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Psychologists and the Use of Torture in Interrogations

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This article argues that psychologists should not be involved in interrogations that make use of torture or other forms of cruel, inhumane, or degrading treatment. The use of torture is first evaluated in light of professional ethics codes and international law. Next, research on interrogations and false confessions is reviewed and its relevance for torture-based interrogations is explored. Finally, research on the negative mental health consequences of torture for survivors and perpetrators is summarized. Based on our review, we conclude that psychologists' involvement in designing, assisting with, or participating in interrogations that make use of torture or other forms of cruel, inhumane, or degrading treatment is a violation of fundamental ethical principles, a violation of international and domestic law, and an ineffective means of extracting reliable information. Torture produces severe and lasting trauma as well as other negative consequences for individuals and for the societies that support it. The article concludes with several recommendations about how APA and other professional organizations should respond to the involvement of psychologists in interrogations that make use of torture or other forms of cruel, inhumane, or degrading treatment.

The United States and its military should immediately ban the use of torture, and psychologists should be expressly prohibited from using their expertise to plan, design, assist, or participate in interrogations that make use of torture and other forms of cruel, inhumane, or degrading treatment. The use of torture as an

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interrogation device is contrary to ethical standards of conduct for psychologists and is in violation of international law. Torture is ineffective as a means of extracting reliable information, and likely leads to faulty intelligence. Torture has long-term negative consequences for the mental health of both survivors and perpetrators of torture. The use of torture has far-reaching consequences for American citizens: it damages the reputation of the United States, creates hostility toward our troops, provides a pretext for cruelty against U.S. soldiers and citizens, places the United States in the company of some of the most oppressive regimes in the world, and undermines the credibility of the United States when it argues for international human rights.

1. Torture as a Violation of Professional Codes of Conduct

The American Psychological Association's *Ethical Principles of Psychologists and Code of Conduct* encourages psychologists to, " ... strive to benefit those with whom they work and take care to do no harm" (APA, 2002). These guidelines incorporate *basic principles* or *moral imperatives* that guide behavior as well as specific *codes of conduct* describing what psychologists *can* or *cannot* do (Gauthier, 2005) and are, therefore, directly applicable to the participation of psychologists in torture or in interrogation situations involving harm. Psychologists, physicians, and other health and mental health professionals are also guided by international and inter-professional codes of ethics and organizational resolutions, such as the 1985 joint statement against torture issued by the American Psychiatric Association and the American Psychological Association (APA, 1985). In 1986, the American Psychological Association passed a *Resolution against Torture and Other Cruel, Inhuman, or Degrading Treatment* (APA, 1986). Both statements "condemn torture wherever it occurs."

The International Union of Psychological Science (IUPsyS), the International Association of Applied Psychology (IAAP), and the International Association for Cross-Cultural Psychology (IACCP) are collaborating in the development of a Universal Declaration of Ethical Principles for Psychologists. They have identified "principles and values that provide a common moral framework ... [to] "guide the development of differing standards as appropriate for differing cultural contexts"(www.am.org/iupsys/ethintro). An analysis of eight current ethical codes identified across multiple continents revealed five cross-cutting principles: (1) respect for the dignity and rights of persons, (2) caring for others and concern for their welfare, (3) competence, (4) integrity, and (5) professional, scientific, and social responsibility (Gauthier, 2005). Sinclair (2005) traced the origins of these eight codes to 12 documents including the Code of Hammurabi (Babylon, circa 1795–1750 BC), the Ayurvedic Instruction (India, circa 500–300 BC), the Hippocratic Oath (Greece, circa 400 BC), the (First) American Medical Association Code of Ethics (1847 AD), and the Nuremberg Code of Ethics in Medical Research

(1948 AD) (Sinclair, 2005). Among the ethical principles proposed as universal for all psychologists is that they "uphold the value of taking care to do no harm to individuals, families, groups, and communities."

A wide range of declarations, conventions, and principles govern the conduct of doctors and all health professionals in the context of torture (e.g., the World Medical Association's (1975) Tokyo Declaration), including the establishment of international standards for medical assessments of allegations of torture (e.g., the *Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (Istanbul Protocol)*, United Nations, 1999). Specific restrictions prohibiting the participation of medical personnel in torture and degrading interrogation practices were established in the 1982 United Nations' "*Principles of Medical Ethics* (United Nations, 1982)." The World Medical Association (1975) has also established that it is not ethically appropriate for physicians or other health professionals to serve as consultants or advisors in interrogation.

Psychologists can find themselves in contexts where expected professional and ethical conduct and the protection of human rights conflict with compliance with government policies and practices. A 2002 report of Physicians for Human Rights described this "dual loyalty" now confronting a growing number of health professionals within and outside of the Armed Forces. This tension is particularly acute when such policies and practices run counter to international declarations, laws, and conventions that protect human rights (see, for example, the report of Army Regulation-15, 2005).

2. Torture as a Violation of Law

As citizens, psychologists in the United States are required to observe a wide range of international and national treaties, conventions, and laws that prohibit torture. The *Universal Declaration of Human Rights* (United Nations, 1948) and the *International Covenant on Civil and Political Rights* (United Nations, adopted in 1966, entered into force, 1976), alongside six other core international human rights treaties, constitute an international "bill of human rights" that guarantees freedom from torture and cruel, inhuman, or degrading treatment (see Article 5 of the Universal Declaration on Human Rights).

Article 1 of the UN *Convention against Torture and other Cruel, Inhuman or Degrading Treatment (CAT),* (United Nations, 1984, 1987), which was signed by the United States in 1988 and ratified in 1994, defines torture during interrogation as:

> Any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession . . . when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.

Article 2 (2) of the Convention outlines specific additional prohibitions and obligations of states that: "No exceptional circumstances whatsoever, whether a state of war or a threat of war, internal political instability or any other public emergency, may be invoked as a justification of torture." (A listing of a range of relevant UN treaties, declarations, etc. is available at www.ohchr.org/english/law/index.htm).

Multiple U.S. laws and resolutions, including the U.S. Bill of Rights, the U.S. Constitution, and the joint congressional resolution opposing torture that was signed into law by President Reagan on October 4, 1984 (United States Congress, 1984), prohibit cruel, inhuman, or degrading treatment or torture. Other conventions to which the United States subscribes prohibit any form of torture as a means of gathering information in times of war (see, for example, the *Geneva Conventions* (1949) and the *European Convention (1989)* relative to the treatment of prisoners of war and to the prevention of torture. In this tradition, Senator John McCain's Amendment (section 1403 of H.R. 1815), approved by the U.S. Congress and signed by President Bush at the end of 2005, prohibits torture and cruel, inhumane, and degrading treatment. However, President Bush's less widely publicized accompanying "signing statement" indicated that he would interpret the law in a manner consistent with his presidential powers, reigniting debate in many circles within and beyond government. The inconclusiveness of debates among branches of government, and the condemnation of the United States's treatment of prisoners at Guantánamo and Abu Ghraib by foreign governments as well as the UN Committee Against Torture, underscore the urgent need to clarify ethical guidelines for psychologists.

3. Research on Interrogations and the Utility of Torture as an Interrogation Tool

Although the primary purpose of torture is to terrorize a group and break the resistance of an enemy (Scarry, 1985; Conroy, 2000), the use of torture is frequently justified as an interrogation device. However, there is no evidence that torture is an effective means of gathering reliable information. Many survivors of torture report they that would have said anything to "make the torture stop" (Mayer, 2005; McCoy, 2006). Those who make the claim that "torture works" offer as evidence only unverifiable anecdotal accounts. Even if there are cases where torture may have preceded the disclosure of useful information, it is impossible to know whether less coercive forms of interrogation might have yielded the same or even better results.

Because torture-based interrogations are generally conducted in secret, there is no systematic research on the relationship between torture and false confessions. However, there is irrefutable evidence from the civilian criminal justice system that techniques *less coercive* than torture have produced verifiably false confessions in

a surprising number of cases (Costanzo & Leo, 2007; Kassin & Gudjonsson, 2004). An analysis of DNA exonerations of innocent but wrongly convicted criminal suspects revealed that false confessions are the second most frequent cause of wrongful convictions, accounting for 24% of the total (see www.innocenceproject.org). In a recent large-scale study, Drizin and Leo (2004) identified 125 proven false confessions over a 30-year period. Two characteristics of these known false confessions are notable. First, they tended to occur in the most serious cases—81% confessed to the crime of murder, and another 9% confessed to the crime of rape. Second, because only *proven* false confessions were included (e.g., cases where the confessor was exonerated by DNA evidence or cases where the alleged crime never occurred), the actual number of false confessions is likely to be substantially higher. Military action based on false information extracted through the use of torture has the potential to jeopardize the lives of military personnel and civilians.

The defining feature of an interrogation is the presumption that a suspect is lying or withholding vital information (Inbau, Reid, Buckley, & Jayne, 2001). If torture is an available option, interrogators are likely to resort to torture when they believe a suspect is lying about what he or she knows or does not know. However, there is no reason to believe that interrogators are able to tell whether or not a suspect is lying. Indeed, there is considerable research demonstrating that trained interrogators are *not* accurate in judging the truthfulness of the suspects they interrogate. Overall, people with relevant professional training (e.g., interrogators, polygraphers, customs officers) are able to detect deception at a level only slightly above chance (Vrij, 2004; Vrij & Mann, 2001; Garrido, Masip, & Herrero, 2004). Moreover, some researchers have identified a troubling perceptual bias among people who have received interrogation training—an increased tendency to believe that others are lying to them (Meissner & Kassin, 2002; Masip, Alonso, Garrido, & Anton, 2005). In addition, although specialized training in interrogation techniques does not improve the ability to discern lying, it does increase the confidence of interrogators in their ability to tell whether a suspect is lying or withholding information (Kassin & Fong, 1999). The presumption that a suspect is lying, in combination with the overconfidence produced by interrogation training, leads to a biased style of questioning which seeks to confirm guilt while ignoring or discounting information that suggests that a suspect is being truthful (Kassin & Gudjonsson, 2004). There is also evidence that interrogators become most coercive when questioning innocent suspects, because truthful suspects are regarded as resistant and defiant (Kassin, Goldstein, & Savitsky, 2003). Thus, interrogators may be especially likely to resort to torture when faced with persistent denials by innocent suspects. Under such conditions, torture may be used to punish a suspect or as an expression of frustration and desperation on the part of the interrogator. More broadly, there is substantial evidence that judgments about others are influenced by conscious and nonconscious stereotyping and prejudice (Dovidio & Gaertner, 1997). Prejudice may lead interrogators to target suspects

for torture based on physical appearance, ethnicity, or erroneous stereotypes about behavioral cues.

Unless local authorities (e.g., commanders in charge of a military detention facility) explicitly prohibit the use of torture in interrogations, the risk of torture will be unacceptably high. Decades of research by social psychologists has demonstrated that strong situational forces can overwhelm people's better impulses and cause good people to treat others cruelly (Ross & Nisbett, 1991). These forces include the presence of an authority figure who appears to sanction the use of cruelty (e.g., Milgram, 1974), and a large power disparity between groups, such as the disparity that exists between prisoners and guards (Haney, Banks, & Zimbardo, 1973). In addition, the dehumanization and demonization of the enemy that occurs during times of intense group conflict—particularly during times of war—reduce inhibitions against cruelty (Waller, 2002). All of these conditions, combined with the stresses of long-term confinement, appear to have been present at Abu Ghraib. The well-documented reports of torture at the Abu Ghraib and Guantanamo Bay facilities serve as disturbing reminders that it is essential for military authorities to issue clear directives about unacceptable practices in the interrogation of prisoners (Fay, 2004; Physicians for Human Rights, 2005; Center for Human Rights and Global Justice, 2006). These directives need to be combined with effective monitoring of military detention facilities, especially during times of war.

In an effort to circumvent ethical concerns and the lack of evidence about the effectiveness of torture, advocates of the use of torture often resort to hypothetical arguments such as the "ticking time bomb scenario" (e.g., Dershowitz, 2003). This frequently used justification for the use of torture as an interrogation tactic presupposes that the United States has in its custody a terrorist who has knowledge of the location of a time bomb that will soon explode and kill thousands of innocent people. Embedded in this implausible scenario are several questionable assumptions: that it is known for certain that the suspect possesses specific "actionable" knowledge that would avert the disaster; that the threat is imminent; that only torture would lead to the disclosure of the information; and that torture is the fastest means of extracting valid, actionable information. Of course, this scenario also recasts the person who tortures as a principled, heroic figure who reluctantly uses torture to save innocent lives. While this scenario might provide a useful stimulus for discussion in college ethics courses, or an interesting plot device for a television drama, we can find no evidence that it has ever occurred and it appears highly improbable.

4. The Effects of Torture on Survivors and Perpetrators

Torture is one of the most extreme forms of human violence, resulting in both physical and psychological consequences. It is also widespread and occurs

throughout much of the world (Amnesty International, 2006). Despite potentially confounding variables, including related stressors (such as refugee experiences or traumatic bereavement), and comorbid conditions (such as anxiety, depression, or physical injury), torture itself has been shown to be directly linked to post-traumatic stress disorder (PTSD) and other symptoms and disabilities. The findings from both uncontrolled and controlled studies have produced substantial evidence that for some individuals, torture has serious and long-lasting psychological consequences (Basoglu, Jaranson, Mollica, & Kastrup, 2001; De Jong, 2001; Silove, Steel, McGorry, Miles, & Drobny, 2002; Thapa, Van Ommeren, Sharma, DeJong, & Hauff, 2003).

Most trauma experts—including survivors of torture, mental health researchers, and therapists—agree that the psychiatric diagnosis of PTSD (American Psychiatric Association, 1994) is relevant for torture survivors. However, these same experts emphasize that the consequences of torture go beyond psychiatric diagnoses. Turner and Gorst-Unsworth (1990) highlighted four common themes in the complex picture of torture and its consequences: (1) PTSD as a result of specific torture experiences; (2) depression as a result of multiple losses associated with torture; (3) physical symptoms resulting from the specific forms of torture; and (4) the "existential dilemma" of surviving in a world in which torture is a reality. The 10th revision of the *International Classification of Diseases* (World Health Organization, 1992) includes a diagnosis of "Enduring Personality Change after Catastrophic Experience" as one effort to capture the long-term existential consequences of the tearing up of a social world caused by torture. The profound psychological and physical consequences of torture are also evident in several carefully written personal accounts of the experience of torture (Ortiz, 2001; Ortiz & Davis, 2002).

Comprehensive reviews of the psychological effects of torture (Basoglu, Jaranson, Mollica, & Kastrup, 2001; Gerrity, Keane, & Tuma, 2001; Quiroga & Jaranson, 2005; Turner, 2004) have systematically evaluated research with torture survivors, examining the unique consequences associated with torture and the complex interaction of social, environmental, and justice-related issues. As noted in these reviews, the psychological problems most commonly reported by torture survivors in research studies include (a) psychological symptoms (anxiety, depression, irritability or aggressiveness, emotional instability, self-isolation or social withdrawal); (b) cognitive symptoms (confusion or disorientation, impaired memory and concentration); and (c) neurovegetative symptoms (insomnia, nightmares, sexual dysfunction). Other findings reported in studies of torture survivors include abnormal sleep patterns (Astrom, Lunde, Ortmann, & Boysen, 1989), brain damage (Bradley & Tawfiq, 2006), and personality changes (Ortmann & Lunde, 1988). The effects of torture can extend throughout the life of the survivor affecting his or her psychological, familial, and economic functioning (Basoglu et al., 2005; Mollica, McInnes, Poole, & Tor, 1998; Quiroga & Jaranson, 2005). Such

consequences have also been shown to be transmitted across generations in studies of various victim/survivor populations and across trauma types (Daud, Skoglund, & Rydelius, 2005; Yehuda, et al., 2005).

Studies conducted over the past 15 years strongly suggest that people who develop PTSD may also experience serious neurobiological changes (Friedman, Charney, & Deutch, 1995; Southwick, & Friedman, 2001), including changes in the body's ability to respond to stress (through alterations in stress hormones) (Charney, Deutch, & Krystal, 1993), and changes in the hippocampus, an area in the brain related to contextual memory (Bremner et al., 1995; Gurvits et al., 1996). Thus, the development of PTSD has direct and long-term implications for the functioning of numerous biological systems essential to human functioning.

For survivors, having "healers" participating in their torture by supporting interrogators or providing medical treatment in order to prolong torture can erode future recovery by damaging the legitimate role that physicians or therapists could provide in offering treatment or social support, essential components in the recovery of trauma survivors (Basoglu et al., 2001; Quiroga & Jaranson, 2005). For these reasons, numerous medical associations, including the American Psychiatric Association and the World Medical Association, include as part of their ethical and professional standards a complete prohibition against participation of their members in interrogation, torture, or other forms of ill treatment (United Nations, 1982). Similarly, the South African Truth and Reconciliation Commission documented how health providers were at times complicit in human rights abuses under apartheid, and through their report, hoped to shed light on this worldwide phenomenon and work toward an international effort to prevent such abuses from occurring (Physicians for Human Rights, 1998).

Research that focuses directly on the participation of health professionals in torture and interrogation has documented important contextual issues for understanding how such participation can occur. Robert Lifton (1986) interviewed Nazi doctors who participated in human experimentation and killings, and found them to be "normal professionals" who offered medical justifications for their actions. In studies of physicians and other health providers who are involved in forms of military interrogation, Lifton (2004) elaborates on "atrocity-producing" environments in which normal individuals may forsake personal or professional values in an environment where torture is the norm. Furthermore, these same health care professionals may, through their actions, transfer legitimacy to a situation, supporting an illusion for all participants that some form of therapy or medical purpose is involved.

Other studies of those who torture (Gibson, 1990; Haritos-Fatouros, 2002; Wagner & Rasmussen, 1983) have provided details about the step-by-step training that can transform ordinary people into people who can and will torture others, by systematically providing justifications for actions, professional or role authority, and secrecy. Participation in torture and other atrocities has been shown to have long-term negative psychological consequences for perpetrators, even in situations

where professional or environmental justifications were offered to them in the context of their actions (Falk, Gendzier, & Lifton, 2006; Lifton, 2004).

5. Consequences of Torture for Society

The acceptance and use of torture and other forms of cruel, inhumane, or degrading treatment in military or law enforcement situations have far-reaching implications for society. Impunity for perpetrators of torture (whether offered directly as a result of legal action or indirectly through neglect or incompetence) has been examined for ways in which it can affect the survivor, the perpetrator, and the community, including through an erosion of moral codes; an implied acceptance of violent behavior in the community; feelings of fear; helplessness and insecurity in society; and "social alienation" manifested by feelings of failure and skepticism, frustration, and addictive and violent behavior (Lagos & Kordon, 1996; Neumann & Monasterio, 1991; Roht-Arriaza, 1995). These potential outcomes are supported by cognitive theories of trauma, which maintain that PTSD is mediated by violation of previously held assumptions of invulnerability and personal safety (Janoff-Bulman, 1992), inability to find an acceptable explanation for the trauma (Lifton & Olson, 1976), and violation of beliefs that the world is a just and orderly place (Lerner & Miller, 1978).

The relation of sociopolitical processes to the psychiatric and cognitive effects of torture on survivors has also been examined, particularly the sense of injustice arising from perpetrator impunity (Anckermann et al., 2005; Basoglu et al., 2005). In these cases, even more significant than retribution and reparation are the loss of control and the ongoing fear that survivors may experience within their communities. Restoring a sense of safety and control in relation to the perpetrators of torture is critical to the recovery of a healthy society, as well as a positive therapeutic outcome for individual survivors. Such restoration is even more important in countries where those responsible for human rights violations continue to be in power.

Finally, as noted in recent congressional debates, the use of torture by the American military undermines the credibility and authority of the United States when advocating human rights abroad. The use of torture by the United States also lends credibility to the claims of those who wish to harm U.S. soldiers and citizens and provides an apparent justification for the acts of terrorists. By resorting to torture, the United States joins ranks with countries that fail to abide by national and international standards for humane and ethical treatment of detainees, and endangers American citizens who are being held in custody anywhere in the world. The United States cannot expect others to treat its soldiers and citizens humanely if it tortures those in our custody. The participation of all U.S. citizens, including military and civilians, in the use of torture and other cruel, inhumane, or degrading treatment should end.

Therefore, we urge APA and other scholarly and professional associations of psychologists to:

1. Unambiguously condemn the use of torture and other forms of cruel, inhuman, or degrading treatment as interrogation devices and call upon the U.S. government and its military to explicitly ban the use of such treatment and enforce all laws and regulations prohibiting its use.
2. Conduct an independent investigation of the extent to which psychologists have been involved in using torture or other cruel, inhuman, or degrading treatment as interrogation tools. If psychologists are found to have participated in the design or conduct of interrogations that have made use of torture, they should be appropriately sanctioned by APA and other professional organizations.
3. Expressly forbid psychologists from planning, designing, assisting, or participating in interrogations that involve the use of torture and any form of cruel, inhuman, or degrading treatment of human beings.[1]
4. Develop specific guidelines and explicit codes of conduct for psychologists working in contexts of war and imprisonment. These guidelines should be consistent with international treaties and human rights covenants as well as guidelines developed for health professionals. Such guidelines should include meaningful enforcement, processes for the investigation of violations, and professional and legal consequences for violations.

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[1] This is in sharp contrast to the *Report of the American Psychological Association Presidential Task Force on Psychological Ethics and National Security* (PENS) (American Psychological Association, 2005) which supports psychologists' participation in interrogation activities as part of national security-related and law enforcement roles.

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