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the
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WHY DOCTORS ARE UNDER PRESSURE TO
RATION CARE, PRACTICE POLITICS, AND
COMPROMISE THEIR PROMISE TO HEAL

M. GREGG BLOCHE, M.D.

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THE HIPPOCRATIC MYTH

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chapter seven

doctors as warriors I

america's frisson with torture

Dr. Uithol

On a chilly November night in 2003, a plane carrying army major Scott Uithol touched down in Baghdad after a steep, lights-out descent, meant to make a missile strike less likely. Uithol, a psychiatrist, was desperately needed. Armed resistance to America's presence was surging. Baghdad's streets had become deadly and terrifying. Battle stress symptoms were affecting a third or more of soldiers in many units, wearing away at their judgment and ability to fight. Dr. Uithol was set to deploy to a combat stress control team, tasked to treat soldiers traumatized by the terrors of urban warfare. But a day or so after landing in Baghdad, Uithol learned that his assignment had changed. On November 15, he reported to the Baghdad Central Confinement Facility, which would later become known to the world as Abu Ghraib.

For the next thirty-three days, Dr. Uithol served with the 205th Military Intelligence (MI) Brigade, advising interrogators intent on breaking their captives' will to resist. He was removed from his medical chain of command and assigned to lead Abu Ghraib's new "Biscuit," or behavioral science consultation team. What, precisely, he and the Biscuit did at Abu Ghraib remains a mystery—something he won't talk about, at least for the record, to

this day. But Uithol's friends report that he went into a near panic over what MI expected him to do.

"When I got to Abu Ghraib," he told me years later, "I didn't know what a Biscuit was."¹ Close to clueless about interrogation, he tried an online search, seeking tips his clinical training hadn't provided. The MI chain of command wasn't much interested in what he found. Interrogation of "high-value" detainees by the men and women of the 205th didn't hew to traditional military or civilian approaches. The job of the Biscuit at Abu Ghraib was to craft and oversee schedules of sleeplessness, shackling, sexual insult, and other stressors to fit each uncooperative prisoner's personality and mood. That this role was at odds with doctors' duties as non-combatants under the Geneva Conventions seemed not to matter to the 205th's commander, Colonel Thomas Pappas. The Biscuit's mission was to develop personalized interrogation plans in collaboration with the 205th's Tiger teams—groups of interrogators assigned to high-value detainees. To put these plans into effect, interrogators instructed guards to strip and shackle prisoners, keep them awake according to prescribed schedules, and otherwise stress and debase them as directed.²

According to Pappas, Dr. Uithol wasn't a mere bystander. Pappas would later tell army investigators that interrogation plans "include a sleep plan and medical standards" and that "a physician and a psychiatrist are on hand to monitor what we are doing."³ "As to what is implemented," Pappas claimed, the doctors "have the final say." To this end, said Pappas, Uithol would go to the cell blocks with interrogators, review detainees "under a management plan," and "provide feedback as to whether they were being medically and physically taken care of." Uithol's skills as a healer were thus pressed into service to support the combat mission—and to aid interrogation practices that flouted the laws of war.

The interrogation strategy he briefly oversaw was conceived long before he arrived at Abu Ghraib. Doctors designed it, administered it, and spread word about it to America's post-9/11 archipelago of interrogation sites. Doctors, moreover, were central to the Bush administration's efforts to legally justify it—and to protect its practitioners from criminal accountability for

torture. Parts of this story are known from journalistic accounts and releases of once-secret materials. Other parts of the story are reported here for the first time, based on interviews with principals who haven't previously spoken, as well as documents newly obtained from participants and through the Freedom of Information Act.

Scott Uithol knew nothing of this history. "I'm excited about the mission," he told a colleague when he first learned of his surprise posting. Other army psychiatrists didn't share his enthusiasm. When word spread to the several other in-country psychiatrists that MI wanted one of them for Abu Ghraib, they pulled strings to avoid the assignment. Uithol welcomed it. "He's gung ho," another army colleague, also in Baghdad at the time, told me. "He bleeds army green. He's a decent guy who wants to do the right thing but sometimes gets a little overexcited."

Uithol's qualms came later, amid Abu Ghraib's chaos. Cut off from the army's medical chain of command, he had no senior colleagues to turn to as a counterweight to MI's expectations. And these expectations were without precedent in the history of American medicine. Saying "no" wasn't an option, as he saw things. He'd committed to the army as a career, and he wasn't about to wreck his prospects by disobeying an order or even intimating that he harbored doubts. But he read through the Geneva Conventions and decided that he shouldn't further confuse matters by providing medical care to detainees, as some at Abu Ghraib wanted him to do. "I'm not your doctor," he would tell prisoners he encountered. "I'm with the guys with the guns."

Later, Uithol would look back on Abu Ghraib with a remix of feelings and a sense of relief that his stint lasted only thirty-three days. "You wouldn't believe what went on there," he told a colleague. "I was sidetracked," he said to me years later, declining to speak about his Biscuit duties. After his stint with MI, he was reassigned to the work he'd prepared for, with a combat stress control team. Upon his return home from Iraq, he found his way back to the role he'd first trained for, as a child psychiatrist, caring for children with parents on active duty. Meanwhile, the ethical quandaries he faced at Abu Ghraib remained literally unspeakable. Told to keep his Biscuit service secret, he pulled out of a scheduled October 2004

panel discussion at a high-profile conference on psychiatry and law. He made a point of avoiding conversations with civilian colleagues if he sensed any risk that the subject would come up. Senior military colleagues advised him to do so; any hint of doubt or dissent in a junior officer's record could ruin his prospects for promotion, ending his career.

On April 28, 2004, Abu Ghraib became a household word. The CBS News program *60 Minutes II* broadcast the photos that became iconic. Nude men stacked like cordwood, a detainee nicknamed "Gus" on a leash, and a shrouded prisoner perched precariously on a cardboard box, wires tied to his fingers, transformed the politics of the Iraq war and the image of America. More grotesque images, some on videotape, were never released. Eleven military police guards were eventually convicted for bringing to life their perverse sexual imaginings.

Amid the chaos of Abu Ghraib, sadistic excess became the norm. Insurgents' mortar shells landed almost daily, killing and maiming soldiers and prisoners. Detainees rioted, sometimes using smuggled weapons. Bedlam begat boundary transgressions—some were necessary, even heroic; others rose to the level of atrocity. In the medical clinic, desperately short of staff and supplies, physicians' assistants amputated limbs, a dentist did heart surgery, and nurses took chest tubes from the dead for reuse.⁴ And in the cell blocks, the stripping, shackling, and stress positions ordered up by interrogators devolved, in *Lord of the Flies* fashion, into madness—on Scott Uithol's watch. He would later be blamed by some for fomenting the madness—for being one of "America's torture doctors,"⁵ in the words of a prominent medical ethicist who published a j'accuse against military medicine after the photos emerged. The irony behind this portrayal is that Abu Ghraib wouldn't have become a household word had Uithol been able to impose the tight control his superiors envisioned.

Beginnings: Toward a Science of Interrogation

The interrogation strategy that went awry at Abu Ghraib dates back a half-century, to Americans' alarm over "brainwashing" by communist

interrogators. Accounts of forced conversions of wayward Chinese during the early months of Maoist rule were soon followed by the broadcast “confessions” of captured U.S. pilots. Airmen downed during the Korean War were taken across the Yalu River to China, where dozens “admitted” on tape to having committed war crimes. More than two-thirds of the 7,000 U.S. servicemen held by the Chinese either signed statements urging America to quit the conflict or “confessed” to sundry wrongdoings. The American public—and the military and intelligence communities—reacted with shock and embarrassment. Eminent researchers, including the psychologist Irving Janis, warned that the communists were employing drugs, hypnosis, and shock treatments to reorganize minds and induce trances. Novelists and filmmakers embellished the possibilities, imagining brainwashing techniques capable of turning people into robotic agents able to overthrow governments or kill their leaders.

Within the intelligence community, concern grew over the possibility that America’s enemies had developed a scientific method for breaking prisoners’ spirits. CIA director Allan Dulles turned to medicine for help. He engaged a Cornell neurologist, Harold Wolff, to investigate Maoist and Soviet counterresistance techniques.⁶ The CIA and the Defense Department gave Dr. Wolff extraordinary access to former Soviet and Chinese interrogators, ex-POWs, and still-classified sources. Other researchers joined in the effort: the army engaged psychiatrist Robert Lifton and the air force enlisted sociologist Albert Biderman. They sought to reconstruct the methods used, to better grasp what these methods could and couldn’t accomplish and to understand how and why they worked. CIA and military leaders had both offensive and defensive purposes in mind. They were intent on catching up with the communists in the race to develop more powerful counterresistance techniques, and they wanted to better prepare Americans for the possibility of capture by foes with contempt for the laws of war.

The conclusions from this crash program of inquiry into communist methods were more prosaic than many expected. Chinese and Soviet interrogators didn’t use drugs or hypnosis, nor were they steered by Pavlovian mental programmers or other mad scientists of the sort imagined on Hollywood sets.

Some of their tactics were centuries old, dating back to the Inquisition and passed down since as a kind of torturers' lore. But the tactics weren't "torture" as most people imagine it. There were no thumbscrews, racks, bamboo splinters, or other devices for inflicting agony. Beatings were common, but interrogators rarely meted out lasting physical pain. To the contrary, they avoided face-to-face contests of physical endurance between themselves and the men they tried to break. Instead, they set these men against themselves—by, for example, forcing them to sit or stand in awkward positions that became excruciating over time. "The immediate source of pain," Biderman wrote, "is not the interrogator but the victim himself. . . . The motivational strength of the individual is likely to exhaust itself in this internal encounter."⁷

Invoking different models and metaphors, Wolff and others converged on similar understandings of what our foes did to soften their captives' minds. In the first phase, they found, those in charge took total command of each captive's environment, dictating minutia like the length of bathroom breaks and body positioning while sitting or standing. Prolonged isolation, flavorless food, confinement in tiny spaces, and extended darkness (or bright light) achieved what Biderman called "monopolization of perception." Sleep deprivation, loud noise, frigid temperatures, and disruption of daily routines wore down detainees. Small gestures of contempt—facial slaps and frequent insults—humiliated them. Threats fed fear and dependence. Filthy living conditions and lack of privacy further degraded them.

Under such conditions, Wolff and the others concluded, hopelessness and despair could take hold within weeks. These states of mind set the stage for the next phase: motivating captives to comply. To this end, the interrogator established an aura of omnipotence. For prolonged periods, he was his prisoner's sole human connection, with monopoly power to praise, punish, coax, scold, and reward. Rapport with the interrogator offered the only escape from despair. This opened possibilities for the sculpting of behavior and belief. Chinese and Soviet interrogators employed this strategy with an eye toward winning "confessions" of political error. Compliance, though, could take other forms. A half-century later, critics of the interrogation tactics employed at Abu Ghraib would neglect Biderman's distinction between

“inducing” and “shaping” compliance. The Chinese and Soviets “shaped” compliance by rewarding sham confessions. But interrogators could, in theory, pursue other behavior-shaping goals, including getting prisoners to tell the truth.

By the late 1950s, CIA-sponsored physician-researchers were pursuing this possibility with fervor. Just because the communists hadn’t used hypnosis, psychotropic drugs, or shock treatments didn’t mean that our side couldn’t give these and other technologies a try. We did so—on unwitting subjects—in a series of CIA-funded experiments that began during the Korean War and lasted until 1963. In the most notorious of these, Ewen Cameron, a Scotsman turned Canadian who climbed the academic ranks to become one of the most distinguished psychiatrists of his day, combined frequent, high-voltage shocks with weeks-long, drug-induced sleep to “de-pattern” the minds of mental patients. Dr. Cameron’s avowed aim was to cure schizophrenia by wiping out deranged patterns of thinking, then refashioning patients’ minds along healthier lines. To this end, he pressed ahead with shock treatments and drugged sleep until his patients became confused about time and place and unable to remember the past, to the point that they spoke only of their immediate bodily needs.

Only then did he try to reorder their minds, employing a strategy he called “psychic driving.” For weeks, his stuporous patients listened, sixteen hours a day, every day, to tape loops condemning them for life failures they’d admitted in earlier interviews. Author John Marks⁸ gives one example—a loop played to a thirty-year-old woman whose husband brought her to Dr. Cameron after she’d suffered a nervous breakdown:

Madeleine, you let your mother and father treat you as a child all through your single life. You let your mother check you up sexually after every date you had with a boy. . . . You never stood up for yourself. . . . They used to call you “crying Madeleine.” Now that you have two children, you don’t seem to be able to manage them and keep a good relationship with your husband. You are drifting apart. You don’t go out together. You have not been able to keep him interested sexually.⁹

After a few or more weeks of such material, Dr. Cameron switched to a positive message:

You mean to get well. To do this you must let your feelings come out. It is all right to express your anger. . . . You want to stop your mother bossing you around. Begin to assert yourself first in little things and soon you will be able to meet her on an equal basis. You will then be free to be a wife and mother just like other women.¹⁰

The obvious resemblance between Cameron's high-voltage (figuratively and literally) approach and communist detention regimens as reconstructed by Wolff and others caught the notice of a CIA psychologist, John Gittinger, in 1956. Cameron had developed depatterning and psychic driving as therapies. But in 1957, the CIA offered to fund his work. He embraced the opportunity, adding prolonged sensory deprivation to his depatterning regimen and trying LSD on some patients to augment their psychic driving experiences. For the next several years, the agency pursued an expanding array of research protocols aimed at enhancing the basic interrogation strategy it had reverse-engineered from studies of Chinese and Soviet methods. CIA researchers hired prostitutes to sneak LSD to clients, experimented with extracts from Amazon plants, and developed novel methods to make sensory deprivation nearly complete. A few subjects died under murky circumstances.¹¹ The CIA's Technical Services Division supported more than a hundred researchers at scores of institutions, managing to keep this funding mostly secret. Cameron's work, though, came the closest to achieving the agency's goal: a high-tech approach to "inducing" and "shaping" compliance.

By the early 1960s, though, CIA officials had given up on this goal. Neither Cameron nor others had figured out how to ensure that dazed, disoriented, dependent prisoners told interrogators the truth. The agency's research portfolio, moreover, came under scathing internal criticism in a 1963 report by the CIA inspector general, who warned that it put "the rights and interests of all Americans in jeopardy" and breached the medical ethics proscription against non-therapeutic "manipulation of human behavior."¹² The CIA officially suspended

the program (though some claim it continued in diminished fashion for another decade¹³). When, in 1975, the program became public, as did its internal moniker, MK-ULTRA, a name the cleverest conspiracy theorist couldn't have dreamt up, vast numbers of Americans reacted with astonishment.

By then, the CIA had long since moved on. After the embarrassing disclosures of 1975, the agency abandoned its sponsorship of scientific efforts to improve on Soviet and Chinese interrogation methods. There were reports, though, that agency operatives taught harsh methods to Latin American militaries well into the 1980s.¹⁴ And there were allegations that military dictatorships in Argentina, Chile, Uruguay, Guatemala, and elsewhere put these lessons to use to torture their opponents.¹⁵ CIA training manuals from this period¹⁶ tracked the model Wolff and his colleagues had constructed a generation before. They referenced psychoactive substances and even hypnosis as tools for bringing about the dependent state of mind necessary to "cause capitulation," and they endorsed "silent administration"—euphemistic for drugging subjects on the sly.¹⁷ But they also warned of the unreliability of information so obtained. People can lie while under hypnosis, the authors noted. And drugs can cause hallucinations, delusions, and other alterations of belief, grossly distorting interrogators' results.

The most influential of these manuals, known as *Kubark Counterintelligence Interrogation*,¹⁸ held that physicians were essential. So was teamwork between doctor and interrogator:

The effect of most drugs depends more upon the personality of the subject than upon the physical characteristics of the drugs themselves. If the approval of Headquarters has been obtained and if a doctor is at hand for administration, one of the most important of the interrogator's functions is providing the doctor with a full and accurate description of the psychological make-up of the interrogee, to facilitate the best possible choice of a drug.¹⁹

"The judicious choice of a drug with minimal side effects, its matching to the subject's personality, careful gauging of dosage, and a sense of timing" were vital to ensure that its "silent administration" went undetected by the

subject. The effects of drugs given covertly would be “compelling to the subject since the perceived sensations originate entirely within himself.” The doctor’s “sense of timing” was also key to reducing the risk that drugs would elicit false information. “Their function is to cause capitulation, to aid in the shift from resistance to cooperation,” the Kubark authors explained. “Once this shift has been accomplished,” use of “coercive techniques,” including psychoactive substances, “should be abandoned.”²⁰ Thus the purpose of the drugs was to *motivate compliance*, not to *shape behavior*. The interrogator would shape behavior after resistance had been broken.

The various manuals made no reference to medical ethics qualms about this emphatically non-therapeutic work. And when the manuals became public after the Clinton administration declassified them in 1997, the press paid no attention to these qualms—or to the close match between the Kubark theory of interrogation and the model reverse-engineered from studies of Chinese and Soviet methods forty years before. The ensuing political furor centered on foreign policy: The manuals and other newly disclosed materials made it plain that the United States had taught counterinsurgency tactics widely seen as torture to thousands of Central and South Americans during the Reagan years.²¹ The CIA stopped doing so in 1986, as reports of human rights abuses in Latin America mounted.²² Thereafter, the agency’s facility with Kubark methods atrophied quickly, according to psychologists and psychiatrists in the national security community with whom I’ve spoken. Institutional memory ebbed as those familiar with these methods (and capable of employing them) quit or retired. By the time of the 9/11 attacks, the CIA’s capabilities in this realm were a thing of the past. They became so without any official verdict—from the CIA, its congressional overseers, or professional bodies—concerning the propriety of medical involvement of the sort Kubark required.

Learning from the Enemy: The “Pre-academic Laboratory”

But the model that Wolff, Biderman, and their colleagues had constructed persisted in another setting. “Confessions” by downed pilots taken prisoner in North Korea shocked the air force into developing a training program

for personnel at risk of capture. The army and navy would follow suit. The program, which became known as SERE (survival, evasion, resistance, and escape), aimed to prepare participants for ill treatment of the sort endured by American POWs in Korea. To this end, the air force relied on the Wolff-Biderman model to reverse-engineer the enemy's methods. Trainees spent weeks in the wilderness eating bugs, eluding pursuers, and otherwise honing survival skills. After they were "captured," they were held in mock prison camps and subjected to assorted abuses.

Clinical psychologists oversaw and sequenced these abuses, including sleep deprivation, exposure to cold temperatures, prolonged standing in painful positions, and confinement in tiny spaces. But whereas Wolff and Biderman had outlined a process for reducing prisoners to despair, the "pre-academic laboratory" (Pentagon-speak for the mock POW experience) was designed to build trainees' confidence. The idea was to push trainees to the edge, but not over it, to boost their resistance. "The [mock] interrogator must recognize when a student is overly frustrated and doing a poor job resisting," a SERE school operating manual warned. "At this point the interrogator must temporarily back off."²³ To this end, psychologists watched trainees closely, stopping the water-dousing or forced standing when stress seemed to overwhelm them.

That the psychologists sought to build resistance, not to break it, is underscored by an internal battle over waterboarding's place in the curriculum. By 2007, only the navy's SERE school still included it—a bow to fliers who'd been waterboarded while captive in Vietnam. It was "an emotional issue with former Navy POWs," a SERE official observed.²⁴ "Nostalgia," a former SERE psychologist told me less sympathetically. In 2007, the interservice agency that oversees SERE acted to drop it. "[T]he water board should not be used," agency officials told navy and Marine Corps commanders. "[I]t leaves students psychologically defeated with no ability to resist under pressure. Once a student is taught that they can be beaten, and there is no way to resist, it is difficult to develop psychological hardiness."²⁵

The power of the waterboard to teach hopelessness arises from the biology of suffocation: Water is poured over a cloth that covers the trainee's nose and

mouth. This creates an airtight seal, making it impossible to inhale. This sensation triggers reflexive terror. Subjects gasp and flail about. The mind is useless as a defense. Trainees know that it's just an exercise and that their "interrogators" will remove the soaked cloth in seconds. Yet they experience drowning and think they will die. The craving for air overpowers all. The waterboard, wrote chief SERE psychologist Gary Percival, thus "risks promoting learned helplessness."

Percival's concern about learned helplessness reflected SERE training doctrine. "Maximum effort will be made to ensure that students do not develop a sense of 'learned helplessness' during the pre-academic laboratory,"²⁶ a 2002 training manual stated. Use of this term in a training manual constituted a conceptual leap beyond the Wolff-Biderman model. SERE psychologists had embraced a clinical theory of despair, built upon behavioral psychologist Martin Seligman's 1960s experiments with dogs exposed to electric shocks. Seligman caged and shocked his animals under varying conditions: Some could escape (by moving to a safe area) or stop the shocks (by pressing a lever); others could do nothing to discontinue them or make them less frequent. The unlucky creatures in the latter group typically stopped trying, to the point that they made no efforts to escape even when moved to a setting that offered them a way out.²⁷

Seligman coined the term "learned helplessness" to capture this phenomenon, and he promoted it as a way to think about how people become depressed. Psychiatrists seized on this idea, and Dr. Seligman became famous, as both a behavioral science pioneer and a guru of positive thinking. He authored best-selling books with such titles as *Learned Optimism*, *The Optimistic Child*, and *Authentic Happiness*²⁸ and in the 1990s became recognized as a preeminent figure in the treatment of depression. People develop depression, Seligman and his followers hold, when they come to believe they can do nothing about the bad that comes their way. Inveterate optimists have the best odds for averting depression, but pessimists can protect themselves, by resisting their own can't-do thoughts as they arise. And for the already-depressed, psychotherapy should have a simple aim: persuade patients to believe there's a way out even when things look bleak, and they'll break out of their dysphoric funks. To this end, psychologists and psychiatrists developed what they called cognitive behavioral

therapy (CBT), aimed at reframing people's understandings of life's possibilities in more positive terms. Studies of CBT's efficacy found it did better than other treatments.²⁹ People who move from "I can't do anything right" toward belief that they can shape their own fates become more hopeful and otherwise less symptomatic. CBT also proved effective against anxiety disorders, including posttraumatic stress disorder.

SERE psychologists took notice. They reimagined resistance training as a total-immersion variant of CBT. Just as cognitive therapists verbally escorted their patients through bad memories (and even, at times, took patients on location to reenact stressful experiences), SERE trainers guided "students" through sequences of abuse, with an eye toward growing their belief in their capacity to cope. "Consider everything the enemy does as a technique," navy command psychologist Bryce Lefever told me in November 2009, recalling his days as a SERE trainer. "You are less likely to be taken in by it. . . . They are going to try to destroy your hope, they are going to threaten you with death, they are going to make you miserable. . . . Our job was to expose them to all these techniques so they could say, 'Oh, yeah, I really fell for that. I'm going to do better next time.'"

Psychiatrists call this stress inoculation, a term SERE's designers embraced. At their annual meetings each spring, SERE psychologists focused on the study of resilience. All of this happened behind high walls: The SERE program is classified, ostensibly to keep enemies from outwitting it. As a result, SERE psychologists could neither publish their thinking nor bring in outside colleagues to critique it. Isolated from their peers, they created a parallel professional universe, rotating among SERE schools, clinical care, and support for Special Forces. They sometimes went on special-ops missions, rappelling from helicopters and advising on battlefield deception. "Some of these guys were op docs—SEAL wannabes," a former navy psychologist told me. They breathed in the special-ops culture of audacity and segregated themselves from their closest civilian counterparts—psychologists and psychiatrists who consult to criminal investigators and practice in prison settings.

This separation had consequences—for their career chances and their understanding of interrogation. Doctors who serve in the armed forces

follow a more or less standard career trajectory—twenty years, or a little more, during which they rise to the rank of colonel or lieutenant colonel (in the army and air force) or captain (in the navy). They then “retire” in their forties or fifties (with pensions in excess of 40 percent of their final pay) to lucrative civilian jobs. But SERE psychologists had a rougher time of it. Special-ops derring-do didn’t translate into civilian opportunities. Neither did knowledge of the cognitive psychology of torture. It was as if police departments, private investigators, and other civilian employers had posted signs saying, “No SERE alumni need apply.”

Some SERE alums marketed their training methods to multinational corporations, offering to prepare at-risk executives to handle hostage takers. But others saw broader possibilities. They came to believe that torture, or something close to it, could extract truth, if well-planned. “We all knew from experience,” said Dr. Lefever, “that these techniques, these SERE training techniques, were pretty effective not only at training but . . . at exposing vulnerabilities in our own students.” Before they were taken “prisoner,” trainees were given mock secrets to keep. Routinely, they failed. “It was a kind of astonishing thing,” Lefever recalled. “You could have truly brave American patriots, even in a training setting, talking rather freely about stuff they shouldn’t have been talking about.”

In the wake of revelations about abusive, post-9/11 interrogation practices at Guantanamo and Abu Ghraib—practices that mimed SERE methods—political liberals, including myself, preferred to believe that these practices didn’t “work”—that they didn’t draw out accurate information. But a body of evidence, mostly classified, supports Lefever’s claim that SERE methods *can* extract truth in training settings, even though trainees know that their captivity isn’t real.

“Voodoo Science?”

This possibility intrigued James “Jim” Mitchell, SERE’s chief psychologist for much of the 1990s. When Mitchell retired from the air force in May 2001, he set about becoming a resistance training entrepreneur. He created

companies and hired former military colleagues to market his mix of clinical knowhow and special-ops daring. He had no shortage of self-confidence: He'd joined the air force out of high school in 1974, learned to defuse bombs, gone to college while on active duty, then collected a PhD in psychology.³⁰ Stress management seized his interest early on. It was essential to his work as a bomb disposal tech and central to his doctoral thesis on behavioral approaches to high blood pressure. And he took an interest in Seligman's ideas and their potential for empowering people to cope with dire circumstances.

The world of SERE and special ops was a perfect match for Mitchell's mix of machismo and behavioral science background. And his charisma and networking skills were just as good a match for the business of seeking corporate and government contracts. He offered himself as a scientist—and as a bridge between cutting-edge research and real-world needs. Preparing executives to handle hostage situations, assessing the reliability of informants, and getting reluctant sources to talk were among the services his several firms offered. He made the science seem simple to potential clients with no patience for academics' "on the other hand" reservations.

Among some in the SERE and special-ops communities, Mitchell's marketing pitch aroused concern. "Jim says he's a scientist, but he's not a scientist," a prominent physician and SERE researcher told me. "The Mitchell that I met in the past was usually someone who said 'I know.' . . . Every time you'd ask him a question, he'd look impatient and irritable. He didn't enjoy being questioned about data."

When nineteen hijackers seized four planes and killed more than 3,000 people, Mitchell's moment came. Within weeks of the 9/11 attacks, the CIA and Special Forces were collecting captives—and close to clueless about how to get reliable information from them. No research decisively answered the question of which interrogation techniques "work." Nor could it have, since research of this sort is both unethical and barred by international law. The Nuremberg Code, promulgated in 1947 by the court that condemned seven Nazi doctors to die, forbade research on human subjects without their consent.³¹ So have multiple treaties, regulations, and codes of ethics since. CIA and military interrogators were thus left with their hunches and traditions.

An army field manual offered some guidance on how to manipulate emotions and build rapport within the confines of the Geneva Conventions.³² New enlistees—typically teenagers without college experience—could become interrogators by taking a several-week course at the Army Intelligence Center in Fort Huachuca, Arizona. They learned to show kindness, feign empathy, flatter, and shame—and to exploit contradictions and come up with clever ruses. In tents and shacks at Bagram, Kandahar, and other sites across Afghanistan, anecdotes became “knowledge” as interrogators swapped stories about prisoners whose language they didn’t speak and whose politics they didn’t understand. “Interrogation doctrine in this country is based on old wives’ tales,” a high-ranking military intelligence specialist told me in a 2009 interview, recalling his work with interrogators in Afghanistan and, later, Iraq. “They come out of the booth and say: ‘Oh, that was effective.’ But how do they know—compared to what?”

In 9/11’s immediate wake, effectiveness was an urgent matter. War against spectral extremists and their networks required pinpoint intelligence—about plans, capabilities, and personal relationships. In World War II, Korea, the first Gulf War, and even Vietnam, interrogation was peripheral; massive firepower and the technology to deliver it mattered more. But in Afghanistan and across the webs and warrens of jihadist fanaticism from Europe to the Philippines, interrogation was central. And fear of another cataclysm like 9/11, or worse, kept the CIA and military focused on the task of extracting maximum information from captives who might harbor pieces of the puzzle. At the CIA’s McLean, Virginia headquarters, though, expertise on how to interrogate anyone, let alone Islamic fundamentalists, was lacking. As agency operatives, special-ops soldiers, and their Afghan allies-of-convenience took territory and prisoners, Counter-Terrorism Center chief Cofer Black cast about for interrogation solutions. That’s when a former Veterans Administration psychologist, Kirk M. Hubbard, redirected the course of America’s post-9/11 campaign against terror.

More than a decade earlier, Hubbard had made an unusual career switch, from clinical practice at the Hampton, Virginia VA Medical Center to a job at the CIA, supporting clandestine operations overseas. He served in To-

kyo, London, and possibly elsewhere, impressing superiors with his savvy. By 9/11, he'd done stints back at headquarters for a unit whose existence remains secret, the Operational Assessment Division (OAD). His opaque OAD job titles, Chief of Operations, then Chief of the Research and Analysis Branch, reveal little about his responsibilities beyond the hint that he had an important role in assessing clandestine activities. But the contacts he forged with mental health professionals working in national security convey his main interest: bringing behavioral science to the front lines of the fight against terror.

Hubbard's position at the CIA gave him the chance to do so. Paramilitary teams run by the agency's Directorate of Operations worked closely with army, navy, and air force special operations units. Hubbard became part of an informal network of military and civilian psychologists and psychiatrists with shared interests in psyops, Special Forces selection, resistance training, and the reliability of "humint" (human intelligence). He wasn't a SERE psychologist, but he went to their professional meetings. He wasn't a research scientist, but he was inveterately curious—open to fresh ideas and disinclined to stay within bureaucratic silos. How he came to meet Jim Mitchell remains unclear. What's certain, though, is that Hubbard came to see the challenge of extracting humint from hostile prisoners Mitchell's way.

Thanks to superb reporting by Scott Shane, Mark Benjamin, and Katherine Eban, the fact that Mitchell personally waterboarded several Al Qaeda detainees held by the CIA is widely known. So is the fact that Mitchell drew on his SERE experience to design regimens to break these detainees. Mitchell "reverse-engineered" SERE, the story goes, without regard for common knowledge that torture doesn't work. He was a rogue operator—a practitioner of "voodoo science"³³—who somehow wheedled the CIA into allowing him to have his way with its captives. I helped to tell this story, in articles I wrote (with British human-rights lawyer Jonathan Marks) for the *New England Journal of Medicine* and the *New York Times*.

But the story is incomplete. It's indeed common wisdom among political progressives that torture doesn't work—if, by "work," we mean extraction of accurate information from hostile informants. Miming communist

interrogation methods, Marks and I wrote in 2005, yields compliance of a mindless sort: People being abused to the breaking point will say anything to get the torture to stop. This makes torture a powerful tool for extracting false confessions (once you break your victim, you need only provide the script) but a poor means for seeking truth, since the truth might differ from what the victim figures his torturer wants to hear.³⁴

From a human rights perspective, this is a nice, win-win story: Avoid torture (or anything approaching it) and you'll get *better* information from reluctant interviewees. But this story overlooks a point Albert Biderman made fifty years earlier. If well designed and strategically sequenced to reduce captives to despair, the abuses he cataloged could "induce" a compliant state of mind. But the "shaping" of compliant behavior was another matter. It turned on the interrogator's perceived omnipotence—his monopoly power to punish and reward. He could use this power as the Chinese and Soviets did, to extract false confessions. But he could also use it to force fearful and hopeless prisoners to tell the truth—if he could detect falsehoods in real time and punish them swiftly.

SERE psychologists grasped this latter possibility. They'd seen it play out as American soldiers spilled "secrets" under the pressures of the "pre-academic laboratory." Like Bryce Lefever, Jim Mitchell believed that the stressors they'd designed to inoculate trainees against torture could be re-mixed—and enhanced—to extract lifesaving intelligence from actors intent on doing Americans harm. But the breaking of prisoners, by itself, wouldn't be enough. Biderman's insight here was critical. The interrogator would need to shape the behavior of the men he broke by distinguishing truth from invention, then rewarding the former.

Kirk Hubbard became convinced that this model could deliver better results, more quickly, than the "rapport-building" techniques used by law enforcement agencies. It was science *based*—grounded in Wolff's, Biderman's, and Seligman's work—albeit not scientifically *proven*. In the weeks after 9/11, as the White House and CIA sought frantically to prevent the next attack, Hubbard arranged for Jim Mitchell to meet with CIA leadership. "I didn't make the decision to hire them," Hubbard told me in an

e-mail about the roles played by Mitchell and John “Bruce” Jessen (a former SERE colleague who would become Mitchell’s partner). “I just introduced them as potential assets.”³⁵

The CIA Buys In

Within the CIA, Hubbard had to reckon with a rival. Psychologist R. Scott Shumate—trained, like Hubbard, as a therapist—had for years worked in support of clandestine operations overseas. A 2005 bio blurb, prepared by Shumate to promote his candidacy for an American Psychological Association committee, boasted of his “extensive experience and knowledge of Middle Eastern culture” and service “under highly stressful and difficult circumstances.”³⁶ He claimed credit for having “interviewed many renowned individuals associated with various terrorist networks” and said he’d served as “the chief operational psychologist for the [CIA] Counter-Terrorism Center.”

Shumate would later tell colleagues in the national security community that he’d objected to Mitchell’s methods, warning that his approach was ethically dubious and unlikely to work. But according to Hubbard, Shumate’s pushback was self-serving: “Scott saw himself as the chief psychologist in CTC and was very protective of ‘his turf’ . . . [H]e wanted to control (if possible) psychology in CTC, or at least be a part of it if could not control it [*sic*].” What, exactly, Shumate had in mind as an alternative to Mitchell’s “enhanced” interrogation strategy remains uncertain. What’s clear is that Shumate lost out—within CTC, then within the CIA as a whole. “He simply wasn’t a player in CTC when it came to the interrogation program,” Hubbard said. “He was in way over his head, I believe. I think he truly believes that he objected to the EITs [enhanced interrogation techniques] on moral or ethical grounds, but I think there is much more to it than that.”

When, exactly, CTC director Cofer Black and CIA director George Tenet decided to go with Mitchell is unclear. But by December 2001, Mitchell and Hubbard had won out. As the CIA inspector general reported in 2004 (in a “Special Review” of “Counterterrorism Detention and Interrogation

Activities” that wasn’t declassified until 2009), the agency gave Mitchell the nod to prepare a report on how to counter Al Qaeda’s interrogation resistance techniques.³⁷ Mitchell enlisted Bruce Jessen as his coauthor. This decision would prove momentous. Jessen brought little to the partnership by way of new ideas. But he was still on active duty as the senior SERE psychologist at the Joint Personnel Recovery Agency (JPRA), a Spokane, Washington–based unit that oversaw army, navy, and air force resistance training. Jessen could, and did, tap into JPRA and the services’ SERE schools for information about the physical and psychological effects of isolation, waterboarding, and other stressors. More important, he could, and later would, use JPRA as a platform to promote “enhanced” interrogation methods to U.S. commanders around the world.

Mitchell and Jessen rushed their project to completion. By February 12, 2002, they’d written a paper, “Recognizing and Developing Countermeasures to Al-Qa’ida Resistance to Interrogation Techniques: A Resistance Training Perspective.” Not only did CIA leadership embrace the Mitchell-Jessen approach; the agency asked JPRA to arrange training in SERE methods for interrogators in Afghanistan and Guantanamo Bay. In his capacity as JPRA’s SERE psychologist, Jessen did so. JPRA’s chief, meanwhile, sent Mitchell’s and Jessen’s paper to top army, navy, and air force commanders, urging them to look to SERE for help in extracting information from hostile detainees. “After over 30 years of training,” he offered, “we have become quite proficient with both specialized resistance and the ways to defeat it.”³⁸ The idea of using SERE stressors to break prisoners’ resistance spread to commanders in every theater, including Afghanistan and Guantanamo Bay.

But Mitchell took the idea to its farthest extreme, on the CIA’s behalf. How, exactly, he understood the ethics of tapping his clinical and behavioral science background to reduce prisoners to despair remains unknown.³⁹ But Hubbard’s understanding is clear. In an unpublished commentary he shared with me, he rejected the relevance of clinical ethics, including the “do no harm” ideal, to psychologists and physicians “not serving in a doctor/patient role.” Doctors, he said, owe it to their country to become involved:

What does seem unethical is for psychologists/psychiatrists to not use our knowledge of human behavior to assist in preventing terrorist threats to innocent victims or to our Western democratic way of life. I reject the notion that it is somehow unethical to put the lives of innocent Americans ahead of the interests of Islamic terrorists. . . . I think each of us has an obligation to try to balance the law, our duty to our fellow citizens, and [the] ethical codes of our professional organizations. For me, this balance favors society over the so-called rights of terrorists.

The limits that mattered for Hubbard and Mitchell were those that U.S. law imposed—in particular, federal statutes banning torture. Hubbard’s interrogators would need a legal safe harbor—a definition of “torture” sufficiently capacious to allow Mitchell to take his methods into the field. So, in the late winter and early spring of 2002, the agency set about constructing one. CIA officials consulted with psychologists, psychiatrists, and others in academia and the military, looking to make the “enhanced” approach more effective and to build support for their claim that it didn’t constitute “torture.”

Early on, they tapped JPRA for both purposes. By early March, Jessen had developed slide presentations, titled “Al Qaeda Resistance Contingency Training” and “Exploitation,” setting out a strategy for extracting information from uncooperative prisoners. These presentations included slides on “isolation and degradation,” “sensory deprivation,” “physiological pressures” (a SERE euphemism for beatings and other physical abuse) and “psychological pressures.”⁴⁰

JPRA also assembled findings on the mental health effects of resistance training—findings that backed SERE psychologists’ claim that it strengthened students’ coping skills. Bush administration legal policy makers would later invoke these findings as evidence that “enhanced” interrogation wasn’t torture.⁴¹ SERE training, according to JPRA, had negligible psychiatric side effects in the elite war-fighters selected to receive it. SERE methods thus wouldn’t cause “severe mental pain or suffering”—the law’s test for psychological torture—when used to break terror suspects’ resistance.

Hubbard embraced this proposition, ignoring the critical difference between resistance training and use of SERE methods to crack resistance. SERE training built resistance, with minimal mental health side effects, because psychologists took care to avoid inducing a sense of helplessness. Jessen and Mitchell, though, made learned helplessness their goal. SERE trainers' success at avoiding psychiatric sequelae was thus beside the point. Mitchell's method could succeed only by inflicting mental suffering—suffering “severe” enough to bring on learned helplessness.

Mitchell and Hubbard also consulted with Martin Seligman. In December 2001, according to Scott Shane of the *New York Times*, Seligman hosted the two (along with others) at his suburban Philadelphia home.⁴² Did Seligman advise Mitchell or Hubbard on how to employ learned helplessness to break prisoners' resistance? His denials have been emphatic. “I am grieved and horrified,” he wrote in a short memo he sent me, “that good science, which has helped so many people overcome depression, may have been used for such dubious purposes.” He acknowledged only that he spoke on learned helplessness at a JPRA meeting in May 2002 and that Mitchell and Jessen were in the audience:

I was invited to speak about how American . . . personnel could use what is known about learned helplessness to resist torture and evade successful interrogation by their captors. This is what I spoke about.

Seligman added:

I have had no professional contact with Jessen and Mitchell since then. I have never worked under government contract (or any other contract) on any aspect of torture, nor would I be willing to do work on torture. I have never worked on interrogation; I have never seen an interrogation and I have only a passing knowledge of the literature on interrogation.

But sometime in the spring of 2002, according to a CIA source, Seligman met with Mitchell, Jessen, and Hubbard in Philadelphia. “The fact that

we had a meeting in Philadelphia,” said the source, a meeting participant, “means that Mitchell/Jessen were at least thinking about interrogation strategies.” Seligman wanted to help and understood what Mitchell had in mind. But having built his reputation as a clinical pioneer—the man who’d discovered learned helplessness, then transformed depressed people’s lives through “learned optimism”—he didn’t want to be seen as telling CIA operatives how to break people by inducing despair. So he walked a careful line, keeping to the question of what the science did and didn’t support while abstaining from how-to advice. Seligman, said the CIA source, had a “classic approach-avoidance conflict regarding helping us.”

Parsing Seligman’s denials leads to the conclusion that he feinted left but didn’t lie.⁴³ He declined an interview, which made follow-up questions difficult. But when I asked him (by e-mail) whether Mitchell and Jessen had acted unethically by turning learned helplessness theory toward the task of breaking terror suspects,⁴⁴ he responded: “I went to a college whose motto was, ‘Princeton in the nation’s service.’ I admired Gen. [George] Casey’s quote of Isaiah at the Ft. Hood service [for victims of the Fort Hood massacre]: ‘Who will answer the call? Whom shall I send? Here am I. Send me.’”

Going Live

By the time of the Philadelphia meeting, CIA preparations for “enhanced” interrogation had reached high intensity, energized by what looked like an extraordinary opportunity. At 2 AM on March 28, a Pakistani SWAT team seized Abu Zubaydah, a Saudi whom some at the CIA thought was Al Qaeda’s third in command. Top CIA officials convinced themselves—and told the president—that Zubaydah harbored a trove of information about pending attacks and sleeper cells. Zubaydah, who barely survived horrific wounds,⁴⁵ was flown to a secret CIA site outside Bangkok. He was treated and then interrogated, initially by FBI agents who used conventional, “rapport-building” techniques. CIA officials, though, were sure Zubaydah was withholding details that could save thousands. So they decided to send Jim Mitchell to break him—if they could get the lawyers to go along.

Months would pass before final Justice Department approval for what Mitchell had in mind. But once approval seemed likely, CIA leadership made the call. Kirk Hubbard answered it, quite literally, on the way back from Philadelphia. “I received a phone call indicating ‘they’ wanted Mitchell to depart that night along with others from CTC,” Hubbard remembers.⁴⁶ “Mitchell had about twelve hours’ notice that he was being flown to meet AZ [Zubaydah].” Exactly when Mitchell began his brutish efforts with Zubaydah (and based on what sort of approval) remains a matter of dispute. An FBI interrogator who remained on the scene after Mitchell took charge alleged that Mitchell and his team engaged in “borderline torture” many weeks before the Justice Department’s Office of Legal Counsel (OLC) gave its final okay in its notorious August 2002 “torture memos.”⁴⁷ And much of the press coverage of Mitchell’s activities casts him as a cowboy—a rogue player who disregarded limits set back in McLean. Not true, Hubbard insisted: “Jim Mitchell, et al. didn’t take a pee without written approval from headquarters. . . . CIA leadership approved and is responsible for all that occurred. Mitchell & Jessen were not mavericks operating on their own.”

What is clear—and remarkable—is that even as Mitchell served as maestro of the abuse that much of the world came to see as torture, he kept his clinical hat on, purporting to care for Abu Zubaydah’s mental health. His doing so played a critical role in the development and spread of “enhanced” interrogation. His “psychological assessment” of Zubaydah, based on “direct interviews with and observations of the subject,”⁴⁸ gave the OLC cover to conclude that waterboarding wouldn’t cause Zubaydah “severe mental pain or suffering.” Later, it would shield the OLC’s lawyers against charges of misconduct.

Mitchell’s “assessment” was a series of claims, unmoored from evidence, about Zubaydah’s “incredibly strong resolve” and hardiness under stress.⁴⁹ It was transparently designed to meet the needs of OLC’s lawyers by lending clinical weight to their claim that Mitchell’s remix of SERE methods wasn’t torture. Zubaydah, he wrote, was “remarkably resilient,” “ab[le] to manage his mood and emotions,” and without known “history of mood disturbance

or other psychiatric pathology.” Mitchell marshaled no evidence to back these assertions. His “assessment” lacked the detailed reporting on mood, feelings, and thought processes necessary for a clinical evaluation to be of passable quality. He disregarded word from FBI and CIA analysts who had reviewed Zubaydah’s diaries and found a tendency to collapse under stress.⁵⁰ Mitchell also ignored the possible effects of a severe head wound that Zubaydah had suffered in battle against the Soviets as a teen.

Circular Lawyering

Measured by conventional clinical standards, Mitchell’s “assessment” was malpractice. But for the lawyers this didn’t matter. Its clinical mien, not its medical science, gave the OLC the cover it sought. And more than seven years later, Mitchell’s unsupported claims about Zubaydah’s mental strength became a basis for the Justice Department’s decision to absolve the torture memos’ authors of professional misconduct. The department’s ethics arm issued a finding of misconduct, based in part on the authors’ misuse of JPRA data showing that SERE training posed minimal mental health risk.⁵¹ The authors had claimed mental harm to Zubaydah was “highly improbable” since SERE students hadn’t suffered it. But the ethics office at Justice said this assertion improperly overlooked the difference between use of SERE methods to build and to break resistance. True enough, said a top Justice official, but Mitchell’s “individualized” assessment filled this analytic gap. It supported the conclusion that “mental health consequences” were “highly improbable.” On this basis, the department threw out the misconduct finding against the torture memos’ two authors, Jay Bybee (now a federal judge) and John Yoo (who parlayed the memos’ notoriety into prominence as a conservative commentator).⁵²

There was more than a bit of bootstrapping involved. The doctor and the lawyers relied on each other to justify practices that the rest of the world later saw as torture. Mitchell’s “assessment,” unhinged from fact, empowered the lawyers to make a case unhinged from law. His clinical credentials were

enough—a substitute for facts, in the minds of attorneys who were supposed to reason tightly from facts. The lawyers' conclusions, in turn, shielded Mitchell from criminal accountability for what he did to Zubaydah and, later, others. And in the end, his "assessment" protected the lawyers from career-ending sanctions.

Physicians had an equally important role in the bootstrapping. By the time Yoo and Bybee gave their okay (orally in late July 2002, then in writing on August 1), CIA physicians were on hand with Mitchell at the Bangkok black site.⁵³ Yoo and Bybee conditioned their approval on the presence of a "medical expert with SERE experience," tasked with stopping the proceedings if "medically necessary to prevent severe mental or physical harm to Zubaydah."⁵⁴ "Medical necessity" had acquired a new meaning, outside the health insurance realm.

The physician in attendance played another, more pernicious role in the Yoo-Bybee legal design. To be a torturer in the eyes of the law, pain or suffering tantamount to torture isn't enough; "specific intent" to inflict the suffering is required. That means, in practice, that the suffering must be the torturer's *purpose*; knowledge that suffering might ensue isn't enough.⁵⁵ Yoo and Bybee seized this opening. Having a doctor on hand was key. The "constant presence of personnel with medical training who have the authority to stop the interrogation," they claimed, was enough to show absence of "specific intent" to inflict severe pain or suffering.⁵⁶ The presence of physicians proved "good faith"—an "honest belief" that severe pain or suffering wouldn't occur. The "honest belief" might be wrong, but this was beside the point: "Honest belief" was enough to show that committing torture didn't make one a torturer. Thus the doctors' mere presence guaranteed impunity, *whether or not* they protected Zubaydah from pain or suffering rising to the level of torture.

Handed this lawyerly *carte blanche*, Mitchell went to work with ferocity. Over the summer, Bruce Jessen joined him, leaving the air force to become a principal in Mitchell's firm. Meticulous records were kept, including detailed interrogation logs and ninety-two videos (all later destroyed) of encounters with Zubaydah. Physicians and other medical personnel observed

the “enhanced” procedures and made notes.⁵⁷ A review by the CIA inspector general counted eighty-three waterboarding “applications”—that is, eighty-three separate simulated drownings. (By comparison, SERE trainees typically endured just one or two.)

Each application, moreover, went well beyond what SERE students experienced. In SERE training, a cloth was first draped over the student’s eyes and forehead, then soaked with water from a small cup and lowered to cover the nose and mouth. To keep the cloth saturated (so as to make breathing difficult), the instructor added water for twenty to forty seconds; then the cloth was removed.⁵⁸ But according to the inspector general, Mitchell’s team poured much more water—“large volumes.” Mitchell and Jessen, said the inspector general, “acknowledged that the Agency’s use of the technique differed from that used in SERE training [*sic*] and explained that the Agency’s technique is different because it is ‘for real’ and is more poignant and convincing.”

Scaling Up

Whether Mitchell’s “alternative set of procedures,” as President Bush later called them, extracted lifesaving intelligence from Zubaydah is a matter of fierce dispute. What’s clear, though, is that word got around quickly within the national security establishment that Mitchell’s methods *worked*. The false story spread that Zubaydah had agreed to tell all after only thirty-five seconds on the waterboard.⁵⁹ His interrogation became the prototype for a clandestine cottage industry. By the end of May 2005, the CIA was holding ninety-four terror suspects at “black sites” around the world and had subjected twenty-eight to Mitchell’s methods.

Jessen himself developed the first “curriculum” for CIA interrogators.⁶⁰ His JPRA colleague, psychologist Gary Percival, led the first training session, on July 1–2, 2002. Percival and JPRA instructor Joseph Witsch explained and demonstrated “physical pressures,” including waterboarding, to CIA officers preparing to deploy to Afghanistan and elsewhere.⁶¹ By November 2002, the agency had its own two-week course, “designed to train, qualify,

and certify individuals as agency interrogators.” The “curriculum” included a week of classroom instruction, followed by a week of “‘hands-on’ training in EITs.”⁶² To perform EITs, certification was essential. The CIA had created a corps of operatives trained to torture,⁶³ pursuant to a plausible, science-based model.

“Medical” Procedures

As “enhanced” interrogation scaled up, medical involvement became integral, to the point that waterboarding, sleep deprivation, “walling,”⁶⁴ and other abuses were reinvented as medical procedures. Condemnation of the Yoo-Bybee memos, leaked in 2004,⁶⁵ occasioned this reinvention. In high-visibility fashion, the Bush administration withdrew the memos, backing away from their sweeping claims about the president’s power to ignore the law. But a secret set of replacement memos insisted that Mitchell’s methods weren’t torture, so long as “medical personnel” helped to design them and oversaw their administration.⁶⁶

To this end, CIA physicians reengineered waterboarding to make it “medically appropriate.” They required that potable saline solution, not “plain water,” be poured, to prevent detainees who drink it from developing hyponatremia—a dangerously low concentration of sodium in the blood. To guard against aspiration (inhalation of vomited food), they ordered that detainees be put on a liquid diet before waterboarding. And to respond to spasms of the larynx—life-threatening when they persist after water is poured—they mandated that tracheotomy equipment be on hand.⁶⁷ The CIA’s Office of Medical Services (OMS), moreover, required that a physician be present to watch for respiratory distress, loss of consciousness, and other problems.⁶⁸ That such problems arose is strongly suggested by a warning in the OMS “Guidelines” for medical attendance at “enhanced” interrogations: “In our limited experience, extensive sustained use of the waterboard can introduce new risks.”⁶⁹ OMS acknowledged in its “Guidelines” that it was conducting an experiment of sorts, noting that SERE students were typically

waterboarded only once. To learn the most possible from this novel endeavor, OMS told its physicians, rigorous data collection was essential.

In order to best inform future medical judgments and recommendations, it is important that every application of the waterboard be thoroughly documented: how long each application (and the entire procedure) lasted, how much water was used in the process (realizing that much splashes off), how exactly the water was applied, if a seal was achieved, if the naso- or oropharynx was filled, what sort of volume was expelled, how long was the break between applications, and how the subject looked between each treatment.⁷⁰

Most of the CIA's medical judgments were less evidence based. Sleep deprivation of up to 180 hours, imposed by shackling and forced standing, was said not to "have significant physiological effects" aside from a "temporar[y]" impact on brain function.⁷¹ This claim ignored growing evidence that sleep loss predisposes people to cardiovascular disease, cancer, diabetes, and infection as well as disorders of mood and thought.⁷² And at the CIA's black sites, medical personnel who oversaw walling, stomach slaps, cold-water dousing, and other "procedures" were instructed to stop these when "medically appropriate"—as if clinical researchers had studied these procedures and developed science-based practice protocols. Physiological jargon—discussions of metabolic compensation for cold temperatures, avoidance of "extension-flexion injury" and bodily heat loss during immersion in frigid water⁷³—masked the lack of scientific answers to questions that couldn't ethically be studied.

"To Do No Harm"

Incongruously, the OMS instructed doctors who oversaw interrogation that "[a]ll medical officers remain under the professional obligation to do no harm." This absurdist directive silenced conversation about the tension between Hippocratic ideals and what they were doing. It feigned

uncompromising Hippocratic commitment, making it awkward for CIA doctors to admit that they were straying.

For the CIA's physicians, there were dodges aplenty: (1) the doctors *helped* detainees by making the "procedures" more humane; (2) they were "just following orders" (others made the decision to adopt the Mitchell model); and (3) they weren't acting as physicians—or, at least, as caregivers—and thus weren't bound by medical ethics. These dodges were disingenuous. Had the doctors not helped to plan and supervise "enhanced" interrogation, the CIA couldn't have gone ahead with it—the lawyers wouldn't have approved. And the "following orders" claim begs the question of the orders' propriety: The law requires CIA physicians to adhere to their profession's ethical obligations even when this means saying no to instructions from above. The proposition that the doctors weren't acting as physicians is a prevarication. Not only did they exercise clinical judgment, science based or otherwise; they intervened as caregivers, ordering a halt to "procedures" and providing treatment when injury ensued.

Physicians served a larger function in the CIA's black sites: They lent an aura of benevolence and restraint to a brutish endeavor. Bush administration lawyers tacitly acknowledged this in their memos by making medical involvement critical to their conclusion that enhanced interrogation wasn't torture. Physician involvement enabled the lawyers to characterize the brutishness in clinical terms, both figuratively and literally. Convincing Americans—even Bush administration lawyers—to openly allow torture would have been too hard a sell. The CIA's doctors enabled the agency to finesse this problem through artful definition.

This finesse also protected the doctors themselves. Numerous codes of medical ethics prohibit physician participation in torture. The most widely cited such code, passed by the United Nations General Assembly in December 1982, not only bars "participation" and "complicity" in torture; it also warns that "it is a contravention of medical ethics for health personnel . . . [t]o apply their knowledge and skills in order to assist in the interrogation of prisoners and detainees in a manner that may adversely affect the physical or mental health or condition of such prisoners

or detainees *and which is not in accordance with the relevant international instruments.*"⁷⁴

This language leaves plenty of space for parsing. It *permits* doctors to assist interrogators—even if what they do “may adversely affect the . . . health” of prisoners—so long as interrogation stays within the bounds of international law. And according to the Bush administration’s lawyers, medical assistance itself was grounds for claiming that enhanced interrogation was compatible with international law.⁷⁵ The doctors’ participation itself was thus reason for concluding that their participation was ethical—a tour de force of circular reasoning!

This ethical “reasoning” has ongoing legal bite. State medical licensing boards have the power to punish physicians for ethical lapses by suspending or revoking their licenses. People can sue doctors for harm caused by unethical conduct. And hospitals can refuse to grant admitting privileges to physicians with ethically dubious pasts. CIA doctors dread a storm surge of disciplinary complaints and lawsuits by human rights activists, former detainees, and others. And they fear that their pasts will haunt them, should they seek post-CIA careers as clinical caregivers. They’ve avoided these risks, so far, by staying anonymous—something the clandestine status of “enhanced” interrogation has enabled them to do. But keeping one’s career under cover has its professional costs, and succeeding at doing so is hardly a sure thing. Being able to argue that they acted ethically, in the nation’s service, thus matters greatly to these doctors. The legal architecture under which they served empowers them to do so.

That the clinical science supporting this legal architecture was questionable didn’t concern the CIA. The agency’s most senior officials deferred to the doctors, some of whom weren’t shy about stretching the science. The CIA’s disregard for science even extended to Mitchell’s arguments for “enhanced” interrogation. Hubbard, who introduced Mitchell to counterterrorism policy makers and still insists that his methods worked, claims that Mitchell had good science behind him but that the agency’s leadership didn’t care. “The CIA is only interested in results,” he told me. “Their eyes glaze over when you start talking science, research.”

A Battle of Brawn

Disregard for the science was evident as the CIA scaled up its use of enhanced methods. The agency stuck to the Biderman-Seligman story, telling administration lawyers that “the goal of interrogation is to create a state of learned helplessness.”⁷⁶ But a CIA background paper on enhanced interrogation reveals a descent into raw thuggishness. Instead of wearing away resistance through such measures as prolonged isolation and sleep deprivation, black-site interrogators tried immediately to intimidate. Slaps to the face and stomach, throwing detainees against a wall (“flexible,” we’re reassured), and hosing with cold water became part of the mix within a day or two of a detainee’s arrival. Such acts pit the prisoner’s will against the interrogator’s. They *provoke* anger, thereby *stiffening* resistance.

But they offer a heady payoff: the chance to go mano-a-mano with “the worst of the worst” in a battle of brawn. A December 2004 CIA description of the “prototypical interrogation” is clinical in its tone but clear about what black-site interrogators did. Within hours of “admission” to a secret site, the detainee was stripped naked, shackled, and placed in a “walling collar.” Interrogators then told their captive that they “will do what it takes to get important information.” They backed this up with slaps to the face and stomach when the detainee did or said “anything inconsistent with the interrogators’ instructions.” And, said CIA officials, “once it becomes clear” that the detainee “is lying, withholding information, or using other resistance techniques,” interrogators hurl him repeatedly against a wall—the “walling” for which the collar was designed.⁷⁷ Whether this bullying yielded lifesaving intelligence will long remain a matter of debate. What’s indisputable is that it channeled American outrage over the murder of 3,000 people on 9/11 and the frightening sense of vulnerability that followed.

In its “Guidelines” for the black sites, the CIA’s medical office said “enhanced” interrogation is “designed to psychologically ‘dislocate’ the detainee,” to “maximize his feeling of vulnerability and helplessness.” Dislocation and vulnerability are what vast numbers of Americans felt in 9/11’s wake. “Enhanced” interrogation turned this feeling back onto those who attacked

us—or, at least, onto the few whom we'd managed to take alive. It brought some of us, therefore, security of the psychic sort—a sense, however chimerical, that we could assert control in the face of sudden, dislocating helplessness. And the doctors who supervised the black sites fed that sense of control, or its illusion, by lending an aura of precision and constraint to a ferocious endeavor.

Dr. Burney

Within the CIA's black-site archipelago, enhanced interrogation remained a cottage industry. The armed services, by contrast, embraced it on an industrial scale. By the early spring of 2002, Mitchell's and Jessen's proposal to mine SERE methods for actual interrogation had spread to every theater of post-9/11 warfare. It moved through chains of command, from JPRA to Joint Forces Command and the Pentagon, then to the regional commands responsible for Afghanistan and Guantanamo Bay. And it spread virally among lower-ranking officers who wondered how to get useful information from new captives.

At the highest levels of government, there was near certainty that men held at Guantanamo knew about plots in progress, secret cells, and the whereabouts of Al Qaeda leaders. Guantanamo's commander for intelligence gathering, Major General Michael Dunlavey, was under growing pressure to report breakthroughs. And the toughness of the Mitchell model fit his own take on the men he held, an impression influenced by his years as a juvenile court judge. He had lots of experience with kids who didn't feel guilt—teens who dealt drugs or did worse, without a sense of remorse. The detainees being offloaded from Afghanistan, he told me years later, weren't so different. "They're sociopaths," he said. "They like to kill. They use the excuse of religion to justify it."⁷⁸ And they'd respond to rewards and punishment.

In June 2002, a young psychiatrist, Major Paul Burney, and a clinical psychologist, Major John Leso, arrived at Guantanamo, expecting to treat soldiers with mental health problems.⁷⁹ So it came as a surprise to both that Dunlavey had assigned them to Guantanamo's new Behavioral Science Con-

sultation Team, part of Joint Task Force 170, the unit responsible for interrogation. “[We] were hijacked,” Dr. Burney recalled in 2007.⁸⁰ Like Scott Uithol when he landed in Baghdad, neither had any training or experience in interrogation. Burney was a general psychiatrist with some forensic experience; Leso had developed some expertise in the stresses associated with flight. When I spoke with Dunlavey, he acknowledged their lack of background but defended involving them anyway. “Nobody,” he said, “knew what to do.”

Dr. Burney, though, would become a central figure in the spread of interrogation methods bordering on torture to Guantanamo, then Abu Ghraib. In an e-mail interview, he acknowledged his role, but he insisted he’d voiced misgivings from the start, misgivings that his chain of command ignored. Who at Guantanamo made the ultimate decision to adopt SERE methods is likely to remain a mystery, shrouded in selective memory lapses and incompatible denials. But the basics are clear from interviews with participants in the decision, statements made to Senate Armed Services Committee investigators, and documents that have emerged from government inquiries.

For starters, Dunlavey had decided to “get rough,” whether on his own initiative or under pressure from Washington. “There was pressure for immediate results,” Burney told me, “frequent pressure to produce daily or . . . weekly ‘breakthrough’ of new intelligence information.”⁸¹ And there was, he said “pressure to find a link between Iraq and Al Qaeda” as the Bush administration built its case for war to remove Saddam from power.

Rumsfeld’s List

It was in this charged context that Drs. Burney and Leso reached out to the army’s chief SERE psychologist, Lieutenant Colonel Louie “Morgan” Banks, to arrange training in SERE techniques. “The psychologist on the team [Leso] personally knew Colonel Morgan Banks from prior experiences,” Burney explained. “We thought that if there was any place in the army that could teach us about interrogation in general, it would be Colonel Banks and the army SERE school. Colonel Banks knew and we knew our supervisors wanted us to bring back a ‘how-to’ list of interrogation techniques.”

Banks delivered. He arranged with JPRA for a September training session at Fort Bragg (home to the army SERE school), run by psychologist Gary Percival, who'd taught CIA interrogators two months earlier.⁸² The four-day program included presentations on "rough handling," disruption of sleep cycles, "walling," exploitation of phobias, and exposure to cold.⁸³ Percival insisted to me in an interview that he had no idea how Burney and Leso might use the training (a claim undermined by the fact that four Guantanamo interrogators took part in the program⁸⁴). Banks knew full well what Burney and Leso had in mind. But Banks convinced Burney that use of SERE techniques would backfire. "The goal of the SERE school," Burney told me, "is ultimately to bolster a soldier's ability to resist interrogations, and implementation of similar techniques with detainees would likely do the same."

Kirk Hubbard and James Mitchell wouldn't have disagreed. The SERE experience was designed to inoculate "captives" against learned helplessness; the Mitchell model meant to induce it. Journalists who've said that Mitchell reverse-engineered SERE⁸⁵ missed this point. Mitchell *reengineered* SERE to achieve what SERE trainers sought to guard against. Burney and Leso missed this distinction as well.⁸⁶ They left Fort Bragg with a list of harsh tactics but without an understanding of how to use them to do what Mitchell envisioned.

Despite his doubts, Dr. Burney pressed ahead. Within a few weeks of his return to Guantanamo, he'd drafted a memo with a list of SERE techniques. He told Senate Armed Services Committee investigators that there was "a lot of pressure to use more coercive techniques" and that if his memo didn't include them, "it wasn't going to go very far."⁸⁷ Burney's memo went far indeed. It went up his chain of command, to Dunlavey, then to Southern Command (which oversaw Guantanamo), and then to the Pentagon. There were some tweaks along the way. Simulated suffocation with a wet towel was added; a few items were subtracted, but Burney's list of "techniques" remained mostly intact. On December 2, Secretary of Defense Donald Rumsfeld approved the proposed "techniques," famously writing below his signature, "I stand for 8–10 hours a day. Why is standing limited to 4 hours?"⁸⁸

Remarkably, Burney warned in his memo that his own proposals were dangerous and wouldn't work. SERE techniques, he'd written, put detainees' "physical and/or mental health" at risk and were "likely to garner inaccurate information and create an increased level of resistance."⁸⁹ But this caveat was edited out—"simply ignored and cut," he told me—before his proposal made its way off the island and farther up the chain of command.

Rumsfeld's sign-off formally applied only to Guantanamo but was widely taken as broader approval. Word spread to Afghanistan and, months later, to Iraq that the gloves were off—that it was okay, even desirable, to get tough with terrorists by tapping the list of methods Burney had devised. Local commanders varied the sequencing (and some of the techniques). But the SERE classics—slaps, stress positions, sleep deprivation, nudity, isolation, walling, and water-dousing—were almost always part of the repertoire. Dunlavey's successor, Major General Geoffrey Miller, not only embraced Burney's coercive scheme with ardor at Guantanamo; he brought the approach to Iraq when Pentagon officials sent him there a year later to "Gitmo-ize" interrogation. "You have to treat them like dogs," Miller reportedly said,⁹⁰ circling back, unwittingly or otherwise, to the new interrogation model's origins in Martin Seligman's studies of learned helplessness. The Abu Ghraib Biscuit on which Scott Uithol served was Miller's idea.

Looking Back

Dunlavey took advantage of Burney's standing as a psychiatrist to gain clinical legitimacy for a get-tough approach. Dr. Burney, though, was no mere cog in the machine. More than he preferred to admit after the fact, he took the initiative, consulting colleagues, then crafting a coercive plan. But he judged that the plan wouldn't work—a conclusion disregarded by superiors intent on their get-tough course. Like the CIA's leaders and the lawyers who immunized the Mitchell model, the chain of military command cared much less about the professional rationale for (or against) fierce tactics than about the feel-good message of precision and restraint that medical involvement sent.

As liberals who believe Burney and other military and CIA doctors should face professional discipline have warned, this feel-good message makes room for treatment of prisoners to become more dangerous. Surprisingly, perhaps, Burney agrees. “I think having a BSCT [Biscuit] gives interrogation practices an illusion of medical endorsement,” he told me, “even if the BSCT team has no voice in actually approving or disapproving interrogation policies.” The risk created is that the presence of doctors signals interrogators that they needn’t worry about setting limits. The docs will keep things from going too far, or so the interrogators assume. Meanwhile, there’s a pull on doctors to show that they’re part of the team—to let interrogators push boundaries, especially when boundaries are blurry. The net effect of this dialog of expectations, as Jonathan Marks has suggested,⁹¹ may be to let the ferocity go further than it otherwise might.

Yet Dr. Burney turns this argument back on itself. By contributing to interrogation policy and practice at Guantanamo, he believed, he could set limits: “People have written that I should have simply not participated at all. In retrospect, perhaps that would have [been] best for my own self interest, but I had been educated about the Zimbardo effect, and I knew what would happen if a group of interrogators was simply left alone with a group of detainees with no directions or boundaries for a long enough period of time.”

What *can* happen—what *did* happen at Abu Ghraib, Burney argues—is descent into sadism. In psychologist Philip Zimbardo’s mock prison, set in a Stanford basement, nine “guards,” responsible for nine “prisoners” (all student volunteers randomly assigned to their roles) and left unsupervised, became shockingly abusive over just a few days.⁹² Guantanamo interrogators, Burney said, “were woefully underprepared.” Biscuit doctors could draw on their clinical experience to offer guidance and impose restraint. But, he said, “seasoned, experienced interrogators would have been a much better option than us.”

Dr. Burney’s situational defense of the ethics of his Biscuit service is at odds with the argument the Pentagon made—that medical ethics were beside the point because Biscuit doctors didn’t act as physicians. “I tried my best,” he told me, “not to be a doc when I was at [Guantanamo]. I had my

Geneva Convention card changed from noncombatant to combatant status. I refused to medically evaluate or treat detainees. Try as I might though, I can't help it. I am a doc."

Could Dr. Burney have refused Biscuit service—or, at least, declined to draft the list of techniques that Rumsfeld eventually approved? Typically, army physicians can raise ethical concerns with senior colleagues via the military's distinctive, medical chain of command. Within the armed forces, medicine maintains a surprising degree of autonomy. Doctors serve in separate, clinical units with distinctive legal protections and obligations. They're non-combatants under international law (even army cooks are considered combatants; clergy are the only others with similar standing). Opposing forces can't attack them, and they're not permitted to fight: They can carry arms but they're allowed to use them only in self-defense. They're expected—under army regulations and international law—to adhere to established precepts of medical ethics. And they're required by the Geneva Conventions, the main source of the law of war, to treat friend and foe alike, prioritizing care based on clinical need.

Biscuit service was a radical departure. Biscuit doctors were deployed as combatants, apart from medical units. "A [Biscuit] team," Burney observed, "is the only place I've ever heard of in the army where the doc's chain of command is completely out of the medical system." Dr. Burney reported to a combatant commander. He had no *medical* superior with whom to raise his concerns about the ethics of his role. Moreover, a military intelligence officer (the colonel who supervised him) and Generals Dunlavey and Miller were responsible for his performance evaluations. To do other than comply with their orders posed an enormous career risk. It could even have gotten him court-martialed. Military law requires obedience to commands unless they're "patently illegal."⁹³

Burney could have argued before a court-martial that what he'd been asked to do was illegal, both because the harsh tactics violated military law and because medical complicity in such abuse was unethical. Military regulations require medical officers to adhere to professional ethics, which, in turn, proscribe complicity in tactics contrary to international law. But Dunlavey

had obtained a legal memo from Guantanamo's Judge Advocate General officer approving the techniques.⁹⁴ This was enough to establish that they weren't *patently* unlawful—and that medical assistance in designing and employing them was, therefore, not *patently* unethical. Had Burney refused to prepare the proposed list of coercive techniques, he could have been court-martialed and convicted.

Discussion of the awkward fit between Biscuit service and Hippocratic ideals was, in short, silenced by career anxieties, legal apprehension, and the command scheme at Guantanamo. The claim that Biscuit doctors didn't act as clinicians and that medical ethics thus didn't apply substituted for serious conversation about ethics. Secrecy protected Biscuit doctors and their commanders from accountability for this arrangement until the midnight wilding at Abu Ghraib led to exposure of the interrogation policy that Burney helped to fashion.

