REVIEW ARTICLES

Hostage retrieval

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From scientific papers and autobiographical accounts it is clear that released hostages can benefit greatly from psychological debriefing. This consists of making a detailed, progressive review of the events since the identified critical incident with a systematic review of the facts and the emotional reactions associated with those experiences. The debriefing work must be undertaken with a flexible and non-judgmental approach at a pace largely determined by the survivor(s). The aims include reconstruction of the memories of the traumatic events without distortions, assimilation of the yielded and clarified material, integration of meaning, and emotional ventilation without the encouragement of catharsis. Emotional catharsis is not seen to be helpful because it implies loss of control whereas one of the aims is restoration of control. The overall goal is to restore normal function[1]. Here I review the psychological response to confinement and torture, and record some experience with ex-prisoners-of-war from the Gulf and ex-hostages from the Lebanon.

TORTURE

From the moment of capture the victim is held in a state of 'torture' by his captors. The World Medical Assembly has defined torture in the declaration of Tokyo of 1975 as

> the deliberate or wanton infliction of physical or mental suffering by one or more persons acting alone or on the orders of any authority, to force another person to yield information, to make a confession or for any other reason.

Physical and psychological means of torture are used. Physical torture has both a physical and a psychological impact. Psychological tortures are subdivided by Somnier and Genefke[2] into 'weakening techniques' and 'personality destroying techniques'. The former are designed to induce helplessness and the latter to induce guilt, fear and loss of self-esteem. The three main strategies of torture are described as deprivation, constraint and communication.

Deprivation involves reduction of environmental stimulation. Visual deprivation can be achieved by poor lighting, reduced exposure to different colours and the use of blindfolds[3]. Auditory stimulation is minimized by insistence that hostages talk in whispers and by muting of sounds from the external environment. Sensations of smell and taste are restricted by monotonous diet and a stale atmosphere. Touch may be limited by the confines of a small cell and lack of personal possessions. Kinaesthetic deprivation results from constraint of limbs with ties and chains—with consequent impairment of movement, physical discomfort and pain[4].

Constraint forcibly subjects victims to experiences and stimuli alien to their accustomed codes of conduct and personality. Victims are commanded to obey regulations in a setting of close supervision over which they have no control. Violation of these rules results in punishment. Dignity and identity are violated by humiliation and further degraded by inadequate sanitation and poor hygiene. Impossible choices and mock executions also come under this heading. Hostages are forced to suppress their emotional reactions. Aggressive drives might threaten survival of self or the group.

Communication strategies expose captives to ambiguous and contradictory messages designed to induce a state of bewilderment.

PSYCHOLOGICAL REACTIONS TO TORTURE

Turner and Gorst-Unsworth[5] described psychological reactions to torture as tri-dimensional. First there is the traumatic stress reaction—characterized by the usual core features of post-traumatic stress disorder including persistent, intrusive and distressing recollections, hyperarousal and avoidance behaviours. Second there is the existential dilemma of clinging to hopes of returning to a 'normal' world which they realize from first-hand experience contains such horrors as torture. Hostages also feel guilty about elements of their behaviour during incarceration. They are afraid that these elements might be revealed to others after release. Third is the development of depression, which is mainly the result of loss events—including the loss of parts of the body, health, family, friends, freedom and social status.

VICTIM RESPONSES

Symonds[6] recognized that victim responses follow a common pathway irrespective of the type of insult. He drew his conclusions from extensive studies of hostage

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takings, kidnappings, robberies and rape. All these types of experience shared suddenness, unpredictability and violence. He described four phases, the duration and intensity of each being influenced by the nature and quality of contact with the perpetrator. Phase 1 is shock and disbelief—a denial mechanism. Then come emotional reactions including rage, apathy, resignation, irritability and mental tension—also recollection of the trauma through dreams and fantasies. Self-recrimination is a frequently encountered component of this second phase. In phase 3 previous personality traits begin to exert their influence. Those with high dependency traits tend to become depressed and introspective; phobic behaviours often develop. These survivors are at risk of forming hostile and dependent relationships with family and friends after the ordeal. Others with more freedom-oriented, detached, aggressive personalities reveal intensified trait behaviours leading to social withdrawal and reclusive paranoid irritability. Phase 3 is seen only in traumatic events of short duration. Long-term hostages tend to remain in phase 2 because the trauma continues, frequently in the form of torture. Finally the individual tries to integrate the traumatic experience and come to terms with it. This phase of resolution and integration is characterized by the development of strengthened psychological barriers such as defensiveness and increased vigilance. Revision of values and also changes in attitudes to other people are often profound.

In the case of hostages held for long periods, these phases cannot be tackled until after release. The exposure to torture and solitary and group confinement will have led to complex patterns of adaptive behaviour during captivity, the resolution of which presents a challenge to all those involved in rehabilitation.

SOLITARY AND GROUP CONFINEMENT

Solitary confinement is the extreme form of isolation. It may be inflicted as a special punishment, part of a psychological torture, or it may be inevitable if the victim is the only hostage taken. The effects of isolation were recognized long ago by Allers[8] and Eitinger[9]. Both reported acute psychotic disturbances among prisoners-of-war who were unable to communicate effectively because of language barriers. In voluntary immigrants an increased incidence of psychosis may have represented a similar phenomenon[10]. Eitinger's later study of voluntary immigrants and refugees[11] revealed an incidence of psychosis five times higher than expected in the Norwegian population.

At face value, group confinement appears less harmful than solitary confinement but group confinement does present special difficulties[4]. *Interpersonal stresses* are the result of overt and covert frictions leading to irritability and hostility[12]. *Group interactions* depend on the members' interdependence for survival. In effect, this means that individuals cannot alienate the remainder of the group and overt expressions of the problems provoked by the confinement are blocked. Communication and other interactive processes decline with time. Territoriality and privacy needs become steadily pre-eminent and the end result is withdrawal from group activities. Zubeck[4] describes the paradox of loneliness despite sharing confinement with others. In some cases this can take the form of diurnal inversion, sleeping by day and being awake and by oneself at night[13]. Some hostages develop the ability to dissociate at will[13]. This affords a 'comfort zone', always attainable provided that distractions are kept to a minimum, and an unbroken thread of 'escape' and 'release' to be woven into the otherwise flimsy and ragged fabric of an existence filled with wretchedness, despair and pessimism.

To hostage groups the outside world loses some of its meaning and influence, and thus constitutes a useful target for outward projection of frustrations. People and objects outside the group are attacked. Politicians, governments and even friends or relatives are frequent targets for vicious criticism. A special difficulty is encountered when an established group of hostages try to integrate another hostage who has previously been held in solitary confinement. Here the two different styles of adaptation clash in an extreme way. Turnbull[7] reports the remarkable supremacy of repressive defence mechanisms over expressive defences. Only following release were conflicts revealed, during the confidential debriefing sessions. Much anger will be directed against the captors, but transference and counter-transference issues[6] cannot be ignored.

COPING WITH CONFINEMENT

According to Schultz[3] the most frequent technique used by hostages and others to cope with confinement is some form of mental exercise—from counting or arithmetic to complex intellectual diversions. Keeping a diary or log is another technique used, as is some form of work[14–16].

Another common factor found in survivors of confinement was the conviction that they would inevitably survive. A striking example of this phenomenon is described by Cohen[17] who emphasizes that, despite the high death rates in the Nazi concentration camps, the optimism for ultimate survival increased the longer the imprisonment lasted. Moreover, survival by any means became the dominant motivating factor in such cases.

There are considerably fewer descriptions of troublesome emotional distress arising in confined groups than in cases of individual isolation. Descriptions of illusions, hallucinations and other psychotic symptoms are rare in

confined groups. More characteristic are insomnia, depression, compulsive behaviour and psychosomatic disorders[4].

The effects of group and individual isolation have seldom been compared. In one such study, Ursano *et al.*[18] observed that psychiatric symptoms, mainly those of post-traumatic stress disorder, were less likely to develop in the United States Air Force Vietnam veterans who were captured after 1969, when solitary confinement fell out of favour as a means of holding prisoners-of war. And another study led them to conclude that the 'group' exerts a strongly protective effect for confined prisoners[19]. Despite the development of an increased sense of territoriality and need for privacy, and despite the influence towards social withdrawal, prisoners in group confinement are still likely to talk at least informally together about their predicament[13,20]. Indeed, strong bonds of friendship may develop which persist after release. The realities of their situation, resultant emotional reactions and their sensory perceptions or lack of them can be shared and compared and contrasted. These strategies are strongly representative of the basic elements of critical incident stress debriefing[21] and psychological debriefing[22] which may be protective against the development of chronic post-traumatic stress disorder. Those confined in a group may, therefore, instinctively 'debrief' each other as their shared predicament unfolds. In the case of the British hostages released from Beirut in 1991, improvement in living conditions, including the provision of a radio which permitted contact not only with the outside world but also with their own culture, may have facilitated their 're-entry'.

THE PSYCHOLOGICAL IMPACT OF BEING A HOSTAGE

The experience of being held hostage exposes victims to a wide variety of stressors. Thus we might expect the psychological impact to have multiple facets. There appear to be four distinct categories of psychiatric sequela—*stress disorder*, mainly post-traumatic stress disorder as a result of the initial trauma of capture, subjection to torture, solitary and group confinement; *depressive disorders*, most strongly correlated with torture and the experience of loss while being held hostage; *cognitive defect states*, related to weight loss and central nervous system damage; and *psychosis*, strongly associated with solitary confinement and sensory deprivation.

Any attempt at rehabilitation after release of hostages must therefore take into account that all or some of these clinical states might be present. The rehabilitation effort can begin only after careful assessment. For this reason the psychiatrist has a crucially important role in the initial states. A knowledge of clinical medicine is of enormous value, but at the same time one must avoid over-medicalization. It is of great importance to nurture the 'mind-set' in survivors that they have been injured as a direct result of their traumatic experiences rather than that their experiences have unveiled a vulnerability to a medically recognizable illness[7].

Re-entry of the released hostage involves reunion with family, friends and associates. In promoting reintegration of the family unit, an effort must be made to understand the psychological consequences for the family members left behind. Enforced separation has made them hostages as well.

SENSORY DEPRIVATION

History provides many examples of distortions of perception in individuals who have become isolated, either because they chose to be solitary or because they were deprived of their freedom. There are accounts of perceptual distortions in sailors undertaking single-handed voyages, polar explorers, priests and mystics in retreat, space explorers and even long-distance lorry drivers as well as prisoners and hostages. When individuals are cut off from virtually all sensory stimulation, distortions of perception are inevitable. When isolated individuals attempt to re-enter the normal world, these distortions cause trouble. Visual illusions and hallucinations are the most prominent features but these expressions are underpinned by more subtle psychological, emotional and cognitive disturbances[23].

'Brainwashing' was a common experience of prisoners-of-war during the Second World War, and William Sargant's book on brainwashing and sensory deprivation, *Battle for the Mind*[24], was based upon his clinical experience with returned hostages and other war-trauma victims. In the same volume Robert Graves, invited to review the history of brainwashing, emphasized that basic human behavioural patterns had changed little with the passage of time.

Hebb[25] took the phenomenon of solitary confinement into the laboratory to test the hypothesis that an important element in brainwashing is prolonged exposure to sensory isolation. The experiments demonstrated that volunteers deprived of visual, auditory, and tactile simulation for up to seven days developed increased suggestibility. Some individuals also acquired symptoms of the sensory deprivation state—anxiety, tension, inability to concentrate, body illusions, somatic complaints, uncomfortable and distressing mood states, and vivid sensory imagery which sometimes reached the proportions of hallucinations with a delusional quality.

DEBRIEFING OF BRITISH PRISONERS-OF-WAR AFTER THE GULF WAR, 1991

When British prisoners-of-war (POWs) were released after the Gulf conflict it was predicted that they would want to

return to a familiar, structured environment. Psychological debriefing became an integral part of operational debriefing. The team that was chosen to conduct the psychological component of the debriefing had a clearly defined leader—a military psychiatrist who was experienced in the management of trauma victims. The overall responsibility for the debriefing effort (both psychological and operational) was given to the psychiatrist. This required continuous and close liaison with commanders, intelligence officers and other medical specialists who were primarily concerned with physical recovery throughout the process.

To begin with, released POWs were kept separate as a group, to preserve privacy during the initial phase of re-entry. This strategy also provided freedom from intrusion by the media. A general military hospital was selected as the most appropriate and safe environment but steps were taken to deinstitutionalize the surroundings. Curtains on windows, rugs on floors, pictures on walls, replacement of typical hospital beds with divans, radios and televisions all helped to make surroundings more domestic. Holding the debriefings in a hospital meant that medical and surgical facilities were close at hand.

The POWs were able to choose their own clothing. Writing materials were freely provided to enhance a sense of freedom or self-expression. Use of the telephone to contact spouses, partners and friends was positively encouraged. The provision of wrist-watches seemed to restore a sense of orientation, control and independence (watches were always among the first items taken away by captors). To fill the information-gap created by time spent in captivity, videotapes of condensed news programmes and back-dated copies of newspapers proved very useful. Released POWs felt up to date for the imminent return home.

Psychological debriefing, which adhered closely to established principles[21,22], was intended basically to secure answers to two questions: what happened to you, and what were your emotional reactions to events? To combine the initial phase of the psychological debriefing with the operational debriefing proved not only convenient but also beneficial. Ex-POWs felt supported throughout the unpleasant but necessary process of recollecting events which are frequently strongly evocative of life-threatening traumatic experiences. They also appreciated that they would not have to relate their experiences on more than one occasion formally. This led to concentrated and full accounts. The combined strategy may prove an important development for future planning.

The second phase concentrated on emotional reactions. Putting a layer of emotional meaning on top of cognitive understanding of events seemed acceptable, controlled and constructive.

Released POWs were debriefed mainly in groups. Care was taken to group those veterans who had shared experiences. There were three such groups—released Royal Air Force POWs, released Army POWs and fast-jet aircrew who had not been captured but who had come to the debriefing to support their friends who had been released. Two dedicated debriefers were assigned to each group and saw the process through with their group. A strong educational element was included in the process, designed to help with recognition of post-traumatic stress reactions and to defuse anxieties about possible psychiatric illness. The clear message was given that many symptoms reflect adaptive mental processes involved in the assimilation of new information required for survival[26,27].

Pamphlets about traumatic stress reactions had already been produced for general use in the Gulf War. The information they contained was deliberately brief and practical and congruent with the description of the natural history of traumatic stress reactions given during the debriefings. There were two versions of the pamphlet. One was designed for ex-combatants and the other for those at home (spouses, partners and close relatives).

Although the groupwork played a key role in the psychological debriefings, individuals also wanted to discuss some issues one-to-one. There was a general encouragement to use the group. These strategies were designed to restore personal dignity, integrity and independence, while maintaining a group identity.

The debriefers were themselves debriefed. Experienced in the management of trauma victims, all were aware of the 'ripple effect' whereby the traumatic impact re-lived by those being debriefed can be transmitted to those involved in debriefing. Support or secondary debriefing is not the same as supervision. It follows the principles of primary debriefing. Support debriefers must be trusted, respected, have an understanding of trauma and be known to all the debriefers. The POW debriefing took place in Cyprus in a Royal Air Force Hospital. Fortunately, a highly valued member of the RAF Psychiatric Division was available on the island to undertake the work. His role was to hear descriptions of debriefing work undertaken that day and impressions gained from the work, and to identify tiredness, 'mirroring' and any over-involvement. The support debriefer also facilitated the emotional ventilation necessary among the debriefers; tested hypotheses and offered alternatives; encouraged the development of strategies but avoided directing them; and was always mindful of the importance of the leader role for the debriefers and those being debriefed.

For practical reasons it was not possible to reunite released POWs with their partners or close relatives before they returned home, though this strategy is desirable and was universally favoured.

The psychological debriefing appeared to be successful. Objective evidence was that the groups had regained their group identities, had a much better grasp of what they had been through, had rediscovered a sense of humour and felt that they were back in control of their lives. There was general approval for the debriefing even if there had been suspicion at the beginning. All of the aircrew returned to flying duties within three months.

PSYCHOLOGICAL DEBRIEFING OF RELEASED BRITISH HOSTAGES FROM THE LEBANON, 1991

To a large extent the debriefing of released POWs provided a template for the debriefing of the released hostages from the Lebanon later the same year. One difference was that there was more time for planning the debriefings. For example, it proved possible to meet the relatives at home before the hostages returned. There were three debriefings. These were for John McCarthy, Jackie Mann and Terry Waite and their families. In the case of the last hostage-retrieval there was time for the debriefing team to meet all the primary relatives and acquaint them with the place in which the debriefing would take place (provided that released hostages agreed with the plans), so that the only unknown factor was the state of the released hostage himself.

As much information as possible was gathered, partly by liaison with the British Foreign and Commonwealth Office and Military Intelligence. The team of primary debriefers required sufficient members to provide an individual debriefer for each person or small group identified as having that need. Small groups included children or family members other than partners. A liaison officer ('Mr Fixit') was chosen. The liaison officer, regarded as a primary member of the debriefing team, took no part in the primary debriefings but was always involved in secondary debriefing sessions. He dealt with administrative matters such as phone calls, organization of meal-times, and meetings with the media. Although all members of the primary debriefing team were active Royal Air Force personnel, only 'Mr Fixit' worked in uniform (because of his interfacing role with military and other authorities).

The debriefings of the three released British hostages all took place in the secure environment of a Royal Air Force base in the UK. The officers' mess accommodation afforded a suite of rooms that could be cut off from the rest of the building. This facilitated decisions made by released hostages and their families to choose for themselves how much exposure they and their families wanted from the outside world and the media. Media interest was intense, and it seemed prudent to set aside time at the outset to re-establish a sense of control and equilibrium before the hostages faced the cameras. Raw impressions of what had happened during captivity, including relationships with other hostages, needed to be thought through and refined before being reported. This was a recognition that the released hostages made for themselves. They were unsure of the validity of their thought processes and reactions after such long periods of incarceration. As a group, the released hostages were keen to talk about their experiences but concerned about inaccuracies, distortions and catharsis during interviews with the media. As they gained confidence they made decisions to give interviews at press conferences at their own pace. The debriefers regarded confidentiality as supremely important and notes were not made either during debriefing sessions or afterwards. The move away from this security to the uncertain situation of recording a live interview for television meant that some time had to pass before such a confrontation could be seen for what it was, a well-meaning and welcoming interview rather than another interrogation. Interviews immediately after release can stimulate recollections of interrogation and torture events during the captivity itself, however skilled the interviewers.

The core philosophy of the debriefing team was to avoid giving the impression to released hostages and their families that they had become patients and we were their medical advisers. The questions of research and review had to be handled with care.

Confidentiality was of the utmost importance and note-taking during discussions was unthinkable. The assumption was that those who had emerged from life-threatening captivity would naturally be suspicious of others' motives and would seek relationships with those they could trust. Therefore, to be included in this 'inner circle' it was necessary to inspire confidence in the outcome of the process, and to be utterly reliable. The programme for the day had to be adhered to by the debriefing team unless changes were negotiated bilaterally. In this way a sense of reliable structure was gradually built up. An events diary was devised, taking the form of a white board on which were written events for the few days ahead.

The general plan was for each survivor to hold a sequence of one-to-one meetings with his dedicated primary debriefer, for full group meetings to be held on an irregular but frequent basis (usually daily) and for the primary debriefing team itself to be debriefed daily by the support debriefers. As was the case in the POW debriefings earlier in the same year the main task of the support debriefers was to listen to the impressions gained by the primary debriefers, avoid criticism and provide positive reinforcement. Throughout the debriefings the primary debriefers lived very close to their work. The support debriefers, in sharp contrast, carried on with their normal working lives as mental health professionals and made time each day to visit the focused rarefied world of the debriefings.

CONCLUSION

Because the method of psychological debriefing was not designed as a research project there are no objective data to assess its successfulness or otherwise. The numbers of people were small. But other hostages released at about the same time were not debriefed in the way described. Generally, those who were debriefed did not develop serious post-traumatic stress reactions, depressions, other illnesses or disruption in their relationships. Those who were not debriefed did suffer some of these consequences. In the case of the released POWs, after the debriefing there was an obvious uplift of spirits, a return of group identity, and restoration of a sense of humour; perhaps most impressive, those initially most antagonistic became the most supportive of the idea that the process should be adopted as a normal part of rehabilitation and management after release. All of those managed in this way have returned to service life and fulfil accustomed roles. Of course, this might have happened anyway. Nevertheless, it seems that real benefits were derived from the debriefing process because it permitted some of the 're-entry' issues to be tackled privately before return to family and professional lifestyles.

In the case of the released British hostages from the Lebanon the debriefings provided a 'breathing space' to begin to integrate their traumatic experiences and look into the future. There is some evidence that released hostages from other nations have experienced difficulties in adjustment which the British ex-hostages have not experienced.

The Royal Air Force debriefing teams had no doubts that psychological debriefing of released POWs and hostages was a valuable course to follow. They hoped that some of their ideas and experiences might stimulate interest in making psychological debriefing an integral part of the re-entry process for future hostages. Similar techniques might be appropriate in the attempts to rehabilitate prisoners who have completed long jail sentences and also those who have been exposed to periods of sensory deprivation, such as lone sailors and astronauts. The core techniques have already been incorporated into a successful group-oriented treatment for chronic post-traumatic stress disorder[28].

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