COMMENTARY

Uncertainties in practice: terrorism and mental illness

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COMMENTARY ON… TOWARDS AN INTEGRATED PRAGMATIC APPROACH IN TERRORISM AND MENTAL ILLNESS[†]

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SUMMARY

Ho *et al* (2018) tackle a controversial and sensitive issue on which clinicians and the public have strong, often irreconcilable views, fuelled by their own experiences and political positions about the causes, consequences and necessary responses to political violence. This commentary explores some of the assumptions and uncertainties they present, as well as the framing of their position.

DECLARATION OF INTEREST

None.

KEYWORDS

Terrorism; mental illness; research; practice.

Terrorism in the high-income countries is relatively rare, and the discourse is largely about threats by so-called 'Islamist' groups or individuals who proclaim religious justifications both to persuade people to engage in terrorist acts and to justify those acts (Statista 2017). The rhetoric is presented as if driven by religious faith, and there is persecution of religious minorities. Data from the Global Terrorism Database, itself criticised for perhaps adopting a US perspective on what is or is not classified as a terrorist incident, demonstrates that most attacks take place in Muslim-majority and low-income countries, where most of the victims are Muslims, often in the context of political unrest, poor state governance, civil conflict and international war (Radicalisation Awareness Network 2012; Parliamentary Office of Science and Technology 2016; Statista 2017).

In high-income countries, even though the number of terrorism-related deaths is comparatively low, state actions are necessarily strong to quell fears and to ensure the security of the public and service men and women. There are real fears among the public. Actual incidents do cause terrible suffering, loss of life and disabilities for those who survive (Alexander 2005). Nevertheless, counterterrorism responses must not be unnecessarily harsh or tyrannical, as this would be disproportionate, and disproportionate responses are used by terrorist groups to further justify their actions and drive attempts to recruit more men and women to their cause.

The problem of definitions

One of the challenges of examining the literature in this field is of definitions. How are terrorist incidents classified and why do some incidents, not obviously terrorism-related but involving religious, ethnic or racial minorities, get labelled as terrorist whereas others, involving population majorities, are not be so labelled? States define non-state actors and proscribed groups. The police, states and the public apply labels to individual acts, often before an investigation, proclaiming that hateful and nauseating actions can only be explained as terrorism or a result of mental illness, creating unhelpful links in the public imagination and in the subsequent reporting and discourse. Actually, people with mental illnesses are more likely to be the victims than the perpetrators of violence (Glied 2014; Khalifeh 2015; Varshney 2016), but there is no doubt that an untreated mental illness is associated with a slightly higher risk of violence, and in individual circumstances and instances of dangerous psychopathology, the remit of forensic services, the links are more evident and obvious (Arseneault 2000; Flynn 2014).

The term mental illness is often applied in a non-specific manner, as it has been in studies of lone actors and official press releases from the police and government. These conflate psychoses, depression, substance misuse and intellectual disability. They rarely involve any structured assessment of psychopathology but only the perceptions and impressions, of clinicians or the police or referring agencies. These are good starting points, but must not be the basis of evidence-based policy or practice. All concerns leading to a shift in practice should be tested against evidence. There will be unintended

consequences that need to be considered and mitigated.

Data on offenders who are convicted or suspected of terrorist offences are often mixed up with data from studies of populations in the 'pre-criminal space', i.e. those who have not committed any criminal offence, but may be at risk of doing so (Bhui 2012; Dom 2018). Thus, studies of radicalisation in populations in the pre-criminal space in high-income countries should not be conflated with studies of radicalisation in those with close links to terrorist organisations or studies in conflict or war zones, in which political violence might be argued to be the norm. Unlike terrorist and radical groups, state actors are usually accountable to laws and conventions (national and international), democratic decisions and professional codes of conduct. These distinguish terrorists from those engaged in the armed forces or legal political protest. Yet all these expectations are challenged in specific scenarios: for example, inquiries into Iraq and Afghanistan question legal compliance, whether professionals comply with professional codes of conduct or if democratic decisions were endorsed by democratically-elected governments; and Chilcot raises important questions about legitimacy of actions by a democratically-elected government. State actors are usually accountable to international law and conventions, democratic decisions and professional codes of conduct. Yet all these are challenged in specific scenarios that have been subjected to inquiries, for example, on Iraq, Afghanistan etc.

Cultural delusions and enabling protest

We are witnessing a time of extreme politics in the USA, UK and European Union, and one might argue that this adds fuel to polemic as a tool for justifying extreme actions and decisions without evidence or deliberations to recommend them. Cultural psychiatry makes reference to common popularly held beliefs that are not consistent with empirical evidence, but seem to have some cultural grounding and are therefore assumed to be acceptable; these are called cultural delusions and, given the ability to mobilise collective actions, these can be more dangerous than real delusions resulting from mental illness. We must guard against such cultural delusions as the basis for actions. We need better research and evidence that counters violence more generally as well as violent extremism in populations, alongside making targeted efforts with offenders. A concerted effort by those in the fields of research, policy and practice is needed; we all need to combat popular collective beliefs that are wrong.

We should also consider protective factors, social networks, positive role models, political engagement and authentic religious teachings. Through education and inclusion in a just and fair society in which protest can be channelled through non-violent and democratic means we could create opportunities for protesters to be heard and to be seen to influence decision-making, practice and policy.

Research and practice dilemmas

Research into terrorism and political violence is not easy. There are ethical concerns about asking people about violent offending or indeed any offending, especially as the answers may lead to self-incrimination. Longitudinal designs and trials are clearly more worrisome the nearer the individuals are to offending behaviours, thus research in the pre-criminal space on preventing violence in general and political violence specifically would be fruitful.

Use of assessment instruments and overreliance on their predictive powers is clearly a faulty premise. However, any tool that helps to structure assessments and is used alongside biographical and other information to create a report that is ultimately subjected to professional judgement (ideally by a multidisciplinary risk panel) has to be mainstreamed. Yes, we must question ethical dilemmas and perceived discrimination and, ostensibly, public servants being asked to undertake state duties related to security and safety. Psychiatrists and other mental health professionals already do this in other situations, and the extensive body of professional skills of psychiatrists, psychologists, social workers, nurses, managers, leaders and mental health actors of any persuasion must be recognised and deployed for public health and safety. Creating special measures, for example changing risk assessment and violence prevention specifically for radicalisation, seems to imply that our science on the prevention and detection of terrorism or radicalisation is better than that on violence generally. I would argue the opposite. We are still investigating the causes of radicalisation and terrorism and opportunities to prevent them.

Psychiatrists have a role as citizens and as experts in mental disorders, public mental health and preventive psychiatry to reduce violence generally as well as to reduce violence by and against those with mental illness. These are established roles. Counterterrorism is yet another important facet of their work, requiring better evidence of risk management, transparent audit of practice outcomes and 'prevent programmes', more research and, as a result, effective policy that has the support of patients and the public and professional bodies.

References

Alexander DA, Klein S (2005) The psychological aspects of terrorism: from denial to hyperbole. *Journal of the Royal Society of Medicine*, **98**: 557–62.

Arseneault L, Moffitt TE, Caspi A, et al (2000) Mental disorders and violence in a total birth cohort: results from the Dunedin Study. *Archives of General Psychiatry*, **57**: 979–86.

Bhui KS, Hicks MH, Lashley M, et al (2012) A public health approach to understanding and preventing violent radicalization. *BMC Medicine*, **10**: 16.

Dom G, Schouler-Ocak M, Bhui K, et al (2018) Mass violence, radicalization and terrorism: a role for psychiatric profession? *European Psychiatry*, **49**: 78–80.

Flynn S, Rodway C, Appleby L, et al (2014) Serious violence by people with mental illness: national clinical survey. *Journal of Interpersonal Violence*, **29**: 1438–58.

Glied S, Frank RG (2014) Mental illness and violence: lessons from the evidence. *American Journal of Public Health*, **104**(2): e5–6.

Ho CSH, Quek TC, Ho RCM, et al (2018) Towards an integrated pragmatic approach in terrorism and mental illness. *BJPsych Advances*, this issue.

Khalifeh H, Moran P, Borschmann R, et al (2015) Domestic and sexual violence against patients with severe mental illness. *Psychological Medicine*, **45**: 875–86.

Parliamentary Office of Science and Technology (2016) *Addressing Islamic Extremism*. POST (https://researchbriefings.parliament.uk/ResearchBriefing/Summary/POST-PN-0526).

Radicalisation Awareness Network (2012) *Proposed Policy Recommendations for the High Level Conference: from the RAN Derad Working Group*. European Commission (https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-high-level-conference/docs/proposed_policy_recommendations_ran_derad_en.pdf).

Statista (2017) *Terrorism – Statistics & Facts*. Statista Inc (https://www.statista.com/topics/2267/terrorism/).

Varshney M, Mahapatra A, Krishnan V, et al (2016) Violence and mental illness: what is the true story? *Journal of Epidemiology and Community Health*, **70**: 223–5.

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