The Expected Psychiatric Impact of Detention in Guantanamo Bay, Cuba, and Related Considerations

GRANT HILARY BRENNER, MD
William Alanson White Institute, New York, New York, USA

What are the likely mental and related physical health consequences of prolonged exposure to common stressors to detainees at Guantanamo Bay, Cuba? Significant distress leads to high rates of psychiatric disorders, medical problems, and functional impairments. The consequences are severe, physically and psychologically, affecting the individual, his or her family, and the culture at large. Damaging conditions endured by detainees are multiple and severe and are reviewed here in detail. The author identifies parallels between Guantanamo detainees and similarly mistreated populations (e.g., prisoners of war, asylum seekers, prisoners) to draw inferences from existing research regarding likely outcomes for Guantanamo detainees. Protective factors normally present are systematically disrupted at Guantanamo. Overall, it is likely that detainees and their families are experiencing significant mental and physical health problems as a result of overlapping severe and chronic stressors related to detention and that this will worsen over time, particularly in the absence of appropriate assessment and treatment. The author addresses political and ethical
INTRODUCTION

It is now common knowledge that Guantanamo detainees endure conditions that consist of abuse and trauma embroiled within complex geopolitical, societal, cultural, and ethical contexts. Guantanamo has become emblematic, but there are many other places where such offenses occur. In this article, I discuss the available literature regarding various forms of mistreatment, abuse, and distress as experienced by Guantanamo detainees; review relevant literature about the impact on family systems; and discuss the implications of these findings. Pathological outcomes have been found in all researched populations subjected to similar conditions. There is no reason to believe that Guantanamo detainees will fare better; in fact, conditions at Guantanamo are such that resilience and coping factors are systematically disrupted. For example, social supports and religious activity are often disrupted, and interrogation techniques arguably result in chronic disruptive altered states of consciousness (Vaitl et al., 2005).

Scant data are available on current rates of mental illness among Guantanamo detainees because independent medical evaluations are not permitted. Reports from lawyers, reporters, and released detainees describe increasing depression, anxiety, psychosis, and personality disorders (Amnesty International [AI], 2007; Gebauer, Goetz, & Sandberg, 2009; Goetz & Sandberg, 2009; Gorman, 2007; Razek, 2006). Physicians for Human Rights (PHR, 2005) reported that military sources confirmed high rates of mental illness among Guantanamo detainees, noting that in 2003 there were 350 reported acts of self-harm, including 120 attempted hangings. Despite the opening of a psychiatric facility in 2004, there were 110 incidents of self-harm. Self-injurious actions are often considered by the military to be manipulative, a belief that reduces the level of care (PHR, 2005). Erik Saar, who worked as a military interrogator in Guantanamo for more than 6 months, reported that detainees were screened for evidence of mental illness and self-injurious ideations, but the screenings were perfunctory, with superficial denial of problems (Saar & Novak, 2005). Although evaluation of detainees generally remains prohibited, recent reports (AI, 2007; Gebauer et al., 2009; Goetz & Sandberg, 2009; Gorman, 2007; Human Rights Watch
[HRW], 2008; PHR, 2008; Razek, 2006) confirm that mental and physical health continue to deteriorate. Treatment and evaluation remain inadequate, with ongoing psychiatric complaints and suicide attempts. This is exacerbated when detainees have been cleared for release and have nowhere to go, trapped in purgatory between fearing torture if they return to their home countries and lacking asylum from other countries (HRW, 2008; PHR, 2008).

The role of mental health and medical professionals in working with detainees has sparked national debate. The original version of this article was a report used in a successful lawsuit by several detainees against their government in the European Court of Human Rights. Although it is not my primary purpose here to address ethical and moral considerations, they are implicit and, at times, explicit. Here I report the relevant literature and argue for effective prevention, assessment, and follow-up for individuals and their families. I hope this article will support efforts toward social justice. Advocacy helps individuals via multiple pathways, mitigating against cycles of retraumatization on a societal level (Lindner, 2002) and reestablishing professionals as trustworthy and ethical (Freyd, 2009; Pope & Gutheil, 2009). What is disturbing is that the abuses described herein continue at Guantanamo and elsewhere in spite of public awareness and successful advocacy efforts (Gebauer et al., 2009; Goetz & Sandberg, 2009; HRW, 2008; PHR, 2008).

Very few studies in the reviewed body of literature directly address the role of dissociation. Researchers and clinicians should include this key missing element in the study of torture and related abuses to improve effectiveness in many spheres—clinical, research, and advocacy.

SPECIFIC CONDITIONS AT GUANTANAMO

Prolonged Isolation and Sensory Deprivation

Authorities routinely confine detainees in isolation at Guantanamo, often for 22 hr per day, in small rooms with minimal exercise or stimulation. Nearly 80% are isolated, often for years. In maximum security areas, there is minimal activity, companionship, or physical exercise. Between detention and capture, authorities transport detainees in confinement and isolation; hooded, restrained, wearing thick gloves and dark goggles, trapped in shipping containers with loud music playing constantly (AI, 2007; Center for Constitutional Rights [CCR], 2006; PHR, 2005, 2008). The military has held detainees in isolation, deprived of food and medical care, regardless of declining health (Gorman, 2007).

Andersen et al. (2000) reviewed research on the effects of solitary versus non-solitary confinement, reporting that solitary confinement is associated with a higher degree of psychopathology and is “a stress factor giving rise to a surplus of symptoms” (p. 19), while noting minor contradictory find-
ings. In a follow-up longitudinal study, they found that those in solitary confinement had higher rates of psychiatric disorders (28% vs. 15%) with increased anxiety, depression, and psychosomatic complaints. A minority reported hallucinations after 3 weeks of solitary confinement, other perceptual changes, and derealization and depersonalization (Andersen et al., 2000) without quantified assessment of dissociative symptoms. Linkages between solitary confinement and mental illness have been confirmed in other studies of prisoners in North America (Suedfeld, Ramirez, Deaton, & Baker-Brown, 1982) without clear assessment of dissociative symptoms.

Researchers have studied prolonged isolation and sensory deprivation in extreme environments, including polar expeditions and capsule habitats. Such environments (i.e., isolated, confined environments) affect human beings consistently across diverse contexts (Suedfeld & Steel, 2000). Crews on polar expeditions experience isolation, confinement, crowding, reduced natural light, and disrupted circadian rhythms, evidencing high levels of depression, anxiety, paranoia, and sleep disorders. Commonly reported complaints include fatigue, weight gain, abdominal problems, rheumatic problems, headaches, disrupted sleep, impaired cognition, susceptibility to suggestion, dissociative states (“Antarctic stare”), negative emotions, and interpersonal tension and conflict (Palinkas & Suedfeld, 2008). Researchers reported similar findings in studies of confinement during space missions (Harrison, 2001). Such problems occur in ergonomically designed environments among individuals selected and trained for increased resilience. In Guantanamo, in contrast, protective factors are deliberately and systematically disrupted.

Sensory Overstimulation, Sleep Deprivation, and Circadian Cycle Disruption

Multiple sources extensively document the use of sensory overstimulation at Guantanamo. Detainees are exposed to loud repetitive music during interrogation and transport as well as constant noise within detention facilities, creating a highly distressing and chaotic environment. Such conditions are intended to disrupt normal thought patterns and biological cycles, to facilitate interrogation by lowering resistance. Continuous exposure to fluorescent light 24 hr per day is well documented (except when darkness is used for sensory deprivation), with deliberate disruption of normal sleep cycles (AI, 2007; CCR, 2006; Cusick, 2006; Peisner, 2006; PHR, 2005; Saar & Novak, 2005). Studies of lighting in occupational medicine and of unnatural (fluorescent) light show a consistent pattern of negative impact from suboptimal light (Küller & Thorbjörn, 1998). The absence of natural lighting is associated with health problems and poor performance (Van Bommel, 2006).

Cusick (2006) described the effects of directed acoustic energy weapons in discussing how music and sound may be used to torture people. The Joint
Non-Lethal Weapons Task Force has developed such weapons, which have “disabling or lethal” effects on human beings, for use in crowd control or hostage situations. The Long Range Acoustic Device, which projects a cylinder of sound with a volume of 120 to 150 dB, is used for secure communication and clearing crowds. It is also used to flush combatants into the open, where they can be killed with conventional weapons.

Intense sound is capable of inducing nosebleeds, severe ear pain, massive anxiety, disorientation, and disrupted cognition. Cusick reported that loud music and disturbing sounds are used routinely during interrogations in combination with other techniques, leading to “identity disintegration” within a matter of days as a form of “no-touch torture.” She cited research from government-funded studies at Yale, Cornell, and McGill and integration of the findings from these studies into the Central Intelligence Agency Kubark Counterintelligence Interrogation Handbook (Cusick, 2006). In the face of ongoing, overwhelming distress, dissociative defenses are heavily used, predisposing one to later pathology (Breh & Seidler, 2007; van der Hart, van Ochten, van Son, Steele, & Lensvelt-Mulders, 2008).

Numerous studies—animal and human—have chronicled the effects of noise on neuroendocrine, cardiovascular, and sleep function. Exposure to loud noise has been associated with impaired cardiovascular function, hypothalamic–pituitary–adrenal axis dysfunction, impaired hippocampal and memory encoding activity, elevated amygdala activity, and increased recall errors (Andren, 1982; Burow, Day, & Campeau, 2005; Eggertsen, Svensson, Magnusson, & Andren, 1987; Gesi et al., 2001; Hirano et al., 2006). Stress hormone dysregulation and amygdala–hippocampal dysfunction have been implicated in posttraumatic stress disorder (PTSD) and other psychiatric disorders, including depression, anxiety (Nemeroff et al., 2006), and dissociative disorders (Simeon et al., 2007).

Military procedure prescribes sleep deprivation and disruption of sleep schedules for Guantanamo detainees, purportedly to assist in interrogation efforts by softening defenses. Personnel expose detainees to artificial light around the clock, disrupting normal circadian rhythms. Individual reports from human rights groups, eyewitness accounts, the International Committee of the Red Cross, and affidavits from lawyers and released detainees show that standard operations deprive detainees of restorative sleep. Interrogation procedures frequently dictate that detainees be woken up and moved every few hours on a regular schedule, forced to remain upright for hours on end, and exposed to constant loud music played over extended periods of days to weeks or longer (AI, 2007; CCR, 2006; Cusick, 2006; HRW, 2008; Peisner, 2006; PHR, 2005, 2008; Saar, 2005).

In studies of the health impacts of sleep cycle disruption, participants developed a variety of severe psychological and medical problems, including cardiovascular, gastrointestinal, and metabolic disturbances. They showed decreased performance and increased likelihood of accidents
and injuries (Klerman, 2005). Sleep deprivation contributes to infection, fibromyalgia, cancers, decreased cognitive performance, impaired emotional function, mood disturbance, cumulative neurobiological changes, and ineffective coping (Rogers, Szuba, Staab, Evans, & Dinges, 2001). These factors replicate biological changes associated with depression and other mood disorders and contribute to an increased incidence of pathology (Meerlo, Sgoifo, & Suchecki, 2008).

Sleep deprivation and disruption are core features of PTSD and are contributory factors to more severe illness and disability (Caldwell & Redeker, 2005). The treatment of sleep disturbance and resumption of normal sleep behavior is a key component in effective treatment and prevention (Germain, Buysse, & Nofzinger, 2007).

Sleep and trauma are related in other important ways as well. Impaired sleep decreases memory processing, predisposing one to ongoing posttraumatic stress, and impedes recovery (Breh & Seidler, 2007; van der Hart et al., 2008). Cumulative experiences of trauma correlate with higher degrees of sleep disturbance. Hyperarousal associated with sleep disturbance impairs cognitive functioning and effective coping (Caldwell & Redeker, 2005). However, no studies have specifically examined the causal impact of sleep cycle disruption on dissociative disorders.

Sexual Abuse and Humiliation

Various sources report that military and intelligence personnel have forced detainees to interact sexually with one another and have exposed them to explicit sexual material (both to humiliate and to act as incentive for sharing information). Female personnel have used sexually provocative behavior and attire to distress detainees whose beliefs and culture often prohibit such interactions with women. Personnel have used gender-based humiliation to interfere with religious practices (e.g., mock soiling of Islamic detainees with menstrual blood, rendering them unclean and unable to pray). Other practices include forced nudity, deprivation of basic privacy, and reports of compulsory body cavity searches for purported medical purposes (e.g., on at least one occasion the forcible insertion of an enema). Such activities, especially for observant Muslims, interfere with the ability to practice religion, destroying sources of resilient coping, and furthermore are directly traumatizing and abusive (AI, 2007; CCR, 2006; Clark, 2006; Greenberg & Dratel, 2005; Lewis, 2004, 2005; PHR, 2005, 2008; Saar & Novak, 2005).

Although sexual humiliation and abuse against men is common during war, it remains minimized because women have traditionally been seen as the sole victims of rape—a belief that is bolstered by cultural and legal definitions of rape that exclude male sexual abuse—and because of the stigma and consequent underreporting associated with male sexual abuse.
Psychiatric Impact of Detention in Guantanamo Bay

Clinicians are often not trained to address the psychological effects of sexual assault on men (Gartner, 1999; Stener, 1997). Potential consequences include sexual dysfunction, PTSD, depression, dissociation, and psycho- and somatoform symptomatology (Gartner, 1999; Lunde & Ortmann, 1990; Oosterhoff, Zwanikken, & Ketting, 2004; Peel, Mahtani, Hinshelwood, & Forrest, 2000). Sexual abuse in military contexts is reportedly pervasive and systematic in military culture, leading to repetitive cycles of suppression, secrecy, and abuse (M. Hunter, 2007), predisposing military personnel to enact familiar patterns of abuse with detainees. The deleterious effect on mental and physical health, and relationships and family (discussed later), is likely to be massive and inadequately addressed.

Religious and Cultural Abuse

Sexual and cultural humiliations go hand in hand. Many instances of non-sexual cultural humiliation have been reported to occur at Guantanamo. Religious tolerance for Islamic practice is ostensibly preserved according to the U.S. military’s standard operating procedures for Guantanamo (G. D. Miller, 2003). The reality is that expert consultation is not used to protect religious practice but is subverted (and arguably perverted) to guide disruption of religious practices in order to weaken detainees’ psychological resistances (Colley, 2006; PHR, 2005). Despite assurances that breaches of standard operating procedure are rare, journalistic reports indicate that desecrating the Koran (e.g., by mishandling it, splashing it with urine, touching it, stepping on it and kicking it across the room, throwing it on the ground, placing unclean items such as underwear on top of it, and even flushing it down the toilet), a violation of Islamic law, is common (Mayer, 2005). Music is prevalent (as noted previously), despite the fact that for many observant Muslims listening to music is forbidden. The regular practice of using religious beliefs as part of a system designed to break down detainees’ resistance to interrogation is part of the recommendations of the U.S. Department of Defense Behavioral Science Consultation Team (Bloche & Marks, 2005), in glaring contradiction to the standard operating procedures.

The CCR confirmed that such practices are used to “soften up” detainees by “abusing items or disrupting rituals known to have particular importance for Muslims” (p. 25), often with the expertise of chaplains (an ethical violation mirroring ethical concerns surrounding the role of health care providers). Reported practices include defilement of the Koran; forced shaving (prohibited by Islamic law); punitive shaving of the beard and head in one case, leaving a “cross-shaped” patch of hair; mocking of the call to prayer; removal of detainees’ pants (pants are required for participation in Muslim prayer); and confiscation of religious items such as prayer mats as part of the disciplinary system (CCR, 2006). These practices further disrupt resilience, increasing the likelihood of pathological outcomes (Bonanno & Mancini, 2008).
Threats of Death, Mock Executions, and Other Physically Aversive Treatment

Practices of either a threatening nature or direct harm are reportedly commonplace at Guantanamo and during capture and transport. During detention, initial capture, and transport to Guantanamo, authorities use psychologically and physically aversive practices in a supposed effort to obtain intelligence information. Such practices include physical beatings by interrogators (most commonly reported); coercive death threats; witnessing of mock executions; threats and attacks using military dogs; stress positions, such as “short-shackling” (being chained for hours at a time in a half-standing, half-crouching position) and prolonged forced standing; exposure to extremes in temperature; injury (both intentional and inadvertent) by Immediate Reaction Force teams with inadequate training; threats of being transferred to another country for torture; and coercion with false information that family and loved ones are also in captivity and will be harmed.

Military personnel reportedly often disguise mistreatment as disciplinary action, whereby detainees are intentionally provoked to justify aggressive retaliation and the imposition of even harsher measures (CCR, 2006; Clark, 2006; Greenberg & Dratel, 2005; HRW, 2008; Mayer, 2005; PHR, 2005, 2008; Razek, 2006; Saar & Novak, 2005). Psychological distress is intended to “induce regression, physical disintegration, and feelings of helplessness that lower prisoners’ defenses” (p. 16), according to the Central Intelligence Agency Kubark manual on counterintelligence interrogation (CCR, 2006).

RESEARCH ON SIMILAR POPULATIONS

There is considerable research on populations exposed to conditions similar to those in Guantanamo. These include studies of prisoners of war (POWs), veterans, political prisoners, victims of political torture, and refugees.

Research on POWs has shown that harsh treatment leads to premature aging; increases in musculoskeletal injuries; peptic ulcer disease; peripheral neuropathies; higher risks of late-life mortality from heart disease and stroke; higher risk of death from cirrhosis and liver cancer; and psychological problems such as apathy, dependence, reclusiveness, irritability, anxiety, PTSD, depressive disorder, and generalized anxiety disorder. POWs have high rates of PTSD and depression. One study estimated levels of PTSD at 35% to 50% and levels of depression at 50% to 80%, higher than in non-POW control groups (Ursano, 2003).

Another study observed rates of PTSD of 86% for POWs versus 9% for non-POW combat veterans, with similar differences in anxiety disorders, mood disorders, and a variety of physical complaints. More than 80% reported difficulty with concentration, emotional numbing, inability to express feelings, loss of interest in usual activities, memory problems,
tension and anxiety, irritability, restlessness, and distrust of others. Both groups described periods of excessive alcohol consumption. Personality analyses of POWs indicated interpersonal detachment, alienation, self-devaluation, and negativity. The authors concluded that “intense, prolonged stress may lead to development of psychiatric disorders in almost anyone, relatively independent of premorbid adjustment and/or individual difference factors, and that these are remarkably resistant to extinction over time” (Sutker, Winstead, Galina, & Allain, 1991, p. 71).

Similar patterns of illness, post-repatriation disability, and interpersonal dysfunction have been reported in World War II POWs, Korean War POWs, and Lebanese hostages of war. Symptom severity is correlated with intensity of mistreatment (Klonoff, McDougall, Clark, Kramer, & Horgan, 1976; T. W. Miller, Martin, & Spiro, 1989; Ritchie, 2002; Saab, Chaaya, Doumit, & Farhood, 2003).

Findings for former political prisoners in East Germany and Romania are similar. Focusing on assessing the long-term impact of political imprisonment, Bauer, Priebe, Haring, and Adamczak (1993) reported on political persecution and imprisonment in the German Democratic Republic. Participants had sleep disturbance, depression, anxiety, PTSD, and somatic disorders. In addition, 33% met criteria for two diagnoses, most commonly PTSD and major depression (Bauer et al., 1993). Dissociation was not assayed. A more recent study, also of former German Democratic Republic political prisoners, reported similar findings and documented claustrophobia, social phobia, and higher rates of clinically significant dissociative symptoms and substance abuse (Maercker & Schutzwohl, 1997). Studies of Romanian political prisoners show similar results (Bichescu et al., 2005).

Other studies, including those of multiple ethnic groups and Holocaust survivors, report similar findings. Additional reported key factors include recognition of the need for appropriate assessment (as affected individuals often do not share information because of shame), the need to identify and treat the physical consequences of mistreatment, the importance of recognizing the limitations of traditional medical approaches and research, and the importance of understanding the difficulties individuals may have upon reentering society. Impaired ability to relate to family and friends, persistent anger toward governmental entities, and impaired occupational functioning interfere with returning to normal life upon release (Allodi, 1991; Corrado & Tompkins, 1989; Gorst-Unsworth, Van Velsen, & Turner, 1993; Kagee & Naidoo, 2004; Levav, Levinson, Radomislensky, Shemesh, & Kohn, 2007; Levine, 2001; Mollica, 2004).

Studies of refugees seeking political asylum (who are often held in detention centers for prolonged periods awaiting decisions about their status) report high levels of psychological distress without appropriate assessment or treatment. For example, 86% of detainees in a Bellevue/New York University and PHR study in New York City had clinically significant depressive symptoms,
77% had significant anxiety symptoms, and 50% met criteria for PTSD. Moreover, 56% had serious medical problems, with difficulty accessing services (Keller, 2007; PHR/New York University, 2003). In a study of Bhutanese refugees in Nepal, rates of depression, PTSD, pain disorders, and dissociative syndromes were statistically higher among tortured versus nontortured refugees (Van Ommeren et al., 2001). A study of Bosnian refugees found that those with PTSD had selective affective numbing for positive affect (Spahic-Mihajlovica, Craytona, & Neafsey, 2005). A study of Punjabi Sikhs exposed to human rights violations and torture found high rates of PTSD and depression. Chronic injury correlated highly with PTSD and, to a lesser extent, depression and was hypothesized to be mediated via numbing and avoidance (Rasmussen, Rosenfeld, Reeves, & Keller, 2007).

In a study of risk and resilience in Gulf War I veterans, investigators used a statistical factor analysis/structural model to identify experiences contributing to pathological outcomes. Several factors accounted for 64% of the variance in the subsequent development of posttraumatic symptomatology, including (in order of contribution) war zone factors, post-deployment factors, and pre-deployment factors. Perceived threat was the biggest war zone factor, childhood environment and prior stressors were the biggest pre-deployment factors, and low social support was the biggest post-deployment factor (Vogt & Tanner, 2007).

Finally, PTSD, depression, other anxiety conditions, and somatic complaints are highly associated with long-term occupational difficulties and impaired quality of life in populations affected by the violence of war and other forms of political trauma (Henning, Turk, Mennin, Fresco, & Heimberg, 2007; Mollica et al., 1999; Rytsala et al., 2007; Stein, Cox, Afifi, Belik, & Sareen, 2006). In contrast, few studies have looked at functional outcomes with dissociative disorders, though studies report greater symptom severity in dissociative disorders versus non-dissociative disorders (Santo, Pio-Abreu, & Pio-Abreu, 2008; Steinberg, Barry, Sholomskas, & Hall, 2005) and elevated rates of repetitive suicidal behavior in dissociative disorders (Foote, Smolin, Neft, & Lipschitz, 2008).

It is likely that Guantanamo detainees will have increased mental and physical pathology and poor functional/occupational outcomes, mirroring findings in similar populations. Specific consideration needs to be given to assessing dissociative disorders in detainees given the already elevated rates of observed suicide attempts in this population and the correlation between dissociative disorders and suicidality.

EFFECTS ON RELATIONSHIP WITH FAMILY AND IMPACT ON FAMILY MEMBERS, SPOUSES, AND SEXUAL INTIMACY

How will detention affect family members, family function, and relationships upon reunion? Here I review the literature regarding the impact on the family
Psychiatric Impact of Detention in Guantanamo Bay

Included are studies of veterans, POWs, refugees, and their families; civilian populations affected by wars; children of torture victims; parents exposed to high-stress environments; and non-war-related effects of parental separation and loss on children.

A controlled study of spouses of Australian Vietnam veterans with PTSD found significantly higher rates of somatic symptoms, anxiety, insomnia, social dysfunction, depression, low self-esteem, and difficulty coping. Researchers observed higher levels of conflict and less cohesion and expressiveness within the family. Children reported higher levels of conflict, indicating awareness of family problems (Westerlink & Giarrantano, 1999). Recent statistics on American veterans of Iraq and Afghanistan show similar disturbing trends of increasing mental health complaints coupled with inadequate assessment and treatment, ascribed in part to feelings of stigma about mental health problems and the possible consequences of their recognition and treatment in the military (Milliken, Auchterlonie, & Hoge, 2007; Reeves, Parker, & Konkle-Parker, 2005; Seal et al., 2008). Concerns for the family include divorce, intimate partner violence, and child mistreatment (La Bash, Vogt, King, & King, 2009).

Families of survivors of World War II prison camps showed elevated divorce rates, poor coping and unresolved grief, depression, and posttraumatic symptoms (E. J. Hunter, 1986; Sigal, 1976). In a study of Iraqi refugees living in London, in which 52% of parents showed high rates of distress, children had significant difficulty with adjustment. Researchers found a high correlation between parent and child distress (Hosin, Moore, & Gaitanou, 2006).

The literature concerning prolonged separation from families—including studies of conditions involving high actual and perceived threat, such as military separation, work-related separations in high-risk jobs, and separations in civilian groups (e.g., journalists covering war and political situations)—shows that in the most distressing situations, there is no expectation of immediate resolution or the status of the missing person cannot be known. These studies report higher rates of depression and referral for psychiatric evaluation among military wives; high rates of “anticipatory grief,” especially with high-threat assignments; strong correlations between maternal and child coping; and difficulty with paternal reintegration upon reunion. One study of a group of wives and children whose husbands and fathers were missing in action or held as POWs found repetitive nightmares, spontaneous weeping, fears of aggression toward their children, dread of incapacitating illnesses, phobias, insomnia, anxiety, difficulty making decisions, and excessive overprotectiveness. Somatic complaints (e.g., headaches; musculoskeletal problems; cardiac, pulmonary, and gastrointestinal complaints) were also increased (Busuttil & Busuttil, 2001; E. J. Hunter, 1986). A study examining the effect of war-related trauma and psychological distress due to separation and loss of fathers/husbands in the 1991 Iraqi
invasion of Kuwait found high levels of depression and anxiety in children and mothers (Hadi, Llabre, & Spitzer, 2006).

Reunion produces significant difficulties for many families. In one study, ease of reunion paralleled the husband’s ability to cope during captivity and the presence of psychiatric problems following release. Psychiatric conditions were associated with protracted difficulties readjusting to family life, correlating with higher rates of psychiatric illness in family members (Busuttil & Busuttil, 2001).

Children of torture victims suffer similarly. In one study of five families, children were found to be anxious, depressed, and regressive, with psychosomatic symptoms, sleep disorders, and family and school problems. They had diminished developmental flexibility and developmental delays, findings corroborated by previous studies (Montgomery, Krogh, Jacobsen, & Lukman, 1992). In a study of children affected by parental separation due to divorce, one third of study participants had significantly impaired academic performance, confirming previous findings (Bisnaire, Firestone, & Rynard, 1990).

Impaired sexual functioning and problems with sexual intimacy will affect detainees’ relationships with spouses. As noted previously, sexual humiliation and abuse is associated with subsequent difficulty with sexual function and intimacy. In addition, nonsexual traumatic experiences have an independent negative effect. Researchers reported that participants found sex boring and/or burdensome, with painful somatic symptoms and disgust during sex, decreased libido, and erectile dysfunction (De Silva, 2001).

These studies suggest that Guantanamo detainees will experience difficulty with interpersonal functioning upon return and that there will be a detrimental effect on the family. Few studies have assayed dissociation directly or quantitatively. A significant percentage of partners and children are expected to have functional deficits in social, behavioral, and occupational/academic spheres and will require treatment. A significant percentage of marriages are not expected to survive.

**CONCLUSIONS**

The literature reviewed and data presented here speaks for itself—Guantanamo detainees are human beings who, when subjected to distress and trauma that overwhelm and disrupt resilience, are likely to develop pathological outcomes that will reverberate beyond themselves to their families and society. A more hopeful perspective is that detainees, their families, and society at large may learn and grow in response to this adversity.

Despite the self-evident nature of these findings, words are in order to synthesize the data and draw provisional conclusions. The experience of detention at Guantanamo inflicts complex traumas from multiple
life-threatening and highly stressful conditions (physical, emotional, and relational) experienced on a daily basis over a period of months and years, often against a background of prior distress, if not trauma, from pre-capture circumstances. The conditions described at Guantanamo systematically disrupt natural resilience, an independent risk for the development of problems. Physiological stressors and physical injuries contribute to psychiatric and medical illness, and vice versa. In fact, conditions known to cause infirmity are deliberately implemented and maintained at Guantanamo and related centers with the much-debated rationale of producing credible intelligence information.

Individuals exposed to such conditions for a short time, let alone a period of months to years, are likely to develop high rates psychiatric and medical illnesses. Upon return (if they are able to return home), many will have personal, social, and occupational impairments, and many may require assessment (which itself will present significant challenges), assistance with readjustment, and possibly long-term treatment. Family members will be negatively impacted. According to the available research, impairment may be long term, persisting for decades and potentially the rest of the individual’s life.

Of note is that most studies reviewed did not assay for dissociative disorders; those that did seldom used reliable and validated research tools. A growing body of literature demonstrates the importance of dissociation for research and clinical applications. Information regarding peritraumatic and chronic dissociation would be useful for predicting illness and guiding screening and treatment. Future studies should include assays for dissociative disorders to provide useful information to guide ongoing research and clinical work and to enhance understanding of complex traumatic experiences. Researchers, clinicians, and educators should continue to advocate for the inclusion of the trauma and dissociation framework in broader contexts.

It has been noted that distinguishing between torture and cruel, inhuman, and degrading treatment is not a useful distinction for predicting health outcomes; regardless, the consequences are severe to both individual and society, causing harm to individuals and their families, eroding the values of human rights–oriented societies (Miles, 2007), and contributing to the intergenerational transmission of trauma. Advocacy on the societal level to secure eroded human rights and to reestablish caregivers as trustworthy and ethical (Freyd, 2009; Pope & Gutheil, 2009) and on the individual level for appropriate assessment and treatment of detainees and their families is required to mitigate future harm and break the vicious cycle of humiliation and retaliation (Lindner, 2002). Detainees are likely to face additional challenges to recovery from ethnic and cultural bias, ongoing war and social problems, the loss of social and religious supports, mistrust of caregivers and authorities, and the negative reciprocal effects of physical and mental health problems.
REFERENCES


