

The Dilemma of Predicting Violent Radicalization

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Parents, educators, law enforcement officials, and health professionals are all concerned about the violent radicalization of adolescents. Health professionals may be called on to assess teenagers regarding the risk that they will become dangerous. We present a case in which a psychiatrist is asked to do a forensic evaluation of a young adolescent who said troubling things and had some concerning posts on his Facebook page. The evaluation reveals things about both the young boy and his community.

Among immigrant youth today, the phenomenon of violent radicalization strikes fear into the hearts of parents, educators, law enforcement officials, and health professionals. As health professionals, we may be called on to assess teenagers regarding the risk that they will become dangerous. We present a case in which a psychiatrist is asked by the police to do a forensic evaluation of a young boy who said troubling things and had some concerning posts on his Facebook page.

THE CASE

Mohamed is a 12-year-old boy of South Asian Muslim descent who was referred by the police to your child psychiatry clinic for evaluation. Mohammed was born in Canada. His parents emigrated from Bangladesh. His family is religious. His mother wears a hijab. The police were called by Mohammed's school after an incident in which some older boys at his school spat on his mother and called her racial epithets. Mohammad texted his friends "I feel like killing these guys." One of his classmates told his parents about this text. The schoolmate's parents looked up Mohammed on Facebook and discovered that, on his Facebook page,

he wrote his profession was "serving Allah." They also found a picture of him in a Rambo-like pose, holding a rifle. The parents informed school officials. The school officials were concerned about these death threats by a potentially radicalized individual, so they called the police. The police arrested Mohamed outside his home. Mohamed was indefinitely suspended from school and was referred to a child psychiatrist to evaluate whether he was a danger to others at school. The initial assessment revealed the boy comes from a warm and cohesive family that seems to be well integrated into Canadian society. Mohamed's father is a hunter of small game (birds) and has taught his son how to hunt. The boy was proud of his hunting permit and posted a photo of himself with his father's hunting gun. There is no past psychiatric history. The boy was popular, had friends, and played basketball. As a psychiatrist who has been asked to do a forensic evaluation, what are your next steps?

Cecile Rousseau, MD, Comment

This case illustrates the dilemmas that arise in assessing youth who may be at risk for violent radicalization. It shows how the much-needed alertness to this phenomenon in the education and health systems may sometimes

abstract

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provoke harm for the youth and his or her family. Practitioners' feelings of urgency and fears of catastrophe may interfere with standard assessment procedures. These understandable fears lead to some delicate questions: Is this form of harm avoidable? What are the individual and collective costs of security approaches in education and health care? How can education and health professionals navigate between a necessary awareness of potential problems of youth radicalization and appropriate sensitivity to the risk of profiling and stereotyping? To begin to reflect on these questions, I discuss the evidence on detection of youth radicalization. Then, I will discuss the essential role of an interdisciplinary approach to guide youth practitioners in their decisions.

There is some evidence available to inform professionals and institutions working with youth in health, social services, and education about the risks and benefits associated with their participation in or collaboration with security programs and measures associated with the prevention of violent radicalization.^{1,2} First, there is a worldwide upsurge in the attention given to different forms of radicalization leading to violence in adolescents and young adults. Second, although the processes underlying religious, ethnic, nationalistic, or political radicalization have been shown to be similar, radical individuals' profiles and radicalization trajectories are highly heterogeneous. Third, community stakeholders have often asserted that state-driven initiatives focused on security policies lead to increased profiling and ostracism and subsequent collateral damage, but there is little research supporting these observations.

In the United States, the evaluation of targeted initiatives to promote partnerships between the police, communities, and health and

education institutions have yielded ambiguous results in terms of community perceptions.³ In France, the national plan clearly encourages schools to report youth suspects to the authorities. In the aftermath of the Charlie Hebdo shooting, community organizations reported that many children and youth in schools were suspected (or even punished in some cases) for having refused to endorse the social media "I am Charlie" slogan. The treatment of these non-conforming students led some inner-city youth to feel resentment toward other students and school officials. Some students sympathized with the perpetrators' feelings of exclusion and discrimination, even as they rejected their violence. These people had no avenue to express their ambivalence, even passively, in the school setting. In England, the Prevent program is increasingly criticized because of its association with an upsurge in profiling of Muslim youth and families.^{4,5} It should be noted that, because of the ethical sensitivity of the issue, the available data on youth violent radicalization have been mostly collected on youth >18 years of age, although the policies do apply to minors who are sometimes treated like adults.

In the absence of specific evidence on the risks and benefits of security approaches in health, social services, and education institutions, 2 preexisting and related bodies of literature can inform decision-making in this area for practitioners working with youth: the literature on the impact of the War on Terror (WOT) policies and the evidence in the field of youth violence prevention.

THE ROLE OF HEALTH, SOCIAL SERVICES, AND EDUCATION INTERVENTIONS WITHIN THE WOT CONTEXT

During the last decades, the direct involvement of physicians and

psychologists in interrogations in military settings have led to heated debates about the role of health professionals.⁶ The associated medicalization and psychology of radical violence tends to minimize the importance of social determinants in the present upsurge of extremist violence (eg, religious, neo-Nazi, and white supremacist violence, among others). It is not clear how to decrease the risk of violence. The increase in social stereotypes associated with the WOT has increased discrimination and exclusion and fueled the psychological distress of minority youth in educational settings.⁷ Identity affirmation has often become a strategy for youth to express dissent and/or to reenact trauma by assuming a proactive stance. Health services professionals appear to be ill-equipped to deal with the hurt stemming from this divisive social context.

SCHOOL VIOLENCE AND SECURITIZATION

The available evidence on school violence and securitization comes mostly from research in the United States. The increase in school shootings and the associated feelings of threat⁸ prompted policies of zero tolerance for suspected violent activities. Such policies were implemented in >75% of American schools by 2008. These policies require an increase in surveillance measures and early identification of students deemed at risk.⁹ Research suggests that these policies have not led to improved identification of potential aggressors. Instead, these measures have shattered the trust in the education system not only for targeted students, but also for their parents and peers.¹⁰ Vulnerable youth have consequently become reluctant to ask for help from counselors or psychologists because they are afraid of being labeled as dangerous. This reluctance to ask for

help is particularly true for children from ethnic and social minorities.¹¹ Based on this evidence, it seems that zero tolerance policies have failed to decrease actual violence and have undermined vulnerable youths' trust in their schools and in health professionals.

IN THE RELATIVE ABSENCE OF EVIDENCE, APPLYING THE PRECAUTIONARY PRINCIPLE MAY BE WISE

Given that there are no valid screening or detection tools for violent radicalization, the harm associated with the profiling of youth and the associated distrust toward health, social services, and education institutions appears to outweigh the potential benefits of identifying radicalized individuals. If valid tools were to be elaborated, then a rigorous analysis of the potential benefits would be warranted given the existing evidence of harm in the prevention of youth violence and WOT research fields. However, even when screening tools are available, they can still lead to detrimental profiling of youth. Practitioners should be aware that violent radicalization can be a way to express distress for youth, and that calls for radicalization may interact with preexisting mental health disorders to increase the risk of violent behavior in some youths.

When practitioners suspect that there could be a problem related to violent radicalization, what might be an appropriate course of action? Direct reporting of youth to security forces by the social services and health system may breach confidentiality and undermine the credibility of the health system as a source of trust and help for families, communities, and the youth themselves. The ethical rules that apply to other sensitive situations should therefore probably also apply to violent radicalization situations.

That is, reports should only be made when there is imminent risk of harm to identified individuals.

Discussing these issues with clinicians who care for teenagers often elicits anxieties associated with the feeling of risk taking. Clinicians should be encouraged to use their clinical and intervention skills to perform an initial assessment in situations in which youth radicalization is suspected. This assessment process can address the concerns of the school or the clinical team while preserving the alliance with the youth and his or her family. Practitioners should be able to ask for help from other professionals to understand what is going on. Psychological and medical knowledge is useful to understand the individual and group dynamic dimensions of social phenomena and to support vulnerable individuals and families.

Security forces can, appropriately, request professional help for vulnerable individuals whom they have identified and who accept the help on a voluntary basis. Health professionals should never help security forces get information from vulnerable individuals. They can continue to be involved in cases in which, after assessment, serious security concerns are present, but only as health professionals, not as members of the security team.

B. Heidi Ellis, PhD, Comment

The story of Mohamed shines a light on fault lines across multiple levels of the society in which he lives. His story also highlights lost opportunities to promote a more healthy and resilient environment.

First, the case begins with a heinous act of disrespect, even hate, toward Mohamed's visibly Muslim mother by Mohamed's schoolmates. The fact that boys at his school engaged in such reprehensible behavior signals that a larger problem pervades the school community. Where did

these boys learn and come to adopt beliefs and values that allow for the degradation of others? What is happening in the school itself, or the boys' families and neighborhoods, that allows such behavior to occur? Although it is possible this behavior was anomalous, it is also possible that tacit acceptance of smaller acts of bias and discrimination in the school community created an environment where escalating acts of hate were possible. Thus, the first level of intervention calls for sustained engagement with the school to help support a shift toward a culture of inclusion, respect, and support for all. Importantly, this means not only support for minority youth who may be targeted (such as Mohamed), but also support for those engaging in aggressive behaviors so that any insecurities, misunderstandings, or personal problems that may have contributed to their behavior can be addressed.

The second fault line exposed by this case is the bias and stereotyping that pervades society. When Mohamed's friend's parents view Mohamed's Facebook page, a statement of religious devotion and a picture of boyish pride are viewed through a lens of violent Islamic terrorism. Would a Facebook page of a white youth that referred to Jesus as a savior and similarly showed a boy with a hunting rifle have led to similar level of concern? Since September 11, 2001, far-right extremism has been responsible for more deaths in the United States than Islamist extremism. The recent attack on a Quebec mosque by white supremacist, Alexandre Bissonnette, highlights the growing concern of right-wing extremism in Canada as well. In both the United States and Canada, the number of deaths due to terrorism are dwarfed by those resulting from other kinds of violence, such as gang violence. Community-level education is needed to bring perspective to the

exaggerated fears of the threat of terrorism and the disproportionate fear of Islamic extremism.

There are opportunities as well for diverse segments of our society to interact together. On a simple level, one might ask whether Mohamed's friend's parents had met Mohamed. Had they spent time with their friend's son? Had they met his family and learned on a personal level what kind of people they were? Perhaps even this simple action of engagement would have changed the way in which they saw and interpreted Mohamed's text and Facebook page. Such engagement might have led to a different response. Instead of his arrest, it might have led to indignation about the hate directed toward Mohamed's mother and concern for how enraged Mohamed must have felt when his mother was insulted and disparaged.

A third fault line appears when the police, prompted by the schools' decision to report information about Mohamed as a potential threat, respond with a dramatic, public show of law enforcement. Here, 2 systems that should be promoting safety, security, and well-being of students and citizens act in ways that undermine these very goals. Did the school have mental health staff available to meet with Mohamed and better understand the nature of the concerns raised? Did school staff and police have training in understanding threats and awareness that a crude checklist of "Muslim, gun owner, statement that he/she feels like killing someone" is insufficient to determine whether someone is radicalizing to violence? These events should never be viewed in isolation of the larger context and clinical picture. Either the school system or the police department could have been the nexus for profoundly positive intervention. They could have investigated more fully the context surrounding the incident, expressed support for

Mohamed and concern regarding the hateful acts of the older boys, and unequivocally communicated to Mohamed, his family, and the school community that discrimination based on their Muslim religion would not be tolerated. The police could have taken this opportunity to build bridges to Mohamed's family and the broader Muslim community. If they had, this would have demonstrated both an appreciation for protecting all citizens from hate crimes and a fair and balanced understanding of what truly constitutes a threat.

Across each of these fault lines, we see opportunities lost and the injection of risk into the life course of an otherwise healthy-developing youth. In the moments before the story begins, Mohamed was a well-adjusted student with strong ties to family, school, and his religion. By the time he appears in the office for a psychiatric evaluation, he is contending with rampant acts of discrimination, pervasive stereotypes of him and his religion as violent, a record of school suspension, and public humiliation and suspicion. His ties to friends, school, community, and government institutions have been tested and, in all likelihood, weakened. The very factors that promote healthy development have been undermined.

Psychiatry is based around the notion that health or illness lies at the level of the individual. As this case illustrates, however, sometimes the problem is located not in the individual but in the social environment. Although responding at the level of the individual to reinforce Mohamed's strengths to him, his family, and the courts is necessary, it is not sufficient. To truly help Mohamed and to reduce the likelihood that others will suffer what he has, it is necessary to intervene at the level of the social environment. The damage may not be undone, but perhaps this opportunity can be taken to challenge stereotypes,

promote inclusive communities, and build a more resilient community moving forward.

OUTCOME OF THE CASE

The arrest and the school suspension had a catastrophic effect on the boy and the family who felt they were profiled and treated unfairly. Mohamed, although he was 12 years old, was handled by the police like an adult suspect, a traumatizing process for him and his father who witnessed this and tried to protect him. Although eliciting some initial resistance ("My son is not crazy"), the child psychiatry assessment provided some relief to the family who felt respected and appreciated through being considered in the formulation of the intervention plan. The psychiatric assessment, because it acknowledged the hurt stemming from the discrimination and the cultural misunderstanding, although also strongly condemning all forms of death threats, reestablished some degree of trust between the family and the education and health institutions.

If the school had requested the health and social services intervention before calling the police, they would probably have preserved their alliance with the family and minimized the harm to the boy. The clinicians were subsequently able to rebuild some trust between the family and the school. Mohamed was reintegrated in a different school to avoid the massive stigma that resulted from the initial intervention. He is doing well in his new school.

Collaborations between health professionals, schools, and police are key to address the social context of youth violent radicalization. Health and education professionals working with youth need to be aware of the different forms in which this context can shape youth experiences. Presently, the available evidence in related fields does not

support the legitimacy of a breach in the existing professional ethical rules that would lead to health and educational institutions becoming branches of the security services. On the contrary, clinical and research evidence suggest that this may increase profiling and shatter the trust of the youth, their families, and communities in these institutions. More research is needed both on the complex relations among determinants of violent radicalization and on the risks and benefits of intervention and prevention programs for youth. Until research provides some answers, there is no good reason for health and education sectors to alter their traditional ethical commitments to confidentially care for troubled youth.

John D. Lantos, MD, Comment

The case illustrates the dangers of thinking about risk through the lens of our current cultural fears. The teenagers who truly presented a risk to the community, those who insulted Mohamed's mother, were not perceived as risky. Instead, Mohamed, who only wanted to protect his mother, was mistakenly assumed to be dangerous. The circumstances of this case mirror the circumstances of violent crimes in the United States. Far more violent crime is attributable to native-born Christians than to foreign-born Muslims. Think of Newtown, Columbine, Aurora, Umpqua Community College, Colorado

Springs, or Charleston. In all these cases, the assessment of riskiness or radicalization would be difficult. Educators and health professionals need to be vigilant, but they also need to remember that our biases and prejudices may lead us to see risk where there is none and to overlook risks that don't map onto our previous probabilities.

ABBREVIATION

WOT: War on Terror

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