Thwarting Terrorists: Can Psychiatry Help?

Terrorism and hostage-taking are becoming so commonplace they may be spawning a whole new branch of psychiatry. While a handful of psychiatrists have shown interest in the field for about a decade, the increase in terrorist acts in the past few years has prompted the 25,000-member American Psychiatric Association to institute a Task Force on the Psychiatric Aspects of Terrorism. "Terrorism is going to be around for a while .... It will be like looking at a scorecard on the sport pages to see which group is ahead," one psychiatric expert is reported to have said.

While the future may not be that ominous, there is little question that terrorist attacks are on the rise. A recent Central Intelligence Agency study reports that at least 587 persons were killed in terrorism incidents in 1979 alone. And since 1968, terrorist acts have accounted for about 2,000 deaths — "ten thousand, if you include quasi-wars," estimates one psychiatrist.

But because only about one-third of such acts result in any physical casualties at all, the primary concerns in the rest of the attacks involve the mental health of the victims, both during and after the siege. This, combined with the potentially expanding use of psychiatrists in hostage negotiations, is causing members of the profession to closely examine their possible roles in an area in which very few of them have any experience. It is a question they approach gingerly, if not reluctantly — where in their hands may rest the fate of not one patient, but many persons; where their actions might conceivably influence entire nations; where they must work at least partially under the ethics of the military or law enforcement agencies, rather than psychiatry.

As front pages splashed coverage of the daring commando rescue at the Iranian Embassy in London two weeks ago, the psychiatric task force met at the APA's annual meeting in San Francisco. And while the full details of the pre-rescue negotiations and planning are not known, it is almost certain that the British situation contained emotionally charged decisions over which any consulting psychiatrist would agonize.

"Psychiatrists involved in ... terrorist situations will face formidable ethical dilemmas," says John R. Lion, professor of psychiatry at the University of Maryland School of Medicine in Baltimore. Unlike the hospital or office practice to which the psychiatrist is accustomed, the hostage/terrorist situation often requires split-second decision making on the basis of "imperfect ... sparse data," Lion says. "Further, a physician can be coerced, overtly or subtly, by the police or governmental agencies who attribute to him an expertise he does not and cannot possess."

Tehran terrorists keep U.S. hostages isolated much of the time, psychiatrists say.

Lion should know. He tells of an incident in which law enforcement authorities roused him from his home without notice and whisked him and a Catholic clergyman to Baltimore-Washington International Airport to convince an armed skyjacker to surrender. Lion, it turned out, had seen the skyjacker previously in one brief consultation — which was of little help when the police urged Lion and the clergyman to stand exposed on the runway to show their good faith. The man eventually surrendered, but the incident left Lion with an understandably bitter aftertaste. "... many of the skills required to deal with terrorist activities are best carried out by experts in negotiation who are not physicians," he says.

Nevertheless, it is not the physical dangers to themselves that most concern psychiatrists — it is the ethical problems. And as of now, there are far more questions than answers available. Perhaps the fundamental question is "Who is the 'patient?'" says University of Wisconsin psychiatrist Burr Eichelman. Whether it is the hostages, the terrorists or the government may be unclear in each situation. In addition, says Lion, "the physician can be asked at which point the hostage [takers] are more vulnerable to a surprise attack, whether they should be starved, whether medication [such as the antipsychotic drug chlorpromazine] should be surreptitiously added to food, and other questions which are far beyond the realm of traditional practice." In addition, Lion says, the military/police ethic of "acceptable losses" in a terrorism situation is about as "far removed" from medical and psychiatric ethics as possible.

Still, despite the obvious pitfalls, psychiatrists seem to concur that in certain hostage-taking situations they can play valuable roles — if not in actual negotiations, then in police training or, perhaps most important, in working with released hostages. "The clearest role for the clinician is to help the victim in the de-briefing stage," Lion says.

Psychiatrists have outlined fairly standard stages of hostage reactions during captivity: After the initial shock, disbelief and denial give way to reality (when the victim may become hysterical), then a form of traumatic depression (often called the "I am stupid" phase), characterized by apathy or rage and other symptoms such as insomnia. Somewhere along the line, the victim may come to identify with the captor to make feelings of fear and dependency less frightening.

This sequence appeared to be evident with the 13 U.S. hostages released last November after more than two weeks of captivity in the U.S. Embassy in Tehran. Though they were in adequate physical condition, the released hostages — blacks and women — had all undergone "a constant sense of dread" during their captivity, says Col. Robert J. Sokol of the army's Letterman General Hospital in San Francisco and one of the psychiatrists who met with the hostages in Germany after their release. Exactly how such former hostages may be affected over the long term is not known, but the task force is now following up survivors of several terrorist attacks in the 1970s, including the Entebbe and Mollucan incidents, according to Elissa Benedek of the University of Michigan and moderator of the task force panel. As for the emotional status of the current U.S. hostages in Iran, she says, "we simply don't know what's happening."

Psychiatrists do know that about two-thirds of terrorist attacks involve 10 countries, including the United States, Great Britain and West Germany, according to William Reid of the University of Nebraska. "And whether successful or not, there is something in the action that rewards the terrorist." For now that too remains a mystery. □