*L. N. Daly,*[1] *M.D.*

# Terrorism—What Can the Psychiatrist Do?

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**ABSTRACT:** The 1970s have yielded many situations in which psychiatrists have been summoned by agents of the state for help in resolving terrorist-related crises. This paper tries to examine the evolving role of forensic psychiatrists as they participate in such situations and reviews some of the functions involved in open community/terrorist confrontations, closed community/terrorist confrontations, and psychiatrist/terrorist relations. Positive contributions have been made by psychiatrists, but there is a lack of available information to assist them in fulfilling their tasks. Specific recommendations are made that may be of benefit to the psychiatrist.

**KEYWORDS:** psychiatry, terrorism

My practical experience relating to terrorism has been limited to my work in Dublin as director of forensic psychiatry from 1971 to 1979. In this capacity I was an employee of the Health Board, a consultant to the Justice Ministry, and a psychiatrist to the prison population. Although during that time the Republic of Ireland enjoyed a relative period of peace compared with the situation prevailing in Northern Ireland, there were a number of incidents involving the creation of fear in the population by a minority for various political ends, but most particularly for the unification of Ireland.

Some psychiatric authors have offered definitions of the term "terrorism," choosing to distinguish between the behavior of the "urban-guerilla" fighting a "just war of national liberation" and the terrorist whose goal is "social blackmail" [*1,2*]. The impact, however, of both such national groups of activists on the population appears to be that of creating a state of recurring fear, which, like war, creates health problems and requires the attention of the physician.

For the sake of the North American reader it should be mentioned that Ireland remains divided into the Republic of the South and Northern Ireland, a mainly Protestant principality linked with the United Kingdom. The political institutions of the latter have been suspended since the onset of the present unrest in the 1960s. Although paramilitary Protestant groups exist in the North, most remain inactive because of their support for the British governmental security forces there. An uneasy alliance exists between the governments of Great Britain and the Republic of Ireland with regard to coping with paramilitary activity. Most of this activity is perpetrated by the illegal Provisional Irish Republican Army (IRA), whose mainly Catholic membership spans the border but, as has been indi-

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[1] Assistant professor, Department of Psychiatry, Baylor College of Medicine, Houston, Tex. 77030, and ward physician, Veterans Administration Medical Center, Houston, Tex. 77211.

cated, directs most of its activities to the North. In spite of world-wide concern about terrorism, there seems to have been little attention paid to it in the psychiatric literature. As this decade dawns, it seems likely that terrorism will remain and that there will be a persistent need for the attention of psychiatrists to the health aspects of paramilitary activities.

**Psychiatrist as Sympathizer**

There is an ambiguity in the title of this paper that may not be initially apparent. There is in fact a great deal that the psychiatrist can do to foster terrorism. Becker [*3*] gives an account of Dr. Wolfgang Huber, a psychiatrist in a teaching post at Heidelburg University, who instructed his patients in group therapy in the use of firearms and explosives. He formed a Socialist Patients Collective responsible for assassination in Berlin and an embassy siege in Stockholm that ended in tragedy. He was last believed to be somewhere in the Middle East, having served a prison sentence for "criminal conspiracy." The doctor-revolutionary is not easily perceived as a physician, but we might refer to one in exploring our topic further. Frantz Fanon [*4*], a black psychiatrist, was a voice of military revolution in the Franco-Algerian War. Working in a hospital in North Africa, he treated casualties of torture, both torturers and victims, never failing to observe their mutual fear and human concerns. He documents clinical histories of patients experiencing delayed guilt reactions to their own bombsetting. He alleges the misuse of psychiatry by the French authorities whereby confessions were elicited from prisoners by psychiatrists falsely claiming to act on behalf of the defense. He later gave full expression to his sympathies for the Algerian rebels by joining the National Liberation Front and providing psychiatric services in their camps. Throughout, he remained fascinated with the capacity of normal human beings to express infinite rage. He enables his readers to work towards some understanding of reactive ruthlessness [*4*].

**Psychiatric Functions in Terrorist-Related Situations**

Understandably, forensic psychiatrists in the West have made their contributions in roles that, unlike the foregoing examples, are nonactivist. Ochberg has closely studied the European terrorist theater from a psychiatric perspective (Fig. 1). In an article in *The Practitioner* [*5*], he makes a particular plea for greater awareness and understanding of the victim of terrorism. He described the plight of a Dutch journalist, Gerard Vaders, selected during the Groningen train seige as an execution victim. He avoided execution by a number of factors tending to operate in his interest: he managed to maintain a sense of professional identity by observation and writing and he demonstrated his humanity by reiterating some deeply felt sentiments for his family to a messenger in the presence of the captors. In addition, the atmosphere on the train was conducive to some bonding between hostage and captor so that a degree of the Stockholm Syndrome was achieved [*5*]. This is a phenomenon of emotional attachment that sometimes develops in siege situations. It was first described with reference to an incident in a bank in Stockholm when a robber was forced to hold out in the vault by the police. He formed a close sexual attachment with one of his female hostages during the siege. Subsequently, the female hostage expressed positive feelings towards her captor that were almost directly proportional to her negative feelings toward the state authorities who had rescued her. Available information does not indicate which sort of personalities are prone to the Stockholm Syndrome and which are not. Its existence may be life-saving, as with the train siege, but some of its disadvantages are that it may prevent cooperation between victim and would-be rescuer. Also, in the case of Mr. Vaders, some of his subsequent writings, which were not so much pro-captor as anti-government, led to unpleasant repercussions for his family.

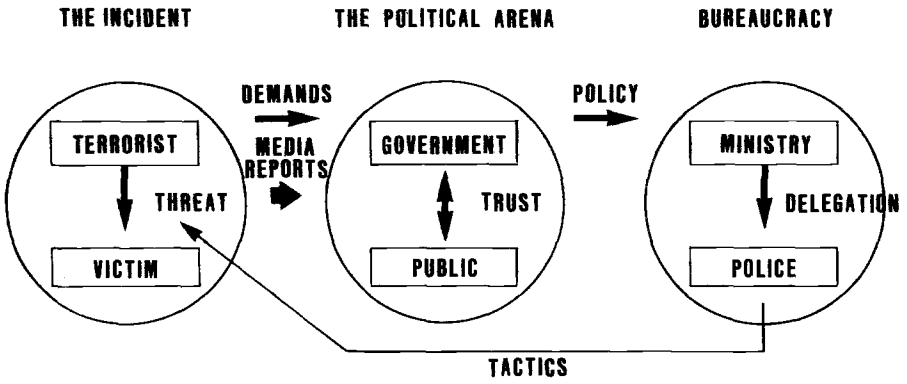


FIG. 1—*Ochberg's hostage incident flow chart. (Reprinted by permission from Ref 5.)*

**Irish Experiences: Hostages**

In the fall of 1975 a kidnap siege occurred in the Irish Republic. The captors were two maverick members of the Provisional IRA, Gallaher and Coyle. The hostage was Dr. Herrema, a Dutch industrialist whose academic background was psychology. The incident affords us our first example of the misuse of psychiatry in terrorist situations. During the siege one of the forensic psychiatrists was asked to be available for consultation to the state authorities. The solitary request was that he comment on the feasibility of breaking into the siege room with anesthetic gases. He referred officials to a pharmacologist. Towards the end of the siege, I, on arriving home from overseas leave, was greeted with a telephone call from a journalist representing the foreign press. I was asked by the psychology correspondent for the London *Sunday Times* to comment on the government's handling of the siege. I declined comment. However, on being asked if there was an awareness of the psychology of siege in the Forensic Service, I hastily replied in the affirmative and had an abstract discussion on the use of intermediaries in siege situations. On the following day journalistic license took the form of an article in the *Times* [*6*] naming me as an Irish psychiatrist who was severely critical of his government's handling of the siege. I availed myself of the opportunity to immediately deny the allegation in the Irish media, but thenceforth in similar situations there was understandable distrust in the relationships between governmental law agencies and the Forensic Service.

The Herrema siege terminated with the surrender of the kidnappers. Dr. Herrema survived, possibly through establishing a fairly positive relationship with Gallaher, with whom he had extended political discussions. The most successful intermediary used by the government was a detective chief superintendent whose presence was requested by Gallaher. The latter had known and trusted the police officer from previous experience.

**Irish Experiences: The Hunger Strike**

An example of a closed community/terrorist confrontation occurred in the spring of 1977 when some 20 imprisoned members of the Provisional IRA staged a hunger strike in search of political prisoner status. The hunger strike is a particularly potent weapon in Irish conflict and has a long and respected history originating in heroic Celtic mythology [*7*]. The strikers were moved when their protest was well established to a military hospital and were confined to their beds under military guard. Two of the strikers developed a variety of physical and psychophysiologic reactions. They were given permission by their leaders

to terminate their fast and to receive psychiatric assistance. When one of the leaders requested that the psychiatrist interview a third member of the group, the psychiatrist agreed to do so only on condition that the reason for referral could be discussed with the leader. Permission was given by the medical officer and the interview with the young striker took place. He was experiencing severe episodes of anxiety, panic, and death wishes. When the psychiatrist endeavored to visit the leader, he was informed that permission had been rescinded by the officer in charge of security.

The medical officer immediately appealed to headquarters and permission was granted after a delay of several hours. The Provisional leader in the interview indicated his concern for the mental health of the young man. He did not want any of his comrades fasting who were not able to make a rational decision to do so. He also indicated that he was beginning to fear that they were all going to die "for want of an intermediary" because certain distinguished visitors had already been denied access to the prisoners. He was told by the psychiatrist that his concerns would be conveyed to the Justice Ministry. On the following day a member of the Catholic hierarchy was allowed to visit the strikers. He was professionally qualified for his task in that he also lectured in industrial relations in the national university, and he was successful in that the strike was terminated immediately.

## Background Information

All parties involved at the interface in crisis situations may benefit from an awareness of conflict resolution by intervention. The interface in a terrorist-induced situation is best illustrated by Ochberg's analytic diagram (Fig. 1) and may be defined as the linkage of the various agents participating in resolving a crisis. Oberschall [*8*] describes some of the functions of the "conciliatory interviewer" as (1) easing tensions, for example by reducing provocative stimuli; (2) representing the public interest; (3) defining realities of the situation to each side; (4) observing the "ethic of symmetry" which may be roughly equated with the principle of give and take; and (5) being a viaduct of information.

The late Peter Scott, the famous British forensic psychiatrist, was believed to have rendered consultative assistance during siege situations that culminated without bloodshed, but, prolific writer though he was, his experiences have not been published. The Dutch train siege was allegedly attended by psychiatrists who were called to the military service, but their experiences have not been published.

## Hospital Security

A few members of the Provisional IRA who suffered psychotic breakdowns in Portlaoighise Prison were given permission by their leader to receive psychiatric treatment and with considerable display of armed security were transferred to the Central Mental Hospital in Dundrum. Their presence created unhappiness in the medical staff. The independent psychiatrist experienced no conflict visiting the prison or the military hospital, but at Dundrum he was obliged to provide unarmed security as well as treatment. This is a role traditionally accepted in forensic psychiatry, but membership by the patient in an armed organization adds a new and difficult dimension to that role.

In 1978–1979, there were two armed escape actions in the hospital. In the first, a patient recovering from a psychotic episode escaped by scaling the perimeter wall during an exercise period. The rescue party included an individual on the wall with a submachine gun who guarded the escape route. The second escape followed the smuggling of two handguns by the girl friend of a patient. Nursing staff were held up and forced to surrender their keys. The nurses were then locked in a linen closet. One of the fugitives, still actively psychotic, decided to remain on the grounds and surrendered to other members of the staff.

Because some members of the Provisional IRA have visited the Middle East, where Dr. Huber is suspected to reside, there was some remote suspicion of Dr. Huber's confreres who have occasionally treated members of the Provisional IRA known to have visited the Middle East. The question of malingering by the patients was raised, but there was no evidence that any of the escapees had faked illness or had visited the Middle East.

These unhappy events have yielded additional difficulties for the Forensic Service. There have been occasions when fitness to plead (competency) has been an issue and Provisional IRA prisoners have declined to be examined by "governmental" psychiatrists even though the service considers itself to be free from immediate ministerial control.

## Recognized Contributions

In one particular role concerning terrorism, the psychiatrist appears to remain indispensable. It is that of expert witness, especially in the evaluation of the victims of terrorist-induced trauma. Fanon [*4*] identified a group of patients experiencing reactive psychoses. He classified another group (Series D) as suffering psychoneurotic disorders, including stomach ulcers, nephritic colic, amenorrhea, idiopathic tremors, paroxysmal tachycardia, impotence, and premature graying. More recently, the evidence of Daly [*9,10*] and Bastiaans to the European Human Rights Court at Strasburg concerning the effects of interrogation in depth on suspects in custody significantly contributed to British governmental acceptance of legal responsibility for the traumata involved.

In Northern Ireland, terrorism may emanate from various sources other than the paramilitary Catholic and Protestant organizations. At Strasburg the terror source cited was the state itself.

The psychiatrist venturing into this arena merits the full support of his profession. The Tokyo Declaration framed by the World Medical Assembly [*11*] is invaluable to the psychiatrist working with terrorists, who is advised to seek the formal support of the profession in all matters dealing with the health of prisoners. For example, independent opinions should be sought whenever a controversial treatment is proposed, such as electroconvulsive therapy for a psychotic hunger striker. Furthermore, forced feeding of sane prisoners is held to be unethical. Such a guideline has proven to be invaluable to psychiatrists who may have felt themselves under pressure to forcefully terminate hunger strikes.

The following case report is another example of recognized contributions by forensic psychiatrists. A 20-year-old politically oriented former patient of the Forensic Service acquired a pistol "to liberate the people." He later became involved in a vicious argument with an acquaintance, whom he shot. He fled to the apartment of a girl friend whom he evicted at gunpoint and announced his intended suicide. A siege ensued, possibly prolonged by the unsolicited arrival of a local physician-politician. Through the police, the former patient requested the presence of his psychiatrist. The latter attended the scene each day, allowing the patient to articulate his grief and remorse but promising future therapeutic support. The patient surrendered to the police.

## Behavioral Studies

While most writers have dealt with the sociocultural bias of terrorists, a few, mainly North American, have maintained that the personality perspective is more important. Hubbard [*12*] has profiled hijackers and with F. Gentry Harris has concluded that most terrorists probably suffer from faulty vestibular function in the middle ear. In an interview with *Science* [*13*], Hubbard claimed that 80 terrorists examined by a consortium in eleven centers have certain similarities. They are typically obsessed with "notoriety, sovereignty, and martyrdom" and 85 to 90% give clear clinical evidence of "vestibular abnormality manifested by such indicators as a history of learning to walk late, dizzy spells,

visual problems, and general clumsiness." Hubbard has further elaborated on this theory with several linguistic illustrations of skyjackers utterances in an appendix to his study in which he emphasizes their conscious and unconscious awareness of proprioceptive function. It seems, however, that extensive scientific and neurologic quantification is awaited.

Miron and Pasquale [*14*] have conducted psycholinguistic analyses of coercive communications of terrorists and observed three characteristic dimensions: impotence denial, destructive reaction, and affiliative need.

Kent and Nichols [*15*] have written provocatively on the psychodynamics of terrorism, postulating that the origins include deeply repressed hatred lying in parental abuse. They conclude that political terrorism involves the exploitation of mentally ill people by journalistic media claiming to represent the public.

## Conclusions

1. The psychiatrist may have a contribution to make to the resolution of terrorist-linked incidents as an accepted intermediary rather than as a behavioral scientist; psychiatrists have apparently not added significantly to our knowledge of terrorist psychopathology. Much information probably remains classified. Furthermore, a psychiatrist summoned to consult in a terrorist-induced crisis would be well advised to refuse unless he or she is granted full access to background information concerning the incident. The psychiatrist should be prepared to function as an intermediary in certain situations but should define such a role to the terrorists as well as to the state authorities.

2. There is much that a psychiatrist can do to help the victim of terrorism, including assessment, rehabilitation, and presentation of medicolegal evidence.

3. Naive interaction with the media can be avoided by appropriate governmental briefing. Furthermore, psychiatrists at risk for duties in these circumstances are sometimes expected to function as spokesmen. The sum of knowledge regarding terrorism is limited, and the psychiatrist would be well advised to deal only with known data and avoid public speculation on the many aspects of terrorism.

4. Forensic psychiatrists should seek the formal approval of the medical profession so that there is no question concerning their professional identity. They cannot afford to be perceived as policemen, jailers, or collaborators.

5. Terrorist-patients are a particularly difficult clientele. They cannot be treated in unsecured forensic psychiatry hospitals because of the proven danger to staff and other patients created by their presence. Facilities should be earnestly sought in the prison system. Although probably not relevant to large countries, this consideration may well have implications for small countries other than the Republic of Ireland.

6. Although most of the material exemplified here concerns political terrorism, some psychiatric patients may behave as terrorists during episodes of relapse. The psychiatrist in such a situation can frequently resolve the crisis for the community by communicating with and supporting his patient.

7. Dealing with terrorism is a potentially hazardous but relevant extension of the role of the forensic psychiatrist.

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Address requests for reprints or additional information to
L. N. Daly, M.D., F.R.C.Psych.
Central Mental Hospital
Dundrum, Dublin, Republic of Ireland