

Anders Breivik, the public, and psychiatry

On July 22, 2011, Anders Breivik detonated a car bomb outside the office of the Norwegian Prime Minister. The explosion killed eight people, and inflicted grievous damage on the infrastructure of the Norwegian Government. If he had done nothing else, that was already the worst act of terrorism in the history of Scandinavia. But as we know he did not stop there. Dressed in a police uniform he drove to Utøya, where he murdered a further 69 people, mainly teenagers attending a summer camp organised by Norway's Labour party's youth league.

In September, 2011, I was asked by the Norwegian Government to join an International Advisory Council tasked with reviewing the emergency response, both medical and psychosocial, to the dreadful events of July 22. Before coming to our conclusions, which were that the "Norwegian Health Service had responded very well to the greatest challenge it had ever faced",¹ we were briefed by many of those intimately involved in the events. We were left in no doubt that the crimes had shaken Norwegian society to the core. Nevertheless, much of the world came to admire the way in which the nation came together to reaffirm its commitment to a tolerant liberal society.² But people remained perplexed about Breivik himself. What were his motives, and how should justice be done?

When people struggle to comprehend what lies behind the mass murder of adolescents gathered for a weekend of discussions and campfires, the simplest response is that the killer "must be mad". The inexplicable can only be explained as an act of insanity, which by definition cannot be rationally explained. The act was so monstrous, the consequences so grievous, that the perpetrator had to be insane. Yet whilst I was in Oslo, the country was preparing to learn the results of Breivik's psychiatric examinations and all those who we spoke to were insistent that he should not be regarded as mad. And when, to everyone's surprise including my own, the psychiatrists did indeed state that Breivik was suffering from schizophrenia,³ there was an outcry.⁴ Such reactions are common. All the psychiatrists who interviewed Peter Sutcliffe, the so-called Yorkshire Ripper in the UK, agreed that he had schizophrenia. Normally this would lead to a finding of diminished responsibility and admission to a secure hospital facility. But despite defence and prosecution

being in agreement the Judge insisted that the matter had to be put to a jury, because the general public would feel that otherwise Sutcliffe had escaped punishment.⁵ In practice it made little difference. Sutcliffe was convicted of murder and sent to prison, but soon transferred to Broadmoor Secure Hospital, where he will end his days. Whether he was being punished in prison, or treated in hospital, there was no doubt that he would never be released, since no Home Secretary would agree to that.

But Norway should be different. Norway is a country with one of the best developed mental health systems in the world.⁶ It prides itself on its tolerant attitude towards mental disorders. When former Prime Minister Kjell Magne Bondevik took leave of absence to be treated for depression in 1998 his career did not come to a halt.⁷ Offenders diagnosed with mental illness are dealt with within the health, not the criminal justice, system. And if the person then recovered, they would be released from hospital on the authority of the psychiatrists, without the possibility of political interference.⁸ But tolerance can only go so far, and the majority of the Norwegian public saw a label of schizophrenia as allowing Breivik to avoid having to answer to his crimes, and worse, that a psychiatric diagnosis raised the spectre that he could be free again.⁹

In fact that was always improbable. Many Norwegians themselves were confused about the checks and balances within their own judicial system. A prosecutor can, although they rarely do, challenge the psychiatrist's decision and the matter be returned to Court. And even if the offender has recovered, the power exists to transfer him to prison indefinitely if judged a continuing threat to society.⁸ Although at the time of writing the Court's verdict remains unknown, as Breivik gives his chilling testimony in Court the chances that he receives a psychiatric disposal rather than a criminal conviction seem to be receding.

The Breivik case highlights two popular misconceptions. First, that outrageous crimes must mean mental illness. Diagnoses in psychiatry are made on the basis of symptoms and motivations, rather than outcomes. For schizophrenia to explain Breivik's actions, they would have to be the result of delusions. Delusions are beliefs that are not only wrong, in the sense of not corresponding to the world as we know it, but they must also not be shared with others of the same cultural



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background. A psychiatric classic established that individuals with schizophrenia can identify others as mad, even when they share the same delusions.¹⁰

Breivik's views on the evils of multiculturalism, immigration, and the threat of Islam mixed in with nonsense about the Knights Templar and so on, are absurd, reprehensible, and abhorrent, but he is not alone. One fears that in the backwoods of Montana or among those who subscribe to what is loosely called "anti Jihadism" are other people like him, who may also have devoted a summer to playing World of Warcraft and believe that Dan Brown writes history. The meticulous way in which he planned his attacks does not speak to the disorganisation of schizophrenia. My colleagues in forensic psychiatry struggle to think of anyone who has had the foresight to bring along a sign stating "sewer cleaning in progress" to avoid drawing attention to the smell of sulphur from the homemade explosives in the back of his vehicle. If a psychiatric parallel is needed, the closest might be the classic case of German school teacher Ernst Wagner, who murdered 15 people in a small village, and was diagnosed with paranoia, or delusional disorder as it is now known.¹¹

The second misconception is that the purpose of psychiatry is to "get people off". In the UK, however, if you commit murder and want to spend as little time in detention as you can, putting forward a mental illness defence may mean that you will spend more—not fewer—years behind bars.¹² And the forensic psychiatry system is not a soft or popular option either. Most offenders have the same prejudices towards mental illness as the general population, and would rather take their chances in prison than be what they call "nutted off". Similarly, it is a commonplace observation among British forensic psychiatrists that those who have experienced both prison

and hospital often prefer the former because "at least they don't try to do your head in". The widespread anger when it seemed that Breivik was going to be sent to hospital rather than prison reminds us that liberal attitudes to mental illness are still often only skin deep.

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I declare that I have no conflicts of interest.

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Seizing the opportunities of adolescent health

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Economic and social change have brought great opportunities and threats to adolescent health for rich and poor nations alike. The health transition, together with changes in adolescent social roles, has shifted the burden from childhood infectious diseases towards adolescent injuries and health-jeopardising behaviours in all but the poorest countries. Fortunately, research has clarified many determinants of these behaviours, and wide-ranging

prevention approaches to minimise harm and promote health have been identified. The challenge is how to increase use of efficacious policies and programmes worldwide, while recognising that communities and nations differ and need to make local decisions. Likewise, there is a need to understand that adolescent health contributes to adult health and can deliver economic dividends to nations that invest wisely in adolescent health.^{1,2}