Mental health and violent radicalisation

Amid the continuing debate about the recent attack in Woolwich that led to the murder of Fusilier Lee Rigby what hasn’t been widely discussed in the media is the role of mental health in the process of violent radicalisation.

Violent radicalisation is a process of indoctrination and incitement to violence on the basis of political protest. This process has been linked with Islamic extremism in the wake of 9/11 in New York and 7/7 in London, and more recently to the bombings in Boston in the US. Now the concept has been revitalised with Fusilier Rigby’s very public murder.

Michael Adebolajo and Michael Adebowale, who have been charged with the murder that took place on a busy high street in broad daylight, have been called ‘terrorists’. Terrorist acts are effectively mass homicide and there is a natural response of disgust, a human reaction that demands punishment and justice for those who have lost their lives.

This response is especially powerful if there are suggestions that the perpetrators are waging some sort of cultural, religious or tribal war against society. Their proclaimed difference from their victims can perhaps produce a response that triggers primitive emotions and simplistic explanations of attacks by ‘foreigners’.

The public, influenced by the media lens, tend to see mental health problems as extreme states of momentary loss of awareness characterised by psychosis, which include hallucinations (seeing and hearing things that are not there) or delusions (beliefs held despite evidence to the contrary and out of keeping with the cultural and social group to which an individual belongs).

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But less attention is paid to the many forms of mental distress and disorders that are more common, including anxiety, depression and relational or personality problems. Personality problems have been particularly difficult to understand and treat especially where criminality is involved. Indeed, one of the diagnostic criteria for an anti-social personality disorder is repeated criminality and an inability to learn from experience.

Research has shown that personality disorders are less often diagnosed in people of black Caribbean and black African origin (McGilloway et al., 2010). Violent radicalisation may be related to abnormal personality development during the early years. The idea that a psychological explanation exists, or mental disorders might be implicated, is not attractive to the public, media or criminal justice agencies because such an assertion is seen to offer unjustified mitigation when there has been little evidence among convicted terrorists of severe psychosis.

In my work with the Cultural Consultation Service I have a long-standing clinical and research tradition of exploring the interfaces between cultural and religious beliefs and behaviours, criminality and mental disorders. Carefully planned acts are difficult to explain away as a momentary or temporary aberration of the mind, which is the usual legal defence in instances of homicide (Swinson et al., 2011).

People with severe mental disorders are always perceived to be dangerous, partly because of pejorative media attention that unquestioningly links mental disorder to violence. The last thing people with mental disorders want to provoke in others is a fear of them, when usually it is they who are terrified.

By linking violent radicalisation with mental health risks stigmatising and further excluding people with psychological distress and diagnosed mental disorders. This may explain the reluctance by journalists and others to mention mental disorders or psychological processes when violent radicalisation is given as an explanation for terrorist acts.

Understandably, the criminal justice system favours

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**Target audience**

- Mental health professionals working with those from black and minority ethnic communities, especially young people, who may be at risk of radicalisation.

**Take-home messages**

- Public health approaches targeted at social isolation and risks of radicalisation need to be grounded in community narratives
- The potential role of mental health in violent radicalisation is often underplayed but should not be ignored.
a pure criminal justice response, such as taking account of expert witness evidence from psychologists and psychiatrists. But receiving such evidence doesn’t always lead to an acceptance of any mitigation.

Yet seeing Adebola and Adebawale on television, speaking proudly about their violent act and intent while making no attempt to escape, must make mental health specialists wonder about their state of mind, the use of drugs and whether personality development and disorders alone may explain their behaviour.

Virtually radicalisation
Strikingly, virtually radicalisation was not applied to Anders Breivik, the Norwegian who killed 77 men, women and children in 2011 on the grounds of political protests against Islam’s ‘perceived’ threat to Christianity in his native country and Europe.

Virtually radicalisation is rarely applied to any faith other than Islam but is often applied to those perceived as ‘foreigners’ despite being indigenous to the country in question (LaFree & Ackerman, 2009). This selective application of the term, just like the use of the word ‘terrorist’ in the Rigby case, can disguise the root causes, such as a lack of integration into society and psychological processes that produce a fragile mind. A fragile mind can be vulnerable to some sorts of distress and at the same time produce dangerous behaviours and ideas.

Breivik was a loner. He was not in a consistent social network, but often sought out groups that might support his cause. The prosecution claimed he was insane—holding delusional beliefs on which he acted—yet he and the defence team convincingly argued that his actions had a political intent and were well planned and executed.

The debate between the legal teams in his case was about paranoid schizophrenia or narcissistic personality disorder. Neither of these diagnoses can ‘explain’ the behaviour. Beliefs, motivations, cultures of violence and personality development have to be relevant, even if they are not offered as mitigating factors.

The judgment about whether someone is mentally ill, and therefore has diminished responsibility, is not easy to entertain when terrorism is suspected. Even if diminished responsibility is accepted for homicide, this usually means an indefinite detention in a secure psychiatric facility for longer than maybe a conviction would afford, and the courts in England are increasingly reluctant to accept such a defence (Swinson et al, 2011).

Religious beliefs can be expressions of mental illness, making judgements about the cause of extreme and religious views a critical part of any forensic assessment. But using the word terrorist cuts through the possibility of any defence or understanding of the part played by psychological distress or religious beliefs that is expressed during an illness.

Religious and grandiose beliefs can be expressed as part of a psychosis and may be one of the earliest symptoms, as described among people of African and Caribbean origin in Littlewood and Lipsett’s seminal volume *Aliens and Alienists: Ethnic minorities in psychiatry* (1982).

With firmly held beliefs, a grandiose and garrulous presentation and unspeakable convictions, offenders with mental disorders often show no contrition as they believe their cause to be just. Being able to distinguish whether such beliefs relate to personality factors, psychosis or simple political attitude is as much about experience and judgement as it is about logic and evidence.

Vulnerability to indoctrination
So what is it that makes people vulnerable to indoctrination? Adebola and Adebawale were former Christians who were converted to Islam, although the brand of Islam they were taught may not have been orthodox in its outlook.

It is known that among migrants cultural, religious and ethnic identity changes over time, and that these transitions are associated with a greater risk of mental ill health, especially if individuals become socially and culturally isolated (Bhui et al, 2008; Bhui et al, 2012).

Cultural isolation is of particular concern as it offers the potential for less orthodox influences to entice people onto riskier pathways at a time of psychological vulnerability and without the buffer of more positive and secure influences and relationships (McCaulay & Moskalenko, 2011). Cultural isolation may also result from cultural adaptation following migration, or during maturation when family and parental influences are lifted and people experiment with new relationships and beliefs.

Cultures are not static. Group beliefs, as well as personal beliefs, are constantly negotiated and tested. It is this inexorable process that makes it hard to assess people for mental health problems if the specialist assessor is not from the same background, or even if they differ in their education, social class, age and worldview.

But talking about faith and religion within health and social care service settings risks pathologising by professionals of important coping strategies and sacred traditions that are essential elements of cultural identity (Ginges et al, 2008). When professionals question the basis of religious beliefs as part of a health assessment they risk being chastised by regulatory bodies for touching on personal material that is perceived not to be of health relevance.

For example, some doctors have been criticised by the General Medical Council for asking about religion. But religious beliefs can be expressions of mental illness. It does not make sense to argue religious beliefs are beyond clinical scrutiny in health settings and yet at the same time they are readily criminalised in legal settings, such as in the case of terrorists and violent radicalisation where they are seen as evidence of intent.

All of which makes it difficult for psychiatric evidence to be understood by the courts and legal experts. If we are to prevent violent radicalisation, the debate needs to be opened up about the very different ways in which health and legal systems respond to religious beliefs and expressions of faith in the context of offending behaviour in general and violent radicalisation specifically.

Preventing conversion
Prevention against conversion at a point of vulnerability means working with young people. We know that young people of all ethnic backgrounds developing a bi-cultural or integrated identity have better mental health, whereas religious converts are known to have some confusion of identity and are at greater risk of psychosis. Converts and people facing identity transitions have also been found to be at risk of radicalisation because of their search for a more potent identity and group
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belonging (McCauley & Moskalenko, 2011).

If an isolated individual searching for an identity encounters a potent radicalising group, or even a charismatic lone-wolf, then they are more vulnerable than those already embedded within a safe network of friendships, family and community.

Youth projects are all about providing safe environments and nurturing personal aspirations to achieve in education, sport or employment. We need youth groups to reach across the cultural and religious divide to understand what communities think and how they want to combat social isolation and radicalisation.

There is no evidence that the process of violent radicalisation can be applied to all members of the public, or that people who believe in one faith or another are more or less likely to engage in such behaviour. With this in mind, is there a role public health can play in identifying some of these risk factors in early life, which might be more amenable to modification if identified early enough in young people (Bhui et al., 2012).

Public health intervention might help to make people less vulnerable to psychological strain and radicalisation. The evidence is that risk factors of importance for emotional and social development, like isolation and poor cultural integration, are the same ones as those found in people vulnerable to violent radicalisation.

Public health measures are used to tackle violence, drug abuse, crime and to address inequalities in wellbeing, health and income. In support of a public health approach to violent radicalisation, we must engage with community perspectives, including Muslim communities. We need to think about wellbeing as including feeling positive about the self and group identity, and about the society in which we are raised, educated and in which we invest. Discrimination, Islamophobia and social and health inequalities are modifiable factors. The value of this approach is undeniable when you consider the government’s counter-radicalisation measures. They can only be effective through a community and culturally-informed approach. This will enable communities to respond appropriately to government measures to reduce the risk of their children and family members being converted to radicalisation.

Projects to prevent post-natal depression, improve nutrition for new born babies, inspire smoking cessation or end youth knife crime are all grounded in community narratives and health promotion. Why can’t the same be applied to social isolation, cultural adaptation of identity and the risks associated with radicalisation?

Role of the internet

Another growing risk is the role of the internet and marketing. The art of persuasion relies on using underlying vulnerabilities in individuals’ lives, for example, their search for a more potent identity, a cause they feel is just or for group belonging. Such individuals are more likely to respond to marketing messages that play on injustice or resort to violence when in fact they are being co-opted, thinking they are choosing rather than being brainwashed (Bhui & Ibrahim, 2013).

How do young people come to sympathise with terrorists, gangs or gun and knife crime? Access to information via the internet is one component, making the marketing of political ideas and violent protest easier than ever. Once again, an individual’s vulnerability will lead them to terrorist websites that propagate messages of hatred and violence, to make repeated visits and to engage in dialogue in order to be persuaded.

Risk factors that can be accommodated within a public health agenda include cultural identity, social isolation and inter-generational narratives of injustice inflicted on a group’s religion, as well as the impact of inequalities and unjust foreign policy. These factors can all play on the minds of ideologically-driven young people expecting a socially just society.

Schools, families and social groups must be able to discuss how to provide safe societies. Teaching accurate histories, debating skills, politics and citizenship are important if we are to nurture democratic and peaceful methods of challenging perceived historical or current political injustices.

We need more high-quality empirical research about the process of violent radicalisation, the role of personality, of mental health as well as mental disorders and the types of community relations and cohesion that can protect against extremism and violent radicalisation. Only then can we start the flow of vulnerable people towards radicalising influences.

We cannot rely only on selective opinion polls, media speculation and ill-informed narratives that are never subjected to scientific scrutiny. Nor can we rely only on convictions as these don’t appear to act as a deterrent.

The way the courts handle the legal and psychiatric evidence in the case of Adebolajo and Adebowale will be of interest, not least as comparisons with Brevik are inevitable. The perpetrators in both instances claimed a political cause, based on their fears of threats to their religious life. Also there are low-key concerns about the place of mental disorders being relevant factors.

But the outcome in the case of Adebolajo and Adebowale, against a backdrop of racially-charged stereotypes of black men and mental health and radicalisation, may lead to a very different assessment.


