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The times

The management of hostages after release*

The Psychiatric Division of the Royal Air Force Medical Service

The recent release of British and American hostages held by fundamentalist Islamic groups in Lebanon has received national and international publicity. The Psychiatric Division of the Royal Air Force Medical Service has been involved with the management of released British nationals and others but, in the interests of the hostages and their families, has delayed public discussion of the matter. From the British and American viewpoint the recent hostage crisis in the Lebanon has now resolved. It therefore now seems appropriate to describe in general terms the principles upon which early management was based.

Reports suggested that previously released American hostages had suffered physical and psychological maltreatment. Poor diet, cramped, unhygienic conditions, the use of physical restraints and unprovoked beatings, caused disease and injury. Solitary confinement, blindfolds, social deprivation and mock executions contributed to episodes of despair, helplessness and, in some hostages, a genuine wish to die. Feelings of guilt and self-recrimination for the distress caused to those left behind were common, and were exacerbated by the lack of outside information until the latter part of the hostage crisis. It was to be expected that the effect of solitary confinement experienced by the hostages would be significant and that post release depression, emotional lability and impaired speech and thinking with some degree of social phobia might occur. The likelihood that some hostages would identify with their captors [the so-called Stockholm Syndrome] (Ochberg, 1980) was anticipated.

It was clear that the difficulties facing any individual who regained his freedom and stepped into the international spotlight could be substantial and wide-ranging, and extend to his family, friends and employer. Plans for the immediate management of the most obvious needs were prepared in advance of the release of the first British hostage in August 1991. The Royal Air Force Psychiatric Service's involvement in the debriefing of British Prisoners of War [Aircrew and Special Forces] after the Gulf War, had provided a learning opportunity for the application of heretofore largely theoretical techniques, and useful practical experience. For example, good use was made of video newsreels [kindly provided by the BBC] to help former hostages to catch up on world events. Nevertheless, uncertainties regarding the most helpful form of early intervention remained until a thorough assessment could be made of the first British case. The lessons learnt on that occasion proved valuable in the treatment of others. We learnt that after long periods of solitary confinement the hostages spent some time in small groups and had no communication problems but residual social phobia. It was also evident that the Stockholm Syndrome did not develop. It became apparent that successful management depended upon the ability of the treating teams to draw upon a wide range of therapeutic models. Spiritual values were a source of strength to some and comfort was gained by being able to make sense of their experiences in these terms. Concepts from individual therapies, family and group therapies, crisis intervention, psychological debriefing techniques, rehabilitation and occupational psychiatry were drawn upon to good effect.

The aim of initial management was to give the released hostage the best chance of rebuilding his life with those people most important to him and try to prevent or minimise subsequent psychological morbidity. The following describes in basic terms the strategies found to be of most value.

Protection

Public interest in the hostages and curiosity regarding their condition on release prompted widespread media coverage. The persistent demands of the press for interviews and photographs gave rise to determined attempts to gain access to these individuals. Secure surroundings were essential to facilitate rehabilitation and permit encounters to take place in conditions of relative sanctuary. The Officers' Mess at Royal Air Force Lyneham was the most frequently used venue which provided adequate protection, although other locations were utilised which fulfilled the same requirements.

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Officers' Mess, RAF Lyneham

Apart from the media, pressure to meet the hostages came from other sources. Friends, relatives, politicians, workers in pressure groups, colleagues and former hostages were justifiably concerned and keen to make contact and celebrate the release. These approaches required careful regulation in order to prevent the situation from deteriorating into an ordeal.

The emotional reaction to release varied between hostages and these emotions were subject to change over a short period of time. Excitement and withdrawal both altered the individual's judgement and capacity for decision making. A degree of protection from the overwhelming number of requests that were put before the hostages was necessary until they had been able to complete important early tasks of readjustment.

Priorities

Release from years of deprivation back into a changed world presents great difficulties. There is a requirement to make rapid choices covering important areas of the individual's life. The current status of each hostage is irreversibly changed. Offers of large sums of money for their stories and various awards, honours and tributes in recognition of their suffering and endurance have an impact which can alter one's perspective on life. The need for sensible priorities and a firm set of guiding principles with which to steer through a prolonged period of uncertainty is apparent. Individuals were encouraged during discussion and counselling to concentrate their efforts upon re-establishing solid and lasting relationships with those of most importance to them, and to regard this as their first priority. A supportive social network was considered fundamental to the process of successful long-term rehabilitation. Although there was no pressure placed on hostages to make a rapid return to work, they were recommended to consider regaining secure and satisfying employment, rather than relying wholly on rather hit and miss opportunities to profit financially from recounting their experiences.

Picking up the threads

Re-establishing close, stable relationships was an understandably complicated business. The success of this stage of early readjustment depended to a degree upon the quality of relationships prior to the individual's capture and the circumstances in which close relatives and friends had been left. Furthermore there were changes to the immediate family such as bereavements and the addition of new members. There was a reluctance on the part of relatives and friends to discuss or impart bad news. This stemmed from concern for the hostages' well-being, uncertainties over their ability to cope, and because it did not seem appropriate at a time of rejoicing to talk about upsetting events. However, such concerns blocked the process of honest open exchange and inhibited the development of emotional closeness. People wanted to talk about significant issues, but were afraid to do so. Judicious and gentle exposure to these issues improved the process of clarification and understanding, with the effect of opening up the possibilities for intimacy and a sense of reconciliation. It must be emphasised that this operation was reciprocal and that relatives and friends themselves had been harmed, having suffered years of uncertainty and distress.

Preparation for the future

During the latter part of the hostage care, time was dedicated to anticipating future difficulties and devising problem-solving strategies to overcome them. Potential snags were multiple: coping with celebrity and hero status with persisting media and public attention; continuing demands for their experiences to be repeated; social invitations and possible associated excessive alcohol intake; changes to their financial position; deciding where to live; adjusting to normality after a period of prominence; accepting the fact that nobody could accurately understand what they had been through. The emphasis during this stage of management was on encouraging autonomy for the hostage and for those closest to him. Problem-solving techniques were rehearsed if necessary.

Psychiatric screening

Throughout the initial period of care hostages were screened for evidence of psychiatric disorder. This facility was also available for relatives and friends who were involved during the early management period. The hostage received a standard psychological debrief (Dyregrov, 1989) in the hope that this might mitigate against the future development of Post Traumatic Stress Disorder. A thorough medical

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examination was also part of the screening procedure, and conducted by other members of the Royal Air Force Medical Branch.

Several Royal Air Force psychiatrists and psychiatric nurses gained experience of hostage handling. Management was intended to be brief, the duration ranging from ten days to three weeks. Termination was governed by the completion of necessary tasks and the confidence of the hostage and his immediate relatives and friends in their ability to cope on their own. Although flexibility and pragmatism were paramount, staff involved generally adopted one of two roles.

Primary debriefers [one of whom was team leader] worked closely together to undertake the intensive psychological debriefing of the hostage, his family and associates. Where political, intelligence or technical debriefing was necessary the primary debriefer was present both to acquire background information and to protect the hostage.

Outside formal sessions, much was achieved in informal and social settings, the hostage, his family and staff meeting frequently, although care was taken to allow necessary privacy and sanctuary. Alcohol was available, and its moderate use by participants [including staff] appeared to be useful, and certainly caused no problems.

Support debriefers facilitated systematic review of the debriefing process by the primary debriefers and provided opportunity for ventilation and release of the intense personal feelings experienced within the group and by individual staff members. It was also found to be useful to have a team manager who dealt with practical issues and handled communication with the outside world. It was usual for teams of two psychiatrists and two nurses to work as primary debriefers with a smaller number of support debriefers in the background. Other combinations proved equally effective, but a team of five appeared to be the optimal number. The approach used proved to be successful in helping the hostage negotiate the first stage of rehabilitation. It must be stressed that the hostages had physical, psychological, social and spiritual aspects to their readjustment, and management was not restricted to the narrow limits of psychological disorder.

Conclusions

Recent releases of hostages held for several years of captivity in the Lebanon have posed questions on how best to manage the emotional sequelae of their experiences, and how to facilitate their social reintegration. The Psychiatric Division of the Royal Air Force Medical Branch, tasked with managing these problems, has developed a broad programme of screening, debriefing and support in order to promote the process of reintegration and to protect the hostages and their families from outside exploitation. It is hoped that this programme which was undertaken by Royal Air Force psychiatrists and nurses, and adopted a very pragmatic approach which crossed professional and theoretical boundaries and generally eschewed the Medical Model, will help to prevent future development of Post Traumatic Stress Disorder and other psychological problems. The lessons learnt will, it is intended, be used in the management of survivors of other stressful experiences, and with treatment of Post Traumatic Disorder.

References

DYREGROV, A. (1989) Caring for helpers in disaster situations: psychological debriefing. *Disaster Management*, **2**, 25–30.

OCHBERG, F. (1980) Victims of terrorism. *Journal of Clinical Psychiatry*, **41**, 73–74.

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