

Neuropsychiatric evidence of waterboarding and other abusive treatments

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In 2004, the news that Americans had committed abuse and mistreatment in Abu Ghraib and Guantánamo was shocking. Even more alarming, were the revelations that physicians, psychiatrists, and other mental health professionals had assisted with interrogations that bordered on torture. In the span of just two generations, the United States had drifted from condemning Nazi physicians at the Nuremberg Trials for their collusion with torture, inhuman experimentation, and cruel mistreatment to justifying waterboarding in the pursuit of better intelligence.

As a retired US brigadier general and army psychiatrist, committed to a strong military and national defense, I find these scandals to be most disturbing. The complicity of psychiatrists and other physicians clearly deviates from the fundamental ethical principles of the medical profession and military medicine. My generation of soldiers, who had served during the Vietnam War, vowed not to repeat the misdeeds of the My

Lai massacres and rampant indiscipline we witnessed.

After the attack on the World Trade Towers, fear and anger dominated the country's emotional climate and the principles of our profession were hijacked. The incessant drumbeat of political rhetoric that 'the war on terror is a war like no other' and that 'we must take all measures possible to stop the enemy,' made it somehow easier for psychiatrists and other physicians to apply their skills and training to exploit the vulnerabilities of prisoners. To this day, former US government officials justify cruel and inhuman treatment of detainees at Bagram and Guantánamo with unsubstantiated assertions that their confessions led to the trail of Osama bin Laden. The public supported such conduct, and the television show '24' gained wide popularity as viewers were captivated by threats of violence and new gimmicks for bringing the bad guys down. Even the Presidential candidates in 2008 were ambushed by questions that judged their fitness to be Commander-in-Chief by their willingness to torture a suspect who planted a "ticking bomb."

But, there is no evidence to confirm the assertions that torture of prisoners has helped the war effort at all.

Direct clinical evidence of the real value or effects of waterboarding and as-

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sociated abusive treatments of detainees is limited. The public records refer to only three detainees who are currently classified as high-value at the Guantánamo Detention Facility, and their medical records are not available. Discerning the direct effects of waterboarding on their state of mind has been constrained without the possibility of direct examination including mental status evaluation.

Research studies, direct clinical observations, and reviews of medical records document the adverse and harmful impact of tactics associated with enhanced interrogation. Sleep manipulation contributes to cognitive impairment and disruption, with psychotic features emerging within one week, and can lead to self-harm, including symptoms resembling paranoid schizophrenia. Sensory deprivation, including hooding and isolation, leads to severe anxiety, depression, and psychotic-like thinking with serious health consequences. Repetitive exposure to frightening and life-threatening circumstances contributes to debilitating post-traumatic stress disorder (PTSD). Victims of abusive interrogation suffer with anxiety and depressive disorders, manifest brief psychotic disorders, including delusions and hallucinations, develop obsessive-compulsive disorder, and are moved to the brink of suicide. Many are demoralized and hopeless. The combined techniques of sleep manipulation, social isolation, and sensory bombardment with loud music can lead to vivid imagery approaching hallucinatory and delusional processes, body image distortion, temporal disorientation, and cognitive impairment.¹ Statements made by detainees in an impaired mental state when interrogated have not been admissible in court proceedings.²

Many detainees (whom I have interviewed or reviewed their medical records) subjected to abusive treatments suffer with

signs and symptoms of PTSD. It is likely that their conditions and state of mind were either induced or aggravated by being subjected to abusive treatment that simulated and resembled waterboarding.

Truthfully, we don't know, and probably will never know, the facts about waterboarding and psychologically based abusive interrogation practices. The findings and details of the interrogations are closely held secrets. High-level government officials have asserted that such 'aggressive' techniques have worked, and that the agencies have secured invaluable information.

Nonetheless, the guidelines published by the Office of Medical Services (OMS) of the US Central Intelligence Agency recognized the inherent dangers of waterboarding and other stress-inducing tactics. The OMS warned that waterboarding creates risks of drowning, hypothermia, aspiration pneumonia, or laryngospasm; that cramped confinement could result in deep vein thrombosis; and that death could result from lengthy exposure to cold water. The Agency nevertheless approved these and all other methods then in use so long as "limitations" were employed to seek to prevent death and avoid permanent physical impairment. These limitations included durational limits for exposure to a specified temperature, either up to the time when hypothermia would be expected to develop or upon evidence of hypothermia; food intake reductions until the detainee lost 10% of body weight or evidence of significant malnutrition appeared; and exposure to noise just under the decibel levels expected for permanent hearing loss. They advised that emergency resuscitation equipment be available when waterboarding was employed. The guidelines noted that stress positions were permitted up to 48 hours so long as the hands are no higher than the head and the detainee's weight

is borne by the lower extremities and pre-existing injuries were not aggravated. They approved confinement in a box within time limits but for the larger box allowed 8 consecutive hours and 18 hours per day.³

The use of stress-inducing and psychological techniques in torture and abuse challenge the practice of forensic medicine. Forensic specialists called to assess the cases encounter difficulty in validating allegations of torture and abuse. Despite the potential dangers, the evidence of mistreatment is ambiguous and subtle. There are no findings or evidence that confirm having been subjected to waterboarding or having suffered a brief psychotic episode secondary to sleep deprivation. Few, if any, laboratory or radiologic tests can confirm a history of psychological or stress-inducing torture. The burden falls on forensic medical specialists to become familiar with the application of stress-inducing tactics and their effects. In time, developments in neurosciences may provide better tools for assessment and diagnosis of psychologically based torture and mistreatment.

In truth, the use of torture and practices of cruel, inhuman, and degrading treatment detract from the military mission and compromise the political and social stature of the countries and entities who indulge the practices. Torture and abuse harms the victims, damages the perpetrators, and weakens national security. Nonetheless, torturers and perpetrators sadly have become more sophisticated and increasingly use stress-inducing tactics that inflict physical harm without leaving scars and telltale markings. Even though the signs of the mistreatment are less visible, the victims are no less damaged.

Recently, Physicians for Human Rights (PHR) has initiated training on the Istanbul Protocol to improve assessment and treatment of victims of torture, especially those subjected to extreme stress. PHR's goal for

the Istanbul Protocol Plan of Action is to provide States a roadmap for the implementation of standards for the effective investigation and documentation of torture and cruel, inhuman and degrading treatment or punishment. PHR proposes that providing comprehensive training to medical, judicial, and police officials in States can expand awareness and understanding of the stress-inducing practices that do not leave visible physical marks and scars. An underlying principle is that physical and psychological responses to the infliction of severe physical and mental pain vary considerably among individuals. The act of attempting to inflict severe physical and/or mental pain, alone, imputes the intent of torture and/or ill treatment; it does not require material medical (physical and/or psychological) evidence. For example, the act of attempting to asphyxiate an individual constitutes torture, and does not require specific physical and/or psychological evidence to be validated. Although physical and psychological evidence of torture and ill treatment may persist for years and even a lifetime, some symptoms and disabilities may resolve or diminish over time, and some forms of torture may not result in measurable physical and psychological evidence. The absence of physical and/or psychological evidence of alleged torture and ill treatment should not be construed to mean that torture and ill treatment did not take place.

Our nation has regarded waterboarding as torture and cruel, inhuman, and degrading treatment since the late 19th century. There is no question about it – waterboarding inflicts serious physical harm – and it inflicts serious psychological damage. It has no place in the armamentarium of effective interrogation.

Forensic medicine experts and physicians bear a special burden in opposing the odious

effects of torture and cruel, inhuman, and degrading treatment. Standing up for human rights has come front and center both as a matter of national strategy and measure of human decency. Historically, the human rights stance against torture has been unequivocal, one of the few absolutes in human rights law: It is never permitted, never excused, never to be balanced against national needs or interests – even in cases of national emergency. Torture is forbidden under the laws of war. It is considered a war crime under the Geneva Conventions.⁴

To some, the “ticking bomb” scenario is an exception to these rules and standards. But there should be no exceptions. The “ticking bomb” is fictitious and a tool for campaign rhetoric. The scenario evokes fear to rationalize an “anything goes” mentality to “hunt those guys down.” It induces terror to defend against terror and hijacks reasoned conversation and calm deliberation. Psychiatrists and forensic experts have the tools to defang the perpetrators of terror and torture.

This is not a question about law or even medical standards of care. What is at stake in this discussion is the moral stature and respect of our nation across the globe. The United States of America engaged on a ‘war against terrorism’ ostensibly to signal to the world that, as a free democracy, we live by and uphold higher standards and moral values. The cost to civilized nations – to their prestige, and to the safety and welfare of their soldiers and citizens – is much too high to rationalize endorsing waterboarding or any other cruel, inhuman, or degrading treatment as a standard. Such practices defile the very core of our principals and values as physicians and professionals dedicated to healing.

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