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Terrorism and Mental Illness: Is There a Relationship?

David Weatherston
Jonathan Moran

Abstract: *This article examines the connections between mental illness and terrorism. Most social scientists have discounted a causal relationship between mental illness and terrorism. This is not necessarily always the case within terrorism studies, the media, or political circles where the psychology of terrorism is often expressed in the language of mentalisms, and theories of pathologisation continue to exist. This article reaffirms the view that apart from certain pathological cases, there is no causal connection between an individual's mental disorder and engagement in terrorist activity. The individual terrorist's motivations can be explained by other factors, including behavioural psychology. However, there may be a connection between an individual engaging in terrorist activity and developing a mental disorder[s]. Certain stressors that occur because of terrorist activity may result in psychological disturbance in terrorist individuals. These factors may partially explain terrorist group instability and should be taken into account when detaining and interrogating terrorist suspects.*

Keywords: *terrorism; mental illness; terrorist psychology*

The debate concerning the causal connection between mental illness and terrorism remains an important one. The accepted view within the literature is that there is little evidence that prior pathology causes individuals to engage in terrorist acts (Ginges, 1997; Shaw, 1986). This article concurs with this view and briefly examines and critiques approaches that posit a causal link between mental illness and terrorism. This is an appropriate task in the current context, where atrocities of incredible magnitude and severity are often illuminated by reference to the mental health of their perpetrators. However, this article also argues that there may be evidence linking the long-term engagement of individuals in terrorist activity with subsequent mental health problems, provided certain factors are present. This is a factor that must be taken into account during the evaluation and interrogation of terrorist suspects.

THE MEDICAL MODEL AND TERRORISM: SOME EXAMPLES

This section details briefly the existing arguments that posit a causal link between mental illness and terrorism. With regard to terrorism, the medical model

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has produced some interesting divisions, but many retain a clear or implicit idea that pathology leads to terrorist activity. Here, most authors base their analysis on individual psychology rather than any biological component.¹ Two main approaches rest first on the theory that terrorists may be judged a priori as pathological. Some trenchantly asserted: "Most political terrorists have not been normal" and "Not all political terrorists are insane or mentally disturbed, but most are" (Parry, 1976). In addition, "Most terrorists are crazy, they have to be crazy" (Parry, 1977). Pearce (1977), in describing the terrorist (to an intended readership of police negotiators) claimed: "Their behaviour may show some evidence of psychopathy, paranoia, or other psychiatric lacunae," and continued (in the section of the article, "The Political Terrorist"): "This individual may be an aggressive psychopath, who has espoused some particular cause because extremist causes can provide an external focal point for all the things that have gone wrong in his life." Pearce advised the reader (presumably a police negotiator) that the best tactics when dealing with the terrorist "are those similar to the ones employed with the criminal psychopath" (pp. 171-174). Contrasting small terrorist groups with regular armed forces, West (1982) argued "Armies in general, regardless of the acts in which the army engages, tend to be made up of people selected for good mental health" and compared members of the armed forces with the "solo mad bomber who terrorises a city like New York by setting off bombs. . . . When they are finally apprehended, such individuals almost invariably prove to be psychotic. Although their reasons for bombing may ostensibly be delusional" (p. 104). He finalised his analysis by stating "In clinical psychiatry we sometimes deal with groups of fairly disturbed people . . . like the Baader-Meinhof" (p. 104).²

Second, terrorism may result from certain personality types. In a study of terrorist personality types, Johnson and Feldman (1992) argued that "In a sense, many terrorists may be viewed as people with marginal personalities who are drawn into the group by their own self deficiencies. . . . Personalities with paranoid, antisocial, and sadomasochistic tendencies would also be drawn to the violence fostered by terrorism" (pp. 300-301). The theory of narcissism appears to offer a nonpathological explanation for terrorism, based on the fact that the professed cause and strident rhetoric of the terrorist group enables individuals to commit violent acts. These acts externalise the individual's anger and frustrations that arise from his or her incomplete identity. For example: "The lives of the terrorist before joining [the group] were characterised by social isolation and personal failure. For these lonely and alienated individuals from the margins of society the terrorist group was to become the family they never had" (Post, 1987, p. 307; see also 1984, 1990). Pearlstein (1991) offered a theory of Freudian secondary narcissism in which the individual reconstructs reality, externalising negative self-images onto objects. Narcissistic rage may be manifested in aggression and other acts which restore self-esteem (Pearlstein, 1991).

In addition there is often a direct or implied association between pathology and terrorism. In the context of Provisional Irish Republican Army punishment beatings, is the comment: "Events such as this must surely raise questions about the

mental health of the individuals responsible. Is it unrealistic to presuppose the existence of sadism in these instances?" (Horgan & Taylor, 1997, p. 29). Similarly, pathological/epidemiological analogies may be used to explain (some) terrorist acts. Professor John Deutch, former director of U.S. central intelligence and deputy secretary of defence stated: "It [terrorism] is a disease that is spreading, its cure unknown" (Deutch, 1997, p. 10). Oots and Wiegele (1985) proceeded from a review of psychiatric, psychological, and physiological contributions to the terrorist literature to argue "Direct contact among carriers (terrorists) and the susceptible population (potential targets) is not necessary, however, since the media provide exposure to the disease (terrorism)" (p. 8). Although the authors stated that their model does not fit most individuals—who will never become terrorists and it may not fit all terrorists—the medical/pathological metaphors are evident.

It is not suggested that all the mentioned theorists claim to put forward a general or universal theory because it is clear from their argumentation that they are offering a partial explanation. However, they represent an idea that prior pathology is important in explaining subsequent terrorist activity.

THE CONTEXT OF TERRORISM AND MENTAL DISORDERS

These approaches can be challenged on theoretical and empirical levels. A priori theories appear functionalist. For example, West's (1982) logic seems to imply that when acts of extreme violence, irrespective of motive, severity, or other considerations, are perpetrated by armed forces personnel, those carrying out the actions are deemed mentally fit. However, if acts of extreme violence are carried out by terrorists, then they must be mentally ill. Given the well-documented atrocities committed by legitimate armed forces personnel, the distinction that West attempted to make becomes inexplicable.³

Similarly, with regard to personality types, although the argument concerning terrorism and narcissism is made in an attempt to situate the terrorist within the spectrum of normal personality types, in practice the conceptualisation of narcissism and its employment by some theorists is consistent with pathologisation. For the narcissistic personality to fall within the spectrum of normal requires a wide definition of normality; it is reasonable to suppose from the textual evidence here that narcissism in this context is malignant (Kernberg, 1990).⁴ The terrorist personality remains abnormal. Furthermore, the evolution of terrorist groups does not necessarily signify the transference of hate or the expression of rage, but rather the techniques of justification and neutralisation that may be learned behaviour and/or a culturally derived vocabulary (Sykes & Matza, 1957). Terrorists experience guilt, deny they are terrorists, and use blocking techniques (Heskin, 1984; Taylor, 1998, 2000).

On the empirical level, evidence on life histories and recruitment presents a problem for such theories. With regard to the Baader-Meinhof, Rasch (1979)

examined 11 members of the group and could find evidence in only one case in which the activist engaged in political violence to draw attention to himself. In all other respects, the group members were considered psychologically healthy (Rasch, 1979). della Porta (1990), reviewing individual motivations of Italian activists, highlighted the lack of family or socialisation problems and noted that more than one half of the left-wing militant activists in underground movements grew up in left-wing families. Far from conflicting with the values of their parents, they, in fact, carried on the radical traditions. Crenshaw (1981) found that there was no evidence of psychopathology in her study of the National Liberation Front in Algeria. Within the context of the Northern Ireland theatre of conflict, clinical examinations comparing 59 “ordinary killers” with 47 “political murderers” who killed as members of either Loyalist or Republican paramilitary organisations revealed: “Political murderers were found to be generally more stable than non-political murderers . . . the non-political murderers appear to come from a rather more unstable family background and a much greater number of non-political murderers showed evidence of mental illness” (Lyons & Harbinson, 1986, p. 193). The histories and trajectories of terrorist groups in Northern Ireland show that groups contained a mixture of individuals, however most were within the range of normal personalities, an observation supported by an interview with a clinician experienced in dealing with incarcerated terrorists.⁵ Evidence shows the unremarkable home lives of many of those who became major Republican and Loyalist terrorists figures, compared with the personal incidents experienced, witnessed, or gained knowledge of through friends, relatives, or the media that created the motivation to engage in terrorist acts (Holland & McDonald, 1994; Taylor, 1998, 2000).

There are undoubtedly cases in which individuals engage in terrorism because of prior mental illness. However, as with general criminal activity, this figure is likely to be low. We know from evidence in the United Kingdom that the number of mainstream criminal offenders who are mentally ill is small, possibly roughly 1% (Badcock, 1999). Although the prevalence of psychosis among male prisoners in the United Kingdom is higher, at 7% (Sugarman, 2002), this may be a result of the smaller sample group and the effects of incarceration. Furthermore, insofar as symptoms of disorder are relevant, they have to be considered in the context of other variables (biological, psychological, and sociological) (e.g., Ferracuti & Bruno, 1981).

Indeed, other factors, such as network theory, learned behaviour, and behavioural psychology, have to be examined (Hogan, 2000; Taylor, 1988, 1991) in addition to social learning and situational group pressure (Matza, 1969; Sutherland & Cressey, 1966). The significance of these processes is evident in the account of Republican terrorists by Bowyer-Bell (1992), which confirms that one of the best single predictors of human behaviour—in this case terrorism—is the strength and structure of interpersonal relationships. It is not within the remit of this article to consider in any detail such theories. Suffice it to argue, they may provide illumination with regard to terrorist actions. The next section continues the

theme by arguing that when terrorists do exhibit symptoms of mental illness this may be as a result of their terrorist activity.

THE TERRORIST AND MENTAL ILLNESS

Where terrorism and mental illness may be connected is in the effects produced in some individuals because of their engaging in terrorist activity. The process of going underground and engaging in violent clandestine activities is, by its very nature, hazardous and stressful. Symptoms of pathology may be a natural reaction within the circumstances and not indicative of a disorder, and if the presence of mental disorders is detected in a terrorist, it cannot be concluded that the mental disorder was the cause of terrorist activity. In addition, those terrorists who have been subject to detailed psychiatric assessment have been examined under conditions of incarceration, and therefore the circumstances of their arrest and detention in producing mental disorder need to be considered. The effects of these need to be taken into account when making a psychological assessment of terrorists.

The variables that may be of importance in contributing to mental illness may include

- terrorist lifestyle
- terrorism effects
- terrorist group conflict
- interrogation effects
- the effects on the individual of the conditions of imprisonment (incarceration)

It is not claimed that exposure to these conditions induces psychiatric disorders in every case, but that these factors have the potential to contribute to mental illness in some individuals.

Terrorist lifestyle—post-traumatic stress disorder (PTSD). The diagnostic nomenclature on psychological disorders resultant of conflict situations has been modified over the years since the syndrome was first recognised as “soldier’s heart” by DaCosta (1871). Post-traumatic stress disorder (PTSD) is featured in the *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., rev.) (American Psychiatric Association [APA], 1994) as a condition brought about by an experience outside of the norm that “would be markedly distressing to almost anyone.” Such experiences would include threats to life, exposure to actual or threatened serious harm to self or significant others, or being witness to the serious injury or death of others because of accident or violence. Symptoms include acute psychological distress, perceptual disorders (illusions/hallucinations), disturbances of affect (becoming emotionally cold), and displays of anger (APA, 1994). The condition is a natural psychological reaction to an extreme situation

and is experienced not only by combatants but also is manifested by those involved in extraordinary threatening situations (Cavenar & Spaulding, 1976; Kentsmith, 1984). Significant evidence demonstrating that PTSD is specifically linked to intense stressors is provided by a rigorous study of 3,016 military and nonmilitary personnel of similar characteristics that took account of differential exposure to conflict and concluded that "These findings provide some empirical support for the notion that exposure to life-threatening, catastrophic events, such as combat, increases one's risk for experiencing a range of severe chronic states" (Jordan et al., 1991, p. 215).

Some endorsed premilitary factors as principal determinants for the development of the disorder (Worthington, 1978), others attached significance to post-military factors (Keane, Scott, Chavoya, Lamparski, & Fairbank, 1985); others viewed the development of the disorder as a result of a combination of these two factors (Helzer, 1984). However, evidence provided by Ursano (1983) shows that predisposition to psychiatric illness, even after exposure to the most severe trauma, is not necessary or sufficient for the development of psychiatric illness. There is also evidence to show that previous morbidity is not necessary to develop illness because of trauma in war generally (Card, 1983; Laufer, 1985; Soloman, Oppenheimer, & Noy, 1983). According to one evaluation of the rigorous selection and training of Special Forces soldiers, training does not provide immunity from the syndrome (Chemtob, Bauer, & Neller, 1990). The data consistently reports the nonsignificance of premorbid factors (Green, Grace, Lindy, Gleser, & Leonard, 1990; Watson, Brown, Kucala, Juba, Davenport, & Anderson, 1993).

As well as combatants, PTSD has also been diagnosed in nonmilitary personnel operating in similar conditions. The syndrome has been identified in police officers (Mann & Neece, 1990), members of the emergency services (Anderson, Anders, & Peterson, 1991; Armstrong, O'Callahan, & Marmar, 1991), accident victims (Badenhorst & Van-Schalkwyk, 1992; Hickling, Blanchard, Silverman, & Shirley, 1992), victims of abuse and violent crime (Bownes & O'Gorman, 1991; Graziano, 1992; Mcleer, Deblinger, & Orvaschel, 1992; Riggs et al., 1992),⁶ and security forces personnel tasked with combating terrorists (Ryder, 2000).⁷ Zawodny (1983), a former member of the Polish Underground, deduced a similarity between terrorist groups and the wartime resistance movement, and a link between resistance veterans and PTSD is provided by a study of the Dutch underground (Hovens et al., 1992).⁸ Of equal import is the condition is not restricted to advanced industrial societies, it is also found in traditional nonindustrialised cultures, some of which experience political violence. *Ataques de nervios*, a response to trauma or loss, is noted within Hispanic cultures, and Salvadoran women have displayed *calor*, heat fever induced by traumatic loss.

That the disorders are a natural phenomena and readily susceptible to effective treatment is evidenced by the actions of the Israeli military psychiatric services who, in response to the serious threat to military capability posed by the escalating number of stress-related psychiatric casualties that resulted from exposure to the combat environment, developed and implemented an effective preventative and

treatment programme that enabled soldiers to be returned quickly to active duties (Bleich, 1992; Holden, 1998; Moses, 1992).

In overview, we can say that the development of psychological signs/symptoms as a response to trauma is widely acknowledged and recognised as being distinct from a mental disorder “proper”; that they are manifested in people who are considered to be psychologically healthy; that there is little or no relationship with premorbid disposition; and more important, even the most rigorous preparation or training does not confer immunity from developing the syndrome. This last point is crucial in that it belies any cynical assumption that, when an individual considered to be a terrorist presents recognised signs/symptoms, this must be an exploitative or manipulation technique devised to thwart the authorities.⁹ We are not comparing soldiers, police, and terrorists as moral equals, merely identifying the general factors that might be associated with the development of mental health problems, such as the long-term exposure to the threat of physical harm in uncertain circumstances. Simply put, there is no reason as to why a terrorist should not succumb to the trauma of conflict or the stress imposed by the terrorist lifestyle, and as such these factors merit serious consideration and cannot be reduced to a pre-existing psychopathological condition.

The effects of terrorism. This discussion refers to the disorders of varying seriousness that may result from terrorist activities, such as perpetrating violence. As Taylor (1988) pointed out, “Mental illness may not be a particularly helpful way of conceptualizing terrorism, (but) the acts of terrorism and membership in a terrorist organization may well have implications for the terrorist’s mental health” (p. 93). Biographies show that some individuals become progressively alienated from their actions. The detailed account by Collins, who played a major role in the South Armagh Provisional Irish Republican Army (PIRA), clearly demonstrates that his roles, involving planning murders and as a member of an internal security unit, led to depression, anxiety, and near breakdown, symptoms reinforced by his later role as a “supergrass” (criminal informant) (Collins, 1998). Others appear to derive satisfaction from violence, leading to an acceleration of violent acts. Lenny Murphy was a member of the protestant group, the Ulster Volunteer Force (UVF). Although legal at the time, the UVF engaged in terrorist activities. Murphy and fellow UVF supporters began an extremely violent series of murders of Catholics. Bruce (1992) argued that abnormal psychology cannot explain the activities of these “Shankill Butchers” and that the activities can be set in the context of traditional use of extreme violence to discipline or terrorise. This can indeed be seen at present in Ulster, in the often viscerally violent punishment attacks on members of paramilitary organisations or locals who have acted antisocially. However, Bruce failed to take account the process by which progressive violence may lead to changes in the protagonist’s cognitive processes and mental health. The Shankill Butchers became progressively more violent, and when Murphy left prison after serving a sentence for a firearms offence, within 24 hours he murdered a complete stranger for no apparent reason (Bruce, 1992). Although it is

accepted that violent murders and punishment beatings do not signal disorder, Bruce's analysis, and others who reject a link between mental illness and terrorism (Heskin, 1984) do not appreciate that there may be a dynamic in operation—the long-term use of violence as a political weapon, as a method of solving internal disputes, and as a regular reaction to disputes may lead to the perpetrator developing mental disorder[s]; that is, the use of instrumental and expressive violence may indeed come to reflect the fact an individual may “be [a] psychopathic or psychotic reveler in violence” (Levi & Maguire, 2002, p. 811). This is not even taking account of the effect of single actions on individuals. Taylor (2000) recounted the case of a young man in the UVF who committed a murder of a Catholic in 1982, was imprisoned, suffered depression for years afterward, and finally committed suicide 12 years later. These results may occur even when, according to subcultural theory, violent actions are rational in the group context, particularly as the subculture may not be monolithic, and individuals may display differing reactions to group and individual actions. The fact that certain terrorist behaviours—such as spiraling violence and the process of gradually becoming divorced from reality as described by Ferracuti (1990) as engaging in a “fantasy war”—may be explicable from a social psychological standpoint does not preclude the existence of pathology.

Terrorist group conflict. Heskin (1984) argued that the organisational features of the PIRA signify the members are not psychopaths, because the members display attitudes of dedication, co-operation, and loyalty. Although we agree with his proposition that there is no relationship between psychopathy and the PIRA, Heskin's analysis overlooks the high level and intensity of violent feuding within the PIRA. The PIRA killed a significant number of its own men on various flimsy pretexts, and recent accounts and research into the history of the PIRA demonstrate a lack of trust and loyalty, as well as recourse to violence within the organisation (Collins, 1998; Harnden, 1999; O'Docherty, 1998). Terrorist groups are notably internecine, unstable, as well as facing opposition from security services; group trajectories display patterns of internal conflict, breakaways, schisms, and subsequent conflict within other groups. In addition to the PIRA, organisations that display these features include the loyalist Ulster Defence Association and the republican socialist Irish National Liberation Army (INLA), both of which displayed extreme levels of factionalism even within the normally balkanised universe of paramilitary groups (Holland & McDonald, 1994; Taylor, 1998, 2000) and the far right in the United Kingdom and Europe (Lowles, 2001; Thurlow, 1998). Such internal problems seem to have produced a range of abnormal and pathological behaviours in some members, including states of paranoia, aggression, and delusion in certain individuals. In addition, those who turn informant may be subjected to tremendous pressure and consequently develop disorders (Collins, 1998), a trait evident in normal criminal informants (Thompson, 2000). A Home Office psychiatrist identified this in interview with one of the authors:

Q. You have outlined the problems in conducting medical assessments, have you found any evidence of pathology? “The difference between men and women is striking. I have not seen a disordered man in prison . . . the only man who did present with psychiatric symptoms, that I have seen, was somebody who had turned informant and had been relocated and given a new identity . . . he was in constant fear of discovery, hyper vigilant.”

Q. Did this man have a previous history of mental problems? “No.”

Effects of interrogation and incarceration. The terrorist lifestyle is also likely to expose the participant to the effects of interrogation and incarceration. Although these have been listed as two separate criteria, they overlap and therefore for the purposes of this discussion, they are considered jointly.

In terms of interrogation, a number of conditions have been identified with regard to standard U.K. police procedures that, in addition to the actual interrogation itself, act as stressors. Although the context of their examination concerns retracted confessions, they identify the following factors that they claim may be more important than the interrogation in producing phenomena, such as false confessions:

- long detention in custody
- no access to legal advice, family, or friends
- lack of control over physical environment
- confinement in unfamiliar environment
- subordination to powerful legitimate authority
- not being able to eat, sleep, or rest properly
- feeling intimidated by police officers
- fear of personal safety, mental and physical health (Gudjonsson & MacKeith, 1988).

“Normal people are likely to confess to crimes they have not committed if they are placed under sufficient, or the right type, of pressure. Indeed, if the pressures are extreme then it is the characteristics of those who do not confess which are likely to be most unusual” (Gudjonsson & MacKeith, 1988, p. 193). Gudjonsson and MacKeith (1982) maintained that the conditions of detention and interrogation could cause a gross stress reaction that, in some cases, may lead to long-term disability, even in cases in which the suspect is innocent.¹⁰ As with the case of PTSD as a consequence of conflict situations, rigorous training to resist interrogation techniques does not prevent the onset of trauma-induced disorders (Hallstrom, 1974).

In terms of incarceration generally, we know that the significant level of mental disorders in U.K. prisons may partially be because of the effects of incarceration in producing disorders or accelerating previous disorders (Morgan, 2002; Peay, 2002). In terrorist terms, Amnesty International’s (1997) study of Special Security Units (SSUs) focused on those special units designed to hold exceptional-risk Category A prisoners including convicted terrorists and persons on remand for

terrorist offences. A report prepared by three psychiatrists concerning the effects of the SSUs concluded: [the regime] “comprises an environment, a set of practices in that environment and a set of rules . . . which constitute a systematic physical and psychological stressor likely to lead to mental and physical disorders” (Amnesty International, 1997, p. 7). The psychiatrists also examined five prisoners (including prisoners convicted of terrorist offences) who had served a period of time detained in a SSU at Whitemoor Prison. The medical opinion of the psychiatrists was that “four of these defendants have developed mental illnesses which go beyond the ordinary and expected anticipatory anxiety. In each case the men are labouring under cognitive impairment” (Amnesty International, 1997, p. 7). They found that the conditions “combined to produce a serious mental illness” (Amnesty International, 1997, p. 7). Again, as with normal incarceration, these conditions may produce apparent pathology:

Q. It seems to me that you regard these “patients” as very devious individuals who require to be dealt with by a great deal of caution. How then do you form a psychiatric opinion of them?

The bottom line is that, as a psychiatrist, you have to form some form of judgment. The medical officer has to make a decision. . . . You must be thorough. . . . I examined a member of Abu Nidal. This man complained that his food was being poisoned, he became very withdrawn, lost weight, his behaviour was very paranoid, and he appeared psychotic. We used a competent interpreter and found that it was at the time of the Lockerbie bombing, which was said to be the act of his terrorist group, and because of the anger which this incident generated he feared for his safety. In prison, it is not unusual for prisoners who are disliked to be assaulted or to have their food contaminated by other inmates. This seemingly psychotic behaviour had a rational explanation.

Thus, the variables of terrorist lifestyle, interrogation, and incarceration have the capacity to produce a range of symptoms that may appear indicative of underlying pathology but which may be a normal reaction to extreme circumstances.

CONCLUSION

There is no evidence to support the claim that there is a general connection between an individual's mental illness and his or her participation in terrorism, though there will continue to be cases of terrorists whose activity is connected to their pathology. Certainly, this is the accepted view within much contemporary terrorism research; however, the image of the psychopathic terrorist persists in the mass media and to varied extents within academic and policy circles. On a more diffuse level, medical metaphors and analogies connecting terrorism with illness remain.

However, there may be another direction of causality in some terrorists, whereby participation in a terrorist unit may not be conducive to long-term mental health. The terrorist lifestyle may produce the structural conditions whereby a significant number of individuals develop short- or long-term mental health problems of varying intensity. Thus in any terrorist group there will be individuals who succumb, as many nonpathological individuals would, to mental health problems, others who remain normal, and others who exhibit pathological tendencies that may explain their involvement in terrorism. The trajectories of Republican, Loyalist, and far-right terrorist groups in the United Kingdom demonstrate this.

This article highlighted only a number of areas that might provide useful research findings. Combined with a wider perspective, incorporating the social and political context, behavioural psychology, and network theory, this approach may provide some insight into group instability, an important area of study as Wardlaw (1998) identified.

Concerning postarrest and/or postconviction, there are a number of issues, which may require research.¹¹ Mental illness should be taken into consideration when evaluating terrorist suspects during incarceration and interrogation and when such policies are designed by security forces personnel. Such policies might include a preinterrogation psychological health check. This can be combined with a detailed assessment taking into account significant information on the detainee's personal history, policies designed to minimise the production of false confessions, policies and procedures governing conditions of incarceration that take into account any special needs, such as the feasibility of access to other group members and policies to provide in-reach mental health services, one area highlighted by the Home Office psychiatrist:

What is so striking about female terrorists you have encountered? "Mental instability and a history of eating disorders is common."

In the reported cases, is it your opinion that they were mentally unstable before incarceration or as a consequence of prison?

In the case of the earlier convicted Republican prisoners, before, not post incarceration. These women [cited four examples] were predominantly unstable, they were considered expendable by the organisation. The recent ones are different, they are committed and dedicated. Unstable terrorists occasionally conflict with the organisation, that is why they have support groups . . . waverers are intimidated, warned off . . . the organisation keeps in contact. Many of the [Republican] women become engaged or marry convicted IRA men, this way they get accumulated visits. It's a way of maintaining contact and preserving their belief system.¹²

Furthermore, on the same topic, in-reach services may be appropriate for those terrorists who wish to reintegrate with society. Evidence from Northern Ireland shows that the support services for former terrorists are patchy (albeit excellent in some cases), and there is a need for evidence on the reintegration of terrorists

generally, such as the *pentito*—former Red Brigade members in Italy who have dissociated themselves from terrorism.

NOTES

1. Although an interview given by David G. Hubbard, M.D. (Hubbard, 1978) appeared to find a chemical basis for terrorism, and later moved to link it with a disorder of the middle ear, (McGuire, 1977) claims viewed as preposterous (Hopple, 1982).

2. “The larger the organisation, the less sick the individual members have to be” (West, 1982, p. 104).

3. For example by the Wehrmacht and Soviet forces in the Eastern Front during World War II (Clark, 1966).

4. An argument Post (1993) seemed to concede.

5. David Weatherston interviewed an independent consultant forensic psychiatrist who has been called on by the U.K. Home Office and defence and prosecution council to examine accused and convicted terrorists. The clinician has examined more than 40 individuals convicted of terrorist offences. The conclusion reached by this psychiatrist is that, with the exception of eating disorders in certain female terrorists, terrorists appear to be normal. (For security and professional reasons, the identity of this clinician is withheld.)

6. Disaster studies are not considered useful in that, as reported by Turner, Nigg, and Paz (1986) in their study of residents living on the San Andreas Fault in California, these people knew the source, nature, and propensity of a disaster that enabled them to render the threat manageable. Similar defence mechanisms have been observed in victims of sudden and unforeseen disasters (Erikson, 1976).

7. Due to the prevalence of mental health problems, the Royal Ulster Constabulary (RUC) established an Occupational Health Unit. The Unit’s 1988 survey showed 1 in 10 officers were being treated for stress-related complaints, and that from 1970 to 1995, 55 police officers committed suicide (Ryder, 2000). One RUC constable, following the funeral of a close colleague, went on a drinking and shooting spree that ended when he took his own life. The officer had a distinguished service record but had become obsessional, drank heavily, and engaged in acts of unprovoked violence (Ryder, 2000).

8. As Brewer (1987) noted, people involved in such unpredictable circumstances resort to a series of adjustment mechanisms involving structured linguistic strategies to normalise fatalism, “If your number comes, your number comes” (p. 662). However these may not be effective over the long term for certain individuals.

9. Although it may well be the case: How do [disruptive] techniques affect your work as a clinician?

“There was an incident that involved a colleague of mine. He was approached by a prisoner who complained of psychiatric symptoms. He prescribed medication. The prisoner then made a formal complaint of being forcibly medicated. That person alleged that the request was for an alternative treatment. When I saw the person I offered a range of treatments and told her to go away, decide which one she preferred and to come back to me. She never did. The point is, the issue [of forcibly medicating Republican prisoners] it was raised in the dail [the Eire parliament] and had diplomatic implications and was used for propaganda purposes by the organisation.”

10. In 1980, a study carried out on behalf of the Royal Commission on Criminal Procedure observed the interview procedures carried out by detectives at Brighton Police Station. This study involved observing the interviews of 80 detained suspects, with particular attention paid to interview techniques and the mental state of the suspect. It is significant to note that of the 16 suspects who were either intoxicated, low in intelligence, had learning difficulties, or were mentally ill, 13 were so

frightened the author concluded: "Such symptoms [of fear] indicate an abnormal state although, because it arises naturally, it is qualitatively different from mental handicap or intoxication effects. Taking these groups together, nearly half of the suspects observed were in an abnormal state immediately prior to being interviewed" (Irving, 1980, p. 135). The report also highlighted the observable distress exhibited by the suspects as a result of the effects of custody, and the marked fear reactions of those charged with sex crimes. It is suggested this factor is significant because terrorism and sexually deviant crimes have a propensity to arouse intense disapprobation, and it is, therefore, conceivable that suspects, being aware of the disdain they cause, react in similar ways. It is well known that convicted terrorists and sex offenders are subject to personal violence, and this may cause stress and the development of psychopathological features.

11. An anonymous reviewer suggested many of the ideas in this section.

12. We stress the caveats concerning the overmedicalisation of female behaviour.

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