Chapter 17

MILITARY PSYCHIATRY AND HOSTAGE NEGOTIATION

FRANKLIN D. JONES, M.D., F.A.P.A.*

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

INTRODUCTION

The principles of treating combat stress casualties were derived empirically during World War I[1] although their anlage can be seen in the treatment of nostalgia developed by Larrey as quoted in Rosen[2] during the Napoleonic Wars. These principles for treating the acute, situational-induced symptoms of combat stress can be usefully applied to the handling of stress experienced by hostages. The role of the mental health worker in a hostage situation, however, is of broader scope than just treating the victims. This chapter will address that role during the various phases of hostage negotiation.

Hostage negotiation as a legitimate strategy for handling certain forms of criminal behavior is of relatively recent origin. Following the terrorist attack at the 1972 Munich Olympics, the New York Police Department (NYPD)[3] pioneered the development of the principles and techniques of hostage negotiation under the leadership of Harvey Schlossberg, Ph.D., a psychologist who had been an NYPD patrolman. His work was furthered by collaboration with another NYPD officer, Frank A. Bolz.[4,5] Since then, others ranging from psychiatrists[6] to labor negotiators[3] have added to the current consensus on how such situations should be handled. The first application of formal hostage-negotiation techniques developed by the NYPD occurred during the takeover of a sporting goods store by African-American Muslims in January 1973.[3] Since then, there have been numerous, almost always successful, negotiations.[3]

TYPES OF HOSTAGE SITUATIONS

There appear to be three main types of hostage situations that differ according to the personalities and intentions and, to some extent, the victims of the hostage taker. Because these differences are relevant to the negotiation, they will be addressed briefly.

Criminal

With the advent of the widespread usage of silent alarm warning systems in the United States, criminals caught in the criminal act have become a major source of hostage taking. The purpose of the hostage taker is to escape from the law and the victims are likely to be a cross-section of middle-class persons who work at or frequent banks or stores.[3] Another hostage situation involving criminals can occur during riots in prisons. In these situations, the hostage takers are likely to be multiple and include a range of criminal backgrounds; the hostages may include unlucky visitors in addition to prison guards or authorities against whom some prisoners may hold grudges.

The hostage-taker personality type is likely to be antisocial or inadequate and immature. The negotiator advantage is that such individuals are usually acting out of their own rational self-interest so that harm to the hostages may be less likely. Disadvantages in the case of the antisocial, in particular, are that he seldom develops positive feelings toward his captives, and he may have an extensive prior criminal record so that he feels he has nothing to lose by further violence. In addition, the antisocial, like some terrorists, usually has a callous disregard for his captives.[3,7]

The immature or inadequate criminal is more likely to develop positive feelings toward captives and is likely to be inept, giving hostages more chances to escape. Disadvantages of negotiating with the immature hostage taker are that his demands tend to be exorbitant, and his own ineptitude may lead to unintended violence.[3]

Domestic

The victims of the domestic hostage taker are usually relatives, often spouses and children; however, friends and suspected lovers may become captives.[5] Such hostage takers often suffer from severe mental illness rather than personality disorders, making them less amenable to rational discourse. In addition, in some cases, particularly those in which the captor is severely depressed, the hostage-taking incident often shades into a suicidal or homicidal/suicidal act.[3]

Often hostage takers in domestic situations are found to have schizophrenic and bipolar illnesses, especially when paranoid thinking is present. In

such cases, imagined enemies, public officials, and innocent bystanders are frequent victims.[3]

Unlike the inadequate personality who makes exorbitant demands, the antisocial who makes moderate demands or the depressed person who usually makes no demands other than to be left alone, the paranoid schizophrenic makes strange demands. In January 1976, Miklos Petrovicks, a hostage taker later found to be mentally ill, was called "the birdseed bandit" because of his demands that tons of birdseed be distributed at banks in Los Angeles.[3]

Terrorist

There have been few terrorist hostage-taking incidents in the United States; however, many Americans stationed in other countries have been such victims. Only three groups, the Puerto Rican nationalists Fuerza Allianza Libertad Nacional (FALN), the Croatian nationalists, and the Cuban Freedom Fighters have been active in the United States. There have also been sporadic incidents such as the Symbionese Liberation Army abduction of Patricia Hearst,[8] the Hanafi Muslim takeover of federal government offices,[9] the Jewish Defense League activities,[10] and the 1993 World Trade Center bombing in New York City by Muslim fundamentalists.[11] Federal Bureau of Investigation (FBI) studies[7] have revealed a fairly standard organizational profile of terrorist groups. The leader is usually an ideologue, often of upper class or middle-class upbringing, usually considered to be honest and upright, although ruthless, and usually well-educated. The leader furnishes the ideological rationale for the terrorist activities. In the FALN, the leadership includes college professors and lawyers.[3,7]

Followers frequently use the group as a family substitute. They may be quite dedicated but have usually been "losers" in life with immature personalities, job instability, and sexual problems. The third element, which often plays a leadership role during incidents of violence, is primarily criminal, usually with antisocial tendencies. In the Symbionese Liberation Army, this figure was Cinque, a man with a long criminal record.[3,7]

The motives of the terrorist are usually quite different from those of the common criminal, such as a Mafia "enforcer," although the method is similar—coercion of others by inducing overwhelming fear (terror). The victim is an integral part of the attack and is often chosen for purposes of demonstrating the impotence of constituted authority. For this reason, the innocent are as likely, or even more likely because they are unprotected, to be victims as those in authority.[3,7]

PRINCIPLES OF HOSTAGE NEGOTIATION

Two assumptions make hostage negotiations differ from other forms of kidnapping: (1) confrontation is necessary; that is, the hostage taker is potentially within the control of the law enforcement agency with reasonably direct communication with him being possible; and (2) it is not in the criminal's interest to do violence to the hostage.

When hostages have been taken, one or more of several courses of action by law enforcement personnel are possible. These possibilities are listed below in decreasing order of preference:

- Contain, isolate, and negotiate.
- Contain, isolate, and demand surrender.
- Use chemical agents to flush out.
- Use sharpshooters to wound or kill.
- Assault the barricaded hostage taker.

Negotiation, the first alternative, will result in the safe release of hostages in 97% of cases.[3] The failure of this alternative can later allow escalation to the other more dangerous (for police and hostages) alternatives. In a study[3] of a number of incidents in which assault was the alternative chosen, 65 hostages and 355 law enforcement agents were involved. Assault resulted in the deaths of 3% of participants during negotiations, and 12% died during assaults. One problem with the use of sharpshooters is that the hostage taker may have or claim to have a bomb.[3]

Chemical agents produce risks of fires (for example, the Symbionese Liberation Army home was probably burned down from ignition by a tear gas grenade at a time when Patricia Hearst was still thought to be a hostage[3]), chemical pneumonia and respiratory problems among hostages, and risks the deaths of hostages because chemicals work too slowly to incapacitate the hostage taker before he has a chance to kill the hostages. In addition, in these times of specialization, some hostage takers may have gas masks. Similarly, a demand for surrender can push the hostage taker into violence directed at hostages.

Hostage reactions are similar to those of disaster victims, with three types described by Tyhurst.[12] These may be universal responses to sudden, unexpected, life-disrupting events:

1. *Effectives* may take independent action dangerous to the group.
2. *Ineffectives*, those who are hysterical or agitated, mainly pose a danger to themselves by irritating the hostage taker.
3. *Dependents* readily develop the Stockholm syndrome; they do what they are told to do.[3]

The Stockholm syndrome refers to the positive feelings that develop on the part of the hostages toward their captor which engender similar positive feelings by the captor toward his captives.[3] It is the task of the hostage negotiator to try to encourage development of the dependent category because experience has shown them to be most likely to survive. Interestingly, the effectives and ineffectives do best in the long run (if they survive); the Stockholm syndrome usually does not develop in them.[3]

THE NEGOTIATION

The hostage negotiator should be a relatively junior law enforcement officer who is in good physical health, is good with words, and is of rather placid temperament. If he is of higher rank, he may not be able to stall for time by claiming a need to consult with a superior; that is, he will have too much authority to make decisions. Also senior officials generally do not have the desired placid temperament; if they did, they would not have become senior officials.[3]

The basic approach of the negotiator is to stall for time until the fundamental human needs, both biological and psychological, will force the hostage taker to make concessions. The skillful use of time will also reduce anxiety and increase rationality in the hostage taker, which should reduce his expectations. Time will frequently produce rapport between the hostage taker and negotiator, thus increasing the negotiator's ability to influence the hostage taker. Finally, time will often allow the formation of the Stockholm syndrome.

An unfortunate but inevitable additional element of the Stockholm syndrome is the formation of negative feelings of the hostages toward law enforcement personnel. The negotiator, nevertheless, attempts to foster the Stockholm syndrome because it becomes a powerful factor in the survival of the hostages. The development of the Stockholm syndrome is a normal, survival-oriented adaptation to an abnormal situation. This tendency to cling to a person who has the power of life or death over one may have roots in the instinctual behavior of man's hominid ancestors,[13] and this same instinctual matrix may account for similar behavior on the part of battered spouses and children.[3,14]

The negotiator may foster this development by asking about hostages through the hostage taker and by furnishing bulk food that requires the captor and captives to work together in its preparation. Similarly, the hostage taker may be induced to become responsible for disbursement of medications to hostages who often have stress-induced medical problems. Because he can prescribe medications, the psychiatric consultant is of particular value in this situation.

Other than stalling for time during which biological and psychological variables can be manipulated, the negotiator has certain guidelines to follow with regard to handling demands, including those from the media. These guidelines take into account the police priorities (established by the NYPD) and are listed below.

1. Preserve the lives of the hostages, the public, police, and hostage taker.
2. Apprehend hostage taker.
3. Recover and protect property.

Experience[3,4] has shown in terms of the demands made by hostage takers that some items are negotiable and some are not. These demands are listed in Table 17–1.

Regarding hostage demands, the negotiator attempts to avoid giving anything without getting some concessions in return, avoids suggesting possible demands, avoids offering anything unless it is requested, avoids giving more than is requested, and avoids dismissing any demand as being trivial. In terms of the developing biological needs, food, water, and amenities (such as portable toilets, air conditioning, and so forth) become preeminent and should not be given away without gaining concessions despite one's humanitarian impulses.

Alcoholic beverages are frequently requested by criminal hostage takers and usually they should not be given unless it is known that the hostage taker's

TABLE 17–1

HOSTAGE TAKER DEMANDS

ITEM	NEGOTIABLE	SITUATIONAL	NONNEGOTIABLE
Food	X		
Water	X		
Amenities	X		
Money	X		
Alcohol		X	
Transportation		X	
Media Coverage		X	
Weapons			X
Exchange Hostages			X

Source: Adapted with permission from Lancely F, DeSarno J. *Advanced Hostage Negotiation Course.* Quantico, Va: FBI Academy; 11–22 January 1982.

response to alcohol is benign, such as falling asleep.[3] Transportation is usually demanded, and, if given, frequently creates problems in command (who is in charge—local, military, federal, or airline officials), in communication (telephones and other systems may not be available), and in control (the captor may escape and continue to keep the hostages).[3]

If possible, demands for media coverage should only be met after the hostage taker has surrendered. Crowd control can become a very serious problem and can produce unnecessary loss of life. Media coverage can exacerbate this problem as well as create problems in the negotiation. For example, television reports showing heavily armed special weapons and tactics (SWAT) teams can deter a subject from surrendering.[3]

Although the hostage taker is not told so (he is stalled), weapons and exchange of hostages (with rare exceptions) are not negotiable demands. The reason for not giving weapons is obvious; however, the rationale for not exchanging hostages is not so obvious. For example, some countries may consider giving hostages in exchange for visiting dignitaries taken hostage to avoid involving friendly countries in a terrorist incident and also to use this exchange as a sign of good faith during the negotiations. The reasons for not exchanging, however, are persuasive and have to do with the willingness of the hostage taker to kill those under his control or himself.

The hostage taker may feel less guilt in killing a law enforcement official than an innocent bystander whom he has captured. Killing an authority may be more likely also in terms of the hostage taker's self-esteem; that is, more prestige is associated with killing a policeman or government official. The person demanded by the hostage taker may well be someone whom he wishes to kill but otherwise does not have the opportunity. Even if the person requested is a relative, especially a spouse, this person may be the desired victim or the deranged hostage taker may wish the person demanded to be present as an audience for his suicide. The presence of persons significant to the participants may, at minimum, increase the tension level and hinder one of the aims of the negotiation, decreasing tension and increasing rationality. The exchanged person can also increase the tension level if he is a trained law enforcement official because he will be viewed as a greater threat.

Finally, even if the exchanged person would not increase tension for reasons mentioned, he would still disrupt the nascent development of the Stockholm syndrome. Probably such exchanges should only be made in desperate circumstances in which the exchange is used as a ploy in anticipation of an assault operation.

MENTAL HEALTH PROFESSIONALS AND HOSTAGE NEGOTIATION

The military mental health professional is likely to be called on during hostage-negotiation procedures because of availability and presumed knowledge of crisis situations. It is important for the

professional to be familiar with the basic principles of hostage negotiation outlined above and of the usages to which his expertise can best be put. It is also important for him to know how he should not be utilized. In a recent misuse of a mental health professional, a well-known Baltimore psychiatrist was asked by police to approach an airplane hijacker face-to-face and unprotected.[15] The mental health professional must remain in the consultant role except, perhaps, in the rare instance in which the hostage taker is his patient. The professional rarely has the knowledge of police resources and methodology or has the correct temperament for the hostage-negotiator role.[3]

In the consultant role, he can offer expert advice about the psychological and, if a psychiatrist, the medical aspects of the situation. He can usually help the negotiator to understand which of the personality types or illnesses are found in the hostage taker and possible responses that can be expected. For example, he can often advise of the need for immediate gratification and low frustration tolerance of the antisocial, the suspiciousness of innocent actions of the paranoid, and the degree of suicidal potential of the depressed hostage taker. He can also help arrange for appropriate treatment of a mentally ill hostage taker and occasionally may even begin that treatment during negotiations.

As an observer of the effects of stress and fatigue on the negotiator and other team members, he can warn of the loss of objectivity and need for replacement. In addition, the expertise of the negotiator is widely variable ranging from very sophisticated, trained negotiators to first-time rookies. He can aid the latter negotiator to understand the negotiation process and its expected course.

The mental health professional may also play a role during the negotiation in helping to relieve the distress of relatives of the participants, especially of the hostages. This role is primarily in terms of support, reassurance, and sometimes anxiolytic medication. In prolonged situations such as those that occurred in the capture of the USS *Pueblo* by North Korea[16] or the takeover of the U.S. Embassy in Iran, this can be a most important role.[17] Further, in such prolonged incarcerations, mental health personnel are important in planning the decompression (initial release) and follow-up handling of such hostages and families. Even after brief episodes, postincident help may be appropriate, particularly in ameliorating the unwanted aspects of the Stockholm syndrome.

The application of combat psychiatric principles[18] is most appropriate in handling the victims of a hostage taking. They begin with treating as proximally and quickly as possible (proximity and immediacy). With hostages, this treatment starts with a "decompression" period, immediately after release, allowing a respite from demands and responsibilities. This initial intervention is brief and involves physiological restoration through rest, sleep, and alimentation. Complicated psychodynamic formulations are avoided to make the point that the victim is not ill but had a normal reaction to the circumstances (principle of simplicity). This approach is especially important if the victim has guilt about "collaborating" with the hostage taker to save his own life and "survivor guilt" if deaths have occurred.

Critical incident stress debriefing[19] or historical group debriefing[20] to abreact, clarify, reconcile, and gain cognitive mastery over the traumatic memories may be useful. This debriefing can be done one-on-one with individual victims and, even better, in groups with multiple hostages. It is also worthwhile for the negotiator teams, SWAT teams, snipers, and medical caregivers, especially if the incident did not resolve happily.

These interventions should create an expectation that the individual is normal and will quickly return to normal functioning (principle of expectancy). The expectation of compensation, on the other hand, even if only in the form of special consideration, can undermine this approach and lead to disability.

The final principle of centrality, or echelon treatment, is important because the natural supports in the victim's environment are substituted for the mental health worker as soon as possible to avoid the development of a dependent relationship.

SUMMARY AND CONCLUSION

In summary, a body of knowledge exists concerning the personality types of hostage takers and the psychological responses of their victims. Mastery of this knowledge and application of principles derived from the treatment of combat psychiatric casualties will allow the mental health professional to play a variety of roles in the various phases of a hostage negotiation, drawing on his expertise in human behavior.

REFERENCES

1. Salmon TW. *The Care and Treatment of Mental Disease and War Neuroses ("Shell Shock") in the British Army.* New York: War Work Committee of the National Committee for Mental Hygiene, Inc.; 1917.

2. Rosen G. Nostalgia: A "forgotten" psychological disorder. *Psychol Med*. 1975;5:340–354.

3. Lancely F, DeSarno J. *Advanced Hostage Negotiation Course.* Quantico, Va: FBI Academy; 11–22 January 1982.

4. Bolz F, Jr. The hostage situation: Law enforcement options. In: Eichelman B, Soskis DA, Reid WH, eds. *Terrorism: Interdisciplinary Perspectives.* Washington, DC: American Psychiatric Association; 1983: 99–116.

5. Hassel C. Preparing law enforcement personnel for terrorist incidents. In: Eichelman B, Soskis DA, Reid WH, eds. *Terrorism: Interdisciplinary Perspectives.* Washington, DC: American Psychiatric Association; 1983: 117–128.

6. Ochberg F. Victims of terrorism: Psychiatric considerations. *Terrorism: An International Journal.* 1978;1(1):147–168.

7. Special Operations and Research Staff (SOARS), Federal Bureau of Investigation Academy. *Terrorist Organizational Profile: A Psychological Role Model.* Quantico, Va: SOARS, FBI Academy; 1982.

8. Payne L. *The Life and Death of the SLA*. New York: Ballantine Books; 1976.

9. National Advisory Committee on Criminal Justice Standards and Goals. *Disorders and Terrorism.* Washington, DC: GPO; 1976.

10. Dolgin JL. *Jewish Identity and the JDL*. Princeton, NJ: Princeton University Press; 1977.

11. Wright R, Ostrow RJ. Incident may signal new round of terrorist action (bombing of NYC's World Trade Center). *Los Angeles Times*. 28 February 1993, Vol 112:A1.

12. Tyhurst JS. Individual reactions to community disaster: The natural history of psychiatric phenomena. *Am J Psychiatry*. 1951;107:764–769.

13. Wilson EO. *Sociobiology: The New Synthesis.* Cambridge, Mass: Belknap Press of Harvard University Press; 1975.

14. Ochberg F. Hostage victims. In: Eichelman B, Soskis DA, Reid WH, eds. *Terrorism: Interdisciplinary Perspectives*. Washington, DC: American Psychiatric Association; 1983: 83–88.

15. Lion J. Personal Communication, March 1981.

16. Spaulding RC. The *Pueblo* incident: Medical problems reported during captivity and physical findings at the time of the crew's release. *Milit Med*. 1977;142(9):681–684.

17. Jones FD. Personal Communication. 1981.

18. Jones FD, Johnson AW. Medical and psychiatric treatment policy and practice in Vietnam. *J Soc Issues*. 1975;31(4):49–65.

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

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