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EDITORIALS

# Mental illness and terrorism

## Oversimplification and lack of evidence stigmatise people with mental illness and impede prevention efforts

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Terrorism is a politically defined act of attack against a state by non-state actors. It is thus not just criminal behaviour but given special status as a threat to the citizens of the national state and assumed to be politically motivated. Terrorist acts are often justified as responses to oppression, discrimination, inequality, persecution, and adversity or, as in the case of Islamist extremist movements, a desire to impose an alternative religious, cultural, and legal framework on society. Terrorist movements can come into existence primarily to fulfil political objectives and as a protest against social and cultural practices.

Although terrorism is known to lead to fear, psychological distress, and adverse health consequences,[1 2] less attention has been given to possible causes of terrorist threats. We do not know enough about these antecedents nor the process by which individuals become "radicalised" to take up terrorist causes.[3 4] Evidence is emerging that there are many varieties of terrorists, just as there are many different psychological, social, and behavioural antecedents, and that adversity and discrimination may not always feature.[5 6] Terrorist groups and networks seem to avoid recruiting people with mental health problems, probably because they share some of the same stigmatised views as the rest of society and see people with mental health conditions as unreliable, difficult to train, and a security threat.[7]

Recent attention has shifted to lone actors, individuals who are not linked to established terror networks but are attracted to their aspirations and act in their interests.[8] Such people seem to have a different profile, in which mental illnesses are more common and they seem to be influenced by their immediate social networks.[6] People with mental illness can develop delusional beliefs that include political or religious content and these are difficult to disentangle from overvalued ideas common in political or religious ideology—for example, in the case of the Norwegian mass murderer Anders Brevik.[9] To make matters more complex, no single diagnosis is associated with "lone actor" terrorism—reported diagnoses include antisocial and narcissistic personality disorders, schizophrenia, delusional disorder, and autism spectrum disorder. A psychiatric diagnosis where appropriate is important, but it does not explain motivation—diagnosis will interact with prevailing social and cultural concerns.

We are too ready to invoke "terrorism" as the cause of most sudden and unprovoked acts of individual or group violence, and simultaneously to propose mental illnesses as the explanation behind such complex behaviours.[9] Not only does this unfairly stigmatise the many millions with mental health problems, perhaps deterring people from seeking help, but it can also stand in the way of the careful analysis that must be undertaken in each case before coming to judgment.

In response to these political and societal challenges, the UK government launched a counterterrorism strategy (CONTEST) that included Prevent, a set of preventive actions.[10] Specified authorities, including health bodies, are now obliged to show due regard to preventing people from being drawn into terrorism.[10] This has alarmed many practitioners, who are dismayed at their expected participation in state security and point to the paucity of published evidence for the effectiveness of the programme.[11] There are also concerns that doctors will be drawn into state interventions that may breach acceptable ethical standards of practice.[12] Concerns about extremist ideas that could result in actual violence are difficult to quantify, but health professionals, including psychiatrists, are asked to follow their organisational guidance on confidentiality and multiagency risk assessment and management.

The Royal College of Psychiatrists has set out ethical and clinical guidance to ensure psychiatrists and other mental health professionals support Prevent on an evidence based footing.[13] Specifically, it seeks an evidence based approach to policy and practice, the sharing of research and clinical data so that lessons can be learnt and good practice supported, and careful delineation of the roles and responsibilities of doctors and mental health professionals more generally.

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We know from the science of predicting extremely rare events—for example, suicide and homicide—that precision is impossible to achieve. Instead it gives way to the art of good clinical practice supported by research evidence, audit data, and continuous learning cycles. The National Confidential Inquiry into Suicide and Homicide is one example of how this approach can help reduce these events among people with mental illness. Careful media reporting may be required to reduce copycat episodes, especially among those with depressive or pessimistic outlooks.[14] An effective counterterrorism strategy, which is in all our interests, will be more successful if it engages fully with mental health professionals, public health agencies, and communities, making the research evidence and the basis of recommended actions as transparent as possible without undermining genuine security concerns.[15] This will create more trust and support for Prevent from all quarters.

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