**From:** "Banks, Louie M. COL" <>

**Date:** August 12, 2005 3:45:21 AM PDT

**Subject:** Re: Confidential- Today's broadcast

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security

<PENS@ >

To all:

I wish I were half as articulate as Scott. I was and am honored to have worked on the Task Force, and believe that everyone demonstrated a level of integrity and thoughtfulness that left me truly impressed. I have psychologists working everyday, in very dangerous environments, who are trying to serve, while trying to maintain a clear ethical stance on these issues. The TF's work provided them a strong anchor for their behavior. They cannot thank you in person, but they have all thanked me for your work.

Last Friday, I spent eight hours with the Army's Surgeon General, LTG Kiley, along with Larry James, Debra Dunivin, and several others. We were trying to establish the doctrinal guidelines and training model for psychologists performing this job. The TF report provided, again, a solid anchor to use in our deliberations.

The professionalism of the deliberations of the Task Force set a standard that I have not seen even attempted in the press. Very respectfully,

Morgan Banks

**COL L. Morgan Banks**

**Director, Psychological Applications Directorate**

**US Army Special Operations Command**

**DSN COM**

**From:** Olivia Moorehead-Slaughter < >  
**Date:** August 15, 2005 12:01:18 PM PDT  
**Subject:** Re: Confidential- Today's broadcast  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

To All:

Your thoughtful consideration of all of the feedback that we are receiving is much appreciated. I hope that all of you continue to feel the important impact of your efforts in the feedback given by Morgan as well as Scott. If the Task Force report is providing ethical guidance for those working in national security, we have done our job.

Olivia

**From:** Jean Maria Arrigo < >  
**Date:** August 16, 2005 10:03:22 PM PDT  
**Subject:** [PRESIDENTIAL Task Force] - CIA psychologists?  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Olivia,

I am very pleased with the Task Force participation of psychologists from the armed services. I am not aware of any commitment from psychologists who work for the CIA or other intelligence agencies.

Jean Maria

**From:** "R. Scott Shumate" <>  
**Date:** August 17, 2005 5:27:22 PM PDT  
**Subject:** Re: Confidential- Today's broadcast  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Olivia: It was nice to run into you today at the convention center, I appreciate you

giving me a quick read of the changes that are being incorporated into the ethics of interrogation. I look forward to getting the final version so that we can consider what if anything of significance may have changed. Scott

**From:** "Gelles, Mike" < >  
**Date:** August 22, 2005 7:41:44 AM PDT  
**Subject:** **Re: Two Commentaries on our Report: Message from Steve**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Colleagues,

I wanted to leave a short note regarding the Ethics in National Security Panel presentation at the APA Conference on Friday. While this was not related to the Task Force, there were many questions and comments regarding the Task Force report posed to Dr. Steve Behnke who chaired the panel. I was once again impressed with how Dr. Behnke eloquently represented our work and insured the confidentiality of the panel, despite pressure to reveal the identities of the task force members and the process that unfolded during the Task Force meetings. Steve was respectful, gracious and polite in response to some very direct and provocative questions and comments.

Mike

Michael G. Gelles, Psy.D.  
Chief Psychologist  
Naval Criminal Investigative Service

**From:** Barry Anton < >  
**Date:** August 22, 2005 8:18:26 AM PDT  
**Subject:** **Re: Two Commentaries on our Report: Message from Steve**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Colleagues:

I was at the presentation which included many active duty military in uniform, and I'm sure others who were not. There were also people who had strong feelings, both about the political issues as well as the issues our task force addressed. I believe there were over 125 people in the room, most of whom stayed for the entire two hours.

Because of his humility, Mike did not mention the incredibly sensitive, informative, honest, and powerful talk he gave. Kudos to you Mike. And he is correct that Steve masterfully managed the emotion-laden questions from the audience with aplomb. I was sad Robert Fein was not able to attend as he would have added another dimension from the TF discussions which would have helped emphasize the complexity of the

issues.

As you know, Council accepted our report and set the stage for the next step in the process. My hope is that we will all be able to work on this step together in the near future.

Best,

Barry

**From:** Olivia Moorehead-Slaughter < >  
**Date:** August 22, 2005 9:37:03 AM PDT  
**Subject:** Re: **Two Commentaries on our Report: Message from Steve**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Mike and Colleagues

I am pleased to hear how well the discussion portion of the session went as I had to leave during the second presentation. Mike, I very much enjoyed your presentation.....eloquent, informative, and compelling. I'm sorry that I couldn't remain for the session in its entirety, but I had committed to another session which overlapped with this one. Such is the Convention..... I have no doubts that Steve was respectful and masterful in preserving the integrity of our Task Force process and at the same time allowing for insightful discourse around the issues. Thanks Steve.

Olivia

P.S. Scott, Larry, and Bryce.....great running into you at Convention!

**From:** Olivia Moorehead-Slaughter < >  
**Date:** August 22, 2005 9:42:17 AM PDT  
**Subject:** Re: **Two Commentaries on our Report: Message from Steve**  
**Reply- To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Barry and Colleagues,

Barry, it's good to hear yet another testimony of the impact of the session. From my vantage point at the very back of the room (easy exit about 45 minutes into the session), it was indeed a packed room. Of course, you know that I whole heartedly agree with your thoughts about Mike's presentation. I also wanted say that I share your sentiments about our report making its way successfully through Council and to thank you and Gerry for your support throughout.



My best.

Olivia

**From:** Olivia Moorehead-Slaughter < >  
**Date:** August 30, 2005 10:35:36 AM PDT  
**Subject:** Council acts on PENS report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Colleagues,

You may be eager to know what happened at Convention, specifically at the Council of Representatives, regarding our Task Force Report. I am attaching two documents, that are the motions Council voted. In short, Council accepted all of our recommendations, and then added four additional points, which I believe we will all be very comfortable with. (The original item is the first attachment; the additional four points are contained in the second attachment).

Council wants us to proceed with the commentary project we recommended, and would like us to work collaboratively with the Ethics Committee. I know that we all viewed the commentary on the Report as a very important contribution, and I look forward to working with you on this project. We'll get more information soon about the process; my understanding is that there will be a period of inviting people to submit their questions about the Report (to help the commentary address where people are unclear/have questions), and the Board will act on additional funding at its December meeting. So we will likely be looking at another meeting in 2006.

Also, below please find a link to a program that featured Steve discussing our Report (WHYY, Philadelphia's NPR station). (You can listen to the program through this link.)

<http://www.whyy.org/podcast/082505100630.mp3>  
or  
<<http://www.whyy.org/cgi-bin/newwebRTlookup.cgi>>

Warm Regards,

Olivia

<<PENSCOR7B.doc>> <<PENSCOR7Bcont'd.doc>>

**From:** Nina Thomas < >  
**Date:** August 30, 2005 1:57:45 PM PDT  
**Subject:** Re: Council acts on PENS report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security

<PENS@ >

Dear All -

I apologize for having been out of the loop on the various discussions about our report, etc., over the course of the last month. I have been traveling throughout the month of August with little chance for e-mail access except in really smoking internet cafes in Cape Town and Moscow. None at all available on the various slopes of Scotland (I'd have been laughed off the bog if I had asked). I will now immerse myself in the e-mail exchanges in an attempt to catch up.

Regards,  
Nina

Nina K. Thomas, Ph.D.

**From:** Olivia Moorehead-Slaughter < >

**Date:** August 31, 2005 11:24:35 AM PDT

**Subject:** Re: Council acts on PENS report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Welcome back, Nina!

Olivia

**From:** Nina Thomas < >

**Date:** September 1, 2005 7:18:51 AM PDT

**Subject:** Re: Council acts on PENS report

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Thanks for the welcome Olivia. Clearly I missed some very important discussions and meetings particularly at Convention. From various reports Steve did a bang up job (is that perhaps the wrong metaphor?) in the various contexts that he has represented us. I was pleased to read the one report that applauded our efforts. I look forward to continuing to participate in whatever way the TF will proceed at this point.

Warm regards for a productive fall. (Cape Town conference was spectacular, btw. What an impressive group of people.)

Nina

Nina K. Thomas, Ph.D.

**From:** Olivia Moorehead-Slaughter < >

**Date:** September 1, 2005 2:03:43 PM PDT

**Subject: Roll up your sleeves.....**

**Reply-To: Presidential Task Force on Psychological Ethics and National Security**  
<PENS@ >

Dear Colleagues,

As my last message indicated, Council has endorsed all of our recommendations, including our recommendation that a casebook/commentary be written to demonstrate how our Report applies in actual practice. I'm very excited about continuing our work together, pleased that Council felt this recommendation (and all of our recommendations) worthwhile to support, and a bit anxious about the task that lies ahead. Council directed us to work with the Ethics Committee (of which I am currently vice-chair) on this project, and I anticipate a collaborative and collegial effort where the Ethics Committee presses us for clarity and ensures that we are fully informed about the APA Ethics Code and how it relates to our work.

Council directed the Ethics Office to put out a call for questions and comments on the Report, so that we may be aware of what questions and uncertainties people have. This information will be both important and valuable as we write, and will help ensure that we speak to the issues people are struggling with and uncertain about.

I believe this call, which I have both attached and copied below, will be distributed Tuesday, September 6.

Warmly,

Olivia

<<PENScallmemo.doc>>

APA Presidential Task Force on Psychological Ethics and National Security  
(PENS)  
Call for Questions and Comments

At its February 2005, meeting, the Board of Directors voted to establish and fund an APA Presidential Task Force to explore the ethical role of psychologists in national security-related investigations (PENS Task Force). The Task Force met in June and shortly thereafter issued a report (attached). The PENS Task Force report contains twelve statements that govern the involvement of psychologists in national security-related activities. In addition, the PENS Task Force made ten recommendations that were reviewed by the Board of Directors and the Council of Representatives in August 2005.

One recommendation of the PENS Task Force, endorsed by Council at its August meeting, concerns writing a casebook/commentary with illustrative examples, to demonstrate how the Report's twelve statements are to be interpreted and applied in practice.

The purpose of this communication is to encourage all interested individuals and groups to submit questions or comments regarding the Task Force Report to APA, so that the PENS Task Force, working with the APA Ethics Committee, can be fully



informed about questions and areas of uncertainty in order to write a casebook/commentary that provides as much direction and is as helpful as possible.

The question/comment period will be through December 31, 2005. Please submit your questions/comments on the PENS Task Force report by email, to PENS@ <mailto:PENS@ >, or by post to: APA Ethics Office; Attn: PENS; 750 First Street, NE; Washington, DC, 20002-4242.

Also, if you are aware of individuals or groups outside of APA who would be interested in providing a question/comment for the casebook/commentary writing process, please submit a name and address.

In addition to the attachment, the PENS Report can be found at:  
<http://www.apa.org/releases/PENSTaskForceReportFinal.pdf>

**From:** Olivia Moorehead-Slaughter < >

**Date:** January 11, 2006 2:35:24 PM PST

**Subject:** Greetings and update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear PENS Colleagues,

I hope this message finds all of you well in the New Year and flourishing in your work and non-work lives. I am writing to update you on our PENS work, and to ask for times that we can speak by phone next week.

In August, Council resoundingly supported our recommendation that a casebook/commentary be written on the PENS report, and directed the task force to write the casebook/commentary in collaboration with the APA Ethics Committee (you will recall that the Ethics Committee determined that the twelve statements in the report were appropriate "applications and interpretations" of the APA Ethics Code.) Norman Anderson has raised the possibility that the PENS report and the casebook/commentary be published in the American Psychologist.

I would like to schedule a conference call to discuss how we may proceed with our work, in collaboration with the Ethics Committee. There are a variety of issues to discuss, and I am very eager to hear from everyone regarding your thoughts and ideas about how best to proceed.

In September, a "call for comments" on the PENS report was distributed, which asked that anyone interested submit comments on the report. The initial deadline was December 31; we have now extended the deadline to June 30, to ensure that as many individuals and groups as possible have the opportunity to weigh-in. The Ethics Office will be compiling these comments and distributing them to us at regular intervals. I am attaching the report and the renewed call for comments.

I am hoping we will be able to speak next week. Please let Rhea in the Ethics Office know whether you are available next Tuesday, January 17, at 7 or 8 pm East Coast time, or Thursday, January 19, at 7 or 8 pm East Coast time, for a call. Please contact Rhea at [ or at [rjacobson@](mailto:rjacobson@apa.org) ]



As the next "installment" of the work of this Task Force gets underway, please know that I continue to appreciate your commitment to this important endeavor.

Olivia

**From:**  
**Date:** January 14, 2006 1:06:01 PM PST  
**Subject: Re: Greetings and update**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Olivia,

It is likely that I will be doing a short stint at sea next week. I am interested in continuing the dialog and will catch up on the activities of PENS when I return. I will be in my office on Tuesday morning.

Take care,  
Bryce  
Bryce Lefever, Ph.D. ABPP  
CAPT MSC USN  
Department Head  
Substance Abuse Rehabilitation Program  
Naval Medical Center Portsmouth, Virginia

**From:** Mike Wessells < >  
**Date:** January 15, 2006 12:55:10 PM PST  
**Subject: PENS work**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Olivia,

I've been meaning to write you in regard to my participation in the continuation of the PENS work but my schedule has consistently interfered. Now, with the teleconference being scheduled for next week, I wanted to write at least a brief note.

Out of ethical concerns, I have decided to step down from the PENS Task Force because continuing work with the Task Force tacitly legitimates the wider silence and inaction of the APA on the crucial issues at hand. At the highest levels, the APA has not made a strong, concerted, comprehensive, public and internal response of the kind warranted by the severe human rights violations at Abu Ghraib and Guantánamo Bay. The PENS Task Force had a very limited mandate and was not structured in a manner that would provide the kind of comprehensive response or representative process needed. In serving initially on the Task Force, I had hoped that the APA would treat

PENS as one element in a strong, proactive, comprehensive response affirming our professional commitment to human well-being and sounding a ringing condemnation of psychologists' participation not only in torture but in all forms of cruel, inhumane and degrading treatment of detainees, including the use or support of tactics such as sleep deprivation. In the past six months, no such response has come from the Association, which has tended to treat the PENS Task Force as its primary response to the situation. Even the requirement by the APA Council for wide publicity of APA's 1986 resolution on human rights and torture has not been answered adequately. The quiet, timid approach the APA has taken on these issues is inappropriate to the situation, inconsistent with the Association's mission, and damaging to our profession. It has been encouraging to see a more robust statement recently from the President of the American Psychiatric Association. This is the kind of leadership warranted in the situation we face.

My concerns reflect no ill feelings toward the PENS group, which I felt honored to have worked with. Also, my concerns do not relate primarily to the PENS Task Force report. Although the report could have been stronger in many ways, I thought it made a contribution relative to the terms of reference given to the Task Force.

Sincerely,

Mike Wessells

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**From:** "Gerald P. Koocher, Ph.D." < >

**Date:** January 15, 2006 2:04:03 PM PST

**Subject:** Re: PENS work

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

I hope you will reconsider, Mike.

APA is in the process of doing more, a lot more. I do think it important that we make our statements loud, clear, and rigorous. I think that many things in the works, including the casebook will prove to have substantial enduring merit.

Sadly, American Psychiatric's president is best characterized by the famous verse

from Macbeth's Act 5, Scene 3:

"That struts and frets his hour upon the stage  
And then is heard no more: it is a tale  
Told by an idiot, full of sound and fury,  
Signifying nothing."

In fact, American Psychiatric has yet to release a official position, and their draft position does not preclude the use of drugs in interrogations. I have pasted in below, the first draft of a coulumn I wrote for the February APA Monitor. I ask that it not be circulated before it appears in print two weeks from now:

In early July the task force on Psychological Ethics and National Security (PENS), appointed a few months earlier by then President Ron Levant, released a thorough and thoughtful report detailing the ethical constraints on psychologists who serve in or consult to military and security agencies of our government. The task force included a broad range of psychologists with career interests in ethics, government service, peace and negotiation studies, and the victims of torture. The task force took as its starting point APA s strong historic stand against the use of torture, as well as the ethical foundation that unlawful acts against others also constitute ethical misconduct.

The group became aware of several incidents in which psychologists serving in the military had intervened, putting their own careers at some risk, by taking strong stands against abusive actions toward people held in detention both in Iraq and at Guantánamo Naval Base. For example, one APA member has been credited with alerting his superiors as early as in 2002, about questionable interrogation of detainees at Guantánamo. The task force members had a keen awareness of reports in the news media of alleged ethical misconduct by mental health professionals involved in the interrogation of such detainees, predicated chiefly on rumor and speculation regarding a confidential report by the Red Cross, which has never become public.

The task force members drafted a thoughtful, detailed report and sent it on to the APA Ethics Committee for study. The Ethics Committee, the only body of APA authorized by our *Bylaws* to interpret our ethics code, reviewed the report, made some edits, and confirmed that the guidance offered by the PENS task force conformed full to the *Ethical Principles of Psychology and Code of Conduct*. The report then went to the APA Board of Directors for review and approval for its public release on July 5, 2005.

A number of opportunistic commentators masquerading as scholars have continued to report on alleged abuses by mental health professionals. However, when solicited in person to provide APA with names and circumstances in support of such claims, no data have been forthcoming from these same critics and no APA members have been linked to unprofessional behaviors. The traditional journalistic dictum of reporting who, what, where, and when seems notably absent. The published accounts to date bear an amazing similarity to the Bush administration s claims regarding weapons of mass destruction (WMD) in Iraq, prior to the our invasion of that country, with one noteworthy exception: President Bush has admitted he was wrong about the WMD.

The PENS report makes clear that any APA member who participates in torture, cruel, inhuman, or degrading treatment of people, or who enables use of information

gleaned in a health or mental health care relationships to the detriment of a person's safety and well-being, stands in violation of our ethics code. Our task force declined to use the words "coercive" or "harmful" in describing ethical misconduct, because many legitimate professional roles of psychologists could prove problematic in that regard. The psychologist who acts as a mandated reporter of abusive behavior toward children or dependent persons may cause harm to the perpetrator, while acting to protect the more vulnerable party. The psychologist who helps the authorities to assemble profiles of suspects in criminal cases may cause harm to the offenders. Clinicians who conduct custody evaluations, criminal competency assessments, or independent disability evaluations will often evaluate people who feel coerced to cooperate by the legal system. We undertake such assignments with appropriate disclosure to the parties and a solid commitment to promoting a world where our scientific and clinical skills benefit society as a whole, and its most vulnerable citizens in particular.

Sadly, many people, including some public luminaries, some of our own members, and some of our psychiatric colleagues have leaped to find fault with the PENS report. Ironically, many appear to have offered their critical commentary without carefully reading the report or by selectively ignoring key elements. Many of our psychiatric colleagues have offered interpretive criticism, although their professional association has yet to agree on an official position. One proposed draft before the psychiatric association includes an itemization of specific prohibited tactics they deem as torture. When carefully scrutinized, their draft bears a remarkable resemblance to our position, although no journalist has yet commented on this point. Likewise, no journalist -- including those critical of the PENS Report -- have commented upon an interesting irony: despite psychiatrists' opposition to prescription privileges for psychologists, the psychiatric association's list of forbidden coercive techniques omits any mention of the use of drugs, implicitly allowing such practices.

Many APA members oppose current government war policies, strongly support victims of torture, or want to proudly uphold our strong tradition of advocacy for social justice. All our members can take pride in the work of the PENS task force and the strong ethical positions held by APA. If you have not yet done so, I encourage you to read the full report. It can be found at {insert web site address here}.

Regards,  
Gerry

Gerald P. Koocher, PhD, ABPP  
Dean and Professor  
School for Health Studies  
Simmons College

President, American Psychological Association  
Editor, *Ethics & Behavior*  
[www.ethicsresearch.com](http://www.ethicsresearch.com)

**From:** "Barry S. Anton, PhD" < >  
**Date:** January 15, 2006 4:30:00 PM PST  
**Subject:** Re: PENS work  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security

<PENS@ >

Dear Mike:

I too hope that you will reconsider. I believe that you can do more good from continuing on the TF than not. Gerry has articulated many of the reasons why your expertise and perspective is invaluable to our ongoing work.

Best,  
Barry  
\*\*\*

Barry S. Anton, Ph.D., ABPP  
Distinguished Professor  
University of Puget Sound

**From:** Nina Thomas < >  
**Date:** January 16, 2006 5:11:44 AM PST  
**Subject:** Re: PENS work

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Dear All -

I share Mike Wessell's concerns about APA's failure to act more strongly in response to the ongoing issue of inhuman treatment and torture and the participation of psychologists, though I have not decided what that concern means for my own continued participation on the Task Force. Whatever my choice, I am in the dark about the "teleconference" Mike's email refers to. Will someone explain?

Nina

Nina K. Thomas, Ph.D.

**From:** "Levant,Ronald F" < >  
**Date:** January 16, 2006 4:51:14 AM PST  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

**From:** "Levant,Ronald F" < >  
**Date:** January 16, 2006 5:02:13 AM PST  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

**From:** "Levant,Ronald F" < >  
**Date:** January 16, 2006 5:45:47 AM PST  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Mike: I also would urge you to reconsider. For it is not true that "At the highest levels, the APA has not made a strong, concerted, comprehensive, public and internal response of the kind



warranted by the severe human rights violations at Abu Ghraib and Guantánamo Bay."

First, I would note that APA's position throughout all of last year has been consistently mischaracterized by a group of medical reporters and journalists. As I wrote in my APA Presidential address (please do not circulate this yet, as it is still in press): "Despite the clear statements in the PENS report, and the affirmation of the report by the Ethics Committee, Board of Directors and Council, commentators have seriously mischaracterized APA's position on these matters in well-respected journals such as *Lancet*, where an editorial stated that according to APA, psychologists have no ethical obligations whatsoever when acting outside traditional health care provider roles (Wilks, 2005). APA holds precisely the opposite position as the editorial claimed. The entire point of the PENS report is to set forth the ethical obligations of psychologists in a non-traditional setting. Recognizing this error, *Lancet* provided APA space for a correction, but to the best of my knowledge the author of the editorial has never retracted this statement, which has been repeated in other venues of equal stature." Second, we have made a strong effort to correct the record on APA's position, as evidenced by multiple attempts to publish Letters to the Editor in leading newspapers and medical journals like the *New York Times*, *Los Angeles Times*, *Boston Globe*, *Washington Post*, and *Lancet*, a number of which did get published.

Third, as Gerry aptly pointed out, APA President Steven Sharfstein has consistently been less than clear about his organization's position, which is in fact no position. There are two competing positions in APA (one approved by the Board and one by the Assembly of Delegates), the latter of which is close to APA's, but neither of which condemn the use of psychiatric drugs in interrogation.

Thanks for reading this.

Ron

Ronald F. Levant, EdD, ABPP, MBA  
Dean and Professor of Psychology  
Buchtel College of Arts and Sciences  
The University of Akron  
Past President, American Psychological Association  
"Making Psychology a Household Word"

**From:** "Kelly, Heather" < >

**Date:** January 16, 2006 8:07:46 AM PST

**Subject:** Re: PENS work

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Hi, Mike and the PENS Task Force:

Sometimes from a staff level we're not as good as we should be at widely publicizing our work, but you all should know that APA advocated very strongly and very publicly on behalf of the McCain amendment (attached at various points of time to both the FY06 defense funding and authorizing bills), the language calling for a prohibition on cruel, inhuman and degrading treatment of detainees, which attracted such controversy and heat from Republicans within Congress and the Administration.

I coordinated our in-house effort for over a month, which included personal letters to each of the defense appropriations subcommittee leaders (Republican and Democrat) urging them to include the McCain amendment in the conferenced version of the defense funding bill. We also sent out a grassroots action alert to APA members encouraging you to call and email your

congressional delegations and providing specific language to use during these contacts -- we have the capacity to track the results of this action alert and there were many more calls and emails on this issue than are typically sent by APA members. We also contacted Sen. McCain directly to thank him for his attention to human rights within the military context (I have worked with his office on a number of occasions and his staff have a high regard for APA's efforts in the clinical and policy arenas). APA felt so strongly about this human rights issue that we advocated very loudly at the subcommittee level despite the fact that we had funding for a new psychological training program up before this same subcommittee, and it was quite possible that the Republicans supporting this training program would drop it in light of our opposition to their stance against McCain. Our CEO, Norman Anderson, made it quite clear that advocacy for McCain was of paramount importance.

In addition, Steve Behnke has maintained a wonderful relationship with Physicians for Human Rights, and we worked with their staffer to coordinate APA's endorsement and sign-on to a letter to the Editor of the New York Times in favor of the McCain amendment at the height of Republican opposition -- the signers were Ron Levant on our behalf, the other APA, and the American College of Physicians. My email from home isn't letting me paste in directly, but the November letter stated:

"The intense government debate over the treatment of detainees, given its importance to our country as a whole, requires broad public participation. Recently, the American College of Physicians, the American Psychiatric Association and the American Psychological Association, together representing more than 300,000 members, have gone on record endorsing Senator John McCain's proposal to prohibit the 'cruel, inhuman or degrading treatment' of detainees. The fate of this proposal deeply concerns American health professionals. Our ethics codes condemn torture and cruel, inhuman and degrading treatment and prohibit health professionals from supporting such abuses.

If approved intact by Congress, the McCain amendment, by proscribing abusive treatment of all detainees in United States custody, would help ensure that our colleagues in the national security setting are never drawn into abusive, harmful or unethical interrogations and detention practices. Above all, it would eloquently clarify our country's values and our traditional, legal and moral commitment against torture and abuse." [signed by Ron and the leaders of ACP and apa]

I'm hoping this gives you a fuller sense of some of our activity in this arena, and we'll try to keep our ongoing work less quiet!

Best to you all,

Heather  
Heather O'Beirne Kelly, PhD  
Senior Legislative & Federal Affairs Officer  
Public Policy Office, Science Directorate  
American Psychological Association

**From:** Olivia Moorehead-Slaughter < >

**Date:** January 16, 2006 3:56:37 PM PST

**Subject:** Re: PENS work

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Dear Mike,

I am sorry to read your most recent submission to the PENS group in which you write of your intention to leave the Task Force. In true Mike Wessells style, you were most thoughtful and considered in your email and I "get" the depth of passion behind your words. I am sure that I do not speak only for myself in saying that I have highly valued the contributions that you uniquely bring to the Task Force and would be very sorry to see you leave. I do believe that each member was chosen with great deliberateness and care and that our continued ability to contribute (as I believe that we must) would be diminished by any one of the group leaving. That said, while gathering by conference call does not seem logistically possible this week due to disparate schedules, I do think that it is important for all of us to caucus by phone to talk together about all of the issues at hand, including the ones which you detail in your email. I would like for you to give the group an opportunity to respond to your thoughts about the work of the Task Force as well as APA prior to making a final decision about remaining with the Task Force. I fully expect that we will be able to schedule this conference call within the next several weeks and I would ask that everyone make every effort to facilitate this happening as the proposed times are circulated.

Our work is not done. Your sense of urgency and commitment to our profession's contributions and involvement in the area of national security are precisely why I would regret seeing you leave the Task Force.

I look forward to hearing from you.

My best.

Olivia

**From:** Mike Wessells < >

**Date:** January 17, 2006 3:37:14 PM PST

**Subject:** Re: PENS work

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Dear Colleagues,

Many thanks to Gerry, Ron, Heather, Barry, and Olivia for your thoughtful replies and encouragement to continue. I'm soon leaving the country for a month and am pressed on time. My decision remains unchanged but I'd like to respond briefly because the points made are serious and warrant attention.

Gerry, it's encouraging to see APA doing more as it has a key role to play professionally and in the public arena on these issues. The casebook under development will indeed be a significant long-term contribution. And I can well imagine the American Psychiatric Association doesn't yet have a coherent position. If they erred by having strong public statements issued prematurely, I'd respectfully suggest that our APA has erred in the other direction of excessive delay and quietness on key points. In the end, our reference point should not be what other associations say but the human rights standards to which we are collectively obligated. By that criterion, the Association remains subject to the points I raised. Early on, there should be strong statements condemning the use not only of methods that violate human rights but that are based on psychology. These should be coupled with assertive efforts to educate the public, our members, and policy makers about the damage done by use of methods such as sleep deprivation, hooding, etc. and to help people understand why particular methods may be even more damaging for detainees from cultures other than our own. There could have been an appeal to human rights as setting standards for all professions' ethics codes (and as trumping military



regulations where the latter fall beneath the bar set by international standards), but these things and many others did not occur.

Ron, I agree that APA's position has been mischaracterized in numerous venues, and this speaks poorly of the lack of professionalism in some journalistic portrayals. That said, things would have gone better had the APA made strong, unequivocal statements very early on along the lines mentioned above. Although PENS has made a contribution and has every prospect of continuing to do so, the strategy of having PENS carry the main burden of response to the situation faced was ill advised.

Heather, I'm very impressed with APA's support of the McCain Amendment and owe everyone involved in it a big "Thanks." It's also very encouraging to see the ongoing dialogue with Physicians for Human Rights. For me, what was missing was a concerted effort to achieve an independent, bipartisan inquiry into the allegations of human rights violations, with attention to the possible role of psychologists and medical personnel in that context. Even if we think whatever wrongdoing has occurred is past and corrective steps have been taken, it's essential to identify what had enabled the violations and to do so in ways that go beyond military investigations, valuable though they may be, too.

I realize these comments are too brief and am keenly aware that we will disagree on many points. Disagreement is often constructive, and I learned much through our discussions on PENS. In the end, though, I feel what I can contribute best comes from outside the process. Olivia, I very much appreciate your kind words and your stewardship of the PENS process. I hope you understand that my small action of conscience is not about PENS per se but its context and the Association responsibilities overall on these issues. Each of us makes difficult decisions about the most appropriate course and my decision has not been easy. Nevertheless, I stick by it in hopes of enabling our profession to make a wider contribution on the issues.

Many thanks for listening.

Mike

**From:** Olivia Moorehead-Slaughter < >

**Date:** January 18, 2006 1:40:59 PM PST

**Subject:** Re: PENS work

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Hi Mike,

Thank you for responding to our messages in spite of your travels. I totally respect your decision and the principles upon which you stand. Please know that I remain appreciative of your wise counsel during the first phase of the PENS process and look forward to your input as the Task Force proceeds with the next part of its work. I am sure that you will continue to make invaluable contributions in this area and I look forward to working with you again.

Olivia

**From:** Nina Thomas < >

**Date:** January 19, 2006 8:58:40 PM PST

**Subject:** Re: Greetings and update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security

<PENS@ >

Dear Olivia -

I have not received the notice of the conference call you want to hold but only have learned of it thru the copy of some members of the task force. Hence my late response which will be even later since I have to review my schedule about when I can have time to participate. Is there some glitch in my listing on the listserv that I didn't get your posting of Jan. 11?

Nina

Nina K. Thomas, Ph.D.

**From:** "Behnke, Stephen" < >

**Date:** January 19, 2006 9:09:06 PM PST

**Subject:** Re: Greetings and update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Hi Nina,

I will check to make sure that the listserve is working properly. Given everyone's schedules, we were not able to schedule the call as we had planned, so nothing has been missed.

Steve

**From:** Olivia Moorehead-Slaughter < >

**Date:** January 20, 2006 9:22:33 AM PST

**Subject:** Re: Greetings and update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Hi Nina,

Sorry to hear that you might not have been "in the loop." I think that this happened to you once before so it's worth doing a "test run" with Rhea perhaps to be sure that we have the correct information for you. Please let me know if you get this message. As for the conference call, it did not happen due to scheduling issues. Stay tuned.....

My best.

Olivia

**From:** Nina Thomas < >

**Date:** January 20, 2006 1:58:32 PM PST

**Subject: Re: Greetings and update**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Yup, I got this one and the weird thing is that I got the response from whoever it was who said he would be at sea tho not the original announcement. Who knows?

Nina K. Thomas, Ph.D.

**From:** "Gilfoyle, Nathalie" < >

**Date:** January 20, 2006 2:43:14 PM PST

**Subject: Re: Greetings and update**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

In postings this week to another APA list , those with aol accounts did not receive the postings. Nina I can't tell if that is an issue for you. The suggestion from our MIS department was to separately enter the individual addresses for those with aol email addresses. Apparently the problem is limited to listservs. Nathalie

**From:** Nina Thomas < >

**Date:** January 21, 2006 8:46:07 AM PST

**Subject: Re: Greetings and update**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Thanks to Nathalie suggesting that the difficulty in my getting the announcement from the listserv may have been an aol problem. May I ask if everyone who gets this would mind just sending me a response that has their individual email address on it so I can enter it and, I hope, assure that I get future listserv postings. Who knows wherein the gremlins lay?

Thanks,  
Nina

Nina K. Thomas, Ph.D.

**From:** "R. Scott Shumate" < >

**Date:** January 21, 2006 11:58:43 AM PST

**Subject: Re: Greetings and update**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Nina: Glad to hear you have the gremlin duct taped to the floor. Scott

**From:** Jean Maria Arrigo < >  
**Date:** January 21, 2006 9:12:10 PM PST  
**Subject:** Re: Greetings and update  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Here I am, Nina. Jean Maria  
On Jan 21, 2006, at 8:46 AM, Nina Thomas wrote:

**From:** "Col. Larry C. James PhD" < >  
**Date:** January 22, 2006 2:23:55 PM PST  
**Subject:** Re: Greetings and update  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Hi Olivia and everyone, I'm located in Hawaii which means that I am 5 hours behind EST. so an early afternoon time would be better for me. which would be around noon or 1 p.m. your time.  
thanks,

Larry

**From:** Nina Thomas < >  
**Date:** January 22, 2006 3:03:36 PM PST  
**Subject:** Re: Greetings and update  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

For whatever reason I seem to be getting postings very late. For example, I am only now getting Olivia's posting regarding a conference call (that I know did not take place) this past week. Are we attempting to hold one?  
Thanks,  
Nina

Nina K. Thomas, Ph.D.

**From:** "Banks, Louie M. COL" < >  
**Date:** January 23, 2006 6:10:08 AM PST  
**Subject:** Re: Greetings and update  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >



Nina,

I hope you are well, and that the gremlins are gone.

Morgan<

**P>COL L. Morgan Banks**

**Director, Psychological Applications Directorate**

**US Army Special Operations Command**

**DSN COM**

**From:** Olivia Moorehead-Slaughter < >

**Date:** January 23, 2006 8:13:25 AM PST

**Subject:** Re: Greetings and update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Thanks for letting us know this Larry. We'll keep this time difference in mind as we plan.

Olivia

**From:** Olivia Moorehead-Slaughter < >

**Date:** January 23, 2006 8:15:45 AM PST

**Subject:** Re: Greetings and update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Hi Nina,

We are planning a conference call in the coming weeks. You have not missed any important announcements concerning the scheduling of this call.

However, please let me know when you receive this message since timeliness seems to be a concern in terms of when you are getting messages through this listserve. Still tracking those gremlins.....

Olivia

**From:** Nina Thomas < >

**Date:** January 23, 2006 1:38:51 PM PST

**Subject:** Re: Greetings and update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

In a message dated 1/23/2006 8:42:09 AM Pacific Standard Time, writes:

Hi Nina,

We are planning a conference call in the coming weeks. You have not missed any important announcements concerning the scheduling of this call.

However, please let me know when you receive this message since timeliness seems to be a concern in terms of when you are getting messages

through this listserve. Still tracking those gremlins.....

Got it today. who understands these things?

N

Nina K. Thomas, Ph.D.

**From:** "R. Scott Shumate" <>

**Date:** January 23, 2006 5:50:47 PM PST

**Subject:** Re: For consideration

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Dear PENS Colleagues,

Like all of you, I'm sure, I feel that Mike's resignation is a considerable loss for our group. His thoughtful and principled approach was a great asset to our work, and our report bears his mark throughout. I'm very grateful for having had the opportunity to collaborate with him, and hope that he will stay involved with APA working on these important issues.

In thinking about Olivia's message and what remains to be done, I've had some thoughts I'd like to share. The basic thrust of my comments comes from the necessity of the practical considerations involved in what I believe is an excellent concept for a commentary and casebook. While I am enthusiastic about the idea in principle, as a practical matter I think we need to think very carefully about whether it makes sense for PENS to remain involved in the project.

First, in terms of vignettes, we would need to get the task force together and frame out the cases and how psychologists would consult on an interrogation. The process would be involved and require considerable amount of time developing the cases and putting sufficient depth to the material. This brings to mind a recent experience I've had, of writing an article for the Journal of Military Psychologist. As with all publicly released information, DoD and other Governmental officials have to have their work reviewed by various elements within the Government, and in this case specifically by the Department. While articles are frequently approved after going through the review, there is usually a certain amount of additional work that is required for final release. The problem is that this additional work usually requires considerations that the larger PENS group would not be cleared to consider. Since this is a group effort and the final product would end up being a combination of the larger PENS group and then final edits by the DoD members only, I began to recognize that our requirement to have the review by the Department would interfere, perhaps significantly so, with the group's joint efforts, given the likely length and complexity of the document we would be producing. Further, any changes by APA Ethics Committee and/or APA at large would have to be re-reviewed by the Department prior to release. This requirement is something we can not avoid, and could considerably prolong the process of producing this very important document.

The PENS task force was assembled to look at the ethical considerations of psychologists being involved as consultants to the interrogation process and successfully accomplished their mission, something I am very proud of. The

discussions and exchange of information was substantial and we produced the ethical recommendations as a group, with members from various viewpoints within APA having input. It was a wonderful learning experience and affirmation of the professionalism of psychologists and I think it speaks highly of every member of the PENS task force as well as the Ethics Committee.

At this time I offer for consideration that the PENS task force has accomplished what it was originally assembled to do. I think that all things considered, it may be best if APA's Ethics Committee undertake this next step, of putting together a Case Book independent of the PENS task force. The Ethics committee would be able to produce a casebook without this potentially lengthy and time consuming review.

I look forward to discussing my thoughts but also believe at the end of the day, most members of the PENS will recognize that this suggestion is the best alternative available.

**From:** "Banks, Louie M. COL" <>

**Date:** January 25, 2006 10:47:16 AM PST

**Subject:** Re: For consideration

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

PENS Colleagues and friends,

Like you, I have been reading the messages on the list serve very carefully. I am saddened by Mike's decision, but I know that his voice will continue to be heard on this issue. I know that I benefited greatly from my discussions with Mike, and believe that his input was essential to the report.

The topic that Scott addresses is another that I have been struggling with since our last meeting. I must provide clear guidance to the Army psychologists I supervise in this area, and have done so. This guidance includes both ethical and technical supervision. The Task Force report has been crucial in formalizing the ground rules for their work in this area. As I continue to develop specific guidance for my psychologists, to include examples, a significant problem has developed. All of my examples and commentary are classified, and cannot be shared outside of the DoD community. I have tried to figure a way around this, but without success. Although it may be possible for us to come up with some hypothetical examples, it does not look possible that I could add any of my actual examples, at least at present. As I read Scott's thoughts, I am unfortunately heading in the same direction. Writing up examples may become very difficult for those of us in DoD. I am leaning in favor of asking the APA Ethics Committee to consider writing up the casebook. I must add that not only am I honored to have participated up to this point, but will continue to participate in any way that I can be of use. I am very interested in what the rest of the PENS Task Force thinks about this.

Morgan

**COL L. Morgan Banks**  
**Director, Psychological Applications Directorate**  
**US Army Special Operations Command**

**From:** Olivia Moorehead-Slaughter < >  
**Date:** January 26, 2006 4:37:26 AM PST  
**Subject:** response

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Hello Everyone,

Just a brief response to the messages sent by Scott and Morgan. They have indeed identified some serious complexities at this juncture for several of you on the Task Force. Moving forward at this point with a Commentary from PENS is seeming less and less feasible. It is certainly possible that the Task Force has made its contribution to this process and that now it is best for the Ethics Committee to complete this work. I would love to hear from other members of the Task Force and appreciate the time and energy that you all continue to give in the midst of your very busy lives.

My best.

Olivia

**From:** "Gerald P. Koocher, Ph.D." < >  
**Date:** January 26, 2006 7:50:17 AM PST  
**Subject:** Re: response

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Olivia Moorehead-Slaughter wrote:

Hello Everyone,

Just a brief response to the messages sent by Scott and Morgan. They have indeed identified some serious complexities at this juncture for several of you on the Task Force.

It seems to me that since the APA Ethics Committee is the only group charged by the APA By-laws to interpret the ethics code, one logical alternative would be to fund the ethics committee to draft the commentary. They could then circulate the commentary to this group and other groups as well. People could provide public or private comments back to the committee, which could take them into account. In that way both our members with institutional constraints and other interested persons could have input without having to deal with bureaucratic constraints.

Gerry

**From:**



**Date:** January 26, 2006 9:56:03 AM PST

**Subject:** On the PENS case book

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

[Olivia, it appears you did not receive the message I sent last night to forward to the Task Force, so I will attempt to rewrite it in brief from my hotel computer.]

Colleagues:

Many critics of the PENS report have complained of the majority membership from the military, 6 of 10 members. I have defended this composition of the Task Force on the grounds that strong military participation is necessary for the Task Force to have any practical relevance to the national security system.

The Task Force was appointed because the Ethics Committee lacked the background and expertise to address the PENS issues by itself. The Ethics Committee similarly cannot produce a valid and relevant casebook for the PENS report. Without such a casebook, the PENS report could be considered a list of platitudes, like an injunction to love one's neighbor without any models. I think it is time for the military members to justify their predominance on the Task Force by helping to produce the casebook. Yes, there are institutional difficulties, but confronting these difficulties is a crucial ethical process. The military and CIA have not been able to prosecute adequately its officers for homicides of detainees and illegal torture for institutional reasons, and the comparison will not be lost on PsySr and Div. 48 critics of the Task Force. I could provide interrogation case histories to the Ethics Committee from my oral histories, but only the current military members could present the standards now deemed appropriate. And I think the military would rather have more common examples explained than the outliers that are likely to arise from volunteered sources.

The casebook was offered at the PENS meeting in DC to mitigate my concern about the weak relevance of the report. This concern has only increased for me and others.

I am writing to you from the Joint Services Conference on Professional Ethics in DC, where I am co-organizer of the follow-on conference Ethics and Intelligence 2006.

Jean Maria

**From:** Olivia Moorehead-Slaughter < >

**Date:** January 27, 2006 6:38:07 AM PST

**Subject:** Fwd: PENS-Reply to Schumate & Banks

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

----- Original Message -----

Thursday, January 26, 2006 4:33:49 AM

Message

From: < >

Subject: PENS-Reply to Schumate & Banks

To: Olivia Moorehead-Slaughter

Dear Olivia, I am writing from hotel WEB access and unable to send a group message to the Task Force. Please forward my message to the group, including Steve Behneke. Thank you. Jean Maria

**From:** "Gerald P. Koocher, Ph.D." < >

**Date:** January 27, 2006 9:46:47 AM PST

**Subject:** Casebook on Psychological Ethics and National Security

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

I feel the need to respectfully correct some of Jean Maria's statements.

#1 - By my count only 3-4 of the participants in the PENS task force qualify as military personnel (i.e., Morgan, Larry, Bryce, and possibly Michael; I'm not sure whether Michael is active duty military or a civilian employee of NCIS).

Scott is a civilian expert working for the Department of Defense.

Robert is a private consultant who has advised a wide range of civilian (e.g., police, Secret Service, etc.) and military security agencies, but is not a military employee.

Jean Maria, Olivia, Nina, and Mike have no military or defense connections that I know of, and neither Barry nor I (who served ex officio) have any.

Therefore, Jean Maria, your assertion regarding a "military majority" is factually inaccurate and potentially misleading in an inflammatory (albeit unintentionally so) manner. Please correct that misconception in any future communications with outside groups.

#2 - The Ethics Committee not only has the knowledge, but also the mandate necessary to produce the casebook. Members have significant expertise in trauma as well as psychological and biomedical ethics. It includes a public member (i.e., pulmonary physician with expertise in bioethics) and at least one member with personal and family experience with concentration camps, torture, and political imprisonment. It also includes a faculty member who teaches ethics at one of the U.S. military academies.

The mandate of the committee per the APA Bylaws states:

"Members of the Ethics Committee shall be selected to represent a range of interests characteristic of psychology. The Ethics Committee shall have the power to receive, initiate, and investigate complaints of unethical conduct of Members (to include Fellows), Associate members, and Affiliates; to report on types of cases investigated with specific description of difficult or recalcitrant cases; to dismiss or recommend action on ethical cases investigated; to resolve cases by agreement where appropriate; to formulate rules or principles of ethics for adoption by the Association; to formulate rules and procedures governing the conduct of the ethics or disciplinary process..."

Bottom line: the APA Ethics Committee has much broader expertise in application and interpretation of psychological ethics across a wide range of settings and contexts than the more narrowly formed PENS task force.

#3 - There is nothing to prevent the Ethics Committee from seeking broad input from Jean M aria (i.e., torture case narratives) or other experts, and I would expect them to do so, as they have done historically in generating other case books and guidance documents.

#4 - Having the case book originate with the Ethics Committee maximizes authoritative interpretation of the code, enables rapid formulation of any needed changes to the code, and permits others who by virtue of employment status or other official roles might not be allowed to have their names associated as authors or contributors to the report. The net effect will be to ensure the broadest possible input to the process.

Regards,

Gerry

Gerald P. Koocher, Ph.D. ABPP  
Professor and Dean  
School for Health Studies  
Simmons College  
President, American Psychological Association

Editor, *Ethics & Behavior*

Visit: [www.ethicsresearch.com](http://www.ethicsresearch.com)

From: "Gelles, Mike" < >

Date: January 27, 2006 1:37:05 PM PST

Subject: Re: Casebook on Psychological Ethics and National Security

Reply-To: Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Mike Gelles is a civilian.

-----  
Sent from my BlackBerry Wireless Handheld

**From:** "Gerald P. Koocher, Ph.D." < >  
**Date:** January 28, 2006 10:06:39 AM PST  
**Subject: Re: Casebook on Psychological Ethics and National Security**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Aha! I thought so. Gerry

Gelles, Mike wrote:

Mike Gelles is a civilian.

Sent from my BlackBerry Wireless Handheld

**From:** "Gelles, Mike" < >  
**Date:** January 30, 2006 12:34:17 PM PST  
**Subject: Re: Casebook on Psychological Ethics and National Security**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

For the sake of reply. I too am in agreement that the APA Ethics Committee should pick up where the PENS Task force has left off. I do believe a casebook is necessary and not in complete agreement with some of the other DOD folks regarding examples. While it is true that specific content of cases cannot be included the themes, tactics and techniques can be illustrated in examples which have been published in several recent publications. I look forward to supporting the APA Ethics Committee from the perspective of providing examples for the case book.  
Mike Gelles

**Michael G. Gelles, Psy.D.**  
Chief Psychologist  
Naval Criminal Investigative Service

**From:** Olivia Moorehead-Slaughter < >  
**Date:** January 30, 2006 12:51:01 PM PST  
**Subject: Re: On the PENS case book**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Hi Jean Maria,



I have now received both messages. Thanks for "doubling back" just in case!

Olivia

**From:** Nina Thomas < >  
**Date:** January 30, 2006 6:37:39 PM PST  
**Subject:** Re: Casebook on Psychological Ethics and National Security  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

In a message dated 1/30/2006 12:45:39 PM Pacific Standard Time, writes:

While it is true that specific content of cases cannot be included the themes, tactics and techniques can be illustrated in examples which have been published in several recent publications

Interesting difference in interpretations on this. So do we assume the decision is to leave to the Ethics Comm. the task of developing the commentary?  
Nina

Nina K. Thomas, Ph.D.

**From:** "Gelles, Mike" < >  
**Date:** January 31, 2006 4:33:13 AM PST  
**Subject:** Re: Casebook on Psychological Ethics and National Security  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Nina

Attached is a book chapter on interrogation from a recently published book on Investigative Interviewing. It contains some techniques and themes. I will provide the cite of Journal of Psychiatry article when available due out this Spring. I believe that the task of writting a casebook should be executed by the Ethic Comm..My view is that while there is much information that is sensitive, the topics that lend the greatest concern on interrogation and indirect assessment do not have to remain a mystery, and that there are a number of ways to demonstrate that what psychologists do in the service of national security is not a secret. I believe for both psychologists in law enforcement and the intelligence community there needs to be some degree of exchange with our colleagues outside our community so not to end up so isolated that the relationship between national security psychology and psychology as a whole becomes adversarial.

Mike

Michael G. Gelles, Psy.D.  
Chief Psychologist

Naval Criminal Investigative Service

**From:** Nina Thomas < >

**Date:** January 31, 2006 6:52:11 AM PST

**Subject:** Re: Casebook on Psychological Ethics and National Security

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

THanks Mike for sending along the chapter....I look forward to reading it. Hope you are well,  
Nina

Nina K. Thomas, Ph.D.

**From:** Olivia Moorehead-Slaughter < >

**Date:** January 31, 2006 7:06:05 AM PST

**Subject:** continued discourse

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Hello Everyone,

There seems to be an emerging consensus that the Ethics Committee is the appropriate body to continue this work. However, I would very much like to hear from other members of the Task Force who have not posted a message about this before a final decision is made.

Olivia

**From:** "Col. Larry C. James PhD" < >

**Date:** January 31, 2006 8:14:45 AM PST

**Subject:** Re: continued discourse

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

I to believe that it is best for the ethics committee to do the casebook. I would also welcome the opportunity to participate.

Thanks,

Larry

**From:**

**Date:** January 31, 2006 9:38:32 AM PST

**Subject:** Re: continued discourse

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security

<PENS@ >

Dear Olivia and Colleagues,

Here are a smattering of observations, reflections, opinions and ideas:

1. As long as there were non-attribution regarding where and from whom any hypothetical story or vignette came from, I see no harm in participating in a case book. In fact I would hope that those of us who have experience in these matters would participate. The standard disclaimers about "no actual person or event" should apply. I have no particular opinion as to whether the ethics committee or PENS (or both) is the appropriate author of the casebook. And I have some stories or examples to contribute.

2. I want to participate and I believe that no real change or growth is possible without thoughtful, experienced, concerned psychologists working together, articulating positions, and participating. I would not withdraw simply because I did not like what was going on.

3. In fact the PENS meeting was a steep learning curve for me in that it was a far more political process than I anticipated and I had hoped that we would have worked out our positions via intellectual or philosophical debate. When I brought up the idea of harm, and what is harm, it fell on deaf ears. I pointed out that behavioral and psychological techniques used in training our high-risk-of-capture students in Survival Schools are viewed as vital, necessary, good, and for the greater good. Psychologists are strong proponents of these techniques even though they inflict psychological and physical pain. Yet the very same behaviors are proscribed by the Department of Defense and viewed as harmful when applied to America's prisoners. Neither this topic nor any specific example was addressed by PENS. Now it is clear that specific examples must be addressed.

4. I know that I reveal my naivete --and I have been naive on political matters my entire life. Yet I also know that the political process has tremendous shortcomings--especially when it comes to three wolves and a sheep deciding on what to have for lunch.

5. As a "happy idiot," I view things simply: For me to follow what is going on, our basic philosophies must be understood and out on the table. These philosophies lead to positions. Context determines meaning in behavior. Identical behaviors viewed as beneficial in training are viewed as harmful in other contexts. For example, if one has the philosophy that all violence is bad and therefore any participation in the military is wrong, then any participation by psychologists in the military is also wrong. This would be a pacifist position. I do not subscribe to this philosophy--yet I know it well from my father, an ethicist, who acquired this ideology from his church (Church of the Brethren).

6. Lastly (for now), the fundamental meanings of morals (mores) and ethics (ethos) is the ways of the people, the ways of the community, and the values of the community. To some extent, "ethics" has also implied a codified version of these values (which true of the APA). These words--morals and ethics--do not mean "the ways of the individual" or individual rights. Any time the rights of the individual are placed above what is best for the community, it is, by definition, unethical or immoral.



The discussion of individual rights is the domain of "human rights" organizations (like ACLU). I grant that most of the time, that which is good for the individual is also good for the community--but not always. But it frustrates me when attempts are made to trump ethics with individual rights--it confuses the issue.

Bryce Lefever, Ph.D. ABPP  
CAPT MSC USN  
Department Head  
Substance Abuse Rehabilitation Program  
Naval Medical Center Portsmouth, Virginia

**From:** Robert Fein < >  
**Date:** January 31, 2006 11:19:11 AM PST  
**Subject:** Re: continued discourse  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Colleagues,

I think it is a wise decision for the Ethics Committee to take responsibility to write the casebook and commentary. Like others, I would be glad to try to contribute if the Ethics Committee sees fit.

Sincerely,

Robert Fein

**From:** Olivia Moorehead-Slaughter < >  
**Date:** January 31, 2006 2:48:39 PM PST  
**Subject:** our next steps  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear PENS colleagues,

Thank you for contributing such thoughtful messages about the role of the PENS task force in the casebook/commentary writing process. Each of you has given a great deal of your time and energy to our important work, and it is clear that you all will continue to be available to contribute your talents. In reading over your posts, I feel comfortable in reaching two conclusions. First, all of you think that this project is a challenging and worthwhile endeavour for APA, the field of psychology, and society. I wholeheartedly agree. To a person you have offered to continue to participate in the project and I think that is critical. Each of you has important contributions to make, and I see your contributions as essential to a successful casebook/commentary.

My second conclusion is that a consensus has emerged among our group, that the Ethics Committee should take responsibility for this project. While our feelings about



handing the project over to the Ethics Committee are complex and not unitary, a majority believe that this transition would work best for them and would alleviate a potentially burdensome process of approval and clearance that could play a significant role in the project moving forward in an expeditious manner. For my own part, it seems important to consider that our Report was based on the Ethics Code, and the Ethics Committee has the authority (in fact, alone has the authority) to say what the Code means. Also, the Ethics Committee has the authority to include whomever they deem appropriate in the writing process, and as chair of the Committee I can assure you that the Committee will reach out to each of you individually for your assistance.

I will write a letter to Ron and Gerry, and post on the list tomorrow for your review.

Warmly,

Olivia

**From:** Olivia Moorehead-Slaughter < >  
**Date:** February 1, 2006 6:35:10 PM PST  
**Subject:** letter

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear PENS Colleagues,

In yesterday's message, I said I would post a letter to Gerry and Ron concerning our thinking as a group. Attached please find the letter I have written. I welcome any of your comments.

Warmly,

Olivia

[See PENS LETTER 0206.]

**From:** "Col. Larry C. James PhD" < >  
**Date:** February 1, 2006 8:59:55 PM PST  
**Subject:** Re: letter

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Hi Olivia,  
a very well written letter.  
thanks,

Larry

**From:** Jean Maria Arrigo < >

**Date:** February 1, 2006 9:53:29 PM PST

**Subject:** Fwd: [PRESIDENTIAL] letter

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Olivia,

It is a beautifully written letter on behalf of the Task Force majority. I would like to append a minority statement on behalf of Mike Wessells and myself, in disagreement with the assertion, "At this point in time, the PENS Task Force believes that it has provided the American Psychological Association the best service it is able ...." Mike, after all, resigned because he believed the Task Force fell far short of its ethical obligation, and I expressed strong reservations. I have just returned from a long conference trip but will write this minority statement in the next day or two. Thanks very much.

Jean Maria

**From:** "Gelles, Mike" < >

**Date:** February 2, 2006 4:32:38 AM PST

**Subject:** Re: Fwd: [PRESIDENTIAL] letter

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Olivia,

Thanks. I agree with Larry it was a very nice letter.

Michael G. Gelles, Psy.D.  
Chief Psychologist  
Naval Criminal Investigative Service

**From:** "Banks, Louie M. COL" < >

**Date:** February 2, 2006 4:47:13 AM PST

**Subject:** Re: letter

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Olivia,

The letter craftfully captures what I believe the Task Force achieved, and points us all in the direction of future collaboration. I strongly support it.

Morgan  
COL L. Morgan Banks  
Director Psychological Applications Directorate  
US Army Special Operations Command  
DSN COM

**From:** "Gerald P. Koocher, Ph.D." < >

**Date:** February 2, 2006 5:28:54 AM PST

**Subject:** Re: Fwd: [PRESIDENTIAL] letter

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Jean Maria Arrigo wrote:

Dear Olivia,

It is a beautifully written letter on behalf of the Task Force majority. I would like to append a minority statement on behalf of Mike Wessells and myself, in disagreement with the assertion, "At this point in time, the PENS Task Force believes that it has provided the American Psychological Association the best service it is able ...." Mike, after all, resigned because he believed the Task Force fell far short of its ethical obligation, and I expressed strong reservations. I have just returned from a long conference trip but will write this minority statement in the next day or two. Thanks very much.

Jean Maria

Mike chose to resign and publicize that step. I respect his personal position, but he did resign. It seems a bit over the top to now write a "minority statement" purporting to represent him.

I suggest you simply write whatever you want on behalf of yourself.

Gerry

**From:**

**Date:** February 2, 2006 7:37:38 AM PST

**Subject:** Re: letter

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Olivia,  
Well done.  
Bryce

**From:** Olivia Moorehead-Slaughter < >  
**Date:** February 3, 2006 8:51:02 AM PST  
**Subject:** to everyone

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear PENS Colleagues,

Thank you for your comments. Jean Maria has indicated that she would like to provide an additional statement, and I want to ensure that anyone on PENS who would like to do so has this opportunity. I think it makes most sense to set a date certain, and I will forward your collective statements/comments to Ron and Gerry. Realizing how busy everyone is, but also that we don't want an undue delay in bringing our work to a close, I am going to suggest Monday, February 13 as the date on which I should receive whatever you would like to have included. Please tell me if you think you would need additional time; I would like to be both flexible and timely.

Warmly,

Olivia

**From:** "Gerald P. Koocher, Ph.D." < >  
**Date:** February 3, 2006 9:27:11 AM PST  
**Subject:** Re: to everyone

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Olivia Moorehead-Slaughter wrote:

I want to ensure that anyone on PENS who would like to do so has this opportunity. I think it makes most sense to set a date certain, and I will forward your collective statements/comments to Ron and Gerry. Realizing how busy everyone is, but also that we don't want an undue delay in bringing our work to a close, I am going to suggest Monday, February 13 as the date on which I should receive whatever you would like to have included.

I agree completely.

We can then make sure that any individual comments are provided to the Council prior to their discussion of the PENS report.

Gerry

**From:** Jean Maria Arrigo < >

**Date:** February 12, 2006 10:18:45 PM PST

**Subject:** PENS - Addendum to Casebook Letter

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

**February 12, 2006**

Dear Olivia,

Please attach to your February 1, 2006, letter to Drs. Koocher and Levant, Mike Wessells' letter of resignation from the Task Force and my letter below, for a representation of the minority voices on the original Task Force. Mike withdrew on January 15, 2006, because continuing work with the Task Force tacitly legitimates the wider silence and inaction of the APA on the crucial issues at hand. Below, I outline my disagreement with the majority opinion in your letter.

I appreciate your graciousness as moderator.

Jean Maria

=====

Addendum to Dr. Morehead-Slaughter's February 1, 2006, letter to Drs. Koocher and Levant on behalf of the PENS Task Force

I disagree with two major assertions in this letter: (1) that the Ethics Committee is the most appropriate group for writing the casebook/commentary, and (2) that the Task Force has provided the American Psychological Association the best service it is able. Also, I remark on two related concerns: (3) lack of independence of the Task Force and (4) lack of Task Force transparency.

**1. Authorship of the casebook.**

Creation of the casebook is more demanding of specialized knowledge concerning interrogations than is articulation of the general ethical principles, because of the legal and political ramifications. Task Force members whose defense department affiliations prevent them from participating in the casebook can defer to their colleagues and myself to provide realistic examples for the casebook and to assist the Ethics Committee in formulating realistic advice. Without the participation of the Task Force members with defense department affiliations, the ecological validity of the casebook is apt to be low or absurd. What psychologists know about culture, setting, organizational roles, social influence, and so on, points to the need for insiders to provide the sample cases from domains clouded in secrecy. In my view, a body of illustrative examples for the Final Report is a crucial contribution of Task Force members affiliated with the national security system and would justify their majority presence on the Task Force.

**2. Task Force fulfillment of service**

For best service to the APA, from the beginning I have urged that the Task Force expand the scope of its inquiry. The Final Report narrowly focuses on ethical decision making by morally autonomous military psychologists faced with interogatees at a detention center under U.S. authority. This scenario captures only a fragment of

psychological ethics related to interrogation of terrorist suspects. Central topics are missing: (a) interrogation outside of premises controlled by the U.S. military, where interrogators and consultants have to maneuver gingerly with foreign counterterrorist police and military units; (b) utilization of Behavior Specialists, mental health counselors, and other paraprofessionals trained in psychology, who may easily be substituted for psychologists; (c) career and financial pressures on psychologists, for instance, on recipients of national security scholarships, fellowships, and internships; and (d) other institutional arrangements that may support psychologists unethical participation in interrogation, for opportunities and procedures persist in large bureaucracies. I think that the model of the morally autonomous psychologist in the U.S. detention center, as put forth in the Final Report, will fade as soon as realistic cases are examined.

### 3. Independence of the Task Force as an advisory body

APA sources have consistently characterized the Final Report as the product of deliberations by the ten named members of the Task Force. Dr. Koocher voiced strong opinions on the Task Force listserv and during the final deliberations in Washington. There was a continuous presence of APA functionaries, as informational resources, at the other end of the conference table. I presume these circumstances accord with APA by-laws and traditions. Nevertheless, any implication that the Task Force served as an independent advisory body to the APA President is simply false.

In my view, the external social pressure prevented the Task Force from reviewing the ethical implications of its limited mandate, a mandate that excluded investigation of the participation of psychologists in coercive interrogation.

The present letter from the Task Force chair, addressed to Drs. Levant and Koocher, informs Dr. Koocher of a decision in which he substantially participated.

### 4. Transparency of the Task Force

Confidentiality of Task Force proceedings was advanced on two grounds: the members with national security affiliations could not sufficiently inform our deliberations except under a promise of confidentiality, and a united Task Force position would diffuse divisive and counterproductive criticism of the APA, both from within and without. I think the first reason was valid, but the second has worked against resolution of the question of psychologists involvement coercive interrogation. To many APA members, as evidenced by public letters from Divisions 48 and 51, the Task Force appears to be a tool of appeasement, created by the APA leadership to obscure members demands for an investigation. Honest discussion from Task Force members about the conflicted proceedings (preserving confidences related to national security) would have been much more fruitful than the gag rule. Such discussion would have been a valid step in addressing members concerns. We can still take that step.

Jean Maria Arrigo



**From:**

**Date:** February 13, 2006 5:27:34 AM PST

**Subject:** Re: PENS - Addendum to Casebook Letter

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

I must confess that I do not know what "morally autonomous" means.  
Bryce Lefever

**From:** Olivia Moorehead-Slaughter < >

**Date:** February 13, 2006 10:27:20 AM PST

**Subject:** Re: PENS - Addendum to Casebook Letter

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Jean Maria,

Thanks for sending me your letter. Mike's letter has already been forwarded to Council.

My best.

Olivia

**From:**

**Date:** February 15, 2006 11:21:34 AM PST

**Subject:** FW: LeFever - "Moral autonomy" & ref request

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Jean Maria,

Thank you for your reply. I am forwarding this string so that this discussion remains inside the fold. I am still confused about "moral autonomy." This phrase, to me, is an oxymoron. While I may be physically or geographically separated from my colleagues, family, church, or community, I am not separated by our common morality. If my choices are independent or autonomous of the groups to which I belong, then I am behaving immorally, independently and selfishly. Moral behavior is never "autonomous." It is always connected to the community. Any "autonomous" choice may or may not be in keeping with the community values (e.g. APA) to which I adhere--and the extent to which a choice is egregious (out of the flock) it is unethical. If I faced an adverse or hostile situation--if there were, in the immediate environment, pressures on me to behave contrary to my sworn codes--I can do my utmost to resist those and behave morally. This takes courage. Some call it moral courage.

Regarding your journal article and the question as to whether U.S. troops, or any person can hold out for a day under torture, the answer is--there is no guarantee. By "counterinterrogation" I presume you mean *resistance*, and we do train US troops in *resistance techniques*. There have been many instances of brave, heroic Americans holding out under extreme torture for several days, a week, perhaps longer. And there are many examples where these same Americans managed to resist for only a few minutes. Read When Hell Was in Session, by Jeremiah Denton, or In Love and War, by James B. Stockdale for many examples of resistance under torture. Even Admiral Stockdale, who was awarded the Medal of Honor for his extraordinary resistance and leadership while in prison for 7 years in the Hanoi Hilton, capitulated as soon as his captors re-broke his left knee. This took only a matter of minutes. A person's ability to resist is due to many factors and may change over time and circumstances. Some patriotic American military personnel are not able to muster adequate resistance even in a training environment and may talk way too freely in much less than 24 hours. So, again, there is no guarantee that 24 hours could be maintained--and no guarantee that the "broken" captive will do anything but tell the truth when broken. You may quote me by name on this.

Take care,  
Bryce

**-From:** Jean Maria Arrigo [mailto: ]  
**Sent:** Tuesday, February 14, 2006 1:22 PM  
**To:** LeFever, Bryce E. (CAPT)  
**Subject:** LeFever - "Moral autonomy" & ref request

Bryce,

"Moral autonomy" roughly refers to the ability to make moral decisions independently, without overriding controls, debilitating conditions, concealed causes and consequences, etc. As a role player in organizations with strict behavior codes and much supervision, e.g., as a Carmelite nun, a person may be acting very morally yet still not exercise much moral autonomy. In Nazi concentration camps, there was also not much scope for moral autonomy by guards, but a few

For a personal example, in the mid-80s I took part in a 3-week human rights march in Third World country. This was a considered act of moral choice, at considerable sacrifice of resources. Once involved though, options quickly diminished. Our passports were held for safety in an administration van, with the result that members could not leave at one of the spare and unpredictable transportation opportunities. A military unit accompanied us, to protect us from insurgents, which cast us in an unintended political position. False rumors and news reports abounded. We were cut off from valid information about the effects of our march. Saboteurs within the march corrupted our governing process and skewed our activities. That's when I swore off group peace activism.

Can you provide any reference for the expectation that U.S. or other troops trained in



counterinterrogation techniques will hold out for a day under torture interrogation, so as to give their colleagues time to regroup before they leak information? I need this for a paper with philosopher Vittorio Bufacchi on the ticking-bomb scenario, soon to go to press in the *Journal of Applied Philosophy*. Or just confirmation of this point from you, if I remember correctly, would be enough. I could give the citation: "Anonymous personal communication from a trainer of counterinterrogation techniques," if you didn't wish to be named. Of course, if I am wrong on this point, please correct me.

Thanks very much.

Jean Maria

**From:** Olivia Moorehead-Slaughter < >

**Date:** February 15, 2006 11:57:05 AM PST

**Subject:** Fwd: note for your letter to Drs. Levant and Koocher

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

FYI---To keep all of you in the loop..... Regards, Olivia.

----- Original Message -----

Tuesday, February 14, 2006 4:52:36 PM

Message

**From:** Robert Fein < >

**Subject:** note for your letter to Drs. Levant and Koocher

**To:** Olivia Moorehead-Slaughter

**Cc:**

**Attachments:** Attacho.html 3K

Dear Olivia,

Below is a note that I request be appended to your letter to Drs. Levant and Koocher.

Thanks very much.

Robert

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February 14, 2006

Olivia Morehead-Slaughter, PhD

Chair, Presidential Task Force on Psychological Ethics and National Security

Chair, Ethics Committee

American Psychological Association

Dear Olivia,

As someone who was privileged to serve on the PENS Task Force and who as a psychologist has worked for the last 30 years in areas concerned with preventing violence, I write to affirm what many consider to be a thoughtful, nuanced, reflective task force report. The discussions of Task Force members were respectful, detailed, and vigorous. They were managed with grace and sensitivity by the Chair and assisted by the technical expertise of APA staff.

In my view, the PENS Task Force Report charts a responsible course toward an uncertain future, delineating the bounds of ethical behavior for psychologists working in the area of national security while providing opportunities for psychological knowledge and expertise to be ethically utilized in the service of keeping this country and its citizens safe.

Sincerely,

Robert

Robert A. Fein, Ph.D.  
Member, PENS Task Force

**From:** Olivia Moorehead-Slaughter < >  
**Date:** February 16, 2006 4:45:51 AM PST  
**Subject:** letter

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

FYI--- This letter will be sent along with the letters from Jean Maria and Robert to Gerry Koocher and Ron Levant. Warmly, Olivia.

February 15, 2006  
Gerald P. Koocher, PhD  
President, American Psychological Association  
Ronald F. Levant, EdD, ABPP, MBA  
Past President, American Psychological Association  
Dear Drs. Koocher and Levant,

I am attaching two letters that individuals who served on the Presidential Task Force on Psychological Ethics and National Security have requested be appended to my February 1 letter to you. The opportunity to submit a letter in this fashion was given to all Task Force members, and it is my understanding that these materials will be provided to Council. I think it is appropriate to clarify two statements in these letters. First, the Task Force decided that its proceedings would be confidential. The purpose of confidentiality was to allow a free exchange of ideas and to promote robust discussion and debate. Political considerations were not advanced in any fashion as a basis for confidentiality. Second, the Task Force was given a specific mandate, to determine whether the Ethics Code adequately addresses the ethical dilemmas that arise in a particular area of practice. The Task Force worked very hard and efficiently to answer this question, and produced a report over a single weekend's meeting. Had

Task Force members wished to raise additional issues for discussion following completion of the Task Force report then I, as Task Force chair, would have wholeheartedly supported engaging in further discussions about any aspect of our work that members felt important to consider and convey to APA.

Sincerely,  
Olivia Moorehead-Slaughter, PhD

**From:** Jean Maria Arrigo < >  
**Date:** February 16, 2006 8:56:22 PM PST  
**Subject:** Re: letter

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Olivia,

Although I found the Task Force proceedings significant and rewarding, I did not come away with the same impression on either of your points below.

On the first point, concerning confidentiality and political considerations, I recall much concern at our Sunday meeting that the Task Force present a unified position to the public. A few authorities were designated as spokespersons, including Steve Behneke, an APA public relations person, and possibly yourself. The rest of us were to direct all public inquiries to the spokespersons. In another context, I recently faced a similar dynamic. The eight organizers of the January 27-28 conference Ethics & Intelligence 2006 received many inquiries from domestic and foreign reporters. Because of the explosive potential of this conference, with both intelligence insiders and outsiders, we considered funneling a prepared press release through a single spokesperson. After discussion, we finally decided on free communications with the media by all organizers. I understand the stakes, but I think that the Task Force and APA leadership made a disadvantageous choice in the long run.

On the second point, concerning freedom to discuss the limits of the Task Force mandate, I quote a passage from Pres. Koocher's July 10, 2005, letter to me on the Task Force listserv:

Nonetheless, some of your comments above go well beyond the scope of the assigned task force mission (e.g., interrogation outside of premises controlled by the military, historical examples...and procedures in large bureaucracies, and demographics of military personnel). If you were dissatisfied with the scope of work defined for the task force, you could have chosen not to serve. However, it is grossly inappropriate (in my opinion) to criticize the product or the group for staying within its assigned parameters.

Mike Wessells' letter of resignation also expressed grave concern with our assigned parameters because the APA treated the Task Force Final Report as its entire response to members' concern about psychologists' participation in coercive interrogation. As a matter of ethics, I think it is always proper for an appointed task force to assess the implications of accepting the parameters as assigned. Otherwise, a task force may easily be guided for political purposes. As an illustration, President Clinton's Advisory



Committee on Human Radiation Experiments agreed to consider only experiments performed within the United States. The Advisory Committee therefore refused to hear testimony about human radiation experiments designed by U.S. government officials and performed abroad, the data then returned to U.S. scientists for processing. The National Association of Radiation Survivors, the National Association of Atomic Veterans, and other advocacy groups accused the Advisory Committee of participating in the coverup because it stayed within its assigned parameters. Assessment of its assignment shows accountability and enhances the moral legitimacy of a task force.

Thank you for hearing me out a second time.

Jean Maria

**From:** Jean Maria Arrigo < >

**Date:** February 21, 2006 12:35:13 PM PST

**Subject:** PENS - Moral autonomy again

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Bryce,

Back to moral autonomy, this has to do with whether behavior is principally governed by character or situation. Whole books have been written on the topic. Empirical studies show that forceful environments, ambiguity of the situation, secrecy, and distance from familiar moral guideposts (family, church, etc.) tend to tip the scales in favor of situation. I think that the presumption that character is the primary determinant of moral behavior at interrogation centers would need much support, although I am aware of the JSCOPE view that the character of officers is primary in all situations.

Regarding initial resistance to torture interrogation, a historian told me that agents of the French Resistance were committed to 48 hours of stoicism under Nazi torture interrogation, so that their colleagues could regroup and change plans. So few survived, the historian said, that their actual performance could not be gaged. A Black member of an opposition group in South Africa in the 1980s told me that members of his group committed to 24 hours of resistance to torture. He had been arrested and tortured three times, and he thought his colleagues generally managed to hold their secrets for 24 hours. The limited time period was no doubt a morale booster. If one could hold out for a day or two, then at least one could keep one's honor and envision one's comrades safe. Protecting the shifting plans of a small team would be very different from protecting the secrets of a settled government though. Maj. Bill Casebeer, USAF intel, agrees with the picture you present. Thanks for your help.

Jean Maria

**From:** Olivia Moorehead-Slaughter < >

**Date:** February 22, 2006 9:16:44 AM PST

**Subject: Greetings and Update**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear PENS Colleagues,

I wanted to let all of you know that the PENS Task Force Report update was very well received this past weekend at the APA Council Meeting. I presented our work before the entire Council and had an opportunity to have many individual conversations with members both before and after the presentation. They were impressed with the clarity of purpose that the report communicated, the collegial tone of our deliberations, and the level of investment that all of you showed in bringing the document to fruition. Council was entirely supportive of continuing this work through the Ethics Committee's drafting of the casebook/commentary. I am writing up the remarks that I delivered at Council, which I believe will be published in the April Monitor. As soon as they are in a presentable form, I'll distribute them to all of you. Council also received my letter to Gerry and Ron, along with those of Mike, Jean Maria, and Robert.

During the meeting, Gerry Koocher clarified the issue relating to the Task Force's existence and made it known that it has fulfilled its function and actually no longer existed as an entity after 12/31/05. Each of you remains critically important for your individual contributions to the work that lies ahead and I do hope that you will continue to contribute your insights, knowledge, and wisdom to this next part of the work. I can not say thank you often or ardently enough to express how appreciative I am for all that each of you have contributed thus far. You should know that your fellow psychology colleagues acknowledged the stellar job that all of you have done and I could not have been more honored or proud to have chaired this task force. Working alongside all of you has been both personally and professionally rewarding and I look forward to staying in touch with each of you in the months ahead.

My best.

Warmly,

Olivia

**From:** Jean Maria Arrigo < >

**Date:** February 24, 2006 10:51:33 AM PST

**Subject:** Re: Greetings and Update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Olivia,

I appreciate the news of your report to the APA Council. It sounds as though you did good work in generating support for the casebook/commentary.

In the April MONITOR, can space also be allotted to Mike Wessells and myself for a dissenting position? We will want to express this in some venue, and it seems most

dignified for the Task Force itself to acknowledge and make space for dissension.

Thanks very much.

Jean Maria

**From:** Olivia Moorehead-Slaughter < >

**Date:** February 25, 2006 9:40:28 AM PST

**Subject:** Re: Greetings and Update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Hi Jean Maria,

I received your message with your request for space in the Monitor. However, I do not make the decisions around what gets printed in the Monitor. I will forward your request to the party who can do so.

My best.

Olivia

**From:**

**Date:** February 25, 2006 10:10:22 AM PST

**Subject:** Re: Greetings and Update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Jean Maria, Olivia and PENS,

I must protest. We agreed to work from within. We agreed to keep our proceedings private. As part of the group, each of us signed on to the product of the group (i.e. the Report). Anyone might have a disagreement with this or that, but we agreed as a group to work together to produce a (one) Report. I know I harp on this, but the meaning of ethics is "that which is in the best interest of the community." The community or group, in this instance, is the PENS Taskforce which serves the APA. To say, in effect, "I am the author of this report, but I do not agree with this report," is hypocritical. To go outside the group (meaning to not work from within to the benefit of the group) is, by definition, unethical behavior. In my opinion, both you and Mike contributed to the report when working from within. Why now dissent or oppose the group from the outside?

Yours truly,  
Bryce

**From:** "Gerald P. Koocher, PhD" < >

**Date:** February 25, 2006 11:32:37 AM PST

**Subject:** Re: Greetings and Update

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

With due respect, I find Jean Maria's request grossly inappropriate. Consider the following facts:

- #1 - The task force completed its work in June, 2005.
- #2 - While I do understand that Mike Wessells, Jean Maria, and possibly others wish that the task force had gone further in some respects than the published report, they did sign on to that report.
- #3 - The task force appointed by Ron Levant officially ceased to exist when his presidency of APA ended December 31, 2005.
- #4 - No request for published disagreement regarding the report became evident during the existence of the task force.
- #5 - Several members of the task force expressed reservations about working on a casebook, should the life of the group be extended for that purpose. (I therefore chose not to re-appoint the task force, and instead recommended that the APA Council charge the Ethics Committee with that role and fund development of the casebook. The Council acted favorably on that recommendation.)
- #6 - For reasons known best to him, Mike Wessells felt the need to make a public display of resigning from a task force that no longer existed in January, 2006, more than 6 months after agreeing to the PENS report content.
- #7 - I have no idea what Jean and Mike now wish to "dissent" about, but by any reasonable definition the appropriate time and forum for any such concerns have long since passed.

Gerry

**From:** Jean Maria Arrigo < >

**Date:** February 27, 2006 4:28:55 PM PST

**Subject:** MONITOR protocol

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Olivia,

Thank you for this courtesy.

Jean Maria

On Feb 26, 2006, at 10:58 AM, Olivia Moorehead-Slaughter wrote:

**From:** Olivia Moorehead-Slaughter < >

**Date:** March 1, 2006 7:48:52 AM PST



**Subject: Monitor response**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

FYI---This is the response from Rhea Farberman for all of you to see regarding the printing of a statement in the Monitor. Be well. Olivia

Olivia,

In response to your question, about other members of the PENS Task Force having statements in the Monitor relating to the work of the Task Force and your remarks before Council, the appropriate forum is the letters to the editor section in the following (May) issue. Letters to the editor should be submitted to [mailto:letters.monitor@ ]letters.monitor@ , and the word limit is typically 250 words. Editorial staff review the letters for possible publication, and if anyone from the PENS Task Force wishing to submit a letter lets Steve know, I will be sure the letter gets a careful review. The letter will need to be received by March 15 in order to be considered for the May issue.

Rhea Farberman  
Executive Director, Public and Member Communications

**From:** Jean Maria Arrigo < >

**Date:** March 1, 2006 7:56:55 AM PST

**Subject: Re: Monitor response**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Thanks very much for your inquiry, Olivia. Jean Maria

**From:** Jean Maria Arrigo < >

**Date:** March 2, 2006 11:59:43 AM PST

**Subject: Criticism of final report**

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Bryce,

I want to say at the outset that I respect the confidences of Task Force members who spoke from their national security backgrounds.

Regarding critiques of our final report though, I think the Task Force would have done better to reflect on them than to dismiss them, especially those critiques lodged by APA divisions. Task Force solidarity was supposed to promote accord within the APA, but I believe this was a miscalculation on our part. Secrecy about our proceedings and resistance to critique have made us the enemy of some APA divisions and other parties that have a legitimate stake in the Task Force position.



Indeed, I am one of the authors of the report and I gladly uphold the report *as far as it goes*. But I do not commit to the report as a vital and practical response to the PENS concerns of APA members. From the beginning I have articulated my misgivings about the narrowness of the scope of our report. The Task Force itself has not followed up on proposed activities that might have satisfactorily enlarged the scope of the report and rendered it practicable.

An alternate view is that our task was too difficult and complex for a 2-1/2-day meeting.

Sincerely,  
Jean Maria

**From:** Jean Maria Arrigo < >  
**Date:** March 10, 2006 9:11:06 PM PST  
**Subject:** PENS - Letter to MONITOR editor  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear Rhea,

Attached is my 250-word letter to the Editor of the APA MONITOR, in response to the February President's Column about the PENS Task Force. Thanks very much for your consideration.

Jean Maria

Jean Maria Arrigo, PhD  
Project on Ethics and Art in Testimony

**From:** Jean Maria Arrigo < >  
**Date:** June 15, 2006 9:55:15 AM PDT  
**Subject:** PENS - Expiration of ban  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

PENS Colleagues:

At our June meeting last year, two reasons were advanced for the ban on public discussion of Task Force proceedings: (a) calmer resolution of public conflict over psychologists involved in interrogation, through appearance of Task Force unanimity, and (b) ease of discussion of sensitive issues by some members with national security jobs and their personal safety from terrorist retaliation. Public response to the PENS report has now largely taken its course. We all owe respect for conversations with

national security professionals on sensitive topics, but that does not require a blackout on proceedings.

The matter of the ban arose for me recently while reviewing Alfred McCoy's *A Question of Torture*. I was well underway in the review invited by *PsycCritques* when I came upon McCoy's one-page condemnation of the PENS report (p. 183) and felt obliged to comment as an interested party.

In Washington, we did not discuss the expiration date of the ban on public discussion of PENS Task Force proceedings. Even the military has a time limit on classified materials. There is much to be lost by secret process in professional associations. December 31, 2005, the date of termination of the Task Force, seems to me the appropriate date for expiration of the ban, in a spirit of organizational transparency.

Jean Maria

Jean Maria Arrigo, PhD

Project on Ethics and Art in Testimony

**From:** Nina Thomas < >

**Date:** June 24, 2006 1:24:03 PM PDT

**Subject:** Jean Maria's email

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Dear All -

If there has been any response to Jean Maria's email several weeks (?) ago regarding her decision to terminate the confidentiality we all agreed to, I have not seen any. I know that I was disturbed by the "unilateralness" of that decision, particularly as our original determination was made on the basis of what members felt was very real need. So am I coming into an issue that's over and done with? Has there been any discussion of this? What's up, in other words?

Nina

**From:** "LeFever, Bryce E. (CAPT)" < >

**Date:** June 26, 2006 7:39:44 AM PDT

**Subject:** Re: Jean Maria's email

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

Nina,

I agree--and I also expected some reaction. Here is mine: It is patently unethical to go contrary to what was mutually decided to be in the best interest of the group (PENS). It is also hypocritical to agree to a standard--then "unilaterally" decide that the standard no longer applies.

Take care,

Bryce

**From:** "Banks, Louie M. COL" <>

**Date:** June 26, 2006 9:41:29 AM PDT

**Subject:** Re: Jean Maria's email

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security  
<PENS@ >

To all,

My position is that I agreed not to discuss the proceedings of the Task Force. I will certainly keep to that promise.

Very respectfully,

Morgan

**COL L. Morgan Banks**

**Director, Psychological Applications Directorate**

**US Army Special Operations Command**

**DSN COM**

**From:** "Gerald P. Koocher, Ph.D." < >

**Date:** June 26, 2006 9:58:14 AM PDT

**Subject:** Re:

**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

I concur with Dr. Banks.  
Gerry Koocher

**Gerald P. Koocher, Ph.D. ABPP**  
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Editor, *Ethics & Behavior*

**From:** "Col. Larry C. James PhD" < >  
**Date:** June 26, 2006 11:42:32 AM PDT  
**Subject: Re: Jean Maria's email**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

I agreed to not discuss it and refer all questions to Steve and/or Olivia,

I'm still o.k. with this.

Larry

**From:** Olivia Moorehead-Slaughter < >  
**Date:** June 26, 2006 1:15:36 PM PDT  
**Subject: Re: Jean Maria's email**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Nina,

What you are seeing over the past day or so are the responses that have been received. You have not been out of the loop. Just wanted you to know this.

Olivia

**From:** Nina Thomas < >  
**Date:** June 26, 2006 2:57:53 PM PDT  
**Subject: Re:**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

In a message dated 6/26/2006 1:05:28 P.M. Eastern Standard Time, writes:

I concur with Dr. Banks.

I hope with me as well.

N

Nina K. Thomas, Ph.D., ABPP

**From:** Nina Thomas < >  
**Date:** June 26, 2006 7:24:50 PM PDT  
**Subject: Re: Jean Maria's email**  
**Reply-To:** Presidential Task Force on Psychological Ethics and National Security <PENS@ >

Thanks Olivia. Just was concerned since I found the email inflammatory. But I guess other people's tinder points are above mine.

Hope you are well.

Nina

Nina K. Thomas, Ph.D., ABPP

11

13

16 > Morgan law/thesis

18 > "

22 Larry

26 Morgan

\* 41 Morgan

\* 54 "

\* 63 > Asriga - deficits not needed

73 Asriga

80 > outline

\* 125 > Ron  
specific tasks ~~task~~  
Free report



175

weekly reports

A REPORTER AT LARGE  
JULY 11, 2005 ISSUE

## THE EXPERIMENT

*The military trains people to withstand interrogation. Are those methods being misused at Guantánamo?*

BY JANE MAYER

**O**n a steamy morning last month, as Congress was debating the treatment of the approximately five hundred terrorist suspects being held inside the United States-run military detention center in Guantánamo Bay, Cuba, a small delegation of American officials led a tour through one of the prison camp's empty cellblocks. The International Committee of the Red Cross has made inspections of the site, the results of which it keeps confidential, and a few dozen American lawyers have had limited visits with detainees. Yet most of the prisoners, who come from some forty countries, have been held virtually incommunicado, without legal charges, for three and a half years.

The cellblock, which had been fashioned from steel shipping crates, resembled a horse barn. Six-foot-by-eight-foot cells, with walls and doors of metal mesh, stood in two facing rows. The cells were protected by a low metal roof but were open to the tropical air. Each door featured a narrow slot, at waist height, through which meals and other items could be handed to detainees, and handcuffs and belly chains could be secured. The first cell on the right was laid out like a display model, with neatly folded prison garb and an array of what the officials called “comfort items”—awarded to detainees for good behavior, or confiscated as punishment. Among these luxuries was a roll of toilet paper. The cell was furnished with a thin plastic-covered mattress on a metal slab; a metal sink; a metal toilet; and a surgical mask, which could be hung from the wall, allowing a detainee to store a small Koran inside it.

“I’d be proud to let the media see anything in this camp,” Colonel Mike Bumgarner, the commander of the Joint Detention Operations Group, the military unit that oversees the daily handling of detainees, said. “I’d gladly invite the world in to see our guards in action. I’m very proud of what they do. They treat the detainees humanely.” Meals, he said, were excellent. “They get honey-glazed chicken and rice pilaf. They get lemon-baked fish.” He noted that some detainees don’t like to have their vegetables touching their meat: “So we serve them separately, in little Styrofoam clamshells, like the ones you get at a fast-food restaurant.” He went on, “We have to be like the parents here. In loco parentis. That’s how we look at it. It’s like a big family.”

As we reached the end of the cellblock, hysterical shouts, in broken English, erupted from a caged exercise area nearby. “Come here!” a man screamed. “See here! They are liars!” He was middle-aged, with a full beard and skinny bow legs, and wore an orange shirt and shorts. (“Privileged”—that is, cooperative—detainees wear white or beige uniforms.) “No sleep!” he yelled. “No food! No medicine! No doctor! Everybody sick here!” A soldier near the detainee began ferociously signalling to the officials leading the tour to usher me out. As I was leaving, the detainee pointed to his own cellblock, which was off limits to journalists, and screamed, “They are liars! Liars! Liars!”

“His English is pretty good,” one official joked wanly.

The military officials who run the Guantánamo prison maintain that almost all of the detainees’ charges are untrue. A training manual written by Al Qaeda leaders, which is known as the Manchester Manual, because a copy of it was confiscated during a 2000 raid in England, counsels Islamists to “complain of mistreatment while in prison” and say that “torture was inflicted on them.” Bumgarner said, “They are trained to make false accusations. It’s part of their P.R.”

Brigadier General Jay W. Hood, the top commander of the camp, has worked to improve administrative control since taking over, in March, 2004. He has implemented random inspections of the cellblocks, to insure that “standard operating procedures” are being followed, and he has banished regular “cavity searches” for detainees. Lawyers and human-rights workers say that detainees are being treated less harshly, although their mental state continues to deteriorate. In an interview, Hood said that there have been “no demonstrated or consistent trends of abuse” inside Guantánamo, and “certainly nothing rising to the level of torture.” From the beginning, however, the Guantánamo Bay prison camp was conceived by the Bush Administration as a place that could operate outside the system of national and international laws that normally govern the treatment of prisoners in U.S. custody. Soon after September 11th, the Administration argued that the Guantánamo site, which America had been leasing from the Cuban government since 1903, was not bound by the Geneva Conventions. Moreover, the Administration claimed that terrorist suspects detained at the site were not ordinary criminals or prisoners of war; rather, they would be classified under a new rubric, “unlawful combatants.” This new class of suspects would be tried not in U.S. courts but in military tribunals, the Administration announced. In February, 2002, President Bush issued a broad directive that required American troops to treat detainees “humanely,” in a manner consistent with the Geneva Conventions, within the limits of “military necessity.” A year later, he explicitly denounced the use of torture.

A series of internal Department of Defense investigations found what General Hood described as “isolated cases where individuals hadn’t followed standard operating procedures.” Many of the incidents addressed by the Pentagon had been widely reported in the media, making the camp a focus of international outrage. In one case, a female



interrogator, attempting to unsettle a Muslim detainee, smeared fake menstrual blood on him. And on five separate occasions Korans were defiled; one soldier urinated through a ventilation shaft, splashing the text—accidentally, according to the Pentagon. (This spring, *Newsweek* reported that military investigators had evidence that guards at Guantánamo had flushed a Koran down a toilet. The Bush Administration adamantly denied the charge, and, ultimately, the magazine admitted that it did not have sufficient sourcing to stand by the story.) In each acknowledged case of impropriety at Guantánamo, Hood stressed, the transgressors had been reprimanded, but he doubted that their actions could be said to “rise to the level of abuse.”

Last year, Vice-Admiral Albert T. Church III was appointed by the Pentagon to investigate the problem of detainee abuse. This spring, he released a three-hundred-and-sixty-eight-page report, most of which remains classified. In an unclassified section, Church concluded that there was “no link between approved interrogation techniques and detainee abuse.” When cruelties did occur, the report claimed, they were rare mishaps, the result of combat stress, insufficient oversight, or a “breakdown of good order and discipline.”

Yet a number of critics, including human-rights officials, detainees’ lawyers, and others with knowledge of the inner workings of the detention center, believe that the problems at Guantánamo are the result of a more systematic effort. The strange accounts of torment that have steadily emerged, these critics say, are connected to decades of research by American scientists into the psychological nature of warfare and captivity. The research, which began during the Cold War, developed new currency after September 11th, when the Bush Administration declared a global war on terror and began trying to extract intelligence from radical Islamists, many of whom have been trained not to reveal anything about their activities. Since 2001, the critics say, medical and scientific personnel have played a role, largely hidden, in helping to design and monitor interrogations that are intended to exploit the physical and mental vulnerabilities of detainees. According to a former interrogator at Guantánamo who was interviewed at length by a lawyer, behavioral scientists control the most minute details of interrogations, to the point of decreeing, in the case of one detainee, that he would be given seven squares of toilet paper per day.

“It is both illegal and deeply unethical to use techniques that profoundly disrupt someone’s personality,” Leonard S. Rubenstein, the executive director of Physicians for Human Rights, an advocacy group that has been critical of the Bush Administration, says. “But that’s precisely what interrogators are doing, in order to try to get people to talk.”

Baher Azmy, a professor at Seton Hall Law School, in Newark, New Jersey, represents a Guantánamo detainee named Murat Kurnaz, a twenty-three-year-old Turkish citizen who was born in Germany. Kurnaz, who was apprehended while on a trip to Pakistan,

has been detained in Guantánamo since 2002. Azmy told me that Kurnaz has complained of being sexually taunted by female interrogators who, he said, offered to have sex with him in exchange for giving information. When one woman began embracing him from behind, Kurnaz said, he turned and head-butted her. According to Kurnaz, he was then beaten by members of the Initial Reaction Forces, a military-police squad that patrols the cellblocks. Kurnaz claimed that he was made to lie on the floor, with his hands cuffed behind his back, for nearly a day. He also told Azmy that he was threatened with starvation and forcibly injected with unknown and debilitating drugs. (All of Kurnaz's charges have been denied by U.S. authorities.) Azmy told me, "These psychological gambits are obviously not isolated events. They're prevalent and systematic. They're tried, measured, and charted. These are ways to humiliate and disorient the detainees. The whole place appears to be one giant human experiment."

**C**oncrete evidence of the medical and psychological mistreatment of detainees is all but impossible to obtain, in part because the Justice Department, in contravention of all national and international norms, has repeatedly blocked attempts by lawyers to get copies of detainees' medical records. "Prisoners, even terrorists, have the right to their medical records, according to federal laws, common laws, the American Medical Association, and court trials," Arthur Caplan, a bioethicist at the University of Pennsylvania, says. In an interview at Guantánamo Bay, Dr. John S. Edmondson, a Navy captain who oversees the facility's medical command, denied that he had refused to turn over medical records. "I believe we've complied with the requests that have reached me," he said. A respect for confidentiality, he said, prevented him from specifying the names of detainees whose medical records he had released. Yet Rob Kirsch, a partner at the law firm Wilmer Hale, who represents six Guantánamo detainees, provided me with a file of letters from the Justice Department denying him access to his clients' medical records, even though he had obtained waivers from the clients authorizing their records to be released to him. "They still wouldn't let us see the records," he said. Kirsch contends that at Guantánamo medical care is sometimes withheld or dispensed depending on a detainee's willingness to talk to interrogators. All his clients, he said, have made this complaint, despite having had no opportunity to talk to one another. One of his clients, Mustafa Ait Idir, was deemed resistant by guards, and they allegedly broke two of his fingers; Idir was not allowed to see a doctor after the incident, Kirsch said, and his hand is now severely misshapen. (Kirsch visited Idir at Guantánamo several times after the hand was damaged.) All six of Kirsch's clients have requested dental care to no avail. One client's teeth were so damaged that he was unable to eat regular food; after dental treatment was withheld, the prisoner requested a soft-food diet, which tasted so bad that he lost forty pounds. Edmondson denied that care had been deliberately withheld from any detainee. He also denied that medical professionals under his command had colluded with interrogators.

Scott Sullivan, a lawyer at Allen & Overy, a firm that represents eleven detainees from Yemen, alleged that medics under Edmondson's command routinely violated codes of medical ethics. For example, medics supervised the beating of one of his clients, Saeed Abdullah Sarim, he said. After Sarim was hit repeatedly in the face, an English-speaking detainee nearby allegedly told him that a medic had tried to calibrate the abuse, saying, "Hit him *around* the eye, not *in* the eye." After the beating, according to a report compiled by Sullivan's firm, Sarim asked a nurse for stitches. The nurse, Sarim said in the report, "did not answer me and did not treat the wound."

Another client of Sullivan's, Abdul Aziz al-Swidi, claimed to have been interrogated by a psychiatrist, who allegedly showed him a picture of a telephone and asked him what it was. When Swidi answered that it was a telephone, the psychiatrist angrily responded, "It's not a telephone—it's a bomb!" Swidi was shown other images and asked to identify them, and each time he was told that his answer was wrong. The goal of the exercise, Sullivan believes, was to make Swidi think that he was going crazy. ("We have no records or reports of this allegation," a Guantánamo spokesman said.)

Last month, a report in the *Times* said that doctors at Guantánamo had provided interrogators with information from some detainees' medical records. In one case, interrogators were told that a detainee had a profound fear of the dark, and ways were suggested to exploit this phobia, in order to break down the detainee's resistance to questioning. Also last month, an article in *The New England Journal of Medicine* revealed that a military policy statement instructed caregivers at Guantánamo to offer clinical information to interrogation teams on request. And last year a confidential report by the International Committee of the Red Cross, parts of which were leaked to the *Washington Post*, charged that doctors consulted detainee medical records to help interrogators, in a "flagrant violation of medical ethics." Edmondson said that the Red Cross's charges were wrong, but he added that national-security concerns might sometimes justify the breaching of a detainee's medical confidentiality.

**T**he role of physicians, who take the Hippocratic oath to "do no harm," is ethically complicated in wartime. Doctors are often described as having "dual loyalties," to patients and to country. But at the Nuremberg trials, after the Second World War, revulsion at Nazi atrocities led to the establishment of rules barring medical mistreatment, even for reasons of national security. A section of the 1950 Geneva Convention, for example, states that "no prisoner of war may be subjected to physical mutilation or to medical or scientific experiments of any kind which are not justified by the medical, dental or hospital treatment of the prisoner concerned." In 1962, the U.S. passed the first law requiring doctors to obtain "informed consent" from patients. And in 1975 the World Medical Association, or W.M.A., issued the Declaration of Tokyo, which barred medical personnel from participation in either torture or abuse, even as monitors. The American Medical Association is a member of the W.M.A., which means that U.S. doctors must follow its ethical standards.

In June, the Pentagon released a new set of formal ethical guidelines, titled “Medical Program Principles and Procedures for the Protection and Treatment of Detainees in the Custody of the Armed Forces of the United States.” The document, which was issued by Dr. William Winkenwerder, Jr., the Assistant Secretary of Defense for Health Affairs, stresses the importance of upholding “the humane treatment of detainees.” It states that “health-care personnel charged with the medical care of detainees” cannot participate in interrogations. In this phrase is embedded a troubling loophole, however: scientific and medical personnel who are not directly responsible for a patient’s care may take part in interrogations. Leonard Rubenstein, of Physicians for Human Rights, argues that “the Administration has basically given a green light for medical personnel to participate in abuse.”

Winkenwerder, who formerly worked in the insurance industry, argues that most of the detainees have never received better care than they have been getting at Guantánamo. The Pentagon, he told me, took extraordinary pains to insure that detainees were treated in compliance with medical ethics and American values, and he presented statistics showing that last year Guantánamo detainees got more frequent medical treatment than most Americans. A state-of-the-art field hospital had been set up on the periphery of the prison camp, he said, and trained Navy medical corpsmen checked on the detainees’ health and welfare three times a week. “A lot of good people are being besmirched by these stories,” he said, referring to media reports that have described abuses of detainees at Guantánamo.

Winkenwerder did acknowledge, however, that a number of medical and scientific personnel working at Guantánamo—including psychologists and psychiatrists—are not providing care for detainees. Rather, these “non-treating” professionals have been using their skills to “assist the interrogators,” as he put it.

People working in this advisory capacity are members of what are called Behavioral Science Consultation Teams, or BSCTs. (In military jargon, the teams are known as “Biscuits.”) In past wars, the U.S. military has used health-care consultants for therapeutic purposes, to evaluate the combat readiness of soldiers with psychological or physiological problems, and to provide soldiers with counselling and psychotropic drugs. But Major General Geoffrey D. Miller—who commanded the Guantánamo Bay detention center between November, 2002, and March, 2004, and who was then sent by Secretary of Defense Donald Rumsfeld to manage Abu Ghraib prison, in Iraq—established a new role for health-care advisers. “These teams, comprised of operational behavioral psychologists and psychiatrists, are essential in developing integrated interrogation strategies and assessing interrogation intelligence production,” Miller explained in an internal report in September, 2003.

Winkenwerder told me that BSCT members are not under his command; rather, they fall under military intelligence. He said that he knew little about the program's daily operations but had heard that a number of BSCT psychologists and psychiatrists had received specialized training. "It's connected to some military acronym," he said. "Something to do with Survival and Evasion."

**W**inkenwerder was referring to a Pentagon-funded program known as SERE, which stands for "Survival, Evasion, Resistance, and Escape." SERE was created by the Air Force, at the end of the Korean War, to teach pilots and other personnel considered at high risk of being captured by enemy forces how to withstand and resist extreme forms of abuse. After the Vietnam War, the program was expanded to the Army and the Navy. Most details of the program's curriculum are classified.

Each branch of the military now has its own version of SERE training. The flagship program is conducted by the Army's John F. Kennedy Special Warfare Center and School, at Fort Bragg, North Carolina, where Green Berets train. There are several levels of SERE courses; one, Level C, includes a gruelling exercise in which trainees endure days of physical and psychological hardship inside a mock prisoner-of-war camp.

This spring, I spoke at length with several people familiar with the SERE programs, including a longtime affiliate. According to these sources, a small number of psychologists and other clinicians oversee the SERE program at Fort Bragg. The supervisors discreetly check on trainees' progress at frequent intervals, keeping extensive charts and records of their behavior and medical status. Numerous experiments aimed at documenting trainees' stress levels have been conducted by SERE-affiliated scientists. By analyzing blood and saliva, they have charted fluctuations in trainees' level of cortisol, a stress hormone, and these data have been used to understand what inspires maximum anxiety in the trainees.

The theory behind the SERE program is that soldiers who are exposed to nightmarish treatment during training will be better equipped to deal with such terrors should they face them in the real world. Accordingly, the program is a storehouse of knowledge about coercive methods of interrogation. One way to stimulate acute anxiety, SERE scientists have learned, is to create an environment of radical uncertainty: trainees are hooded; their sleep patterns are disrupted; they are starved for extended periods; they are stripped of their clothes; they are exposed to extreme temperatures; and they are subjected to harsh interrogations by officials impersonating enemy captors. (Colonel Hans Bush, a spokesman at Fort Bragg, declined to "disclose the details of the specific challenges our students face.") Research in social psychology has shown that a person's capacity for "self-regulation"—the ability to moderate or control his own behavior—can be substantially undermined in situations of high anxiety. If, for instance, a prisoner of war is trying to avoid revealing secrets to enemy interrogators, he is much less likely to succeed if he has been deprived of sleep or is struggling to ignore intense pain.

According to the SERE affiliate and two other sources familiar with the program, after September 11th several psychologists versed in SERE techniques began advising interrogators at Guantánamo Bay and elsewhere. Some of these psychologists essentially “tried to reverse-engineer” the SERE program, as the affiliate put it. “They took good knowledge and used it in a bad way,” another of the sources said. Interrogators and BSCT members at Guantánamo adopted coercive techniques similar to those employed in the SERE program. Ideas intended to help Americans resist abuse spread to Americans who used them to perpetrate abuse. Jonathan Moreno, a bioethicist at the University of Virginia, is a scholar of state-sponsored experiments on humans. He says, “If you know how to help people who are stressed, then you also know how to stress people, in order to get them to talk.”

**C**arol Darby, a spokeswoman at Fort Bragg, said that the SERE program has not deviated from its original purpose. In an e-mail, she wrote, “SERE training is not designed and it does not teach anyone how to interrogate individuals. Students who go through SERE are taught methods to resist interrogation techniques that may be used against them; they are taught how to respond when they are on the receiving end of interrogation.”

Yet many of the interrogation methods used in SERE training seem to have been applied at Guantánamo. One component of the training program, called the “religious dilemma,” parallels Guantánamo detainees’ chronic complaints about Koran abuse. At SERE, trainees in the Level C course are given the choice of seeing a Bible desecrated or revealing secrets to interrogators. “They are challenging your faith,” the SERE affiliate explained. “The Holy Book is torn up. They say they’ll stop if you talk. Sometimes they rip the Bible and throw it in the air.” The goal is to make detainees react emotionally to the desecration. Some trainees who are devout Christians become profoundly disturbed during the exercise.

In May, an e-mail written by a graduate of the SERE program was posted on Informed Comment, the blog of Juan Cole, a history professor at the University of Michigan, who is critical of the Bush Administration. The e-mail, which was anonymous, asserted, “Gitmo must be being used as a ‘laboratory’ for all these psychological manipulation techniques.” Cole provided me with contact information for the SERE graduate, and I spoke on the phone with him. He confirmed his identity, but said that he wished to remain anonymous, fearing that his comments about the program might have legal repercussions.

The SERE graduate explained that he had attended Army Ranger school, and had served on active duty in the Marines for eleven years, part of the time as an intelligence officer. In 1999, he attended the Navy’s SERE training program in Coronado, California.

He told me that the program had been “very professionally run.” But, he said, when he read about the treatment of detainees at Guantánamo he was reminded of his experiences during SERE training simulations.

On the blog, the graduate offered a detailed account of a SERE training exercise. (He confirmed the account’s details with me.) He wrote, “One of the most memorable parts of the camp experience was when one of the camp leaders trashed a Bible on the ground, kicking it around, etc. It was a crushing blow, even though this was just a school.”

The graduate wrote that his experience with the “Bible trashing” took place “towards the end of the camp experience, which was 2-3 days of captivity.” He continued:

We were penned in concrete cell blocks about 4’ x 4’ x 4’—told to kneel, but allowed to squat or sit. There was no door, just a flap that could be let down if it was too cold outside (which it was). Each trainee was interrogated to some extent, all experienced some physical interrogation such as pushing, shoving, getting slammed against a wall (usually a large metal sheet set up so that it would not seriously injure trainees), with some actually water-boarded (not me).

The Bible trashing was done by one of the top-ranked leaders of the camp, who was always giving us speeches—sort of “making it real” so to speak, because it is a pretty contrived environment. But by the end it almost seemed real. Guards spoke English with a Russian accent, wore Russian-looking uniforms. So the Bible trashing happened when this guy had us all in the courtyard sitting for one of his speeches. They were tempting us with a big pot of soup that was boiling—we were all starving from a few days of chow deprivation. He brought out the Bible and started going off on it verbally—how it was worthless, we were forsaken by this God, etc. Then he threw it on the ground and kicked it around. It was definitely the climax of his speech. Then he kicked over the soup pot, and threw us back in the cells. Big climax. And psychologically it was crushing and heartbreaking, and then we were left isolated to contemplate this.

The SERE graduate, who is religious, said that the repeated mistreatment of the Koran at Guantánamo was “sickening” and “immoral.” Referring to the interrogators there, he said, “They have turned the whole world against us.”

The graduate’s claim that waterboarding took place at the Navy’s SERE school was confirmed by the SERE affiliate. Waterboarding is intended to simulate drowning and asphyxiation. Khalid Sheikh Mohammed, a top Al Qaeda operative who was apprehended in Pakistan in 2003, has reportedly been subjected to it. (It is unknown if the technique yielded useful intelligence.) In the version used in the Navy’s SERE training program, the affiliate said, the student is bound to an inclined board, his feet higher than his head. A stream of water is then slowly poured up his nose. In SERE training, the technique is highly controlled to prevent serious physical harm (although

the trainees don't sense this). There is a strict limit of only a few cups of water per student. As an extra precaution, the trainees do jumping jacks first, to elevate their heart rate, which enables them to hold their breath for long periods during the ordeal.

Another SERE technique that has apparently surfaced at Guantánamo is the use of "noise stress." The SERE affiliate told me that trainees often think that the interrogation portion of the program will be the most grueling, but in fact for many trainees the worst moment is when they are made to listen to taped loops of cacophonous sounds. One of the most stress-inducing tapes is a recording of babies crying inconsolably. Another is a Yoko Ono album. Detainees at Guantánamo have reportedly been subjected to blaring audiotapes of loud music, cats meowing, and human infants wailing.

Critics also allege that the SERE program has become a testing ground for interrogation techniques involving sexual embarrassment and humiliation. (Detainees at Guantánamo have complained of such methods, and the scandal at Abu Ghraib last year revealed that guards there photographed prisoners naked and in sexually humiliating poses.) A former military-intelligence officer who was familiar with practices at Guantánamo told me that a friend who had gone through Level C SERE training, which lasts three weeks, said that he had been sexually ridiculed by females during the program. "They strip you naked and make you do work while women laugh at the size of your 'junk,'" the intelligence officer told me. "Apparently, it's very humiliating." The SERE affiliate described another disturbing training technique: the "mock rape." In this exercise, a female officer stands behind a screen and screams as if she were being violated. A trainee is told that he can stop the rape if he cooperates with his captors.

Erik Saar is a former Army intelligence analyst at Guantánamo and the author of "Inside the Wire," published in May, which first disclosed the interrogation incident involving fake menstrual blood. He told me that the perpetrator of this particular form of abuse might have come up with the idea herself. But he said that the notion of using sexual gambits to unnerve detainees was promoted by "the BSCTs, who were these psychiatrists and psychologists from Fort Bragg." He went on, "The BSCTs would help interrogators strategize about what techniques to use, and where someone would be vulnerable, and what the best ways to manipulate them would be. Sex, I believe, came from the BSCTs. I have a hard time thinking it was a couple of rogue interrogators, if that's what the Army says, because it was very systematic. It wasn't hidden."

The manipulation of national flags for psychological effect is another element of SERE training. The mock captors create psychological stress in trainees by mutilating and burning the American flag, in a procedure known as the "flag dilemma." This technique also has echoes in the experience of detainees at Guantánamo. The American Civil Liberties Union recently revealed the contents of a confidential e-mail written by an F.B.I. agent stationed in Guantánamo to his superiors. It describes a detainee "sitting on the floor of the interview room with an Israeli flag draped around him, loud music being



played and a strobe light flashing.” Marc Falkoff, a lawyer defending several Guantánamo detainees, informed me of another flag incident. According to Falkoff’s clients, a mass suicide attempt at Guantánamo, in August, 2003, in which two dozen or so detainees tried to hang or strangle themselves, was provoked by instances of Koran mistreatment—including one in which the text was allegedly wrapped inside an Israeli flag and stomped on.

Although the SERE affiliate said that many of the program’s officials were careful and dedicated people, he said that “some of the folks” associated with the program seemed to enjoy using manipulative techniques. “They’d play these very aggressive roles, week after week,” he said. “It can be very seductive.” Although there is no scientific basis for believing that coercive interrogation methods work better than less aggressive ones, the affiliate said that some of the SERE psychologists he knew believed that to get someone to talk “you have to hurt that person.”

Retired Army Colonel Patrick Lang, who was both a Special Forces officer and a Defense Intelligence Agency expert on the Middle East, told me that he had attended a SERE school as part of Special Forces training, and had found the experience disconcerting: “Once, I was on the other side of the exercise, acting as captor and interrogator,” he said. “If you did too much of that stuff, you could really get to like it. You can manipulate people. And most people like power. I’ve seen some of these doctors and psychologists and psychiatrists who really think they know how to do this. But it’s very easy to go too far.”

**I**t is not yet possible to pinpoint when ideas from the SERE program began to influence interrogations of terrorist suspects. But, as early as March, 2002, James Mitchell, a psychologist formerly affiliated with SERE, appeared inside an interrogation room where the C.I.A. was holding a “high-value” Al Qaeda suspect. (The interrogation took place at an undisclosed location.) Mitchell worked for years as a SERE administrator. In an interview, he said that he is now a private contractor and does not currently work with the Department of Defense. Asked if he has worked with the C.I.A., conducting interrogations, he said, “If that was true, I couldn’t say anything about it.” (A press officer at the C.I.A. also declined to comment on Mitchell.)

According to a counter-terrorism expert familiar with the interrogation of the Al Qaeda suspect, Mitchell announced that the suspect needed to be subjected to rougher methods. The man should be treated like the dogs in a classic behavioral-psychology experiment, he said, referring to studies performed in the nineteen-sixties by Martin Seligman and other graduate students at the University of Pennsylvania. The dogs were placed in harnesses and given electric shocks that they could not avoid; they were then released into pens and shocked again, but this time they were given a chance to escape the punishment. Most of them, Seligman observed, passively accepted the shocks. They had lapsed into a condition that he called “learned helplessness.” The suspect’s resistance,

Mitchell was apparently saying, could be overcome by inducing a similar sense of futility. (Seligman, now a psychology professor at Penn, has spoken at a SERE school about his dog research.)

Mitchell's position was opposed by the counter-terrorism expert, who had not spent time at a SERE school. He reminded Mitchell that he was dealing with human beings, not dogs. According to the expert, Mitchell replied that the experiments were good science. The expert recalled making the argument that the U.S. should not "do things that our enemies do, like using torture." When asked about this incident, Mitchell confirmed that he admired Seligman's research. He declined to comment on any interrogations that he might have taken part in, though he added, "I don't have anything to hide."

Another scientist connected to SERE, Colonel Louie (Morgan) Banks, a senior Army psychologist who is an administrator of the program, has played a significant advisory role in interrogations at Guantánamo Bay. He has recommended that the psychologists working with the BSCTs in Guantánamo have SERE backgrounds. In an interview, Banks said, "I do go down to Guantánamo occasionally. I have provided assistance." He said that he saw no problem with psychologists helping in interrogations, "as long as they don't break the law." Asked to provide details of his consulting work, he said, "I just don't remember any particular cases. I just consulted generally on what approaches to take. It was about what human behavior in captivity is like."

Banks emphatically denied that he had advocated the use of SERE counter-resistance techniques to break down detainees. When asked about the similarities that have emerged between SERE training methods and interrogation practices at Guantánamo, he replied, "I'm not saying people don't do some stupid things sometimes. Some people who received SERE training may have sometimes done things they shouldn't because they misunderstood what the training was about. I'm not going to tell you it didn't happen. I can't say that someone didn't say, 'Hey, let's try waterboarding' because they'd seen it at SERE." In fact, the problem was pervasive enough so that, last year, Banks introduced a new requirement at SERE: graduates must sign a statement promising not to apply the program's counter-resistance methods to U.S.-held detainees. "We did this when we learned people were flipping it," he said.

Banks has a Ph.D. in psychology from the University of Southern Mississippi. A biographical statement for an American Psychological Association task force on psychological ethics and national security, which Banks serves on, mentions that he "provides technical support and consultation to all Army psychologists providing interrogation support." It also notes that, starting in November, 2001, Banks was detailed to Afghanistan, where he spent four months at Bagram Airfield, "supporting combat operations against Al Qaeda and Taliban fighters." In an interview at Guantánamo Bay, General Hood spoke warmly of Banks. "He is a very bright guy," the General said. "He's very qualified. He has assisted in offering assessments on several of our detainees."

Esteban Rodriguez, a Cuban-American civilian who has overseen the interrogation program at Guantánamo since July, 2003, as director of the Joint Intelligence Group, told me that Banks had been a valuable adviser, particularly on the subject of “resistance” to interrogation. “I talk to him all the time,” Rodriguez told me in his office at Guantánamo. “He’s a very good man.”

Rodriguez has had twenty-six years of experience in the field of interrogation. In the nineteen-eighties, he worked for the Defense Intelligence Agency and was stationed in Berlin, where he debriefed émigrés from East Germany. In comparison with the Cold War, he said, the war against terrorism seems confusing and uncivilized. “You don’t know who the enemy is,” he said. Speaking of Guantánamo, he said, “There are some very dangerous people here.” One detainee vowed, if he ever got out, to slit Rodriguez’s throat. Rodriguez told me that a number of SERE psychologists had been helpful to the BSCTs at Guantánamo. “The SERE people have learned the psychology of what prisoners of war go through,” he said. As a result, he said, “they may have advice, and be able to see certain things going on, such as if this person has been trained in how to avoid interrogation.” In such cases, he said, SERE officials can offer valuable advice on “how to use different tactics.”

Rodriguez declined to say what kinds of “different tactics” were used on detainees. He emphasized that with most prisoners his interrogators simply tried to use what he called “the direct approach,” in order to “build rapport.” He said that during his tenure waterboarding had never been used “on this island.”

Sex, Rodriguez said, was never offered as an enticement to detainees, but he sometimes used women interrogators, who acted as surrogates for wives and mothers. “It’s about finding ways to build rapport,” he said, adding, “I wouldn’t rule out coercion. It just has to be the individual cases.” He estimated that there had been twenty-eight thousand interrogations since Guantánamo opened. Of these, he guessed that “ten to twenty per cent” involved tactics other than just talking. “We do use additional tactics,” he acknowledged. “I have a few tools left in my arsenal. I hate to discuss them.” He winked. “Nothing to do with coercion or fear.”

Rodriguez told me that only a quarter of the detainees hold any intelligence interest for him at this point. The rest, he said, are no longer being interrogated. Even these detainees, however, could remain incarcerated indefinitely. The Pentagon considers many of them to be security threats.

Rodriguez would not reveal which cases SERE psychologists had been directly involved in. However, one clue has emerged. On June 3, 2004, General James T. Hill, of the U.S. Southern Command, held a press conference at which he mentioned how interrogators at Guantánamo had tried to break an especially resistant, and presumably important, detainee. (The detainee’s name was not made public.) The detainee, he explained, “had

been trained in resistance techniques and was using them.” To get him to talk, Hill said, officials at Guantánamo looked for expert help in counter-resistance. He said, “The staff at Guantánamo, working with behavioral scientists, having gone up to our SERE school, developed a list of techniques which our lawyers decided and looked at, [and] said were O.K. I sent that list of techniques up to the Secretary”—Rumsfeld—“and said, in order for us to get at some of these very high-profile, high-value targets who are resistant to techniques, I may need greater flexibility.”

Hill, who retired in January, could not be reached for comment. A source familiar with the episode that Hill was describing says that the detainee in question was No. 063, Mohammed al-Qahtani, who was captured in Afghanistan and is reputedly the missing “twentieth hijacker” in the September 11th conspiracy—the plotter who failed to board the United Airlines plane that crashed in Pennsylvania. But by the summer of 2002 military interrogators were reportedly frustrated by their inability to elicit useful information from him.

Documents related to interrogation practices that were released by the Administration last year show that in October, 2002, Guantánamo officials asked the Pentagon for permission to use several harsh interrogation techniques on highly resistant detainees, including isolation, sensory deprivation, removal of clothing, hooding, exploitation of the detainee’s phobias (such as a fear of dogs) to induce stress, and “scenarios designed to convince the detainee that death or severely painful consequences are imminent for him and/or his family.” The officials also requested permission to use waterboarding.

In a memo to General Richard B. Myers, the chairman of the Joint Chiefs of Staff, Hill wrote that he was “uncertain whether all the techniques” were “legal.” He expressed concern that some of them might violate the federal statute against torture. Another obvious obstacle was the Uniform Code of Military Justice, which prohibits U.S. forces from engaging in “cruelty,” “maltreatment,” or “oppression” of prisoners, and bars both physical assault and threats of injury.

Pentagon lawyers, however, tried to find ways around this, documents released by the Administration show. In October, 2002, Diane Beaver, a lawyer at the Pentagon, wrote a memo to superiors, arguing that waterboarding might “be permissible if not done with the specific intent to cause prolonged mental harm, and absent medical evidence that it would.” She added, “Caution should be exercised with this method, as foreign courts have already advised about the potential mental harm that this method may cause.” She noted that physical contact with the detainee “will technically constitute an assault under . . . UCMJ.” But Beaver’s memo implied that if an interrogator were to obtain “immunity” from command authorities in advance, the laws criminalizing waterboarding and other rough techniques could be circumvented. There is no evidence that anyone in the chain of command, apart from Hill, objected to the content of Beaver’s memo.

As it turned out, Rumsfeld did not authorize waterboarding or threats to harm family members. Nevertheless, the documents released by the Administration show that in December, 2002, he signed off on sixteen other aggressive counter-resistance techniques for use on Qahtani and others, beyond those authorized in the Army Field Manual. This June, *Time* published a report containing excerpts of the interrogation logs, which revealed that Qahtani was forced to strip naked, told to bark like a dog, deprived of the opportunity to use a toilet after having been force-fed liquids intravenously, ordered to dance with a mask on his face, sat on by a female interrogator, exposed to loud noise, allowed limited sleep, and forced to pick up piles of trash with his hands cuffed while he was called “a pig.” According to the *Times*, Qahtani also underwent a phony kidnapping, during which he was injected with tranquilizers and taken up in a plane wearing blackened goggles.

The logs show clearly that a BSCT psychologist participated in the interrogation and they reveal that, after three days of sleep deprivation, Qahtani became ill. A doctor was summoned, and the coercion stopped, but even then Qahtani was subjected to noise levels that kept him from sleeping. His heart rate dropped. A brain scan was performed. He was given an ultrasound, to check for blood clots; none were found. Stephen Xenakis, a psychiatrist and former brigadier general in the Army medical corps, questioned whether the doctors involved notified authorities about how ill the treatment was making Qahtani, as is required by virtually every code of medical ethics. In an e-mail, Xenakis told me, “The clinical picture indicates that the combined effects of the interrogation over December 4-7 contributed to significant physical and metabolic symptoms such that he required close cardiac monitoring. He is evaluated for ‘blood clots’ . . . which can be fatal.” Xenakis asked whether this carefully monitored interrogation, authorized at the top levels of the Pentagon, put “this patient in danger of dying.”

According to Elena Nightingale, a pediatrician and the co-editor of a 1985 anthology of essays about doctors and torture, “The Breaking of Bodies and Minds,” medical experts are often called on to assist with torture, because “people trust and confide in them, which is useful to torturers, and because they have the know-how to keep a person under torture alive, so that more information can be extracted.” Dr. Darryl Matthews, a psychiatrist whom the Army brought in as a consultant after many suicide attempts at Guantánamo, and who has since become a critic of conditions at the prison camp, told me, “As psychiatrists, we know how to hurt people better than others. We can figure out what buttons to push. Like a surgeon with a scalpel, we have techniques and we know what the pressure points are.”

Leonard Rubenstein, of Physicians for Human Rights, described the role of psychologists and medical personnel in the Qahtani interrogation as “conduct that’s been considered forbidden for thirty years.” Psychologists, he said, are subject to the same

standards as medical doctors. “Of course they can’t participate in coercive interrogations!” he said. “It’s clear as day. You can’t advise, you can’t develop plans, you can’t review interrogations, you can’t sign off on them, and you can’t even be present in the room.”

The Pentagon has argued that Qahtani’s treatment was rough but always “humane.” However, documents released by the A.C.L.U. reveal that F.B.I. officials were disturbed when they learned of it. In May, 2004, for instance, an F.B.I. memo entitled “Detainee Interviews (Abusive Interrogation Issues)” noted the Bureau’s “concerns” and “objections” to “SERE techniques to interrogate prisoners.”

In August of that year, an F.B.I. agent who visited Guantánamo sent an e-mail to his superiors. “On a couple of occasions, I entered interview rooms to find a detainee chained hand and foot in a fetal position to the floor, with no chair, food or water,” he wrote. “Most times they had urinated or defecated on themselves, and had been left there for 18 to 24 hours or more.” The agent related that he had also visited an “almost unconscious” prisoner in a room where the temperature was “probably well above 100 degrees.” There was a “pile of hair next to him.” (He seemed to have pulled out his own hair.)

In a subsequent letter, other F.B.I. agents claimed to have observed, in November, 2002, a Guantánamo detainee “after he had been subjected to intense isolation for over three months.” The letter continues, “During that time period, [the detainee] was totally isolated (with the exception of occasional interrogations) in a cell that was always flooded with light. By late November, the detainee was evidencing behavior consistent with extreme psychological trauma (talking to non-existent people, reporting hearing voices, crouching in a corner of the cell covered with a sheet for hours on end).”

Soon after the establishment of the Guantánamo camp, the F.B.I. sent several of its top counter-terrorism agents to the prison to interview detainees. By the fall of 2002, these agents believed that they were making progress with detainees, including Qahtani, by slowly establishing a dynamic of friendly rapport. According to several sources at the F.B.I., when General Miller assumed his administrative role at Guantánamo he became impatient with the F.B.I. interrogations, and insisted that harsher methods be used. The agents said that even if other interrogators managed to break the detainees through force the intelligence would be unreliable, and it would be impossible to prosecute the cases in any U.S. court. These clashes are now under investigation by the Justice Department’s Inspector General, who is trying to determine if laws were broken during interrogations at Guantánamo and elsewhere.

**A** former F.B.I. official who has extensive experience interviewing terrorist suspects spoke to me at length about his battles with Department of Defense officials. The former official said that he had used only noncoercive, “rapport-based” techniques in his interviews with terrorist suspects. “You can know how evil suspects are, and still make them think you’re their friend,” he said.

The former official said that he and other F.B.I. agents didn't want to interview detainees without first reading them their Miranda rights. But the military officers argued that if detainees were read their rights "they'd be able to get lawyers and due process, which would clog the whole system." The former official said that he told a Pentagon official, "Some of these techniques, I don't want to see, or be part of. I took an oath to the Constitution to uphold the laws against enemies both inside the U.S. and out." He recalled, "The D.O.D. guy got really upset. He said he took the oath, too. I told him that we must have different interpretations, then." (A Pentagon spokesman said, "Miranda rights are not applicable to enemy combatants detained in the war on terrorism. . . . They are treated in accordance with the Geneva Conventions subject to military necessity.")

The former F.B.I. official said that he opposed coercion on practical grounds, as much as anything else. "I don't believe these things make successful strategies—sensory deprivation and such," he said. "There's a big lack of knowledge about the mind-set of extremists. Doing these things just makes them more determined to hate us. And eventually they are going to be released. When they are, they're going to talk and exaggerate what happened to them. They're going to become heroes. So then we'll have more extremist networks and more suicide bombers." He also felt that there was a moral imperative to avoid coercive interrogations. "We can't go down to the level of our enemies," he said. "If we do, it's going to come back at us later on."

Officials at the Washington headquarters of the Naval Criminal Investigative Service were also incensed by the use of coercive techniques at Guantánamo. Some N.C.I.S. officials are participating in a combined task force preparing detainee cases for eventual prosecution, and they had access to computerized versions of the interrogation logs at Guantánamo. When the officials read the details of Qahtani's interrogation, they had an extraordinary internal dispute.

According to a passage in Vice-Admiral Church's report that is unclassified but has not been released to the public, in December, 2002, Dr. Michael Gelles, the chief psychologist at the N.C.I.S., spoke with Alberto J. Mora, the Navy's general counsel, saying that, in his professional opinion, "abusive techniques" and "coercive psychological procedures" were being used on Qahtani at Guantánamo. Gelles warned of a phenomenon known as "force drift," in which interrogators encountering resistance begin to lose the ability to restrain themselves.

In July, 2004, Mora wrote a memo to Church's investigative team, in which he recounted his discussion with Gelles. He said that he had found the tactics he had read about in the Qahtani interrogation logs to be "unlawful and unworthy of the military services." Mora argued that these practices "threaten the entire military commission process." According to the Church report, an N.C.I.S. official subsequently said that if the abusive practices continued "N.C.I.S. would have to consider whether to remain co-located" in

Guantánamo. According to a recent ABC News report, in January, 2003, Mora also told William J. Haynes, the Pentagon's general counsel, that "the use of coercive techniques" could expose both interrogators and their administrators to criminal prosecution.

That same month, Rumsfeld suspended his earlier authorization of harsh interrogation methods at Guantánamo. He put together a working group on the subject of interrogation, which, on March 6, 2003, drafted a memo stating that to continue using such aggressive techniques would require Presidential authorization. There is no evidence to date that such an authorization was granted.

Eight days after the release of the draft memo, the Justice Department's Office of Legal Counsel released a classified legal opinion clarifying the Administration's policy on interrogation. Vice-Admiral Church was allowed to read the document, but he was not given a copy. According to Church, the memo's language was "virtually identical" to an August, 2002, memo approved by Jay S. Bybee, then the assistant attorney general, in which torture was defined as anything causing pain comparable to "physical injury such as organ failure, impairment of bodily function, or even death."

The pressure on interrogators, meanwhile, particularly during 2002 and 2003, remained intense. The military-intelligence officer who was familiar with practices at Guantánamo told me that the order from above was "Get me results!" He said, "There was huge frustration. General Miller really unleashed a lot of aggressive tactics." He added, "At the time, we didn't even understand what Al Qaeda *was*. We thought the detainees were all masterminds. It wasn't the case. Most of them were just dirt farmers in Afghanistan."

Earlier this year, a former interrogator at Guantánamo, whose statement to a lawyer was obtained by *The New Yorker*, said that he had refused to use more "assertive" methods on the detainees, and had incurred the anger of his superiors. Extensive records of interrogations were meticulously kept, he said, in what were called "knowledgeability briefs," copies of which were sent to officials at the Pentagon. The former interrogator said that BSCT psychologists were heavily involved in drawing up and monitoring interrogation plans, which were designed individually for each detainee. At least one of the BSCT scientists he worked with, he said, was a medical doctor. Sleep deprivation was such a common technique, he said, that the interrogators called the process of moving detainees every hour or two from one cell to another "the frequent-flier program." He said that interrogators also used pornography to manipulate detainees, giving pictures as a reward to compliant prisoners who were not religious, and forcing "noncompliant" Muslims to look at them. Detainees were routinely shackled in painful "stress positions." The interrogator said that he overheard colleagues talking about the possibility of waterboarding detainees, but he never saw waterboarding used himself.



Until the spring of 2003, the former interrogator said, he had open access to detainees' medical histories. But after that he had to go to the medical staff whenever he had a health-related question, and a staff person would retrieve the records. As an example, the interrogator provided details of a medical problem involving a detainee who claimed that his eyesight was deteriorating. The interrogator said he knew that the detainee had a genuine problem with his eyes, because "I read it in his medical files." When he mentioned the detainee's medical complaints to authorities, he said, they refused to do anything, saying, "Fuck him. He should have gotten the medical help before he went on his jihad."

A Guantánamo detainee who appears to fit this description is Rhuhel Ahmed. In 2004, Ahmed, a British citizen, was released without charges. A statement put out by his lawyer says, in part, "Rhuhel in particular has suffered irreversible damage to his eyes. He suffers from a condition where the cornea of his eye is misshapen (into a shape like a rugby ball). The condition is controllable by a gas-permeable contact lens. . . . Throughout the time he was at Guantánamo, he was urgently asking for lenses. . . . No lenses were ever provided. . . . His eyesight has drastically deteriorated as a result."

In the former interrogator's view, fewer than a quarter of the detainees had any intelligence value. More important, he said that most of the coercive methods used on the detainees at Guantánamo were counterproductive. As he explained to the lawyer, "If you don't have a terrorist now, you will by the time he leaves."

**E**steban Rodriguez, the chief of interrogations, said that the interrogations at Guantánamo have provided invaluable information that may have saved American lives. He said that he still uses BSCT members in interviews with detainees. He also said that he doesn't use techniques such as sleep deprivation, sexual humiliation, or isolation. "I have no place to isolate people!" he said. This argument seemed dubious after I toured Camp Five, a new maximum-security facility in Guantánamo Bay, in which high-value detainees are confined in sealed white climate-controlled cells. (Officials later explained that they call this "segregation," not "isolation.")

Lawyers for the detainees also dispute Rodriguez's claim. Although they acknowledge that the situation at Guantánamo has improved, they say that some of the aggressive techniques are still practiced. Joshua Colangelo-Bryan, an associate at Dorsey & Whitney, a law firm that represents six detainees from Bahrain, recently told me, "I have clients who have been kept for over a year in cells by themselves. Other than for interrogations or occasional showers, they are allowed out of their cells for no more than an hour of exercise a week, during which they are alone in small exercise pens. That those who run Guantánamo choose not to describe these arrangements as isolation or solitary confinement does not change reality. My clients have been utterly deprived of human contact—other than with interrogators and guards—for over a year and, according to the government, could be deprived of human contact for the rest of their lives."

During Colangelo-Bryan's last two visits to Guantánamo, in October, 2004, and March, 2005, one of his clients, Jumah al-Dossari, a Bahraini whom U.S. authorities caught in the Tora Bora region of Afghanistan, described his experience. Dossari said that a man who called himself Dr. P.—and who military police told him was a psychiatrist—had ordered him placed in isolation and deprived of both toilet paper and water for washing himself. Another psychiatrist quizzed him in detail about his childhood. On a separate occasion, he said, an interrogator wrapped him in Israeli and American flags. The interrogator told him that there was a war going on between the Star of David and the Cross, on one side, and the Red Crescent, on the other. Then, Dossari said, the interrogator stepped on a Koran. Dossari told Colangelo-Bryan that he found the whole experience “bizarre.”

Dossari also claimed that he was beaten by riot police after he complained about personal items having been moved in his cell. During the beating, which was corroborated by Human Rights Watch, his head was bashed so hard against the metal floor that he fainted. He was taken to the naval hospital, where he was given a brain scan. According to Dr. Edmondson, the Navy captain, no doctor raised any questions with him about abusive treatment of Dossari.

Dossari also told Colangelo-Bryan that one time he was taken into an interrogation room whose door was open to an adjacent room filled with computers. Military police shackled him to the floor, he said. In the computer room, a naked man and woman were having sex on a table. Afterward, he said, the man put on his clothes and started to question him, telling him that if he coöperated he, too, could have sex with his “girlfriend.” Dossari said that he did not respond. (Esteban Rodriguez said that he had never heard of such an incident.)

Dossari claims to have spent the past eighteen months in solitary confinement. Colangelo-Bryan said that he had concerns about his client's mental state. He told me, “On the last day of one visit, as I was about to leave, he looked me directly in the eye and in a very quiet voice asked, ‘What can I do to keep myself from going crazy?’”

Exerting psychic stress is, of course, the goal of the SERE program. To the extent that scientists and doctors are implicated in this process, Jonathan Moreno, the bioethicist, worries that “Guantánamo is going to haunt us for a long time.” He said, “The Hippocratic oath is the oldest ethical code we have. We might abandon our morality about other professions. But the medical profession is sort of the last gasp. If we give that up, we’ve given up our core values.” ♦



24 June 2006

James E. Mitchell, Ph.D.  
[REDACTED]  
[REDACTED]


JUN 28 2006

To: APA Membership Department  
750 First Street, NE  
Washington, DC 20002-4242

My APA membership number is [REDACTED]

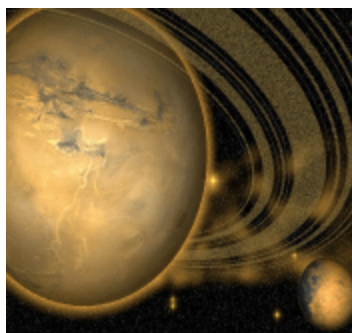
Effective immediately, please consider this my official resignation from the American Psychological Association. My dues are paid up through 2007; however, I no longer wish to be a member of this voluntary organization. Hereafter, I do not want to receive APA mailings or requests for payment of membership dues.

Thank you,

  
James E. Mitchell, Ph.D.

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## Can the Name of an Organization Be an Ethical Issue? (pp. 13-15)

**\$45.00**

**Authors:** H. Steven Moffic

### Abstract:

For many years now, as a psychiatrist, I've been concerned with the acronym APA. Although it can refer to the American Philosophical Association, most commonly in our work sphere, it refers either to the American Psychiatric Association or the American Psychological Association. Does the potential confusion of sharing this acronym matter? And, if it does matter, does it matter in an ethically significant way? It is well known that the public often confuses the identity of psychiatrists versus psychologists. In that sense, sharing the APA moniker continues that confusion. Of course, the worst ethical outcome in this sense is that the public can seek the wrong professional for what they need. Perhaps we need some data on that. Psychiatrists sometimes try to get around this by calling ours the "Big APA" and the psychologist one the "Little APA". Maybe that refers back to the earlier origin of the American Psychiatric Association. But it is not close to being the biggest in current numbers. How psychologists make any distinction I'm not sure of. Now, Section 2 of the American Association of Psychiatric Administrators' (AAPA) "Ethical Principles for Psychiatric Administrators" states that "A physician shall deal honestly . . ." This APA acronym may not quite meet that principle, wouldn't you agree?

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Friday 26 June, 2015

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## Interrogation & Risk Assessment.

Gelles - Tension between jumping in to help  
US. standing off due to ethical concerns.

Consulting on an unknown adversary.

Psychologists as adjuncts to interrogation

Fitting in when expertise is demanded

How to understand our own competence

The article was set to draw boundaries.

## Shamate

Take on oath to protect & defend

engaging enemy capable of mass destruction  
put in difficult circumstances

Tactical information & intelligence

standards of conduct may differ from  
strategic circumstances.

Practical application of ethical codes in  
context of competing duties and oaths.

Ticking bomb scenario, how do they effect  
decision-making process.

Tony Clint Eastwood

Greater goods

Absolute vs. Relative ethics.

Customs & Morals of other cultures we're dealing with.

Morgan

Hard to resist the outside world's view that mental health professionals must have an answer - we're quick to offer even when we don't know.

Geller - notion that I can't get the info you can. These are not patients. Very about is the interrogation.

Phillips - role in agency

conflicts of conscience vs. it's all inherently unethical.

Shenute - interrogations run across extremes.  
benign → to

Kinnscheff -

Situational assessments -

- Cocktail conversation

- surreptitious access of private computer records

Jeff - Identifying as mental health professionals  
and say who were working for  
- whether forensic or clinical under a policy

Granitz

- we've been called to serve
- duty to deliver credible, ethical service.  
citizens and psychologists.

Survey of APA ethical codes

1st and foremost responsibility,  
patient, client.

reference in current code to the group  
"society"

Supposed to do no harm.

mental health professional working on  
capital murder case

Kirk

use power of psychology to exploit  
and manipulate

Fern - 3 Case for detainment.

Intelligence value

Law enforcement value

risk of release



little in the literature to guide  
Guantanamo detainees.

Asked to advise on the risk assessment  
piece w/o real training  
who is the community that we can talk  
to for guidance.

Bond

Emergency psychiatry  
involuntary commitment or restraint or  
medication.

Make these decisions everyday but  
don't go the torture route

There are models.

Morgan: people give us permission to do that.

Guantanamo - as a giant Skinner box positive reinforcement  
why didn't we shape their behaviour? Prison model  
Chinese very good at it

Growth - a 9-11 II

Kinschell - lots of naturalistic experiments  
go in on.

At what point does deception work

Kandarian - interrogation manual found  
counter-responses.

Gelles - What is our role  
The agency is the client.  
interrogator  
behind the glass  
sit in the room  
design the strategy  
write the script.

Andy - Milgram  
couldn't replicate at Bridgeport.  
What helps us check our behavior.

Skurnate - Classified forum where consult  
isn't an option.

or where consult is with those who are  
thinking the way you do.

Psychologists as part of identity.

Ethics code helps provide an internal check.

Gelles & Jellison.

If the client is the interrogator  
do you owe nothing to the subject.

Honesty and striving for objectivity.

Wilford et al -

Use of versed vs. self-inflicted gunshot wound

Dr. gives police drug to use.

Schemate

Permanent impact.

Phillips - honesty to the client vs. process.

Cred example

Gelles - understanding the client/agency  
competence

Not a clinician, not a mental health professional  
now a behavioral scientist.

MD's are trained as clinicians first.

Should psychologists conduct interrogations

Gronitz - public perception of Dr 50 & 50  
Philips - distancing yourself from your identity  
your 1<sup>st</sup> capacity should dictate behaviour.

Jellrey - why are you in the room  
can't just drop your hat conveniently  
to fit the situation.

Gronitz - can't wear both hats at once

Kinschell -

Tony - encouraging multiple personalities

Philips - we have greater clarity between  
clinical and forensic but less so about  
consultative services in intelligence work.

Kinschell -

Rape case - trophy-taking - deception.  
Balancing values and interests.

Tarasoff doesn't apply in Virginia

Morgan - coercing patients all the time.

{ Ethics codes modified with exceptions all the time - on privacy, deception.

Schemate - death of information on what works in interrogation.

Morgan.

Official undercover - on the stand.

Fein - How can APA be a resource?

Morgans - Don't ask Don't tell example.

Behrke - What resources are available to those in the agencies.

Russ - notes that this group is not dissimilar from other pockets of the practice community on other issues

Fein - Assessing credibility of Embassy walk-in  
Communicating on classified issues.

Schumate-

Morgan- using available venues. to  
conduct empirical evaluations.

Kish- New on separate section of code.



**PUBLIC POLICY UPDATE**

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## When legislative objectives are in conflict

**APA's support of antitorture legislation and a Department of Defense psychology training program pays off.**

By Geoff Mumford, PhD  
March 2006, Vol 37, No. 3  
Print version: page 68

In response to the national tragedy of Sept. 11, APA's Science Directorate staff convened a series of workshops to advance psychological research relevant to counterterrorism and national security issues. As such, the Science Directorate entered new territory, reaching out to federal personnel in the homeland security, law enforcement, defense and intelligence communities in an effort to integrate psychological theory and practice in these areas. As the directorate developed relationships with psychologists working in these settings, APA learned that they face a unique set of concerns.

### **Psychological ethics and national security**

More than a year and a half ago, APA held a first-of-its-kind meeting at its headquarters in Washington, D.C., to begin discussions about the extent to which the APA Ethics Code adequately served psychologists operating in national security settings. The meeting was held in response to APA members from these communities who had approached APA, seeking help in defining ethical guidelines to govern their work. The meeting was exploratory in nature and brought together a unique group, including representatives of other mental health associations as well as behavioral scientists and operational personnel working in the law enforcement and intelligence communities. That seminal meeting led APA to begin to explore the extent to which its Ethics Code spoke to the unique circumstances that sometimes surround gathering information related to national security. The Presidential Task Force on Psychological Ethics and National Security (the PENS Task Force) explored these questions in greater depth.

The PENS Task Force met last June. The resulting task force report was released in July for public comment and was a vanguard policy statement well in front of other mental health professional associations. Importantly, the task force report reaffirmed APA's 1986 Council resolution against torture and other forms of cruel, degrading or inhuman treatment, and also affirmed the appropriate role psychologists can play in supporting national security investigations as well as the strict ethical boundaries that will inform that role. The report furthermore recommended that psychologists continue to conduct research relevant to national security settings. The report was approved as policy by the APA Board of Directors in July and was accepted by APA's Council of Representatives later that fall.

Although some popular press reports and some mental health professionals criticized and miscast the APA position, it should be noted that APA took every opportunity to correct the record and clarify its position with, for example, high profile placements in *The New York Times* and *The Lancet*.

However, the issue of detainee abuse intensified when it was reported that several men held in a Baghdad prison under Iraqi Interior Ministry control had suffered grievously at the hands of their guards and that foreign prisons under CIA control were being used for interrogation. These and mounting concerns about what exactly constituted torture eventually led to a showdown between Sen. John McCain (R-Ariz.) and the Bush administration. But what APA members may not realize is the unusual position APA was in at that point from a public policy perspective.

An amendment to the defense appropriations bill, popularly known as "the McCain amendment," called for uniform standards of interrogation for Department of Defense detainees and a prohibition on the use of cruel, inhuman or degrading treatment of individuals in custody of, or under the physical control of, the U.S. government, whether it be in the United States or internationally. The amendment provided an opportunity for APA to take a very public stand

because the text was entirely consistent with our decadelong position against torture and other cruel, inhuman or degrading treatment.

Interestingly, the Senate and House of Representatives, although both led by Republican majorities, were at very different places in the overall debate. While the Senate approved the amendment overwhelmingly, the House was backing the Bush administration and vehemently opposed any provision that would limit the range of executive branch interrogation practices. However, the tension between the two chambers held even greater significance for APA because attached to the House version of that bill was an Education Directorate training initiative coordinated by APA education policy staff and designed by Department of Defense (DoD) psychologists (see box). APA realized that backing the McCain amendment would likely put in jeopardy funding for a program that would benefit psychology and psychologists because the Republican champion for this nascent Defense Graduate Psychology Education (D-GPE) Program might not be inclined to continue supporting it in the final bill if he took umbrage at APA's endorsement of an amendment he opposed.

### **A program in jeopardy**

This situation brings to light just how complex some of our policy issues become when pursuit of broader APA interests potentially jeopardize federal program initiatives developed and advanced by APA staff and members. In this case, the proposed \$4 million D-GPE program was put in potential jeopardy when APA went on record in support of the McCain amendment. There was no question that it was the right thing for APA to do, but it was also a sad day for the internal and external advocates of the D-GPE program who were looking at the possible adverse outcomes. Many of us feared for the worst: that not only would the McCain amendment fail to pass but also that the D-GPE provision would be dropped from the final bill.

On Oct. 28, APA sent letters to the leaders of the conference negotiations in the House and Senate who were working out the differences between the two versions of the defense funding bill. The letters reaffirmed APA's 1986 Council of Representatives resolution against torture and support for the U.N. Principles of Medical Ethics and requested that they support the McCain amendment. In addition, APA distributed an action alert via its Public Policy Advocacy Network requesting that APA members contact their elected representatives and urge support for the McCain amendment.

Fortunately, APA's stance in support of human rights prevailed when the administration agreed to a compromise and the House passed the defense appropriations bill with the McCain amendment attached. And while funded at \$3.4 million rather than the original \$4 million request, the D-GPE program likewise remained in the bill.

As for the PENS Task Force report, it remains open for public comment through June 30. Comments will be essential in following a PENS Task Force recommendation that a casebook/commentary on the task force report be written. Such a casebook/commentary will certainly benefit from reviews of research on topics such as confirmation bias in investigational settings, the ease with which individuals can be coerced into false confessions and improved methods for detecting deception. APA encourages individual scientists to think broadly about how their own research might inform such an effort and submit comments for possible inclusion in the commentary. Science Directorate staff will continue to staff the PENS Task Force in conjunction with the Ethics Office to help ensure that the special knowledge base that psychology offers can be brought to the fore in the service of our national security interests.

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#### **Find this article at:**

<http://www.apa.org/monitor/mar06/ppup.aspx>























## Hard Copy Comments

Email exchange between Edmund Nightingale and Celia Fisher, July 2001

What a wonderfully complete reply. Thank you for your efforts on behalf of the revision, but more especially for the thoughtfulness of your reply.

I am not in agreement with the move away from specificity in standards and away from guidelines toward more generalities. I suppose that this sea change may suit the needs of some constituencies who are concerned about lawsuits and overly zealous boards, but my own concern is educative, both for psychologists, students, and for the public, and from my own point of view, those needs are better served by standards which address some of the concerns of specific groups. Isolated guidelines run the risk of being just that, isolated. I have been a APA accreditation site visitor for 15+ years. One of the things I look for in departments is a set of APA documents to include the Ethics Code AND the various sets of guidelines appropriate to the setting and or training to be provided. I nearly always find copies of the current Ethics Code. I have found only one instance where a sets of guidelines appropriate to the setting were found - other than to say they "...are in the back issues of the American Psychologist to be found in our library..." - not exactly living documents.

Obviously people of good will may differ on their approach to these issues. The process is necessarily political and I may speak for a minority of psychologists.

Thanks again for your conscientious and well thought out reply. May I forward it to the Division 18 listserv?

Edmund J. Nightingale, Ph.D. ABPP  
Director for Psychology  
Minneapolis VAMC

Dear Ed,

Thank you again for your kind comments on Draft 5. This email is written to give you some background on the ECTF June 2001 discussions and to assure you that the concerns of police and correctional psychologists are of continuing importance to the ECTF.

In response to over 800 comments, at our June meeting the ECTF discussed how to consolidate elements in the Code so that it would be as generally applicable as possible. One issue that we struggled with was whether we could identify terminology that would be inclusive of work with individual, organizational, and public service clients and practice settings. Out of the ECTF discussions came the recognition that such an approach could not adequately serve each of these areas of practice. We therefore asked a group composed of ECTF members Dennis Grill (representing the perspectives of public service psychology) and Tom Oakland (representing the perspectives of school psychology) and ECTF observers present at the meeting from Division 13 (consulting psychology) and Division 14 (organizational psychology) to provide us with specific recommendations for addressing the issues of psychologists working in organizational and public service settings for the ECTF's next meeting scheduled for October 2001.

I will be in contact with this group prior to our October meeting and would welcome the opportunity to meet with you at APA in San Francisco to get your additional input.

However, I would like to provide you information as to two basic characteristics of the current APA Ethics Code and the revision to date. These include a) limited references to specific areas/specialties and b) limited inclusion of statements that are more generally considered "guidelines" for best practices within specific areas or specialties of psychology rather than ethical "standards." The number of references to specialties or areas of psychology in the current Ethics Code are very limited, and appear almost entirely in the third paragraph of the Introduction. The number that might be added are large, and the ECTF has been cautious in making such additions. In the February 2001 published draft, only three significant

changes were made in this regard: "not limited to" was added to make that point explicit, "school" (one of four areas covered in specialty guidelines) was added to "the clinical or counseling practice...." and "forensic activities" was added. No significant change was made from the published draft to Draft 5. A challenge for inclusion of reference to any specific group is to establish the need to include that group in a way that would not argue for inclusion of numerous others.

As you may recall, at both our October 2000 and June 2001 meetings the ECTF worked to address the issues raised by yourself and Gil Sanders (in my phone conversation with him). In addressing the specific points about challenges facing police and correctional psychologists the ECTF had to weigh what it considers material for "guidelines" and not for Ethics Code standards. This is the style of the current Ethics Code, and comments received by the ECTF argue for continuing this style. Some groups (e.g. the I/O, forensic, and teaching divisions) have produced their own documents providing guidance about the Ethics Code without extending its enforceable scope. APA documents such as the "Record Keeping Guidelines" are specifically designed not to be part of the Ethics Code. Based on comments from APA constituencies, even the footnote in the current Ethics Code that lists the guidelines was deleted from Draft 5 of the revision.

Within this context we attempted to address three concerns of public service psychologists. The first (a change made from the current Ethics Code to the published draft) was to change the title of what is Standard 1.02 in draft 5 to "Conflict Between Ethics and Law, Regulations, or Other Governing Legal Authority." This change was made to address the concern that psychologists in correctional facilities are often caught between conflicting demands of their facilities and the ethics code, and that it should be completely clear that conflict between ethics and law in this context includes conflicts between ethics and law, regulations, and legal governing authority.

The ECTF also continued to try to address concerns of psychologists working in public service and organizational settings regarding informed consent for assessments. Standard 9.03(a) "Informed Consent for Assessments" now reads:

"(a) Psychologists obtain informed consent for assessments, evaluations, or diagnostic services, as described in Standard 3.10, Informed Consent, except when (1) testing is mandated by law or governmental regulation, (2) informed consent is implied because testing is conducted as a routine educational, institutional, or organizational activity (e.g., when participants voluntarily agree to assessment when applying for a job); or (3) one purpose of the testing is to evaluate decisional capacity.

Finally, we were very aware of the concern that psychologists in correctional facilities are often viewed as "correctional staff" first, and psychologists second. Therefore, superiors can order a psychologist to take a correctional staff role that requires them to "pat down" or even "shoot" someone they may be seeing as a client/patient in their role as a psychologist. The ECTF recognized that psychologists in these facilities would like more support from the code in helping them to refuse to participate in these types of activities. We attempted to clarify this standard in a way that we hope is helpful for psychologists in correctional facilities. Based upon the general standard format that I have described above, we were not able to include terminology specific to correctional institutions, but we do think that serving in the dual roles described above falls under the Standard 3.05, Multiple Relations description of proscribed multiple relationships:

"A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist or otherwise risks exploitation or harm to the person with whom the professional relationship exists." (See full text of Draft 5 Standard 3.05).

I would also like to call attention to my cover memo to Draft 5 that provided rationale for the deletion of the forensic section in Draft 5. In response to member comment, the assessment by the ECTF was that the overall Ethics Code would be best served by eliminating this section.

Received by e-mail, February 20, 2002

Nightingale, Edmund J. wrote:

Hi Celia,

Nicely done at COR last weekend! The point which I mentioned briefly is that the current ethics code focuses on a number of general issues and then upon certain specific activities of psychologists such as assessment, therapy, teaching, and research.

I wondered aloud whether activities such as advising a physician on psychotropics, a politician on self-presentation and "spin" on information and events, "psychological profiling", hostage negotiation, consultation with police interrogators in vivo who are trying to "break down" a suspect [at this point still innocent until proven guilty], with SWAT teams, national intelligence organizations (CIA, NSA, FBI, etc) would have anything in common with each other which would not be covered already in the more general principles. Perhaps the general principle of "beneficence" covers it, but there are certainly competing views about who benefits from some of these activities....perhaps some principles on Consultation as an activity would make explicit what is already implicit in the larger picture.

Perhaps another time, another place would be the venue for these issues to be considered.

Edmund J. Nightingale, Ph.D.ABPP  
Director for Psychology  
Minneapolis VAMC

## Online Comments

Comment ID = 122 Nightingale, Edmund

1.01 (a) Misuse of Psychologists' Work

BY "SUCH AS THOSE PROVIDED IN LEGAL PROCEEDINGS" ARE YOU REFERRING TO THE PROCESS OF CROSS-EXAMINATION, REBUTTAL, ETC.? Are there other examples of such 'correctable fora'?

Comment ID = 123 Nightingale, Edmund

5.01 (c) Avoidance of False or Deceptive Public Statements

I note that in (b) academic degrees and "credentials" are mentioned separately, but in (c) credentials seem to be limited (by the grammatical construction) to only degrees. I would like to see something said about other credentials which individuals routinely proffer: Diplomates; Certifications by Am Grp Psychotherapy Assn; American Soc of clin Hypnosis, etc. I am especially concerned about the proliferation of "vanity boards" not a part of the ABPP process (the Monitor even accepts ads for them), and their presentation by psychologists as credentials. Is ABPP accredited by a recognized body? If so, can the use of such credentials be limited to Boards with such recognition?

ECTF Review: Nabil El-Ghoroury

Change in language is required

Proposed Change: 5.01c Psychologists claim as degrees for their psychological work that were either 1) earned from a regionally accredited educational institution, or 2) the basis for psychology licensure by the state in which they practice.

Rationale: 5.01 c as it stands is talking about degrees that psychologists hold, not credentials (such as ABPP, fellow status, etc). If it refers to only degrees, then we should limit the standard to degrees. as the reviewer notes, 5.01b distinguishes between degrees and credentials. If we want to limit credentials as well, then perhaps 5.01 b should be amended. I'm not sure what to do about the question about vanity boards.

Comment ID = 124 Nightingale, Edmund

5.02 (c) Statements by Others

"as such" has an unclear referent. Could be the fact of being a paid ad, or the fact of being a description of a PSYCHOLOGIST'S activities. Could say "recognizable as an advertisement."

Comment ID = 125 Nightingale, Edmund

6.01 Documentation of Professional and Scientific Work and Maintenance of Records

(b) This standard is unworkable in many settings where there is a "paperless" medical record. No one is able to predict which clinicians at what times may have access to the information, now or in the future. Admittedly, patients in large medical centers give a general consent to having their data shared with their entire care team, on a need to know basis, but the record has a life of its own.....

Comment ID = 127 Nightingale, Edmund

6.01 Documentation of Professional and Scientific Work and Maintenance of Records

I see no reference here to the "Record Keeping Guidelines" issued by APA within the last few years, and after the 1992 code was issued. Should these parameters not be spelled out or at least referenced here?

Comment ID = 126 Nightingale, Edmund

6.02 (b) Maintenance, Dissemination, and Disposal of Confidential Records of Professional and Scientific Work

I accidentally put my comments for this section under 6.01. Please see that comment as to why this section needs to be dropped.

Comment ID = 128 Nightingale, Edmund

6.05 (e) Fees and Financial Arrangements

I would say something here about recipients of capitated services. "Psychologists do not knowingly enter into capitation agreements which would lead them to limit care to recipients of their services solely for financial reasons."

Comment ID = 129 Nightingale, Edmund

6.06 Barter With Clients/Patients

add a third condition to barter... "and (3) where the terms of the barter (relative value of services) are set by a third party or bartering brokerage." This insures that decisions about the relative value of the labor are not determined in a relationship of unequal power.

Comment ID = 130 Nightingale, Edmund

6.08 Referrals and Fees

Some statement should be made to discourage arrangements which are clearly exploitative of the psychologists who enters into a quasi "rental" arrangement. In some, 50% of the fee charged is considered "rental" or overhead for the owner of the clinic.... "Psychologists neither pay nor ask for "rental fees" for space, with or without referral of clients, which are based on a percentage of billings or of fees collected"

Comment ID = 131 Nightingale, Edmund

8.02 Informed Consent to Research

(a) (5) "any prospective research benefits for themselves or for the advancement of the science." This is especially important in medical research, in which psychologists often participate as co-investigators or as methodologists....

Comment ID = 132 Nightingale, Edmund

8.07 (b) Deception in Research

delete the word "severe." Is emotional pain any less important than physical pain? Do we really want to endorse infliction of any kind of pain without consent?



Comment ID = 133 Nightingale, Edmund

8.08 (c) Debriefing

In those instances where deception limited the freedom of the individual to choose whether or not to be exposed to physical or mental harm, the researcher must be prepared to underwrite ameliorative care.

Comment ID = 134 Nightingale, Edmund

8.11 Plagiarism

The construction here seems murky to me. We do or do not present others work as out own. Needless to say "not." The qualifying phrase is confusing. Better to state. All such work imported into one's own product is fully cited at every instance of its use."

Comment ID = 135 Nightingale, Edmund

8.12 (a) Publication Credit

Add the word "substantially" to the end of the sentence. Minor contributions should be acknowledge only with a footnote. "Proprietorship of a lab or clinical research environment does not entitle the proprietor to a co-authorship, nor does proprietorship of data grant autmatic entitlement to such recognition. "

Comment ID = 136 Nightingale, Edmund

9.02 (a) Development and Use of Assessments

This standard seems to preent a pretty high level of requirement for the scientific demonstration of an instrument's utility. When we talk about empirically supported Treatments, there are usually three levels or classifications: (1) Fully proven; (2) Those with some empirical support; (3) Those with some clinical evidence....I am not recalling the "terms of art" for these three levels, but should we not provide a similar latitude to medicine's community standard?

Comment ID = 139 Nightingale, Edmund

9.02 (d) Development and Use of Assessments

I would be more explicit here about the limitations of cross-linguistic testing. There are at least four versions of the MMPI-2 in Spanish (Cuban, Puerto Rican, Mexican, etc) some of which have been carefullu translated and back translated for accuracy. Most are still without their own normative data -- use of these tests based upon American norms is iffy at best, inappropriate at worst....

Comment ID = 137 Nightingale, Edmund

9.03 (b) Informed Consent In Assessments

"...nature and purpose of the proposed assessment services, and of any any emotional distress which may ensue during the process...." At our facility we typicly inform a patient that they might find the interview or testing disturbing information or thoughts are elicited. They are invited to share that experience with the examiner who can intervene as appropriate.

Comment ID = 138 Nightingale, Edmund

9.04 Release of Test Data

This statement is too inclusive and not specific enough. e.g. IQ scores would be covered here. While our practice is to report the label of the range into which a score falls, we typically report the IQ parenthetically. State law here gives a client full access to their records, except for the actual test protocols manual, scoring algorithms, etc which are proprietary and need to be protected to maintain their validity. Another issue is the vagueness of the standard about who is qualified to receive the information. Most psychiatrist will consider themselves qualified to receive the information (whether they are qualified to interpret it or not). I like the old standard which spoke to release of "raw data"-- because it allowed more wiggle room. Once a report has been written with appropriate scores included, it is no longer "raw." If another professional chooses then to re-interpret and misinterpret what is there, that is their liability, not ours. Radiologists have the same issues, yet they do not restrict access to the films by other clinicians. They simply insist that films not be released without a radiologist's report....

Comment ID = 140 Nightingale, Edmund

9.07 Assessment by Unqualified Persons

There are a number of instruments which are sold by publishers (a number of firms directed by psychologists) to all comers. Our new Test-user qualification standards are more of a self-user guide than a publisher guide. MMPI-2 training conferences are offered to psychologists, psychiatrists, and some social workers. We need to say more OR less. More would be to add that those training test users need to assure themselves that the backgrounds of the participants in testing or measurement theory is sufficient to be able to use the instrument intelligently, OR we need to restrict the process to psychologists (probably untenable) in the current climate. Consider that the MMPI was developed by a psychiatrist and a psychologist. The Beck, etc...

Comment ID = 141 Nightingale, Edmund

9.08 (a) Obsolete Tests and Outdated Test Results

Add here "Psychologists do use old data, provided they can be assured of its accuracy and the conditions under which it was gathered, as points of comparison with current data in an effort to understand clinical changes which may have taken place over time."

Comment ID = 142 Nightingale, Edmund

9.09 (c) Test Scoring and Interpretation Services

add "Unedited automated (therefore "blind") interpretations are never to be presented to the public as valid, nor as the psychologist's own work."

Comment ID = 143 Nightingale, Edmund

10.01 (a) Informed Consent to Therapy

"...nature and anticipated course of therapy, risks and expected benefits of the proposed intervention(s), other empirically supported alternative treatments..."

Comment ID = 144 Nightingale, Edmund

10.02 (b) Couple and Family Relationships

This statement waffles, ought to be more explicit about which role is incompatible. Obviously a psychologist who testified against one partner and for another in a custody eval would probably not be appropriate as a therapist for the couple who are thinking of reconciliation. It seems to me that a psychologist who undertakes couples therapy which fails to restore the bond, commits a betrayal of that relationship when testifying about custody. I think that should always be referred out.

Comment ID = 145 Nightingale, Edmund

10.03 Group Therapy

change "and the limits of confidentiality" to read "and the limits of confidentiality when parties other than the psychologist are party to the information."

Comment ID = 146 Nightingale, Edmund

10.08 (b) Sexual Intimacies With Former Therapy Clients/Patients

"...nor do they engage in sexual relations with parents, guardians, spouses, partners, or former partners of former patients after the two-year period without due consideration for all of the issues outlined in this section."

Comment ID = 147 Nightingale, Edmund

11. FORENSIC ACTIVITIES

A section similar to this ought to be added for provision of psychological services by police and public safety psychologists OR correctional psychologists. It ought to cover the necessity for special training and for empirical study of techniques used in hostage negotiation, deferral to SWAT team decisions, and providing advice live, out of sight, to interrogators of suspects in criminal investigations. There ought to be a standard about the involvement of forensic or social psychologists in jury selection, a process which may be used to subvert or enhance a judicial outcome, depending upon your point of view.

Comment ID = 148 Nightingale, Edmund

This comment was made on behalf of the group Division 18

11. FORENSIC ACTIVITIES

I meant to characterize my prior comments about this section and the suggestions about a section on Police and correctional psychology as made on behalf of Div 18

# Report of the American Psychological Association Presidential Task Force



## *on Psychological Ethics and National Security*

**NOTE:** In July 2013, APA's governing Council of Representatives adopted the "[Policy Related to Psychologists' Work in National Security Settings and Reaffirmation of the APA Position Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment](#)." This policy unifies into a single document prior APA policies dating to 1986 related to detainee welfare and interrogation. **As part of the policy reconciliation process, the council also voted to rescind the 2005 Report of the APA Presidential Task Force on Psychological Ethics and National Security (PENS) and two other APA policies dated 2007 and 2008.** These policies had become outdated or rendered inaccurate with the passage of subsequent policies, most notably a 2010 revision of the APA Ethics Code and the 2013 policy.

**June 2005**

# **REPORT OF THE PRESIDENTIAL TASK FORCE ON PSYCHOLOGICAL ETHICS AND NATIONAL SECURITY**

## **I. Overview of the Report**

The Presidential Task Force on Psychological Ethics and National Security (PENS) met in response to the Board of Directors' February 2005 charge, that the Task Force:

[E]xamine 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 whether APA should develop policy to address the role of psychologists and psychology in investigations related to national security.

Recognizing the ethical complexity of this work, which takes place in unique settings and constantly evolving circumstances, the Task Force was nonetheless able to set forth 12 clear and agreed-upon statements about psychologists' ethical obligations.

As a context for its statements, the Task Force affirmed that when psychologists serve in any position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies. The Task Force thus rejected the contention that when acting in roles outside traditional health-service provider relationships psychologists are not acting in a professional capacity as psychologists and are therefore not bound by the APA Ethics Code.

The Task Force noted that the Board of Directors' charge did not include an investigative or adjudicatory role, and as a consequence emphasized that it did not render any judgment concerning events that may or may not have occurred in national security-related settings. Nonetheless, the Task Force was unambiguous that psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment and that psychologists have an ethical responsibility to be alert to and report any such acts to appropriate authorities. The Task Force stated that it is consistent with the APA Ethics Code for psychologists to serve in consultative roles to interrogation and information-gathering processes for national security-related purposes, as psychologists have a long-standing tradition of doing in other law enforcement contexts. Acknowledging that engaging in such consultative and advisory roles entails a delicate balance of ethical considerations, the Task Force stated that psychologists are in a unique position to assist in ensuring that these processes are safe and ethical for all participants.

The Task Force Report concludes with a series of recommendations to the American Psychological Association Board of Directors.

## II. Introduction to the Report

The Task Force believes it is critical for the American Psychological Association to address the ethical challenges facing psychologists whose work involves national security-related activities. APA is the world's largest association of psychologists. Article I of the Association Bylaws states:

The objects of the American Psychological Association shall be to advance psychology as a science and profession and as a means of promoting health, education and human welfare by the...improvement of the qualifications and usefulness of psychologists through high standards of ethics...[and] by the establishment and maintenance of the highest standards of professional ethics and conduct of the members of the Association...<sup>1</sup>

Many association members work for the United States government as employees or consultants in national security-related positions. It is the responsibility of APA to think through and provide guidance on the complex ethical challenges that face these psychologists, who apply their training, skills, and expertise in our nation's service.

The Task Force addressed the argument that when psychologists act in certain roles outside traditional health-service provider relationships, for example as consultants to interrogations, they are not acting in a professional capacity as psychologists and are therefore not bound by the APA Ethical Principles of Psychologists and Code of Conduct (hereinafter the Ethics Code).<sup>2</sup> The Task Force rejected this contention. The Task Force believes that when psychologists serve in a position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies. Thus in any such circumstance, psychologists are bound by the APA Ethics Code.

Principle B of the Ethics Code, Fidelity and Responsibility, states that psychologists "are aware of their professional and scientific responsibilities to society." Psychologists have 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. The Task Force believes that a central role for psychologists working in the area of national security-related investigations is to assist in ensuring that processes are safe, legal, and ethical for all participants.

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<sup>1</sup> American Psychological Association (2004). *Bylaws of the American Psychological Association* [Brochure]. Washington, DC: Author. (Also available at <http://www.apa.org/governance/>)

<sup>2</sup> American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060–1073. (Also available at <http://www.apa.org/ethics/>)

The Task Force looked to the APA Ethics Code for fundamental principles to guide its thinking. The Task Force found such principles in numerous aspects of the Ethics Code, such as the Preamble, “Psychologists respect and protect civil and human rights” and “[The Ethics Code] has as its goals the welfare and protection of the individuals and groups with whom psychologists work”; Principle A, Beneficence and Nonmaleficence, “In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons”; Principle D, Justice, “Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices”; and Principle E, Respect for People’s Rights and Dignity, “Psychologists respect the dignity and worth of all people.” The Task Force concluded that the Ethics Code is fundamentally sound in addressing the ethical dilemmas that arise in the context of national security-related work.

### **III. Twelve Statements Concerning Psychologists' Ethical Obligations in National Security-Related Work and Commentary on the Statements**

**1. Psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment.** The Task Force endorses the 1986 Resolution Against Torture of the American Psychological Association Council of Representatives,<sup>3</sup> and the 1985 Joint Resolution Against Torture of the American Psychological Association and the American Psychiatric Association.<sup>4</sup> (Principle A, Beneficence and Nonmaleficence, and Ethical Standard 3.04, Avoiding Harm) The Task Force emphasizes that the Board of Directors' charge did not include an investigative or adjudicatory role and so the Task Force does not render any judgment concerning events that may or may not have occurred in national security-related settings. The Task Force nonetheless feels that an absolute statement against torture and other cruel, inhuman, or degrading treatment is appropriate.

**2. Psychologists are alert to acts of torture and other cruel, inhuman, or degrading treatment and have an ethical responsibility to report these acts to the appropriate authorities.** This ethical responsibility is rooted in the Preamble, "Psychologists respect and protect civil and human rights...the development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically [and] to encourage ethical behavior by...colleagues," and Principle B, Fidelity and Responsibility, which states that psychologists "are concerned about the ethical compliance of their colleagues' scientific and professional conduct." (Ethical Standard 1.05, Reporting Ethical Violations) The Task Force notes that when fulfilling the obligation to respond to unethical behavior by reporting the behavior to appropriate authorities as a prelude to an adjudicatory process, psychologists guard against the names of individual psychologists being disseminated to the public. Inappropriate or premature public dissemination can expose psychologists to a risk of harm outside of established and appropriate legal and adjudicatory processes. (Ethical Standard 3.04, Avoiding Harm)

**3. Psychologists who serve in the role of supporting an interrogation do not use health care related information from an individual's medical record to the detriment of the individual's safety and well-being.** While information from a medical record may be helpful or necessary to ensure that an interrogation process remains safe, psychologists do not use such information to the detriment of an individual's safety and well-being. (Ethical Standards 3.04, Avoiding Harm, and 3.08, Exploitative Relationships)

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<sup>3</sup> American Psychological Association Council of Representatives. (1986). American Psychological Association resolution against torture. Retrieved from <http://www.apa.org/about/division/cpminternatl.html#3>

<sup>4</sup> American Psychiatric Association & American Psychological Association. (1985). Against torture: Joint resolution of the American Psychiatric Association and the American Psychological Association. Retrieved from [http://www.psych.org/edu/other\\_res/lib\\_archives/archives/198506.pdf](http://www.psych.org/edu/other_res/lib_archives/archives/198506.pdf)



**4. Psychologists do not engage in behaviors that violate the laws of the United States, although psychologists may refuse for ethical reasons to follow laws or orders that are unjust or that violate basic principles of human rights.** Psychologists involved in national security-related activities follow all applicable rules and regulations that govern their roles. Over the course of the recent United States military presence in locations such as Afghanistan, Iraq, and Cuba, such rules and regulations have been significantly developed and refined. Psychologists have an ethical responsibility to be informed of, familiar with, and follow the most recent applicable regulations and rules. The Task Force notes that certain rules and regulations incorporate texts that are fundamental to the treatment of individuals whose liberty has been curtailed, such as the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and the Geneva Convention Relative to the Treatment of Prisoners of War.<sup>5</sup>

The Task Force notes that psychologists sometimes encounter conflicts between ethics and law. When such conflicts arise, psychologists make known their commitment to the APA Ethics Code and attempt to resolve the conflict in a responsible manner. If the conflict cannot be resolved in this manner, psychologists may adhere to the requirements of the law. (Ethical Standard 1.02) An ethical reason for psychologists to not follow the law is to act “in keeping with basic principles of human rights.” (APA Ethics Code, Introduction and Applicability) The Task Force encourages psychologists working in this area to review essential human rights documents, such as the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and the Geneva Convention Relative to the Treatment of Prisoners of War.<sup>6</sup>

**5. Psychologists are aware of and clarify their role in situations where the nature of their professional identity and professional function may be ambiguous.**

Psychologists have a special responsibility to clarify their role in situations where individuals may have an incorrect impression that psychologists are serving in a health care provider role. (Ethical Standards 3.07, Third-Party Requests for Services, and 3.11, Psychological Services Delivered to or Through Organizations)

The Task Force noted that psychologists acting in the role of consultant to national security issues most often work closely with other professionals from various disciplines. As a consequence, psychologists rarely act alone or independently, but rather as part of a group of professionals who bring together a variety of skills and experiences in order to provide an ethically appropriate service. (Ethical Standard 3.09, Cooperating with Other Professionals)

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<sup>5</sup> United Nations. (1987, June 26). *Convention against torture and other cruel, inhuman or degrading treatment or punishment*. Retrieved from [http://www.unhchr.ch/html/menu3/b/h\\_cat39.htm](http://www.unhchr.ch/html/menu3/b/h_cat39.htm)

United Nations. (1950, October 21). *Geneva convention relative to the treatment of prisoners of war*. Retrieved from <http://www.unhchr.ch/html/menu3/b/91.htm>

<sup>6</sup> Ibid.

Regardless of their role, psychologists who are aware of an individual in need of health or mental health treatment may seek consultation regarding how to ensure that the individual receives needed care. (Principle A, Beneficence and Nonmaleficence)

**6. Psychologists are sensitive to the problems inherent in mixing potentially inconsistent roles such as health care provider and consultant to an interrogation, and refrain from engaging in such multiple relationships.** (Ethical Standard 3.05, Multiple Relationships, “A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist’s objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.”)

**7. Psychologists may serve in various national security-related roles, such as a consultant to an interrogation, in a manner that is consistent with the Ethics Code, and when doing so psychologists are mindful of factors unique to these roles and contexts that require special ethical consideration.** The Task Force noted that psychologists have served in consultant roles to law enforcement on the state and federal levels for a considerable period of time. Psychologists have proven highly effective in lending assistance to law enforcement in the vital area of information gathering and have done so in an ethical manner. The Task Force noted special ethical considerations for psychologists serving as consultants to interrogation processes in national security-related settings, especially when individuals from countries other than the United States have been detained by United States authorities. Such ethical considerations include:

- How certain settings may instill in individuals a profound sense of powerlessness and may place individuals in considerable positions of disadvantage in terms of asserting their interests and rights. (Ethical Standards 1.01, Misuse of Psychologists’ Work, and 3.08, Exploitative Relationships)
- How failures to understand aspects of individuals’ culture and ethnicity may generate misunderstandings, compromise the efficacy and hence the safety of investigatory processes, and result in significant mental and physical harm. (Principle E, “Psychologists are aware of and respect cultural, individual, and role differences, including those based on...race, ethnicity, culture, national origin... and consider these factors when working with members of such groups”; Ethical Standard 2.01(b), Boundaries of Competence, “Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with...race, ethnicity, culture, national origin...is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals...”; and Ethical Standard 3.01, Unfair Discrimination, “In their work-related activities, psychologists do not engage in unfair discrimination based on...race, ethnicity, culture, national origin...”)

- How the combination of a setting's ambiguity with high stress may facilitate engaging in behaviors that cross the boundaries of competence and ethical propriety. As behavioral scientists, psychologists are trained to observe, respond to, and ideally correct such processes as they occur. (Principle A, Beneficence and Nonmaleficence, and Ethical Standard 3.04, Avoiding Harm)

**8. Psychologists who consult on interrogation techniques are mindful that the individual being interrogated may not have engaged in untoward behavior and may not have information of interest to the interrogator.** This ethical obligation is not diminished by the nature of an individual's acts prior to detainment or the likelihood of the individual having relevant information. At all times psychologists remain mindful of and abide by the prohibitions against engaging in or facilitating torture and other cruel, inhuman, or degrading treatment. Psychologists inform themselves about research regarding the most effective and humane methods of obtaining information and become familiar with how culture may interact with the techniques consulted upon. (Principle E, Respect for Peoples' Rights and Dignity; Ethical Standards 2.01, Boundaries of Competence; 2.03, Maintaining Competence; and 3.01, Unfair Discrimination)

**9. Psychologists make clear the limits of confidentiality.** (Ethical Standard 4.02, Discussing the Limits of Confidentiality). Psychologists who have access to, utilize, or share health or mental health related information do so with an awareness of the sensitivity of such information, keeping in mind that "Psychologists have a primary obligation and take reasonable precautions to protect confidential information..." (Ethical Standard 4.01, Maintaining Confidentiality) When disclosing sensitive information, psychologists share the minimum amount of information necessary, and only with individuals who have a clear professional purpose for obtaining the information. (Ethical Standard 4.04, Minimizing Intrusions on Privacy) Psychologists take care not to leave a misimpression that information is confidential when in fact it is not. (Ethical Standards 3.10, Informed Consent, and 4.02, Discussing the Limits of Confidentiality)

**10. Psychologists are aware of and do not act beyond their competencies, except in unusual circumstances, such as set forth in the Ethics Code.** (Ethical Standard 2.02, Providing Services in Emergencies) Psychologists strive to ensure that they rely on methods that are effective, in addition to being safe, legal, and ethical. (Ethical Standards 2.01, Boundaries of Competence; 2.04, Bases for Scientific and Professional Judgments; 9.01, Bases for Assessments)

**11. Psychologists clarify for themselves the identity of their client and retain ethical obligations to individuals who are not their clients.** (Ethical Standards 3.07, Third-Party Requests for Services, and 3.11, Psychological Services Delivered to or Through Organizations) Regardless of whether an individual is considered a client, psychologists have an ethical obligation to ensure that their activities in relation to the individual are safe, legal, and ethical. (Ethical Standard 3.04, Avoiding Harm) Sensitivity to the entirety of a psychologist's ethical obligations is especially important where, because of a setting's unique characteristics, an individual may not be fully able to assert relevant rights and interests. (Principle A, Beneficence and Nonmaleficence, "In their professional

actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons...”; Principle D, Justice, “Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices”; Principle E, Respect for People’s Rights and Dignity, “Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making”; Ethical Standard 3.08, Exploitative Relationships)

**12. Psychologists consult when they are facing difficult ethical dilemmas.** The Task Force was emphatic that consultation on ethics questions and dilemmas is highly appropriate for psychologists at all levels of experience, especially in this very challenging and ethically complex area of practice. (Preamble to the Ethics Code, “The development of a dynamic set of ethical standards for psychologists’ work-related conduct requires a personal commitment and lifelong effort to act ethically...and to consult with others concerning ethical problems”; and Ethical Standard 4.06, Consultations)

The Task Force drew several other conclusions:

- The development of professional skills and competencies, ethical consultation and ethical self-reflection, and a willingness to take responsibility for one’s own ethical behavior are the best ways to ensure that the national security-related activities of psychologists are safe, legal, ethical, and effective.
- It is critical to offer ethical guidance and support especially to psychologists at the beginning of their careers, who may experience pressures to engage in unethical or inappropriate behaviors that they are likely to find difficult to resist.
- APA should develop a process whereby psychologists whose work involves classified material and who need ethical guidance or consultation may consult their national organization for assistance and support.
- Psychologists should encourage and engage in further research to evaluate and enhance the efficacy and effectiveness of the application of psychological science to issues, concerns and operations relevant to national security. One focus of a broad program of research is to examine the efficacy and effectiveness of information-gathering techniques, with an emphasis on the quality of information obtained. In addition, psychologists should examine the psychological effects of conducting interrogations on the interrogators themselves to explore ways of helping to ensure that the process of gathering information is likely to remain within ethical boundaries. Also valuable will be research on cultural differences in the psychological impact of particular information-gathering methods and what constitutes cruel, inhuman, or degrading treatment.
- The Task Force noted a potential area of tension between conducting research that is classified or whose success could be compromised if the research purpose and/or methodology become known and ethical standards that require

debriefing after participation in a study as a research subject. (Ethical Standards 8.07, Deception in Research, and 8.08, Debriefing) APA should identify and further examine the ethical dimensions of such tensions.

- Psychologists working in this area should inform themselves of how culture and ethnicity interact with investigative or information-gathering techniques, with special attention to how failing to attend to such factors may result in harm.

The Task Force engaged in vigorous discussion and debate and did not reach consensus on several issues:

- *The role of human rights standards in an ethics code.* While all Task Force members felt that respect for human rights is critical, some task force members felt strongly that international standards of human rights should be built into the ethics code and others felt that the laws of the United States should be the touchstone.
- *The degree to which psychologists may ethically disguise the nature and purpose of their work.* While all members of the Task Force agreed that full disclosure of the nature and purpose of a psychologist's work is not ethically required or appropriate in every circumstance, members differed on the degree to which psychologists may ethically dissemble their activities from individuals whom they engage directly.
- *Whether the discussions of the Task Force should have been made available outside the Task Force.* Some members believed that sharing the substance of the discussions, debates, and disagreements of the Task Force would be helpful to others in fostering the development of professional ethics in other areas of national security. Others felt that not sharing information beyond this report and other public statements would facilitate richer and more productive exchanges during the Task Force meeting. The Task Force voted on this issue. By a vote of seven to one, with one abstention, the Task Force voted to limit what information is disclosed concerning its deliberations to this report and other public statements made by the Task Force as a whole.

### **III. Recommendations**

The Task Force recommends that APA:

1. Publicly reaffirm its 1986 Resolution Against Torture and Other Cruel, Inhuman, or Degrading Treatment.
2. Develop a document that will serve as a companion to the 12 statements contained in this report, for the purpose of providing illustrative examples and commentary. Such a document will be especially important if APA adopts the statements as guidelines or if the Ethics Committee deems the statements appropriate interpretations and applications of the Ethics Code.
3. Continue to examine the goodness of fit between the Ethics Code and this area of practice. While the Task Force believes the Ethics Code is fundamentally sound and adequately addresses the great majority of ethical dilemmas that arise in national security-related settings, there are certain aspects in which the Code does not speak as well to this area of practice as the Code speaks to other areas of practice. The Task Force believes the Ethics Committee could undertake this task.
4. Develop a process to offer ethics consultation to psychologists whose work involves classified material and who seek ethical guidance.
5. Continue to develop a strong relationship with psychologists working in national security-related settings, with special attention to the unique ethical challenges these psychologists confront in their daily work, and collaborate with organizations having national security-related responsibilities to promote psychological practice consistent with APA Ethical Standards.
6. Forward a copy of this Task Force Report, or a summary of the report, to the United States Department of Defense and other relevant government agencies and bodies, as the government develops policy on these complicated and challenging ethical issues.
7. Encourage psychologists to engage in further research relevant to national security, including evaluation of the efficacy and effectiveness of methods for gathering information that is accurate, relevant, and reliable. Such research should be designed to minimize risks to research participants such as emotional distress, and should be consistent with standards of human subject research protection and the APA Ethics Code.
8. Recognize that issues involving terrorism and national security affect citizens in all countries and so encourage behavioral scientists to collaborate across disciplines, cultures, and countries in addressing these concerns.
9. Consider supporting the creation of a repository to record psychologists' contributions to national security. Such information, divided into classified and unclassified sections, could serve as a historical record and a resource concerning how psychologists involved in national security-related activities have met the ethical challenges of their work.

10. View the work of this Task Force as an initial step in addressing the very complicated and challenging ethical dilemmas that confront psychologists working in national security-related activities. Viewed as an initial step in a continuing process, this report will ideally assist APA to engage in thoughtful reflection of complex ethical considerations in an area of psychological practice that is likely to expand significantly in coming years.

**7. APA PENS Task Force Report**

**A. First draft of PENS report, June 24, 2005**

**B. Second draft of PENS report, June 25, 2005**

**C. Third<sup>2 later s</sup> draft~~s~~ of PENS report, June 26~~s~~, 2005**

**D. *Report of the American Psychological Association  
Presidential Task Force on Psychological Ethics  
and National Security* (final report)**



**7. A. First draft of PENS report, June 24, 2005**

Draft # 1

Steve Behnke's First Draft of PENS report.

June 24, 2005. after lunch recess.

et al.

Lunch

Gerry Kushner had to leave. family medical emergency

Lunch conv. w. Bryce Leferer, says

→ my father should be congratulated

SB. The bottom line from this morning.

Doc. A.

- 1 The APA Ethics Code states that psychologists "are aware of their professional and scientific responsibilities to society and to the specific communities in which they work." (Principle B) Psychologists have a valuable and ethical role to assist in gathering information that can be used in our Nation's and other nations' defense. A central role for psychologists working in the area of national security related investigations is to assist to ensure that all processes are safe, legal, and ethical for all participants in the process.
- 2 The Ethical Principles of Psychologist and Code of Conduct (2002) applies to psychologists across a range of behaviors. Whether the APA Ethics Code applies is not dependent upon a psychologist serving in a health care provider role.
- 3 The Preamble to the APA Ethics Code states "Psychologists respect and protect civil and human rights."
- 4 Psychologists do not condone or participate in torture.
- 5 Psychologists do not engage in behaviors that violate the law of the United States. Psychologists involved in national security-related activities follow all applicable rules and regulations that govern their roles. Over the course of the United States involvement in numerous locations, such as Afghanistan, Iraq, and Cuba, such rules and regulations have been significantly developed and refined. Psychologists have an ethical responsibility to be informed of, familiar with, and follow the most recent applicable regulations and rule.
- 6 Psychologists are aware of their competencies. Psychologists do not act beyond their competence, except in unusual circumstances., such as set for in the Ethical Principles of Psychologists and Code of Conduct, standard 2.02.

- 7 Psychologists are aware of their role and clarify their role in situations where the nature of their professional identity and professional function may be ambiguous. Psychologists have a special responsibility to clarify their role in situations where individuals may have an incorrect impression that the psychologists are serving in a health care provider role.
- 8 Psychologists clarify the identity of their client. *See std. 3.07*
- 7 Psychologists who may serve in the role of supporting an interrogation do not use health care related information <sup>to the detriment of subjects</sup> except for the purpose of promoting or safeguarding an individual's safety and well-being. *JMA. The ps should take a broad view of the possible situation of disadvantage*

BL Can  $\psi$  recommend playing on a person's fears. Ex. of suicidal <sup>Islamic</sup> detainees threatened if dies will buy u. a py.

RN. In treating teens, manipulated them all the time for their well being.

SB Certain words very revealing: exploit, manipulate, interrogate.

MB. Doc A-9. At some pt Citrus doctors would not give any info. Detainee had gunshot wound to leg.

Q: Does he have gunshot wound. Wanted to identify guy

RF Suppose if identified, he will then be ~~for~~ interrogated, or this info exploited.



**7. B. Second draft of PENS report, June 25, 2005**

## REPORT OF THE PRESIDENTIAL TASK FORCE ON PSYCHOLOGICAL ETHICS AND NATIONAL SECURITY

**DRAFT** # 2 (?)

*with margin notes by JMA*

The Presidential Task Force on Psychological Ethics and National Security (PENS) met on the weekend of June 24-26. The PENS Task Force met in response to the Board of Directors February, 2005 charge, that the Task Force:

**“...examine 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 whether APA should develop policy to address the role of psychologists and psychology in investigations related to national security.”**

The Task Force believes it is critical for the American Psychological Association to address these issues. The American Psychological Association is the world’s largest association of mental health professionals. The United States Department of Defense is the largest single employer of psychologists in the country, and many psychologists who do not work for the Department of Defense are involved in work related to our national defense and our national security. It is the responsibility of APA to accept the challenge of thinking through and providing guidance on the complex ethical dilemmas that face psychologists working in our nation’s service.

In the American Psychological Association Ethical Principles of Psychologists and Code of Conduct (hereinafter the APA Ethics Code), Principle B, Fidelity and Responsibility, states that psychologists “are aware of their professional and scientific responsibilities to society.” Psychologists have 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. The Task Force believes that a central role for psychologists working in the area of national security-related investigations is to assist to ensure that processes are safe, legal, and ethical for all participants in the process.

The Task Force confronted the argument that when psychologists act in certain roles outside traditional health-service provider relationships, for example as consultants to interrogations, they are not acting in a professional capacity as psychologists and are therefore not bound by the APA Ethics Code. The Task Force rejected this contention. The Task Force believes that when psychologists serve in a position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies. In any such circumstance, psychologists are bound by the APA Ethics Code.

The Task Force looked to the APA Ethics Code for fundamental principles to guide its thinking. The Task Force found such principles in the Preamble to the APA Ethics Code, which states “Psychologists respect and protect civil and human rights” and “[The Ethics



63. wants to say Ps can do interrogation if trained. Other mts. objected. By  
the build to ensure! Ex. being swept up in espionage or homicide case.  
"harassment" looks to future of national security.

arg. about "never", a 4 as interrogator. Mil. counseling  
Code] has as its goals the welfare and protection of the individuals and groups with  
whom psychologists work"; Principle A, Beneficence and Nonmaleficence, which states  
"In their professional actions, psychologists seek to safeguard the welfare and rights of  
those with whom they interact professionally and other affected persons"; Principle D,  
Justice, which states "Psychologists exercise reasonable judgment and take precautions to  
ensure that their potential biases, the boundaries of their competence, and the limitations  
of their expertise do not lead to or condone unjust practices"; and Principle E, Respect for  
People's Rights and Dignity, which states "Psychologists respect the dignity and worth of  
all people." The Task Force derived a number of positions from these and other  
statements in the APA Ethics Code.

First, psychologists do not condone or participate in torture. The Task Force endorses the  
1986 Resolution Against Torture, adopted by the American Psychological Association  
Council of Representatives, and the 1985 Joint Resolution Against Torture of the  
American Psychological Association and the American Psychiatric Association.

Second, psychologists have an ethical responsibility to report acts of torture to the  
appropriate authorities when they become aware of such acts. This ethical responsibility  
is rooted in the Preamble, which states "Psychologists respect and protect civil and  
human rights...the development of a dynamic set of ethical standards for psychologists'  
work-related conduct requires a personal commitment and lifelong effort to act ethically  
[and] to encourage ethical behavior by...colleagues," and Principle B, Fidelity and  
Responsibility, which states that psychologists "are concerned about the ethical  
compliance of their colleagues' scientific and professional conduct." (Ethical Standard  
1.05, Reporting Ethical Violations)

Third, psychologists do not engage in behaviors that violate the laws of the United States.  
Psychologists involved in national security-related activities follow all applicable rules  
and regulations that govern their roles. Over the course of the recent United States  
military presence in locations such as Afghanistan, Iraq, and Cuba, such rules and  
regulations have been significantly developed and refined. Psychologists have an ethical  
responsibility to be informed of, familiar with, and follow the most recent applicable  
regulations and rules. The Task Force notes that certain such rules and regulations  
incorporate texts that are fundamental to the treatment of individuals whose liberty has  
been curtailed, such as the Geneva Conventions. ~~Scrutiny to Act 4 HR.~~

Fourth, psychologists are aware of their role and clarify their role in situations where the  
nature of their professional identity and professional function may be ambiguous.  
Psychologists have a special responsibility to clarify their role in situations where  
individuals may have an incorrect impression that psychologists are serving in a health  
care provider role. The Task Force derived this position from standards in the APA  
Ethics Code that address the importance of clarity regarding a psychologist's role (Ethical  
Standards 3.07 and 3.11).

Fifth, psychologists are sensitive to the problems inherent in mixing potentially  
inconsistent roles, such as health care provider and consultant to an interrogation, and



refrain from engaging in such multiple relationships (Ethical Standard 3.05, "A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.")

Sixth, the Task Force reviewed roles that psychologists take in national security-related activities. The Task Force reviewed in particular the role of a consultant to interrogations, and believes that psychologists can serve in this role in a manner that is entirely consistent with the APA Ethics Code. The Task Force noted that psychologists have served in consultant roles to law enforcement on the state and federal levels for a considerable period of time, and have proven highly effective in lending assistance to law enforcement in the vital area of information gathering. The Task Force could find no persuasive arguments that such support to law enforcement is ethically inappropriate. The Task Force noted special ethical considerations for psychologists serving in this role, especially when individuals from countries other than the United States have been detained by United States authorities. Such ethical considerations include:

- Ways in which certain settings may instill in individuals a profound sense of powerlessness and may place individuals in considerable positions of disadvantage in terms of asserting their interests and rights. (See Ethical Standards 1.01, Misuse of Psychologists' Work and 3.08, Exploitative Relationships)
- Ways in which a failure to understand aspects of an individual's culture and ethnicity may generate misunderstandings and compromise the efficacy and hence the safety of investigatory processes. (Principle E, "Psychologists are aware of and respect cultural, individual, and role differences, including those based on...race, ethnicity, culture, national origin... and consider these factors when working with members of such groups"; Ethical Standard 2.01(b), Boundaries of Competence, "Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with...race, ethnicity, culture, national origin...is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals...", and Ethical Standard 3.01, Unfair Discrimination, "In their work-related activities, psychologists do not engage in unfair discrimination based on...race, ethnicity, culture, national origin...")

- Seventh, psychologists do not consult on techniques that would cause psychological distress except for a clear, legitimate purpose, such as to prevent future acts of violence. Punishment and obtaining a confession do not constitute legitimate purposes. If psychologists consult on activities that would cause psychological distress, they follow the restrictions on psychological distress set forth in Ethical Standard 8.07, Deception in

6. MW in  
Int'l Convention  
against torture  
compares it  
w/ Bush doctrine  
This discrepancy  
leaves open  
unethical  
procedure for  
LJ. DoD when  
have to agree

10. RF in big  
research in  
effects.  
Wants research  
Analyzing part  
Can get  
complaint  
by force but  
no little  
support for  
getting accurate  
info.  
in MW

The documentation  
technique  
review.

Our reputation  
in this  
profession  
depends on  
this doc.

12. MW  
wants to  
postpone  
SS action  
not

13. I mean  
Not See in TDC.  
Foreman sep

14. BA looks  
at Task Force  
mandate.

MW What causes  
pain stress in  
our culture is  
different from other  
Not just "misunder-  
standing"

B. Thinks  
confessions  
legitimate

5. 4s do not consent interrogation except possibly in emergency field conditions

(11A. Offer to try to exploit & distress. Then 3s need the hands.  
11B. Creating conflict in p is the way to move towards confession.



Is there debriefing  
on deception?

Research, which places boundaries on the degree of psychological distress researchers may impose upon research subjects.

5. At

was back to  
over 3-part  
mandate  
to it!

Don't pass the  
back.

BL says  
same thing  
not the back  
the Ham  
Helm  
summon

reported at  
as given

Is Ethics  
Code  
adequate?

Eighth, psychologists who may serve in the role of supporting an interrogation do not use health care related information for the detriment of an individual's safety and well-being. (Ethical Standard 3.04, Avoiding Harm).

Ninth, psychologists who have access to, utilize, or share confidential medical or mental health related information do so with an awareness of the sensitivity of such information, keeping in mind that "Psychologists have a primary obligation and take reasonable precautions to protect confidential information..." (Ethical Standard 4.01, Maintaining Confidentiality). When disclosing confidential information, psychologists share the minimum amount of information necessary, and only with individuals who have a clear professional purpose for obtaining the information. (Ethical Standard 4.04, Minimizing Intrusions on Privacy) *BL NO privacy rt.*

Tenth, psychologists are aware of their competencies. Psychologists do not act beyond their competence, except in unusual circumstances, such as set forth in the Ethics Code. (Ethical Standard 2.02, Providing Services in Emergencies) Thus, psychologists ensure that their activities are effective, in addition to being safe, legal, and ethical. (Ethical Standards 2.01, Boundaries of Competence; 2.04, Bases for Scientific and Professional Judgments; 9.01 Bases for Assessments)

Eleventh, psychologists clarify the identity of their client and retain ethical obligations to individuals who are not their clients. Regardless of whether an individual is considered a "client," psychologists have an ethical obligation to ensure that their activities in relation to the individual are safe, legal, ethical, and effective. Sensitivity to the entirety of a psychologist's ethical obligations is especially important where, because of a setting's unique characteristics, an individual may not be fully able to assert relevant rights and interests. (Principle A, Beneficence and Nonmaleficence, "In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons..." and Principle D, Justice, "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.")

Twelfth, psychologists have an ethical obligation to consult when they are facing difficult ethical dilemmas. The Task Force was emphatic that consultation on ethics questions and dilemmas is highly appropriate for psychologists at all levels of experience, especially in this very challenging and ethically complex area of practice. (Preamble to the Ethics Code, "The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically...and to consult with others concerning ethical problems.")

The Task Force drew several other conclusions:

19. Discuss of cost-effective  
Backlash part of it

20. Ethics cases for mid & end of an report?  
An ethics case book?

BL Must show application of  
ethics code to an issue.

Big support of example

BL says Though that examples  
would claim about psych sec ?? 173



20. RF: *Extra Problem an article for the Am Psych that we could refer to*  
*56 Examples rec. but examples should be a exemplum*

21. MW - Still worried about the gray area.

22. BA 2

RN

*searching*

*for an analogue  
to 4 countries  
for interrogations*

*T- 4 advising  
in child  
custody issues*

*RN advising in  
depositions*

*Analogue not  
found*

23. The point  
on the deal.  
Do we need  
to address this  
we will  
be asked.

*Eg sleep  
deprivation*

*Recommend*

*that APA create*

*practically 70%*

*a national*

*process. It's*

*multi-step educating*

*informing.*

*NT. What about*

*4's consulting in*

*difficult cases.*

*in APA has no*

*provisions for*

*classified consultation.*

*PT LT couldn't do it.*

*The mil people*

*except for LT suggest*

*this.*

*RF wants a process*

*forming formal*

*asked APA recommend*

*Such a system be*

*established.*

- The development of professional skills and competencies, ethical consultation and ethical self-reflection, and a willingness to take responsibility for one's own ethical behavior are the best ways to ensure that the national security-related activities of psychologists are safe, legal, ethical, and effective
- It is critical to offer ethical guidance and support especially to psychologists at the beginning of their careers, who may experience pressures to engage in unethical or inappropriate behaviors that they find difficult to resist
- The American Psychological Association should develop a process whereby psychologists in need of ethical guidance or consultation may consult their national organization for assistance and support
- Psychologists should engage in research to examine and develop effective ways of obtaining information for the purpose of preventing acts of violence. Psychologists conducting such research should focus on the quality of the information obtained through various techniques. In addition to research into the effectiveness of information gathering techniques, psychologists should examine the psychological effects of conducting interrogations on the interrogators themselves, to explore ways of helping to ensure that the process of gathering information is likely to remain within ethical boundaries.

The Task Force engaged in vigorous discussion and debate and did not reach consensus on several issues:

- The role of human rights standards in an ethics code. While all Task Force members felt that respect for human rights is critical, some task force members felt strongly that international standards of human rights should be built into the ethics code and others felt that the laws of the United States should be the touchstone. The degree to which psychologists may ethically disguise the nature and purpose of their work. While all members of the Task Force agreed that full disclosure of the nature and purpose of a psychologist's work is not be ethically required or appropriate in every circumstance, members differed on the degree to which psychologists may ethically dissemble their activities from individuals whom they engage directly.
- Whether the discussion of the Task Force should have been made available outside the Task Force. Some members believed that sharing the substance of the discussions, debates, and disagreements of the Task Force would be helpful to others in understanding how the Task Force reached its conclusions. Others felt that not sharing information beyond this report and other public statements would facilitate richer and more productive exchanges during the Task Force meeting. The Task Force voted on this issue. By a vote of seven to one, with one abstention, the Task Force voted to limit what information is disclosed concerning its deliberations to this report and other public statements made by the Task Force as a whole.

25. Draft -

*Members. The parties*

*on the head story.*

*RN very much in*

*favor of this example.*

*MB Sere training*

*not have 4 on site.*

BL

*26. Re confidentiality*

*RN keep pt. 9.*

*because public brought*

*up about use of med.*

*info. Discuss about*

*whether what the law*

5

*details we need more*

*...*

*We must discuss*

*confidentiality*

*...*

25. MW in the US interrogations

rule v. concerned

26. MW A practice

ethics code wants to address

27. MW

to them but cannot be

29. I talk about interrogation

in Middle East. into 4's.

4's should be made substantive



Sat afternoon

20. Div 48 letter ~~introduced~~  
introduced -  
MW & I wanted

~~to~~ ~~APA~~ 25 ~~Shulkin~~  
There 2002?  
1000 + 2500  
treatment

do I want care + research.

21 MW wants to say welcome  
future occur - we deplore it -

RN Much effort to calm  
public attacks.

Anderson ...

LT Never was at extm.

NT Shuts me up abruptly

MT "No thanks he is a kook."  
We agree w you

RN Do our process, not Div 48's.

BS takes offense at my  
"hush-hush"

NT We've been asked to review.

but we don't have to respond.

Any response will be inadequate.

MW wants a true review.

~~MT~~

OT Now, what is now here.

2 Think about the code.

LT About treatment.

RF This process is and is  
APA should continue

I ask for recommendations  
to attend later to many  
other psych - not 1 security  
concern. Several, incl.

NT, back me on this one.

Supply examples.

Disc of privacy

"informed assessment" who does it?  
Mid. interest & discussion.

MTA  
Oral histories.

Colburn.

LT SS, RF, for this.

RF will write story.

Classified - yes.

MT also suggests an undamped view.

Argument between MG & MB

about whether there should be 4s in  
all investigation centers. I say

I value 4s for bringing reasons

2 accountability into investigation

MG disagrees strongly w the  
implication that they should be

monitors.

NT et al make discussion of "drift"

-

I raise issue of vulnerability of frameworks.

A struggle to clarify.

SB. The goodness of RT be  
ethics code is

RF Many & not function & agencies  
not represented here. But

need an ongoing process. Sol

Solicit perspectives.

VS. Yes. need more discussion.

Mid. Yes, we have to redefine basis to  
apply the APA code.

MG If ~~understand~~ APA says informed consent  
needed for informed assessment, he would have to

SS off the record - provides deniability to both  
to probe possibility of

RF 2/ APA disavows and 4, then checks.

RN Happened w. Media Psych Div.

~~MT~~

to my attention. In my introductory remarks to Council, I acknowledged the work of Division 48 in bringing forth your new business item. I thank you for your initiative.

Last Sat aft.

- Communicating in the Press -

RF Young & an unnamed individual  
Tells them to use code & to get  
A, B, C . . . . It's clarified. Myos  
don't want to anger &, who have  
power

Met. The met & more interested in ethical  
issues.

RF Likes our openness.

as opposed to people who say you're  
a bad person

Met. APA person took a discussion  
like this nat'l security community  
a few years ago. Nat'l security  
Aks delighted - "an" profession

Met. former a decade . . .

I ask about ~~APA~~ about  
about the meaning of ~~APA~~ in  
APA having to do with int'l  
law. LS shuts me up.

as a last proviso, I clarify  
That the ethical code tells  
what how to behave if you  
are a met & but does  
not endorse working as an

Am &.

Going forward - can we civil.  
Others met. N. our met.  
Cannot talk with them.

## **7. C. Third draft of PENS report, June 26, 2005**



*Am. Psych. Assoc.*

## PRESIDENTIAL TASK FORCE ON PSYCHOLOGICAL ETHICS AND NATIONAL SECURITY

### Final Draft Report #3 ?

*APA*

The Presidential Task Force on Psychological Ethics and National Security met to address ethical challenges facing psychologists whose work involves national security-related activities. Recognizing the ethical complexity of this work, which takes place in unique settings and constantly evolving circumstances, the Task Force was nonetheless able to set forth clear and ~~unanimous~~ *consensus* statements about psychologists' ethical obligations. The Task Force first states that psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment. This report contains eleven additional Task Force statements and a series of recommendations to the American Psychological Association Board of Directors.

*another footnote the Task Force.*

The Presidential Task Force on Psychological Ethics and National Security (PENS) met on the weekend of June 24-26. The PENS Task Force met in response to the Board of Directors February, 2005 charge, that the Task Force:

[E]xamine 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 whether APA should develop policy to address the role of psychologists and psychology in investigations related to national security.

The Task Force believes it is critical for the American Psychological Association to address these issues. APA is the world's largest association of mental health professionals. Article I of the Association Bylaws states:

The objects of the American Psychological Association shall be to advance psychology as a science and profession and as a means of promoting health, education and human welfare...by the improvement of the qualifications and usefulness of psychologists through high standards of ethics...[and] by the establishment and maintenance of the highest standards of professional ethics and conduct of the members of the Association...

*Many association members work for the <sup>respective</sup> ~~United States~~ <sup>governments</sup> government as employees or consultants in national security-related positions. It is the responsibility of APA to think through and provide guidance on the complex ethical challenges that face these psychologists, who apply their training, skills, and expertise in our nation's service.*

*in the national security systems.*

In the APA Ethical Principles of Psychologists and Code of Conduct (hereinafter the Ethics Code), Principle B, Fidelity and Responsibility, states that psychologists "are



aware of their professional and scientific responsibilities to society." Psychologists have a valuable and ethical role to assist in protecting our nation, <sup>other nations</sup> ~~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. The Task Force believes that a central role for psychologists working in the area of national security-related investigations is to assist to ensure that processes are safe, legal, and ethical for all participants.

The Task Force addressed the argument that when psychologists act in certain roles outside traditional health-service provider relationships, for example as consultants to interrogations, they are not acting in a professional capacity as psychologists and are therefore not bound by the APA Ethics Code. The Task Force rejected this contention. The Task Force believes that when psychologists serve in a position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies. Thus in any such circumstance, psychologists are bound by the APA Ethics Code.

The Task Force looked to the APA Ethics Code for fundamental principles to guide its thinking. The Task Force found such principles in the Preamble to the Ethics Code, "Psychologists respect and protect civil and human rights" and "[The Ethics Code] has as its goals the welfare and protection of the individuals and groups with whom psychologists work"; Principle A, Beneficence and Nonmaleficence, "In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons"; Principle D, Justice, "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices"; and Principle E, Respect for People's Rights and Dignity, "Psychologists respect the dignity and worth of all people." The Task Force concluded that the Ethics Code is fundamentally sound in addressing the ethical dilemmas that arise in the context of national security-related work. but

**First**, psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment. The Task Force endorses the 1986 Resolution Against Torture, adopted by the American Psychological Association Council of Representatives, and the 1985 Joint Resolution Against Torture of the American Psychological Association and the American Psychiatric Association.

- **Second**, psychologists are alert to acts of torture or other cruel, inhuman, or degrading treatment and have an ethical responsibility to report these acts to the appropriate authorities. This ethical responsibility is rooted in the Preamble, which states "Psychologists respect and protect civil and human rights...the development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically [and] to encourage ethical behavior by...colleagues," and Principle B, Fidelity and Responsibility, which states that psychologists "are concerned about the ethical compliance of their colleagues' scientific and professional conduct." (Ethical Standard 1.05, Reporting Ethical Violations)



? **Third**, psychologists do not engage in behaviors that violate the laws of the United States, although psychologists may refuse to follow laws or orders that are unjust or that violate basic principles of human rights. Psychologists involved in national security-related activities follow all applicable rules and regulations that govern their roles. Over the course of the recent United States military presence in locations such as Afghanistan, Iraq, and Cuba, such rules and regulations have been significantly developed and refined. Psychologists have an ethical responsibility to be informed of, familiar with, and follow the most recent applicable regulations and rules. The Task Force notes that certain such rules and regulations incorporate texts that are fundamental to the treatment of individuals whose liberty has been curtailed, such as the Geneva Conventions.

The Task Force notes that psychologists sometimes encounter conflicts between ethics and law. When such conflicts arise, psychologists make known their commitment to the APA Ethics Code and attempt to resolve the conflict in a responsible manner. If the conflict cannot be resolved in this manner, psychologists may adhere to the requirements of the law. (Ethical Standard 1.02) If psychologists follow the law in such circumstances, they do so "in keeping with basic principles of human rights." (Introduction and Applicability section of the APA Ethics Code) The Task Force encourages psychologists working in this area to review essential human rights documents, such as the Geneva Conventions.

**Fourth**, psychologists are aware of and clarify their role in situations where the nature of their professional identity and professional function may be ambiguous. Psychologists have a special responsibility to clarify their role in situations where individuals may have an incorrect impression that psychologists are serving in a health care provider role. The Task Force derived this position from standards in the APA Ethics Code that address the importance of clarity regarding a psychologist's role. (Ethical Standards 3.07 and 3.11)

The Task Force noted that psychologists acting in the role of consultant to national security issues most often work closely with other professionals from various disciplines. As a consequence, psychologists rarely act alone or independently, but rather as part of a group of professionals who bring together a variety of skills and experience in order to provide an ethically appropriate service. (Ethical Standard 3.09, Cooperating with Other Professionals)

**Fifth**, psychologists are sensitive to the problems inherent in mixing potentially inconsistent roles, such as health care provider and consultant to an interrogation, and refrain from engaging in such multiple relationships (Ethical Standard 3.05, "A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.")

**Sixth**, the Task Force believes that psychologists may serve in various national security-related roles, such as a consultant to interrogations, in a manner that is consistent with the



Ethics Code, provided that psychologists are mindful of factors unique to these roles that require special ethical consideration. The Task Force noted that psychologists have served in consultant roles to law enforcement on the state and federal levels for a considerable period of time. Psychologists have proven highly effective in lending assistance to law enforcement in the vital area of information gathering and have done so in an ethical manner. The Task Force noted special ethical considerations for psychologists serving as consultants to interrogation processes in national security-related settings, especially when individuals from countries other than the United States have been detained by United States authorities. Such ethical considerations include:

- How certain settings may instill in <sup>detainees</sup> individuals a profound sense of powerlessness and may place individuals in considerable positions of disadvantage in terms of asserting their interests and rights. (Ethical Standards 1.01, Misuse of Psychologists' Work, and 3.08, Exploitative Relationships)
- How failures to understand aspects of <sup>detainees</sup> individuals' culture and ethnicity may generate misunderstandings, compromise the efficacy and hence the safety of investigatory processes, and result in significant mental and physical harm. (Principle E, "Psychologists are aware of and respect cultural, individual, and role differences, including those based on...race, ethnicity, culture, national origin... and consider these factors when working with members of such groups"; Ethical Standard 2.01(b), Boundaries of Competence, "Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with...race, ethnicity, culture, national origin...is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals..."; and Ethical Standard 3.01, Unfair Discrimination, "In their work-related activities, psychologists do not engage in unfair discrimination based on...race, ethnicity, culture, national origin...")
- How the combination of a setting's ambiguity with high stress may facilitate <sup>captives, personnel</sup> individuals engaging in behaviors that cross the boundaries of competence and ethical propriety. As behavioral scientists, psychologists are trained to observe, respond to, and ideally correct such processes as they occur. (Principle A, Beneficence and Nonmaleficence, and Ethical Standard 3.04, Avoiding Harm)

<sup>from</sup> **Seventh**, psychologists who consult on interrogation techniques are mindful that the subject of the interrogation may not have engaged in untoward behavior and may not have information of interest to the interrogator. When psychologists serve as consultants to interrogation, and especially when such consultation concerns techniques that potentially generate psychological distress, psychologists consider whether the techniques consulted upon would be deemed ethically appropriate should such <sup>The</sup> subjects ultimately be determinations related to guilt and relevance ultimately be made. At all times psychologists remain mindful of the prohibitions against engaging in or facilitating

<sup>investigator</sup> The investigator determine the subject has not engaged in untoward behavior & does not have inf. of interest to the interrogator. A special obligation to the subject ultimately be <sup>assess</sup> if need be.

detainees - to be monitored or not monitored  
#6 is not our sector



torture and other cruel, inhuman, or degrading treatment. Psychologists inform themselves about research regarding the most effective and humane methods of obtaining information and become familiar with how culture may interact with the techniques consulted upon. (Ethical Standards 2.01, Boundaries of Competence; 2.03, Maintaining Competence; and 3.01, Unfair Discrimination)

**Eighth**, psychologists who serve in the role of supporting an interrogation do not use health care related information for the detriment of an individual's safety and well-being. (Ethical Standard 3.04, Avoiding Harm). Regardless of their role, psychologists who become aware of an individual in need of mental health treatment may seek consultation regarding how to ensure that the individual receives needed care. (Principle A, Beneficence and Nonmaleficence)

**Ninth**, psychologists make clear the limits of confidentiality. (Ethical Standard 4.02, Discussing the Limits of Confidentiality). Psychologists who have access to, utilize, or share medical or mental health related information do so with an awareness of the sensitivity of such information, keeping in mind that "Psychologists have a primary obligation and take reasonable precautions to protect confidential information." (Ethical Standard 4.01, Maintaining Confidentiality). When disclosing sensitive information, psychologists share the minimum amount of information necessary, and only with individuals who have a clear professional purpose for obtaining the information. (Ethical Standard 4.04, Minimizing Intrusions on Privacy) Psychologists take care not to leave a misimpression that information is confidential when in fact it is not. (Ethical Standards 3.10, Informed Consent, and 4.02, Discussing the Limits of Confidentiality)

*when does he quite end?*

**Tenth**, psychologists are aware of and do not act beyond their competencies, except in unusual circumstances, such as set forth in the Ethics Code. (Ethical Standard 2.02, Providing Services in Emergencies) Thus, psychologists ensure that their activities are effective, in addition to being safe, legal, and ethical. (Ethical Standards 2.01, Boundaries of Competence; 2.04, Bases for Scientific and Professional Judgments; 9.01 Bases for Assessments)

*opague to me.*

*Psychologist?*  
*for information*  
**Eleventh**, psychologists clarify the identity of their client and retain ethical obligations to individuals who are not their clients. Regardless of whether an individual is considered a "client," psychologists have an ethical obligation to ensure that their activities in relation to the individual are safe, legal, ethical, and effective. Sensitivity to the entirety of a psychologist's ethical obligations is especially important where, because of a setting's unique characteristics, an individual may not be fully able to assert relevant rights and interests. (Principle A, Beneficence and Nonmaleficence, "In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons..." and Principle D, Justice, "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices.")

*and authorities are may lose their moral compass.*



**Twelfth**, psychologists have an ethical obligation to consult when they are facing difficult ethical dilemmas. The Task Force was emphatic that consultation on ethics questions and dilemmas is highly appropriate for psychologists at all levels of experience, especially in this very challenging and ethically complex area of practice. (Preamble to the Ethics Code, "The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically...and to consult with others concerning ethical problems.")

*heading*  
The Task Force drew several other conclusions:

- The development of professional skills and competencies, ethical consultation and ethical self-reflection, and a willingness to take responsibility for one's own ethical behavior are the best ways to ensure that the national security-related activities of psychologists are safe, legal, ethical, and effective.
- It is critical to offer ethical guidance and support especially to psychologists at the beginning of their careers, who may experience pressures to engage in unethical or inappropriate behaviors that they are likely to find difficult to resist.
- APA should develop a process whereby psychologists whose work involves classified material and who need ethical guidance or consultation may consult their national organization for assistance and support.
- 4. • Psychologists should <sup>occasionally</sup> engage in research to examine and develop effective ways of obtaining information, ~~for the purpose of preventing acts of violence~~. Psychologists conducting such research should focus on the quality of the information obtained through various techniques. In addition to research into the effectiveness of information gathering techniques, psychologists should examine the psychological effects of conducting interrogations on the interrogators themselves, to explore ways of helping to ensure that the process of gathering information is likely to remain within ethical boundaries.
- The Task Force noted a potential area of tension between conducting research that is classified or whose success could be compromised if the research purpose and/or methodology become known, and ethical standards that require debriefing after participation in a study as a research subject. (Ethical Standards 8.07 and 8.08). APA should identify and further examine the ethical dimensions of such tensions.
- Psychologists working in this area should inform themselves of how culture and ethnicity interact with investigative or information-gathering techniques, with special attention to how failing to attend to such factors may result in harm.

The Task Force engaged in vigorous discussion and debate and did not reach consensus on several issues:

- The role of human rights standards in an ethics code. While all Task Force members felt that respect for human rights is critical, some task force members felt strongly that international standards of human rights should be



built into the ethics code and others felt that the laws of the United States should be the touchstone.

- The degree to which psychologists may ethically disguise the nature and purpose of their work. While all members of the Task Force agreed that full disclosure of the nature and purpose of a psychologist's work is not ethically required or appropriate in every circumstance, members differed on the degree to which psychologists may ethically dissemble their activities from individuals whom they engage directly.
- Whether the discussion of the Task Force should have been made available outside the Task Force. Some members believed that sharing the substance of the discussions, debates, and disagreements of the Task Force would be helpful to others in understanding how the Task Force reached its conclusions. Others felt that not sharing information beyond this report and other public statements would facilitate richer and more productive exchanges during the Task Force meeting. The Task Force voted on this issue. By a vote of seven to one, with one abstention, the Task Force voted to limit what information is disclosed concerning its deliberations to this report and other public statements made by the Task Force as a whole.

*in fostering development of other professionals in national security in other settings*  
*and facilitating development of other topics in other settings*  
*to this report*

### Recommendations:

The Task Force recommends that:

- 1) APA publicly reaffirm its 1986 Resolution Against Torture and Other Cruel, Inhuman, or Degrading Treatment.
- 2) APA consider whether it would be appropriate to adopt the twelve statements in this Task Force Report either as guidelines or as official statements interpreting the APA Ethical Principles of Psychologists and Code of Conduct.
- 3) APA develop a document that will serve as a companion to the twelve statements contained in this report, for the purpose of providing illustrative examples and providing commentary. Such a document will be especially important if APA adopts the statements as guidelines or official interpretations of the Ethics Code.
- 4) APA continue to examine the goodness of fit between the Ethics Code and this area of practice. While the Task Force believes the Ethics Code is fundamentally sound and adequately addresses the great majority of ethical dilemmas that arise in national security-related settings, there ~~may~~ be certain aspects in which the Code does not speak as well to this area of practice as it does to other areas of practice. The Task Force believes the Ethics Committee could undertake this task.
- 5) APA develop a process to offer ethics consultation to psychologists whose work involves classified material and who seek ethical guidance.
- 6) APA continue to develop a strong relationship with psychologists working in national security-related settings, with special attention to the unique ethical challenges these psychologists confront in their daily work, and that APA

*1) This doc has no new principles, can be approved quickly.*  
*If new principles, it takes 7 [Russ Newman provided this info. -JMA 9/4/06]*  
*a year to approve.*

collaborate with organizations having national security-related responsibilities to promote psychological practice consistent with APA Ethical Standards.

- 7) APA forward a copy of this task force report, or a relevant summary of the report, to the United States Department of Defense, as the Defense Department develops policy on these complicated and challenging ethical issues.
- 8) APA encourage psychologists to engage in research to evaluate the efficacy of methods for gathering information that is accurate, relevant, and reliable. Such research should be designed to minimize risks to research participants such as emotional distress, and should be consistent with standards of human subject research protection and the APA Ethics Code.
- 9) APA consider supporting the creation of a repository to record psychologists' contributions to national security. Such information, divided into classified and unclassified sections, could serve as a historical record and a resource concerning how psychologists involved in national security-related activities have met the ethical challenges of their work.
- 10) APA view the work of this Task Force as an initial step in addressing the very complicated and challenging ethical dilemmas that confront psychologists working in national security-related activities. Viewed as an initial step in a continuing process, APA may use this Report to engage in thoughtful reflection of complex ethical considerations in an area of psychological practice that is likely to expand significantly in coming years.



# PRESIDENTIAL TASK FORCE ON PSYCHOLOGICAL ETHICS AND NATIONAL SECURITY

Final Draft Report ~~#3~~ #4

6/26/05

## I. Overview of the Report

The Presidential Task Force on Psychological Ethics and National Security (PENS) met in response to the Board of Directors February, 2005 charge, that the Task Force:

[E]xamine 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 whether APA should develop policy to address the role of psychologists and psychology in investigations related to national security.

Recognizing the ethical complexity of this work, which takes place in unique settings and constantly evolving circumstances, the Task Force was nonetheless able to set forth twelve clear and agreed upon statements about psychologists' ethical obligations.

The Task Force noted that the Board of Director's charge did not include an investigative or adjudicatory role, and as a consequence emphasized that it did not render any judgment concerning events that may or may not have occurred in national security-related settings. Nonetheless, the Task Force was unambiguous that psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment, and that psychologists have an ethical responsibility to be alert to and report any such acts to appropriate authorities. The Task Force stated that it is consistent with the APA Ethics Code for psychologists to serve in consultative roles to interrogation and information gathering processes for national security-related purposes, as psychologists have a long-standing tradition of doing in other law enforcement contexts. Acknowledging that engaging in such consultative and advisory roles entails a delicate balance of ethical considerations, the Task Force stated that psychologists are in a unique position to assist in ensuring that these processes are safe and ethical for all participants.

The Task Force report concludes with a series of recommendations to the American Psychological Association Board of Directors.

## II. Task Force Statements

1. Psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment.
2. Psychologists are alert to acts of torture and other cruel, inhuman, or degrading treatment and have an ethical responsibility to report these acts to the appropriate authorities.
3. Psychologists who serve in the role of supporting an interrogation do not use health care related information to the detriment of an individual's safety and well-being.
4. Psychologists do not engage in behaviors that violate the laws of the United States, although psychologists may refuse for ethical reasons to follow laws or orders that are unjust or that violate basic principles of human rights.
5. Psychologists are aware of and clarify their role in situations where the nature of their professional identity and professional function may be ambiguous.
6. Psychologists are sensitive to the problems inherent in mixing potentially inconsistent roles, such as health care provider and consultant to an interrogation, and refrain from engaging in such multiple relationships.
7. Psychologists may serve in various national security-related roles, such as a consultant to interrogations, in a manner that is consistent with the Ethics Code, and when doing so psychologists are mindful of factors unique to these roles and contexts that require special ethical consideration.
8. Psychologists who consult on interrogation techniques are mindful that the individual being interrogated may not have engaged in untoward behavior and may not have information of interest to the interrogator.
9. Psychologists make clear the limits of confidentiality.
10. Psychologists are aware of and do not act beyond their competencies, except in unusual circumstances, such as set forth in the Ethics Code.
11. Psychologists clarify for themselves the identity of their client and retain ethical obligations to individuals who are not their clients.
12. Psychologists have an ethical obligation to consult when they are facing difficult ethical dilemmas.



### III. Introduction and Commentary on the Twelve Task Force Statements

The Task Force believes it is critical for the American Psychological Association to address the ethical challenges facing psychologists whose work involves national security-related activities. APA is the world's largest association of mental health professionals. Article I of the Association Bylaws states:

The objects of the American Psychological Association shall be to advance psychology as a science and profession and as a means of promoting health, education and human welfare...by the improvement of the qualifications and usefulness of psychologists through high standards of ethics...[and] by the establishment and maintenance of the highest standards of professional ethics and conduct of the members of the Association...

Many association members work for the United States government as employees or consultants in national security-related positions. It is the responsibility of APA to think through and provide guidance on the complex ethical challenges that face these psychologists, who apply their training, skills, and expertise in our nation's service.

In the APA Ethical Principles of Psychologists and Code of Conduct (hereinafter the Ethics Code), Principle B, Fidelity and Responsibility, states that psychologists "are aware of their professional and scientific responsibilities to society." Psychologists have 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. The Task Force believes that a central role for psychologists working in the area of national security-related investigations is to assist in ensuring that processes are safe, legal, and ethical for all participants.

The Task Force addressed the argument that when psychologists act in certain roles outside traditional health-service provider relationships, for example as consultants to interrogations, they are not acting in a professional capacity as psychologists and are therefore not bound by the APA Ethics Code. The Task Force rejected this contention. The Task Force believes that when psychologists serve in a position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies. Thus in any such circumstance, psychologists are bound by the APA Ethics Code.

The Task Force looked to the APA Ethics Code for fundamental principles to guide its thinking. The Task Force found such principles in the Preamble to the Ethics Code, "Psychologists respect and protect civil and human rights" and "[The Ethics Code] has as its goals the welfare and protection of the individuals and groups with whom psychologists work"; Principle A, Beneficence and Nonmaleficence, "In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons"; Principle D, Justice, "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices"; and Principle E, Respect for People's Rights and Dignity, "Psychologists respect the dignity and worth of all people." The Task Force concluded that the Ethics Code is fundamentally sound in addressing the ethical dilemmas that arise in the context of national security-related work.

**First,** psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment. The Task Force endorses the 1986 Resolution Against Torture, adopted by the American Psychological Association Council of Representatives, and the 1985 Joint Resolution Against Torture of the American Psychological Association and the American Psychiatric Association. (Principle A, Beneficence and Nonmaleficence, and Ethical Standard 3.04, Avoiding Harm) The Task Force emphasizes that the Board of Directors' charge did not include an investigative or adjudicatory role and so the Task Force does not render any judgment concerning events that may or may not have occurred in national security-related settings. The Task Force nonetheless feels that an absolute statement against torture and other cruel, inhuman or degrading treatment is appropriate.

**Second,** psychologists are alert to acts of torture and other cruel, inhuman, or degrading treatment and have an ethical responsibility to report these acts to the appropriate authorities. This ethical responsibility is



rooted in the Preamble, which states "Psychologists respect and protect civil and human rights...the development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically [and] to encourage ethical behavior by...colleagues." and Principle B, Fidelity and Responsibility, which states that psychologists "are concerned about the ethical compliance of their colleagues' scientific and professional conduct." (Ethical Standard 1.05, Reporting Ethical Violations) The Task Force notes that when fulfilling the obligation to respond to unethical behavior by reporting the behavior to appropriate authorities as a prelude to an adjudicatory process, psychologists guard against the names of individual psychologists being disseminated to the public. Inappropriate or premature public dissemination can expose psychologists to a risk of harm outside of established and appropriate legal and adjudicatory processes. (Ethical Standard 3.04, Avoiding Harm)

**Third,** psychologists who serve in the role of supporting an interrogation do not use health care related information to the detriment of an individual's safety and well-being. (Ethical Standard 3.04, Avoiding Harm). Regardless of their role, psychologists who become aware of an individual in need of health or mental health treatment may seek consultation regarding how to ensure that the individual receives needed care. (Principle A, Beneficence and Nonmaleficence)

**Fourth,** psychologists do not engage in behaviors that violate the laws of the United States, although psychologists may refuse for ethical reasons to follow laws or orders that are unjust or that violate basic principles of human rights. Psychologists involved in national security-related activities follow all applicable rules and regulations that govern their roles. Over the course of the recent United States military presence in locations such as Afghanistan, Iraq, and Cuba, such rules and regulations have been significantly developed and refined. Psychologists have an ethical responsibility to be informed of, familiar with, and follow the most recent applicable regulations and rules. The Task Force notes that certain such rules and regulations incorporate texts that are fundamental to the treatment of individuals whose liberty has been curtailed, such as the Geneva Conventions.<sup>1</sup>

The Task Force notes that psychologists sometimes encounter conflicts between ethics and law. When such conflicts arise, psychologists make known their commitment to the APA Ethics Code and attempt to resolve the conflict in a responsible manner. If the conflict cannot be resolved in this manner, psychologists may adhere to the requirements of the law. (Ethical Standard 1.02) If psychologists follow the law in such circumstances, they do so "in keeping with basic principles of human rights." (Introduction and Applicability section of the APA Ethics Code) The Task Force encourages psychologists working in this area to review essential human rights documents, such as the Geneva Conventions.

**Fifth,** psychologists are aware of and clarify their role in situations where the nature of their professional identity and professional function may be ambiguous. Psychologists have a special responsibility to clarify their role in situations where individuals may have an incorrect impression that psychologists are serving in a health care provider role. (Ethical Standards 3.07, Third-Party Requests for Services, and Ethical Standard 3.11, Psychological Services Delivered to or Through Organizations)

The Task Force noted that psychologists acting in the role of consultant to national security issues most often work closely with other professionals from various disciplines. As a consequence, psychologists rarely act alone or independently, but rather as part of a group of professionals who bring together a variety of skills and experiences in order to provide an ethically appropriate service. (Ethical Standard 3.09, Cooperating with Other Professionals)

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United Nations. (1950, October 21). *Geneva convention relative to the treatment of prisoners of war*. Retrieved from <http://www.unhcr.ch/html/menu3/b/91.htm>



**Sixth,** psychologists are sensitive to the problems inherent in mixing potentially inconsistent roles, such as health care provider and consultant to an interrogation, and refrain from engaging in such multiple relationships (Ethical Standard 3.05, Multiple Relationships, "A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.")

**Seventh,** psychologists may serve in various national security-related roles, such as a consultant to interrogations, in a manner that is consistent with the Ethics Code, and when doing so psychologists are mindful of factors unique to these roles and contexts that require special ethical consideration. The Task Force noted that psychologists have served in consultant roles to law enforcement on the state and federal levels for a considerable period of time. Psychologists have proven highly effective in lending assistance to law enforcement in the vital area of information gathering and have done so in an ethical manner. The Task Force noted special ethical considerations for psychologists serving as consultants to interrogation processes in national security-related settings, especially when individuals from countries other than the United States have been detained by United States authorities. Such ethical considerations include:

- How certain settings may instill in individuals a profound sense of powerlessness and may place individuals in considerable positions of disadvantage in terms of asserting their interests and rights. (Ethical Standards 1.01, Misuse of Psychologists' Work, and 3.08, Exploitative Relationships)
- How failures to understand aspects of individuals' culture and ethnicity may generate misunderstandings, compromise the efficacy and hence the safety of investigatory processes, and result in significant mental and physical harm. (Principle E, "Psychologists are aware of and respect cultural, individual, and role differences, including those based on...race, ethnicity, culture, national origin... and consider these factors when working with members of such groups"; Ethical Standard 2.01(b), Boundaries of Competence, "Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with...race, ethnicity, culture, national origin...is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals..."; and Ethical Standard 3.01, Unfair Discrimination, "In their work-related activities, psychologists do not engage in unfair discrimination based on...race, ethnicity, culture, national origin...")
- How the combination of a setting's ambiguity with high stress may facilitate engaging in behaviors that cross the boundaries of competence and ethical propriety. As behavioral scientists, psychologists are trained to observe, respond to, and ideally correct such processes as they occur. (Principle A, Beneficence and Nonmaleficence, and Ethical Standard 3.04, Avoiding Harm)

**Eighth,** psychologists who consult on interrogation techniques are mindful that the individual being interrogated may not have engaged in untoward behavior and may not have information of interest to the interrogator. This ethical obligation is not diminished by the nature of an individual's acts prior to detainment or the likelihood of the individual having relevant information. At all times psychologists remain mindful of the prohibitions against engaging in or facilitating torture and other cruel, inhuman, or degrading treatment. Psychologists inform themselves about research regarding the most effective and humane methods of obtaining information and become familiar with how culture may interact with the techniques consulted upon. (Principle E, Respect for Peoples' Rights and Dignity; Ethical Standards 2.01, Boundaries of Competence; 2.03, Maintaining Competence; and 3.01, Unfair Discrimination)

**Ninth,** psychologists make clear the limits of confidentiality. (Ethical Standard 4.02, Discussing the Limits of Confidentiality). Psychologists who have access to, utilize, or share health or mental health related information do so with an awareness of the sensitivity of such information, keeping in mind that "Psychologists have a primary obligation and take reasonable precautions to protect confidential information..." (Ethical Standard 4.01, Maintaining Confidentiality). When disclosing sensitive information, psychologists share the minimum amount of information necessary, and only with individuals



who have a clear professional purpose for obtaining the information. (Ethical Standard 4.04, Minimizing Intrusions on Privacy) Psychologists take care not to leave a misimpression that information is confidential when in fact it is not. (Ethical Standards 3.10, Informed Consent, and 4.02, Discussing the Limits of Confidentiality)

**Tenth.** psychologists are aware of and do not act beyond their competencies, except in unusual circumstances, such as set forth in the Ethics Code. (Ethical Standard 2.02, Providing Services in Emergencies) Thus, psychologists strive to ensure that they rely on methods that are effective, in addition to being safe, legal, and ethical. (Ethical Standards 2.01, Boundaries of Competence; 2.04, Bases for Scientific and Professional Judgments; 9.01, Bases for Assessments)

**Eleventh.** psychologists clarify for themselves the identity of their client and retain ethical obligations to individuals who are not their clients. (Ethical Standards 3.07, Third-Party Requests for Services, and 3.11, Psychological Services Delivered to or Through Organizations) Regardless of whether an individual is considered a client, psychologists have an ethical obligation to ensure that their activities in relation to the individual are safe, legal, ethical, and effective. (Ethical Standard 3.04, Avoiding Harm) Sensitivity to the entirety of a psychologist's ethical obligations is especially important where, because of a setting's unique characteristics, an individual may not be fully able to assert relevant rights and interests. (Principle A, Beneficence and Nonmaleficence, "In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons..."; Principle D, Justice, "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices"; Principle E, Respect for People's Rights and Dignity, "Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making"; Ethical Standard 3.08, Exploitative Relationships)

**Twelfth.** psychologists have an ethical obligation to consult when they are facing difficult ethical dilemmas. The Task Force was emphatic that consultation on ethics questions and dilemmas is highly appropriate for psychologists at all levels of experience, especially in this very challenging and ethically complex area of practice. (Preamble to the Ethics Code, "The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically...and to consult with others concerning ethical problems"; and Ethical Standard 4.06, Consultations)

The Task Force drew several other conclusions:

- The development of professional skills and competencies, ethical consultation and ethical self-reflection, and a willingness to take responsibility for one's own ethical behavior are the best ways to ensure that the national security-related activities of psychologists are safe, legal, ethical, and effective.
- It is critical to offer ethical guidance and support especially to psychologists at the beginning of their careers, who may experience pressures to engage in unethical or inappropriate behaviors that they are likely to find difficult to resist.
- APA should develop a process whereby psychologists whose work involves classified material and who need ethical guidance or consultation may consult their national organization for assistance and support.
- Psychologists should encourage and engage in further research to evaluate and enhance the efficacy and effectiveness of the application of psychological science to issues, concerns and operations relevant to national security. One focus of a broad program of research is to examine the efficacy and effectiveness of information gathering techniques, with an emphasis on the quality of information obtained. In addition, psychologists should examine the psychological effects of conducting interrogations on the interrogators themselves, to explore ways of helping to ensure that the process of gathering information is likely to remain within ethical boundaries. Also valuable will be research on cultural differences in the psychological impact of particular information gathering methods and what constitutes cruel, inhuman or degrading treatment.

- The Task Force noted a potential area of tension between conducting research that is classified or whose success could be compromised if the research purpose and/or methodology become known, and ethical standards that require debriefing after participation in a study as a research subject. (Ethical Standards 8.07 and 8.08). APA should identify and further examine the ethical dimensions of such tensions.
- Psychologists working in this area should inform themselves of how culture and ethnicity interact with investigative or information-gathering techniques, with special attention to how failing to attend to such factors may result in harm.

The Task Force engaged in vigorous discussion and debate and did not reach consensus on several issues:

- The role of human rights standards in an ethics code. While all Task Force members felt that respect for human rights is critical, some task force members felt strongly that international standards of human rights should be built into the ethics code and others felt that the laws of the United States should be the touchstone.
- The degree to which psychologists may ethically disguise the nature and purpose of their work. While all members of the Task Force agreed that full disclosure of the nature and purpose of a psychologist's work is not ethically required or appropriate in every circumstance, members differed on the degree to which psychologists may ethically dissemble their activities from individuals whom they engage directly.
- Whether the discussions of the Task Force should have been made available outside the Task Force. Some members believed that sharing the substance of the discussions, debates, and disagreements of the Task Force would be helpful to others in fostering the development of professional ethics in other areas of national security. Others felt that not sharing information beyond this report and other public statements would facilitate richer and more productive exchanges during the Task Force meeting. The Task Force voted on this issue. By a vote of seven to one, with one abstention, the Task Force voted to limit what information is disclosed concerning its deliberations to this report and other public statements made by the Task Force as a whole.

#### IV. Recommendations

The Task Force recommends that APA:

- 1) Publicly reaffirm its 1986 Resolution Against Torture and Other Cruel, Inhuman, or Degrading Treatment.
- 2) Consider whether it would be appropriate to adopt the twelve statements in this Task Force Report either as guidelines or as official statements interpreting the APA Ethical Principles of Psychologists and Code of Conduct.
- 3) Develop a document that will serve as a companion to the twelve statements contained in this report, for the purpose of providing illustrative examples and providing commentary. Such a document will be especially important if APA adopts the statements as guidelines or official interpretations of the Ethics Code.
- 4) Continue to examine the goodness of fit between the Ethics Code and this area of practice. While the Task Force believes the Ethics Code is fundamentally sound and adequately addresses the great majority of ethical dilemmas that arise in national security-related settings, there are certain aspects in which the Code does not speak as well to this area of practice as the Code speaks to other areas of practice. The Task Force believes the Ethics Committee could undertake this task.
- 5) Develop a process to offer ethics consultation to psychologists whose work involves classified material and who seek ethical guidance.
- 6) Continue to develop a strong relationship with psychologists working in national security-related settings, with special attention to the unique ethical challenges these psychologists confront in their daily work, and collaborate with organizations having national security-related responsibilities to promote psychological practice consistent with APA Ethical Standards.



- 7) Forward a copy of this task force report, or a summary of the report, to the United States Department of Defense and other relevant government agencies and bodies, as the government develops policy on these complicated and challenging ethical issues.
- 8) Encourage psychologists to engage in further research relevant to national security, including evaluation of the efficacy and effectiveness of methods for gathering information that is accurate, relevant and reliable. Such research should be designed to minimize risks to research participants such as emotional distress, and should be consistent with standards of human subject research protection and the APA Ethics Code. In addition, the Task Force recommends that APA recognize that issues involving terrorism and national security affect citizens in all countries and so encourage behavioral scientists to collaborate across disciplines, cultures and countries in addressing these concerns.
- 9) Consider supporting the creation of a repository to record psychologists' contributions to national security. Such information, divided into classified and unclassified sections, could serve as a historical record and a resource concerning how psychologists involved in national security-related activities have met the ethical challenges of their work.
- 10) View the work of this Task Force as an initial step in addressing the very complicated and challenging ethical dilemmas that confront psychologists working in national security-related activities. Viewed as an initial step in a continuing process, this Report will ideally assist APA to engage in thoughtful reflection of complex ethical considerations in an area of psychological practice that is likely to expand significantly in coming years.

## PRESIDENTIAL TASK FORCE ON PSYCHOLOGICAL ETHICS AND NATIONAL SECURITY

### Final Draft Report

#### I. Overview of the Report

The Presidential Task Force on Psychological Ethics and National Security (PENS) met in response to the Board of Directors February, 2005 charge, that the Task Force:

[E]xamine 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 whether APA should develop policy to address the role of psychologists and psychology in investigations related to national security.

Recognizing the ethical complexity of this work, which takes place in unique settings and constantly evolving circumstances, the Task Force was nonetheless able to set forth twelve clear and agreed upon statements about psychologists' ethical obligations.

The Task Force noted that the Board of Director's charge did not include an investigative or adjudicatory role, and as a consequence emphasized that it did not render any judgment concerning events that may or may not have occurred in national security-related settings. Nonetheless, the Task Force was unambiguous that psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment, and that psychologists have an ethical responsibility to be alert to and report any such acts to appropriate authorities. The Task Force stated that it is consistent with the APA Ethics Code for psychologists to serve in consultative roles to interrogation and information gathering processes for national security-related purposes, as psychologists have a long-standing tradition of doing in other law enforcement contexts. Acknowledging that engaging in such consultative and advisory roles entails a delicate balance of ethical considerations, the Task Force stated that psychologists are in a unique position to assist in ensuring that these processes are safe and ethical for all participants.

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The Task Force report concludes with a series of recommendations to the American Psychological Association Board of Directors.



*Resolutions*

## II. Task Force Statements

1. <sup>must</sup> Psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment.
2. Psychologists are alert to acts of torture and other cruel, inhuman, or degrading treatment and have an ethical responsibility to report these acts to the appropriate authorities.
3. Psychologists who serve in the role of supporting an interrogation do not use health care related information to the detriment of an individual's safety and well-being.
4. Psychologists do not engage in behaviors that violate the laws of the United States, although psychologists may refuse for ethical reasons to follow laws or orders that are unjust or that violate basic principles of human rights.
5. Psychologists are aware of and clarify their role in situations where the nature of their professional identity and professional function may be ambiguous.
6. Psychologists are sensitive to the problems inherent in mixing potentially inconsistent roles, such as health care provider and consultant to an interrogation, and refrain from engaging in such multiple relationships.
7. Psychologists may serve in various national security-related roles, such as a consultant to interrogations, in a manner that is consistent with the Ethics Code, and when doing so psychologists are mindful of factors unique to these roles and contexts that require special ethical consideration.
8. Psychologists who consult on interrogation techniques are mindful that the individual being interrogated may not have engaged in untoward behavior and may not have information of interest to the interrogator. *more needed*
9. Psychologists make clear the limits of confidentiality.
10. Psychologists are aware of and do not act beyond their competencies, except in unusual circumstances, such as set forth in the Ethics Code.
11. Psychologists clarify for themselves the identity of their client and retain ethical obligations to individuals who are not their clients.
12. Psychologists have an ethical obligation to consult when they are facing difficult ethical dilemmas.



### III. Introduction and Commentary on the Twelve Task Force Statements

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The Task Force addressed the argument that when psychologists act in certain roles outside traditional health-service provider relationships, for example as consultants to interrogations, they are not acting in a professional capacity as psychologists and are therefore not bound by the APA Ethics Code. The Task Force rejected this contention. The Task Force believes that when psychologists serve in a position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies. Thus in any such circumstance, psychologists are bound by the APA Ethics Code.

The Task Force looked to the APA Ethics Code for fundamental principles to guide its thinking. The Task Force found such principles in the Preamble to the Ethics Code, "Psychologists respect and protect civil and human rights" and "[The Ethics Code] has as its goals the welfare and protection of the individuals and groups with whom psychologists work"; Principle A, Beneficence and Nonmaleficence, "In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons"; Principle D, Justice, "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices"; and Principle E, Respect for People's Rights



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**Second**, psychologists are alert to acts of torture and other cruel, inhuman, or degrading treatment and have an ethical responsibility to report these acts to the appropriate authorities. This ethical responsibility is rooted in the Preamble, which states "Psychologists respect and protect civil and human rights...the development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically [and] to encourage ethical behavior by...colleagues," and Principle B, Fidelity and Responsibility, which states that psychologists "are concerned about the ethical compliance of their colleagues' scientific and professional conduct." (Ethical Standard 1.05, Reporting Ethical Violations) The Task Force notes that when fulfilling the obligation to respond to unethical behavior by reporting the behavior to appropriate authorities as a prelude to an adjudicatory process, psychologists guard against the names of individual psychologists being disseminated to the public. Inappropriate or premature public dissemination can expose psychologists to a risk of harm outside of established and appropriate legal and adjudicatory processes. (Ethical Standard 3.04, Avoiding Harm)

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**Fourth**, psychologists do not engage in behaviors that violate the laws of the United States, although psychologists may refuse for ethical reasons to follow laws or orders that are unjust or that violate basic principles of human rights. Psychologists involved in national security-related activities follow all applicable rules and regulations that govern their roles. Over the course of the recent United States military presence in locations such as Afghanistan, Iraq, and Cuba, such rules and regulations have been significantly developed and refined. Psychologists have an ethical responsibility to be informed of,



familiar with, and follow the most recent applicable regulations and rules. The Task Force notes that certain such rules and regulations incorporate texts that are fundamental to the treatment of individuals whose liberty has been curtailed, such as the Geneva Conventions.<sup>1</sup>

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**Sixth**, psychologists are sensitive to the problems inherent in mixing potentially inconsistent roles, such as health care provider and consultant to an interrogation, and refrain from engaging in such multiple relationships (Ethical Standard 3.05, Multiple Relationships, "A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.")

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- How failures to understand aspects of individuals' culture and ethnicity may generate misunderstandings, compromise the efficacy and hence the safety of investigatory processes, and result in significant mental and physical harm. (Principle E, "Psychologists are aware of and respect cultural, individual, and role differences, including those based on...race, ethnicity, culture, national origin... and consider these factors when working with members of such groups"; Ethical Standard 2.01(b), Boundaries of Competence, "Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with...race, ethnicity, culture, national origin...is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals..."; and Ethical Standard 3.01, Unfair Discrimination, "In their work-related activities, psychologists do not engage in unfair discrimination based on...race, ethnicity, culture, national origin...")
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Peoples' Rights and Dignity; Ethical Standards 2.01, Boundaries of Competence; 2.03, Maintaining Competence; and 3.01, Unfair Discrimination)

**Ninth**, psychologists make clear the limits of confidentiality. (Ethical Standard 4.02, Discussing the Limits of Confidentiality). Psychologists who have access to, utilize, or share health or mental health related information do so with an awareness of the sensitivity of such information, keeping in mind that "Psychologists have a primary obligation and take reasonable precautions to protect confidential information..." (Ethical Standard 4.01, Maintaining Confidentiality). When disclosing sensitive information, psychologists share the minimum amount of information necessary, and only with individuals who have a clear professional purpose for obtaining the information. (Ethical Standard 4.04, Minimizing Intrusions on Privacy) Psychologists take care not to leave a misimpression that information is confidential when in fact it is not. (Ethical Standards 3.10, Informed Consent, and 4.02, Discussing the Limits of Confidentiality)

**Tenth**, psychologists are aware of and do not act beyond their competencies, except in unusual circumstances, such as set forth in the Ethics Code. (Ethical Standard 2.02, Providing Services in Emergencies) Thus, psychologists strive to ensure that they rely on methods that are effective, in addition to being safe, legal, and ethical. (Ethical Standards 2.01, Boundaries of Competence; 2.04, Bases for Scientific and Professional Judgments; 9.01, Bases for Assessments)

**Eleventh**, psychologists clarify for themselves the identity of their client and retain ethical obligations to individuals who are not their clients. (Ethical Standards 3.07, Third-Party Requests for Services, and 3.11, Psychological Services Delivered to or Through Organizations) Regardless of whether an individual is considered a client, psychologists have an ethical obligation to ensure that their activities in relation to the individual are safe, legal, ethical, and effective. (Ethical Standard 3.04, Avoiding Harm) Sensitivity to the entirety of a psychologist's ethical obligations is especially important where, because of a setting's unique characteristics, an individual may not be fully able to assert relevant rights and interests. (Principle A, Beneficence and Nonmaleficence, "In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons..."; Principle D, Justice, "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices"; Principle E, Respect for People's Rights and Dignity, "Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making"; Ethical Standard 3.08, Exploitative Relationships)

**Twelfth**, psychologists have an ethical obligation to consult when they are facing difficult ethical dilemmas. The Task Force was emphatic that consultation on ethics questions and dilemmas is highly appropriate for psychologists at all levels of experience, especially in this very challenging and ethically complex area of practice. (Preamble to the Ethics Code, "The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort



to act ethically...and to consult with others concerning ethical problems"; and Ethical Standard 4.06, Consultations).

The Task Force drew several other conclusions:

- The development of professional skills and competencies, ethical consultation and ethical self-reflection, and a willingness to take responsibility for one's own ethical behavior are the best ways to ensure that the national security-related activities of psychologists are safe, legal, ethical, and effective.
- It is critical to offer ethical guidance and support especially to psychologists at the beginning of their careers, who may experience pressures to engage in unethical or inappropriate behaviors that they are likely to find difficult to resist.
- APA should develop a process whereby psychologists whose work involves classified material and who need ethical guidance or consultation may consult their national organization for assistance and support.
- Psychologists should encourage and engage in further research to evaluate and enhance the efficacy and effectiveness of the application of psychological science to issues, concerns and operations relevant to national security. One focus of a broad program of research is to examine the efficacy and effectiveness of information gathering techniques, with an emphasis on the quality of information obtained. In addition, psychologists should examine the psychological effects of conducting interrogations on the interrogators themselves, to explore ways of helping to ensure that the process of gathering information is likely to remain within ethical boundaries. Also valuable will be research on cultural differences in the psychological impact of particular information gathering methods and what constitutes cruel, inhuman or degrading treatment.
- The Task Force noted a potential area of tension between conducting research that is classified or whose success could be compromised if the research purpose and/or methodology become known, and ethical standards that require debriefing after participation in a study as a research subject. (Ethical Standards 8.07 and 8.08). APA should identify and further examine the ethical dimensions of such tensions.
- Psychologists working in this area should inform themselves of how culture and ethnicity interact with investigative or information-gathering techniques, with special attention to how failing to attend to such factors may result in harm.

The Task Force engaged in vigorous discussion and debate and did not reach consensus on several issues:

- The role of human rights standards in an ethics code. While all Task Force members felt that respect for human rights is critical, some task force members felt strongly that international standards of human rights should be



built into the ethics code and others felt that the laws of the United States should be the touchstone.

- The degree to which psychologists may ethically disguise the nature and purpose of their work. While all members of the Task Force agreed that full disclosure of the nature and purpose of a psychologist's work is not ethically required or appropriate in every circumstance, members differed on the degree to which psychologists may ethically dissemble their activities from individuals whom they engage directly.
- Whether the discussions of the Task Force should have been made available outside the Task Force. Some members believed that sharing the substance of the discussions, debates, and disagreements of the Task Force would be helpful to others in fostering the development of professional ethics in other areas of national security. Others felt that not sharing information beyond this report and other public statements would facilitate richer and more productive exchanges during the Task Force meeting. The Task Force voted on this issue. By a vote of seven to one, with one abstention, the Task Force voted to limit what information is disclosed concerning its deliberations to this report and other public statements made by the Task Force as a whole.

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#### IV. Recommendations

The Task Force recommends that APA:

- 1) Publicly reaffirm its 1986 Resolution Against Torture and Other Cruel, Inhuman, or Degrading Treatment.
- 2) Consider whether it would be appropriate to adopt the twelve statements in this Task Force Report either as guidelines or as official statements interpreting the APA Ethical Principles of Psychologists and Code of Conduct.
- 3) Develop a document that will serve as a companion to the twelve statements contained in this report, for the purpose of providing illustrative examples and providing commentary. Such a document will be especially important if APA adopts the statements as guidelines or official interpretations of the Ethics Code.
- 4) Continue to examine the goodness of fit between the Ethics Code and this area of practice. While the Task Force believes the Ethics Code is fundamentally sound and adequately addresses the great majority of ethical dilemmas that arise in national security-related settings, there are certain aspects in which the Code does not speak as well to this area of practice as the Code speaks to other areas of practice. The Task Force believes the Ethics Committee could undertake this task.
- 5) Develop a process to offer ethics consultation to psychologists whose work involves classified material and who seek ethical guidance.
- 6) Continue to develop a strong relationship with psychologists working in national security-related settings, with special attention to the unique ethical challenges these psychologists confront in their daily work, and collaborate with

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organizations having national security-related responsibilities to promote psychological practice consistent with APA Ethical Standards.

- 7) Forward a copy of this task force report, or a summary of the report, to the United States Department of Defense and other relevant government agencies and bodies, as the government develops policy on these complicated and challenging ethical issues.
- 8) Encourage psychologists to engage in further research relevant to national security, including evaluation of the efficacy and effectiveness of methods for gathering information that is accurate, relevant and reliable. Such research should be designed to minimize risks to research participants such as emotional distress, and should be consistent with standards of human subject research protection and the APA Ethics Code. In addition, the Task Force recommends that APA recognize that issues involving terrorism and national security affect citizens in all countries and so encourage behavioral scientists to collaborate across disciplines, cultures and countries in addressing these concerns.
- 9) Consider supporting the creation of a repository to record psychologists' contributions to national security. Such information, divided into classified and unclassified sections, could serve as a historical record and a resource concerning how psychologists involved in national security-related activities have met the ethical challenges of their work.
- 10) View the work of this Task Force as an initial step in addressing the very complicated and challenging ethical dilemmas that confront psychologists working in national security-related activities. Viewed as an initial step in a continuing process, this Report will ideally assist APA to engage in thoughtful reflection of complex ethical considerations in an area of psychological practice that is likely to expand significantly in coming years.

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not draft  
revised by  
ethics review team

## DRAFT REPORT OF THE PRESIDENTIAL TASK FORCE ON PSYCHOLOGICAL ETHICS AND NATIONAL SECURITY

### I. Overview of the Report

The Presidential Task Force on Psychological Ethics and National Security (PENS) met in response to the Board of Directors' February 2005 charge, that the Task Force:

[E]xamine 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 whether APA should develop policy to address the role of psychologists and psychology in investigations related to national security.

Recognizing the ethical complexity of this work, which takes place in unique settings and constantly evolving circumstances, the Task Force was nonetheless able to set forth 12 clear and agreed-upon statements about psychologists' ethical obligations.

As a context for its statements, the Task Force affirmed that when psychologists serve in a position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies. The Task Force thus rejected the contention that when acting in roles outside traditional health-service provider relationships psychologists are not acting in a professional capacity and are therefore not bound by the APA Ethics Code.

The Task Force noted that the Board of Directors' charge did not include an investigative or adjudicatory role, and as a consequence emphasized that it did not render any judgment concerning events that may or may not have occurred in national security-related settings. Nonetheless, the Task Force was unambiguous that psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment and that psychologists have an ethical responsibility to be alert to and report any such acts to appropriate authorities. The Task Force stated that it is consistent with the APA Ethics Code for psychologists to serve in consultative roles to interrogation and information-gathering processes for national security-related purposes, as psychologists have a long-standing tradition of doing in other law enforcement contexts. Acknowledging that engaging in such consultative and advisory roles entails a delicate balance of ethical considerations, the Task Force stated that psychologists are in a unique position to assist in ensuring that these processes are safe and ethical for all participants.

The Task Force Report concludes with a series of recommendations to the American Psychological Association Board of Directors.



## II. Introduction to the Report

The Task Force believes it is critical for the American Psychological Association to address the ethical challenges facing psychologists whose work involves national security-related activities. APA is the world's largest association of mental health professionals. Article I of the Association Bylaws states:

The objects of the American Psychological Association shall be to advance psychology as a science and profession and as a means of promoting health, education and human welfare by the...improvement of the qualifications and usefulness of psychologists through high standards of ethics...[and] by the establishment and maintenance of the highest standards of professional ethics and conduct of the members of the Association...<sup>1</sup>

Many association members work for the United States government as employees or consultants in national security-related positions. It is the responsibility of APA to think through and provide guidance on the complex ethical challenges that face these psychologists, who apply their training, skills, and expertise in our nation's service.

The Task Force addressed the argument that when psychologists act in certain roles outside traditional health-service provider relationships, for example as consultants to interrogations, they are not acting in a professional capacity as psychologists and are therefore not bound by the APA Ethics Code. The Task Force rejected this contention. The Task Force believes that when psychologists serve in a position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies. Thus in any such circumstance, psychologists are bound by the APA Ethics Code.

In the APA Ethical Principles of Psychologists and Code of Conduct (hereinafter the Ethics Code),<sup>2</sup> Principle B, Fidelity and Responsibility, states that psychologists "are aware of their professional and scientific responsibilities to society." Psychologists have 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. The Task Force believes that a central role for psychologists working in the area of national security-related investigations is to assist in ensuring that processes are safe, legal, and ethical for all participants.

The Task Force looked to the APA Ethics Code for fundamental principles to guide its thinking. The Task Force found such principles in numerous aspects of the Ethics Code,

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<sup>1</sup> American Psychological Association (2004). *Bylaws of the American Psychological Association* [Brochure]. Washington, DC: Author. (Also available at )

<sup>2</sup> American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073. (Also available at )



such as the Preamble, "Psychologists respect and protect civil and human rights" and "[The Ethics Code] has as its goals the welfare and protection of the individuals and groups with whom psychologists work"; Principle A, Beneficence and Nonmaleficence, "In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons"; Principle D, Justice, "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices"; and Principle E, Respect for People's Rights and Dignity, "Psychologists respect the dignity and worth of all people." The Task Force concluded that the Ethics Code is fundamentally sound in addressing the ethical dilemmas that arise in the context of national security-related work.

### **III. Twelve Statements Concerning Psychologists' Ethical Obligations in National Security-Related Work and Commentary on the Statements**

**1. Psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment.** The Task Force endorses the 1986 Resolution Against Torture of the American Psychological Association Council of Representatives,<sup>3</sup> and the 1985 Joint Resolution Against Torture of the American Psychological Association and the American Psychiatric Association.<sup>4</sup> (Principle A, Beneficence and Nonmaleficence, and Ethical Standard 3.04, Avoiding Harm) The Task Force emphasizes that the Board of Directors' charge did not include an investigative or adjudicatory role and so the Task Force does not render any judgment concerning events that may or may not have occurred in national security-related settings. The Task Force nonetheless feels that an absolute statement against torture and other cruel, inhuman, or degrading treatment is appropriate.

**2. Psychologists are alert to acts of torture and other cruel, inhuman, or degrading treatment and have an ethical responsibility to report these acts to the appropriate authorities.** This ethical responsibility is rooted in the Preamble, "Psychologists respect and protect civil and human rights...the development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically [and] to encourage ethical behavior by...colleagues," and Principle B, Fidelity and Responsibility, which states that psychologists "are concerned about the ethical compliance of their colleagues' scientific and professional conduct." (Ethical Standard 1.05, Reporting Ethical Violations) The Task Force notes that when fulfilling the obligation to respond to unethical behavior by reporting the behavior to appropriate authorities as a prelude to an adjudicatory process, psychologists guard against the names of individual psychologists being disseminated to the public. Inappropriate or premature public dissemination can expose psychologists to a risk of harm outside of established and appropriate legal and adjudicatory processes. (Ethical Standard 3.04, Avoiding Harm)

**3. Psychologists who serve in the role of supporting an interrogation do not use health care related information from an individual's medical record to the detriment of the individual's safety and well-being.** While information from a medical record may be helpful or necessary to ensure that an interrogation process remains safe, psychologists do not use such information to the detriment of an individual's safety and well-being. (Ethical Standards 3.04, Avoiding Harm and 3.08, Exploitative Relationships)

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<sup>3</sup> American Psychological Association Council of Representatives. (1986). American Psychological Association resolution against torture. Retrieved from

<sup>4</sup> American Psychiatric Association & American Psychological Association. (1985). Against torture: Joint resolution of the American Psychiatric Association and the American Psychological Association. Retrieved from



**4. Psychologists do not engage in behaviors that violate the laws of the United States, although psychologists may refuse for ethical reasons to follow laws or orders that are unjust or that violate basic principles of human rights.** Psychologists involved in national security-related activities follow all applicable rules and regulations that govern their roles. Over the course of the recent United States military presence in locations such as Afghanistan, Iraq, and Cuba, such rules and regulations have been significantly developed and refined. Psychologists have an ethical responsibility to be informed of, familiar with, and follow the most recent applicable regulations and rules. The Task Force notes that certain rules and regulations incorporate texts that are fundamental to the treatment of individuals whose liberty has been curtailed, such as the Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and the Geneva Convention Relative to the Treatment of Prisoners of War.<sup>5</sup>

The Task Force notes that psychologists sometimes encounter conflicts between ethics and law. When such conflicts arise, psychologists make known their commitment to the APA Ethics Code and attempt to resolve the conflict in a responsible manner. If the conflict cannot be resolved in this manner, psychologists may adhere to the requirements of the law. (Ethical Standard 1.02) An ethical reason for psychologists to not follow the law is to act "in keeping with basic principles of human rights." (APA Ethics Code, Introduction and Applicability) The Task Force encourages psychologists working in this area to review essential human rights documents, such as the Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and the Geneva Convention Relative to the Treatment of Prisoners of War.<sup>6</sup>

**5. Psychologists are aware of and clarify their role in situations where the nature of their professional identity and professional function may be ambiguous.**

Psychologists have a special responsibility to clarify their role in situations where individuals may have an incorrect impression that psychologists are serving in a health care provider role. (Ethical Standards 3.07, Third-Party Requests for Services, and 3.11, Psychological Services Delivered to or Through Organizations)

The Task Force noted that psychologists acting in the role of consultant to national security issues most often work closely with other professionals from various disciplines. As a consequence, psychologists rarely act alone or independently, but rather as part of a group of professionals who bring together a variety of skills and experiences in order to provide an ethically appropriate service. (Ethical Standard 3.09, Cooperating with Other Professionals)

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<sup>5</sup> United Nations. (1987, June 26). *Convention against torture and other cruel, inhuman or degrading treatment or punishment*. Retrieved from

United Nations. (1950, October 21). *Geneva convention relative to the treatment of prisoners of war*. Retrieved from

<sup>6</sup> Ibid.



Regardless of their role, psychologists who are aware of an individual in need of health or mental health treatment may seek consultation regarding how to ensure that the individual receives needed care. (Principle A, Beneficence and Nonmaleficence)

**6. Psychologists are sensitive to the problems inherent in mixing potentially inconsistent roles, such as health care provider and consultant to an interrogation, and refrain from engaging in such multiple relationships.** (Ethical Standard 3.05, Multiple Relationships, "A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.")

**7. Psychologists may serve in various national security-related roles, such as a consultant to an interrogation, in a manner that is consistent with the Ethics Code, and when doing so psychologists are mindful of factors unique to these roles and contexts that require special ethical consideration.** The Task Force noted that psychologists have served in consultant roles to law enforcement on the state and federal levels for a considerable period of time. Psychologists have proven highly effective in lending assistance to law enforcement in the vital area of information gathering and have done so in an ethical manner. The Task Force noted special ethical considerations for psychologists serving as consultants to interrogation processes in national security-related settings, especially when individuals from countries other than the United States have been detained by United States authorities. Such ethical considerations include:

- How certain settings may instill in individuals a profound sense of powerlessness and may place individuals in considerable positions of disadvantage in terms of asserting their interests and rights. (Ethical Standards 1.01, Misuse of Psychologists' Work, and 3.08, Exploitative Relationships)
- How failures to understand aspects of individuals' culture and ethnicity may generate misunderstandings, compromise the efficacy and hence the safety of investigatory processes, and result in significant mental and physical harm. (Principle E, "Psychologists are aware of and respect cultural, individual, and role differences, including those based on...race, ethnicity, culture, national origin... and consider these factors when working with members of such groups"; Ethical Standard 2.01(b), Boundaries of Competence, "Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with...race, ethnicity, culture, national origin...is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals..."; and Ethical Standard 3.01, Unfair Discrimination, "In their work-related activities, psychologists do not engage in unfair discrimination based on...race, ethnicity, culture, national origin...")



- How the combination of a setting's ambiguity with high stress may facilitate engaging in behaviors that cross the boundaries of competence and ethical propriety. As behavioral scientists, psychologists are trained to observe, respond to, and ideally correct such processes as they occur. (Principle A, Beneficence and Nonmaleficence, and Ethical Standard 3.04, Avoiding Harm)

**8. Psychologists who consult on interrogation techniques are mindful that the individual being interrogated may not have engaged in untoward behavior and may not have information of interest to the interrogator.** This ethical obligation is not diminished by the nature of an individual's acts prior to detainment or the likelihood of the individual having relevant information. At all times psychologists remain mindful of and abide by the prohibitions against engaging in or facilitating torture and other cruel, inhuman, or degrading treatment. Psychologists inform themselves about research regarding the most effective and humane methods of obtaining information and become familiar with how culture may interact with the techniques consulted upon. (Principle E, Respect for Peoples' Rights and Dignity; Ethical Standards 2.01, Boundaries of Competence; 2.03, Maintaining Competence; and 3.01, Unfair Discrimination)

**9. Psychologists make clear the limits of confidentiality.** (Ethical Standard 4.02, Discussing the Limits of Confidentiality). Psychologists who have access to, utilize, or share health or mental health related information do so with an awareness of the sensitivity of such information, keeping in mind that "Psychologists have a primary obligation and take reasonable precautions to protect confidential information..." (Ethical Standard 4.01, Maintaining Confidentiality) When disclosing sensitive information, psychologists share the minimum amount of information necessary, and only with individuals who have a clear professional purpose for obtaining the information. (Ethical Standard 4.04, Minimizing Intrusions on Privacy) Psychologists take care not to leave a misimpression that information is confidential when in fact it is not. (Ethical Standards 3.10, Informed Consent, and 4.02, Discussing the Limits of Confidentiality)

**10. Psychologists are aware of and do not act beyond their competencies, except in unusual circumstances, such as set forth in the Ethics Code.** (Ethical Standard 2.02, Providing Services in Emergencies) Psychologists strive to ensure that they rely on methods that are effective, in addition to being safe, legal, and ethical. (Ethical Standards 2.01, Boundaries of Competence; 2.04, Bases for Scientific and Professional Judgments; 9.01, Bases for Assessments)

**11. Psychologists clarify for themselves the identity of their client and retain ethical obligations to individuals who are not their clients.** (Ethical Standards 3.07, Third-Party Requests for Services, and 3.11, Psychological Services Delivered to or Through Organizations) Regardless of whether an individual is considered a client, psychologists have an ethical obligation to ensure that their activities in relation to the individual are safe, legal, ethical, and effective. (Ethical Standard 3.04, Avoiding Harm) Sensitivity to the entirety of a psychologist's ethical obligations is especially important where, because of a setting's unique characteristics, an individual may not be fully able to assert relevant rights and interests. (Principle A, Beneficence and Nonmaleficence, "In their professional



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**12. Psychologists consult when they are facing difficult ethical dilemmas.** The Task Force was emphatic that consultation on ethics questions and dilemmas is highly appropriate for psychologists at all levels of experience, especially in this very challenging and ethically complex area of practice. (Preamble to the Ethics Code, "The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically...and to consult with others concerning ethical problems"; and Ethical Standard 4.06, Consultations)

The Task Force drew several other conclusions:

- The development of professional skills and competencies, ethical consultation and ethical self-reflection, and a willingness to take responsibility for one's own ethical behavior are the best ways to ensure that the national security-related activities of psychologists are safe, legal, ethical, and effective.
- It is critical to offer ethical guidance and support especially to psychologists at the beginning of their careers, who may experience pressures to engage in unethical or inappropriate behaviors that they are likely to find difficult to resist.
- APA should develop a process whereby psychologists whose work involves classified material and who need ethical guidance or consultation may consult their national organization for assistance and support.
- Psychologists should encourage and engage in further research to evaluate and enhance the efficacy and effectiveness of the application of psychological science to issues, concerns and operations relevant to national security. One focus of a broad program of research is to examine the efficacy and effectiveness of information-gathering techniques, with an emphasis on the quality of information obtained. In addition, psychologists should examine the psychological effects of conducting interrogations on the interrogators themselves to explore ways of helping to ensure that the process of gathering information is likely to remain within ethical boundaries. Also valuable will be research on cultural differences in the psychological impact of particular information-gathering methods and what constitutes cruel, inhuman, or degrading treatment.
- The Task Force noted a potential area of tension between conducting research that is classified or whose success could be compromised if the research purpose and/or methodology become known and ethical standards that require

debriefing after participation in a study as a research subject. (Ethical Standards 8.07, Deception in Research, and 8.08, Debriefing) APA should identify and further examine the ethical dimensions of such tensions.

- Psychologists working in this area should inform themselves of how culture and ethnicity interact with investigative or information-gathering techniques, with special attention to how failing to attend to such factors may result in harm.

The Task Force engaged in vigorous discussion and debate and did not reach consensus on several issues:

- *The role of human rights standards in an ethics code.* While all Task Force members felt that respect for human rights is critical, some task force members felt strongly that international standards of human rights should be built into the ethics code and others felt that the laws of the United States should be the touchstone.
- *The degree to which psychologists may ethically disguise the nature and purpose of their work.* While all members of the Task Force agreed that full disclosure of the nature and purpose of a psychologist's work is not ethically required or appropriate in every circumstance, members differed on the degree to which psychologists may ethically dissemble their activities from individuals whom they engage directly.
- *Whether the discussions of the Task Force should have been made available outside the Task Force.* Some members believed that sharing the substance of the discussions, debates, and disagreements of the Task Force would be helpful to others in fostering the development of professional ethics in other areas of national security. Others felt that not sharing information beyond this report and other public statements would facilitate richer and more productive exchanges during the Task Force meeting. The Task Force voted on this issue. By a vote of seven to one, with one abstention, the Task Force voted to limit what information is disclosed concerning its deliberations to this report and other public statements made by the Task Force as a whole.



### III. Recommendations

The Task Force recommends that APA:

1. Publicly reaffirm its 1986 Resolution Against Torture and Other Cruel, Inhuman, or Degrading Treatment.
2. Develop a document that will serve as a companion to the 12 statements contained in this report, for the purpose of providing illustrative examples and commentary. Such a document will be especially important if APA adopts the statements as guidelines or if the Ethics Committee deems the statements appropriate interpretations and applications of the Ethics Code.
3. Continue to examine the goodness of fit between the Ethics Code and this area of practice. While the Task Force believes the Ethics Code is fundamentally sound and adequately addresses the great majority of ethical dilemmas that arise in national security-related settings, there are certain aspects in which the Code does not speak as well to this area of practice as the Code speaks to other areas of practice. The Task Force believes the Ethics Committee could undertake this task.
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5. Continue to develop a strong relationship with psychologists working in national security-related settings, with special attention to the unique ethical challenges these psychologists confront in their daily work, and collaborate with organizations having national security-related responsibilities to promote psychological practice consistent with APA Ethical Standards.
6. Forward a copy of this Task Force Report, or a summary of the report, to the United States Department of Defense and other relevant government agencies and bodies, as the government develops policy on these complicated and challenging ethical issues.
7. Encourage psychologists to engage in further research relevant to national security, including evaluation of the efficacy and effectiveness of methods for gathering information that is accurate, relevant, and reliable. Such research should be designed to minimize risks to research participants such as emotional distress, and should be consistent with standards of human subject research protection and the APA Ethics Code.
8. Recognize that issues involving terrorism and national security affect citizens in all countries and so encourage behavioral scientists to collaborate across disciplines, cultures, and countries in addressing these concerns.
9. Consider supporting the creation of a repository to record psychologists' contributions to national security. Such information, divided into classified and unclassified sections, could serve as a historical record and a resource concerning how psychologists involved in national security-related activities have met the ethical challenges of their work.



10. View the work of this Task Force as an initial step in addressing the very complicated and challenging ethical dilemmas that confront psychologists working in national security-related activities. Viewed as an initial step in a continuing process, this report will ideally assist APA to engage in thoughtful reflection of complex ethical considerations in an area of psychological practice that is likely to expand significantly in coming years.

7. D. *Report of the American Psychological Association  
Presidential Task Force on Psychological Ethics  
and National Security (final report)*

REPORT OF THE  
PRESIDENTIAL TASK FORCE ON PSYCHOLOGICAL ETHICS AND  
NATIONAL SECURITY

# Report of the American Psychological Association Presidential Task Force



## *on Psychological Ethics and National Security*

final report #4

June 2005



## **REPORT OF THE PRESIDENTIAL TASK FORCE ON PSYCHOLOGICAL ETHICS AND NATIONAL SECURITY**

### **I. Overview of the Report**

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[E]xamine 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 whether APA should develop policy to address the role of psychologists and psychology in investigations related to national security.

Recognizing the ethical complexity of this work, which takes place in unique settings and constantly evolving circumstances, the Task Force was nonetheless able to set forth 12 clear and agreed-upon statements about psychologists' ethical obligations.

As a context for its statements, the Task Force affirmed that when psychologists serve in any position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies. The Task Force thus rejected the contention that when acting in roles outside traditional health-service provider relationships psychologists are not acting in a professional capacity as psychologists and are therefore not bound by the APA Ethics Code.

The Task Force noted that the Board of Directors' charge did not include an investigative or adjudicatory role, and as a consequence emphasized that it did not render any judgment concerning events that may or may not have occurred in national security-related settings. Nonetheless, the Task Force was unambiguous that psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment and that psychologists have an ethical responsibility to be alert to and report any such acts to appropriate authorities. The Task Force stated that it is consistent with the APA Ethics Code for psychologists to serve in consultative roles to interrogation and information-gathering processes for national security-related purposes, as psychologists have a long-standing tradition of doing in other law enforcement contexts. Acknowledging that engaging in such consultative and advisory roles entails a delicate balance of ethical considerations, the Task Force stated that psychologists are in a unique position to assist in ensuring that these processes are safe and ethical for all participants.

The Task Force Report concludes with a series of recommendations to the American Psychological Association Board of Directors.

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The Task Force believes it is critical for the American Psychological Association to address the ethical challenges facing psychologists whose work involves national security-related activities. APA is the world's largest association of psychologists. Article I of the Association Bylaws states:

The objects of the American Psychological Association shall be to advance psychology as a science and profession and as a means of promoting health, education and human welfare by the...improvement of the qualifications and usefulness of psychologists through high standards of ethics...[and] by the establishment and maintenance of the highest standards of professional ethics and conduct of the members of the Association...<sup>1</sup>

Many association members work for the United States government as employees or consultants in national security-related positions. It is the responsibility of APA to think through and provide guidance on the complex ethical challenges that face these psychologists, who apply their training, skills, and expertise in our nation's service.

The Task Force addressed the argument that when psychologists act in certain roles outside traditional health-service provider relationships, for example as consultants to interrogations, they are not acting in a professional capacity as psychologists and are therefore not bound by the APA Ethical Principles of Psychologists and Code of Conduct (hereinafter the Ethics Code).<sup>2</sup> The Task Force rejected this contention. The Task Force believes that when psychologists serve in a position by virtue of their training, experience, and expertise as psychologists, the APA Ethics Code applies. Thus in any such circumstance, psychologists are bound by the APA Ethics Code.

Principle B of the Ethics Code, Fidelity and Responsibility, states that psychologists "are aware of their professional and scientific responsibilities to society." Psychologists have 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. The Task Force believes that a central role for psychologists working in the area of national security-related investigations is to assist in ensuring that processes are safe, legal, and ethical for all participants.

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<sup>1</sup> American Psychological Association (2004). *Bylaws of the American Psychological Association* [Brochure]. Washington, DC: Author. (Also available at <http://www.apa.org/governance/>.)

<sup>2</sup> American Psychological Association. (2002). Ethical principles of psychologists and code of conduct. *American Psychologist*, 57, 1060-1073. (Also available at <http://www.apa.org/ethics/>.)



The Task Force looked to the APA Ethics Code for fundamental principles to guide its thinking. The Task Force found such principles in numerous aspects of the Ethics Code, such as the Preamble, "Psychologists respect and protect civil and human rights" and "[The Ethics Code] has as its goals the welfare and protection of the individuals and groups with whom psychologists work"; Principle A, Beneficence and Nonmaleficence, "In their professional actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons"; Principle D, Justice, "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices"; and Principle E, Respect for People's Rights and Dignity, "Psychologists respect the dignity and worth of all people." The Task Force concluded that the Ethics Code is fundamentally sound in addressing the ethical dilemmas that arise in the context of national security-related work.

### **III. Twelve Statements Concerning Psychologists' Ethical Obligations in National Security-Related Work and Commentary on the Statements**

**1. Psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment.** The Task Force endorses the 1986 Resolution Against Torture of the American Psychological Association Council of Representatives,<sup>3</sup> and the 1985 Joint Resolution Against Torture of the American Psychological Association and the American Psychiatric Association.<sup>4</sup> (Principle A, Beneficence and Nonmaleficence, and Ethical Standard 3.04, Avoiding Harm) The Task Force emphasizes that the Board of Directors' charge did not include an investigative or adjudicatory role and so the Task Force does not render any judgment concerning events that may or may not have occurred in national security-related settings. The Task Force nonetheless feels that an absolute statement against torture and other cruel, inhuman, or degrading treatment is appropriate.

**2. Psychologists are alert to acts of torture and other cruel, inhuman, or degrading treatment and have an ethical responsibility to report these acts to the appropriate authorities.** This ethical responsibility is rooted in the Preamble, "Psychologists respect and protect civil and human rights...the development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically [and] to encourage ethical behavior by...colleagues," and Principle B, Fidelity and Responsibility, which states that psychologists "are concerned about the ethical compliance of their colleagues' scientific and professional conduct." (Ethical Standard 1.05, Reporting Ethical Violations) The Task Force notes that when fulfilling the obligation to respond to unethical behavior by reporting the behavior to appropriate authorities as a prelude to an adjudicatory process, psychologists guard against the names of individual psychologists being disseminated to the public. Inappropriate or premature public dissemination can expose psychologists to a risk of harm outside of established and appropriate legal and adjudicatory processes. (Ethical Standard 3.04, Avoiding Harm)

**3. Psychologists who serve in the role of supporting an interrogation do not use health care related information from an individual's medical record to the detriment of the individual's safety and well-being.** While information from a medical record may be helpful or necessary to ensure that an interrogation process remains safe, psychologists do not use such information to the detriment of an individual's safety and well-being. (Ethical Standards 3.04, Avoiding Harm, and 3.08, Exploitative Relationships)

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<sup>3</sup> American Psychological Association Council of Representatives. (1986). American Psychological Association resolution against torture. Retrieved from <http://www.apa.org/about/division/cpmainternatl.html#3>

<sup>4</sup> American Psychiatric Association & American Psychological Association. (1985). Against torture: Joint resolution of the American Psychiatric Association and the American Psychological Association. Retrieved from [http://www.psych.org/edu/other\\_res/lib\\_archives/archives/198506.pdf](http://www.psych.org/edu/other_res/lib_archives/archives/198506.pdf)



**4. Psychologists do not engage in behaviors that violate the laws of the United States, although psychologists may refuse for ethical reasons to follow laws or orders that are unjust or that violate basic principles of human rights.** Psychologists involved in national security-related activities follow all applicable rules and regulations that govern their roles. Over the course of the recent United States military presence in locations such as Afghanistan, Iraq, and Cuba, such rules and regulations have been significantly developed and refined. Psychologists have an ethical responsibility to be informed of, familiar with, and follow the most recent applicable regulations and rules. The Task Force notes that certain rules and regulations incorporate texts that are fundamental to the treatment of individuals whose liberty has been curtailed, such as the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and the Geneva Convention Relative to the Treatment of Prisoners of War.<sup>5</sup>

The Task Force notes that psychologists sometimes encounter conflicts between ethics and law. When such conflicts arise, psychologists make known their commitment to the APA Ethics Code and attempt to resolve the conflict in a responsible manner. If the conflict cannot be resolved in this manner, psychologists may adhere to the requirements of the law. (Ethical Standard 1.02) An ethical reason for psychologists to not follow the law is to act "in keeping with basic principles of human rights." (APA Ethics Code, Introduction and Applicability) The Task Force encourages psychologists working in this area to review essential human rights documents, such as the United Nations Convention Against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment and the Geneva Convention Relative to the Treatment of Prisoners of War.<sup>6</sup>

**5. Psychologists are aware of and clarify their role in situations where the nature of their professional identity and professional function may be ambiguous.**

Psychologists have a special responsibility to clarify their role in situations where individuals may have an incorrect impression that psychologists are serving in a health care provider role. (Ethical Standards 3.07, Third-Party Requests for Services, and 3.11, Psychological Services Delivered to or Through Organizations)

The Task Force noted that psychologists acting in the role of consultant to national security issues most often work closely with other professionals from various disciplines. As a consequence, psychologists rarely act alone or independently, but rather as part of a group of professionals who bring together a variety of skills and experiences in order to provide an ethically appropriate service. (Ethical Standard 3.09, Cooperating with Other Professionals)

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<sup>5</sup> United Nations. (1987, June 26). *Convention against torture and other cruel, inhuman or degrading treatment or punishment*. Retrieved from [http://www.unhcr.ch/html/menu3/b/h\\_cat39.htm](http://www.unhcr.ch/html/menu3/b/h_cat39.htm)

United Nations. (1950, October 21). *Geneva convention relative to the treatment of prisoners of war*. Retrieved from <http://www.unhcr.ch/html/menu3/b/91.htm>

<sup>6</sup> Ibid.



Regardless of their role, psychologists who are aware of an individual in need of health or mental health treatment may seek consultation regarding how to ensure that the individual receives needed care. (Principle A, Beneficence and Nonmaleficence)

**6. Psychologists are sensitive to the problems inherent in mixing potentially inconsistent roles such as health care provider and consultant to an interrogation, and refrain from engaging in such multiple relationships.** (Ethical Standard 3.05, Multiple Relationships, "A psychologist refrains from entering into a multiple relationship if the multiple relationship could reasonably be expected to impair the psychologist's objectivity, competence, or effectiveness in performing his or her functions as a psychologist, or otherwise risks exploitation or harm to the person with whom the professional relationship exists.")

**7. Psychologists may serve in various national security-related roles, such as a consultant to an interrogation, in a manner that is consistent with the Ethics Code, and when doing so psychologists are mindful of factors unique to these roles and contexts that require special ethical consideration.** The Task Force noted that psychologists have served in consultant roles to law enforcement on the state and federal levels for a considerable period of time. Psychologists have proven highly effective in lending assistance to law enforcement in the vital area of information gathering and have done so in an ethical manner. The Task Force noted special ethical considerations for psychologists serving as consultants to interrogation processes in national security-related settings, especially when individuals from countries other than the United States have been detained by United States authorities. Such ethical considerations include:

- How certain settings may instill in individuals a profound sense of powerlessness and may place individuals in considerable positions of disadvantage in terms of asserting their interests and rights. (Ethical Standards 1.01, Misuse of Psychologists' Work, and 3.08, Exploitative Relationships)
- How failures to understand aspects of individuals' culture and ethnicity may generate misunderstandings, compromise the efficacy and hence the safety of investigatory processes, and result in significant mental and physical harm. (Principle E, "Psychologists are aware of and respect cultural, individual, and role differences, including those based on...race, ethnicity, culture, national origin... and consider these factors when working with members of such groups"; Ethical Standard 2.01(b), Boundaries of Competence, "Where scientific or professional knowledge in the discipline of psychology establishes that an understanding of factors associated with...race, ethnicity, culture, national origin...is essential for effective implementation of their services or research, psychologists have or obtain the training, experience, consultation, or supervision necessary to ensure the competence of their services, or they make appropriate referrals..."; and Ethical Standard 3.01, Unfair Discrimination, "In their work-related activities, psychologists do not engage in unfair discrimination based on...race, ethnicity, culture, national origin...")



- How the combination of a setting's ambiguity with high stress may facilitate engaging in behaviors that cross the boundaries of competence and ethical propriety. As behavioral scientists, psychologists are trained to observe, respond to, and ideally correct such processes as they occur. (Principle A, Beneficence and Nonmaleficence, and Ethical Standard 3.04, Avoiding Harm)

**8. Psychologists who consult on interrogation techniques are mindful that the individual being interrogated may not have engaged in untoward behavior and may not have information of interest to the interrogator.** This ethical obligation is not diminished by the nature of an individual's acts prior to detainment or the likelihood of the individual having relevant information. At all times psychologists remain mindful of and abide by the prohibitions against engaging in or facilitating torture and other cruel, inhuman, or degrading treatment. Psychologists inform themselves about research regarding the most effective and humane methods of obtaining information and become familiar with how culture may interact with the techniques consulted upon. (Principle E, Respect for Peoples' Rights and Dignity; Ethical Standards 2.01, Boundaries of Competence; 2.03, Maintaining Competence; and 3.01, Unfair Discrimination)

**9. Psychologists make clear the limits of confidentiality.** (Ethical Standard 4.02, Discussing the Limits of Confidentiality). Psychologists who have access to, utilize, or share health or mental health related information do so with an awareness of the sensitivity of such information, keeping in mind that "Psychologists have a primary obligation and take reasonable precautions to protect confidential information..." (Ethical Standard 4.01, Maintaining Confidentiality) When disclosing sensitive information, psychologists share the minimum amount of information necessary, and only with individuals who have a clear professional purpose for obtaining the information. (Ethical Standard 4.04, Minimizing Intrusions on Privacy) Psychologists take care not to leave a misimpression that information is confidential when in fact it is not. (Ethical Standards 3.10, Informed Consent, and 4.02, Discussing the Limits of Confidentiality)

**10. Psychologists are aware of and do not act beyond their competencies, except in unusual circumstances, such as set forth in the Ethics Code.** (Ethical Standard 2.02, Providing Services in Emergencies) Psychologists strive to ensure that they rely on methods that are effective, in addition to being safe, legal, and ethical. (Ethical Standards 2.01, Boundaries of Competence; 2.04, Bases for Scientific and Professional Judgments; 9.01, Bases for Assessments)

**11. Psychologists clarify for themselves the identity of their client and retain ethical obligations to individuals who are not their clients.** (Ethical Standards 3.07, Third-Party Requests for Services, and 3.11, Psychological Services Delivered to or Through Organizations) Regardless of whether an individual is considered a client, psychologists have an ethical obligation to ensure that their activities in relation to the individual are safe, legal, and ethical. (Ethical Standard 3.04, Avoiding Harm) Sensitivity to the entirety of a psychologist's ethical obligations is especially important where, because of a setting's unique characteristics, an individual may not be fully able to assert relevant rights and interests. (Principle A, Beneficence and Nonmaleficence, "In their professional



actions, psychologists seek to safeguard the welfare and rights of those with whom they interact professionally and other affected persons..."; Principle D, Justice, "Psychologists exercise reasonable judgment and take precautions to ensure that their potential biases, the boundaries of their competence, and the limitations of their expertise do not lead to or condone unjust practices"; Principle E, Respect for People's Rights and Dignity, "Psychologists are aware that special safeguards may be necessary to protect the rights and welfare of persons or communities whose vulnerabilities impair autonomous decision making"; Ethical Standard 3.08, Exploitative Relationships)

**12. Psychologists consult when they are facing difficult ethical dilemmas.** The Task Force was emphatic that consultation on ethics questions and dilemmas is highly appropriate for psychologists at all levels of experience, especially in this very challenging and ethically complex area of practice. (Preamble to the Ethics Code, "The development of a dynamic set of ethical standards for psychologists' work-related conduct requires a personal commitment and lifelong effort to act ethically...and to consult with others concerning ethical problems"; and Ethical Standard 4.06, Consultations)

The Task Force drew several other conclusions:

- The development of professional skills and competencies, ethical consultation and ethical self-reflection, and a willingness to take responsibility for one's own ethical behavior are the best ways to ensure that the national security-related activities of psychologists are safe, legal, ethical, and effective.
- It is critical to offer ethical guidance and support especially to psychologists at the beginning of their careers, who may experience pressures to engage in unethical or inappropriate behaviors that they are likely to find difficult to resist.
- APA should develop a process whereby psychologists whose work involves classified material and who need ethical guidance or consultation may consult their national organization for assistance and support.
- Psychologists should encourage and engage in further research to evaluate and enhance the efficacy and effectiveness of the application of psychological science to issues, concerns and operations relevant to national security. One focus of a broad program of research is to examine the efficacy and effectiveness of information-gathering techniques, with an emphasis on the quality of information obtained. In addition, psychologists should examine the psychological effects of conducting interrogations on the interrogators themselves to explore ways of helping to ensure that the process of gathering information is likely to remain within ethical boundaries. Also valuable will be research on cultural differences in the psychological impact of particular information-gathering methods and what constitutes cruel, inhuman, or degrading treatment.
- The Task Force noted a potential area of tension between conducting research that is classified or whose success could be compromised if the research purpose and/or methodology become known and ethical standards that require

debriefing after participation in a study as a research subject. (Ethical Standards 8.07, Deception in Research, and 8.08, Debriefing) APA should identify and further examine the ethical dimensions of such tensions.

- Psychologists working in this area should inform themselves of how culture and ethnicity interact with investigative or information-gathering techniques, with special attention to how failing to attend to such factors may result in harm.

The Task Force engaged in vigorous discussion and debate and did not reach consensus on several issues:

- *The role of human rights standards in an ethics code.* While all Task Force members felt that respect for human rights is critical, some task force members felt strongly that international standards of human rights should be built into the ethics code and others felt that the laws of the United States should be the touchstone.
- *The degree to which psychologists may ethically disguise the nature and purpose of their work.* While all members of the Task Force agreed that full disclosure of the nature and purpose of a psychologist's work is not ethically required or appropriate in every circumstance, members differed on the degree to which psychologists may ethically dissemble their activities from individuals whom they engage directly.
- *Whether the discussions of the Task Force should have been made available outside the Task Force.* Some members believed that sharing the substance of the discussions, debates, and disagreements of the Task Force would be helpful to others in fostering the development of professional ethics in other areas of national security. Others felt that not sharing information beyond this report and other public statements would facilitate richer and more productive exchanges during the Task Force meeting. The Task Force voted on this issue. By a vote of seven to one, with one abstention, the Task Force voted to limit what information is disclosed concerning its deliberations to this report and other public statements made by the Task Force as a whole.



### III. Recommendations

The Task Force recommends that APA:

1. Publicly reaffirm its 1986 Resolution Against Torture and Other Cruel, Inhuman, or Degrading Treatment.
2. Develop a document that will serve as a companion to the 12 statements contained in this report, for the purpose of providing illustrative examples and commentary. Such a document will be especially important if APA adopts the statements as guidelines or if the Ethics Committee deems the statements appropriate interpretations and applications of the Ethics Code.
3. Continue to examine the goodness of fit between the Ethics Code and this area of practice. While the Task Force believes the Ethics Code is fundamentally sound and adequately addresses the great majority of ethical dilemmas that arise in national security-related settings, there are certain aspects in which the Code does not speak as well to this area of practice as the Code speaks to other areas of practice. The Task Force believes the Ethics Committee could undertake this task.
4. Develop a process to offer ethics consultation to psychologists whose work involves classified material and who seek ethical guidance.
5. Continue to develop a strong relationship with psychologists working in national security-related settings, with special attention to the unique ethical challenges these psychologists confront in their daily work, and collaborate with organizations having national security-related responsibilities to promote psychological practice consistent with APA Ethical Standards.
6. Forward a copy of this Task Force Report, or a summary of the report, to the United States Department of Defense and other relevant government agencies and bodies, as the government develops policy on these complicated and challenging ethical issues.
7. Encourage psychologists to engage in further research relevant to national security, including evaluation of the efficacy and effectiveness of methods for gathering information that is accurate, relevant, and reliable. Such research should be designed to minimize risks to research participants such as emotional distress, and should be consistent with standards of human subject research protection and the APA Ethics Code.
8. Recognize that issues involving terrorism and national security affect citizens in all countries and so encourage behavioral scientists to collaborate across disciplines, cultures, and countries in addressing these concerns.
9. Consider supporting the creation of a repository to record psychologists' contributions to national security. Such information, divided into classified and unclassified sections, could serve as a historical record and a resource concerning how psychologists involved in national security-related activities have met the ethical challenges of their work.

10. View the work of this Task Force as an initial step in addressing the very complicated and challenging ethical dilemmas that confront psychologists working in national security-related activities. Viewed as an initial step in a continuing process, this report will ideally assist APA to engage in thoughtful reflection of complex ethical considerations in an area of psychological practice that is likely to expand significantly in coming years.

Presidential Task Force on Psychological  
Ethics and National Security

Members' Biographical Statements

# Members of the Presidential Task Force on Psychological Ethics and National Security

Olivia Moorehead-Slaughter, PhD - Chair

Jean Maria Arrigo, PhD

Morgan Banks, PhD

Robert A. Fein, PhD

Michael G. Gelles, PsyD

Larry C. James, PhD

Bryce E. Lefever, PhD

R. Scott Shumate, PsyD

Nina K. Thomas, PhD

Michael G. Wessells, PhD

## Board of Directors Liaisons

Barry S. Anton, PhD

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## Jean Maria Arrigo, PhD

Jean Maria Arrigo, PhD, has studied ethics of military intelligence and weapons development on human subjects for a decade as an independent scholar. Originally trained in mathematics (University of California, Berkeley, BA 1966; University of California, San Diego, MA 1969), Dr. Arrigo's volunteer human rights work in Central America in the 1980s led her to doctoral studies in social psychology. She initially undertook dissertation research on ethics of weapons development in the "naming, blaming, and shaming" tradition of human rights scholarship. However, her interviews with intelligence professionals and her own experience as a university whistleblower alerted her that moral trade-offs can arise in any idealistic hierarchical institution, whether military or civilian, by similar mechanisms. Her dissertation, *Sins and Salvations in Clandestine Scientific Research* (1999), demonstrated how reasonable epistemic principles of weapons research on human subjects generate intractable moral problems.

In pursuit of cross-disciplinary moral discourse, Dr. Arrigo and ethicist Charles Young organized *A Pilot Workshop on the Ethics of Political and Military Intelligence for Insiders and Outsiders* at Claremont Graduate University (2000). Dr. Arrigo has brought intelligence professionals from the U.S. military and the Tibetan government-in-exile to speak at four APA conventions and has made presentations to the Joint Services Conference on Professional Ethics. In 2004, she served as primary trainer for the TRADOC Chaplain Service School Instructor Training Workshop on the topic of spiritual devastation of covert operators. These activities culminated in *A Dialogue between Peace Psychology and Military Ethics*, coedited with Richard Wagner, for a special issue of *Peace and Conflict* (2005, 11(1)). Fellowships at the University of Virginia and the Institute of Medical Humanities at Galveston enabled Dr. Arrigo to develop educational theater performances about weapons development that represent both military and victim perspectives. Her *Redemption from Black Operations*; *The People Who Disappeared Twice*; *You, the Interrogator*; *The Human Radiation Experiments Roundtable*; and *What Is the Filial Duty of the Daughter of a Torturer?* have been performed at universities and conferences. To continue this path of public education, she founded the nonprofit Project on Ethics and Art in Testimony, Inc.

Dr. Arrigo endeavors to promote intelligence ethics as a field of study and to support moral voices within the national intelligence system. She established the *Ethics of Intelligence and Weapons Development Oral History Collection* (2004) at Bancroft Library, UC Berkeley, and *The Intelligence Ethics Collection* (2005) at the Hoover Institution on War, Revolution, and Peace, Stanford University, to gather oral histories and personal papers from concerned intelligence professionals. Her "Utilitarian Argument against Torture Interrogation of Terrorists" (2004, *Science and Engineering Ethics*, 10, 543-572) and "Perils of Torture Interrogation" (2005, *Armed Forces Journal*, forthcoming) particularly speak to issues that lie before the APA Presidential Task Force on Psychological Ethics and National Security.

## Morgan Banks, PhD

Colonel Morgan Banks, PhD, is currently the Command Psychologist and Chief of the Psychological Applications Directorate of the U.S. Army Special Operations Command (USASOC). This directorate is responsible for the psychological selection and assessment of all USASOC personnel, and for the psychological oversight of high-risk USASOC training. In addition, this directorate is responsible for the creation and execution of leader development programs for Special Forces and 75th Ranger Regiment personnel to include 360-degree assessment instruments. It is also responsible for all operational psychology support to USASOC combat units. Col. Banks provides technical supervision and oversight to all USASOC psychologists. He is the senior Army Survival, Evasion, Resistance, and Escape (SERE) Psychologist, responsible for the training and oversight of all Army SERE Psychologists, who include those involved in SERE training and in the repatriation of former detainees and prisoners of war. He provides technical support and consultation to all Army psychologists providing interrogation support, and his office currently provides the only Army training for psychologists in repatriation planning and execution, interrogation support, and behavioral profiling.

Col. Banks has served over twenty-three years on active duty, most of that time as a Psychologist in Army Special Operations. His initial duty assignment as a psychologist was to assist in establishing the Army's first permanent SERE training program involving a simulated captivity experience. While in this assignment, he established the psychological screening program for U.S. Army Special Forces personnel. His next assignment was as a Medical Company Commander in the 3rd Infantry Division, where he deployed his company into northern Iraq in 1991 to provide medical treatment to Kurdish refugees following the first Gulf War. He was then assigned to the Army's John F. Kennedy Special Warfare Center and School as the Command Psychologist, responsible for conducting the psychological screening of all Special Forces Personnel. Col. Banks was then selected for the Army's Command and General Staff College, and following his graduation in 1995, was again assigned within USASOC to a classified unit as a Command Psychologist. In this position, he provided psychology support to various combat and peacekeeping operations throughout the world. In 1991, Col. Banks was selected to be the Command Psychologist for USASOC. Immediately following 9/11, he was sent to Central Command (CENTCOM), in order to assist in predicting likely terrorist courses of action against the United States. While there, he helped establish the first Joint Interagency Task Force for CENTCOM. In November 1991, he deployed to Afghanistan, where he spent four months over the winter of 2001/2002 at Bagram Airfield, supporting combat operations against Al Qaida and Taliban fighters. He returned to his current position in March 1992. Col. Banks was recently a member of the Department of the Army Inspector General's team studying the treatment of detainees in U.S. custody.

Col. Banks received his Bachelor of Arts in Psychology from the University of New Orleans, his Master of Arts and his Doctor of Philosophy in Psychology from the University of Southern Mississippi, and his Master of Military Art and Science in Military History from the Army's Command and General Staff College.

## Robert A. Fein, PhD

Robert A. Fein, PhD, is a forensic psychologist with a specialty in threat assessment and the prevention of targeted violence. He is currently a consultant to the Directorate for Behavioral Sciences of the Department of Defense Counterintelligence Field Activity (CIFA), the DOD Criminal Investigative Task Force (CITF), and the U.S. Secret Service's National Threat Assessment Center. He also serves as a member of the Intelligence Science Board.

Dr. Fein has spent the last twenty-eight years working to understand and prevent targeted violence. He has conducted forensic mental health evaluations of several thousand violent offenders, has testified in state and federal courts on over 1,000 occasions on questions of "dangerousness," and has consulted on many hundreds of cases of potential workplace violence.

For more than twenty years, Dr. Fein has worked with the U.S. Secret Service. In his work with the Secret Service, he reviewed and consulted on several hundred protective intelligence cases concerning the assessment and management of persons who might present harm to the President and other national leaders. He codirected two major Secret Service operational studies of targeted violence: one on assassination, the other on school attacks. In the first of these studies, Dr. Fein examined the cases of all persons known to have attacked or attempted to attack a prominent public official or public figure in the United States from 1950 to 2000. As part of this work, he personally interviewed more than 20 assassins and near-assassins. In the second study, he and his colleagues systematically reviewed 37 instances of targeted school attacks in the United States in the past twenty-five years.

Recently, Dr. Fein has turned his attention to the prevention of targeted terrorist attacks. He is currently working with the Directorate for Behavioral Sciences of the DOD Counterintelligence Field Activity to conduct operational studies of Al Qaida preattack terrorist behaviors.

Dr. Fein received his Doctor of Philosophy in Clinical Psychology and Public Practice from Harvard University in 1974 and his Diplomate from the American Board of Forensic Psychology in 1982. He received the American Academy of Forensic Psychology's Award for Distinguished Career Contributions to Forensic Psychology for 2003. He holds appointments at the Harvard Medical School and the University of Massachusetts Medical School.

Dr. Fein is coauthor with Bryan Vossekuil of *Threat Assessment: An Approach to Prevent Targeted Violence*, published by the National Institute of Justice in 1995; *Protective Intelligence and Threat Assessment Investigations: A Guide for State and Local Law Enforcement Officials*, published by the National Institute of Justice in 1998; and "Assassination in the United States: An Operational Study of Recent Assassins, Attackers, and Near-Lethal Approachers," published in the *Journal of Forensic Sciences* in 1999. In addition, together with Mr. Vossekuil, he has coauthored a guide to school threat assessment, a monograph on preventing assassination, a book chapter on assassination and stalking behaviors, and other work on preventing targeted violent attacks.

## Michael G. Gelles, PsyD

Michael G. Gelles, PsyD, is the chief psychologist for the Naval Criminal Investigative Service. In this capacity he assists NCIS and a multitude of other federal, state, and local law enforcement agencies with criminal investigations. Dr. Gelles conducts psychological assessments of criminals and victims and psychological autopsies; he also provides insight into interviews and interrogations. Dr. Gelles's forensic expertise is used in forensic hypnosis and risk assessment of workplace violence, stalking, and interpersonal violence. Dr. Gelles is also active in supporting the counterintelligence and counterterrorism missions for NCIS, DOD, and the federal law enforcement community. He was the lead psychologist for the behavioral consultation team for the Criminal Investigations Task force.

Prior to joining NCIS in 1990, Dr. Gelles served as a clinical psychologist for the U.S. Navy. He is active in a number of professional organizations including the American Psychological Association Division of Police Psychology, the International Association of Chiefs of Police, the Psychology Services Section, the Society of Police and Criminal Psychology, and the Association of Threat Assessment Professionals. Dr. Gelles is also a frequent lecturer and has published numerous professional papers on topics relating to forensic psychology, law enforcement, and terrorism.

Dr. Gelles received his Bachelor of Arts from the University of Delaware and his Master of Arts and Doctor of Philosophy in Psychology from Yeshiva University in New York. He completed his clinical and forensic training at the National Naval Medical School and his advanced training at the Washington School of Psychiatry. He holds academic appointments in psychiatry at the Uniformed Services University of the Health Sciences and at the Washington School of Psychiatry.

## Larry C. James, PhD

Colonel Larry C. James, PhD, served as the Chief, Department of Psychology at Walter Reed Army Medical Center for the past five years. In this capacity, he also was the Chief Psychologist for the Army's northeast region and had responsibility over 100 psychologists in this region. Currently, Dr. James is the Chief, Department of Psychology, Tripler Army Medical Center, Honolulu, Hawaii. During the Military's response to 9/11 at the Pentagon, Col. James was the Chief Psychologist for the Mental Health Task Force. Dr. James has been awarded the Bronze Star and the Joint Service Commendation medals for his superior and distinguished services during the global war on terrorism. In 2003, he was the Chief Psychologist for the Joint Intelligence Group at GTMO, Cuba, and in 2004 he was the Director, Behavioral Science Unit, Joint Interrogation and Debriefing Center at Abu Ghraib, Iraq. Col. James was assigned to Iraq to develop legal and ethical policies consistent with the Geneva Convention Guidelines and the APA Ethics Code in response to the abuse scandal. Also, while at Abu Ghraib, Iraq, Dr. James was tasked with developing a mental health clinic to deliver services to approximately 8,000 prisoners.

## Bryce E. Lefever, PhD

Captain Bryce E. Lefever, PhD, received his Doctor of Philosophy in Clinical Psychology from the University of Illinois and joined the Navy in 1987. He was assigned to the Navy's Survival Evasion Resistance Escape (SERE) School from 1990 to 1993, where he insured the safe training of high-risk-of-capture personnel undergoing intensive exposure to enemy interrogation, torture, and exploitation techniques. He served with Navy Special Forces from 1998 to 2003 and was deployed as the Joint Special Forces Task Force psychologist to Afghanistan in 2002, where he lectured to interrogators and was consulted on various interrogation techniques. Capt. Lefever has been deployed to many parts of the world during his career including Haiti, Panama, Israel, Afghanistan, Italy, Bahrain, Crete, Puerto Rico, Iceland, Antarctica, and Spain where he has lectured on Brainwashing: The Method of Forceful Interrogation and taught The Management and Treatment of Combat Stress.

## Olivia Moorehead-Slaughter, PhD

Olivia Moorehead-Slaughter, PhD, is a licensed psychologist with eighteen years of experience in working with children, adults, and families across settings that include schools, outpatient mental health clinics, juvenile and probate courts, community health centers, and social service agencies. In the late 1990s, Dr. Moorehead-Slaughter was the Vice President of Behavioral Health Services at Dimock Community Health Center. Currently, she is the psychologist at The Park School in Brookline, MA, a nursery through Grade 9 independent school. She is a Senior Faculty Consultant for the Center for Multicultural Training Program, an APA-accredited psychology doctoral internship program at Boston Medical Center and Boston University School of Medicine.

Dr. Moorehead-Slaughter's professional endeavors have included extensive involvement as a member of the Massachusetts Board of Professional Licensure of Psychologists. During her almost seven years of membership on this board, Dr. Moorehead-Slaughter has served as Secretary, Vice Chair, and Chair of the board. From 2000 to 2002, she was an Associate Member of the Ethics Committee of APA. She is now a Member of the Ethics Committee serving a term from 2004 to 2006. Dr. Moorehead-Slaughter is the current Vice Chair of the Ethics Committee.

Dr. Moorehead-Slaughter also has a private consulting practice through which she is involved in numerous research and clinical consultation projects with the Boston University School of Medicine, conducts workshops and presentations, and provides clinical consultation.

Dr. Moorehead-Slaughter is married with two sons, ages 15 and 11.



## R. Scott Shumate, PsyD

R. Scott Shumate, PsyD, received his Doctor of Philosophy in Clinical Psychology from the University of Denver in 1985, is licensed to practice in both Virginia and Maryland, and is a member of the National Registry for Health Care Providers. He has worked for the federal government in highly classified positions that have required him to travel extensively and live overseas. He has performed many of his duties under highly stressful and difficult circumstances. In May of 2003, Dr. Shumate accepted a senior position in the Department of Defense as the Director of Behavioral Science for the Counterintelligence Field Activity. Currently, he has 20 psychologists and a multimillion dollar budget as he provides operational psychological support to several Defense Agencies through CIFA. DOD/CIFA is responsible for support to offensive and defensive counterintelligence (CI) efforts to protect and retain security over DOD assets, resources, and infrastructure. His team of renowned forensic psychologists are engaged in risk assessments of the Guantanamo Bay Detainees.

Dr. Shumate's extensive experience and knowledge of Middle Eastern culture have been documented in several classified articles and publications. He was the chief operational psychologist for the Counter-Terrorism Center from 2000 to 2003 and has interviewed many renowned individuals associated with various terrorist networks. He has had the opportunity to interview individuals who were "recruited" to be suicide bombers and either elected not to execute their mission or were apprehended prior to execution or after technical problems that kept the mission from being successful. Having worked in a nontraditional capacity for the better part of two decades, he has wrestled with ethical conflicts and has been sought by other psychologists in the community to consult on cases and issues that often involved ethical dilemmas.

Dr. Shumate has spoken to several classified audiences on the Chinese mindset after spending five years as the Chief Operational Psychologist for China Operations and considerable time in Asia and elsewhere. He is often consulted on issues of recruitment, handling, debriefing, and case management. His extensive experience in these areas as well as in counterterrorism has led to many public speaking engagements, including at Harvard Law School.

Dr. Shumate has been consulted by numerous federal agencies including the U.S. Secret Service, the Federal Bureau of Investigations, the Drug Enforcement Agency, Homeland Security, the Transportation Security Administration, the Department of Energy, the U.S. Air Force Office of Special Investigations, the Navy Criminal Investigative Service, and the U.S. Army Intelligence Command as well as the U.S. Attorney's offices and multiple local and state law enforcement agencies.

## Nina K. Thomas, PhD

Nina K. Thomas, PhD, ABPP (in psychoanalysis), FAPA, received her Doctor of Philosophy in Clinical Psychology from Columbia University Teachers College and holds a certificate in psychoanalysis from the New York University Postdoctoral Program in Psychotherapy and Psychoanalysis. She is in private practice in New York City and Morristown, NJ. A Past President of the New Jersey Psychological Association, Dr. Thomas was awarded NJPA's "Psychologist of the Year" award in 1995 and was the 2003 honoree of the Eastern Group Psychotherapy Society for her work in the aftermath of 9/11.

In addition to her clinical work with individuals, groups, and families, Dr. Thomas is a supervisor and the Cochair of the Relational Orientation of the Post Doctoral Program at New York University and senior supervisor, faculty member, and training analyst at the Contemporary Center for Advanced Psychoanalytic Studies at Fairleigh Dickinson University in Madison, NJ. She presents regularly on the subject of trauma and disaster and has published, among other things, "An eye for an eye: revenge in the aftermath of trauma," in *Living With Terror, Working With Trauma: A Clinician's Handbook*, edited by Danielle Knafo, published by Aronson in 2005. She is also the author of "The Use of the Hero," in the forthcoming *On the Ground after September 11: Mental Health Responses and Practical Knowledge Gained*, edited by Yael Danieli and Robert Dingman to be published by Haworth Press in 2005. Her essay, "When the Rules of War Are Broken," was published in the *Psychoanalyst Activist* in the summer of 2004.

For the past seven years, Dr. Thomas has conducted research on how victim-witnesses of war, ethnic conflict, and political repression are affected psychologically by giving testimony in war crimes tribunals and truth commission proceedings, and particularly on how their expectations for "justice" are relevant for their experiences in the truth recovery processes or for the reconstruction of their lives postconflict. This research emerged from her work in Bosnia immediately following the war in that country, during which time she provided training and consultation to local mental health workers at the invitation of Catholic Relief Services. Her research has taken her to the proceedings of the International Criminal Tribunal for the Former Yugoslavia at The Hague, to Bosnia, and also to South Africa.

In the immediate aftermath of 9/11, Dr. Thomas served as Cochair of the American Group Psychotherapy Association's Disaster Outreach Task Force. The recipient of a multimillion dollar grant from the New York Times Company Foundation, 9/11 Neediest Cases Fund, Dr. Thomas directed the design and implementation of direct clinical services as well as support, education, and training for those agencies and individuals affected by the terrorist attacks. She also cochaired the AGPA conference dedicated to developing protocols for intervening with special populations in the face of future disasters or terrorist attacks.

Within APA, Dr. Thomas has served as a member of the Task Force on Governance, CAPP, the Finance Committee, as well as the Task Force on the Psychological Effects of the Efforts to Prevent Terrorism, with particular focus on the effect on immigrant groups.

## Michael G. Wessells, PhD

Michael G. Wessells, PhD, is Senior Child Protection Specialist for Christian Children's Fund and Professor of Psychology at Randolph-Macon College. He has served as President of the Division of Peace Psychology of the American Psychological Association and of Psychologists for Social Responsibility and as Cochair of the InterAction Protection Working Group. His research on children and armed conflict examines child soldiers, psychosocial assistance in emergencies, and postconflict reconstruction for peace. He regularly advises U. N. agencies, donors, and governments on the situation of children in armed conflict and issues regarding child protection and well-being. In countries such as Afghanistan, Angola, Sierra Leone, Uganda, East Timor, Kosova, and South Africa, he helps to develop community-based, culturally grounded programs that assist children, families, and communities affected by armed conflict.

## PETITION CLOSED

This petition is now closed. You can still make a difference in the Care2 community by signing other petitions today.

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### Against Psychologists' Participation in Interrogation of 'Enemy Combatants'

**author:** Stephen Soldz, Member, Section 9, Division 39, American Psychological Assoc

**target:** Gerald Koocher, President, American Psychological Association

**signatures:** 1,739

**1,739**

**50,000**

we've got **1,739 signatures**, help us get to 50,000 by June 13, 2007

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Please sign the following petition if you want to be among a group of psychologists and APA members who unequivocally state opposition to the participation of psychologists in the interrogation processes at Guantánamo and other similar facilities in which detainees are denied the protection of either due process or Geneva Convention monitoring. As a profession aimed at improving the human condition built upon a respect for human dignity, we believe that our shared base of psychological knowledge should not be used to further what is, at minimum, abusive treatment and, at worst, torture. We call upon the American Psychological Association to direct its members to desist from participating in and consulting to interrogations at Guantánamo and similar facilities.

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WE SIGNED: AGAINST PSYCHOLOGISTS'  
PARTICIPATION IN INTERROGATION OF 'ENEMY  
COMBATANTS'

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Ernesto Rodriguez	Feb 28, 20:46	# 1,742
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Metteline Myhre	Aug 16, 04:09	# 1,741
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Gael Murphy	May 09, 21:37	# 1,740
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rebecca daniels	May 04, 12:37	# 1,739
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Jennifer Faragi	Apr 15, 21:39	# 1,738
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Eric Weinstein, PsyD	Feb 26, 14:53	# 1,737
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Ceri Owen	Feb 23, 13:01	# 1,736
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Jean Thayer Meston, MEd, LMFT	Jan 02, 11:09	# 1,735
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<b>Tania Massotti</b>	<b>Nov 28, 07:57</b>	<b># 1,733</b>
<b>Elizabeth Topitzer, Psy.D.</b>	<b>Sep 09, 10:48</b>	<b># 1,732</b>
<b>Clark E. Allen, Ph.D.</b>	<b>Aug 17, 10:54</b>	<b># 1,731</b>
<b>James P. Healey</b>	<b>Jul 30, 09:09</b>	<b># 1,730</b>
<b>Name not displayed</b>	<b>Jul 13, 13:14</b>	<b># 1,729</b>
<b>EM Bareis</b>	<b>Jul 08, 06:42</b>	<b># 1,728</b>
<b>Marsha Cutting</b>	<b>Jun 26, 13:08</b>	<b># 1,727</b>
<b>Kendall Price</b>	<b>Jun 19, 11:46</b>	<b># 1,726</b>
<b>Sarita Overton</b>	<b>Jun 17, 09:50</b>	<b># 1,725</b>
<b>Jennifer Markey</b>	<b>Jun 16, 18:30</b>	<b># 1,724</b>
<b>Name not displayed</b>	<b>Jun 16, 12:59</b>	<b># 1,723</b>
<b>Penelope Brindley</b>	<b>Jun 10, 10:24</b>	<b># 1,722</b>
<b>Abraham L. Halpern</b>	<b>Jun 08, 14:40</b>	<b># 1,721</b>
<b>Robert Shugoll, Ph.D.</b>	<b>Jun 06, 15:02</b>	<b># 1,720</b>

<b>David Shaffer</b>	<b>Jun 03, 12:26</b>	<b># 1,719</b>
<b>PRIVACY REDACTION</b> seanmegan	<b>Jun 02, 18:37</b>	<b># 1,718</b>
<b>Laurie Sokolsky</b>	<b>Jun 02, 13:17</b>	<b># 1,717</b>
<b>meredith fuller</b>	<b>May 29, 07:05</b>	<b># 1,716</b>
<b>Name not displayed</b>	<b>May 21, 04:27</b>	<b># 1,715</b>
<b>Stephanie Lynch</b>	<b>Apr 29, 20:22</b>	<b># 1,714</b>
<b>Melissa Bardwell</b>	<b>Apr 27, 00:15</b>	<b># 1,713</b>
<b>Jack Beinashowitz, Ph.D.</b>	<b>Apr 18, 07:49</b>	<b># 1,712</b>
<b>D. Bruce Carter, Ph.D.</b>	<b>Apr 13, 14:39</b>	<b># 1,711</b>
<b>Jessica Dávila</b>	<b>Apr 10, 20:13</b>	<b># 1,710</b>
<b>Lin Collazo Carro</b>	<b>Apr 07, 15:49</b>	<b># 1,709</b>
<b>Barbara Pichler</b>	<b>Apr 05, 20:48</b>	<b># 1,708</b>
<b>Edward S. Levin, Ph.D.</b>	<b>Apr 03, 14:37</b>	<b># 1,707</b>



<b>Phyllis L. Sloate, PhD</b>	<b>Apr 03, 12:24</b>	<b># 1,706</b>
<b>harold chorny,ph.d</b>	<b>Apr 03, 11:34</b>	<b># 1,705</b>
<b>Angela Radan</b>	<b>Apr 03, 10:19</b>	<b># 1,704</b>
<b>Name not displayed</b>	<b>Apr 03, 08:59</b>	<b># 1,703</b>
<b>Geeta Aatre-Prashar, Psy.D.</b>	<b>Apr 03, 07:36</b>	<b># 1,702</b>
<b>Kim Kendall, Ph.D.</b>	<b>Apr 02, 21:52</b>	<b># 1,701</b>
<b>Name not displayed</b>	<b>Apr 02, 19:59</b>	<b># 1,700</b>
<b>Name not displayed</b>	<b>Apr 02, 19:02</b>	<b># 1,699</b>
<b>Deborah Clemmensen</b>	<b>Apr 02, 16:46</b>	<b># 1,698</b>
<b>Ariane Getz</b>	<b>Apr 02, 14:55</b>	<b># 1,697</b>
<b>Arnold Z. Schneider, Ph.D.</b>	<b>Apr 02, 14:03</b>	<b># 1,696</b>
<b>Marguerite Vasshti Butler</b>	<b>Apr 02, 13:31</b>	<b># 1,695</b>
<b>Marion M. Oliner, Ph.D.</b>	<b>Apr 02, 13:28</b>	<b># 1,694</b>
<b>Aaron Meyer</b>	<b>Apr 02, 12:55</b>	<b># 1,693</b>

<b>Hina Z. Siddiqui, Psy.D.</b>	<b>Apr 02, 12:40</b>	<b># 1,692</b>
<b>Layla Asamarai, Psy.D.</b>	<b>Apr 02, 12:29</b>	<b># 1,691</b>
<b>Harvey A. Kaplan</b>	<b>Apr 02, 12:24</b>	<b># 1,690</b>
<b>Nancy R. Goodman, Ph.D.</b>	<b>Apr 02, 10:32</b>	<b># 1,689</b>
<b>Marguerita Reczycki</b>	<b>Apr 01, 16:02</b>	<b># 1,688</b>
<b>Holly C. Zeeb, Ed.D.</b>	<b>Apr 01, 12:20</b>	<b># 1,687</b>
<b>Paul Goldmuntz, Psy.D.</b>	<b>Apr 01, 09:22</b>	<b># 1,686</b>
<b>Mary Emerson</b>	<b>Feb 19, 17:16</b>	<b># 1,685</b>
<b>Suzanne Martin</b>	<b>Feb 19, 14:31</b>	<b># 1,684</b>
<b>Shelley R. Doctors, Ph.D.</b>	<b>Feb 19, 13:51</b>	<b># 1,683</b>
<b>Brian A. Schwartz, PhD</b>	<b>Feb 16, 13:09</b>	<b># 1,682</b>
<b>Elan Golomb</b>	<b>Feb 15, 10:18</b>	<b># 1,681</b>
<b>shannon mckillop</b>	<b>Jan 14, 09:47</b>	<b># 1,680</b>

<b>Name not displayed</b>	<b>Jan 14, 01:33</b>	<b># 1,679</b>
<b>Peter Haugen</b>	<b>Jan 13, 12:32</b>	<b># 1,678</b>
<b>Elizabeth Oehr</b>	<b>Jan 11, 20:50</b>	<b># 1,677</b>
<b>Name not displayed</b>	<b>Jan 06, 15:20</b>	<b># 1,676</b>
<b>Roman Soiko</b>	<b>Jan 01, 12:07</b>	<b># 1,675</b>
<b>Lynn Hugger</b>	<b>Dec 30, 19:10</b>	<b># 1,674</b>
<b>Victor Henning</b>	<b>Dec 30, 10:39</b>	<b># 1,673</b>
<b>Lucy March, Ph.D.</b>	<b>Dec 25, 18:51</b>	<b># 1,672</b>
<b>Marcos Monserrat</b>	<b>Dec 19, 15:30</b>	<b># 1,671</b>
<b>Richard Artley</b>	<b>Dec 17, 10:18</b>	<b># 1,670</b>
<b>Ana M.</b>	<b>Dec 16, 03:17</b>	<b># 1,669</b>
<b>Greg Colvin PhD</b>	<b>Dec 13, 14:31</b>	<b># 1,668</b>
<b>Name not displayed</b>	<b>Dec 07, 22:56</b>	<b># 1,667</b>
<b>Name not displayed</b>	<b>Dec 07, 20:57</b>	<b># 1,666</b>
<b>Judith Hecker</b>	<b>Dec 06, 22:47</b>	<b># 1,665</b>

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<b>Mary Hayden</b>	<b>Dec 06, 20:27</b>	<b># 1,664</b>
<b>Joan Rodman</b>	<b>Dec 06, 15:13</b>	<b># 1,663</b>
<b>Alisa Dennis Ph.D.</b>	<b>Dec 06, 12:55</b>	<b># 1,662</b>
<b>Edward J. Bitter, Ph.D.</b>	<b>Dec 06, 09:01</b>	<b># 1,661</b>
<b>Ilene Bell</b>	<b>Dec 05, 22:17</b>	<b># 1,660</b>
<b>James A. Green, Ph.D.</b>	<b>Dec 05, 20:27</b>	<b># 1,659</b>
<b>Paul Arenson</b>	<b>Dec 05, 18:45</b>	<b># 1,658</b>
<b>Leslie Eichenbaum, Ph.D.</b>	<b>Dec 05, 13:06</b>	<b># 1,657</b>
<b>Francisco Rocco</b>	<b>Dec 05, 09:29</b>	<b># 1,656</b>
<b>Iverson M. Eicken, Ph.D.</b>	<b>Dec 05, 07:55</b>	<b># 1,655</b>
<b>Name not displayed</b>	<b>Dec 05, 06:57</b>	<b># 1,654</b>
<b>Harron Kelner</b>	<b>Dec 05, 02:17</b>	<b># 1,653</b>
<b>Toni Cavangh Johnson, Ph.D.</b>	<b>Dec 04, 23:12</b>	<b># 1,652</b>

<b>Miriam Hamideh</b>	<b>Dec 04, 22:22</b>	<b># 1,651</b>
<b>Bonnie A Jacobs, PhD</b>	<b>Dec 04, 22:13</b>	<b># 1,650</b>
<b>Mara Silverman</b>	<b>Dec 04, 22:13</b>	<b># 1,649</b>
<b>Lynne Rustad PhD</b>	<b>Nov 29, 10:02</b>	<b># 1,648</b>
<b>Name not displayed</b>	<b>Nov 28, 22:53</b>	<b># 1,647</b>
<b>Elizabeth Myers, Ph.D.</b>	<b>Nov 28, 21:53</b>	<b># 1,646</b>
<b>Samar Zebian</b>	<b>Nov 24, 14:40</b>	<b># 1,645</b>
<b>Dina Birman</b>	<b>Nov 04, 10:17</b>	<b># 1,644</b>
<b>David Lichtenstein</b>	<b>Oct 13, 14:02</b>	<b># 1,643</b>
<b>Susan Chipman</b>	<b>Oct 13, 10:03</b>	<b># 1,642</b>
<b>fredric weiss</b>	<b>Oct 12, 08:47</b>	<b># 1,641</b>
<b>Name not displayed</b>	<b>Oct 09, 14:03</b>	<b># 1,640</b>
<b>J Dunlap</b>	<b>Oct 06, 00:46</b>	<b># 1,639</b>

**iain sheard**

**Oct 05, 04:12**

**# 1,638**

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<b>Laura Johnson</b>	<b>Oct 04, 16:31</b>	<b># 1,637</b>
<b>claire morris</b>	<b>Oct 02, 04:51</b>	<b># 1,636</b>
<b>Susan Nisbet</b>	<b>Oct 02, 00:01</b>	<b># 1,635</b>
<b>Tyhe Edmondson</b>	<b>Sep 30, 03:58</b>	<b># 1,634</b>
<b>Roy Hunter</b>	<b>Sep 29, 12:50</b>	<b># 1,633</b>
<b>janine soffe-caswell</b>	<b>Sep 21, 02:03</b>	<b># 1,632</b>
<b>Annie Mitchell</b>	<b>Sep 15, 08:39</b>	<b># 1,631</b>
<b>Rachael Fox</b>	<b>Sep 15, 05:15</b>	<b># 1,630</b>
<b>Carl Harris</b>	<b>Sep 15, 03:45</b>	<b># 1,629</b>
<b>Sue Roffey Doc. Ed. Psych.</b>	<b>Sep 15, 02:34</b>	<b># 1,628</b>
<b>Lynne Patience D Clin Psych</b>	<b>Sep 15, 02:24</b>	<b># 1,627</b>
<b>Stephanie Boyle</b>	<b>Sep 15, 02:19</b>	<b># 1,626</b>

<b>Mark Burton</b>	<b>Sep 14, 10:25</b>	<b># 1,624</b>
<b>Jeff Galecki</b>	<b>Sep 10, 18:11</b>	<b># 1,623</b>
<b>David Alter</b>	<b>Sep 08, 06:09</b>	<b># 1,622</b>
<b>David M. Wark</b>	<b>Sep 05, 19:55</b>	<b># 1,621</b>
<b>Cathe Romano</b>	<b>Sep 03, 00:13</b>	<b># 1,620</b>
<b>Andrew Stein</b>	<b>Sep 02, 16:46</b>	<b># 1,619</b>
<b>Judy Lightstone</b>	<b>Aug 30, 17:50</b>	<b># 1,618</b>
<b>Sachi Inoue, Ph.D.</b>	<b>Aug 29, 12:52</b>	<b># 1,617</b>
<b>Ann J. Dolber</b>	<b>Aug 29, 06:05</b>	<b># 1,616</b>
<b>M. A. Bidwell</b>	<b>Aug 29, 03:53</b>	<b># 1,615</b>
<b>michael semos</b>	<b>Aug 28, 20:29</b>	<b># 1,614</b>
<b>Brian Cleary, Psy.D</b>	<b>Aug 28, 19:39</b>	<b># 1,613</b>
<b>Shirley Oxidine, Psy.D.</b>	<b>Aug 28, 19:17</b>	<b># 1,612</b>

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<b>Irina Brenner</b>	<b>Aug 28, 12:40</b>	<b># 1,611</b>
<b>Cress Forester, Psy. D.</b>	<b>Aug 28, 12:08</b>	<b># 1,610</b>
<b>Paul Nash</b>	<b>Aug 27, 22:49</b>	<b># 1,609</b>
<b>Afra Khan</b>	<b>Aug 25, 19:26</b>	<b># 1,608</b>
<b>Julie Eschenlauer, Psy.D.</b>	<b>Aug 25, 09:47</b>	<b># 1,607</b>
<b>Name not displayed</b>	<b>Aug 23, 10:30</b>	<b># 1,606</b>
<b>Carol Panetta</b>	<b>Aug 22, 09:58</b>	<b># 1,605</b>
<b>Mara Wagner</b>	<b>Aug 22, 05:57</b>	<b># 1,604</b>
<b>Daniel A. Johnson</b>	<b>Aug 21, 14:17</b>	<b># 1,603</b>
<b>Don Capone, Psy.D.</b>	<b>Aug 21, 08:20</b>	<b># 1,602</b>
<b>Freida Marie Prescott</b>	<b>Aug 21, 03:55</b>	<b># 1,601</b>
<b>Lance Harris, Ph.D.</b>	<b>Aug 20, 18:42</b>	<b># 1,600</b>
<b>Cecil A. Rice</b>	<b>Aug 20, 10:35</b>	<b># 1,599</b>



<b>claudia luiz</b>	<b>Aug 20, 05:14</b>	<b># 1,598</b>
<b>Anne L Boedecker, PhD</b>	<b>Aug 19, 08:31</b>	<b># 1,597</b>
<b>Name not displayed</b>	<b>Aug 18, 10:31</b>	<b># 1,596</b>
<b>Melvin Kimmel</b>	<b>Aug 18, 08:07</b>	<b># 1,595</b>
<b>David Diamond, Ph.D.</b>	<b>Aug 18, 07:27</b>	<b># 1,594</b>
<b>charles edward robins</b>	<b>Aug 17, 16:11</b>	<b># 1,593</b>
<b>Name not displayed</b>	<b>Aug 17, 07:09</b>	<b># 1,592</b>
<b>Kathryn E. Saylor, Psy.D.</b>	<b>Aug 17, 05:45</b>	<b># 1,591</b>
<b>Michele Lantieri</b>	<b>Aug 17, 00:29</b>	<b># 1,590</b>
<b>Ethel Hull</b>	<b>Aug 16, 19:53</b>	<b># 1,589</b>
<b>Rick Berke</b>	<b>Aug 16, 19:11</b>	<b># 1,588</b>
<b>Name not displayed</b>	<b>Aug 16, 18:16</b>	<b># 1,587</b>
<b>Eric Mart, Ph.D</b>	<b>Aug 16, 14:54</b>	<b># 1,586</b>
<b>Trudy Summers</b>	<b>Aug 16, 09:56</b>	<b># 1,585</b>

<b>Naomi Lee</b>	<b>Aug 16, 05:23</b>	<b># 1,584</b>
<b>Robert Launay, Ph.D.</b>	<b>Aug 14, 08:46</b>	<b># 1,583</b>
<b>Beatriz Ledesma</b>	<b>Aug 13, 18:25</b>	<b># 1,582</b>
<b>Jeffrey G. Johnson, Ph.D.</b>	<b>Aug 13, 16:36</b>	<b># 1,581</b>
<b>Tuba Mustansir</b>	<b>Aug 13, 13:27</b>	<b># 1,580</b>
<b>Antonio Burr, Ph.D.</b>	<b>Aug 12, 20:42</b>	<b># 1,579</b>
<b>Phillis Sheppard, Ph.D.</b>	<b>Aug 12, 09:47</b>	<b># 1,578</b>
<b>Suzanne Rosenfeld</b>	<b>Aug 12, 09:16</b>	<b># 1,577</b>
<b>Terry Johnston</b>	<b>Aug 12, 08:32</b>	<b># 1,576</b>
<b>Carol Kerr, Ph.D.</b>	<b>Aug 12, 08:13</b>	<b># 1,575</b>
<b>Adele Haber</b>	<b>Aug 11, 18:44</b>	<b># 1,574</b>
<b>Mason Haber</b>	<b>Aug 11, 18:38</b>	<b># 1,573</b>
<b>John Dyckman, Ph.D.</b>	<b>Aug 11, 08:41</b>	<b># 1,572</b>

<b>Rob Johnson</b>	<b>Aug 11, 06:19</b>	<b># 1,571</b>
<b>Alex Holcombe, PhD</b>	<b>Aug 10, 19:33</b>	<b># 1,570</b>
<b>Name not displayed</b>	<b>Aug 09, 23:30</b>	<b># 1,569</b>
<b>Name not displayed</b>	<b>Aug 09, 13:46</b>	<b># 1,568</b>
<b>Leanh Nguyen, Ph. D.</b>	<b>Aug 09, 12:08</b>	<b># 1,567</b>
<b>Philip Gallo</b>	<b>Aug 09, 12:06</b>	<b># 1,566</b>
<b>Armida Fruzzetti</b>	<b>Aug 09, 11:34</b>	<b># 1,565</b>
<b>Sean Cook, M.A.</b>	<b>Aug 09, 10:11</b>	<b># 1,564</b>
<b>Marcia Hollingsworth, Ed.D.</b>	<b>Aug 09, 09:34</b>	<b># 1,563</b>
<b>Evalyn F. Segal, PhD</b>	<b>Aug 09, 08:32</b>	<b># 1,562</b>
<b>Gina Walters, Ph.D.</b>	<b>Aug 09, 07:57</b>	<b># 1,561</b>
<b>naumana amjad</b>	<b>Aug 09, 07:25</b>	<b># 1,560</b>
<b>Ilene Cohen</b>	<b>Aug 09, 05:29</b>	<b># 1,559</b>
<b>Rita P. Sussman</b>	<b>Aug 08, 20:30</b>	<b># 1,558</b>

Anne Shaffer	Aug 08, 17:15	# 1,557
Alan E. Fruzzetti, Ph.D.	Aug 08, 13:59	# 1,556
Chris Chatham	Aug 08, 12:15	# 1,555
Andrew Rasmussen	Aug 08, 11:12	# 1,554
Carri Schneider	Aug 08, 08:23	# 1,553
Brent Duncan, Ph.D.	Aug 08, 08:11	# 1,552
Name not displayed	Aug 08, 06:42	# 1,551
William Matthews	Aug 08, 05:31	# 1,550
Kimberley Wade	Aug 08, 04:28	# 1,549
Evelyn Pye, Ph.D	Aug 07, 20:06	# 1,548
Julia Mohr	Aug 07, 18:53	# 1,547
kathleen j. cramer, PhD, LLP	Aug 07, 18:37	# 1,546
Daniel Fishman	Aug 07, 18:09	# 1,545

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Frederick Davis

Aug 07, 17:52

# 1,543

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**How to Win the Peace:**

Academics on Patrol  
Martin Seligman, University of Pennsylvania, Co-ordinator

**PRIVACY REDACTION**

**Executive Summary**

The modern history of Western wars in Muslim countries repeatedly demonstrates that it will be easy to lose the peace in our war against terrorism. So an international group of sixteen distinguished professors and intelligence personnel met on December 15-16, 2001 in Wynnewood, Pennsylvania to consider the "Psychology of Capitulation." The group consisted of experts in terrorism and related topics from psychology, political science, history, Islam, sociology, the CIA and the FBI. Here are our conclusions in the form of six policy recommendations aimed at winning a victory that will lastingly contain global terrorism.

- 1) **Isolate Jihad Islam from Moderate Islam worldwide**
- 2) **Neutralize Saudi support for jihad Islamic fundamentalism worldwide.**
- 3) **Police the Arab Diaspora in Western Europe forcefully**
- 4) **Subvert the social structure of terrorist organizations**
- 5) **Break the link between the terrorists and the pyramid of sympathizers**
- 6) **Build American knowledge of Arab and Muslim culture and language**

The rationale and details for each of these strategies follows, along with some suggested tactics for carrying them out.

## Recommendation 1

Donald Horowitz, James B. Duke Professor of Law and Political Science, Duke University, Chair

### **Isolate Jihad Islam from Moderate Islam Worldwide**

***Islam is a religion with, in principle, a single doctrine, but that doctrine is interpreted in highly variable ways. This doctrinal malleability is one source of our present difficulty. Extremists have seized the initiative and, in the name of Islam, promulgated decrees and organized action inimical to our interests. Yet there are alternative interpreters and interpretations available, and if they can be mobilized this will markedly reduce the influence of and, quite possibly, isolate the Jihadists.***

Many steps can be taken toward this end. A few examples:

1. The Saudis need to be induced to rethink the aggressive spread of their narrow, puritanical version of Islam and their funding of mosques all over the world. The Saudis are a force for radicalizing Islam, and their contributions need to be stopped. This is spelled out in more detail as Recommendation 2 (***Neutralize Saudi support for jihad Islamic fundamentalism worldwide.***)
2. Much more attention needs to be paid to doctrine being spread in mosques and religious schools around the world, including the United States. Moderate ulama, who do not agree with extremist doctrine, need to be mobilized to take a more aggressive stance against it. Moderate, charismatic figures are especially important. Other governments need to pay close attention to the doctrine spread in their countries and to police the flow of funds.
3. Consideration should be given to opening Muslim societies to liberal ideas by supporting moderate newspapers, radio, and TV stations, such as Radio Free Iraq and Radio Orient. The Voice of America ought to be strengthened. Internet communication among moderates can be facilitated.
4. American Muslims need to be engaged in providing an alternative vision of what it means to be a Muslim in a pluralistic world: how one can live peacefully with non-Muslim neighbors, how the West allows completely free religious practice, how democracy and an open economy can provide support for Islam to flourish.
5. Publishing and circulating damning Fundamentalists tracts and moderate responses: for example, a collection of Fatwa (religious decrees), moderate polemical essays against radicalism, and the video of the famous Al-Jazeera debate in which (pro-Qaeda) sheikh, Y.al-Qaradawi, is demolished by Syrian philosopher S.al-Azm (summer, 1999).
6. Islamic Studies, presently an academic backwater, needs to be well funded at major American Universities and Research Centers (see

Recommendation 6, ***Build American Knowledge of Arab and Muslim cultures and languages***)

7. Libraries and study centers that compete with fundamentalist Islam and are pro-western need to be re-established in the Muslim world.
8. Terrorists need to be fought physically and their doctrine simultaneously condemned by religious and governmental authorities in Islamic states. Jihad needs to be aggressively deromanticized, especially among young men, who are its main practitioners.



Recommendation 2

Vali Nasr, Associate Professor, Political Science, University of San Diego, Chair

**Neutralize Saudi support for jihad Islamic fundamentalism worldwide.**

***Saudi Arabia has been the single most important source of support for the spread of jihad Islamic fundamentalism across the Muslim world, and for the rise of violent forces that are associated with it. It is hard to imagine the events of 9/11 occurring without Saudi Arabia's zealous and richly endowed proselytizing for jihad Islamic fundamentalism throughout the world.***

Saudi Arabia has funded radical organizations, seminaries, groups that are associated with the Taliban, militant sectarian forces in South Asia, and anti-minority groups in Southeast Asia and Nigeria. Saudi Arabia has, moreover, has directed its funding at changing the character of Islam across the Muslim world with the aim of replacing existing popular Muslim practices with Saudi Arabia's own puritanical view of Islam. The attempt to "Saudize" Islam everywhere has spread jihad Islamic fundamentalism, lowered the status of women, hurt minorities, slowed social change and political reform, and damaged relations between Muslims and the West. The scope of the Saudi project spreads to the West, and the majority of the mosques in the US and Europe receive funding from Saudi Arabia to promote a puritanical view of Islam.

We recommend the following actions by the U. S. government.

- Leverage Saudi Arabia's connections in American and European mosques to identify militants and potential sources for terrorist recruitment and action.
- Compel Saudi Arabia to cease funding of violent and fundamentalist groups from Southeast Asia to Africa to Europe and the USA.
- Compel Saudi Arabia to dissociate funding of Islamic causes from the promotion of puritanical Islam. This is a critical issue for the future of Central Asia, Albania, Kosovo and Bosnia.
- Compel governments across the Muslim world to police the flow of funds and its impact on their politics. It is not enough to just stop financing of terrorism. It is important to stop the Saudi funding of jihad Islamic fundamentalism.
- Encourage Muslim communities in the US to finance their own religious organizations, mosques and schools locally.

Recommendation 3

Arthur Waldron, Professor of History, University of Pennsylvania, Chair

**The Islamic Diaspora as our Next Target**

***Terrorism often emerges from a Diaspora rather than from the home country; the current wave of Islamic terror may be no exception. The 9/11 attacks were planned in Germany and executed in the United State, and most of the terrorists made their way to the USA through Europe. Therefore the radical network within the larger Islamic Diaspora in Europe may be a key center of gravity and a likely source or, at the very least, a way station for future Jihad terrorism.***

The Islamic Diaspora to Europe and North America includes refugees from militant movements in the Islamic world, expatriates, students from the Islamic world, first generation migrants, and second and third generations (who, surprisingly, seem especially vulnerable to recruitment). In a country such as France or the Netherlands, the poorest quarters of cities are filled with Muslim migrants many of whom, owing to the lack of jobs and abundance of welfare provisions, not to mention the lack of paths towards assimilation (and regular police violence against them) are pushed first into idleness, then petty crime, and then—in some cases—recruited into terrorist groups.

Recruitment to terrorist groups takes place in Western Europe and the US through criminal networks and the social and religious communities associated with mosques and Muslim schools. Some of these are independently operated, but Islamic states also compete to provide patronage. Thus the majority of mosques in France are controlled from Algeria (which has networks in seventeen European countries), with Saudi Arabia running second, and Saudi Arabia exercising dominant influence world wide—extending even to the National Mosque in Washington, D.C.

Young unmarried men are the primary marks. They do poorly in school and drop out repeatedly, are unable to find work or outlets for their energy, and form the vast majority of recruits. Once drawn into militancy, young men find a society within a narrow, self-policing “enclave society” that is in but not of the host country.

Clearly the degree of involvement among Diaspora Arabs varies. Some individuals will become active terrorists, but far more will turn a blind eye, offer a bed and a meal to a fellow countryman, or contribute money. Muslim Diasporas provide such places of refuge and support around the world from Bratislava to Kuala Lumpur and beyond. In some cases the police have them under close watch (though “strict” police action can be counterproductive in some cases). East European states, however, often have weak and easily bribed police who are not effective (The Czech Republic is an exception; Slovakia and Romania are closer to the rule). All of these places are far freer, and thus (unintentionally) more congenial to extremists than are places like Egypt, Syria, or Iraq, which recognize the problem—and solve it by exporting extremists to more tolerant

places like Germany and Canada. European enclaves also stand at the juncture of high technology and Jihad ideology making them ideal stepping-stones to American terror.

So important, therefore, is the Diaspora into Europe that it, rather than the Islamic countries themselves, can be considered the center of gravity in the anti-terrorist struggle. A goal of counter-terrorism must be to isolate the rather small number of radicals from the larger population and to ensnare them. This is made difficult by anti-immigrant policies in European countries, financial retrenchment, and the great difficulty to finding jobs for young men. It is reinforced by the pervasive propaganda efforts, often financed from abroad, associated with schools and mosques.

Nevertheless, the picture is not entirely bleak. The steady pressure of globalization is felt above all in Diaspora communities, who may jeopardize their status within their country of residence if they support radicalism. Also, free media exist: In France, Radio Orient, which plays the popular FAI music blending rap, rock, and Middle Eastern themes, also provides moderate political views. The London newspapers *Al-Hayat*, and *Al-Sharq Al-Awsat* are independent, as is *Al-Quds al-Arabi* (Paris). If these could be broadcast or made available in the Middle East itself, where they are too expensive for most people, influence might be substantial. The same is true for several Algerian papers including *La Liberte* and *La Tribune*.

Obviously intelligence work, surveillance, and force are important in dealing with the Diaspora dangers. The USA should strongly encourage and robustly supplement these throughout Europe.

South America cannot be ignored. Crisis-prone Argentina, Paraguay and Brazil all have large Arab minorities that are monitored locally for outright terrorism, but not for radicalism. We need to support the local policing here. Part of the Arab Diaspora is in America, and it is simply urgent that we **monitor the activities of the American Mosques closely**. Recruiting loyal American Muslims to the task can do much of this.

Recommendation 4

S.J. Rachman, Professor of Psychology, University of British Columbia, Chair

**What do the terrorists fear most?**

**Subverting the social structure of terrorist organizations**

***Knowing what terrorists fear most, and what they do not fear, leads to some practical suggestions for undermining the effectiveness and social cohesiveness of terrorist groups.***

The suicidal attacks of Sept. 11<sup>th</sup> raised some baffling questions, including a want of understanding how the terrorists, groups of them, could sacrifice their lives. Plainly they did not fear death. What then *do* terrorists fear?

Voluminous research has shown that human fears can be grouped into three clusters: the fear of death or injury, social fears, and fears of specific objects (e.g. animals, heights). The first, fear of death or injury, does not seem to be active in suicidal terrorists. Nor is fear of specific objects, except perhaps for pollution and contamination. That leaves the third cluster, social fears, which in the present circumstances are the fears most open to exploitation and manipulation.

Social fears include the fear of disgrace or rejection by one's social group; the family, a small social group such as a terrorist unit; or the larger terrorist organization. Dishonor or disgrace in some terrorist groups is punished by death, severe punishment, dishonor and ostracism of the individual and his entire family. The terrorist's fear of disgrace, say by becoming an informer or even being suspected or accused of informing, is intense. Terrorists may not be inhibited by a fear of death but they are strongly motivated to retain the trust, respect and confidence of their group, especially the trust and respect of their small, cohesive unit. The smallness and cohesion of the active units is a strength but it needs the glue of trust and respect in order to function. If the trust and respect are undermined, the group will be disrupted. The same general approach is also applicable to the larger, less cohesive groups. An undercurrent of distrust can similarly impair the functioning of a larger organization.

The fears of the leaders and planners in terrorist organizations need further analysis, but probably include a fear of loss of honor, loss of respect, loss of status, and loss of followers. Such losses can occur as a result of operational and organizational failures, or unacceptable personal behavior (e.g. misuse of funds, irreligious or immoral conduct, or pollution). Experience in Egypt, Algeria and elsewhere shows that leaders of radical Islamic movements attack apostate rulers, but not the population at large, which is, at worst, deemed misguided. Hence, leaders fear isolation from the fellow (non-member) Muslim populace, both for practical reasons (getting refuge, lodging, information, and money), but also for moral and morale reasons. They need to feel that they serve the cause of the oppressed population. When the population turns against them, as happened in Egypt after the Luxor raid in Nov. 1997, the leaders (of the Jama'a Islamiyya) declared a unilateral cease-fire (which is still being kept). They felt that

the government had diminished their credibility, and had successfully tainted them with the brush of "enemies of tourism, our major foreign currency resource".

Counterterrorist tactics, therefore, should include deliberate attempts to seed dishonor and social rejection and to cause a loss of trust and a loss of respect among followers. Once seeded, feelings of uneasiness and suspicion are difficult to wipe out. Suspicion can act as a virus. Counterterrorist tactics against leaders should include attempts to seed the belief (or the actuality) that they have alienated themselves from the mass of oppressed Muslims. These attempts can be directed at individual terrorists, terrorist cells, organizations, and pools of potential recruits (notably among the large groups of possible recruits in the Diaspora, many of whom are alienated even while familiar with local conditions, customs, language).

If successfully deployed, these disruptions of groups can be of immediate value and also have significant proactive effects. For example, the promotion of suspicion can have an effect on the mechanics and success of recruitment, and undermine the communications within the terrorist groups.

How can these social fears (dishonor, distrust, and so on) be promoted? In broad terms, much can be accomplished by the use of truth, but disinformation, a method that was successfully used by British intelligence in WWII, can also be employed. Given the important advances made in cognitive science over the past few years, a modernized method of disinformation can be elaborated without difficulty. For example, our expanded understanding of the power of the so-called false memory phenomenon can be incorporated into disinformation programs; we have a good idea how false memories are insinuated into individuals and groups and we also know how such memories are communicated and strengthened. In the original disinformation methods, the negative information was carefully embedded into nets of accurate, verifiable information. Radio and newspapers were the main methods of communication, but one need not be restricted to these media.

In summary, we propose that fears of social rejection, disgrace, dishonor be promoted in individual terrorists, terrorist units, organizations and potential recruits. Additionally, feelings of distrust and suspicion can be promoted. Information that the mass of oppressed Muslims is alienated from the movement should be sown as well. The method of disinformation, modernized by recent advances in cognitive science, can be targeted at various terrorist groups, to disrupt the cohesive social structure crucial to successful terrorists acts.

Recommendation 5  
Clark McCauley, Professor, Bryn Mawr College, Chair

**Break the link between the terrorists and the pyramid of sympathizers**

***Terrorists are the apex of a pyramid in which the base is composed of all those who sympathize with the claimed goals of the terrorists. In Northern Ireland, for instance, the bottom of the pyramid is composed of all those who agree "Brits out." For fundamentalist Muslim terrorists, the base of the pyramid is millions of Muslims with a variety of grievances toward the West. From the base to the apex are increasing levels of radicalization, increasing commitment, and increasing risk taking. We can weaken and even break the link between the apex and the base.***

The terrorist organization itself is also a pyramid, in which those who perpetrate violence is the apex and those who direct, supply, inform, and protect perpetrators provide the base. The more organized and bureaucratic the terrorist group, the greater is the degree of specialization and the smaller is the proportion who actually perpetrates violence. The Qaida organization appears to be quite flat and dispersed, with Bin Laden perhaps having little more operational control than the president of the Ford Foundation has over initiatives he supports. In such an organization, much more in the way of initiative is required from the terrorists, especially those living alone in the Muslim Diaspora. Thus Diaspora terrorists need to be more educated and able individuals than the failed suicide bombers in Israel.

Terrorists depend for their lives on their connection to the pyramid of sympathizers. No terrorist group can long survive without silence, camouflage, information, money, and recruits from the pyramid of sympathizers. If "the new terrorism" means anything useful, it means the new problems that arise when the pyramid includes an international Diaspora. Terrorists around the world have learned from the successes of the Jewish Diaspora supporting Israel, of the Tamil Diaspora supporting the Tigers, and of the Irish Diaspora supporting the IRA.

Terrorist groups will decrease their violence when necessary to avoid losing contact with the pyramid. Combined Protestant and Catholic protest marches led the IRA on a number of occasions to apologize and narrow their targeting. Armenian anti-Turkish terrorism was controlled when the Armenian Diaspora determined that it would not put up with this threat to their status and welfare. The terrorists who killed tourists at Luxor were forced to give up after Mubarek succeeded in painting them as thugs who were violating Islamic law and threatening 9 million Egyptian jobs in the tourist industry. There was decreased Palestinian support for violence after the Oslo accords, and a parallel decrease in violence by Hamas.

Long-term suggestions for cutting the link between Muslims and Muslim terrorists include the following.

- press for a two-state solution in Israel/Palestine via the Mitchell plan.

- accept elected anti-modern Islam governments in Arab countries (e.g. Iran moderating now after fundamentalists took over) as long as they are not domestically repressive and internationally aggressive.

Short-term suggestions for cutting the link between terrorists and sympathizers point to two different places in the pyramid: Just below the terrorists at the apex of the pyramid is the level at which new recruits are developed and trained. At the bottom of the pyramid is the mass of Muslims who sympathize. The attack on recruiting is critical and might include the following.

- determine where and who recruits are coming from. “Where” includes institutional settings (schools, mosques, prayer groups) that are often important in structuring recruitment. “Who” usually includes some previous personal relationship between recruiter and recruited. Persuade our allies to do the same, since recruiting occurs in the Diaspora in Europe and Asia
- watch or disrupt the identified recruiting points (see Recommendation 3, **The Islamic Diaspora as our Next Target**).
- Big money rewards for those who report recruiting attempts might make recruiting more dangerous for the terrorists.

Attack on the sympathies of the base of the pyramid might include the following:

- more positive information about the U.S. and its policies in Muslim countries, including U.S. help for Muslims in Bosnia and Kosovo and post-war in Afghanistan. This might include support for AID libraries as well as radio broadcasts such as currently are being beamed to Iraq.
- The base of the pyramid has a different brand of religion from the apex. The apex is more mystical (Sufi) than the base and the apex is not very knowledgeable either about Islamic law or Islamic history. This gap can be exploited.
- more negative information about the terrorists, including special attention to examples of their killing other Muslims. This might include films, teleplays, radio, poetry, art, and music. West-leaning Muslim governments, who have been terrorist targets in the past, should be ready to assist in a culture war to portray terrorists as thugs and/or incompetents. Humor directed against terrorists might be a particularly potent form of attack.
- support for publication/dissemination of work of moderate Muslim intellectuals and journalists. Direct contact with these individuals is dangerous to them and probably counterproductive, but helping to broaden the reach of their work could be useful.

Research relevant to these initiatives might include the following.

- opinion surveys and focus groups, not once or twice but in tracking studies repeated regularly over time in Muslim countries about the beliefs and feelings of the base of the pyramid. Gallup is doing one now.
- similar tracking surveys for Muslims in the U.S., including Black Muslims
- Existing data from U.S. opinion surveys on how Muslim opinions may differ from opinions of others in the U.S.

Recommendation 6

Martha Crenshaw, Andrus Professor of Government, Wesleyan University, Chair

**Build American knowledge of Arab and Muslim cultures and languages throughout the world and communicate positive information about the United States to these areas**

The U.S. government should support and fund efforts by American colleges and universities to improve teaching and research involving area studies and languages, especially Islamic and Middle East/North African studies. As noted in recommendation #1, such efforts could provide a knowledge base that would help the United States to isolate extremist from moderate Islam. Another benefit would be in training analysts for government positions in the diplomatic and intelligence fields, which will be critical to the prevention of terrorism in the future. Such initiatives could take the form of funding graduate study for people starting academic careers, helping faculty “retool” to acquire relevant language skills and area expertise, or permitting educational institutions to add staff such as language instructors. Such programs would be in addition to the National Security Education Program.

It is equally important to communicate positive information about the United States to the Arab and Muslim worlds where the image of American is negative. As noted in recommendations #1, #3, and #5, support for independent news media, both in these areas and within the European Diaspora, could be a means of accomplishing this goal. However, it will be necessary somehow to avoid the American “kiss of death” if such news agencies appear to be subservient to U.S. interests. An alternative is American radio broadcasts such as Voice of America or support for the BBC World Service. Another option is encouraging more American officials and intellectuals to appear on local television and radio programs (the Christopher Ross interview with Al-Jazeera comes to mind).

In addition, an important component would be restoring old and establishing new American libraries in embassies and consulates. These libraries were an important source of information about the U.S., particularly for teachers. These cultural centers provided not only materials for reading and research but also a space for communication and socializing that was otherwise often absent in local societies. Another element of this proposal could be sending more American researchers and teachers abroad for fieldwork. The Ampart program that USIS sponsored could be restored.



## **Roster of Attendees**

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University of British Columbia, Vancouver  
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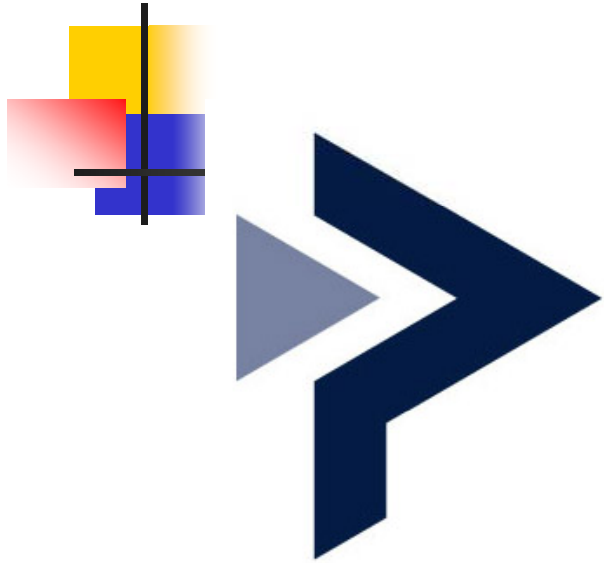
John Reed  
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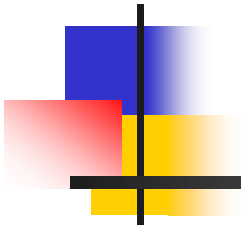
Arthur Waldron  
Lauder Professor of International Relations  
Department of History  
University of Pennsylvania  
Director of Asian Studies, American Enterprise Institute, Washington, DC  
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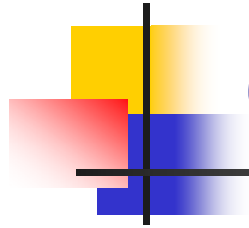
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# Development of Psychological Assessment Tools Based on the Theory of Successful Intelligence and Related Theories



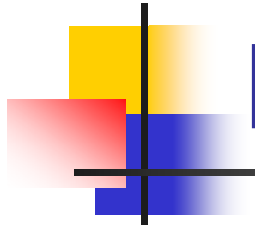
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Yale University



# Collaborators

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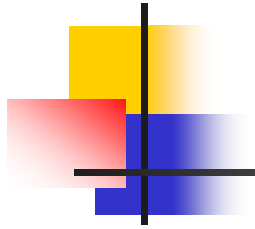
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# Organization of Presentation

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- Background
- Research
  - Analytical Abilities
    - Fluid Abilities
      - Induction
      - Deduction
    - Crystallized Abilities
      - Verbal Comprehension



# Organization of Presentation

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- Creative Abilities
  - Convergent Measures
  - Divergent Measures
- Practical Abilities
- All Triarchic Abilities
- Thinking Styles
- Current and Future Directions



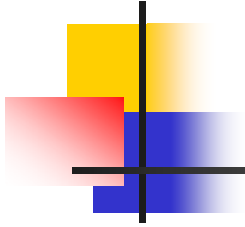


# What is the PACE Center?

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A research team at Yale dedicated to the study of the

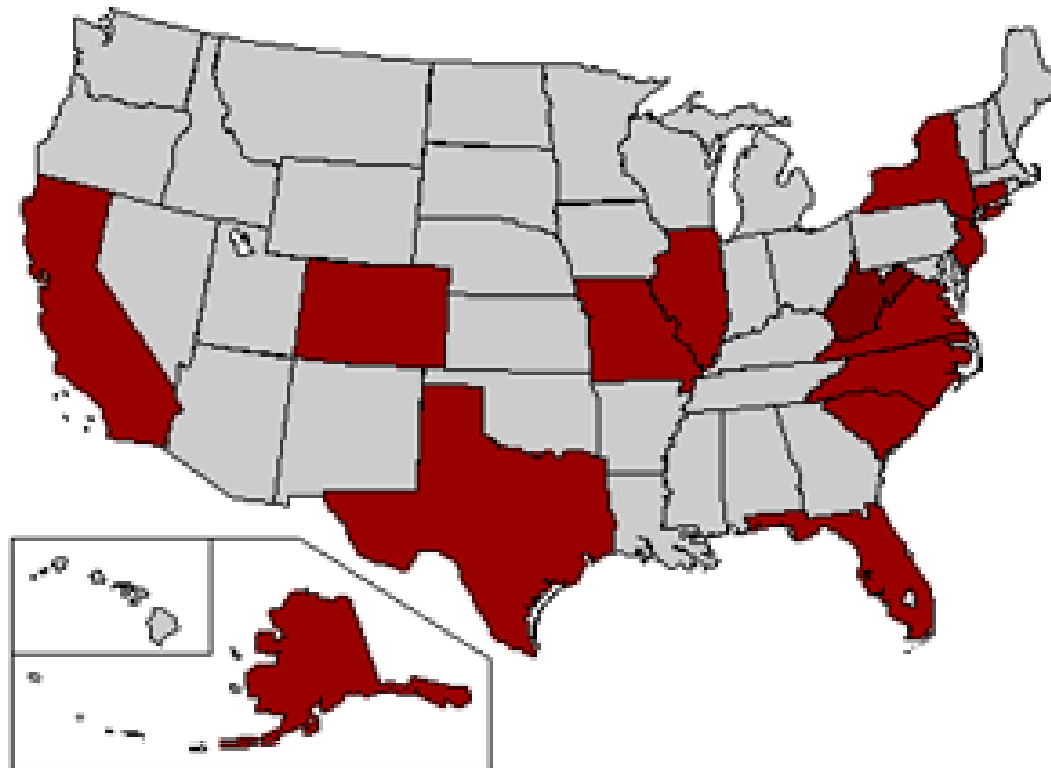
Psychology of Abilities, Competencies, and Expertise

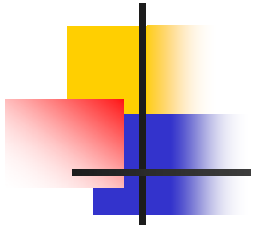


# Mission of the PACE Center

---

- To show how abilities develop into competencies, and competencies into expertise, through
  - Instruction
  - Assessment
- Fundamental notion is that abilities are modifiable in some degree





... and  
across  
the globe.





# View toward Assessment

---

- Assessments measure abilities and competencies as they exist at a given time, in a give place, on a given test or set of tests
- Assessments should always use converging operations
- With appropriate interventions, scores are modifiable



# Why Existing Assessment is Incomplete

---

- So-called *g*-based measures tell part of the story of human abilities, but not the whole story
- Four problems
  - Incompleteness in abilities measured
  - Closed systems
  - Self-fulfilling prophecies
  - Loss of human resources



# Theoretical Orientation

---

- Successful Intelligence
  - Ability to Succeed According to One's Own Definition of Success within One's Sociocultural Context
  - Through Capitalization on Strengths; Correction of or Compensation for Weaknesses
  - Via Analytic, Creative, and Practical Abilities
  - To Adapt to, Shape, or Select Environment



# Three Kinds of Components of Intelligence

---

- Metacomponents
- Performance Components
- Knowledge-Acquisition Components





# Organization of Presentation

---

- Background
- **Research**
- Current and Future Directions



# Conceptual Framework

---

- Definition of each construct
- Why it is important
- Approach to assessment and measurement
- Research findings



# What is Analytical Ability?

---

*Analytical ability* is involved when we

- Analyze
- Compare and contrast
- Evaluate
- Explain
- Judge
- Critique



# Why is Analytic Ability Important?

---

- **ANALYZE** (a large data set, the floor plan of a building, an approach to improving workplace performance)
- **COMPARE AND CONTRAST** (the rhetoric of two political figures, historical and present systems of government in the same country, parenting styles of adults from different cultures)
- **EVALUATE** (multiple possibilities for entering a secured building, a cultural custom, political assumptions and ideologies, alternative solutions)
- **EXPLAIN** (the rationale for a decision, your interpretation of an historical event, the solution to a scientific problem)



# Why New Tests When We Already Have Analytical Tests?

---

- Attain more differentiated information about performance
- Test broader range of analytical skills
  - E.g., everyday induction
- Remove confoundings in conclusions because of non-separated processes
  - E.g., analogies, spatial relations



# What Componential Analysis Tells the Researcher

---

- Component latencies and error rates
- Strategies used
- Mental representations employed
- Correlations of component scores with reference ability tests



# How is Analytical Ability Assessed?

---

- Inductive Reasoning (Fluid)
  - Analogies
  - Classifications
  - Series Completions
  - Everyday Inductions
- Deductive Reasoning (Fluid)
  - Linear Syllogistic Reasoning
  - Categorical Syllogistic Reasoning
  - Conditional Syllogistic Reasoning
- Learning from Context (Crystallized)



# Theory of Inductive Reasoning

---

E.g., Washington : 1 :: Lincoln : (a. 5, b. 10)

- Encoding
- Inference
- Mapping
- Application
- Comparison
- Justification
- Response





# Models of Inductive Reasoning

---

- Fully Exhaustive
- Partially Exhaustive; Partially Self-Terminating
- Fully Self-Terminating



# Analytical Ability: Verbal Classification

---

- Which term belongs with the others?

general, corporal, sergeant, lieutenant

A. ensign, B. admiral, C. private, D. public

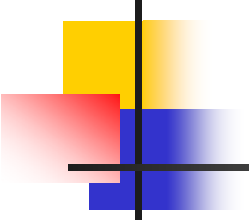


# Data (Sternberg & Gardner, 1983)

---

- Internal Validation:  $R^2$  values
  - Schematic pictures .76
  - Verbal .67
  - Geometric .58
- External Validation: RT Correlations
  - Psychometric reasoning tasks (convergent): -.47 to -.72, median -.64
  - Psychometric perceptual-speed tasks (discriminant): -.13 to .16, median .00

# Complex Verbal Analogies

- 
- Analogies with multiple terms missing
  - Range of number of missing terms: 1 – 3
  - Model
    - Global strategy planning
    - Local strategy planning
    - Performance components
  - Example:
    - Man : Skin :: (Dog, Tree) : (Cat, Bark)



# Complex Verbal Analogies: Data

(Sternberg, 1981)

---

- $R^2$  (internal validation): .97
- Correlations (external validation):
  - With inductive reasoning
    - Global planning .43
    - Local planning -.33
    - Performance components -.42
    - Regression constant -.40





- Prediction/Change

- (b) Rancid



- Postdiction/No Change

- (b) Water





- Postdiction/Change

- 5' 10"

(b) 5' 10"



# Everyday Induction: Data

(Sternberg & Kalmar, 1997)

---

- $R = .62$  (Internal Validation)
- Correlations (External Validation)
  - Induction Deduction Vocab.

■ Latencies	-.53***	-.25	-.23
■ Error Rates	-.61***	-.29	-.44**



# Analytical Ability: Deductive Reasoning

---

- Linear Syllogisms

John is taller than Bill.

Bill is taller than Jack.

Who is shortest?

- Categorical Syllogisms

- All draks are flims. All flims are floms. Are all draks, floms?

- Conditional Syllogisms

- If it rains, it pours. It pours. Can one conclude it rains?



# Mixture Model of Linear Syllogistic Reasoning

---

- Premise Reading
- Marking
- Negation
- Pivot Search
- Seriation
- Question Reading
- Response Search
- Noncongruence
- Reponse



# Data: Linear Syllogisms

(Sternberg, 1980a, 1980b)

- Internal Validation

- $R^2$  .84 (compared to .60 for linguistic model and .58 for spatial theory)

- External Validation

■ Correlations:	Verbal	Spatial
■ Encoding	-.25	-.51
■ Negation	-.10	-.56
■ Marking	-.26	-.65
■ Pivot Search	-.18	-.38
■ Response Search	-.28	-.58
■ Noncongruence	-.41	-.38
■ Response	-.30	-.09



# Data: Linear Syllogisms

(Sternberg & Weil, 1980)

---

- Participants can be taught to use particular strategies
- Not all participants use strategy in which they are trained
- Correlations with Verbal – Spatial Tests
  - Mixture Strategy      -.27      -.45
  - Verbal Strategy      -.76      -.28
  - Spatial Strategy      -.08      -.61
  - Algorithmic Strategy      -.32      -.28



# Theory of Learning from Context

---

- Processes
  - Selective encoding, selective combination, selective comparison
- Context Cues
  - Temporal, spatial, value, stative descriptive, functional descriptive, causal/enablement, class membership, equivalence
- Mediating Variables
  - Number of occurrences, variability of contexts, importance, concreteness, density, usefulness



# Analytical Ability: Learning from Context

---

- He first saw a *blumen* during his trip to Australia. He had just arrived from a business trip to India and felt very tired. Looking out at the plain, he saw the *blumen* hop across it. It was a typical marsupial, getting its food by chewing on the surrounding plants. Squinting because of the bright sunlight and an impending headache, he noticed a young *blumen* securely fastened in an opening in front of its mother.



# Data

(Sternberg, 1987; Sternberg & Powell, 1983)

---

- Internal Validation:  $R^2$  values between model and data
  - .92 for literary passages
  - .74 for newspaper passages
  - .85 for science passages
  - .77 for history passages
- External Validation: Correlations
  - .62 with IQ
  - .56 with vocabulary
  - .65 with reading comprehension



## Analytic Ability: Executive Control of Reading

---

- Executive control involves
  - Determining *what* to read
  - Determining *how* to read it
- Participants have to read 4 passages per block, presented on a computer
- They control time per passage and sequencing



# Executive Control of Reading

---

- Passages
  - $\frac{1}{4}$  from newspapers
  - $\frac{1}{4}$  from novels
  - $\frac{1}{4}$  from humanities textbooks
  - $\frac{1}{4}$  from science textbooks
- Tasks
  - 1 passage for main idea
  - 1 passage for gist
  - 1 passage for detail
  - 1 passage for inference



# Data: Executive Control of Reading

(Wagner & Sternberg, 1987)

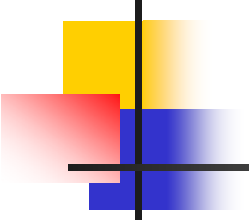
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## ■ Correlations: External Validation

- Vocabulary .57
- Reading Comprehension .48
- Verbal Reasoning .78
- Nelson-Denny Reading
- **Semi-partial coefficient in MR**
- on comprehension** .30
- **R** .85

# Dynamic Assessment of Analytical Abilities

(Sternberg & Grigorenko, 2002)

- 
- Static testing assesses *developed abilities*
  - Dynamic testing, based on Vygotsky, assesses *developing abilities*
    - Combines instruction and assessment
    - Provides direct measure of learning skills



# Dynamic Assessment in Rural Tanzania

---

- Sorting task
- Linear-Syllogisms task
- Twenty-Questions task
  
- Tasks are administered with pretest, instruction, and posttest (experimental group) or simply pretest and posttest (control group)



# Data: Tanzania Project

(Sternberg et al., 2002)

---

- Instructed participants improved significantly from pretest to posttest, and significantly more than did control participants
- Correlation between pretest and posttest was .3 in experimental group, .8 in control group
- Posttest scores correlated better with working memory than did pretest scores



# What is Creative Ability?

---

*Creative ability* is involved when we:

- Create
- Design
- Invent
- Imagine
- Suppose





# Why is Creative Ability Important?

---

- **CREATE** (an explanation for inconsistent evidence on the same phenomenon, a work of fiction)
- **DESIGN** (a new database management system, a method of scientific inquiry, a new approach to solving an old problem)
- **IMAGINE** (what life would be like in another country, what it would be like to be president of a country, how bees communicate with each other)
- **SUPPOSE** (people were paid to inform on neighbors who do not support the political party in power, the ozone layer were completely depleted, voting was compulsory, social security was removed)



# How is Creative Ability Assessed?

---

- Skills Requiring Creative Ability
  - Conceptual Projection
  - Novel Inductive Reasoning
  - Written Storytelling
  - Oral Storytelling
  - Cartoon Captioning
  - Insight
  - Forecasting





# Creative Ability: Conceptual Projection

## Coping with novelty

- Make inferences (projection) about the state of an object in the future given certain rules and a number of propositions (variant of conditional reasoning)
- Propositions: Verbal and Pictorial representation
- Performance predicted by process complexity

<u>Rules</u>		Present time	In 15 years
Blue	→	Blue	Blue
Green	→	Green	Green
Bleen	→	Blue	Green
Grue	→	Green	Blue

## Example Items

Present	15 years	Response Options		
1. 	Grue			I*
2. Bleen		Green	I*	Blue

\*I = inconsistent, 1. = Easy, 2 = Hard



# Conceptual-Projection Data

(Sternberg, 1982)

---

## $R^2$ values (internal validation)

- Green-blue .94
- Liquid-solid .92
- Child-adult .92
- Water-ice .84

## ■ Correlations (external validation)

- Inductive reasoning
- (convergent: holding deduction constant) -.50
- Deductive reasoning
- (discriminant: holding induction constant) -.10



## Creative Ability

### Novel Inductive Reasoning

---

#### **Novel relevant**

Suppose that: Villains are admirable leaders.

Mother Theresa, Martin Luther King, Winston Churchill

(a) NEVILLE CHAMBERLAIN, (b) TOM CRUISE, (c)  
MARILYN MONROE, **(d) ATTILLA THE HUN**

#### **Novel irrelevant**

Suppose that: Water boils at room temperature.

FOG, STEAM, VAPOR, CLOUD

(a) PUDDLE, (b) ICE, **(c) MIST**, (d) RAIN





## Further Findings: Novel Inductive Reasoning

---

- Conclusions

- Both novelty and irrelevance add time to information processing in series completion
- Nonentrenched items were better measures of fluid abilities than entrenched items



# Creative Ability: Insight Problems

---

- (1) If you have black socks and brown socks in your drawer, mixed in the ratio of 4 to 5, how many socks will you have to take out to make sure of having a pair of socks of the same color? [3]
- (2) Suppose you and I have the same amount of money. How much must I give you so that you have 10 dollars more than I? [5]
- (3) Water lilies double in area every 24 hours. At the beginning of the summer there is 1 water lily on a lake. It takes 60 days for the lake to become covered with water lilies. On what day is the lake half-covered? [59]





# Data

(Sternberg & Davidson, 1982)

---

- Correlations (External Validation)
  - Henmon-Nelson IQ .66
  - Inductive Reasoning (letter sets) .63
  - Deductive Reasoning (syllogisms) .34



# Creativity: Free-Form Products

---

- Written Short Stories
  - “Trapped”
- Art Works
  - Earth from an Insect’s Point of View
- Advertisements
  - A New Brand of Door Knob
- “Science”
  - Identifying Extraterrestrial Aliens



# Data: Free-Form Products

(Sternberg & Lubart, 1995)

---

■ Intellectual Processes	.75
■ Knowledge	.49
■ Intellectual Styles	.39
■ Personality	.36
■ Motivation	.53
■ Combined	.83



# What is Practical Ability?

---

*Practical ability* is involved when we:

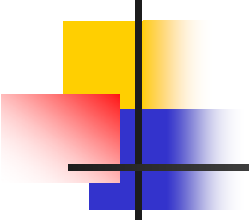
- Use
- Apply
- Implement
- Employ
- Contextualize



# Why is Practical Ability Important?

---

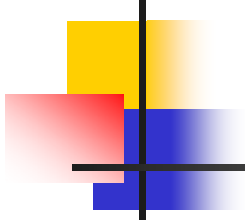
- **USE** (a lesson learned from family interactions to improve your office politics, an explanation for poor subordinate motivation to better understand your teenager, a successful conflict-resolution strategy from work to improve a difficult, non-work interpersonal relationship)
- **APPLY** (what you learned in a foreign-language class to an interaction with a foreigner, knowledge of your organization's history to avoid repeating a mistake made by others, a scientific principle to everyday life)



# How is Practical Ability Assessed?

---

- Skills that require practical ability
  - Social Decoding Scenarios
  - Situational Judgment Tests
  - Tacit Knowledge Inventories
  - Everyday Reasoning
  - Practical Mathematics
  - Route Planning
  - Emotional skills

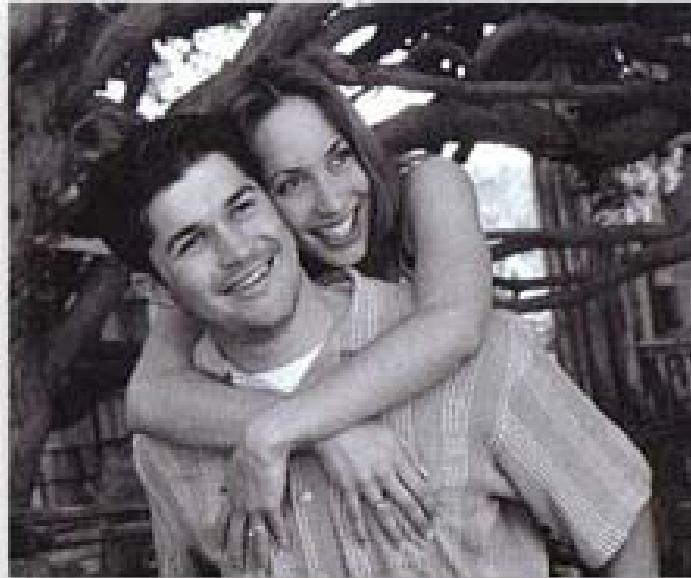


## Practical Ability: Social Decoding

---

- Can you tell if two people standing next to each other are in a relationship?
- Can you tell which person in a photograph is the manager?

# Practical Ability: Social Decoding (Couples Task)





# Practical Ability: Social Decoding (Supervisors Task)





# Data: Social Decoding

(Sternberg & Smith, 1985)

---

- Proportion Correct
  - Couples .60
  - Supervisors .74
- $R^2$  (Internal Validation: of proportion correct/picture on aspects of pictures)
  - Couples .73
  - Supervisors .92
- Correlations (External Validation)
  - .40 with Embedded Pictures
  - No others significant



## Practical Ability: Tacit-Knowledge Inventories

---

- Situational Judgment Testing Methodology
  - Brief vignettes featuring practical problems
  - Several possible response strategies
  - Each response strategy is rated for its perceived quality or effectiveness
  - Score on the inventory is determined by measuring the degree of correspondence with a designated comparison group



# Practical Ability: Tacit-Knowledge Inventories

---

- Management
- Military Leadership (3 levels)
- Principals
- Salespeople
- Elementary-School Teachers
- College Students
- High School Students



## Practical Ability: Tacit-Knowledge—General Workplace

---

You and a co-worker jointly are responsible for completing a report on a new product by the end of the week. You are uneasy about this assignment because he has a reputation for not meeting deadlines. The problem does not appear to be lack of effort. Rather, he seems to lack certain organizational skills necessary to meet a deadline and also is quite a perfectionist. As a result too much time is wasted coming up with the “perfect” idea, product or report.

Your goal is to produce the best possible report by the deadline at the end of the week. Rate the quality of the following strategies for meeting your goal on a 1-7 point scale:

1	2	3	4	5	6	7
Extremely Bad	Very Bad	Somewhat Bad	Neither Good nor Bad	Somewhat Good	Very Good	Extremely Good

\_\_\_ Divide the work to be done in half and tell him that if he does not complete his part, you obviously will have to let your immediate superior know it was not your fault.

\_\_\_ Politely tell him to be less of a perfectionist.

\_\_\_ Set deadlines for completing each part of the report, and accept what you have accomplished at each deadline as the final version of that part of the report.

\_\_\_ Ask your superior to check up on your progress on a daily basis (after explaining why).

\_\_\_ Praise your co-worker verbally for completion of parts of the assignment.

\_\_\_ Get angry with him at the first sign of getting behind schedule.



# Practical Ability: Tacit-Knowledge—Military Leadership

---

1	2	3	4	5	6	7	8
9							
Extremely		Somewhat	Neither Bad		Somewhat		Extremely
Bad		Bad	Nor Good		Good		Good

You are a platoon leader, and one day your driver has a motivational problem while out in the field. He starts mouthing off to you while standing on top of the turret in front of the rest of the platoon. Everyone in the platoon is listening to what he's saying about you, and it is extremely negative and harsh. What should you do?

# Practical Ability:

## Tacit-Knowledge Inventories

Rate the quality of the following things you are considering doing in this situation on the 1-to-9 point scale above.

\_\_\_ Speak to your company commander about the problem and get his/her advice.

\_\_\_ In front of the platoon, order your driver to do an unpleasant task as punishment for his insubordination.

\_\_\_ Pull him aside and read him his rights; really chew his butt.

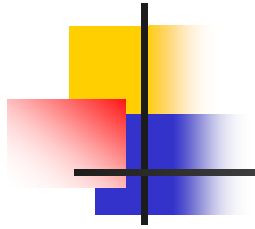
\_\_\_ Go to the PSG and tell him to take care of this problem.

\_\_\_ Order your driver to be quiet and get back to his job.

\_\_\_ Pull him aside and tell him to come speak to you in one hour.



# Practical Ability: Tacit-Knowledge--Management



1 2 3 4 5 6 7  
extremely bad neither extremely good

- An employee who reports to one of your subordinates has asked to talk with you about waste, poor management practices, and possible violations of both company policy and the law on the part of your subordinate. You have been in your present position only a year, but in that time you have had no indications of trouble about the subordinate in question. Neither you nor your company has an “open door” policy, so it is expected that employees should take their concerns to their immediate supervisors before bringing the matter to the attention of anyone else. The employee who wishes to meet with you has not discussed this matter with her supervisor because of its delicate nature.



# Practical Ability: Tacit-Knowledge Inventories

---

Rate the quality of the following things you are considering doing in this situation on the 1-to-7 point scale above.

- \_\_\_\_\_ Refuse to meet with the employee unless the individual first discusses the matter with your subordinate.
- \_\_\_\_\_ Meet with the employee and then with your subordinate to get both sides of the story.
- \_\_\_\_\_ Meet with the employee and then investigate the allegations if an investigation appears warranted before talking with your subordinate.
- \_\_\_\_\_ Find out more information about the employee, if you can, before making any decisions.

# Practical Ability

## Findings: Tacit-Knowledge Inventories

---

- TK inventories have been scored by:
  - correlating responses with an index of group membership (e.g, expert, novice)
  - using professional “rules of thumb”
  - computing a difference score between sample-based responses or expert-based responses.



# Practical Ability: Tacit-Knowledge Inventories

---

## Criteria

- Business Executives – Managerial Simulations
- Military Leaders – Ratings of Leadership Effectiveness, Rank
- Life Insurance Salespeople – Yearly Quality Awards, Yearly Sales Volumes and Premiums, and so on
- Academic Psychologists – Citation rates, Number of Publications, Conference Papers Presented, and so on
- College Students – Freshman GPA, Academic Index, Adjustment Index
- Business Managers – Salary, Number of Employees Supervised, Level of Job Title, and so on

# Practical Ability

## Findings: Tacit-Knowledge Inventories

(Sternberg et al., 2000)

### Correlations With Criteria (External Validity)

Business Executives	<b>.61*</b>
Military Leaders	<b>.14-.42*</b>
Life Insurance Salespeople	<b>.26-.41</b>
Academic Psychologists	<b>.33-.48</b>
College Students	<b>.15-.45</b>
Business Managers	<b>.36-.39</b>

All correlations are statistically significant.

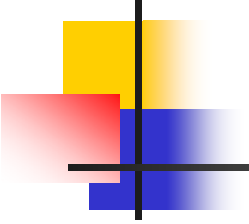
\*Incremental validity above and beyond general intelligence was also tested and shown.

# Practical Ability

## Findings: Tacit-Knowledge Inventories

### Correlations With General Intelligence

Business Executives	<b>.14</b>
Military Leaders	<b>.18-.25</b>
Life Insurance Salespeople	<b>N/A</b>
Academic Psychologists	<b>.04</b>
College Students	<b>.01-.40</b>
Business Managers	<b>N/A</b>



# Practical Ability

## Findings: Tacit-Knowledge—General Workplace

---

### Sample Results: Correlations

My relationship with this employee is good.	.24
I think highly of this employee.	.31**
I am satisfied with this employee.	.33**
This employee's relationships with other coworkers are good.	.15
How would you rate this employee's common-sense ability?	.40**
How would you rate this employee's academic ability?	.44**
How would you rate this employee's creative ability?	.34**
How would you rate this employee at working by him/herself?	.34**
How would you rate this employee at working with others?	.26**
How good is this employee at motivating him/herself?	.44**
How good is this employee at managing tasks?	.38**
How responsible is this employee?	.29**

# Practical Ability

## Findings: Tacit-Knowledge Inventories

In studies conducted with academic psychologists, managers, business executives, salespersons, teachers, principals, and college students:

- TK scores increased, on average, with experience, although learning from experience was what mattered, not experience itself.
- TK scores had null to modest relationships with tests of general ability.
- TK scores had null to modest relationships with scores on tests of multiple abilities (e.g., ASVAB).



# Practical Ability

## Findings: Tacit-Knowledge Inventories

---

- TK scores were uncorrelated with scores on tests of personality or cognitive styles.
- TK scores correlated among themselves.
- TK scores predicted criterion performance as well as or better than did IQ.
- TK scores predicted job-related criteria incrementally over cognitive, personality, and cognitive style measures.



# Practical Intelligence in Special Settings: Rural Kenya

---

- Test of Knowledge of Natural Herbal Remedies:
  - A small child in your family has *homa*. She has a sore throat, headache, and fever. She has been sick for three days. Which of the following 5 *Yadh nyaluo* [Luo herbal medicines] can treat *homa*?
    - 1. *Chamama*. Take the leaf and *fito* (sniff medicine up nose to sneeze out illness)
    - 2. *Kaladali*. Ake the leaves, drink, and *fito*.
    - 3. *Obuo*. Take the leaves and *fito*.
    - 4. *Ogaka*. Take the roots, pound, and drink.
    - 5. *Ahundo*. Take the leaves and *fito*.



# Rural Kenya Data

(Sternberg et al., 2001)

---

- Test of practical intelligence showed *negative* pattern of correlations with measures of fluid and crystallized abilities as well as with achievement tests in English and mathematics



# Practical Intelligence in Special Settings: Rural Alaska

---

- I can usually find the most *atsalugpiat* [cloudberries/salmonberries] in the
  - A. grass far from the water
  - B. tundra
  - C. hills that appear dry
  - D. hills that appear green



# Rural Alaska: Data

(Grigorenko et al., 2002)

---

- Tests of academic and practical intelligence both predict generalized adaptation. Tests of practical intelligence are better measures of rated hunting/gathering skills than are tests of academic intelligence.



# Analytical, Creative, and Practical Abilities

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The CANAL-F test

Cognitive Ability for Novelty in Acquisition  
of Language (Eoreign)



## CANAL-F: Nature

---

- Simulates a situation in which second-language learning occurs largely naturally,
  - by gradually introducing a simulated language
  - embedded in a multifaceted language context
- Dynamic rather than static, in that it tests the ability to learn at the time of the test



## CANAL-F: Structures

---

- Structures Tested
  - lexical
  - morphological
  - semantic
  - syntactic





## CANAL-F: Input

---

### Modes of Input

- Visual
  - predominates in reading and writing
- Oral
  - predominates in listening and speaking



## CANAL-F: Example 1

---

The wealthy hunting *femo-de* of late glacial Europe might have maintained or even enriched culture, or *unta-u erto* to stagnate *ik* decline: *Yuve* could hardly have advanced *erto* to a higher form of civilization, for the environment *neunta-u-erto*. But *Yuve-Yuve* future *cutta-u* not left in *Yuve-Yuve* own *sima-de*. Inexorably, although no doubt to *twum* imperceptibly, the climate changed: *kojok-de* grew longer, *ik* warmer, ice sheets shrank, *ik* glaciers retreated. Enslaved to climate, plant *ik* animal *kiz* had to change also... (etc.)



# Response Options

---

- (1) The passage is largely concerned with: (a) man's conflict with his environment; (b) the effect of climate on man's way of life; (c) changes in plant and animal life in South America; (d) primitive hunting tribes and their culture; (e) extinct prehistoric animals.
- (2) The phrase *fru neunta* most likely means (a) to prevent; (b) to allow; (c) because of; (d) to permit; (e) factor.



## CANAL-F: Example 2

---

In Ursulu,

*Panlin-u Sumu Twah chuck* means I handed a stick to him.

*Panlin-u Yut Twa dozz* means He handed an umbrella to me.

*Panilcos-u Yut Twa flexta* means He handed a piece of paper to me.

*Panleh-u Sumu Twah chuchu* means I handed a rope to him.

- (1) The sentence: *Panilcos-u Sumu Twah otikum* most likely means: (a) He handed a rod to me; (b) I handed a cord to him; (c) I handed a postcard to him; (d) I handed a waterhose to him; (e) I handed a tree-branch to her.

# CANAL-F: External Validation

(Grigorenko, Sternberg, & Ehrman, 2000)

## Correlations Between CANAL-F And Other Measures

### Comment on the student's

- |                        |        |
|------------------------|--------|
| ■ communication skills | .58*** |
| ■ vocabulary           | .45*** |
| ■ writing skills       | .48*** |

### Is your student mostly

- |                    |        |
|--------------------|--------|
| ■ visual learner   | .01    |
| ■ auditory learner | .42*** |
| ■ fast learner     | .52*** |



# The Rainbow Project

(Sternberg & the Rainbow Project Collaborators, 2002)

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- A Measure of Analytical, Creative, and Practical Skills



## Example #1: STAT

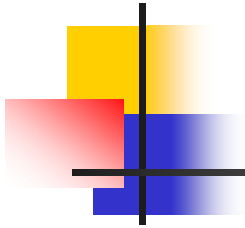
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- Analytic-Verbal

Any retail business that ignores its regular clientele, in order to concentrate on new jids, may discover that sales do not increase. The new interest generated may not be enough to compensate for the loss in sales caused by dissatisfied patrons who begin to shop elsewhere.

Jid most likely means

- A. Product
- B. Customer**
- C. Advertisement
- D. Investment



## Analytical Ability: Number Series

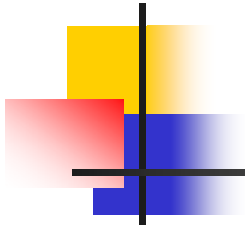
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Pick the next number in the sequence:

2      8      3      27      4      64      5

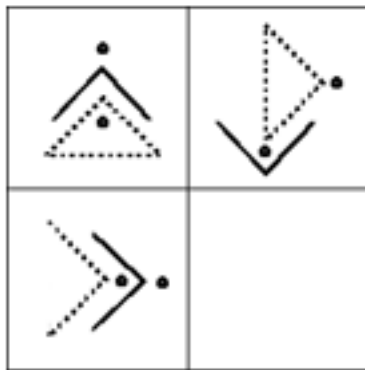
- A. 125**
- B. 100
- C. 121
- D. 81



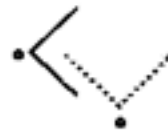


# Analytical Ability: Figural Analogies

Pick the correct figure to fill in the empty space:



A



B



C



D



## Creative Ability: Analogies w/Counterfactual Premise

---

- Creative-Verbal

Money falls off trees.

snow is to shovel as dollar is to

- A. bill
- B. rake**
- C. bank
- D. green



# Creative Ability: Novel Numerical Systems

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- Creative-Math

There is a new mathematical operation called graf. It is defined as follows:

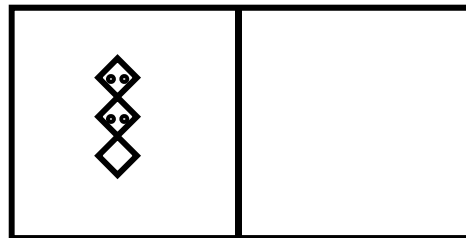
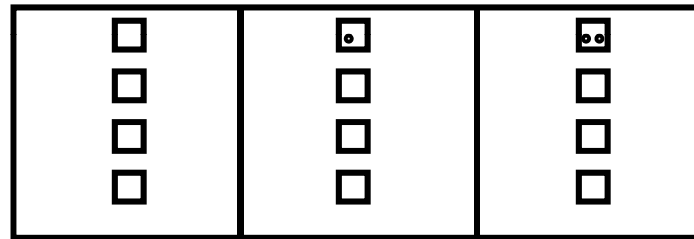
$$\begin{array}{l} x \text{ graf } y = x + y, \text{ if } x < y \\ \text{but } x \text{ graf } y = x - y, \text{ if otherwise} \end{array}$$

How much is 4 graf 7?

- A. -3
- B. 3
- C. 11**
- D. -11

# Creative Ability: Pattern Recognition

- Creative-Figural



A



B



C



D



# Creative Ability: Written Stories

---

## WRITTEN STORY TASK:

- “A Fifth Chance”
- “2983”
- “Beyond the Edge”
- “The Octopus’s Sneakers”
- “It’s Moving Backwards”
- “Not Enough Time”



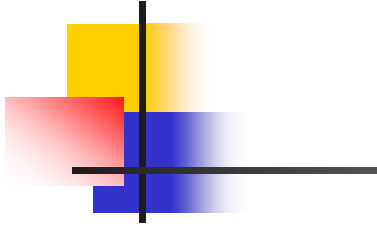
# Creative Ability: Oral Stories

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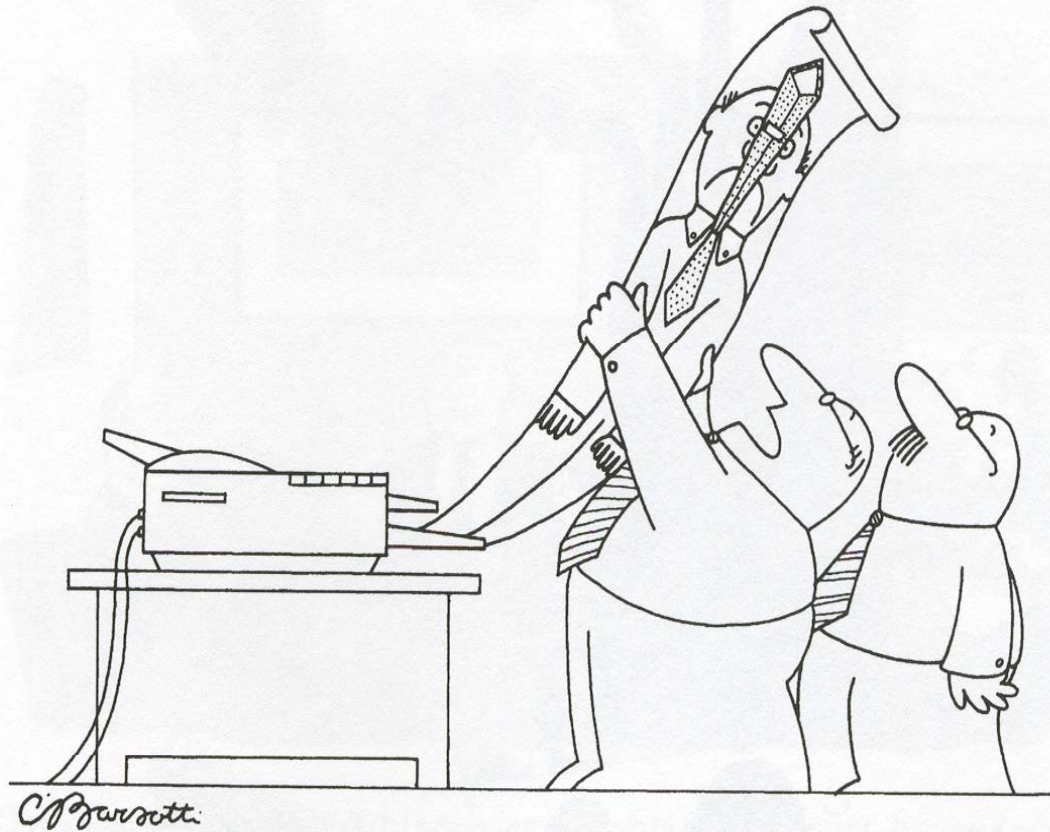
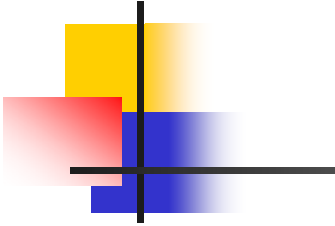
## ■ Task

- 5 sheets of paper, each with several images
- Choose 2 of 5 sheets – separate story for each
- No limits on the content of the stories
- 10 minutes to think
- 5 minutes to dictate
- Scored for originality, cleverness, humor, task appropriateness

# Creative Ability: Oral Stories



# Creative Ability: Cartoon Captioning





# Practical Ability: Everyday Reasoning

## ■ Practical - Verbal

Dear Joey,

I was awarded a scholarship to college for next year. It covers all my expenses except books and supplies, which I think will cost about \$1000 per year. I really want to be completely financially independent, so how can I be independent yet still get the money I need?

Signed,

Broke and on my own

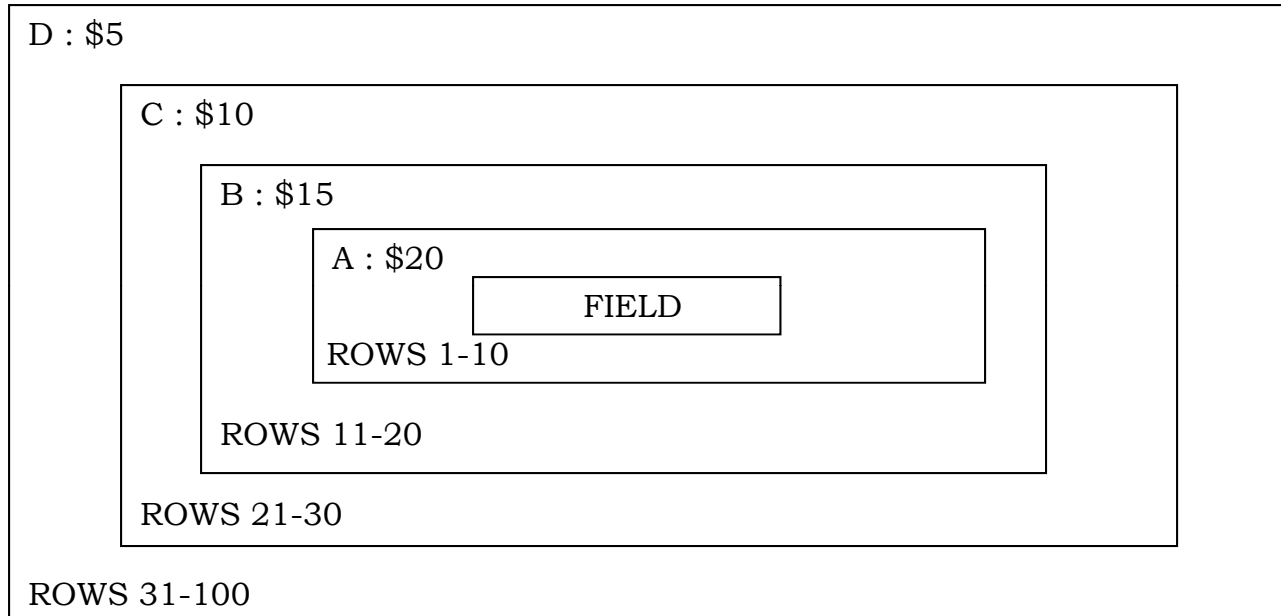
Dear Broke,

You can

- A. use the money you hope to receive from graduation gifts instead of spending it on new clothes for college.
- **B. get a summer job and be willing to work as much as possible.**
- C. take out a student loan.
- D. borrow the money from your parents.

# Practical Ability: Practical Mathematics

## • Practical - Math



Mike wants to buy two seats together and is told there are pairs of seats available only in Rows 8, 12, 49, and 96. Which of the following is not one of his choices for the total price of the two tickets?

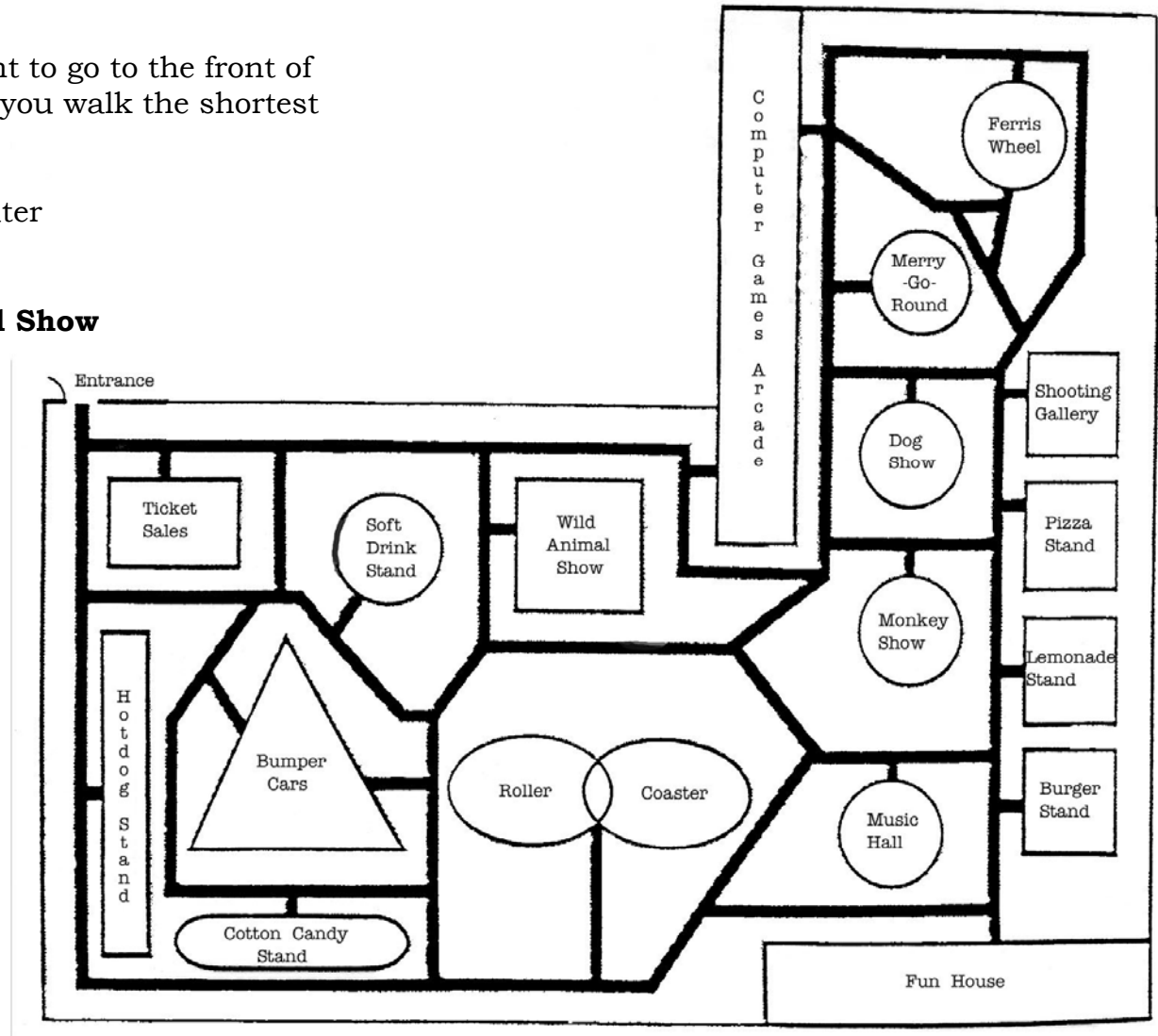
- A. \$10
- B. \$20**
- C. \$30
- D. \$40

# Practical Ability: Route Planning

## • Practical - Figural

You are at the Burger Stand. You want to go to the front of the Ticket Sales to meet some friends. If you walk the shortest way, you will past the entrance to the

- A. Lemonade Stand and Computer Games Arcade
- B. Music Hall and Wild Animal Show**
- C. Music Hall and Soft Drink Stand
- D. Monkey Show and Wild Animal Show





## Practical Ability: Movies

---

- Analogous methodology to other tacit-knowledge inventories
- Vignette material is presented via a live-action film either on the computer or on a videocassette and TV
- Possible response strategies are rated either on the computer or on paper-and-pencil answer sheets



# Tacit Knowledge Inventories: Everyday Judgments

---

**If you were the diner in this scenario which of the following would be your best course of action?**

1	2	3	4	5	6	7
Extremely Bad			Neither Bad Nor Good			Extremely Good

- a) Pay the bill and leave the remaining money as a tip.
- b) Pay the bill and talk to the waitress and excuse yourself for not having money for the tip.
- c) Pay the bill and bring the tip to the waitress the following day.
- d) Use some other form of payment beside cash to pay the bill and then use the cash to leave a tip.
- e) Pay the bill then leave some cigarettes, mints, or other gifts as a tip.
- f) Tell the waitress you'll be right back and then go borrow money from people in your office.

# Results:

## Incremental Validity Beyond SAT

(Sternberg et al., 2002)

### Step 1

■ SAT Verbal	.163*
■ SAT Math	.191*
■ R <sup>2</sup>	.101

## Results:

# Incremental Validity Beyond SAT

---

### Step 2

- SAT Verbal .129\*
- SAT Math -.078
- STAT Analytical .304\*
  
- $R^2$  .148

# Results:

## Incremental Validity Beyond SAT

### Step 3

- SAT Verbal .090\*
- SAT Math -.035
- STAT Analytical .225\*
- STAT Practical
  - Perf Latent .164\*
  - Practical STAT .155\*
- $R^2$  .192





# Results:

## Incremental Validity Beyond SAT

---

### Step 4

■ SAT Verbal	-.005
■ SAT Math	-.027
■ STAT Analytical	.186*
■ STAT Practical	
■ Perf Latent	.071
■ Practical STAT	.100*
■ Creative	
■ Written	.128*
■ Oral	.183*
■ Cartoons	-.005
■ Creative STAT	.180*
■ R <sup>2</sup>	.257



# Ethnicity Effects on SAT and Rainbow Measures

---

	$\Omega^2$
■ SAT-V	.13
■ SAT-M	.16
■ STAT-A	.03
■ STAT-P	.03
■ STAT-C	.02



# Ethnicity Effects on SAT and Rainbow Measures

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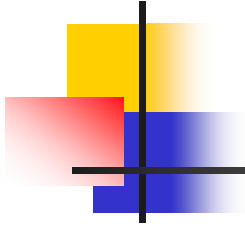
	$\Omega^2$
■ Movies	.00
■ Common Sense	.00
■ College Life	.00
■ STAT-P	.03
■ Practical Perf. Latent	.05



# Ethnicity Effects on SAT and Rainbow Measures

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	$\Omega^2$
■ Cartoon Captions	.03
■ Oral Stories	.04
■ Written Stories	.00
■ Creative Perf. Latent	.00



# Implicit-Theories Studies

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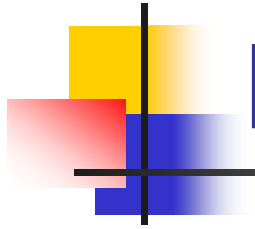
- Mainstream United States (Sternberg et al., 1981)
- Taiwan (Sternberg & Yang, 1997)
- Kenya (Grigorenko et al., 2001)
- San Jose, CA (Okagaki & Sternberg, 1983)



# Implicit Theories

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- U.S. participants asked to rate themselves on statements generated from study of conceptions of intelligence (1-9)



# Factors

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- Practical problem solving
  - Reasons logically and well
  - Sees all aspects of a problem
- Verbal Ability
  - Is verbally fluent
  - Reads with high comprehension
- Social Competence
  - Accepts others for what they are
  - Thinks before speaking and doing



# Implicit Theories: Data

(Sternberg et al., 1981)

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- Multiple Regressions for Hypothetical Individuals (Internal Validation):  $R^2 = .97$
- R of three prototype scores (practical problem solving, verbal ability, social competence) with IQ .55
- Correlations of Self-Ratings with IQ (External Validation)
  - Ratings of Intelligence .52
  - Ratings of Academic Intelligence .56
  - Ratings of Everyday Intelligence .45





# Thinking Styles: The Theory of Mental Self- Government

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- People have preferred ways of using their abilities.
- These preferences can vary across domains.
- The styles are socialized.
- The styles are modifiable.
- The styles are quantifiable.



# Why Thinking Styles are Important

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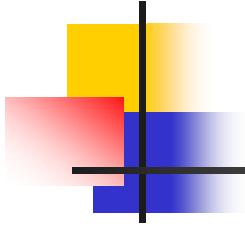
- They affect
  - how teachers teach
  - how learners learn
  - which tasks we seek and which we shun
  - how we best can do our work
  - How we worst can do our work



# Thinking Styles: The Theory of Mental Self-Government

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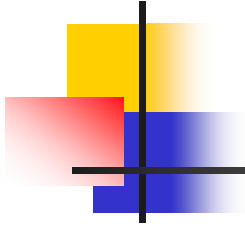
- Legislative
  - When making decisions I tend to rely on my own ideas and ways of doing things.
- Executive
  - When discussing or writing down ideas, I follow formal rules of presentation.
- Judicial
  - I like situations where I can compare and rate different ways of doing things.



# Thinking Styles

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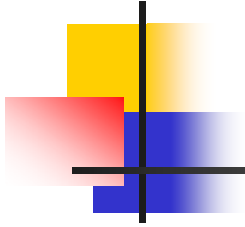
- Monarchic
  - When trying to finish a task, I tend to ignore problems that come up.
- Hierarchic
  - In dealing with difficulties, I have a good sense of how important each of them is and what order to tackle them in.
- Oligarchic
  - Usually, when I have many things to do, I split my time and attention equally among them.
- Anarchic
  - When discussing or writing down new ideas, I use whatever comes to mind.



# Thinking Styles

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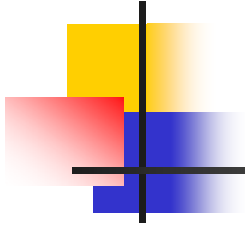
- Global
  - In doing a task, I like to see how what I do fits into the general picture.
- Local
  - I pay more attention to the parts of the task than to its overall effects or significance.



# Thinking Styles

---

- External
  - I like to participate in activities where I can interact with others as part of a team.
- Internal
  - I like projects that I can complete independently.



# Thinking Styles

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- Conservative
  - I stick to standard ways or rules of doing things.
- Liberal
  - I like to change routines in order to improve the way tasks are done.



# Findings: Thinking Styles

(Sternberg, 1997)

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- Lower SES is associated with executive, local, conservative styles
- Later-borns tend to be more legislative
- People overestimate the extent to which others share their thinking styles
- Teachers rate more highly students whose profiles of thinking styles correspond to their own





# Findings: Thinking Styles

(Sternberg, 1997)

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- Institutions have different styles
- Correlations of styles with school grades vary radically across schools depending on the styles of the schools
- People are often promoted for styles that work at one level but do not work at a higher level



# Organization of Presentation

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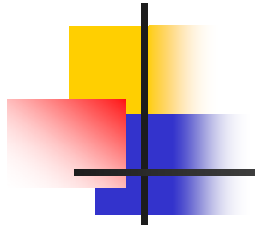
- Background
- Current and Recently Completed Research
- Current and Future Directions



# Complementary Emphasis on Instruction

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- Students learn better when taught to their triarchic strengths (Sternberg et al., 1999)
- Students learn better when taught triarchically than when taught for critical thinking or for memory (Grigorenko et al. 2002; Sternberg et al., 1998, 2002)

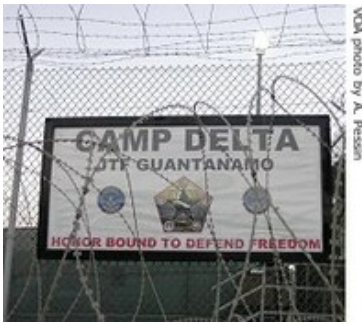


# Current and Future Directions

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- The College Board Rainbow Project
- The ETS-CB Advanced Placement Project
- The University of Michigan Business School Project
- The ARI Mental Flexibility Project
- The IES Giftedness Project
- The NSF Instructional Project
- The W. T. Grant Foundation Wisdom Project

# Testimonies of Standard Operating Procedures



*In November and December of 2007, Wikileaks posted two Guantánamo manuals. They were the 2003 and 2004 Standard Operating Procedures for Camp Delta. CSHRA has extracted the testimony of abuse contained in those manuals, compared the two versions, and placed both in the context of the Geneva Conventions and other international agreements regarding the humane treatment of prisoners. See below.*

*CSHRA has also posted below the Standard Operating Procedures for (a) hunger striking prisoners, (b) Behavioral Studies Consultation Teams (BSCTs), and (c) a couple of citations of the 2005 Camp Delta Standard Operating Procedure manuals. All of these were released by the US Department of Defense.*

*We have posted here also the SERE Interrogation SOP for JTF GTMO (posted in the website of the documentary Torturing Democracy), the Recommended Course of Action for the Reception and Detention of Individuals Under 18 Years of Age (posted in the website of the Toronto Star), and the Guidelines on Medical and Psychological Support approved by the CIA Office of Medical Services (made public in 2009 by the Obama administration).*

- JTF GTMO SERE Interrogation Standard Operating Procedure, December 10, 2002
- Testimonies of Camp Delta Standard Operating Procedures, 2003-2005<sup>1</sup>
  - Standing [sic] Operating Procedures, November 2002
  - Standard Operating Procedures, March 2003
  - Standard Operating Procedures, March 2004
  - Standard Operating Procedures (Citations), December 2005
- Testimonies of the Detention Hospital Standard Operating Procedures
  - Forced feeding as a matter of standard operating procedure
  - Use of physical restraints to force-feed hunger-striking prisoners
  - The administration of drugs with psychotic side-effects
  - BSCTs may check with clinical staff whether a prisoner is medically fit for interrogation
- Testimonies of Hunger Strike Standard Operating Procedures
  - August 11, 2005
  - March 5, 2013
- Testimonies of the BSCT Standard Operating Procedures, 2002-2006
  - 2002
  - 2004

- 2005
- 2006

- Recommended Course of Action for Reception and Detention of Individuals Under 18 Years of Age, January 14, 2003
- Guidelines on Medical and Psychological Support to Detainee Rendition, Interrogation, and Detention. CIA Office of Medical Services (Summary)
  - May 2004
  - December 2004

## **Note**

1. The report of the investigation into the allegations made by Sgt. Heather Cervený mentions a Camp Delta Standard Operating Procedure dated October 15, 2006. No such document has been made public to date.



HEALTH AFFAIRS

THE ASSISTANT SECRETARY OF DEFENSE

WASHINGTON, D. C. 20301-1200

JUN 03 2005

MEMORANDUM FOR SECRETARIES OF THE MILITARY DEPARTMENTS  
CHAIRMAN OF THE JOINT CHIEFS OF STAFF  
UNDER SECRETARIES OF DEFENSE  
COMMANDERS OF THE COMBATANT COMMANDS  
ASSISTANT SECRETARIES OF DEFENSE  
GENERAL COUNSEL OF THE DEPARTMENT OF DEFENSE  
INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE  
ASSISTANTS TO THE SECRETARY OF DEFENSE  
DIRECTOR OF ADMINISTRATION AND MANAGEMENT  
DIRECTOR, PROGRAM ANALYSIS AND EVALUATION  
DIRECTOR, NET ASSESSMENT  
DIRECTOR, FORCE TRANSFORMATION  
DIRECTORS OF THE DEFENSE AGENCIES  
DIRECTORS OF THE DOD FIELD ACTIVITIES

SUBJECT: Medical Program Principles and Procedures for the Protection and Treatment  
of Detainees in the Custody of the Armed Forces of the United States

REFERENCES: (a) DoD Directive 5136.1, "Assistant Secretary of Defense for Health  
Affairs," May 27, 1994  
(b) AR 190-8, OPNAVINST 3461.6, AFJI 31-304, MCO 3461.1,  
"Enemy Prisoners of War, Retained Personnel, Civilian Internees  
and Other Detainees"  
(c) DoD Directive 5100.77, DoD Law of War Program, December 9,  
1998

This memorandum is issued under the authority of reference (a) and reaffirms the historic responsibility of health care personnel of the Armed Forces (to include physicians, nurses, and all other medical personnel including contractor personnel) to protect and treat, in the context of a professional treatment relationship and established principles of medical practice, all detainees in the custody of the Armed Forces during armed conflict. This includes enemy prisoners of war, retained personnel, civilian internees, and other detainees.

It is the policy of the Department of Defense Military Health System that health care personnel of the Armed Forces and the Department of Defense (particularly physicians) will perform their duties consistent with the following principles.

**HA POLICY: 05-006**

## Principles

1. Health care personnel charged with the medical care of detainees have a duty to protect their physical and mental health and provide appropriate treatment for disease. To the extent practicable, treatment of detainees should be guided by professional judgments and standards similar to those that would be applied to personnel of the U.S. Armed Forces.

2. All health care personnel have a duty in all matters affecting the physical and mental health of detainees to perform, encourage and support, directly and indirectly, actions to uphold the humane treatment of detainees.

3. It is a contravention of DoD policy for health care personnel to be involved in any professional provider-patient treatment relationship with detainees the purpose of which is not solely to evaluate, protect or improve their physical and mental health.

4. It is a contravention of DoD policy for health care personnel:

(a) To apply their knowledge and skills in order to assist in the interrogation of detainees in a manner that is not in accordance with applicable law;

(b) To certify, or to participate in the certification of, the fitness of detainees for any form of treatment or punishment that is not in accordance with applicable law, or to participate in any way in the infliction of any such treatment or punishment.

5. It is a contravention of DoD policy for health care personnel to participate in any procedure for applying physical restraints to the person of a detainee unless such a procedure is determined in accordance with medical criteria as being necessary for the protection of the physical or mental health or the safety of the detainee himself or herself, or is determined to be necessary for the protection of his or her guardians or fellow detainees, and is determined to present no serious hazard to his or her physical or mental health.

## Procedures

Consistent with the foregoing principles, the following procedures are established.

1. Medical Records. Accurate and complete medical records on all detainees shall be created and maintained in accordance with reference (b).

2. Treatment Purpose. Health care personnel engaged in a professional provider-patient treatment relationship with detainees shall not undertake detainee-related activities for purposes other than health care purposes. Such health care personnel shall



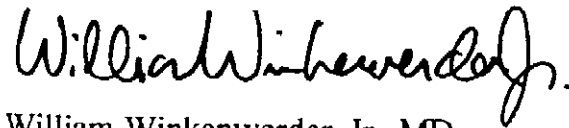
not actively solicit information from detainees for purposes other than health care purposes. Health care personnel engaged in non-treatment activities, such as forensic psychology or psychiatry, behavioral science consultation, forensic pathology, or similar disciplines, shall not also engage in any professional provider-patient treatment relationship with detainees.

3. Medical Information. Under U.S. and international law and applicable medical practice standards, there is no absolute confidentiality of medical information for any person. Detainees shall not be given cause to have incorrect expectations of privacy or confidentiality regarding their medical records and communications. However, whenever patient-specific medical information concerning detainees is disclosed for purposes other than treatment, health care personnel shall record the details of such disclosure, including the specific information disclosed, the person to whom it was disclosed, the purpose of the disclosure, and the name of the medical unit commander (or other designated senior medical activity officer) approving the disclosure. Analogous to legal standards applicable to U.S. citizens, permissible purposes include to prevent harm to any person, to maintain public health and order in detention facilities, and any lawful law enforcement, intelligence, or national security related activity. In any case in which the medical unit commander (or other designated senior medical activity officer) suspects that the medical information to be disclosed may be misused, he or she should seek a senior command determination that the use of the information will be consistent with applicable standards.

4. Reporting Possible Violations. Any health care personnel who in the course of a treatment relationship or in any other way observes circumstances indicating a possible violation of applicable standards, including those prescribed in references (b) and (c), for the protection of detainees, or otherwise observes what in the opinion of the health care personnel represents inhumane treatment of a detainee, shall report those circumstances to the chain of command. Health care personnel who believe that such a report has not been acted upon properly should also report the circumstances to the technical chain, including the Command Surgeon or Military Department specialty consultant. Technical chain officials may inform the Joint Staff Surgeon or Surgeon General concerned, who then may seek senior command review of the circumstances presented. As always, other reporting mechanisms, such as the Inspector General, criminal investigation organizations, or Judge Advocates, also may be used.

5. Training. The Secretaries of the Military Departments and Combatant Commanders shall ensure that health care personnel involved in the treatment of detainees or other detainee matters receive appropriate training on applicable policies and procedures regarding the care and treatment of detainees.

This memorandum, effective immediately, affirms as a matter of Department of Defense policy the professional medical standards and principles applicable within the Military Health System. This memorandum does not alter the legal obligations of health care personnel under applicable law. The principles and procedures contained in this memorandum and experience implementing them will be reviewed within six months, including input from interested parties outside DoD.

A handwritten signature in black ink, reading "William Winkenwerder, Jr." in a cursive script.

William Winkenwerder, Jr., MD

# **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 by the 29<sup>th</sup> World Medical Assembly, Tokyo, Japan, October 1975*

*and editorially revised by the 170<sup>th</sup> WMA Council Session, Divonne-les-Bains, France, May 2005*

*and the 173<sup>rd</sup> WMA Council Session, Divonne-les-Bains, France, May 2006*

## **PREAMBLE**

It is the privilege of the physician to practise medicine in the service of humanity, to preserve and restore bodily and mental health without distinction as to persons, to comfort and to ease the suffering of his or her patients. The utmost respect for human life is to be maintained even under threat, and no use made of any medical knowledge contrary to the laws of humanity.

For the purpose of this Declaration, torture is defined as the deliberate, systematic or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession, or for any other reason.

## **DECLARATION**

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 or to diminish the ability of the victim to resist such treatment.
3. When providing medical assistance to detainees or prisoners who are, or who could later be, under interrogation, physicians should be particularly careful to ensure the confidentiality of all personal medical information. A breach of the Geneva Conventions shall in any case be reported by the physician to relevant authorities.

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.

4. 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.
5. A physician must have complete clinical independence in deciding upon the care of a person for whom he or she is medically responsible. The physician's fundamental role is to alleviate the distress of his or her fellow human beings, and no motive, whether personal, collective or political, shall prevail against this higher purpose.
6. Where a prisoner refuses nourishment and is considered by the physician as capable of forming an unimpaired and rational judgment concerning the consequences of such a voluntary refusal of nourishment, he or she shall not be fed artificially. The decision as to the capacity of the prisoner to form such a judgment should be confirmed by at least one other independent physician. The consequences of the refusal of nourishment shall be explained by the physician to the prisoner.

7. The World Medical Association will support, and should encourage the international community, the National Medical Associations and fellow physicians to support, the physician and his or her family in the face of threats or reprisals resulting from a refusal to condone the use of torture or other forms of cruel, inhuman or degrading treatment.