

Provision of Mental Health Services at the Detention Hospital in Guantanamo Bay

Carrie H. Kennedy, Rosemary C. Malone, and Michael J. Franks

Behavioral Health Services, Joint Medical Group, Joint Task Force, Guantanamo Bay

There is significant interest in the mental health status of the detainees held in Guantanamo Bay (GTMO). At the same time, there are many questions regarding their care and the practices of the mental health providers there. This manuscript provides a synopsis of the general mental health status and care of the detainees, as well as their treatment options, the various roles of the mental health providers in GTMO and several of the challenges associated with providing care to this population.

Keywords: military psychology, detainee, Guantanamo Bay, translator, prisoner of war

The detention situation in Guantanamo Bay (GTMO) is a unique one, particularly in the realm of mental health. This is the first wartime scenario in which detained enemy combatants have been provided unfettered access to mental health evaluation and treatment during their detention. This treatment comes from military providers who are well versed in the emotional impact of prolonged detention, learned from the lessons of our repatriated American prisoners of war (POWs) from World War II, Korea, and Vietnam.

This care, however, has been overshadowed lately in widespread media reports and debates about mental health professionals engaging in other than traditional clinical activities. Concern has been raised about psychologists participating as Behavioral Science Consultation Team (BSCT) members, particularly with respect to their role in interrogations. The American Psychological Association (APA) Presidential Task Force on Psychological Ethics and National Security (PENS Report; APA, 2005) focused on the question of psychologists participating in nontraditional national security roles. While

these functions are not in the purview of the clinical providers, operating in an environment which is overshadowed by these debates has created a situation in which the mental health care available to and provided for the detainees goes largely unreported.

The mental health providers at GTMO provide care in accordance with both the APA and American Psychiatric Association ethical guidelines. The standards set forth by the Geneva Conventions for both medical and mental health care are exceeded by the medical personnel at GTMO. These providers are sworn, by virtue of being in the military, to provide consistent and equal care to all persons, regardless of combatant status, as a part of their military duties (Vollmar, 2003).

Mental Health of the Detainee Population at GTMO

At the time of this writing in August, 2006, there were approximately 50 detainees actively involved with the Behavioral Health Services (BHS) of the roughly 450 detainees then held at GTMO. This constituted approximately 11% of the detainee population at the time. Of these approximate 50 individuals, 43%–45% were diagnosed with a personality disorder, 19%–21% were diagnosed with a psychotic disorder, 17%–19% were diagnosed with a mood disorder, 15%–17% were diagnosed with an anxiety disorder, and 13%–15% were diagnosed with a disorder of a different kind (e.g., sleep disorder, malingering). Diagnoses were made carefully over time utilizing medical records,

Carrie H. Kennedy, Rosemary C. Malone, Michael J. Franks, Behavioral Health Services, Joint Medical Group, Joint Task Force, Guantanamo Bay.

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Correspondence concerning this article should be addressed to Carrie Kennedy, 340 Hulse Road, Pensacola, FL 32508. E-mail: carrie.kennedy@med.navy.mil

serial clinical interviews, behavioral observations, and the routine documented guard observations maintained on every detainee. Approximately 3% of all the camp's detainees were prescribed psychotropic medications, representing about 30% of the ~50 detainees actively followed by the BHS. The types of psychotropic medications prescribed at GTMO, including antipsychotics, antidepressants, hypnotics, anxiolytics, and mood stabilizers, are in accordance with the standard of care provided to patients in the United States.

As of August, 2006, approximately another 55 individuals had been discharged from BHS over the years due to resolution of symptoms, and they are followed quarterly to prevent and screen for recurrence of symptoms. Of those discharged from services, approximately 34%–36% were diagnosed with an anxiety disorder, 28%–30% were diagnosed with a mood disorder, 18%–20% were diagnosed with a personality disorder, and 3%–5% were diagnosed with a psychotic disorder.

While finding a directly analogous population with which to compare the GTMO detainee population was not possible, some numbers from U.S. prisons and jails and historical data from repatriated POWs may assist in putting these numbers in perspective. The rate of mental illness of those incarcerated in U.S. facilities is significantly higher than that seen at GTMO. According to the U.S. Department of Justice, 56% of State prisoners, 45% of Federal prisoners, and 64% of jail inmates had a history and/or active mental health symptomatology (James & Glaze, 2006), with the most common diagnoses being substance abuse or dependence. Depression was reported in 23.9% of inmates in State prisons, 16.2% in Federal prisons, and 30.4% in local jails. Psychotic symptoms were reported in 15% of State prisoners, 10% of Federal prisoners, and 24% of jail inmates.

With regards to POWs, data is available from repatriated service members through various wars. For example, Sutker and Allain (1996) reported that 88% to 96% of surviving American POWs from Korea had a mental health condition related to the experience of their captivity. It is estimated that half of those captured in Germany and Japan during World War II developed post-traumatic stress disorder (PTSD; Goldstein, van Kammen, Shelly, Miller, & van Kammen, 1987; Zeiss & Dick-

man, 1989). The Vietnam findings are significantly different, with 18.6% of repatriated POWs endorsing symptoms of a mental health disorder (Nice, Garland, Hilton, Baggett, & Mitchell, 1996). The significantly lower rate of mental health problems in this population is hypothesized to be due to the fact that the majority of the 661 service members captured during Vietnam were aviators, who were well-educated, high functioning and utilized highly effective coping strategies throughout their captivity (J. Moore, personal communication, October 26, 2007). One study looked at Kuwaiti military personnel during the first Gulf War (Al-Turkait & Ohaeri, 2007). Of this sample, 48% of Kuwaiti POWs repatriated from Iraqi forces endorsed symptoms of PTSD. While the conditions of GTMO are not directly comparable to those of prior wars, the mental health services provided at GTMO take all of this information into account in order to best serve the detainee population.

Behavioral Health Services

Referral Process

The referral process is inherently simple to ensure that all detainees in need of mental health care are offered services. Accordingly, referrals for evaluation can be made by almost anyone in the camp, including self-referrals, medical personnel, the guard staff, and other detainees. The only individuals who are not permitted to refer directly to mental health staff are BSCT members and any personnel involved with interrogations. As the primary mission of the clinical psychologists who serve as BSCT members is not a medical one, ethical codes of conduct and military instructions (APA, 2005; Department of Defense, 2006; Staal & Stephenson, 2006) prevent their direct involvement in any clinical activity related to an interrogation subject. In the event that one of these individuals believes that a detainee may require evaluation, there is a process through which they can communicate this information to a neutral party, who will in turn generate a referral. In the event that BSCT psychologists raise concerns about detainees, there are safeguards in place that prevent them from receiving any feedback regarding mental health diagnosis, evaluation, or treatment of a detainee.

Treatment

BHS falls under the Joint Task Force (JTF) Detention Hospital and shares the mission of providing quality, compassionate, timely, and safe health care services to the detainees. In order to meet this mission, the BHS provides both inpatient and outpatient evaluation and treatment. BHS staff includes approximately 18–20 mental health providers composed of psychiatric technicians and corpsmen, psychiatric nurses, a psychiatrist, and a psychologist, in addition to carefully selected military guards and linguists. The guards act as escorts for detainees within the mental health unit (e.g., to shower, recreation), serve meals, ensure the safety of both detainees and staff members, and enforce the rules of the camp. Camp rules are adapted for the medical mission of the unit and allow increased communication (e.g., open bean holes) and activities (e.g., increased library access) for the detainee-patients held there. The linguists act as interpreters predominantly in Arabic, Farsi, Pashtu, Persian, Russian, Uigher, Urdu, and Uzbek, though linguists are available for all languages spoken in GTMO. The detention facility also employs a formal full-time cultural advisor who interacts with the detainees and provides advice to all components of the facility, including BHS.

Between the inpatient unit and outpatient services, the behavioral health staff logs, on average, over 900 contacts per month, making the BHS the most active health service within the camp. This seemingly high number is reflective of the numerous services provided by BHS. First, there is a need for daily contact with the detainees that have been diagnosed with serious mental or personality disorders. There is also monthly psychological screening conducted with all detainees in certain maximum-security locations for purposes of prevention and early intervention, as well as weekly screening of those on a hunger strike. Traditional treatment, such as psychotherapy and supportive counseling is also provided. In addition, BHS acts as consultant to the Joint Medical Group, and the greater Joint Detention Group and JTF.

Facilities include an inpatient unit (Behavioral Health Unit, BHU) consisting of 16 beds, two recreation areas, and a room for the interview/treatment team meetings. The inpatient census averages eight, and patients carry diag-

noses ranging from schizophrenia to personality disorders. Inpatients are provided standard mental health care services, which include but are not limited to the following: acute stabilization, crisis intervention, observation for diagnostic clarification, pharmacotherapy, and psychotherapy. Treatment plans are developed for each patient to provide therapeutic interventions. Inpatients have daily contact with BHU staff during scheduled meetings and medication times. BHU staff also meets with any patient by the request of the patient or guard staff. As in the United States, primary care physicians, as well as various medical specialists, are consulted when needed to provide management and treatment regarding medical issues. The inpatients at the BHU are provided regular recreation, access to library books, time to read incoming and write outgoing mail, and the opportunity to interact with one another on a daily basis. The psychologist and/or psychiatrist are also available to the detainees for care 24 hr a day, 7 days a week.

Detainees treated on an outpatient basis are afforded similar services as detainees at the BHU, but are integrated into the general population, which provides the added benefits of provision of support from fellow detainees, and in the case of some patients, actual family members. The low rate of clinical depression noted above is thought to be largely due to the fact that the detention facility, as a general matter, intentionally locates detainees with the same cultural and geographical backgrounds together. This prevents isolation and fosters support, which has a significant bearing on morale. This in turn enables implementation of effective coping strategies and prevents feelings of despair. In the case of behavioral health outpatients, this appears to have a protective effect on the reemergence of clinical symptoms.

The outpatient program is based on lessons learned by past U.S. experiences with prolonged captivity (see Doran, Hoyt, & Morgan, 2006). Research has shown that those who have a strong faith in God, country, and one another do better psychologically, as well as those who are able to maintain a sense of humor (Henman, 2001) and focus on issues under their individual control, such as creating and following an exercise plan (Ursano & Norwood, 1996). These concepts are integrated fully into outpatient treatment and in conjunction with cognitive-

behavioral techniques and supportive therapy, have been well received by the detainees. As noted above, also considered is the extensive research on repatriated American POWs and the difficulties they experienced both during and following their captivity (Cohen & Cooper, 1954; Cook, Riggs, Thompson, Coyne, & Sheikh, 2004; Goldstein et al., 1987; Hall & Malone, 1976; Hunter, 1975; Page, Engdahl, & Eberly, 1991; Polivy, Zeitlin, Herman, & Beal, 1994; Query, Megran, & McDonald, 1986; Rundell, Ursano, Holloway, & Siberman, 1989; Sutker, Allain, Johnson, & Butters, 1992; Ursano, Boydston, & Wheatley, 1981; Zeiss & Dickman, 1989). Mental health treatment for the detainees takes all of this into consideration in order to optimize care, prevent mental health symptoms and development of disorders, and to provide consultation to the leadership to assist in further avoiding mental health disorders in the population.

The Role of the Mental Health Provider in the Case of Hunger Strikers

As has been well-publicized, and in accordance with the Department of Defense Instruction 2310.08E, Medical Program Support for Detainee Operations (Department of Defense, 2006), as well as in accordance with the Joint Medical Group's policies at the Detention Hospital, hunger strikers who are medically compromised due to a hunger strike are enterally fed. When a detainee has missed the number of meals required to meet the criteria to be considered a hunger striker, BHS staff screen him to determine if the decision to hunger strike is potentially due to untreated symptoms from an underlying mental illness. Given the inherent stressful nature of hunger striking, as well as the potential emotional and cognitive consequences of a lack of nutrition, all detainees on a hunger strike are monitored weekly by BHS. Of note is that no hunger strikers at GTMO have been deemed by a mental health provider to be refusing food due to mental illness or due to being suicidal (i.e., the primary reason to stop eating was a desire to die). In contrast, all have had specific demands (e.g., to go home, to close the detention facility) with the goal of bringing attention to their cause and to stop the hunger strike once their situation changed in a favorable way.

Suicidality

Although there may be underreporting of suicide attempts and completed suicides in Muslim countries where suicidal behavior is illegal, one recent article concluded that suicide rates are much lower in Muslims than in those belonging to other religious groups (Lester, 2006). In the United States, the annual incidence of suicide in the general population is approximately 10.7 suicides for every 100,000 persons, or 0.0107% of the total population per year (Jacobs et al., 2003).

According to the United States Department of Justice's Bureau of Justice Statistics for 2002 (Mumola, 2005), the suicide rate in State prisons was 14 per 100,000 inmates per year and 47 per 100,000 inmates per year in local jails. However, these rates are not directly applicable to the detainee population at GTMO's Detention Facility. At the time of this writing, no data was available regarding the rates of suicide by Muslims in detention facilities or prisons.

The BHS staff is trained to screen and assess for suicidal ideation, plans, and intentions, and each contact with a detainee specifically assesses the detainee's risk of suicide during the interview. Suicidal ideation is defined as thoughts of wanting to kill oneself. These thoughts vary in severity depending on the degree of planning and intent. Self-injurious behavior consists of suicide gestures, suicide attempts, and completed suicides. A suicide gesture is a deliberate injury to one's own body without intent to die, often in order to obtain secondary gain. Detainees have made suicide gestures at GTMO, for example, because they wanted to move to another cell or block or because they wanted changes made to their diet. A suicide attempt is defined as a deliberate act focused on taking one's life that does not result in death, due to the nonlethality of the method chosen or due to medical intervention. A mental health provider determines if the incident was a suicide attempt based on both implicit and explicit information gathered from the detainee; collateral information from other sources, including, for example, guards, medical staff, medical records, and other detainees; and circumstances of the event, including extent of injury. Suicides are defined as self-inflicted death. At the time of this writing, there have been over 600 suicide gestures, and over 40

suicide attempts made by approximately 26–28 detainees, with one detainee making over 10 attempts. Three deaths in June 2006, considered probable suicides, remained under investigation by the Naval Criminal Investigative Service (NCIS) at the time we departed GTMO. A fourth was reported in May 2007.

Therapy for Detainees

A question that has been asked is whether a Western-trained military provider can adequately evaluate and treat an enemy combatant from a different cultural and religious background, with significantly different views about important aspects of life and self. Issues of rapport building, informed consent, multicultural competence, mixed agency, and other challenges come into play.

Rapport

As one might expect, rapport can be difficult to establish in this environment. There are issues of trust on both sides, with the detainee suspicious of the motives of the mental health provider, who is always a military provider. Conversely, the mental health provider must be cognizant of ulterior motives of the detainee and always take precautions regarding his or her own safety. As with any population of patients, success in building rapport with the detainees varies widely. With those who grow to engage in treatment, rapport is generally gained over time by following through on commitments, being respectful, showing a genuine interest in the detainee's concerns and experiences, actively learning about the detainee's views and beliefs, being willing to be flexible in treatment provision, and directly addressing the assumptions of the detainee regarding mental health treatment and beliefs regarding non-Muslims and Americans.

Informed Consent

Informed consent for mental health evaluation and treatment is a complex issue at GTMO. As mandated by instruction, consent for medical treatment is required for any detainee to be provided any kind of care. Exceptions include emergency medical situations (e.g., suicidality in the case of mental health), medical treatment

required to protect public health (e.g., communicable diseases), and detainees deemed at risk of dying due to a hunger strike (Department of Defense, 2006).

As a general rule, informed consent requires that patients are told about the nature and purpose of any treatment, risks and benefits, and alternative approaches, that consent is voluntary, and that the individual is competent to make meaningful decisions (Grisso & Appelbaum, 1998). The first aspect of informed consent is challenged somewhat by barriers in language and in sometimes disparate cultural views of mental health issues. This topic is elaborated upon in the discussion below of multicultural competence and is not considered an insurmountable obstacle by providers at GTMO.

The second aspect of informed consent, that the patient is voluntarily agreeing to evaluation or treatment without coercion, is more difficult. This, however, is not a situation unique to GTMO. The issue of being able to provide informed consent in any forensically based facility has been questioned, as the relationship between the provider and the patient is inherently different, as is the nature of the environment (Weinstein, 2002). While the coercive authority confound of detention facilities is difficult to eliminate (Rigg, 2002), at GTMO the impact appears to be at least somewhat negated, and this has improved over time as the detainees have become more comfortable that medical providers have a strictly medical mission. Detainees frequently refused evaluation and treatment, including detainees with serious mental health conditions. No detainee was involuntarily treated, unless deemed incompetent and a risk to self or others.

The third general aspect of informed consent, that of competence, was not a primary difficulty for mental health providers at GTMO. Recommendations to involuntarily treat a detainee were made using the same criteria of any mental health patient (e.g., Van Staden & Kruger, 2003). In the case of a detainee being deemed not only incapable of making an informed decision but also imminently dangerous, a presentation was made to the Bioethics Committee at the Naval Hospital, GTMO. This group existed independent of the medical providers who worked with the detainees and provided objective input regarding involuntary treatment.

Multicultural Competency

Rapport building and multicultural competency go hand in hand since the best rapport is established by being a competent provider. While establishing multicultural competency at GTMO is a challenge, one which is compounded by the fact that many patients exhibit extreme political and/or religious views, military mental health professionals may be especially suited to the task. According to Kennedy, Jones and Arita (2007), military psychologists routinely work with large numbers of diverse racial, ethnic, and religious groups, given the demographic composition of U.S. military men and women and their family members, in conjunction with routine military service in other countries. These authors suggest that these experiences and opportunities place military psychologists in a good position “to effectively address the unique issues presented by human diversity (p. 166).”

In this light, the unprecedented mental health scenario in GTMO has required a paradigm shift in practice for U.S. military providers. The acceptance of Western diagnostic formulation among the detainees is low and its appropriateness debatable. At times a patient’s presentation is inconsistent with any formulation using the traditional diagnostic criteria found within the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV, American Psychiatric Association, 1994) and some individuals appear unable or unwilling to accept Western terminology (e.g., the issue of anxiety may be unaccepted and subsequently untreatable, while an individual’s heartbeat abnormality may be effectively treated). In order to enhance this, mental health providers have had to learn a great deal about the various cultures the detainees come from and work within that framework (e.g., Dwairy, 2006). Symptoms that may be considered pathological in one culture can be considered normal in another. In some cases when detainees have been bothered by “jinns or genies” (just one example of a culturally specific phenomenon), it is the other detainees on the block who often offer the most pertinent assistance in the determination if something is considered normal or abnormal. Cultural norms must be applied for some forms of treatment (e.g., fasting or specific changes to diet) and the more traditional Western forms of treatment

have been significantly and successfully re-framed. In order to facilitate multicultural treatment at GTMO, the mental health providers there have access to an Imam and cultural advisor for consultation, are provided mentoring as needed from mental health providers who have already served in GTMO, and incorporate culturally specific training into staff education. In addition, informal education is provided through both professional and social contact with the many linguists at GTMO (see below).

Mixed Agency

Military psychologists and psychiatrists are well acquainted with the notion of dual or mixed agency, the simultaneous obligation to two or more entities. From the first day of work, the responsibility for both the military patient and the Department of Defense is omnipresent (see Zur & Gonzalez, 2002; Howe, 2003b). Treating the detainees of GTMO is no different. There is a dual duty to the detained patient and to the military mission. It is challenging to provide the highest quality mental health care to detainees while at the same time working with the military mission focus. However, as members of the military, mental health staff have been trained to focus on the mission by maintaining situational awareness and managing force protection issues that could disrupt the camp, including preventing self-harm and maintaining order in detention facilities when a detainee’s behavior threatens to disrupt the camp (Department of Defense, 2006). Additionally, and at the same time, these staff members have been trained to know how to provide quality mental health care by managing boundary issues and suspending judgment when treating detainees. Lastly, any health care provider (or staff member) who suspects detainee abuse or maltreatment is mandated to report and document the allegation, which then gets reported to the medical chain of command and investigated by personnel at the Joint Detention Group (Department of Defense, 2006).

Despite the debate over whether psychologists and psychiatrists should be consulting in information-gathering activities, treatment is designed to keep detainees safe and prevent significant problems, as well as to strengthen individuals psychologically. Military providers, in addition to their commitment to the medical

mission, have a strong desire to see captured U.S. servicemen treated well and believe that treating people humanely will have a direct impact in this area. Howe (2003a) indicates that negative attitudes are infrequent among military providers as they relate to treating captured enemy and attributes some of this to mandatory military training for medical personnel and recognition that some detainees were in inordinately poor health independent of the conflict, and identified them simply as patients in need of care.

Unique Challenges Related To Providing Mental Health Services to Detainees

Military Women

Women working in GTMO are often asked how they are received by the detainees. Perhaps partially due to the fact that all GTMO staff, both male and female, are covered at all times (except for hands and head), as well as the lengthy confinement of the detainees and subsequent exposure to U.S. military women, this rarely becomes a problem. The issues that do arise in the mental health treatment situation are usually easily addressed through the male linguists or by using male staff for sensitive information.

Interpreters

Interpreters play an important role in the day-to-day functioning of GTMO. Many of the interpreters have been working at GTMO for a significant period and already have a rapport with the detainees. This is a significant asset given the inevitable turnover of medical staff. Including interpreters formally in the therapeutic alliance is advocated in the field (Miller, Martell, Pazdirek, Caruth, & Lopez, 2005) and these linguists play an integral part in the facilitation of the evaluation and treatment of the detainees. The literature suggests that interpreters can play a major role in the provision of education for professionals regarding cultural issues, assisting in tailoring treatment to optimize evaluations or sessions, and assisting in the accurate assessment of behavior (Schmitt, 2002; Miller et al., 2005). The interpreters at GTMO are utilized for all of these aspects of treatment.

Many of the interpreters at GTMO are highly skilled in being able to take questions and explanations from the military providers and help to translate these in a way applicable to our needs and acceptable to the beliefs of the detainee. The skilled and vigilant linguist is even able to recognize when a question might offend or shut down a patient, and they occasionally clarify that a specific question must be asked or propose an alternative way to ask the question. Reliance on the interpreters for cultural information and guidance is significant and is just one of the ways the staff of GTMO are constantly receiving education on the culture and beliefs of the detainee population.

One interesting phenomenon that has occurred in GTMO is that many of the detainees have become proficient, if not fluent, in English. Despite this, mental health evaluation and treatment is best done through the interpreter. Emotional and embarrassing topics are generally open for discussion if the information is being passed to the interpreter as opposed to directly to the American mental health provider. Consistent with research regarding bilingual speakers being more comfortable speaking in their native tongues regarding physical and mental health issues, many of the detainees also seem more willing to discuss mental health topics in their own language (Javier, Barroso, & Muqoz, 1993).

Personal Safety Precautions

In the detention environment one must always be cognizant about personal safety. Recent news reports have published the reality of the safety concerns of the personnel working in GTMO. Besides physical assaults, personnel are routinely exposed to being spat upon or having excrement thrown at them. The guards bear the brunt of this, followed by the hospital corpsmen, due to their close and constant proximity to the detainees. Medical staff members have been issued stab vests because of the dangers associated with providing medical care to the detainees.

Because of the safety precaution issue, mental health providers at GTMO have had to improvise regarding the best location for specific interventions. The safest place to see a detainee is in his cell, though this generally provides for very little privacy for the detainee. The most

private venue is in the interview room of the BHU, but the drawback here is the fact that the patient must, for safety reasons, be restrained, which is not considered conducive by the mental health staff to therapeutic interventions. The favored location for the provision of services is the recreation areas. This allows safety for the provider and freedom of movement for the detainee; the caveat is not to interfere with the recreation time of the other detainees.

Clinician Role in Information Gathering

There have been several articles published which have cited a confidential International Committee of the Red Cross report and accused medical personnel at GTMO of providing medical information to agencies whose role is to gather intelligence (Bloche & Marks, 2005; Okie, 2005). While we can only speak to our experiences, this is not a practice. The only exception to this is when a determination needs to be made regarding a detainee under our care regarding whether he is considered medically stable for interrogation. This recommendation is forwarded to the JTF Surgeon, who combines our information with that of other treating medical professionals, and then provides a yes or no response, which contains no details or explanations for the decision. The mental health providers at GTMO have no direct professional contact with BSCT psychologists or interrogators, and these individuals have no access to medical records. Individuals who are deemed not competent or potentially vulnerable to harm by virtue of a mental illness, are not approved for information gathering.

One of our main goals in writing this article was to address the misperceptions of the situation at GTMO with regards to detainee mental health and mental health practices. Military mental health staff are trained to adhere strictly to professional codes of ethics (see APA, 2002; American Psychiatric Association, 2006) and to the Uniformed Code of Military Justice, both of which prohibit maltreatment of detainees. In addition, it has been our experience as providers and consumers of medical resources that the detainees have extraordinary access to initial and ongoing care. With regards to mental health, any detainee can access services easily with just a simple

request to any JTF staff member. Even non-urgent requests receive a rapid response by a psychiatric technician and evaluation by a provider within 24 hr.

The situation in GTMO is evolving and has become more finely tuned over time. From the perspective of the mental health providers, corpsmen, and carefully selected and trained guards of the BHS, the detainees are provided the highest quality care. Detainees do not need to have a mental health diagnosis to be provided services. A simple request for supportive counseling due to the difficulty of their situation is readily provided. Anecdotally, of interest is that the largest barrier in accessing services is the same as for service members, the stigma attached to being seen by mental health care providers. Increasing the privacy of meetings and destigmatizing the use of mental health services is a constant focus.

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