

## Keynotes

### The psychiatrist and the siege

#### A PSYCHIATRIST

The idea that a psychiatrist should attend the police operation at a protracted or terrorist siege has gained ground. London has had more than its share of sieges, Balcombe Street, Spaghetti House, Iranian Embassy, and the Libyan Embassy to name four of the most notable. Dr Peter Scott took on the role of adviser to the Metropolitan Police in such incidents single handed until his death in 1978. He gave his own account of his work (Scott, 1978). This current account carries the topic forward a little in the light of experience gained since his death and is in response to repeated requests, by other psychiatrists, for information.

Psychiatric work in Britain in relation to a siege can be divided into three categories: teaching, general advice to the Home Office, and operational advice to police forces at the time of a major incident. The designation "major incident" is important. It would be impossible for sufficient psychiatric resource to be available to deal with all the minor sieges that occur in a big city. In London there is a general rule that psychiatrists are only involved if the police commander estimates that the incident will last more than 24 hours.

#### *Roles for the psychiatrist*

##### Teaching

For some years the Metropolitan Police have run a training course for middle to senior ranking police officers at Hendon training school. It trains officers from all over Great Britain, and a few from overseas. The aim of the course is to teach policemen the special skills which they will require if they are called on to act as negotiators in a siege. By the very nature of police work the role of the specialist negotiator is largely confined to sieges which are serious or prolonged, say, lasting more than six hours. The course is concerned with learning general principles, methods of gathering information, techniques used in previous incidents, special negotiating skills required, practising these skills in simulated conditions, and hearing from the victims of previous sieges.

There is one afternoon set aside for a psychiatric input. Four psychiatrists take turns to cover a number

of topics in a straightforward lecture/seminar setting. The first topic is the nature and role of psychiatry in general, the nature of mental illness and its forms are discussed a little, and finally the role of psychiatrist as it has been enacted in previous incidents is described. An attempt is made to get police officers to understand something of the physiology and psychology of stress, and to know something of the needs of victims in a siege. The effects of stress on the terrorists and their decision-making processes are discussed. The policemen are also taught that they too may become the victims of stress and that they need to accept their own vulnerabilities as human beings in a highly stressful incident. They need to begin to consider some of the dynamics which occur when they are suddenly taken from the usual role of senior officer with autonomous authority, and given a subservient role, under close instruction from the most senior officers in the force. They need to think about some of the emotional issues within themselves that the pressures of a siege will expose. They need to be aware that they will form strong likes and dislikes for the people inside the siege, feelings which could interfere with objectivity.

##### Advice to the Home Office

Advice to the Home Office is sporadic and usually concerned with an immediate or new problem. Topics discussed with the Home Office include the nature of training schemes, the role of the psychiatrist in sieges, possible precautions that likely victims may be able to take, and the differential psychological threats posed by different kinds of terrorist tactics. The Home office encourages police forces in different parts of the country to run mock siege incidents and also to train their officers to cope with such a problem. These mock sieges usually last 24–48 hours. On occasions a psychiatrist joins these training exercises, partly to give a local force experience of the role and employment of a psychiatrist in a siege, and partly to train the psychiatrist in work that is new and difficult.

##### Operational advice to a police force

In a siege there are three main groups of participants: the hostages, the perpetrators, and the controlling

forces, usually the police. The psychiatrist has a role in relation to each of these. The myth that the psychiatrist is involved in tactical decision-making, although ludicrous, has to be dispelled. Senior police officers in Britain with expertise and training in the control of violent incidents do not defer to outside advice about containment and control. The main issues they need advice about are concerned with the illness content of any incident and with the extreme stressfulness of it.

The police are skilled and well versed in verbal arts of negotiation and have had special training in siege negotiations. However, each incident is unique and an appropriate negotiation strategy has to be developed on the spot, so they may discuss the generalities of the task in front of the psychiatrist who brings knowledge of entirely different forms of conversation. The psychiatrist who attends these incidents is therefore not required to know much about police work, but he or she should bring sound knowledge of persuading difficult and intransigent people to change their minds about the use of violence whether directed against the self or against others, and above all the psychiatrist must be familiar with the effects and management of severe stress.

### *Participants in the siege*

#### **Hostages**

To have one's daily routine suddenly disrupted, to be taken captive, and threatened with death over a prolonged period, sometimes several days, is an extremely stressful event; it is destructive to psychological integrity. Individuals react differently, but all will suffer. Early on in an incident, symptoms of stress emerge in the victims. Symptoms will vary widely between individuals and may begin with obvious signs of distress such as weeping, screaming, and running about, but they may also include pains, particularly in the chest and abdomen, palpitations, diarrhoea, dysmenorrhoea, and heavy menstrual bleeding. Anyone who has a pre-existing physical disorder such as chronic heart failure, or diabetes mellitus, will soon run into problems as the stress may destabilise the illness anyway and the captivity will interrupt normal medication routines. Psychological features such as depression, paranoid states, and anxiety, may also be exacerbated or even induced by the circumstances. Affective changes indicated by over-activity, over-talkativeness, and grandiosity are quite common. Thus there is a considerable volume of work for the psychiatrist throughout the operation. He or she will be expected to explain to senior officers what is happening to particular individuals, and advise on the best course of management, remembering that management has to be channelled through first the police negotiator and then the perpetrator.

One of the earliest aims of the police will be to set up an effective system of communication with the perpetrators. This is done by a land line wherever possible so that the negotiator can talk in a normal telephone manner to the perpetrators. During these conversations the negotiator will try to ascertain the condition of everyone in the stronghold, and will point out to the perpetrator that victims who are in a poor state of health pose extra hazards to everybody, including the perpetrators, and therefore it is in their own best interests to release the most severely ill or distressed. Hostage takers are usually unwilling to do this and try to ask instead for either medicines or a doctor to be sent into the stronghold. It is the police policy that no extra potential victims of any kind go into a siege and therefore the request for a doctor is ruled out. Medicines are, however, to some extent negotiable. The police will rely entirely on medical advice in this matter. Psychiatrists are not necessarily the best people to advise about physical illness and so a general practitioner may also be called in to advise on this aspect.

The doctor has to balance the disadvantages of sending into an unsupervised hostile environment drugs which may be misused even to the point of getting to the wrong individual, against the disadvantages of leaving an individual with a serious, potentially lethal, condition untreated. Furthermore, in the case of some disorders, diabetes is an obvious example, dosage is related to the day to day information on the state of the disorder, and therefore negotiations will have to include not only the prescribing and giving of medicines, but the sending in and use of test material, for example testing of urine for sugar content. Police will also seek advice about basic health maintenance of the victims, and the negotiator will do his or her best to transmit the idea to the terrorists that their captives are much more likely to remain amenable and relatively easy to control if they feed them, give them drinks, warmth, sleep, and sanitation. Often the perpetrators will not be able to supply these essentials unaided which may be carefully negotiated into the stronghold.

An important general rule is that only clearly specified people talk to one another in the formal negotiations. This minimises confusion and enables relationships to be developed. Obviously if there are several perpetrators they will choose who will do the negotiating on their side. Hostages are never used for negotiations if that can be avoided. It is almost impossible to know anything about the dynamic relationship between a hostage and his or her captors during the incident because of the limited information available; he or she may be under duress for example. Brief conversations with hostages may be useful to allay some fear in them, but even that is difficult. On the police side only trained negotiators will speak to the perpetrators. The commander does

not, he can only fulfil one full-time job. Decisions have to be thought out, advisers have to be consulted, discussions may need to take place with even higher authority. He needs to stand back from the phone to do all that. The psychiatrist should also stay clear of the negotiations; he is not necessarily skilled in this type of conversation and he does not fit into the police command structure. Individualists are a menace in a disciplined operation. Language interpreters are necessary on occasions, but these should be specially trained if possible and they undoubtedly do introduce an extra layer of confusion.

### **Perpetrators**

There are three kinds of hostage takers to consider: terrorists, criminals, and singletons. These names are not very satisfactory; clearly they are all criminals and equally they all induce terror. The names are used as follows. "Terrorists" are akin to armed soldiers, they usually work for a significant organisation, maybe a government, they have political objectives and ideas, they are selected, they may be trained, they will be reasonably well armed. "Criminals" are people working in small groups with mainly financial and no political objectives, they are self selected, largely untrained (although they may be skilled), and have few links with other help. "Singletons" are individuals creating a personal siege for personal needs; these needs may be an escape, money, or much more complicated needs bound up with personal relationships and neurosis; they may even be psychotic.

Of course, categories are never as clear-cut as this, e.g. terrorists may become bank robbers and get caught in a siege accidentally, but the categories form a useful framework for the development of ideas.

### *Terrorists*

Even terrorists are under severe stress and are afraid for their lives. Of course, they were selected in some way and they knew they were endangering their lives by carrying out the operation, but selection and knowledge does not remove stress, although these factors may help them cope a little better than some of the hostages, and training, which some terrorists have undergone, further helps them to cope with their fear, but all this is limited. In particular, any terrorist who goes into an operation of this kind must have an enormous personal investment which overrides his own safety. At all stages therefore he feels the strain of potential failure. A further strain is diminishing control which the terrorist has over the siege and his own fate as the balance of power swings slowly in favour of the police force. One of the severest strains is isolation. Slowly but surely the

terrorists are cut off from their friends and from outside advice. Very importantly too the terrorists have enormous practical problems. For example, in the well-known Iranian Embassy incident, six gunmen were trying to guard 26 hostages in a very large building, a situation which spelt potential disaster all the time and which must have afforded very little opportunity for sleep. Fatigue is in fact one of the most pernicious stress factors which all participants in the stronghold have to face. Loss of sleep may determine when the siege will end. In the Iranian Embassy incident the senior terrorist was also the only negotiator on their side. Considering the small amount of sleep he must have been able to obtain, it is not very surprising that his coping mechanism failed on the fifth day, and a hostage was shot, precipitating the violent end of the siege.

The questions for the psychiatrist to consider in relation to the terrorists will concern their mental state and volatility. The gunmen may have been selected for their health and mental stability, but nevertheless it is important to determine at an early stage that the gunmen are mentally normal, for negotiations with someone suffering from, say, a paranoid psychosis, are different to those with a rational individual who has definable political objectives. Also, stress may induce illness in the terrorist; indeed the most worrying possibility is the induction of irrationality of one form or another. At all points, therefore, the psychiatrist has to monitor carefully the conversations to detect whether there are signs of change in the mental state which may require different negotiating tactics. It is also important for the psychiatrist to advise negotiators and police commanders about the feeding, drinking, and sleeping requirements of the terrorists. A peaceful outcome may well depend on rational discussions and so it is vital that the terrorists stay in good mental and physical health and the environment must therefore be as good as possible.

The two most important factors needed to control stress in all perpetrators are the raising of self-esteem and the lowering of fear. Both are extremely difficult to achieve in the circumstances, both perhaps a little different from the usual police approach, and both dependent upon as detailed an assessment of the perpetrators as is possible.

### *Criminals*

The hostage takers have features in common with terrorists, but the big difference is that criminal sieges are almost always accidental, e.g. the famous Spaghetti House siege in London which was a robbery that went wrong. This means that the perpetrators are as unprepared as everybody else and have no coherent plan of action. Levels of stress in the perpetrators tend, therefore, to be higher and they

may include among their number relatively unstable individuals. This may make their behaviour more unpredictable and thus more dangerous, but on the other hand the siege may be relatively short (i.e. less than two days). The principles of management are identical to the terrorist siege, but there will be fewer political (governmental) complications.

### *Singletons*

Singleton sieges are much more likely to be caused by people with psychiatric disease than the other categories. The type of disease that can be expected will include personality disorders, chronic psychoses, and mood disorders, especially depression. Paranoid symptoms including delusions and even command hallucinations may all be encountered. Other problems behind a singleton siege often include severe interpersonal difficulties within a family. The siege may then be based on anger, feelings of rejection, despair and hopelessness. Rational negotiation in all these circumstances is difficult. The negotiator has to appeal to the rational and reasonably functioning aspects of the perpetrators' psyche, and sidestep confrontations about delusions, unresolvable conflicts and the like, and try to strike a caring positive bond with the perpetrator, giving the latter lots of clues that his or her plight is understood and has created genuine concern. Such a siege may be partly suicidal in meaning and one serious danger is active suicidal behaviour (see below) which may also include the homicide of the victim.

The rule that only police officers should talk with perpetrators may be broken in special circumstances in the singleton siege. The distressed hostage-taker may indicate a wish to speak to someone, usually for reassurance, i.e. an indication that the other person still cares about him or her. A relative or friend may volunteer that he or she can make the perpetrator "see sense". If such a conversation is to be contemplated then it must be carefully prepared. The relative or friend must be talked with in order to learn more of the relationship with the perpetrator, to discern what negative feelings he or she has towards the perpetrator, and to gauge something of what is likely to be said. If it seems reasonable to proceed then the relative or friend must be carefully briefed and the conversation with the hostage taker controlled to ensure that his or her feelings are improved and not damaged by the conversation.

An important operational difference between the terrorist and criminal sieges on the one hand, and the singleton siege on the other, is the level of back-up force required for an emergency. This need is lower in the singleton siege and really only required at the level necessary to obtain forced entry in carefully planned circumstances. A show of any force (an armed policeman in the street for example) may

terrify the perpetrator and might fuel his paranoid ideas beyond endurance and in itself cause a tragedy.

It is obvious that a singleton siege cannot last as long as any type of siege with two or more perpetrators. Singleton sieges therefore rarely last longer than 36 hours and are usually less than 24 hours. Occasionally perpetrators may prolong their waking time with stimulant drugs such as amphetamines, but they will eventually get tired and the general rule usually applies even in these cases. There is therefore less pressure to organise a feeding routine, although the misery of the captive must always be kept in mind.

### **The police**

The key police officers in a major incident are also under very severe stress. The commanding officer is aware of the glare of publicity and the watchful eye of senior politicians who are not actually running the operation, but who will inevitably have to take some public responsibility for it. The negotiators may be undertaking a real operation of this magnitude for the first time. They too feel the pressure of publicity and immense responsibility and added to their problem is the unusual loss of authority and autonomy which is in itself stressful. During an incident police officers may show symptoms of stress such as anxiety, irritability, and excessive smoking. They may complain of an inability to sleep at night and feel the need to work even longer than the 12 hours they are allocated. On rare occasions they may develop symptoms of affective disturbance, depression, or hypomania. The psychiatrist has to spend a good deal of time with both commanding officers and negotiators, giving them the opportunity to talk, express their feelings, reassuring them when they feel they have made mistakes or failed, and encouraging them to relax in various ways, giving them simple advice about their sleeping and off duty arrangements and the need for sensible drinking. Police culture tends to encourage off-duty drinking anyway; increased arousal during a stressful operation could make this much worse. On occasions it may be appropriate to prescribe night sedation.

The same two factors in stress reduction that are of concern for perpetrators are also important in relation to policemen, that is the raising of self-esteem and lowering of fear. Preoccupying thoughts such as "Oh my God this is taking too long", "this is all going wrong", "unless I get this right I will fail my promotions board", and so on, do nothing to improve a performance. Such thoughts are seldom expressed, but the psychiatrist needs to be aware they are present at all levels and should try to reinforce more helpful notions such as "no one else could do this better", "even if it goes wrong I will have done the job well", "things are going according to plan", "I seem to have a good relationship with the perpetrator".

## Special considerations

### Stockholm Syndrome

The term "Stockholm Syndrome" is relatively meaningless jargon. Many use it to refer to the positive bonds which sometimes develop between hostages and their captors during the course of a lengthy siege. The term originated in the events during a raid on Sveriges Kreditbank in Stockholm in 1973, which turned into a siege in a vault with three victims (two female) being trapped by an armed robber (later two robbers when an accomplice was released from prison to join him). One of the women had a sexual encounter with one of the robbers and continued to visit him regularly during his imprisonment. The victims said they feared the police more than they feared the robbers. Sometimes it is implied that such developments can be expected in every siege and are exclusive to sieges. The phenomenon of developing sudden and strong affective bonds with strangers is not confined to criminal sieges, nor does it always occur. It may happen in other situations when people are thrust together in highly emotional, especially life threatening circumstances. A number of psychodynamic theories have been postulated for this, but a simple explanation could be that an intensely gregarious animal which is very vulnerable when alone or isolated develops strong group bonds when under extreme threat. Bonding or identification with an aggressor may well reduce the aggressor's hostility and ability to destroy the victim.

Ochberg has given a good account of the protective aspects of human empathy (Ochberg, 1977). In the Dutch Mollucan siege of December 1975 the terrorists planned a series of hostage executions. Mr Gerard Vaders, a newspaper editor in his 50s, was chosen as one. He says, "In the morning when I knew I was going to be executed, I asked to talk to Prins (another hostage) to give him a message to my family. I wanted to explain my family situation. My foster child, whose parents had been killed, did not get along too well with my wife, and I had at that time a crisis in my marriage just behind me ... there were other things too. Somewhere I had the feeling that I had failed as a human being. I explained all this and the terrorist insisted on listening".

When Mr Vaders had finished and said he was ready to die, the Mollucan said, "No, someone else goes first" and an unfortunate more anonymous man was led away and shot. Vaders had changed from an object, a bargaining counter, to a human being: they could not longer kill him. With the passage of time and the occurrence of positive experiences between captor and captive, the captive's chances of survival increase.

Some say that the Stockholm Syndrome has three elements:

- (a) positive feelings from hostages to captors
- (b) negative feelings from hostages to police
- (c) positive feelings from captors to hostages.

In reality this is too simplistic and relationships do not always develop that way. Certainly there are occasions when a strong uniform understanding of the siege can develop as happened in Stockholm, a "we are all in this together" feeling, "It's the police who are holding up our safe exits". Certainly to a hostage the law enforcement authorities will always seem slow and careless of life. However experience has shown that all kinds of strong relationships, both positive *and* negative, can develop within any given stronghold, the bigger the number of participants in the incident the more complex the relationships that develop. The only safe bet is that it is extremely difficult to know what those group dynamics are from the outside. A corollary is, never depend upon hostages as natural police allies.

The only generalisation that can be made is that, in the highly charged atmosphere of a siege, bonds and antagonisms will always develop. Such things are part of normal social biology, they are inevitable. Part of the police task is to encourage as much positive bonding between as many individuals as possible. Such bonds are more likely to lead to a non-violent outcome.

### Suicidal incidents

Unless an individual threatening suicide also threatens other people, the situation created can hardly be called a siege. However, suicidal sieges do occur and even when the suicidal person is alone a police negotiator may be called and psychiatric advice sought, so a brief mention here is perhaps in order.

It is worth noting that suicidal behaviour is usually ambivalent and may fluctuate wildly from despair to hope, from aggression to self to aggression to others, from calm to terror. Everything done must be calming, reassuring, hopeful. Some suicidal sieges are the acting out of a fantasy in which the perpetrator is shot. This is a form of heroism and it shares the responsibility for the "sinful" act. Weapons such as firearms are particularly provocative in such incidents and a clear statement that the perpetrator will *not* be shot may be helpful. The cautious introduction of a relative or friend, as discussed above, may be especially useful in the suicidal incident.

### Aftermath

Every incident produces victims. Skilful management may mean that few lives are lost, but for the

hostages there is a long and painful price to pay. Many of them will suffer from symptoms of post traumatic stress disorder for months, perhaps years. They may develop affective disorders, phobias, aggression, irritability, self-destructiveness, and other neurotic symptoms. They may become hostile to authority, especially to the police, they may identify with the terrorist, they may suffer a loss of job, a marriage break-up and other reinforcing social disasters. It is difficult to know whether and how these long-term consequences can be prevented. Society is particularly bad at the management of victims, and the victims of sieges are no exception. It is characteristic of our disdain for victims that at the end of a siege little or nothing is done for the hostages except to take them to a place of safety, debrief them from the police point of view, use them as witnesses in any criminal proceedings, and advise them about contacting their doctor. It could be that much more positive action on the part of psychiatric services would prevent long-term symptoms.

The management of the victim is a major topic outside the scope of this paper, but there are two points worthy of special note here. The first is related to publicity. Before the siege the victim is one sort of person with a slowly developing set of social constructs, after the siege he or she is suddenly a different kind of person, maybe a hero, maybe a social outcast, maybe both. The second problem is that during the siege victims lost control over their personal destiny, a devastating experience. Everything that seems to happen after the siege, especially help that is offered or thrust on them, seems to reinforce that loss of personal control.

Another weakness in our siege management is the management of relatives. During the incident relatives of the hostages are totally distraught and after the incident they have either a great grief and bitterness to cope with, or else they have to deal with a different individual who has lost his or her personal identity and may also have a severe neurotic illness. The relatives too will have to suffer the intrusive, insensitive, and persistent attentions of the media. Ideally we should provide a support and counselling service for relatives during the siege and this should be available for as long as they want it afterwards.

Police officers may also suffer longer term effects from the stress of such an incident. Police negotiators

have suffered affective disorders following a stressful siege. Here again support and counselling services would be very helpful and if necessary referrals to psychiatric clinics which have an interest in this kind of work. Some police forces (e.g. in the United States) have a compulsory debrief in the presence of a health professional. This could be useful, provided such a debrief is clearly separated from any disciplinary procedure or function.

### Comment

To the outsider it may not be immediately obvious that there is a role for a psychiatrist at a police operation managing a terrorist siege. In practice the psychiatrist is likely to be extremely busy and indeed overworked, and if possible should not attend such an incident unsupported by one or two colleagues. The ideal arrangement is for a small team of psychiatrists who know one another well to share the duties in order to avoid excess fatigue and emotional over-involvement.

Is it correct to focus on terrorist sieges? These after all are rare. What about the commoner domestic siege? These do not usually provoke the same need for psychiatric help from the police. This seems paradoxical as domestic sieges are much more likely to be perpetrated by someone who is mentally ill or under great stress. While this is true, sieges perpetrated by a single individual (as domestic sieges usually are) are usually quite short lived and thus produce fewer operational and medical complications. A single individual, especially if terribly upset, usually finds it difficult to maintain any kind of effective siege beyond 24 hours. The call-out rule for psychiatric help should be that the siege is judged as one that is likely to last beyond 24 hours, unless there is a specific psychiatric problem. Aftermath health service arrangements ought to be available for all sieges, but usually they are not.

### References

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