End of Night Shift, Kamenica, Kosovo, by Henrietta M. Snowden, colored pencil on paper, Kosovo, 2000.
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Chapter 14

BEHAVIORAL SCIENCE CONSULTATION TO INTERROGATION AND DETENTION OPERATIONS: POLICY, ETHICS, AND TRAINING

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INTRODUCTION

Psychological services provided in support of military operations in Iraq and Afghanistan during the 21st century have been extensive and, as in previous wars the United States has engaged in, psychologists and other behavioral health professionals have been in high demand for clinical and nonclinical services. Prominent areas of focus for clinical and research psychologists and psychiatrists include:

- adjustment to circumstances across the deployment cycle—before, during, and after deployment—for military service members and their families;
- assessment and treatment of neuropsychological sequelae of traumatic brain injury and posttraumatic stress; and
- prevention, detection, and treatment of suicidal behavior.

There has also been an increasing demand for psychologists and other medical personnel closer to the front embedded in war-fighting units to render care and prevention services in theater.

Increasing demand for clinical services has been accompanied by an increasing demand for psychologist support in nonclinical capacities, such as assisting military commanders to achieve strategic goals and facilitate intelligence collection. An important application of psychological science to national security and defense is behavioral science consultation to interrogation and detention operations. This chapter describes the development of the Department of Defense (DoD) doctrine on behavioral science consultation in military detention facilities and training for military personnel serving on behavioral science consultation teams (BSCTs). This developmental process is juxtaposed with that of the American Psychological Association (APA) and other professional associations as they established positions on behavioral science support for interrogation and detention operations.

HISTORICAL AND LEGAL CONTEXT

A prominent feature of defense operations following the terrorist attacks of September 11, 2001 (9/11), compared to military operations in the previous decade, has been an increased demand for and access to intelligence from human sources (ie, human intelligence [HUMINT]) particularly from captured enemy combatants. Not since the first Gulf War (arguably not since the Korean War or World War II) has the US military detained large numbers of enemy combatants and conducted in-depth intelligence interrogations. The increased access to HUMINT from detainees has created a sustained requirement for behavioral science consultation to the intelligence collection process. This relatively new area of practice is very similar to behavioral science consultation provided by psychologists, psychiatrists, and other behavioral scientists in law enforcement activities and correctional facilities.

Before the 9/11 terrorist attacks and the wars in Afghanistan and Iraq, personnel who were organic to the intelligence and special operations communities provided behavioral science consultation to interrogation operations. The psychologists and other personnel who provided behavioral science support were assigned to military or civilian intelligence agencies or military special operations units, or to law enforcement agencies. Since 9/11, the demand for behavioral science consultants (BSCs) to support HUMINT operations required assignment of psychologists, psychiatrists, and behavioral health technicians from other mission areas within the DoD, specifically the Army Medical Department and the Air Force Biomedical Service Corps. As the requirements for personnel increased, the need also increased for establishing policies regarding procedures and training requirements.

Behavioral science consultation to interrogation and detention operations is not traditionally considered part of forensic mental health practice, and its inclusion in this text on military forensic mental health may seem misplaced. As is true of many emerging and actively evolving areas of professional practice, the historical development of that practice influences its categorization; new areas of practice often overlap several existing areas rather than fitting neatly into them, and categorization may shift over time. Behavioral science consultation is a nonclinical activity that often requires a significant paradigm shift for behavioral health professionals in much the same way as forensic applications of behavioral science often demand of clinicians. Yet it has also been considered a natural extension and full expression of the organizational consultation provided by military psychologists.[1] Providing psychological or behavioral science support to national security activities has been considered an area of operational psychology[2,3] and one of the functional areas of psychological support to counterintelligence operations.[4] Many areas of overlap exist with forensic behavioral sciences, particularly that of organizational consultation, and thus its inclusion in this text is warranted.

As this area of practice emerged, various professional associations and the DoD developed policies to clarify the ethical issues and establish boundaries of practice for psychologists and others consulting to intelligence collection and detention operations. Amid much discussion in the professional and lay press, there has been relatively little focus on policy and procedures underlying the provision of this consultation to the intelligence community and the DoD. Fortunately, there is a growing body of literature by professionals actually working in this area and others exploring the underlying science. See Civiello's review of articles in a special issue of *Consulting Psychology Journal: Practice and Research*[5]; sections on operational psychology in edited texts on military psychology[6–8]; and Dr Randy Borum's website for relevant articles.[9] The seminal publication in this area is the report of the Intelligence Science Board (ISB) on the current state of scientific knowledge on interrogation and other methods of HUMINT gathering, *Educing Information–Interrogation: Science and Art—Foundations for the Future*.[10] Chaired by Dr Robert Fein, the ISB's landmark study on educing information was prompted by concerns about US interrogation activities, investigations, and efficacy of current techniques; it is a foundation to any discussion of interrogation support and has had great influence on the DoD policies and training developed in this practice.

DoD policy on behavioral science consultation to detainee operations is built on the doctrinal foundation established in the mid-20th century post–World War II. Several elements are directly relevant, including the Law of Land Warfare, the Geneva Conventions, and the United Nations Convention Against Torture. The purpose of this doctrine is to protect combatants and noncombatants from unnecessary suffering, safeguard the fundamental human rights of persons who become prisoners, and facilitate peace restoration. More than 50 years later, the United States engaged in clarifying—through congressional legislation, Supreme Court rulings, and executive orders—the applicability of Common Article 3 of these conventions, rights of detainees, and definitional standards for the government's authority to detain terrorist suspects.

The US Congress enacted two particular pieces of legislation that established parameters for the interrogation and treatment of detainees in US custody. Provisions in Public Law (PL) 109-148[11] and PL 109-163,[12] which establish basic standards of care for persons in US custody, specifically prohibit cruel, inhuman, and degrading treatment of any person and also require that DoD personnel adhere to the US Army Field Manual (FM) 2-22.3, *Human Intelligence Collector Operations*.[13] These provisions were added to the defense appropriations and authorization bills through amendments introduced by Senator John McCain and have become known simply as "the McCain amendment." They were later enacted as the Detainee Treatment Act of 2005,[11,12] amended and enhanced by the Military Commissions Acts of 2006[14] and 2009[15] and President Obama's 2009 Executive Orders that—among other things—established Common Article 3 as a minimum baseline for detainee treatment in US custody and set into motion reviews of conditions of confinement at Guantanamo and US detention policy options.[16–18] A provision in one of these pieces of legislation, PL 109-163, also instructed the DoD to establish policy that would apply uniformly throughout the armed forces on the role of military behavioral science personnel in interrogations of persons detained by US forces (Title VII, Sec 750).[12]

Several Supreme Court decisions have direct bearing on the relative powers of the President and Congress to fight terrorism and establish policies for detaining wartime captives and suspected terrorists. Provisions of the Detainee Treatment Act of 2005 and Military Commissions Act of 2006, for example, would have eliminated or reduced the federal courts' statutory jurisdiction over detainees' challenges to their detention through seeking writs of habeas corpus. A series of rulings, including *Rasul v Bush*, *Boumediene v Bush*, and *Kiyemba v Obama*, has attempted to clarify rights of detainees to petition federal district courts for habeas review and determine whether federal district courts have authority to release into the United States detainees found unlawfully held. Detention and interrogation policies and practices implemented by the Bush administration during the global war on terror raised many novel legal questions. A complicated interplay among the executive, legislative, and judicial branches ensued as the US government began to address these questions,[19–22] and this discussion should continue to evolve for many years.

DEPARTMENT OF DEFENSE DOCTRINE ON BEHAVIORAL SCIENCE CONSULTATION

The DoD issued a series of documents, including directives, instructions, and policies, during the first decade of the 21st century that describe in increasingly more detail the activities authorized for personnel providing behavioral science support. As the DoD and the US Army Medical Command (MEDCOM) began developing policy for the practice and training of psychologists consulting with interrogators and detention

facility commanders, many professional associations were discussing ethical aspects of such consultation and issuing position papers, which will be covered in a later section. The US Army, the executive agent for detention of enemy combatants, is responsible for developing detailed policies and procedures for how those operations are conducted based on higher level guidance. A full discussion of US doctrine governing detention and interrogation operations is beyond the scope of this chapter, which is focused on behavioral science consultation. However, familiarity with documents such as the directives and FMs concerning these operations is essential for any practitioner in this area.[13,23–28]

Two specific DoD documents give overarching guidance and structure to the practice and training of BSCs, whereas other documents provide more detail. The first of these documents, DoD Directive (DoDD) 3115.09, *Intelligence Interrogations, DoD Debriefings, and Tactical Questioning*, was issued in November 2005, and then updated and reissued in October 2008 and again in October 2012.[26] The directive requires humane treatment for all persons in custody or physical control of DoD and, among its provisions, gives overarching guidance on what BSCs may and may not do. The directive authorizes BSCs "to make psychological assessments of the character, personality, social interactions, and other behavioral characteristics of interrogation subjects, and to advise authorized personnel performing lawful interrogations regarding such assessments."[26(p7)] The directive also prohibits BSCs from certain activities including providing clinical services for detainees except in an emergency; neither may they "be used to determine detainee phobias for the purpose of exploitation during the interrogation process."[26(p7)] This same document establishes that the military departments must allocate resources to ensure that sufficient numbers of personnel are trained and available to conduct intelligence interrogation operations.

A second document, DoD Instruction (DoDI) 2310.08E, *Medical Program Support for Detainee Operations*, was released in June 2006 and provides more specific guidance in one of its appendices on what BSCs are authorized to do and what they are prohibited from doing.[25] DoDI 2310.08E defines BSCs as "health care personnel qualified in behavioral sciences who are assigned exclusively to provide consultative services to support authorized law enforcement or intelligence activities . . . "[25(p2)] It permits assignment of psychologists and physicians to this role, noting that for reasons of personnel management, physicians would not ordinarily be assigned unless qualified psychologists were unavailable to meet critical mission needs. This DoDI also includes prohibitions against BSCs providing healthcare to detainees or staff; and they may not be identified to detainees as providers. For example, the DoDI distinguishes between healthcare personnel who provide behavioral science consultation and those who provide medical/psychological/behavioral healthcare. The prohibition against providing healthcare is specific and unequivocal—it reiterates the prohibition about providing healthcare to detainees or staff except in emergency situations, and it prohibits any identification as providers. BSCs are authorized to observe but not conduct or direct interrogations, and they may advise command on detention facilities, environment, and determinations of release or continued detention.

Besides DoD level policy, Army doctrine addresses the role, limits, and training requirements for BSCs. The US Army issued the latest revision of the official document governing interrogations, FM 2-22.3, *Human Intelligence Collector Operations*, in September 2006.[13] Interestingly, this FM is the only document of its kind that carries the force of law as discussed in the preceding section. The FM authorizes BSCs "to make psychological assessments of character, personality, social interactions and other behavioral characteristics of interrogation subjects, and to advise HUMINT collectors [authorized personnel performing lawful interrogations] of their assessments, as needed."[13(p7–11)] It is important to note that the delineation of the BSCs and HUMINT collector roles includes limits. The FM prohibits torture and inhumane treatment and explicitly lists and defines such behavior. A separate policy document (discussed below) provides the most detailed guidance on behavioral science consultation.

US ARMY MEDICAL COMMAND DOCTRINE

Concurrent with DoD and Department of the Army efforts to clarify the boundaries of behavioral science consultation, MEDCOM also was developing guidelines. MEDCOM intervention was necessitated by the inclusion of military healthcare providers into jobs previously performed only by operational psychologists. Then surgeon general of the Army, Lieutenant General Kevin Kiley, convened a group in the summer of 2005 to develop doctrine in this specialized area. He assembled subject matter experts, including several psychologists and psychiatrists who had served as BSCs, a medical ethicist, a military attorney, a master interrogator, and two general officers who trained and educated military medical personnel. A genuine effort ensued to understand the dynamics of interrogation and intelligence collection and the

implications for health professionals supporting these operations. The group's main discussion centered on professional ethics associated with psychologist and physician involvement in behavioral science support to interrogation and detention operations, in addition to training requirements for health professionals who would engage in this work.

As MEDCOM policy was being developed, the Office of The Surgeon General (OTSG) and MEDCOM actively followed the discussions occurring within APA, the American Psychiatric Association (ApA), and the American Medical Association (AMA). By December 2005 OTSG and MEDCOM had released interim guidelines to provide general guidance for healthcare personnel assigned to BSCTs. The MEDCOM policy on behavioral science consultation, OTSG/MEDCOM Policy Memo 06-029, was issued in October 2006[29]; it was revised and reissued as OTSG/MEDCOM Policy Memo 09-053 in 2010,[30] and again as OTSG/MEDCOM Policy Memo 13-027 in 2013.[31] MEDCOM policy has provided the most specific guidance on personnel and training requirements, mission, objectives, and authorized and prohibited tasks for psychologists and forensic psychiatrists who perform these duties. About one-third of the policy document addresses professional ethics, and appended to the policy are policies and position statements from APA,[32] AMA's Council on Ethical and Judicial Affairs,[33] ApA,[34] and American Academy of Psychiatry and the Law.[35]

The MEDCOM policy mission statement clearly states the BSCT's priorities and purpose and specifies its mission "is to provide psychological expertise and consultation in order to assist the command in conducting safe, legal, ethical, and effective detention facility operations, intelligence interrogations, and detainee debriefing operations."[31(p6)] The qualifiers are placed in a specific order because they parallel the order in which BSCs should consider their activities. All military personnel are required by law and regulation to ensure the safety of detained persons, and thus it is also required of BSCT personnel. The first demand of BSCs listed in the policy memo is to "adhere to applicable US and international law, regulations, and DoD policies, as well as current professional ethical standards with regard to proper and ethical conduct in support of detention facility operations, intelligence interrogations, and detainee debriefings."[31(p7)] This policy document also identifies several categories of personnel who may serve on BSCTs. In early 2002, when one of the first teams supporting military interrogations was established, Dr Michael Gelles and his colleagues coined the term behavioral science consultation team, known by the acronym BSCT and often pronounced "biscuit" (personal oral communication, July 24, 2007). Psychologists, forensic psychiatrists, and behavioral health technicians who must complete specific training in this specialized area comprise BSCTs. These training requirements are covered in a later section.

The MEDCOM policy outlines the concept of operations with specific proscriptions of what BSCs will do:

- Adhere to applicable US and international law, regulations, and DoD policies, as well as current professional ethical standards with regard to proper and ethical conduct.
- Provide consultative services in a manner that supports authorized law enforcement or intelligence activities, including detention facility, interrogation, and debriefing operations in a manner that promotes the safety and security of both detainees and US personnel; are within applicable legal, regulatory, and DoD policy guidelines; are within the individual practitioner's professional ethical guidelines; and increase the effectiveness of the missions.
- Function as special staff to the commander in charge of both detention facility and interrogation operations.
- Report information that constitutes a clear and imminent threat to the lives and welfare of others.
- Become aware of all applicable policies and procedures regarding circumstances for protection, release, and use of detainee medical information.
- Be alert for signs of maltreatment or abuse of detainees and are obligated, as are all personnel, to report any actual, suspected, or possible violations of applicable laws, regulations, and policies, including allegations of abuse or inhumane treatment in accordance with DoDD 5100.77, DoDD 3115.09, DoDD 2110.08E, this policy statement, and any theater-specific guidance.
- Make psychological assessments of the character, personality, social interactions, and other behavioral characteristics of detainees, including interrogation subjects, and, based on such assessments, advise authorized personnel performing lawful interrogations and other lawful detainee operations, including intelligence activities and law enforcement.
- Provide recommendations concerning interrogations of detainees when the interrogations are fully in accordance with applicable law and properly issued interrogation instructions.
- Observe interrogations but under no circumstances be represented as healthcare providers.

- Provide training for interrogators in listening and communications techniques and skills, results of studies and assessments concerning safe and effective interrogation methods, potential effects of cultural and ethnic characteristics of subjects of interrogation, and recognition of resistance techniques and use of counter-resistance measures; and provide training to interrogation and detention facility personnel on such topics as behavioral drift, warning signs, and mechanisms to prevent behavioral drift from developing. Behavioral drift may be understood as a gradually occurring phenomenon in which new, usually unstated and unofficial standards of conduct are established. This shift from acceptable standards may occur quickly and generally involves a progressive, often subtle, and unintended series of actions that deviate from official behavioral standards. It may occur in high stress settings where individuals have power over significant aspects of others' lives, such as prisons. When left unchecked, the combination of the subtle changes may result in wide deviations from acceptable behavior. Ambiguous guidance, poor supervision, and lack of training and oversight contribute to behavioral drift. Careful observation, frequent monitoring, and specific training is necessary to prevent harm to individuals and detriment to mission.[29–31,36,37]
- Advise command authorities on detention facility environment, organization, and functions; ways to improve detainee operations; and compliance with applicable standards concerning detainee operations.
- Consult at any time with the psychology, forensic psychiatry, or medical ethics consultants or the operational psychology consultant to the Army Surgeon General regarding the roles and responsibilities of BSCs and procedures for reporting instances of suspected noncompliance with standards applicable to detainee operations.

Other provisions of the policy prohibit certain activities such as supporting illegal operations, using medical information in a manner resulting in inhumane treatment, providing medical care to staff or detainees except in emergent conditions, and performing any duties they believe to be illegal, immoral, or unethical. These provisions were intentionally made in accordance with historical, legal, ethical, and—some would argue—moral context.

PROFESSIONAL ASSOCIATION STEPS TO PROMOTE ETHICAL PRACTICE OF BEHAVIORAL SCIENCE CONSULTATION

The APA, AMA, and ApA actively debated the ethics of health professional participation in detainee operations during the first decade of the 21st century. These discussions occurred at the same time the intelligence, defense, and justice communities were struggling to comprehend the complex nature of the dangers posed by Al Qaeda and other terrorists, and the challenges associated with this threat. Some professional associations had issued position statements 20 years earlier prohibiting involvement in torture and other cruel behavior, including a Joint Resolution from ApA and APA in 1985[38] and one from the APA the following year.[39] As the conflict in Iraq and Afghanistan continued, resulting in increasingly larger numbers of detained personnel, other professional associations including the American Nurses Association,[40] the British Psychological Society,[41] and the American Anthropological Association[42] issued such resolutions.

Within a year, three major US health professional associations also issued guidance to their members specifically on ethics and interrogations: for psychologists in June 2005,[32] for psychiatrists in May 2006,[34] and for physicians in June 2006.[33] Shortly thereafter, a number of papers compared and contrasted these positions, with some focusing on the similarities and others on the differences of the positions. Stephen Behnke, JD, PhD, director of APA's ethics office, emphasized several similarities and a significant difference between APA's and AMA's positions,[36] whereas Robert M Sade, MD, chair of AMA's Council on Ethical and Judicial Affairs, emphasized critical differences.[43] Dr Behnke noted that the AMA and APA position statements relied on the same ethical analysis resulting in similar rules governing member behavior whereas the ApA position statement did not articulate its conceptual framework and appeared to use a slightly different analysis.

The crux of the AMA and APA analysis centers on two competing ethical obligations—that "psychologists and physicians have ethical responsibilities to the individual under questioning, as well as to third parties and the public,"[36(p66)] while the ApA statement focuses solely on the first principle of responsibility to the individual under questioning. Dr Sade did not take issue with the ethical analysis and focused on the

limits of participation, most specifically the meaning of direct participation, as discussed in the following paragraphs. Balancing obligations to the individual with obligations to society is not a new concept, nor is struggling with this particular ethical dilemma unique to psychological practice in national security. Thomas Grisso provided a succinct and insightful analysis of this ethical issue when he commented on an article and commentary published in the *Journal of the American Academy of Psychiatry and the Law*.[44–46] The relevance for behavioral science consultation to interrogation support of this particularly insightful analysis has been discussed elsewhere,[37] as have other ethical issues arising in the practice of military and operational psychology.[3,47–49]

Despite the differences among the positions, the associations were unequivocal on several points governing rules of behavior: psychologists and physicians never engage in, facilitate, or countenance torture or other cruel, inhuman, or degrading treatment; nor do they participate in interrogations relying on coercion or threats of harm; any support provided to interrogations should be indirect; and psychologists and physicians do not mix the roles of healthcare provider and consultant to interrogator. The associations appear to differ in what constitutes "direct" participation in interrogation—the AMA and ApA guidelines would permit development of general interrogation strategies but not consultation on strategies that may be effective in a specific interrogation, which the APA guidelines would permit.[36,43] Furthermore, "APA frames a role for which psychologists have unique training to fill: the role of observing interrogations in order to guard against 'behavioral drift' on the part of interrogators."[36(p66)] Psychologists' expertise in human behavior and social psychology, specifically the influence of setting and power differentials on human interactions, provides a unique foundation for prevention of behavioral drift through observation and intervention when necessary.

These rules of behavior, which are consistent with US law and Common Article 3 of the Geneva Conventions, are also consistent with requirements to report and to prevent, whenever possible, any suspected abuses. Although the associations differ in the extent of involvement that constitutes direct participation and whether intervention in the interrogation process is acceptable, all agree that support to interrogation may be conducted in an ethical way and that dual loyalties—balancing obligations to the individual and society—must be carefully managed. In the following sections steps taken by several associations to promote ethical practice in this area, including a visit to a major detention facility, are described in more detail.

Visiting the Joint Task Force Station at Guantanamo Bay, Cuba

In October 2005 delegates from several major health and mental health associations, medical ethicists, a journal editor, a university regent, the US surgeon general, and various DoD officials traveled to the Joint Task Force Station at Guantanamo Bay, Cuba (JTF-GTMO) at the request of the former assistant secretary of defense for health affairs, Dr William Winkenwerder Jr. Some of the visiting delegates described their experiences and impressions and noted that the purpose of the visit was not to evaluate or inspect the detention camp, but to learn more about operations and speak with DoD officials and other delegates about appropriate and effective roles of healthcare professionals in detainee operations.[50,51] (The authors, who were not included in the visiting delegation, base their comments here on written accounts of the visit.)

The visitors toured the medical facilities, met with medical and behavioral health personnel providing detainee healthcare, and met with two psychologists who served on the BSCT. Major General Jay Hood, JTF-GTMO's commander of the detention facility and intelligence-collection operations, hosted the visit and briefed the delegates on overall detainee operations, the history of the GTMO detention facilities, threat assessment, medical care provided to detainees, and BSCT operations. The visiting team subsequently met with Dr Winkenwerder to discuss emerging DoD policies for BSC support to intelligence collection and detention operations. The professional association leaders reported their observations, conversations among the visiting team members, and impressions to their associations' governing bodies as part of their deliberations on the issue of support to national security activities.

One of the delegates reported being impressed by Hood's confidence, clarity, and transparency as he "stated emphatically that there will be no torture under his watch, and . . . that they rely on building rapport and developing relationships as the principle [sic] method of interrogation."[50(p3)] Hood and several members of his staff stated that using a relationship-based approach to interrogation was preferable to the harsh techniques that are controversial on moral grounds and have unsubstantiated effectiveness.[50,51] Hood's briefing also addressed the sharp demarcation of roles drawn for psychologists in JTF-GTMO policies, specifically that a psychologist is prohibited from being both a clinician and behavioral science consultant. BSCT personnel and healthcare providers as well as their commanders consistently voiced this demarcation.

American Psychological Association Guidance to Psychologists Working in National Security-Related Activities

APA has adopted a series of policies regarding psychologists' involvement in national security related interrogations, which has been challenging for its membership. APA has expended considerable time and resources from 2004 to the present examining ethical aspects of this practice. Questions about ethics and national security-related activities raised by APA members led to the decision to address the issue at the association level.[52]

APA President Ronald Levant appointed the Psychological Ethics and National Security Task Force (PENS TF) in 2004, and it convened in 2005 before his visit to JTF-GTMO. The board of directors charged the PENS TF—in an action subsequently endorsed by the council of representatives (ie, APA's governing body)—to:

> [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.[32(p1)]

The board of directors did not give the TF an investigative or adjudicating role, and APA did not have resources to conduct an effective investigation (ie, subpoena authority and security clearances). The PENS TF deliberations and report have been discussed in many other forums,[36,52] and only the main points will be reviewed here.

The PENS TF affirmed that the APA Ethics Code applies to psychologists working in national security activities and concluded that the code is "fundamentally sound in addressing the ethical dilemmas that arise in the context of national security-related work."[32(p3)] The PENS TF members, who recognized the ethical complexity of investigations related to national security and acknowledged that such work is conducted in unique settings and constantly evolving circumstances, still agreed on 12 clear statements about psychologists' ethical obligations when conducting this work. The PENS TF endorsed the resolutions against torture that had been issued by the APA 20 years prior (one a joint resolution with the ApA)[38,39] and reiterated that "psychologists do not engage in, direct, support, facilitate, or offer training in torture or other cruel, inhuman, or degrading treatment."[32(p4)] The TF members further agreed that psychologists:

- are both alert to and ethically responsible to report any such acts to appropriate authorities;
- do not use healthcare-related information to the detriment of the individual's safety and well-being;
- do not violate US laws;
- clarify their role if their professional identity or function is ambiguous;
- refrain from engaging in multiple relationships and mixing potentially inconsistent roles such as healthcare provider and interrogation consultant;
- may consult to interrogations and serve in various other national security-related roles, consistent with the ethics code, and should remain cognizant of any special ethical considerations unique to these roles and contexts;
- should remain cognizant that the "individual being interrogated may not have engaged in untoward behavior and may not have information of interest to the interrogator"[32(p7)];
- make clear the limits of confidentiality;
- except in unusual circumstances, do not act beyond their limits of competence;
- are clear on the identity of their client and retain ethical obligations both to their client and to those individuals who are not their clients; and
- consult when facing difficult ethical dilemmas in this challenging and ethically complex area of practice.

The PENS TF drew some other conclusions:

- The best ways to ensure that psychologists' national security-related activities are *safe, legal, ethical, and effective* [italics added] is through "development of professional skills and competencies, ethical consultation and ethical self-reflection, and a willingness to take responsibility for one's own ethical behavior"[32(p8)];
- It is critical to offer ethical guidance and support, especially to psychologists at the beginning of their careers, when they "may experience pressures to engage in unethical or inappropriate behaviors that they are likely to find difficult to resist"[32(p8)]; and
- "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."[32(p9)]

These principles were incorporated into the design and implementation of the training curriculum established by DoD, as discussed in the following section. Finally, the PENS TF called upon psychologists to:

- engage in further research on the effectiveness of applications of psychological science to national security activities; and
- acknowledge the potential areas of tension when conducting classified research or utilizing sensitive methodologies.

In July 2005 APA's board of directors adopted as policy the 12 statements contained in the PENS Report to provide immediate guidance to psychologists engaged in this work. It was intended as an initial step in APA's efforts in this area. At its August 2005 meeting APA's Council of Representatives adopted several of the TF recommendations, including writing a casebook and commentary on the report and exploring mechanisms to provide ethics consultation to psychologists working in national security activities. APA continued to clarify its position in subsequent actions resulting from ongoing dialogue between its membership and leadership. A series of resolutions and amendments adopted between 2006 and 2008 focused on psychologist behaviors that were permitted, required, or prohibited.[53–55] The 2006 resolution reaffirms the absolute prohibition against torture and incorporates the definition of torture from United Nations Conventions. Resolutions passed in 2007 and 2008 further elaborate on the definition of torture, identifying specific techniques such as waterboarding as prohibited, and they endorsed disobedience in the face of an order to engage in torture or cruel, inhuman, or degrading treatment.[52,53] Resolutions adopted in September 2008 and February 2009 clarify settings in which psychologists are prohibited from working in any capacity other than healthcare provider (ie, unlawful detention settings with a focus on national security).[55,56] APA further clarified its position through an amendment to its ethics code in 2010 by adopting language that in cases where law and ethics conflict, a psychologist may not use the code as a defense to human rights violations, and through a consolidation of the various policies in August 2013.[57–59]

In the years since the PENS TF Report and the visit to JTF-GTMO, APA has provided training and guidance in ethical practice in this area to psychologists working in the national security arena. At the APA 2007 annual convention, the board of directors sponsored extensive programming (ie, nine 2-hour sessions with 44 participants with divergent views on appropriate professional roles) to enhance the debate in an open and collegial forum. As part of APA's ongoing efforts to develop strong relationships with psychologists working in national security-related settings, APA's ethics director, Steven Behnke, JD, PhD, provided continuing education workshops and training for psychologists, psychology interns, internship faculty members, and other persons interested in developing professional skills and ethical competencies in supporting national security efforts. These efforts are consistent with the PENS TF and reconciliation policy recommendations to offer ethical guidance and support, particularly to early career psychologists and psychologists working in national security-related settings, and to collaborate with organizations having national security-related responsibilities. All of this is offered to promote psychological practice consistent with APA ethical standards. APA-sponsored continuing education workshops, dialogue in professional publications,[37,60,61] and the consistent involvement of Dr Behnke have helped ensure an ethical focus while supporting the intelligence collection mission. At the time of this writing, publication of a casebook with commentary, and a consultation process whereby psychologists whose work involves classified material may seek ethical guidance, are in progress.

Guidance from the American Medical Association, the American Psychiatric Association, and the American Academy of Psychiatry and the Law

Two major physician associations, the AMA and the ApA, issued policies in 2006 on physician support to interrogations. The Army Medical Department had waited for issuance of these policies before issuing the MEDCOM policy.[62] In 2005 the AMA House of Delegates adopted a resolution on physician participation in interrogation of prisoners and detainees. Among other things, the resolution "directed the [AMA] Council on Ethical and Judicial Affairs to delineate the boundaries of ethical practice with respect to physician's participation in the interrogation of prisoners and detainees."[33(p1)] Issued in June 2006, the resulting report contained five guidelines for physicians that are similar to the APA guidance in several important aspects, including that the association's code of ethics applies to professionals working in this area:

- Physicians may perform physical and mental assessments of detainees to determine the need for and to provide medical care. When so doing, physicians must disclose to the detainee the extent to which others have access to information included in medical records. Treatment must never be conditional on a patient's participation in an interrogation.

- Physicians must neither conduct nor directly participate in an interrogation, because a role as physician–interrogator undermines the physician's role as healer and thereby erodes trust in the individual physician-interrogator and in the medical profession.
- Physicians must not monitor interrogations with the intention of intervening in the process, because this constitutes direct participation in interrogation.
- Physicians may participate in developing effective interrogation strategies for general training purposes. These strategies must not threaten or cause physical injury or mental suffering and must be humane and respect the rights of individuals.
- When physicians have reason to believe that interrogations are coercive, they must report their observations to the appropriate authorities. If authorities are aware of coercive interrogations but have not intervened, physicians are ethically obligated to report the offenses to independent authorities that have the power to investigate or adjudicate such allegations.[33(p212–213)]

The Council on Ethical and Judicial Affairs also addressed the issue of balancing obligations to individuals to obligations to society in a way similar to the APA's analysis, focusing on forensic psychiatrists as distinct from other physicians in this point:

- Some physicians, most often forensic psychiatrists, may engage in activities that are closely linked to interrogations . . . Physicians sometimes provide consultations to law enforcement officers regarding fruitful approaches to interacting with suspects, for example, in criminal profiling and hostage negotiations.[33(p209)]
- Physicians have long dealt with problems of dual loyalties in forensic roles and as employees of government and business. The same ethical considerations that guide physicians under those circumstances also guide them in matters related to interrogation . . . Questions about the ethical propriety of physicians participating in interrogations and in the development of interrogation strategies may be addressed by balancing obligations to society against those to individuals.[33(p212)]

In May 2006 ApA issued a position statement, which was much briefer (three paragraphs) and contained less discussion of its conceptualization and analysis.[34] ApA's position is consistent with other associations about prohibition on torture and reporting any suspected abuse and the clear demarcation of the roles of healthcare provision and interrogation support. However, it differs on a third significant point: rather than deriving its position from a balance of competing obligations to individuals (do no harm) and to society (by preventing harm), it emphasizes the former, almost to the exclusion of the latter. The statement reads as follows:

- Psychiatrists should not participate in, or otherwise assist or facilitate, the commission of torture of any person. Psychiatrists who become aware that torture has occurred, is occurring, or has been planned must report it promptly to a person or persons in a position to take corrective action.[34(para1)]
- Psychiatrists providing medical care to individual detainees owe their primary obligation to the well-being of their patients, including advocating for their patients, and should not participate or assist in any way, whether directly or indirectly, overtly or covertly, in the interrogation of their patients on behalf of military or civilian agencies or law enforcement authorities.[34(para2b)]
- No psychiatrist should participate directly in the interrogation of persons held in custody by military or civilian investigative or law enforcement authorities, whether in the United States or elsewhere. Direct participation includes being present in the interrogation room, asking or suggesting questions, or advising authorities on the use of specific techniques of interrogation with particular detainees. However, psychiatrists may provide training to military or civilian investigative or law enforcement personnel on recognizing and responding to persons with mental illnesses, on the possible medical and psychological effects of particular techniques and conditions of interrogation, and on other areas within their professional expertise.[34(para3)]

This prohibition against consulting on the interrogation of individual detainees would essentially prevent effective consultation to interrogation operations. However, it was not considered "an ethical rule," according to the ApA president Dr Steven Sharfstein, who maintained that the position statement would not be used to sanction its members for ethical violations for failing to follow the guideline.[62]

Forensic psychiatrists may find additional guidance from the ApA's *The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry*[63]; *The Ethics Primer of the American Psychiatric Association*[64] (particularly the chapter devoted to ethics and forensic psychiatry); and the American Academy of Psychiatry and the Law's *Ethics Guidelines for the Practice of Forensic Psychiatry*.[35] Although these guidelines do not directly address physician involvement in behavioral science consultation to interrogation and detention operations, the analysis presented in the American Academy of Psychiatry and the Law guidelines acknowledges that psychiatrists in a forensic role are called upon to practice in a manner that balances competing duties to the individual and to society. The conceptualization presented therein elaborates the relevant ethical principles of beneficence, nonmalfeasance, autonomy, confidentiality, justice, and social responsibility, and it may be helpful to psychiatrists working in national safety and security.

MEDICAL COMMAND TRAINING PROGRAM FOR BEHAVIORAL SCIENCE CONSULTANTS

The BSCT training curriculum was developed by a panel of subject matter experts from the civilian and military intelligence, forensic, behavioral science, and national security communities over 6 months, based on the requirements established during OTSG's 2005 Summit and guidance set forth by the DoD and MEDCOM. Army, Navy, and Air Force psychologists collaborated closely with personnel from other DoD agencies and ISB members to develop and implement the program. These DoD agencies included the US Special Operations Command, Counterintelligence Field Activity, US Air Force Office of Special Investigations, Joint Personnel Recovery Agency, Intelligence and Security Command, and the Criminal Investigation Task Force. From the earliest stages, professional ethics and law were significant components of the curriculum development process; APA's ethics director and staff judge advocates (attorneys) with expertise in law relative to interrogations and detention operations were consulted to ensure concordance with the ethics and the law.

One of the key concepts of the BSCT training program is being grounded in a center of excellence model, capable of incorporating relevant science and evidence-based best practices to the maximum extent possible. A key premise of the MEDCOM-established training program is that relationship-based approaches to interrogation are more effective because they yield more reliable information than aggressive or coercive approaches. The training underscores the value of understanding the culture and mindset of the individual being interrogated and applying a systematic approach rather than an application of techniques. It is understood that the BSC would not conduct or manage an interrogation, but would be a resource to the interrogator or other members of the interrogation team that might include an analyst, translator, and/or cultural advisor. The model stresses viewing the interrogation process as developing a climate of cooperation or "operational accord" through a strategic approach, and valuing the use of a multidisciplinary team operating within a coordinated systems framework. As one civilian interrogator working for the DoD described her work, "interrogations are about gathering breadth or depth of information. It is not about getting to a single moment of a confession . . . If I am talking to a bomb-maker, I am not trying to get him to tell me he is a bomb-maker. I want him to tell me what students he trained, what their nationalities are, what materials he used and who was funding the project."[65(p3)] Other sources provide fuller discussions of relevant science and the relationship-based approach to interrogations.[10,66,67]

The BSCT training program is composed of an interactive distance learning phase and a resident phase of instruction, including both didactic and practical exercises, in addition to the training all military personnel receive in detainee operations. The distance-learning segment of the BSCT training program takes approximately 40 hours during the month preceding the intensive 3-week resident phase. The sequence of readings, videos, and didactic instruction to impart knowledge and stimulate thinking, followed by practical exercises in the field and role-playing scenarios, provides progressively more complex challenges to the BSCT students. The practical training activities provide opportunities for students to apply what they have learned in preparation for this complex, highly visible, and politically charged mission that often requires a paradigm role shift from healthcare provider to command consultant.

Training includes instruction in the following topics:

- US and international law, regulations, and DoD policy and mechanisms to keep abreast of those legal actions and policy decisions that are rendered during an assignment;
- applicable ethical standards for psychologists or psychiatrists including discussions of common ethical issues and how to resolve ethical conflicts;
- fundamentals of US Army doctrine on detainee operations, intelligence interrogation, and detainee debriefing operations,

including structure, organization, and functions of DoD military intelligence, as well as reporting mechanisms and systems, nomenclature and missions of military intelligence personnel, and security classification guidelines;
- psychological science on social processes that may lead to detainee abuse including such concepts as moral disengagement, behavioral drift, oversight, and control processes that may reduce the incidence of abuse, as well as research on social effects of disparate power relationships;
- indirect and observational assessment of detainees;
- instruction and role playing in behavioral science consultation to the interrogation process that emphasizes application of a relationship-based model of interviewing detained persons;
- cultural, religious, and ideological issues regarding the specific populations under consideration, eg, history of Islam, development of radical Islam and extremism, and the impact of cultural issues on detention operations; and
- education on the missions and roles of various US government departments and agencies, foreign government organizations, and non-governmental organizations present in the theater of operations.[31]

Another key concept that results from basing the BSCT training program in a center of excellence model is that it is capable of ensuring that the course remains flexible and responsive to changing mission requirements as well as the evolving evidence base. This requires incorporating experiences of BSCs returning from deployment and using that feedback to inform curriculum updates, and staying current with the science of educing information and interrogation best practices through continued involvement with the ISB and other civilian and military intelligence subject matter experts. Implementation of the training program fosters mentorship of younger BSCs by more seasoned and experienced consultants through networking, training, and remaining available for support and consultation. As noted, a significant result of the premise that the training, and the practice, should be grounded in the best available science was the incorporation of a model for consultation to rapport-based or relationship-based interrogation. Although some aspects of the training have shifted, this provision remained constant from its inception.

CONCLUSION

The first decade of the 21st century brought unprecedented demands on national safety and security operations. For the first time in half a century, the United States faced an extraordinary threat requiring detention of large numbers of enemy combatants, unprecedented reliance on HUMINT collection, and counterintelligence/counterterrorism strategies. To say that the country was unprepared for these challenges is not an understatement. Many troops and their commanders were placed in situations for which they had little training or expertise. Defense agencies and service members, congressional oversight committees, investigative journalists, and other Americans struggled to understand and find meaning in atrocities such as those occurring at the Abu Ghraib detention facility. As the number of detainees held by US forces increased, allegations of abuse of these detainees began to reach the public. It was natural that the role of psychologists in supporting interrogations would come under increasing scrutiny while training programs and safeguards were being implemented to prevent any further occurrences of activities the American people found morally reprehensible.

Unfortunately, psychologists' preventative value in this arena of interrogation and detention operations only became truly clear as the abuse of detainees came to world attention. The military's awareness and investigation of abuses began in the fall of 2003, well before the cases were reported in the lay press in April 2004. By the time the Honorable James Schlesinger, chair of the Independent Panel to Review DoD Detention Operations, released his report in August 2004, the panel noted that 155 investigations into allegations of abuse had been completed as well as 11 comprehensive investigations.[68] Not long after the first investigations were initiated, military psychologists became seen as critical in assisting commanders in preventing abuse, partly based on their training in social psychology and group processes: dynamics of human interaction, psychological and environmental factors in situations involving power differentials, such as the phenomena of moral disengagement and behavioral drift; the significance of oversight and control processes in preventing abuse from occurring in situations of disparate power relationships; parameters of indirect and observational assessment; and the importance of understanding cultural traditions and context. Reports

from congressional inquiries, DoD investigations, general counsel inquiries, first person accounts, and civilian investigative reporting found that military psychologists have repeatedly criticized harsh techniques and contributed to the overall safety and effectiveness of interrogation operations.[69–74]

It is expected that national security operations will increasingly rely on behavioral science professionals to apply their unique expertise, notably in activities involving HUMINT collection and detention. In fact, a comprehensive review of detainee confinement conditions at Guantanamo Bay Naval Base resulted in a strong endorsement of BSCs. President Obama's Executive Order 13492 initiated the review to ensure that all detainees were being held in conformity with applicable laws including Common Article 3 of the Geneva Conventions.[17] The compliance review specifically addressed management and activities of healthcare personnel including those assigned as BSCs and found that "conditions are in compliance with Common Article 3 of the Geneva Conventions. No prohibited acts were found and conditions are humane."[71(p60)] The report went on to "strongly recommend . . . [that DoD] sustain BSC resources to ensure continued mission support to Joint Detention Group (JDG) Commander and, to a lesser extent, the Joint Intelligence Group (JIG) Director [and to] continue to have Behavioral Science Consultants observe and support the separation of medical information from intelligence operations and continue to provide behavioral consultation aimed at optimizing the safety of the camps."[71(p60)] Finally, the report recommended that DoD "dedicate two Behavioral Science Consultants solely to provide psychological consultation to the CJDG, JIG and CJTF in order to support safe, legal, ethical and effective detention and interrogation operations at JTF-Guantanamo."[71(p60)]

Health professionals working in national security-related activities and military operations must develop a skill set to ethically work through complex situations, often in an evolving legal and political environment. These professionals must prepare themselves with adequate training, be cognizant of practicing within their scope of competence, and develop resources for reach-back and consultation when questions arise. They must answer for themselves and others whether their actions are within legal, ethical, and moral boundaries, while engaged in these activities just as in every other aspect of their professional work. There have been systemic, multidisciplinary efforts by the US government and the professional associations over the past decade to address the appropriate parameters for behavioral science support to national security activities, including those involving detention and interrogation operations. Administration policies related to armed conflict and interrogation of detainees has confounded the public opinion and understanding of the role undertaken by the BSCs. It is hoped that the information provided in this chapter will facilitate the safe, legal, ethical, and effective provision of those services and lead to further constructive discussion regarding this emerging area of professional practice.

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