OFFICIAL ACTIONS

Ethical Dimensions of Psychiatric Intervention in Terrorist and Hostage Situations: A Report of the APA Task Force on Terrorism and Its Victims

The following report was approved for publication by the Board of Trustees at its June 25, 1982, meeting; it is not an official position statement. The task force hopes the report will be useful to psychiatrists who find themselves in situations involving terrorists or hostages.

THE AMERICAN PSYCHIATRIC ASSOCIATION's Task Force on Terrorism and Its Victims has examined the ethical implications of psychiatric intervention in terrorist and hostage-taking situations. The process has had several facets. First, the task force has collected examples of ethical conflicts that might be encountered or have already been encountered by psychiatrists in hostage situations. Second, task force members have discussed their personal perception of ethical conflict areas and attempts to resolve them. Third, the task force has been aided by the participation of involved individuals with professional experience in terrorist or hostage situations at the symposium sponsored by the American Psychiatric Association and Law Enforcement Assistance Administration that was held in September 1979 in Baltimore. Our collection of data from involved professionals has continued at subsequent meetings of the task force. We have also been assisted through parallel efforts of other professional groups, notably the report of the American Psychological Association's Task Force on the Role of Psychology in the Criminal Justice System (1).

In terrorist and hostage situations the psychiatrist may find himself or herself acting under the extreme pressure of time and events, isolated from traditional sources of peer consultation and review by security restrictions, and operating in an area where opinions are strongly held and relevant precedents are few. Even after careful analysis supplemented by peer review, a psychiatrist may find that a given issue cannot be readily resolved. The ethical dilemma may not be a simple conflict between right and wrong but, instead, a complex balancing of valid rights of different parties and sometimes the necessity to choose the lesser evil. In offering the following principles as an informational resource document, the task force seeks to share with colleagues the perspectives that we have found most useful.

In those circumstances where the psychiatrist is functioning in the role of a clinician, most specifically where he or she engages in a direct physician-patient relationship, the task force acknowledges that all elements of the American Medical Association's Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry *(2) should be upheld.*

Although the *Principles* do not specifically mention terrorist or hostage situations, they do contain relevant ethical guidelines. Section I states that "a physician shall be dedicated to providing competent medical service with compassion and respect for human dignity." In a terrorist or hostage situation compassion and respect are required not only for the victims or hostages but for the terrorist or hostage taker and also for the law enforcement or military personnel who are attempting to resolve the situation. This broadened definition of physician responsibility is explicitly acknowledged in the *Principles:* "A physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self."

The psychiatrist may be helped in making decisions about competing needs for professional compassion and respect in a terrorist or hostage situation through attempts to maintain fidelity to his or her healing role. This role is clearest when a victim solicits treatment after a hostage-taking or terrorist incident, when the goal is to minimize the trauma and facilitate return to normal social functioning. The physician role also applies if a patient currently in therapy with a psychiatrist becomes involved in an incident as hostage or hostage taker. In such situations, the involvement of the psychiatrist may be direct or indirect in accordance with his or her clinical judgment of the competing needs of the situation. This may include sharing clinical information, as stated in the *Principles:* "Psychiatrists at times may find it necessary, in order to protect the patient or the community from imminent danger, to reveal confidential information disclosed by the patient."

When a psychiatrist intervenes outside of a patient-physician relationship or is called on to offer professional expertise outside the practice of psychiatry as a healing art and science, he or she must be guided by broader ethical principles. This includes situations where psychiatrists act as employees of or consultants to government agencies. The *Principles* explicitly approve of psychiatric consultation to government but also emphasize the importance of clarifying one's specific role in each situation. Is the psychiatrist speaking as a dedicated citizen, individual clinician, or spokesperson for or employee of an official group?

Psychiatrists who are employees of or consultants to government agencies or private organizations should be free to decline specific interventions in terrorist or hostage incidents if in their judgment these interventions are clinically or ethically contraindicated. If a patient with whom a psychiatrist has had an ongoing therapeutic relationship becomes involved in a terrorist or hostage incident, the psychiatrist must balance clinical and ethical reservations concerning his or her participation against the emergency nature of the situation and the possibilities for providing unique and potentially life-saving input.

Where psychiatrists are free to choose or to shape the nature of their role, there may be possibilities for forms of intervention that are positive in both the clinical and ethical sense and that validly use the psychiatrist's professional expertise in the understanding of human experience and behavior. For instance, when a psychiatrist participates in the training of law enforcement or military officers in peaceful methods of conflict resolution or in preparing responses to terrorist or hostage incidents, he or she may be genuinely serving all

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parties concerned, including the hostages or victims, the terrorists, law enforcement, military, or diplomatic personnel, and society at large. When the clinician is not free to choose his or her role, there are particular dangers of adopting unethical practices because of the stress of emergency situations, pressures from government officials, or attempts to serve valued ends. Psychiatrists in such situations are urged to recall that clinical ends cannot be separated from the means used to pursue them and that techniques such as intentional deception are never free from hazardous consequences for the clinicians who use them.

As in other emergency situations, the need to preserve the confidentiality of the psychiatrist-patient relationship is not an absolute one in terrorist or hostage incidents. Psychiatrists can generally make appropriate decisions in this area based on the same considerations for which confidentiality may be breached in the traditional clinical setting. The task force has found, however, that psychiatrists are particularly liable to error and to misinterpretation when they are given the opportunity to make statements concerning terrorist or hostage incidents to the press or broadcast media. All psychiatrists involved in this area should give careful attention to acknowledging and controlling their own needs for publicity. As stated in the *Principles:* "It is unethical for a psychiatrist to offer a professional opinion unless he/she has conducted an examination and has been granted proper authorization for such a statement."

When a psychiatrist serves as a consultant to an organization where his or her role is specifically defined in advance as partly or wholly nonclinical, the psychiatrist must be cognizant of the difficulties in divesting himself or herself of the social expectations and technical knowledge inherent in the physician role. The realistic importance, widespread publicity, and high emotional pitch of terrorist and hostage incidents may make it difficult for the psychiatrist-consultant to maintain sound personal and professional humility. Even when the psychiatrist realizes his or her limitations, however, the professional isolation inherent in these situations imposes a heavy burden on the individual clinician. The task force encourages individual psychiatrists to seek peer counsel in assessing the ethical and professional complexities and limits of intervention techniques. Realistic concerns about security issues should not prohibit the clinician from obtaining such counsel because these are the situations in which it may be most needed and because other clinicians with appropriate security clearances do exist. Finally, the task force will continue to offer ongoing consultation to psychiatrists and other clinicians who request it.

REFERENCES

1. Report of the Task Force on the Role of Psychology in the Criminal Justice System. Am Psychol 33:1099–1113, 1978
2. The Principles of Medical Ethics with Annotations Especially Applicable to Psychiatry. Washington, DC, American Psychiatric Association, 1981