Preventing radicalisation and terrorism:

is there a GP response?

INTRODUCTION

Radicalisation is a process by which an individual or group comes to adopt increasingly extreme political, social, or religious ideals and aspirations that reject or undermine the status quo.¹ Terrorism is seen as a consequence of such extreme ideals and is defined as, *'any action ... that is intended to cause death or serious bodily harm to civilians or non-combatants, when the purpose of such an act, by its nature and context, is to intimidate a population, or to compel a government or an international organisation to do or to abstain from doing any act.'*² Internationally, in the last year there has been an escalation in terrorist acts.³

MENTAL ILLNESS AND TERRORISM?

Commentators have explored whether there is a psychological profile of a terrorist, with early commentators proposing mental illness, sociopathy, and psychopathy as risk factors for terrorist activity.⁴ However, emotionally unstable individuals tend not to be recruited by terrorist organisations as they are usually deemed too much of a security risk.⁵ However, there is a link between ill-health and terrorism; individuals living in war zones commonly experience post-traumatic stress disorder, 'survivor's guilt', and bereavement of close friends or families. For some, such traumatic life-events are factors leading to committing terrorist acts.⁶ Symptoms of guilt, anxiety, grief, and a need for vengeance, combined with a strong religious belief of a better afterlife in which they will rejoin lost loved ones, explains some terrorist acts.⁷

However, while individual illness may be a contributory factor in an individual becoming radicalised, terrorist activity cannot be explained by a simplistic model of individual illness. Rather than mental illness, for some, identity issues play a pivotal role in the radicalisation process, with a need for belonging, purpose, and meaning cited as significant motivators to join terrorist groups.⁷ People experiencing major life transitions appear to be much more at risk of becoming radicalised, particularly young people still going through psychological development and identity-based changes.⁸ Such transitions might include individuals having to adapt to major educational and/or residential changes. It is argued that such a life stage will make

some, who are already vulnerable, open to recruitment to extremist groups through the social identity conferred from new ways of thinking, different experiences, and an ideological view on world events which resonates with the individual.⁸

SOCIOECONOMIC DETERMINANTS OF TERRORISM

However, individual factors alone (be they illness or poor personal identity) are insufficient for explaining the process of radicalisation, which is a complex interplay between individual, group, organisation, and international factors.⁹ It is argued that terrorist acts are motivated by a sense of grievance; an ideology which provides legitimacy to the individual to carry out their terrorist act from their sense of grievance, facilitated by globalisation (of commerce, travel, and information transfer).^{7,10} Globalisation has highlighted economic disparities between states, and with ideological competition, facilitates cooperative terrorist activity by far-flung but like-minded conspirators.¹⁰

Ideological motivators of terrorists vary. Recent terrorist attacks in Paris, the London bombings of 2005 and the New York '9/11' events of 2001 have been motivated from a fundamentalist Islamist ideology as an aggrieved competitor with the market-economic, democratic, and secular trends of modernity.^{11,10} However, not all terrorist activity is motivated from a religious ideology. Diminished social cohesion, unstable political landscapes, and socioeconomic disparities also contribute towards terrorist activity.¹²

Similarly, the grievances that motivate individuals to carry out terrorist acts vary widely. Perceived or actual discrimination towards certain religious or minority groups play a crucial role in encouraging extremist ideologies and behaviours.¹³ Discrimination can be experienced through socioeconomic disparity, although such a grievance cannot

adequately explain all terrorist activity since many terrorists have grown up in affluent backgrounds.¹⁴ However, from such affluent origins the terrorists invariably have a strong social identity to the 'discriminated' group which supports terrorist activity. In addition to the grievance described before, which stems from surviving as a civilian in war zones, for some, terrorist activity can be motivated by identification with such adverse events if they are occurring in their country of heritage. In the UK and Europe, the evidence suggests that such identification is strengthened by a tiny minority in diaspora communities who perceive a struggle with incorporating their heritage countries' traditions and cultures into their 'new' lives within their adopted countries.^{7,11}

A CREDIBLE GP RESPONSE?

In the face of such a significant challenge to public safety, GPs can feel powerless. Current recommended UK Government strategy regarding the threat of radicalisation is to emphasise to healthcare staff their safeguarding responsibilities by highlighting that with over 1 million contacts with patients every 36 hours, the NHS is key to embedding the principle of the counter-terrorism strategy into everyday safeguarding activity, including mandatory training.¹⁵

The issue of whether healthcare services should be mandated to carry out such tasks is a contentious one. While the Government suggest that health care is crucial in the *'fight against terror'*,¹⁴ many healthcare professionals argue that such measures would cause occupational discomfort at the very least and should be restricted to the job roles of national security professionals.¹⁶

Additionally, some GPs voice concerns that the new protocols would potentially stigmatise already marginalised groups and compromise confidentiality for patients.¹⁷ The Prevent Strategy¹⁴ has also

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caused outrage from many who state there is too much emphasis on monitoring citizens of Muslim faith, which in addition to infringing upon the rights of the individual could result in further alienating individuals with a subsequent risk of further terrorist activity.¹⁸ Clearly there is a balance between confidentiality and protecting the wider public interest, and there is a clear established framework in general practice for breaching confidentiality in the interests of wider public health.¹⁹

In addition to identification and reporting, there are further ways in which GPs can address the risks of radicalisation; crucially, closer working with social services to support vulnerable adults experiencing 'transitions'. For example, a recent media report pertaining to one of the perpetrators of the Paris bombings highlighted allegations that while under the care of foster parents she had applauded news reports of the collapse of the World Trade Centre Twin towers.²⁰ There is little empirical research to guide GPs regarding possible warning signs of an individual at risk of becoming radicalised but such reports, if verified, can help in working with social services departments regarding appropriateness of possible referrals.

Increasingly GPs are consulting with patients seeking asylum from war zones having been traumatised. The evidence would suggest that a small proportion is at risk of becoming radicalised due to unresolved emotions of post-traumatic stress, bereavement of close family members, and survivor guilt. Therefore, GPs will have a key role in closer working with mental health services for those with mental health vulnerability.

A key part of the Prevent Strategy is aimed at Commissioners and many GPs are involved in the commissioning process through their representation on clinical commissioning groups (CCGs). Commissioning activity should focus upon ensuring that no group is disadvantaged from either access to, or career opportunities in, healthcare services on account of a possible discriminatory backlash upon minority Muslim populations in the wake of recent international terrorist atrocities. Finally, CCGs should explore possibilities of working with a wide variety of faith groups to promote interfaith dialogue and address how traditional religious values can be contextualised within modern UK culture. The previous Prevent Strategy recognised the difficulty of the Government taking a position on matters of theology, yet the second edition has designated

Islamic studies as a 'strategically important and vulnerable subject' and promotes networking and collaboration between academics.²¹ Exploratory work has been published but clearly this is an evolving topic of crucial importance.

In summary, GPs have a key role to play in becoming more aware of both health, religious, and wider socioeconomic risk factors for radicalisation. Such awareness can then lead to action at individual patient, practice, and CCG levels.

Nat MJ Wright,

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REFERENCES

1. Wilner A, Dubouloz C J. Homegrown terrorism and transformative learning: an interdisciplinary approach to understanding radicalization. *Global Change, Peace, and Security* 2015; **22(1)**: 33–51.
2. United Nations, General Assembly. *Follow-up to the outcome of the Millennium Summit*. 2004. <https://www1.umn.edu/humanrts/instreet/report.pdf> (accessed 22 Apr 2016).
3. National Consortium for the Study of Terrorism and Responses to Terrorism (START) 2015. Global Terrorism Database. <http://www.start.umd.edu/gtd/> (accessed 22 Apr 2016).
4. Post JM. Terrorist psycho-logic: Terrorist behaviour as a product of psychological forces. In: Reich W, ed. *Origins of terrorism: psychologies, ideologies, theologies, states of mind*. Cambridge: Cambridge University Press; 1990: 25–40.
5. Stoddard F J, Gold J, Henderson SW, et al. Psychiatry and terrorism. *J Nerv Ment Dis* 2011; **199(8)**: 537–543.
6. Speckhard A. *Talking to terrorists: Understanding the psycho-social motivations of militant jihadi terrorists, mass hostage takers, suicide bombers & 'martyrs'*. McLean, VA: Advances Press, 2012.
7. Christmann K. Youth Justice Board, HM Government. *Preventing religious radicalisation and violent extremism: a systematic review of the research evidence*, D144. 2012. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/396030/preventing-violent-extremism-systematic-review.pdf (accessed 22 Apr 2016).
8. Bhui K, Everitt B, Jones E. Might depression, psychosocial adversity, and limited social assets explain vulnerability to and resistance against violent radicalisation? *PLoS One* 2014; **9(9)**: e105918.
9. Victoroff J. The mind of the terrorist: a review and critique of psychological approaches. *J Conflict Resolution* 2005; **49(1)**: 3–42.
10. Keys-Turner K D. *The violent Islamic radicalization process: a framework for understanding* [thesis]. 2011. <http://www.dtic.mil/dtic/tr/fulltext/u2/a556429.pdf> (accessed 14/05/2015)
11. McGregor I, Hayes J, Prentice M. Motivation for aggressive religious radicalization: goal regulation theory and a personality × threat × affordance hypothesis. *Front Psychol* 2015; **6**: 1325.
12. Institute for Economics and Peace 2014. *Global terrorism index 2014: measuring and understanding the impact of terrorism*. http://www.visionofhumanity.org/sites/default/files/Global%20Terrorism%20Index%20Report%202014_0.pdf (accessed 22 Apr 2016).
13. HM Government. *Prevent strategy*, Cm 8092. 2011. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97976/prevent-strategy-review.pdf (accessed 22 Apr 2016).
14. Bhui K, Warfa N, Jones E. Is violent radicalisation associated with poverty, migration, poor self-reported health and common mental disorders? *PLoS One* 2014; **9(3)**: e90718.
15. Garratt H. The *Prevent Strategy* [letter]. https://www.england.nhs.uk/wp-content/uploads/2013/09/Prevent-CCG_Prevent-Letter-for-Commissioner-Organisations.pdf (accessed 22 Apr 2016).
16. Dean E. Healthcare staff told to report patients at risk of radicalisation. *Nurs Stand* 2011; **25(41)**: 6.
17. Lind S. CCGs' duty to help prevent terrorism comes into force. *Pulse* 2015; **1 Jul**: <http://www.pulsetoday.co.uk/news/political-news/ccgs-duty-to-help-prevent-terrorism-comes-into-force/20010411.fullarticle> (accessed 22 Apr 2016).
18. Kundhani A. Claystone. A lost decade: Rethinking radicalisation and extremism. UK: Claystone; 2015.
19. Department of Health 2013. *Information: To share or not to share? The information governance review*, 2900774. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf (accessed 26/11/2015).
20. Simpson J, Sage A. Female jihadist clapped as the twin towers fell. *The Times* 2015; **21 Nov**: <http://www.thetimes.co.uk/tto/news/world/europe/article4620063.ece> (accessed 25 Apr 2016).
21. Suleiman, Y. *Contextualising Islam in Britain: Exploratory perspectives*. Cambridge: Centre for Islamic Studies; 2009.

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regulation theory and a personality × threat × affordance hypothesis. *Front Psychol* 2015; **6**: 1325.

12. Institute for Economics and Peace 2014. *Global terrorism index 2014: measuring and understanding the impact of terrorism*. http://www.visionofhumanity.org/sites/default/files/Global%20Terrorism%20Index%20Report%202014_0.pdf (accessed 22 Apr 2016).
13. HM Government. *Prevent strategy*, Cm 8092. 2011. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/97976/prevent-strategy-review.pdf (accessed 22 Apr 2016).
14. Bhui K, Warfa N, Jones E. Is violent radicalisation associated with poverty, migration, poor self-reported health and common mental disorders? *PLoS One* 2014; **9(3)**: e90718.
15. Garratt H. The *Prevent Strategy* [letter]. https://www.england.nhs.uk/wp-content/uploads/2013/09/Prevent-CCG_Prevent-Letter-for-Commissioner-Organisations.pdf (accessed 22 Apr 2016).
16. Dean E. Healthcare staff told to report patients at risk of radicalisation. *Nurs Stand* 2011; **25(41)**: 6.
17. Lind S. CCGs' duty to help prevent terrorism comes into force. *Pulse* 2015; **1 Jul**: <http://www.pulsetoday.co.uk/news/political-news/ccgs-duty-to-help-prevent-terrorism-comes-into-force/20010411.fullarticle> (accessed 22 Apr 2016).
18. Kundhani A. Claystone. A lost decade: Rethinking radicalisation and extremism. UK: Claystone; 2015.
19. Department of Health 2013. *Information: To share or not to share? The information governance review*, 2900774. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192572/2900774_InfoGovernance_accv2.pdf (accessed 26/11/2015).
20. Simpson J, Sage A. Female jihadist clapped as the twin towers fell. *The Times* 2015; **21 Nov**: <http://www.thetimes.co.uk/tto/news/world/europe/article4620063.ece> (accessed 25 Apr 2016).
21. Suleiman, Y. *Contextualising Islam in Britain: Exploratory perspectives*. Cambridge: Centre for Islamic Studies; 2009.