Chapter 16

MILITARY PSYCHIATRY AND TERRORISM

FRANKLIN D. JONES, M.D., F.A.P.A.* AND YENG HOI FONG, M.D.†

*Colonel (ret), Medical Corps, U.S. Army; Clinical Professor, Uniformed Services University of the Health Sciences; Past President and Secretary and Current Honorary President of the Military Section, World Psychiatric Association
†Former Chief Psychiatrist, Singapore Armed Forces

INTRODUCTION

The related topics of terrorism and hostage negotiations have not been comprehensively reviewed in the psychiatric literature, but recent years have borne witness to a continuous stream of terrorist incidents with hostage taking in numerous countries. This trend has shown no signs of abating, and a number of law enforcement agencies have expressed their anxiety about a possible extension of terrorist activities in frequency, increasing violence, and the use of high technology, possibly nuclear, weapons. It can be argued that the Iraqi missile attacks on Israel during the Persian Gulf War were an attempt to utilize terrorist tactics to influence the course of the war by provoking Israeli retaliation and inflaming Arab sentiments.[1]

With the dissolution of the former Soviet Union and the end of great power rivalries, numerous ethnic rivalries have emerged. This has resulted in mutual terrorist acts, civil wars, and the large-scale Persian Gulf War. Individual terrorist acts have changed political strategies. For example, the marine barracks bombing in Beirut of American peacekeepers resulted in the removal of the U.S. presence and ability to influence events in Lebanon, the escalation of its civil war, and a change of government in Lebanon.[2]

More recently in Somalia, a rescue mission aimed at saving starving Somalis was converted into a police action when a disaffected warlord arranged for the ambushing and killing of more than 20 United Nations (UN) forces. A major mission of UN forces became not only protecting helping personnel but also attempting to capture and punish the warlord.[3]

Official responses to any terrorist incident have, in general, initially been made by civilian law enforcement agencies; however, there have been occasions in the past in which it was deemed necessary to enlist the assistance of military tactical teams to bring terrorist acts to a conclusion. Military personnel, bases, and military family housing areas may be the target of terrorist attack. Military mental health teams, such as the Navy special psychiatric rapid intervention teams (SPRINTs) and the army's 7th Medical Command stress management teams from Heidelberg, Germany, provide expert mental health support after terrorist attacks. For example, the stress management teams from the 7th Medical Command, Heidelberg, Germany, responded to numerous terrorist actions in the mid-1980s. The team included psychiatrists, social work officers, chaplains, psychiatric nurses, psychologists, and enlisted specialists. They deployed to the *Achille Lauro*, a civilian cruise ship that had been hijacked in the Mediterranean, and to Karachi, Pakistan, for a TWA airliner highjacking. The mental health professional working within the police force or the army, therefore, cannot afford to remain uninformed or incapable of rendering assistance when terrorist incidents occur.

Terrorism, as defined by the U.S. Army, is the calculated use of violence or the threat of violence to attain goals, political, religious, or ideological in nature.[5] This is done through intimidation, coercion, or instilling fear. Terrorism involves a criminal act that is often symbolic in nature and intended to influence an audience beyond the immediate victim. A terrorist group, therefore, is any organization that uses terrorism in a systematic way to achieve its goals.[4] The following definitions have been derived from a task force report by the National Advisory Committee on Criminal Justice Standards and Goals.[5] Terrorism acts may be classified according to the motivation and aims of the perpetrators of terrorist violence and whether the activities are carried across national boundaries. There are several subcategories of terrorism. *Political terrorism* is violent, criminal behavior designed primarily to generate fear in the community, or a substantial segment of it, for political purposes. *Nonpolitical terrorism* involves acts of violence inflicted by organized crime, teenage groups, or pathological groups or cults. *Quasi-terrorism* is characterized by activities incidental to the commission of crimes of violence that are similar in form and execution to true terrorism but lacking in a basic ideology, for example, taking of hostages in a bank robbery to secure a means of escape. *International and transnational terrorism* involve acts of terrorism inflicted within other countries, and these acts are further classified as international terrorism when perpetrated by individuals or groups controlled by a foreign state, or transnational when carried out by essentially autonomous, nonstate actors. Terrorism, therefore, is separated from discrete instances of murder for political or social motives of politicians or community leaders by individuals or small groups; that is, political assassinations.

The increasing cooperation between former Soviet republics and western democracies is diminishing the financial resources and safe havens available for terrorists. However, the relative success of transnational terrorists in the past decade has been viewed with increasing alarm by the world community because the failure of countries to agree even on the basic issue of differentiating terrorism and national liberation movements has often prevented effective collective action. Under such conditions, it remains for persons involved in management of terrorist incidents to anticipate them and continually to expand their knowledge and expertise.

MODERN TERRORISM AND FUTURE TRENDS

Basically, the use of terrorist methods occurs when there is an imbalance of power between two antagonists. It is a weapon wielded by the few or weak against the many or strong, and the terrorist's real strength lies in his own ruthlessness, recklessness, or, in the case of a psychotic terrorist, the extent of his mental derangement. In considering a response to terrorism, one needs to know just how far the terrorist will go to attain his objectives. One of the attendant dangers that law enforcement agencies face may be the need to match violence with violence without becoming brutalized and without damaging the population to be protected.

It is important to understand the essentially psychological nature of terrorist objectives. Not only do the terrorists want to flaunt the powerlessness of the authorities to prevent their attacks, they also want to provoke the defending authorities into taking repressive countermeasures that will turn the local population and world opinion (through the media) against the authorities. The terrorists maximize the ambiguity by deliberately hiding among and looking like the people the government or military is supposed to protect. They use ambushes, booby traps, and women and children as auxiliaries and combatants. The extreme ambiguity is deliberately intended to warp the minds of the defenders and make them distrust the local population and consider them unworthy of protection. The high ambiguity elicits misconduct stress behaviors, including excessive force and brutality, alcohol and drug abuse (as compensatory tension relievers that further disinhibit the defenders), insubordination, and commission of atrocities. The mental health team should play a major role in helping command to protect the soldiers against this threat. These issues are discussed in Field Manual 22–51[6] and in the *Combat Stress Control in Operations Other Than War* draft white paper.[7]

Modern society with its dependence on sophisticated services and institutions to provide for its basic needs has rendered itself, as a whole, more vulnerable to terrorist attacks. Modern terrorism has been assisted by developments facilitating international travel and mass communications. Terrorists have been able to travel freely and widely, train with and utilize an assortment of sophisticated weapons, and have used mass media to publicize their activities. Attempts to curb the increasing power wielded by the modern terrorist have to be counterbalanced by an awareness of the need for constraint to avoid infringing the civil rights of, and thus alienation of, the very people who are in need of protection.

Terrorism in its various forms has changed over the years. Some nations have recognized the potential of terrorism and have used the terrorist as the spearhead of a developing theory and practice of surrogate warfare. Governments, unwilling to risk the consequences of conventional warfare to realign the balance of power or to achieve political aims, have been subsidizing, training, and deploying such groups to create terror for carefully designed coercive purposes.[8] The probable trend is for increases in such sponsored forms of terrorism. In addition, there is an increasing likelihood that terrorists will employ sophisticated modern weapons and means of destruction to back their demands as resistance to terrorism stiffens, including the potential use of nuclear devices.

A minor form of terrorism but often having significant financial repercussions is the increasing proliferation of computer viruses. Important military and scientific databases have been adversely affected by such viruses. Unfortunately, military psychiatrists can offer little in this area other than developing perpetrator personality profiles that often reveal a highly intelligent, narcissistic young adult with an extensive computer "hacker" background.[9]

PSYCHOPATHOLOGY OF TERRORISM

Terrorism per se has no ideology, and it merely draws on ideologies of varying vintages or adopts a convenient political umbrella for guidance and rationalization. There appears to be a peculiarly addictive quality to terrorism, and an individual terrorist or terrorist group may change ideology apparently simply to continue perpetrating violence.[10]

Beneath a veneer of ideology, the political terrorist's motivation can usually be seen to be extremely personal. For example, many terrorists are quite paranoid, and the terrorist acts are rationalized expressions of projected hostility. True terrorist behavior often shows an extreme callousness and disregard for the victim and his feelings, thus an antisocial component.[10]

An understanding of the psychopathology of the terrorist is necessary when responding to his act. In addition, an assessment of the mental state, thought processes, and personality of the terrorist will help toward formulating adequate responses in assessing a terrorist threat. It is in this assessment that the behavioral scientist can be of assistance.

There is considerable evidence[10] that contagion and imitation are significant factors in the incidence of terrorist activities, just as suicide, arson, rioting, and other destructive activities seem to be influenced by the same factors. Hijacking of commercial aircraft is a good example. Hijacking has continued to remain a popular terrorist act in spite of the uncertain meeting of terrorist demands in many instances.

What of the terrorist himself? Often, one is tempted to think of him as insane or suffering from a characterological disorder, but this thought is probably too sweeping a generalization. There is, however, strong evidence of the paranoid tendency to hold onto overvalued ideas (even if mutable) on some political or social issue, which has often subsequently led to the perpetration of terroristic acts.

It has been said[10] that few terrorists will push their demands to the extent that they may have to end up paying with their own lives. Events have so far shown[11] this to be generally true, but it would be a mistake to conduct negotiations on this premise. For example, a suicidal fanatic drove a truck loaded with explosives into the marine barracks in Beirut.[11]

CONSEQUENCES OF TERRORISM

The very nature and intent of terrorism are such that apart from the act itself and the principal actors involved, fear and the impression of power vested in the terrorist are communicated to a large population and the whole society. This brings into relief the impotence of the civil authority and leaves the authority with the choice of ignominiously accepting the terrorist demands or else resorting to drastic counteraction in which innocent lives may be lost—a loss for which the authorities can still be blamed.

One terrorist acting alone is sufficient to induce severe psychological stress in a large number of people, but continuous terrorist activity may produce severe long-lasting effects on a society. Such a situation can substantially impair the quality of life in a community, insidiously alter the day-to-day habits of its people, and interfere with the free exchanges and interactions previously possible between people.[10]

Attitudes of the population may change with people becoming suspicious and intolerant. Regard for the authorities may decline, and the authorities may, in efforts to redeem themselves, resort to actions that may further alienate the population they support. This sequence of events is by no means the rule; there are countries that have absorbed the effects of repeated terrorist attacks without having to change the basic tenets of their governments and without subjecting their populations to progressively dictatorial rule. The United Kingdom stands as an example of a nation little changed by repeated Irish Republican Army atrocities, while Ulster (Northern Ireland) has been devastated by opposing terrorist groups.[12]

In terrorist incidents involving mass casualties, a situation similar to the aftermath of a disaster may ensue. It may take months or years for the society to find its equilibrium again.[13]

THE PSYCHIATRIST AND THE RESPONSE TO TERRORISM

Involvement of the psychiatrist or other mental health professional in an antiterrorist response means a significant departure from his normal role. From being a clinician delivering healthcare to pa-

tients, he becomes part of a law enforcement team to probe the psychopathology of a terrorist or terrorist group, to assist in threat evaluation, and to give advice as necessary during negotiations. This role requires a complete change of perspective in the usual practice of psychiatry.

As a rule, it would not be expected that psychiatrists or other mental health professionals would take a central and dramatic role in a terrorist and/or hostage-holding incident except in cases in which the psychiatrist has had previous professional involvement with the terrorist or when negotiations have reached the stage at which further rapport with the terrorist is thought to be possible via the psychiatrist. In spite of the desirability of such rapport, the psychiatrist must remain sensitive to the personalities and dynamics of the situation and guard against an undue identification with the interests of the terrorist. When asked to comment, the psychiatrist should refrain from replying in technical jargon that may prove incomprehensible or objectionable to police or military personnel. The advice should be offered in concise and practical terms.

Two main considerations render the participation of the psychiatrist in terrorist incidents necessary. First, such incidents put participants and law enforcement personnel under severe stress. Second, before a response can be planned, responding personnel must have an understanding of human behavior under stress and of the motivation and behavior patterns of psychotics or antisocial people or normal but stressed terrorists in a terrorist incident. The participatory roles therefore suggested for the psychiatrist are discussed below.

Police and Military Training

The psychiatrist may help in curriculum design and provide lectures involving topics such as the psychopathology of terrorist violence, reactions to stress, methods of coping under the stress of terrorist acts, captor-hostage relationships, threat evaluation, and negotiation techniques. The psychiatrist himself should have gone through such training courses to gain insight into problems for which he might be asked to find solutions.

Threat Analysis

In this instance, the psychiatrist is part of a multidisciplinary team drawn together to assess the credibility and seriousness of a threat of impending violence. His contribution will be related to the field of forensic psychiatry and profiling of the suspect.

Negotiations With Suspects

The psychiatrist generally cannot be assumed to be better qualified as a negotiator in a hostage-holding incident than a law enforcement officer, and, except for the circumstances listed earlier, it would be more appropriate for the psychiatrist to function mainly as an adviser to the main negotiator. Unlike the reality of most psychiatrists, the negotiator generally should be an articulate person of junior rank with a bland, unflappable personality. His junior rank allows him to defer decisions and buy time. Strong personalities tend to alienate hostage takers.

During the course of the negotiations, the psychiatrist should be on hand to detect any untoward effects that long, drawn-out negotiations may have on the negotiators and advise on remedial action. He may also prescribe medications for stress reactions or somatic disorders in hostages and possibly antipsychotic medications for hostage takers. A subsequent role that he can play is to assist in the postoperational review of the negotiations and to prevent post-traumatic stress sequelae among the surviving victims, rescuers, caregivers, and families.

In this context, it may be helpful to conduct formal debriefings of the surviving victims, rescuers, caregivers (eg, medical personnel) and, when feasible, families of victims. These are best done within days of the event, after everyone has rested. This debriefing can follow the civilian[14] critical incident stress debriefing model, the Marshall historical group debriefing model,[15] or several other variations.

Overall Postoperational Review Process

For the psychiatrist, valuable lessons may be learned from the incident regarding terrorist patterns of behavior and their impact on the victims and law enforcement personnel. He will also have an opportunity to assess the efficacy of his evaluation techniques and the success of his psychological management tactics. He may also be called on to comment on the performance of personnel placed under stress and to work out measures for improving his performance.[16]

Research on Terrorist Violence

The public media attention to terrorist activities continues to be provoked by terrorist abuses, indicating the need for mental health professionals to undertake further inquiries into this highly emotional subject. Research into this topic may improve

techniques for threat evaluation and the conducting of hostage negotiations, serve to clarify the role of the psychiatrist as an adviser in the team, and help devise interventions for hostages who suffer posttraumatic reactions or persistent symptoms from their ordeals.

Other areas of involvement that require exploration are the acute and ongoing psychological needs and supports for the victims and the negotiating team. For example, one way of enhancing a victims' self-control during a hostage-holding incident is to provide advance consideration of the prospect of victimization. Ensuring his continued survival may depend on an appropriate behavior pattern based on understanding the psychological relationship between a captor and a victim.[17–19] A particularly vulnerable group of potential victims are diplomatic mission personnel, and following the Iranian hostages situation, many U.S. diplomats received ongoing training in this area.

THE AFTERMATH OF A TERRORIST INCIDENT

The conclusion of a terrorist incident may not mean the real ending of the affair for the psychiatrist. With the apprehension of the terrorist, the psychiatrist will most probably be called on to testify in court as to the sanity of or other testimony about the prisoner. By the very nature of his act, the terrorist raises the suspicion of harboring a mental illness or serious personality disorder. Those diagnosed as psychopathic in particular produce ambiguity. The lay public and sometimes the judiciary are often prejudiced one way or another on hearing such a classification.[10] But in the final analysis, the sentencing of either a psychotic or psychopathic terrorist should follow the letter of the law with the provision that appropriate treatment be provided if it is needed.

SUMMARY AND CONCLUSION

In the roles outlined above, it becomes apparent that the psychiatrist plays an active, interventionist role quite different from traditional office practice but quite similar to that of the combat psychiatrist. Like the transient, situationally induced malfunctions of combat, the stress-induced responses of all participants in a terrorist event will respond to an expectancy of return to normalcy, particularly when physiological needs have been restored and a central policy of intervention has been utilized. The logistics of the situation generally determine the proximity to the arena of action, and proximity, therefore, characterizes interventions taken both in terrorist incidents and combat.

In this chapter, we have attempted to bring into focus the psychiatric aspects of one of the sociopolitical phenomena of today's world and have briefly outlined some areas in which the psychiatrist—especially one working within the armed forces—may find himself a participating member. There is still much to be learned. Terrorism is a constantly changing phenomenon in form and intensity, and accordingly, the response to it must remain in dynamic flux.

REFERENCES

1. Bleich A, Dycian A, Koslowsky M, Soloman Z, Wiener M. Psychiatric implication of missile attacks on a civilian population: Israeli lessons from the Persian Gulf War. *JAMA*. 1992;268(5):613–615.

2. Jenkins BM. *The Lessons of Beirut: Testimony Before the Long Commission.* Santa Monica, Calif: Rand Corporation; 1984.

3. Richburg KB. UN's Somalia quandary: Search for warlord said to limit military options. *Washington Post.* 8 August 1993, vol 116:A19.

4. U.S. Department of the Army. *The Army Combatting Terrorism Program.* Washington, DC: DA; 26 June 1992. Army Regulation 525–13.

5. National Advisory Committee on Criminal Justice Standards and Goals. *Disorders and Terrorism*. National Advisory Committee on Criminal Justice Standards and Goals. Washington, DC: GPO; 1976. Task Force Report. GPO stock no. 052–003–00224–8.

6. US Department of the Army. *Leader's Manual for Combat Stress Control.* Washington DC: DA; In press, 1994. Field Manual 22–51.

7. *Combat Stress Control in Operations Other Than War.* Draft white paper. Preliminary draft FM 8–51–1, CSC in 00TU.

8. Kaplan A. The ethics of terror. In: B Eichelman, DA Soskis, WH Reid, eds. *Terrorism: Interdisciplinary Perspectives.* Washington DC: American Psychiatric Press; 1983: 5–29.

9. Munge P. *Approaching Zero: The Extraordinary Underworld of Hackers, Phreakers, Virus Writers, and Keyboard Criminals*. New York: Random House; 1992.

10. Jenkins B. Research in terrorism: Areas of consensus, area of ignorance. In: B Eichelman, DA Soskis, WH Reid eds. *Terrorism: Interdisciplinary Perspectives.* Washington DC: American Psychiatric Press; 1983: 153–177.

11. Hammel EM. *The Root: The Marines in Beirut, August 1982–February 1984.* San Diego: Harcourt Brace Jovanovich; 1985.

12. Kelley K. *The Longest War: Northern Ireland and the IRA.* Westport, Conn: L. Hill, 1988.

13. Lyons HA. Psychiatric sequelae of the Belfast riots. *Br J Psychiatry*. 1971;118:265.

14. Mitchell JT. Demobilizations. *Life Net* (Newsletter of the American Critical Incidence Stress Foundation). 1991;2(1):8–9.

15. Marshall SLA. *Bringing Up the Rear: A Memoir.* San Rafael, Calif: Presidio Press; 1979.

16. Lancely F, DeSarno J. *Advanced Hostage Negotiation Course.* Quantico, Va: Federal Bureau of Investigation Academy; 1982.

17. Jenkins BM. *Hostage Survival: Some Preliminary Observations.* Rand Corporation. 1976. Typescript.

18. Cooper HHA. The terrorist and the victim. *Victimology*. 1976;1(2):229–239.

19. Jacobson SR. Individual and group responses to confinement in a skyjacked plane. *Am J Orthopsychiatry*. 1973;43(3):459–469.