European Commission

REPORT

on the project-based collaboration on detection, support and management of risks posed by individuals with mental health issues showing signs of radicalisation

LED IN 2019

Migration and Home Affairs

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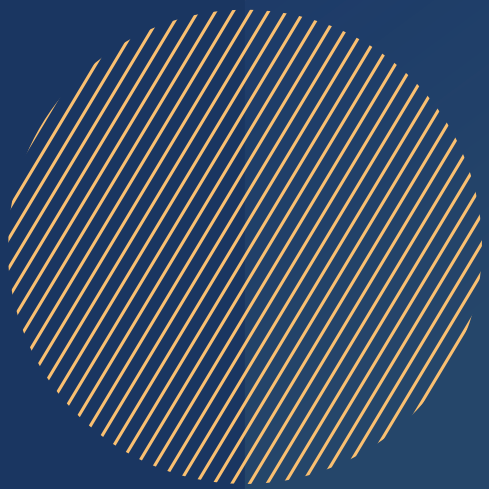


General introduction

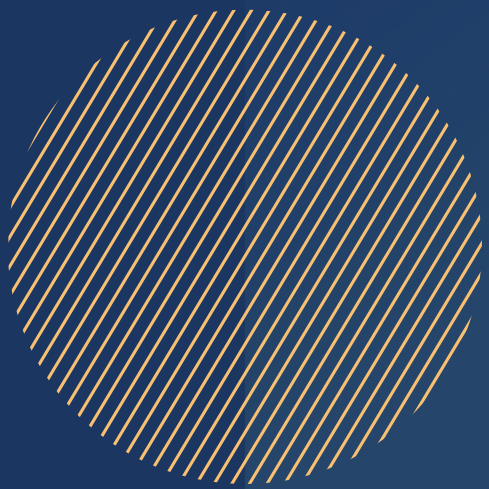
In its final report of 18 May 2018, the high-level Commission expert group on radicalisation (HLCEG-R) recommended creating a new collaborative format: 'project-based collaborations', led by Member States with the support of the Commission.

The purpose and added value of project-based collaborations was to allow like-minded Member States to collaborate through a series of meetings to produce specific deliverables that helped implement better policy responses.

Following input received from the Member States, the Commission organised in 2019 seven projects with various formats: study visits, workshops or combination of study visits and workshops.

Each group working on a project validated a final report with guidance and recommendations.

DETECTION, SUPPORT AND MANAGEMENT RISKS POSED BY INDIVIDUALS WITH MENTAL HEALTH ISSUES SHOWING SIGNS OF RADICALISATION



Detection, support and management risks posed by individuals with mental health issues showing signs of radicalisation

I. Introduction

In 2019, Romania and Finland started a project to provide a comparative view on the challenges faced by EU Member States regarding radicalised persons with mental health issues and to understand how authorities detect, approach and support individuals with mental health issues, which make them more vulnerable to violent extremism. The growing body of research into the subject of mental health and violent behaviour should be used when considering the relationship between violent radicalisation and mental health. As a part of the project, relevant literature was reviewed (examples of the key articles are available in the appendix). During the project, it became clear that this is only the first step and work should continue in this field.

The Member States met twice to work on this complex issue. They discussed a range of related issues, including definitions of mental health and mental disorder, how these related to radicalisation, and what policies and process have been developed to tackle the issue. The final report focused on the following different aspects:

- Main findings of a selected number of research studies – literature review;
- Innovative approaches identified by the Member States;
- Next steps.

Current research into the relationship between mental health and radicalisation is inconclusive.

The Member States identified the need to map public policies related to the link between radicalisation and mental health issues: legislation, plans, and the public structures involved. This map would enable the authorities to gain new insights.

The first meeting took place in Bucharest (Romania) on 23 April 2019 with representatives from Belgium, Denmark, Finland, France and Romania. The Member States decided to carry out a more in-depth inquiry of the public policies that address the link between radicalisation and mental health issues and issued a second questionnaire focused exclusively on public policies (answers were due by 30 June 2019). The final meeting took place in Helsinki in October 2019. At that meeting, participants discussed the recommendations based on a literature review and an overview of relevant public policies.

This paper is the final report of a project initiated by some Member States to explore the link between mental health disorders and radicalisation. The report gives a short overview of the work carried out by Member States this year, especially on terminological and topical issues. The document annexed to the report provides more details on the literature review and could form the basis of further follow-up work in this field.

II. Participating Member States

Finland and Romania led the project; Belgium, Denmark and France actively took part in this project.

III. Main insights

Part 1: From research to policy making

The Member States chose to focus their investigative work on three groups: lone actors, young people and women returnees or refugees, and prisoners. For each category, the Member States assessed what is currently known about the relationship between mental health issues and radicalisation.

The Member States stressed how definitions and methodology are crucial to understand the relationship between mental health and radicalisation to avoid stigmatisation, simplification and claims of causality between the two. They stressed the importance of having shared definitions of mental health and mental disorder and of acknowledging the limitations of current understanding.

1. Terminology and methodology

a) Definition of radicalisation

Definitions of radicalisation leading to acts of terrorism vary widely, depending on the scope and perspective. Academic studies define radicalisation 'as a social and psychological process by which ordinary people become so aggrieved that they are willing to sacrifice their lives and the lives of innocent civilians to make a political protest' (Bhui et al., 2014). Other studies define radicalisation as a process involving an individual or group whereby they are indoctrinated to a set of beliefs that support acts of terrorism, which can be manifested in behaviour and attitudes.

Among the factors leading to radicalisation are a perceived relative deprivation, for instance the failure to fulfil one's aspirations (Moghaddam 2005); experienced prejudice and perceived exclusion from an in-group (Stroink 2007); (J. A. Victoroff 2012); alienation (J. Horgan 2008) (Wilner 2010); threats to collective identity as a result of globalisation (Monahan 2012) and mortality salience (Pyszczynski 2006).

Violent extremism may fulfil a person's 'quest for significance' (A. W. Kruglanski 2009) (A. W. Kruglanski 2014) (Webber 2017) and status in a specific social context (Bartlett 2012). Analyses

of the radicalisation process suggest that a state of uncertainty makes individuals open to radical views, which provide a new sense of certainty and a justification for taking violent action (R. Borum 2011b).

b) Distinctions between mental health and mental disorder

Mental health is a state of well-being in which an individual can realise his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community. According to the World Health Organisation, mental health 'is not just the absence of mental disorders'.
Mental disorders, however, cover a wide range of issues with different symptoms. Generally speaking, they are characterised by a combination of abnormal thoughts, emotions, behaviour and relationships. They include schizophrenia, depression, intellectual disabilities, personality disorders and disorders triggered by drug abuse.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5 or the ICD-10) defines mental disorders as a syndrome characterised by a clinically significant disturbance in an individual's cognition, emotion regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

An expectable or culturally accepted response to a common stress or loss, such as the death of a loved one, is not a mental disorder. 'Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual' (Thyer 2015).

c) Mental health issues as risk factors regarding violence?

It is well known that most patients with stable mental health disorders do not face an increased risk of becoming violent (M. E. Welton, Violence and Mental Illness 2008). It is, however, also known that certain mental disorders are a risk factor for violent behaviour. The psychiatric diagnoses frequently associated with violence are substance-use disorders, some personality disorders, psychotic disorders and affective disorders. The development of a violence risk assessment and management methodology can be used also in the context of radicalisation. This methodology looks at the factors, also factors outside mental health, that contribute to potential violence without implying that any of these factors itself cause violence. In this globally and widely utilised way of assessing and managing violence risk, the focus is in assessing the risk factors and in managing them[1].

[1] Meloy, J.R. & Gill, P. (2016), *The Lone Actor Terrorist and the TRAP-18*, Journal of Threat Assessment and Management, 3(1), 37-52. -; Pressman, E. D. & Flockton, J. (2012), *Calibrating Risk for Violent Political*

The complexity and interdependency of many different risk factors, including mental disorders, cannot be overstated. Therefore, while acknowledging the importance played by mental health disorders in the radicalisation process, it is essential to approach this issue with caution and to acknowledge that correlation does not entail causality, as is done, for example, in the structured risk assessment methods for managing the risk of potential violence[2]**.**

d) Mental disorders and links to potential violent radicalisation

There is no psychopathological profile common to terrorists or a personality profile to account for individuals who have become radicalised. The previously mentioned risk assessment methodology can, however, be used to look at the potential risk of violence and how to manage that.

According to Campelo, psychiatric disorders are rare among radicalised young people. Bazex and Benezech found that most of the individuals tried for radicalisation display various dysfunctional personality traits, without having been given a formal psychiatric diagnosis. Only 10% of the individuals in these study were diagnosed with a psychiatric condition. The others simply displayed anti-social, obsessional and histrionic traits (Campelo, et al. 2018). There is, however, also evidence that mental disorders may have an increased prevalence especially in lone-actor terrorism[3].

Therefore, we can state that, when attempting to discover the factors that contribute to radicalisation that may or may not escalate to violence, the risk assessment and management approaches should be used as the basis.

*

Furthermore, the Member States did not single out specific ideologies among violent extremism; they looked both at far-right extremism and at Islamic extremism and took a comprehensive approach. Further work could be carried out to distinguish the specificity of radicalisation processes linked to mental health issues from the perspective of distinctive ideologies.

Extremists and Terrorists: The VERA 2 Structured Assessment, The British Journal of Forensic Practice, 14 (4), 237-251.

[2] Douglas, K. S., Hart, S. D., Webster, C. D., Belfrage, H., Guy, L. S., & Wilson, C. M, HCR-20V3: *Assessing risk for violence*, 2014, Historical-Clinical-Risk Management-20, Version 3, HCR-20V3: *Development and overview*, The International Journal of Forensic Mental Health, 13(2), 93-108.

[3] Weenink, A.W., *Behavioral Problems and Disorders among Radicals in Police Files*, Perspectives on terrorism, 2015, 9 (2) pages 17-33.

Gill, P., *Lone-Actor Terrorists: A Behavioural Analysis*, Routledge, New York, 2015.

The Member States underlined that the current literature is contingent upon our current knowledge. Further research would yield new results over the coming years, therefore any conclusions drawn should be considered as applicable only to this study.

2. Topics

The Member States decided to closely examine three topics and to scrutinise the literature available in these areas: lone actors, young people and children returnees, and the situation of prisoners regarding mental health issues.

a. Lone actors experiencing mental health disorders

Lone actors can be defined as persons who operate individually, do not belong to an organised group or network, and whose modus operandi is conceived and directed by the individual without any direct outside command or hierarchy' (Spaaij 2010).

The general consensus in the specific literature is that it is not possible to profile terrorists and there is no need to. Accepting this limitation, it is possible to identify some characteristics of lone-actor perpetrators: most studies indicate that the lone-actor 'profile' is heavily male-oriented (S. C. Jeff Gruenewald 2013) (J. H. Paul Gill 2014) (Clare Ellis 2016) with a prevalence of young males. Studies also indicate they are relatively well-educated and relatively socially advantaged (Spaaij 2012).

Some studies into lone actors (Schuurman et al., 2019; Andres and Pisoiu, 2016) have outlined a series of typical actions and behaviours that may indicate violent intentions. These include expressing admiration for murderers; supporting the activity of people who facilitate abortion; expressing a racist online discourse; disseminating execution videos; critically addressing the government's activities and decisions; expressing the desire to act radically, violently, or threatening persons or properties; ignoring operational security and being open with their intentions or actions; and being exposed to mental or physical abuse.

Much of the research points to a strong link between mental disorders and lone-actor violent extremists rather than to group actors (O'Driscoll 2018). Gruenewald, Chermak and Freilich found that 40% of lone actors in their dataset had experienced mental disorders, which was significantly higher than the 7.6 per cent among group-based actors (S. C. Jeff Gruenewald 2013). Recent work by Emily Corner and P. E. Gill concluded that a lone actor is 13.49% times more likely to have a mental disorder than an actor operating as part of a terrorist group (P. E. Gill, E. Corner, 2015).

b. Youth and children returnees and refugees that have been exposed to severe trauma

Although youth and children returnees and refugees are a category of individuals potentially most vulnerable to radicalisation, research into children and violent extremism is still in its initial stages.

Most research studies focus on the radicalisation processes of children recruited by the Islamic State and on the associated range of consequences resulting from this: trauma treatment, family relations, security risk assessment issues. They focus less on rehabilitation and reintegration.

Adolescent children that have returned from Daesh territory have witnessed extreme violence and abuse. The main correlation with this category is that they are less open to initiatives and less capable of change. In addition, there should be significant concern about the spread of radical ideas among their peers (Fergusson, Swain-Cambell and Horwood 2001). Researchers also highlighted that the majority of children returnees suffer from post-traumatic syndrome disease, which can lead them, counter-intuitively, to avoid violence.

When children have been involved in violence, psychological evidence demonstrates an inability to adequately consent to involvement in the violent activity and a lack of capacity to fully understand the consequences of their involvement. A child's upbringing and his/her biological development will determine at what age he or she can be expected to understand and project the consequences of his/her actions. Like child soldiers, child returnees can be seen both as victims and perpetrators at the same time.

Even when they arrive in Europe, away from the conflict zone, practitioners should be aware that children may still be in a transitional environment. This is especially the case when their parents are incarcerated and they are, for example, living in foster care. This can be an impediment to dealing with trauma and rebuilding resilience. The role of grandparents should be taken into account in their resilience.

Regarding experience within refugee camps, current literature on radicalisation in crisis situations typically identifies three drivers of radicalisation: the existence or pervasiveness of an Islamic education; the ability to find gainful employment; and the ability to have freedom of movement (encampment v open camp policies). As possible causes for immigrant youth radicalisation, some authors suggest an identity crisis (Robinson, et al. 2017), while others suggest the need to embrace multiple identities (Knapton 2014). Economical marginalisation is another suggested cause.

Martin-Rayo (2011) suggests in his study on countering radicalisation in refugee camps that access to a well-rounded education is a powerful tool to reduce radicalisation and recruitment.

Part 2: Member State policies

A. National policies on radicalisation and mental health issues

Participants in the project-based collaboration initiative on detection support and the management risks posed by individuals with mental health issues showing signs of radicalisation agreed to send the Member States a questionnaire to put together an overview of national policies in this field. 13 Member States replied to the questionnaire (Belgium, Cyprus, Czechia, Germany, Denmark, Spain, Finland, France, Croatia, Italy, Netherlands, Romania and Sweden).

The following section provides an overview of their policies based on their answers. It also identifies where room for further work could be planned.

Although some Member States identified the link between mental health issues and radicalisation as an issue, just three Member States appear to have implemented policies/action plans/guidelines that deal, support and manage the risks posed by individuals showing both radicalisation and mental health issues (Germany, Denmark and France).

The Member States have different administrative structures regarding their health authorities. Depending on the Member State considered, it could be run at national, federal and/or local level. This means that any further work on this topic needs to factor in the interplay between national and local authorities in a multi-agency approach. The variety of professionals in charge of young people at risk of radicalisation emphasises this need for a multi-agency work.

Regarding specific mental health assessments of radicalised persons, only a few Member States have such specific frameworks. Most Member States have no binding guidelines for handling radicalised individuals with mental issues (except for Belgium, which has set up multi-agency structures to deal specifically with its radicalised population).

Sharing information is obviously an issue for all Member States, even though the large majority of respondents agreed with the status quo of the legislative framework, that radicalisation does not present specific needs in this regard.

Some Member States have regimes of injunction of care (Finland, Belgium, Cyprus, Sweden, Romania, Germany, Denmark and France). There could be scope to conduct further studies on these regimes. These are medical regimes linked to a risk assessment. It is often a multi-actor process (involving doctors, civil authorities and medical structures).

Regarding training, several Member States organise specific sessions on mental health issues with law enforcement agency officers (Czechia, France and Sweden) and mental health

professionals and social workers (Spain, France, Denmark, Germany, Sweden, Belgium and Finland). It could be interesting to develop specific guidance on this point.

On research, a couple of Member States fund specific research programmes to build understanding of the link between mental health issues and radicalisation (Germany and France) while some collect research outcomes to build a literature review on radicalisation and mental health issues (Finland, Germany, France and Romania).

B. Innovative approaches

The meetings gave the Member States the opportunity to share innovative approaches implemented at national level.

Innovative practice on information sharing in Belgium

Under the Belgian national 'Plan R', i.e. Action Plan Radicalisation, Belgium has set up two platforms to boost information sharing between professionals working either on the security side or on the social treatment and prevention side with people of concern.

Firstly, local task forces (LTF) manage the risk(s) from a security point of view. They are operational consultation platforms on policy level for the police, intelligence and security services that operate in a certain geographic/judicial area or district. They monitor prioritised extremist individuals and groups at local level and propose measures to reduce the impact these persons may have and the risk(s) they may pose.

Secondly, local integrated security cells (LISC) are a consultation body operating at local authority level (municipalities) and maintain consistency between prevention, control and monitoring measures. Members of the LISCs are civil society organisations. The main goals of this platform are early detection of radicalisation and designing a tailor-made follow-up plan to manage the risks and needs of the person concerned. The multidisciplinary approach of the members that are part of the LISC is crucial.

An information officer (member of police) acts as the bridge between the LTF and the LISC and ensures the information flows between the different platforms. The different participants of the LISC decide in consensus which information can be shared with the local task force via the information officer.

PSP: a cooperation model involving the police, social services and psychiatric care services in Denmark

The police, social services, and psychiatry – PSP – is a form of structured cooperation between the police, social services, and the psychiatric system in Denmark.

The aim of the PSP is to ensure that relevant information is shared and support measures are enhanced for people at risk. The model involves PSP representatives from each sector meeting frequently. PSP is implemented nationwide by law.

In recent years, dealing with radicalisation and the threat of terrorism have become key issues in society. The PSP cooperation already facilitates work to identify people at many kinds of risk (e.g. suicide, substance abuse, social decline, mental illness), and coordinates relevant initiatives and treatment.

The PSP structure, therefore, provides a professional forum to identify and handle concerns of radicalisation and extremism. This working model includes an upgrade of all local PSP groups and an implementation of a nationwide evaluation of the initiative.

This platform for collaboration has been operational since 2009 in all 12 police districts. It focuses on prevention work in cases of concern where both criminal and mental health issues are at play.

Strategies and multi-professional approaches in Finland

The following forms of work are used in prevention work carried out by the police, with the aim of ensuring effectiveness, quality and impact. The agreed work forms create a basis for developing prevention work by the police and an assessment of its results, considering the changes taking place in the operating environment.

Multi-professional work for Member States (e.g. Anchor)

Multi-professional work has been developed in Finland since the late 1990s. The aim of multi-professional work is to bring together the work and expertise of different public authorities and organisations. From the customers' perspective, the work is often provided as a one-stop-shop service. The aim is that the problems affecting individuals and families can be tackled by identifying the causes of the problems and by dealing with the causes and not just with the symptoms. The aim of the Anchor activities is to provide a tool for early intervention in juvenile delinquency. In many cases, young offenders are also victims of crime. Preventing violent radicalisation is also one of the task of Anchor since 2016. Work under the Anchor scheme will be developed and strengthened over the 2019-2023 strategy period. In the future, the Ankkuri

Anchor activities will be based on an agreement between the National Police Board and the parties responsible for health and social services. The nationwide agreement can be supplemented by local-level agreements.

People of specific concern

People of specific concern are individuals whose behaviour or life situation has aroused particular concern prompting the public authorities to find out more about them. Assisting such people and getting the situation under control often requires joint crime-prevention measures by different public authorities at local level. The purpose of the measures is to prevent offences and to ensure that the individuals in question do not resort to extreme action. To prevent and manage violent behaviour by these people, the police have developed a form of working to assess the threat of focused violence. Monitoring of the people or cases of specific concern as well as the risk management measures taken by the police and other entities continues until the person in question no longer constitutes a threat or the risk of violence is low and the person's behaviour is no longer a cause for specific concern. In that case, it has been determined, on the basis of the information available and adequate intelligence gathering and investigations, that the person in question is able to manage their life and no longer constitutes a threat of terrorism or other serious violence. This form of working is used by the National Bureau of Investigation and police departments. HAH work requires close cooperation with other key authorities, such as health services and the Criminal Sanctions Agency.

Care programme for minors returning from terrorist grouping zones – France

France has hosted 166 minors, mainly coming from Syria and Iraq, over the last few years. It has developed a national care protocol as part of a set of procedures involving other state departments (including the Justice, Education departments).

In each region, a reference hospital has been chosen (including paediatric and child psychiatry teams) responsible for carrying out an initial diagnosis of the children. A child psychiatrist is appointed as a national focal point for training and disseminating good practices among the teams that have contact with the children.

As soon as the children arrive, a complete somatic assessment is carried out and a psychiatric evaluation begins, which can last from three to six months. The psychiatrist makes recommendations for further care if necessary. If they need psychiatric or psychological care, the relay is supported by other professionals close to the children's residence.

The main achievements of this structure are:

- children are overall in better somatic health than expected (from the literature on refugee camps), but the latest arrivals are different. The children have lived in refugee camps for months or years and the podiatrists notice more signs of infections and nutritional problems:
- all children have severe trauma and need psychological care after 6 months;
- professionals encounter difficulties with these children even if they are put in place to take care of traumatised children. These difficulties depend on the context;
- for the psychiatrists, the difficulties are also linked with the age of the children (most of them are under 2) and the lack of information on what they have experienced (mothers are incarcerated and the children don't speak).

Coordination with other relevant professionals is not as easy. For example, specific exchanges of information with judges is counter to the professional culture of each profession involved. Therefore, there is room for improvement in two directions:
- communication between judges and psychiatrists;
- long-term care and monitoring of the children to find the best balance between operational monitoring and the 'right to oblivion' that they deserve: monitoring should not lead to stigmatisation.

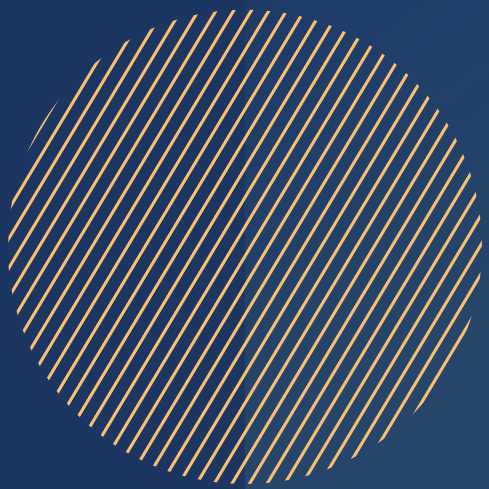
C. Next steps

The Member States that participated in the project also identified aspects that would require further work. They raised the idea of having joint meetings with other 'PBC' groups.

Regarding the topics that could be further explored, the Member States highlighted the following points in particular:

- radicalisation in prison and mental disorders: there is a need to work on the prevalence (or existence) of mental disorders among radicalised detainees, the specific vulnerability of detainees regarding radicalisation, and the grooming process;
- further research into returnees and on lone actors: Member States expressed the need for more research into this specific issue;
- comparison of different types of ideology/radicalisation (hooligans, radical Islamists, far-right extremists, mass murderers) regarding mental disorders;
- mental health issues and local responses: how to create a comprehensive response that can be implemented on the ground? Further work with the PBC on national support to local authorities could be envisaged;
- the role of grandparents of children returnees.

ANNEX TO THE PBC ON MENTAL HEALTH DISORDERS AND RADICALISATION



Annex to the PBC on Mental health disorders and radicalisation

This selected literature survey has been drafted to support the project based collaboration on the **Detection, support and management of risks posed by individuals with mental health issues showing signs of radicalization.**

It therefore has an informative purpose and aims to provide guidelines for a better understanding of mental health issues and the role they play in the radicalisation process of vulnerable individuals.

The survey has been drafted by a team of researchers from the National Institute for Intelligence Studies, "Mihai Viteazul" National Intelligence University, Romania: dr. Cristina Ivan, dr. Ileana Cinziana Surdu, PhD student Alexandra Popescu, PhD student Ioana Chita. A special contribution on the French perspective has been offered by Dr Guillaume Monod, Psychiatrist, PhD in philosophy, Associate member of the LIPHA-Paris-Est.

Contents

Introduction

This report represents a synthetic survey of a selected number of academic studies in the field of radicalization and mental disorders. It has been drafted in the context of the Gravitas[4] project based approach with the aim to provide to policy makers and practitioners a better understanding and perspective on the risks posed by individuals with mental health disorders showing signs of radicalization. Therefore, the document serves as a synthetic overview of academic sources and provides links to further study.

The survey aims to summarize findings that could help answer a set of relevant questions for both policy makers and practitioners. Each of the four distinct chapters/studies aims to highlight relevant findings that might help answer the following research questions:

Are mental health disorders creating a predisposition for radicalisation? (Chapter 1)

What are the interdependencies created between a mental disorder and a process of radicalisation? (Chapter 1)

Do mental disorders create a predisposition to violence? (Chapter 2)

How to deal with radicalisation of individuals with mental health disorders? (Chapter 2)

Are there specific mental health disorders that should be acknowledged in the case of lone actors? (Chapter 3)

Are returnees and refugees, especially minors, suffering form mental health disorders more vulnerable to radicalisation? (Chapter 4)

Methodology

The survey, which takes the form of four distinct studies, synthesizes relevant findings in a selected number of scientific articles published in web of science journals indexed in Science Citation Index Expanded and Social Science Citation Index, with an impact factor from 1 to 3. The set of scientific journal articles was complemented by a series of books in psychology, psychiatry, radicalization and terrorism, security studies, sociology and cultural studies. The keywords used to define the search included: terrorism, radicalization, mental health, mental disorders, psychology, violence, identity, psychological dysfunction, mental illness.

The scientific method applied in drafting the survey was that of a meta-analysis carried out from a constructivist conceptual perspective, special focus being placed on providing a contextual, multi-perspective understanding that allowed the construction of meaning based on the specific context of each sample of studies. The survey makes reference to qualitative and

[4] Gravitas – Project based approach related to detection, support and management of risks posed by individuals with mental health issues showing signs of radicalization

quantitative findings provided by studies in the above mentioned fields, main focus being placed on qualitative findings that allowed for correlation and comparative analysis.

Chapter 1

Surfing through definitions

What is radicalisation and what role do mental disorders play in it?

Definitions of radicalization leading to acts of terrorism vary widely depending on scope and perspective. A number of definitions have been provided by policymakers. The UK government, for instance, defined radicalization as "the process by which people come to support terrorism and violent extremism and, in some cases, then join terrorist groups" (Government), while a European Union definition is that of a phenomenon experienced by people "who regard the use of violence as legitimate and/or use violence themselves in order to achieve their political objectives which undermine the democratic legal order and the fundamental rights on which it is based" (Regions 2016).

Academic studies define radicalization "as a social and psychological process by which ordinary citizens become so aggrieved that they are willing to sacrifice their lives and the lives of innocent civilians to make a political protest" (Bhui et al., 2014). Other studies define radicalization as "a process involving an individual or group whereby they are indoctrinated to a set of beliefs that support acts of terrorism, which can be manifested in one's behavior and attitudes". Radicalism however does not equate to terrorism. While radicalism typically precedes terrorism, (M. Sageman, Understanding terror networks 2007) (Silber 2007) a radicalized individual may not necessarily intend to commit terrorism or a terrorist may not show visible signs of radicalization prior to committing the act (Neumann 2003) (Mandel 2010) (R. Borum 2011a) (Bartlett 2012).

There are many theories and models of the radicalization process. It has been suggested that prior to radicalization the individual experiences a state of uncertainty about the self and the world (M. A. Hogg 2010) (M. A. Hogg 2013) (M. A. Hogg 2012) (Doosje 2013) (Klein 2013) (Meeus 2015), and existential anxiety (McBride 2011).

Among the factors leading to radicalization are included a perceived relative deprivation, for instance the failure to fulfill one's aspirations (Moghaddam 2005); experienced prejudice and perceived exclusion from an in-group (Stroink 2007); (J. A. Victoroff 2012); alienation (J. Horgan 2008) (Wilner 2010); threats to one's collective identity as a result of globalization (Monahan 2012) and mortality salience (Pyszczynski 2006).

These factors may include conditions in the individual's social context or personal crises or "disorienting dilemmas" that act as "transformative triggers" (Wilner 2010) and "turning points" (McAdams 2001) or provide "cognitive openings" (Wiktorowicz 2005) and a "readiness to change." In such situations, the person may be particularly prone to identity transformation. As indicated by social identity theory (Tajfel 1979), this, coupled with an increase in self-esteem, may be facilitated by identification with an available social category, such as might be provided by a radical group (D. M. Taylor 2004) (Dalgaard-Nielsen 2010). The individual may become

increasingly socialized into this group (A. Silke 2008) (Dalgaard-Nielsen 2010) by face-to-face contact or internet "echo rooms" (Geeraerts 2012), while becoming relatively isolated from wider society, including his or her previous social network. The radical group, with its "high tentativity" (coherence) and extreme, clear, and simple view of the world (Savage 2008); (Liht 2013), perhaps expressed in terms of a "sacred canopy" of religious beliefs (Berger 1967); (Griffin 2012), may provide a sense of certainty (M. A. Hogg 2012) about the world, the future, and the self.

The identity of the individual may fuse with the group's identity, which instead rises the individual's willingness to die for the group (W. B. Swann 2009) (W. B. Swann 2014) (Whitehouse 2014) (Atran 2016), especially if the group has a "culture of martyrdom" (P. Gill, A multi-dimensional approach to suicide bombing 2007). This may be particularly so if the worldview embraced involves grievances toward a hated and dehumanized other group (C. a. McCauley 2011) (Monahan 2012). The identity of one can be strengthened in contrast to that of the other (Herriott 2009).

Violent extremism may fulfill one's "quest for significance" (A. W. Kruglanski 2009) (A. W. Kruglanski 2014) (Webber 2017) and status in the specific social context (Bartlett 2012). Analyses of the radicalization process suggest that a state of uncertainty opens the individual to radical views, which instead provides a new sense of certainty and a justification for the violent action (R. Borum 2011b).

"The relationship between mental illness and radicalization is not simple, but is potentially very important" (Andres and Pisoiu, 2016). Lately, researchers and practitioners in the field have joined their efforts in preventing radicalization and countering violent extremism and agreed on the fact that mental health is a factor that needs to be taken into consideration in their work. The new approach involves the collaboration with professionals in the field, like psychologists, psychiatrists, social workers etc. (Andres and Pisoiu, 2016).

Studies in the field have highlighted that the presence of mental health issues might make an individual become (more) vulnerable to radicalization, but no scientific result has proven this hypothesis so far (Misiak et al., 2019). Research showed that 50% of the long-term mental illness start before the age of 14. Analyzes need to focus on the degree to which depression, isolation, or pessimistic attitudes may lead to radicalization, in the context of seeking validation and empowerment (Bhui, 2015; 2018). At the same time, further research should focus on the methodological relevance, including the sample representativeness, or the use of standardized mental disorders tools (Misiak et al., 2019).

What is mental health and what is a mental health disorder?

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (World Health Organisation 2014). According to WHO, mental health "is not just the absence of mental disorder". They include a wide range of

issues that have different symptoms. Generally speaking, they are characterized by a combination of abnormal thoughts, emotions, behavior and relationships. They include schizophrenia, depression, intellectual disabilities and disorders due to drug abuse (World Health Organization 2014).

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), mental disorders traits include a behavioral or psychological syndrome or pattern that occurs in an individual and that reflects an underlying psychobiological dysfunction. The consequences are a clinically significant distress in social, occupational, or other important activities (e.g. a painful symptom) or a disability (i.e. impairment in one or more important areas of functioning) (American Psychiatric Association 2013).

The same manual defines mental disorders as a syndrome characterized by a clinically significant disturbance in an individual's cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.

An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g. political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above" (Thyer 2015).

Do mental health disorders create a predisposition to violence?

Nowadays, violence and mental health disorders are often regarded as inextricably linked, stigmatizing vulnerable patients (M. E. Welton, Violence and Mental Illness 2008). Violence is an increasing concern for psychiatrists and violent patients imply specific challenges for the treatment of their psychiatric disorder.

Swanson, et al. found that the rate of violence among those with a mental illness was twice that of those without a mental illness (H. C. Swanson JW 1990). He also points out that the rate of violence increased linearly with the number of diagnoses, concluding that major mental disorders was one risk factor for violence, among many others.

Psychiatrists assess that most patients with stable mental health disorders don't face an increased risk of becoming violent (M. E. Welton, Violence and Mental Illness 2008). However, in one study on convicted 350,000 persons from Scandinavian countries born between 1944 and 1947 and hospitalized in a psychiatric facility, Hodgkins, et al. concluded that most patients with a psychiatric hospitalization were more likely to be convicted of a crime (Hodgkins S 1996). Similarly, Link's review of 13 studies that were published between 1965 and 1989 concluded that patients with mental illnesses were three times more likely to be arrested than the general population (Link B 1992). Moreover, Steadman and Cocozza stated that psychiatric patients with violent offenses had criminal records prior to their hospitalization (Steadman H 1974).

The psychiatric diagnoses frequently associated with violence are substance use disorders, psychotic disorders, affective disorders, Cluster B personality disorders. Substance use disorders vastly increase the risk of a violent incident. Patients with alcohol or drug use had more arrests over their lifetime than patients with schizophrenia, personality disorders, or affective disorders (Holcomb WR 1988).

Moreover, a long term study on schizophrenic patients concluded that substance abuse increased conviction rates for violent crimes 16-fold among the schizophrenic group (Wallace C 2004). Four out of five patients with psychotic disorder resort to violence out of their beliefs and personality rather than their disorder. Only 20% of violent patients are motivated by the delusions or hallucinations they suffer from (PJ 1985). It seems that patients with paranoid delusions are twice as likely to become aggressive compared with non-paranoid psychotic patients (Buckley PF 2003). Most of the available literature on violence in psychiatric practice is focused on determining static risk factors and dynamic risk factors for the violent behaviour. Static risk factors are patient characteristics that cannot be changed with clinical intervention, such as diagnoses, personality characteristics, and prior history. A history of past violence (JR 2005) (Buckley PF 2003) (Blomhoff S 1990) and a history of impulsivity is also related to future violence (Asnis GM 1997). Other static risk factors include male sex, younger adult age, lower intelligence, history of head trauma or neurological impairment, dissociative states, history of military service, weapons training, and diagnoses of major mental illnesses (Buckley PF 2003).

As regards dynamic risk factors, variables in a patient's presentation that can potentially be improved with clinical intervention, the most frequently cited of them is substance abuse or substance dependence (EP 1994). Other dynamic risk factors include persecutory delusions, command hallucinations, nonadherence with treatment, impulsivity, homicidal tendencies, depression, hopelessness, suicidality, access to weapons, and recent move of a weapon out of storage (Buckley PF 2003).When adequately treated, mental disordered individuals do not pose the risk of becoming violent (Welton 2008). Violence has serious implications for society and psychiatric practice, directly and indirectly affecting the quality of life of patients, their families, the community, and mental health workers. The specter of violence in psychiatric practice demands risk stratification and management as part of the complete patient assessment.

A 2019 Report of the Human Rights Council states the Right of everyone to the enjoyment of the highest attainable standard of physical and mental health:

"Any effective engagement with violence as a determinant of mental health therefore needs to address the role of mental health services in perpetuating violent and paternalistic practices, which have reinforced the myth that individuals with certain diagnoses are at high risk of perpetuating violence and posing a threat to the public. There is no scientific evidence to support this myth, which is instrumentalized by discriminatory mental health laws that deprive people of liberty and their autonomy."

To conclude, we can state that the complexity and interdependency of many different risk-factors, including mental disorders, cannot be overstated. Therefore, while acknowledging the importance played by mental health disorders in the radicalization process, one also needs to always approach this issue cautiously and address all interdependent factors in correlation.

What are the psychological factors that may predispose to radicalization?

The mental factor or psychopathology has been analyzed since the 70's by scientists, after mental disorders have been identified in the case of a significant percentage of the general population. The early years of research have attributed mental disorders to terrorists. More recent studies have identified that **mental disorders don't represent a direct risk factor for radicalization**, as it cannot lead by itself to a radicalized behavior (Schulten et al., 2019). At the same time, research results in the field highlight the role of mental disorders in radicalization, when **combined with other factors**, like emotional traumas, exposure to radicalization, persuasion or substance abuse (Andres and Pisoiu, 2016).

The understanding of the process of radicalization that leads to violent extremism implies a complex psycho-social analysis, including the role of the mental health state of the individuals. "**A functioning mental health paradigm/ approach for the field of P/CVE must address these risk factors**" (RAN (02)). Radicalization, extremism and terrorism cannot be associated to a certain type of beliefs, mental state, situations or personalities, but the phenomena can be prevented or counteracted by identifying risk or determining factors: "We're not good at predicting [who terrorists will be] because it's so rare but we can identify risk factors that make it more likely. (...). We're dealing with a serious question of infectious ideas with divert budgets and we need to see what terrorism is trying to do, to identify and help people who are vulnerable." (Bhui, K., Everitt, B. and Jones, E., 2014). In case of the people with no criminal record, the main issues in a prevention process is how to address the ones who have violent intentions.

There are many factors, however, leading to radicalization processes. Among the psychological factors causing radicalization are included a sense of identity described as a 'quest for significance' (A. W. Kruglanski 2014), 'search for identity contributing to a sense of belonging, worth and purpose' (Dalgaard-Nielsen 2008b), personal fulfillment (Silverman 2017)**,** lack of self-esteem (R. &. Borum 2017) (Chassman 2016) (Christmann 2012) (Dawson 2017) (Lindekilde 2016) (Senzai 2015)**,** the emotion of anger (Stout 2002), individual frustration and insult (Larry E. Beutler, Psychology of terrorism 2007)**,** cognitive-social factors like risk taking and reduced social contact (M. &. Taylor 2006), personal victimization (C. &. McCauley 2011)**,** displacement of aggression (Moghaddam 2005).

Personal uncertainty is at the core of the radicalization process for some authors (Ludot M 2016). Radicalization was also explained through the theories of **narcissism and grandiosity** in groups since the figure of the leader becomes for the group members their ego ideal (R. 2016) (Veldhuis 2009). According to this hypothesis, narcissists, due to their grandiose self-perceptions, need to identify external enemies to blame for their own personal faults. Hence they are attracted to radical organizations that espouse hatred and enmity of certain others. However this hypothesis has not been supported (Veldhuis 2009).

Perceived injustice is frequently mentioned as a determinant of radicalization (L. A. Doosje B 2013) (Moyano M 2014) (Bazex H 2017). In most cases individuals try to give a sense to their existential failure, often provoked by personal experience.

Cognitive dissonance can also play a role in the radicalization process. It refers to a mental discomfort experienced when behavior is not consistent with attitudes or beliefs (Festinger 1957). Therefore, speaking in support of radicalism can strengthen these beliefs in one's mind.

In addition, **cognitive dissonance** also explains the fact that the more the individual sacrifices for a belief, that is, their behaviors, the more they will subscribe to that belief. Carrying out sacrifices is common among people who join a radical group, either by abandoning past behaviors or separating themselves from their families (even ideologically).

Some authors also mention **feelings of humiliation** as contributing to radicalization (J. Stern 2003) (Juergensmeyer 2003) (Richardson 2006) (Jeff Victoroff 2010). For instance, Khosrokhavar (2005) argues for 'humiliation by proxy', in that terrorists are humiliated that their fellow Muslims are being oppressed and retaliate as a form of objection (Khosrokhavar 2005).

Another psychological factor leading to radicalization is **frustration**. Dollard stated that the frustration-aggression hypothesis applies in political violence and terrorism (Cormick 2003). Their hypothesis asserts that when an individual's ideal is incongruent with his/ her actual achievements, they become frustrated and violent. This also applies in cases of relative deprivation, such as that experienced when the ideal society does not match with actual society.

Other authors have put forward various predisposing factors for radicalization, such as **depressive tendencies** (Ariel Merari 2009) (Merari 2010) (J. Victoroff 2005) or the **notions of identity and belonging**. The latter emphasizes that being a member of a radical group and embracing a cause gives a comforting sense of a '**significance quest** ' around a dedication that has an 'empowerment effect' for the radicalized individual (McGilloway A 2015) (Mccauley C 2008) (A. W. Kruglanski 2009). In the cases of psychological vulnerabilities such the depressive dimension, with frequent feelings of despair, radicalization is seen as a solution to fight against depression (Rolling J 2017).

'**Existential fragilities'** are also mentioned as responsible for fostering radical commitment (Kruglanski AW 2013).

Other studies mention **the suicidal intentionality** which could preexist the radicalization process, or is developed due to the promise of a true life in the hereafter (Bouzar D 2016). **Addictive behavior** is also reported since dependence on the radical group may act as a substitute for previous addictions. For instance, alcohol or forbidden substances (Ludot M 2016).

Several authors mention **psychopathological mechanisms** that reinforce radical commitment. For instance, the paranoia mechanism acts as a defence mechanism (Rolling J 2017) (Bazex H 2017) while the splitting process explains how these individuals set aside the moral values they had in the past (Bouzar D 2016) (Schuurman B 2016). Obsessive compulsive habits are frequent among radicalized individuals (29, 30) and they have a function of purification. They are not, however, specific solely to individuals with obsessive compulsive disorders. As psychiatrist Guillaume Monod observes, a number of jihadists and terrorists watch violent videos as a desensitization strategy, so that they will be able to overcome their fears and resistances to committing acts of violence. (Monod 2018/10)

Dalgaard-Nielsen (2008) identifies three pathways of potentially productive examination into individual psychology that could assist to determine the causes leading to radicalization: psychodynamic approaches, identity theory and cognitive approaches.

The psychodynamic approach refers to a combination of psychological features which include narcissism and paranoia and is based on the Freudian tradition of psychoanalysis, thus highlighting the link between violence and post traumatic events.

Identity theory argues that for young individuals in search of identity, ideologies help in identity formation and "joining terrorist groups can act as a strong 'identity stabilizer' providing these young persons with a sense of belonging and purpose" (Dalgaard-Nielsen 2008b). Lastly, according to **cognitive theory** there is a potential link between the cognitive style and the individual's disposition to engage in terrorist acts (Dalgaard-Nielsen 2008b).
A series of **instruments and software applications** may contribute to the identification of factors that make individuals more prone to radicalization. "Profiles of Individual Radicalization in the United States (PIRUS)" is a database which can be explored with the Keshif application, that allows the researchers to analyze different characteristics of 2100 violent and non-violent far right, far left, Islamist or lone extremists who acted in the United States of America between 1948 and 2017. The dataset includes information regarding the characteristics and radicalization processes of the subjects (https://www.start.umd.edu/data-tools/profiles-individual-radicalization-united-states-pirus). *The Belief Diversity Scale* includes 33 items regarding attitudes towards Israel, women, politics, religion, causes, and the West (Bhui et al., 2014). Kennedy et al. (2008) elaborated a 47 items scale, which measures terrorist intentions. Schbley (2003) identified 32 characteristics of a terrorist's profile, including psychiatric aspects and personality factors. *The Radicalization Assessment Monitor* (by Parnassia Group) is an instrument which contributes to the assessment of one's level of radicalization "This monitor identifies a number of risk factors for radicalization (for any type of ideology) such as identity problems, difficult family situation, problems with aggression, sense of hopelessness, status seeking, low self-esteem, inability to resolve problems, absent father, discrimination, and struggles with (cultural) identity. It also describes a number of protective factors that can reduce the risk of radicalization, such as social support, ability to resolve problems, being in a steady relationship, confidence, possessing a certain skill set, and being open and critical" (Paulussen et al., 2017; 10).

The European Psychiatry has emphasized also the reverse possible situation, when people who radicalize and get involved in terrorist activities can lead to mental health instability. The institution proposes that health surveys and censuses should include aspects regarding radicalization and social integration. Also, The International Classification of Diseases and Center for Disease Control included codes for deaths and injuries resulted from terrorist acts, system which facilitates the analysis of terrorist actions and their components (Malik, 2019).

Are mental health disorders a predisposing factor for radicalisation?

It has been well documented and evidenced that no psychopathological profile exists amongst terrorists. Taarnby (2003) argues that terrorists require cognitive and emotional stability to pursue "their plans to fruition, which cannot be achieved with major psychopathology" (Taarnby 2003). However Sarwano (2008) mentions that suicide bombers are not the planners of attacks. This therefore does not rule out the possibility of a mentally unstable disposition in some cases (Sarwano 2008).

Other researchers have also suggested that a personality profile cannot account for individuals who have become radicalized (M. Sageman 2004) (E. 2006) (Veldhuis 2009) (J. Horgan 2008). One hypothesis has been advanced that authoritarian personalities might be more inclined to terrorist behaviour. However, as Veldhuis and Staun (2009) argue, this statement should not be overestimated.

According to Campelo, psychiatric disorders are rare among radicalized youths. Bazex and Benezech found that most of the individuals trialed for radicalization display various dysfunctional personality traits, without having been given a formal psychiatric diagnosis. Only 10% of the individuals in the mentioned study were diagnosed with a psychiatric condition. The others simply displayed anti-social, obsessional and histrionic traits (Campelo, et al. 2018).

However, Gill's work on lone-actor terrorists highlights several cases where the individual experience of mental disorders acted as a background risk factor and combined with a number of more proximal stressors, pushed the individual towards radicalization (J. H. Paul Gill 2014). This is backed up in Corner and Gill's (2015) inferential analysis that compared a sample of mentally disordered lone-actor terrorists with a sample of non-mentally disordered lone-actors. The former group was significantly more likely to experience a recent stressor prior to planning their terrorist attack (Corner and Gill 2015).

Therefore, we can state that, when discussing factors favouring radicalisation, there can only be made reference to possible risk situations or influences: "The notion that social isolation, depression or any other risk factor would produce radicalization rests upon the assumption that exposure to a risk factor causes the outcome of radicalization. What we do not yet know is why people without social isolation or depression go on to radicalization or why most people with social isolation or depression do not become radicalized" (Aggarwal, 2015).

The early research results in the field of radicalization have associated several mental disorders or trauma to terrorists, like antisocial behavior, rage, narcissism, depression, paranoia, enhanced reactions to humiliation, or reduced/ null empathy for the others. Qualitative analyses of the issue, based on interviews with terrorists, have lead to the invalidation of these early results. As such, the lack of statistical results, tests, or control groups have resulted in a continuous need for empirical proof in order to associate certain mental characteristics to a radicalized, extremist or terrorist behavior (Schulten et al., 2019).

The proper understanding of the correlation between mental health issues and radicalization implies the universal understanding of mental health and mental illness, which are subject to

the definition through cultural lenses (RAN (02)). According to The Word Health Organization (WHO, 2018), "mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. Mental health is fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life". The WHO considers as risk factors to one's mental health a series of social, psychological and biological aspects, like poverty, low level of education, rapid social change, stressful working environment, discrimination, social exclusion, or violence, personality, lifestyle, and also genetic factors. On the other hand, "the concept of mental disorders is very broad, as it comprises a broad range of problems that cause mild to severe disturbances in the mood, thinking and behavior of an individual (...) including psychiatric, behavioral and cognitive conditions" (RAN (01), p. 3). The definition agreed within the Radicalisation Awareness Network (RAN (01)), in order to discuss the role of mental health disorders during the radicalization process, includes conditions like depression, bipolarity, schizophrenia, post-traumatic stress disorder (PTSD), or autism (ASD).

The analysis of Misiak et al. (2019) on representative studies which examined radicalization in the context of the presence of mental health disorders revealed an association between depression and risk of radicalization, without resulting whether the issue is the level of resilience or the vulnerability. A study implemented by University College London's department of Security and Crime Science has analyzed 66 terrorist attacks during May 2014 and September 2016. The results showed that 24% of the attackers who sympathize the Islamic State suffered from mental health issues (Holden, 2017).

Radicalization and metal health issues have been observed simultaneously during three type of situations, but only in connection to other factors, like individual, social or political motivational aspects (RAN (02)):

during diagnoses – as a series of disorders have been observed in the case of individuals with a violent behavior, or involved in violent extremism, with a high prevalence of schizophrenia and autism;

psychosocial impairments – situation found in the case of violent individuals;

trauma – violent extremism has been proved to be associated to traumatizing experiences.

Mental illness, as a factor of radicalization, is correlated to others, such as: social ties, political beliefs, cultural background (Bhui, 2018; Andres and Pisoiu, 2016). Poor health, social inequalities, personality features, foreign policy, poor political engagement, migrant status, low social capital, or trigger life events, are all factors that have been identified as drivers to radicalization (Bhui et al., 2014). Case studies have shown that from the range of mental illnesses, psychoses and autism are more common among terrorists (Bhui, 2018).

Analyses run on the dataset "Profiles of Individual Radicalization in the United States (PIRUS)" show that **people who suffer from mental health disorders are more vulnerable to violence than people mentally stable**. At the same time, the dataset results indicate that lone actors present in a higher degree mental illness signs than extremists that act within groups. The statistical analysis of the data resulted with a significant positive correlation between the presence of mental illness and violent behavior, regardless of the time period and of the ideological affiliation (Andres and Pisoiu, 2016).

Shaw, professor of forensic psychiatry at University of Manchester, underlined the fact that people with psychosis and autism are vulnerable to extremist messages which promise them the belonging to a group and give them an identity (Holden, 2017).

Psychiatrist Paul-André Lafleur (Canada), who has worked with former child soldiers of terrorist organizations, evaluated that **extremists are influenced by exterior factors**, like situations that lead to identity crisis, and the only stable aspect in their lives becomes an ideology: "It gives them the sense of an ideal life that they didn't have before. And since it's a cause, it allows them to express their rage and anger, they adhere to this ideology even more" (Derfel, 2014). According to Lafleur, because schizophrenia determines people to be disorganized and loners, extremist attitudes are believed to be more correlated to borderline personality or bipolar disorder, characterized by psychotic behavior (Derfel, 2014).

Among the **explanatory external factors of terrorism** that Schulten et al. (2019) have found, are social, economic or political situations. **Internal risk factors of radicalization**, correlated with mental health disorders, include: a state of helplessness, hopelessness, worthlessness, traumas, uncertainty, or self-victimhood. This type of negative sentiments can lead to suicidal thoughts, depression, and aggressiveness (Bhui, 2015). Malik (2019), the Director of the Centre on Radicalisation and Terrorism at Henry Jackson Society, has affirmed that during her professional experience she has remarked a significant number of attackers who suffer from mental health issues and have experienced domestic violence.

Personality disorders developed at early stages of life, together with a lack of social integration, may lead to radicalized behavior. Even in the case of radicalization, the possible identified causes need to be relevant, such as beliefs, cultural aspects, or personality aspects. (Bhui, 2013).

Psychopathology has been observed along with a range of individual, situational factors, in the case of terrorist behaviors, such as stressful situations, access to weapons, the presence of

ideologies that support violence, extreme ideas, obsessions, radical environments, social isolation, internet influences etc. Also, the empirical results of the study developed by Schulten et al. (2019) argued that mental disorders should be analyzed with a greater focus in case of foreign fighters. Unemployment, marginalization, isolation, poverty, and having been in prison, are all elements that may lead to mental disorders, especially depression (Jones, 2018). Experts and practitioners in the field of radicalization have pointed out the fact that terrorists often register mental health issues, "due to on-line entry, mass recruitment tactics and higher exposure to threats, grievances and propaganda" (RAN (03), 3).

Andres and Pisoiu (2016) underline the fact that diagnosed mental illness is not the only mental health related factor that can lead/ contribute to radicalization, but **emotional trauma** should be taken into consideration as well. Trauma is a factor that has been proved to be correlated to criminal predisposition, without showing a direct causality. PTSD, among other factors, can lead to violent extremism (RAN (01)). Trauma is seen as a response to a traumatic event, which can manifest as fear, a sense of helplessness, and a lack of tolerance, which can lead to an aggressive behavior (RAN (01)). Extremist groups seem to take advantage of the presence of mental health disorders, and exploit such individuals. It is the case exemplified by RAN (01), regarding the situation in Bosnia, where traumatized individuals who come from broken homes, or an abusive environment, have been approached and exploited by extremist groups. In change, the traumatized individuals were offered "comfort" and a "safe environment". On the other hand, French psychiatrist Guillaume Monod indicates cases of returnees from Syria who have chosen to quit the terrorist group they have previously joined and return voluntarily to France as they could no longer cope with the traumatic experience of death and disaster.

Qualitative results run on PIRUS (Andres and Pisoiu, 2016) show that negative feelings like injustice, outrage, the need to get revenged, but also positive feelings like love, can trigger violent behavior. For example, one of the subjects included in PIRUS database, Colleen LaRose or "Jihad Jane" (involved in an assassination attempt), suffered from physical, sexual and mental abuse as a child; Naser Jason Abdo (involved in an attack plan of an army base) has been humiliated by his army companions, and grew up in a family with criminal history; Tamerlan Tsarnaev ("Boston Marathon bomber") suffered from untreated domestic traumas. The analysis indicate that personal trauma, humiliation, abuse, untreated and in the presence of extremist alternatives to gain self-identity or membership to a group or community, can lead disastrous violent results.

Multi-trauma experiences, though, may result in mental health disorders at an older age, which can make an individual become vulnerable to radicalization and extremism. Studies have shown that in order to become radicalized, as result of trauma, an individual would be exposed to other factors as well, like peer group pressure, access to ideological propaganda, aspects that can act as protective and identification factors (RAN (02)).

Substance abuse or the use of addictive substances have been linked to radicalization also, because of the possible impact on adopting a violent behavior (RAN (01)). Substance abuse is seen as a mental disorders also, as it can have an impact over the brain processes, especially during the youth years, when the brain is developing (RAN (01)).

Schulten et al. (2019) have implemented an empirical study, aiming to understand the relationship between mental disorders and terrorism. The methodology included interviews with 4 academics, 4 clinical experts and 1 practitioner, and one focus group. The literature study developed by Schulten et al. (2019) shows that mental disorders have proved to be present in the case of:

- a minority of American right-wing extremists, a minority of French jihadist terrorists – who show signs of psychosis;
- a minority of violent terrorists – who show signs of depression and suicidal predisposition;
- a minority of foreign fighters – who show signs of schizophrenia and psychosis.

Research results after the 9/11 attack in USA show that people who have sympathies for terrorist acts or violent protest are more vulnerable to radicalization than others (Bhui, 2015). Starting from these results, the research conducted by Bhui (2015) has shown that there is a strong correlation between extremist sympathies and being young, enrolled in a full-time formal education system, being a loner, and manifesting signs of depression; the correlation with depression was stronger in the case of the male subjects. Vulnerability to extremist beliefs has not been statistically correlated to frequency of religious worship. Peer pressure, the access to online content and the influence of the entourage can have an important role in one's life choices, especially in the case of youths.

The results of a representative study in two English cities, run on 608 Muslim heritage people aged 18-45, indicate a low percentage of people who sympathize violent protests and terrorist acts. The study highlighted as risk factors to violent radicalization the young age, the high level of wealth and pursuing an education program (Bhui et al., 2014).

Paulussen et al. (2017) have studied the link between radicalization, the foreign fighters phenomenon, terrorism and mental illness in Netherlands. Authors of the study recommended that police or intelligence files be compared with the medical records, and not vice-versa. The discussions with the participants to the study revealed that a high percentage of jihadi radicals, approximately 60% of the subjects, have a mental health condition, from psycho-social issues (e.g. being antisocial, having a borderline personality, relationship problems, behavioral, or emotional issues) to psychiatric disorders (e.g. autism). Notably, approximately 25% of this population of jihadi radicals with mental health issues present severe mental illnesses, and have

proved to play leadership and recruitment roles. The results have underlined **the important role of the family in shaping a foreign fighter**; in most cases, jihadis with mental health issues have experienced either the absence of their father, or an abuse from him during childhood. Some participants evaluated that for part of the foreign fighters, joining a jihadi movement could be the results of trying to run away from the problems they had at home, rather than the influence of a third party. Of course, both push and pull factors have proved to have an important part in joining a violent movement. In the case of women, the trigger for approximately 80% of them has proved to be domestic or sexual abuse, as well as the existence of a post-traumatic stress syndrome (PTSS), personality disorders, suicidal tendencies, or psychotic symptoms. The results of the study implemented by Paulusses et al. (2017) indicate that women, in opposition to men, tend to internalize these mental issues. Substance abuse has also played a role in shaping a conflictual behaviour in some of the men investigated by the experts who participated to the study.

According to Schulten et al. (2019), psychopathology is more common in the case of **lone actors** than of terrorists that act within groups. The mental disorders found frequently in the case of lone actors are schizophrenia, delusions and autism. Studies have shown that terrorists who act within groups are responsible for approximately 95% of the attacks.

The British project *LONDON (Reuters)*, which aimed at analyzing the connections between terrorism and mental health disorders, has been extrapolated from three English cities (London, Birmingham and Manchester) to national level, after identifying a significant number of individuals part of counter-radicalization programs, who also present mental health problems. Holden (2017) highlights the fact that the so-called "lone wolves" attackers have proved to suffer from mental health disorders in a higher proportion than attackers that work as part of groups. The study developed by Misiak et al. (2019) also highlights the association between loan actors and mental health disorders. Experts in the field have linked mental health disorders and the process of radicalization. While studies in the field haven't found a direct connection between the two aspects, it has been observed that in the case of lone actor terrorists, mental health disorders are more common than in the case of terrorists that act within groups (RAN (01)). The results did not indicate a direct correlation, though, between mental disorders and criminal behavior.

Trauma and Post Traumatic Stress Disorder:

Trauma is a very broad term. As a psychological term it basically means a rupture in one's psychic well-being. The rupture can be caused by a specific event or by a series of events. It can also be chronic, like living in an abusive environment or in conflict areas. Such an event can be witnessing violence against family, friends or the wider group an individual identifies with, directly, indirectly or vicariously.

The exposure to these events may cause trauma and possibly Post-Traumatic Stress Disorder (PTSD). Speckhard further argues that these traumatic events can also cause dissociation (a feeling of separation from the body, thoughts, perceptions and/or emotions), which has been offered as an explanation for a number of cognitive responses to trauma (Speckhard 1993). Such trauma may cause an individual to become fixated on revenge and the defense of the group regardless of risk to one's life or well-being (Neil Ferguson and Eve Binks 2015).

Radicalization processes may be strongly connected to trauma. Trauma can produce a kind of "cognitive opening" for people who have experienced it directly. The idea is that a traumatic event fractures the existing worldview to such an extent that one becomes more receptive to alternative ideas, such as those presented by radical groups. The prior traumatic experience encourages a more cut and dry, black-and-white worldview, which radical groups offer.

The terrorist lifestyle obviously involves exposure to violent and traumatic situations. Studies of analogous behaviors like engaging in war or attending a gang highlight that such violent and traumatic situations may lead to psychological problems. For example, conflict experience has induced post-traumatic stress disorder (PTSD) in individuals (Jordan 1991). This disorder is recognized as manifesting in those considered to have no history of mental disorder (Weatherston 2003).

Depression

Depression (major depressive disorder or clinical depression) is a common but also serious mood disorder. (Larry E. Beutler 2007) It causes severe symptoms that affect how one feels, thinks, and handles daily activities, such as sleeping, eating, or working (Health n.d.).

Some risk factors for depression include major life changes, trauma or stress, certain physical illnesses and medications. Bouzar found that 40% of jihadists in a French sample had suffered from depression (Weenink, Behavioral Problems and Disorders among Radicals in Police Files 2015).

Conclusion

The literature review points out that the pathway towards terrorism may be influenced by mental health disorders. Individuals with mental health disorders are the exception rather than the rule. Although there is no specific profile leading to radicalization, the multiple psychological vulnerabilities may play a role in the radicalization process.

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Chapter 2

What happens when radicalized individuals suffer from mental disorders?

Psychic symptoms and psycho-sociological markers displayed by radical individuals

Studies made on psycho-sociological markers could not reach an agreement as to a set of features that can be encountered in all investigated communities. Indicators vary from one community to another and from one country to another.

In a study dedicated to *Behavioral Problems and Disorders among Radicals in Police Files,* Anton W. Weenink explored "to what extent behavioral problems and disorders can be found in a sample of radical Islamists that are known to the police in the Netherlands as actual or potential 'jihadists'". Thus, Weenink analyzed **140** subjects who are considered to have traveled from the Netherlands to Syria, or on whom police had information that they might be preparing to do so and who were therefore entered in police databases (Weenink, Terrorism analyst n.d.). The results of the study demonstrate that the subjects had some characteristics such as:

"that many subjects in our sample seem to come from broken families; six subjects had lost a parent, in two cases due to suicide. Additionally, educational achievements tend to be rather low. We could not find a subject with a completed higher education in the sample thus far. Subjects either did not finish high school or vocational training, or became unemployed afterwards. We did not find subjects who had had a steady career; when they were employed, it was mainly in irregular jobs. As mentioned, several individuals had been homeless – six were at the moment of registration on the LOP–for longer or shorter periods of time. Homelessness seems to be related to conflicts with parents and partners, or with finding no place to live after detention".

In twenty individuals, five women and fifteen men, he found indications of serious problem behavior, or indications of a mental health problem of which he did not find a diagnosis. Also, he found that subjects analyzed have been diagnosed with a mental health disorder. The descriptions reveal comorbidity of difficulties in individuals, and many individuals come from "multi-problem" families.

In France, on the other hand, as psychiatrist Guillaume Monod testifies, in a group of about 60 French prisoners who either attempted to leave for Syria or made it to the conflict zone and returned, 30 of the prisoners had higher education degrees. Similarly, only 1 out of 7 of the mentioned French prisoners had previously served time in prison.

Another study conducted by Corner, Gill and Mason's (2015), demonstrates that individuals with mental health disorders have been involved in terrorism acts, especially the lone-actor terrorists. They empirically compared a sample of mentally disordered lone-actor terrorists with a sample of non-mentally disordered lone-actor terrorists. They found that those who were mentally

disordered were just as (and in some cases more) likely to engage in a range of rational pre-attack behaviors as those who were not (Corner and Gill 2015).

Sample of 153 lone-actor terrorists
1.3% experienced Traumatic Brain Injury (TBI),
0.7% drug dependence, 8.5% schizophrenia,
0.7% schizoaffective disorder,
2.0% delusional disorder,
0.7% psychotic disorder,
7.2% depression,
3.9% bipolar disorder,
1.3% unspecified anxiety disorder,
0.7% dissociative disorder,
1.3% Obsessive Compulsive Disorder (OCD),
3.3% Post-Traumatic Stress Disorder (PTSD),
0.7% unspecified sleep disorder, 6.5% unspecified personality disorder, and
3.3% autism spectrum disorder.

Source: Corner, Gill, and Mason's (2015)

Three disorders exhibited a higher prevalence in the lone-actor sample than in the general population. The disorders are schizophrenia, delusional disorder, autism spectrum disorders. Three disorders exhibited a lower prevalence in the lone-actor sample than in the general population (depression, sleep disorders, and learning disabilities) (E. G. Corner 2015). Both studies highlight the higher proportion of schizophrenia within their samples compared to the wider population. It is important to note however that neither sample is representative of the vast majority of terrorists.

Corner and Gill (2015) utilized a sample of 119 lone-actor terrorists and investigated whether certain behaviors were more likely to co-occur with certain diagnoses than others. Those diagnosed with schizophrenia and associated disorders were the only diagnostic group to be significantly associated with previous violent behavior and this supports past research in the general violence literature (Corner and Gill 2015).

Victoroff (2005) stated that "radicals might be particularly sensitive to humiliation or perceived oppression, they might be novelty seeking, identity seeking, depressed, anxious, or vulnerable to charismatic influence. Perhaps they are, in comparison to non-radicals, more impulsive and lacking self-control" (J. Victoroff 2005).

Also, the same author provided an overview of theories of terrorist behavior and came up with a variety of psychological variables on which radicals can potentially be distinguished from each other, and from non-radicals. For instance, and to a large extent this is influenced by culture, some people are simply more violent, anti-social, or aggressive than others.

If we are to talk about **the link between depression and radicalization**, some researchers found that "depressive symptoms independent of psychosocial adversity were associated with sympathies towards violent protests and terrorism" (Bhui K 2014).

Some authors state that "terrorists are essentially normal individuals", "normal" meaning that they are no more or less likely to experience particular mental disorders than the average individual (Zartman 2007) (Wilson 2010, McDonald 2013) and that the attempts to , "assert the presence of a terrorist personality, or profile, are pitiful" (J. Horgan 2003).

According to Silke, the best of the empirical work does not suggest, and never has suggested, that terrorists possess a distinct personality or that their psychology is somehow deviant from that of "normal' people" (A. Silke 2003) (Silke and Schmidt-Petersen 2015).

Mentally ill terrorists are capable of sophisticated attack planning. Gill, Horgan, and Deckert (2014) highlight that lone-actors diagnosed with mental illness frequently display rational motives and engage in rational and purposive pre-attack behaviors (Gill, J. and Deckert 2014).

Borum (2013) notes numerous mentally ill lone-actors who were capable of sophisticated attack planning (R. Borum 2013). Fein and Vossekuil also found evidence of mentally ill individuals planning and executing attack related behaviors, as effectively as non-mentally ill actors (Fein 1999).

A misconception is that citations treat terrorism in an often generic manner. They fail to acknowledge that being a bomb-maker may be different than being a bomb-planter; that being a foreign fighter may differ from being a terrorist attacking the homeland; that being a terrorist financier may be different than being a gunman; and that being a lone-actor may be different than being a group-actor.

How to deal with the radicalization of individuals with mental health issues?

Experts and practitioners in the field propose **a comprehensive approach** in preventing radicalization in case of persons who suffer from mental health disorders. The process includes three perspectives (RAN (04)):

early prevention – by implementing detection systems and improve access to mental health services,

risk behavior – implementing anticipatory multi-level interventions, by engaging experts in health, education, social services, local authorities etc.

treatment and disengagement – individuals who have committed or are on the verge of committing criminal acts are subject to programs of intervention that target to support them in disengaging from further criminal acts and extremist environments. The process implies the collaboration between health services, the police, the prison and probation services, and local municipalities

Having as base previous explanations of adopting a radical behavior, which underline factors such as persuasive ideologies, poor living conditions, or discrimination, Bhui (2015) has used **the public health approach** in order to understand the risk factors of radicalization. The approach implies the identification of threats, risk factors and resilience factors. Since it has proved to be efficient in the processes of preventing suicide, violence and mental illness, the author proposes the method in the process of preventing radicalization. A public health agenda in the process of preventing radicalization may include cultural identification, social integration, religious differences, generational differences, discrimination awareness, or foreign policies (Bhui, 2013). The prevention activities could results from the collaboration between epidemiology, psychology, sociology, aiming to understand the aspects used in the recruitment process (Malik, 2019).

Criminal justice actions in preventing radicalization have been evaluated as not so efficient methods (Bhui, 2018). Also, in the case of young people, criminalizing acts may prove to be counter-productive: "Young people have a different way of seeing risk – they feel omnipotent. (…) We've got to own our young people – we can learn from them and criminalizing doesn't help." (Bhui, K., Everitt, B. and Jones, E., 2014). Instead, the public health intervention might contribute to preventing people become vulnerable to radicalization, by providing emotional and social contexts for their personal development and social integration. The public health approach can include providing education on cultural identities, providing safety, debating on politics, actions which are associated to community narratives etc. (Bhui, 2013).

Prevention of radicalization implies **working with young people**, as mental health has proven to be more stable in case of people with bi-cultural identity than of converted people to different cultures (Bhui, 2013). In the case of young people, a few methods have been proposed by specialists in the field (Bhui, 2015; Bhui, 2013; Schuurman et al., 2019; RAN (02)), in order to avoid joining gangs or radicalized behavior:

- raising their self-esteem;
- providing religious teaching;
- offering access to accurate history;
- exercising debating skills;
- offering social support;
- providing safe environments and networks;
- inspiring high aspirations for their future, related to education or professional carreer;
- offering alternative narratives to their convictions;
- ensuring a safe environment;
- teaching how to cope with negative emotions;

- access to trust-worthy relationships.

These methods imply the awareness, training and collaboration of schools, families and communities. The proper education in this direction can be achieved only in the context of "high quality empirical research about the process of violent radicalization, 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 radicalization" (Bhui, 2013, p. 26).

Involving mental health experts and social workers in the process of preventing and countering radicalization, extremism and terrorism, may register positive results at local level. The process may stress the importance of collaboration with the local community and authorities, in order to develop abilities of identifying vulnerable individuals and raise the trust level into law enforcement agencies. Andres and Pisoiu (2016) highlight the necessity to understand the role of the mental factor into the radicalization process, along with other trigger factors. The process implies the development and implementation of research methodologies that aim at solving this type of situations (Andres and Pisoiu 2016).

Jones (2018) proposes **the development of cultural models** dedicated to persons who have been stigmatized, socially isolated, traumatized or abused, in order to prevent the leaning to a radicalized behavior. These type of actions imply the collaboration of governments and local authorities.

The WHO (2018) stresses on the importance of **promoting and protecting the people's mental health**. This implies the creation of an environment "that respects and protects basic civil, political, socio-economic and cultural rights (...).Without the security and freedom provided by these rights, it is difficult to maintain a high level of mental health." Also, the national policies should include not only mental disorders aspects, but also the issue of maintaining mental health: "in addition to the health sector, it is essential to involve the education, labor, justice, transport, environment, housing, and welfare sectors". Among the methods of promoting mental health, WHO (2018) proposes:

- providing stability since childhood, including health, food, protection, education, support, interaction;
- sustaining the socio-economic development of women;
- providing social support for the elders;
- developing programs for vulnerable categories, like minorities, or migrants;
- implementing development programs in schools;
- developing mental health programs in working environments;
- implementing programs for the prevention of violence;
- implementing community development programs;
- implementing anti-discrimination awareness campaigns;
- sustaining the rights and opportunities of the people who suffer from mental disorders.

Mental health disorders may be a risk factor for radicalization for any type of individual who supports violence or acts violently. These persons usually have a history of difficulties in

different aspect of their lives, like relationship, school or work environments. Mental health approaches in working with this type of individuals, who can be detected, in most cases, when a crisis occurs, may include (RAN (02)):

- implementing mechanisms of strengthening protective factors;
- implementing intervention and rehabilitation processes for individuals who act violently;
- implement awareness actions for individuals with special needs;
- implementing monitoring activities for best practices and needs of improvement in the field.

Bhui (2013) stressed on the importance of the changes that come with a migration process, that need to be assessed in a prevention process. This can be achieved by acting on a religious, cultural and personal identity level. Also, integrating migrants in safe networks and communities, and even supporting them in being close to their families, makes them less vulnerable to radicalization.

Even though mental disorders have been found in the situation of many radicalized individuals, it hasn't been proved scientifically that it is the trigger factor. Having this in mind, any countering and preventing program should also include the objective of not stigmatizing people with mental health disorders, as they cannot be automatically linked to terrorism (Holden 2017).

Conclusions

Recognizing the signs of mental disorders might be crucial in preventing radicalization. Mental health disorders relevant to radicalisation processes include a series of psychiatric disorders, from anxiety and depression, to schizophrenia (Jones, 2018). These mental problems can have a high impact over one's attitude, behavior and beliefs. If the presence of mental health disorders may lead or not to radicalization hasn't been proved scientifically, but the analysis of casestudies shows that this can be one of the factors making an individual more vulnerbale, unless protective factors are implemented (Schulten et al., 2019). The presence of mental disorders, in correlation to such factors, can trigger a violent behavior. Without proving a direct causality, statistical analyses indicated a positive correlation between mental disorders and violent behavior (Andres and Pisoiu, 2016). Also, emotional trauma has proven to be linked to violent predispositions (Andres and Pisoiu, 2016).

Other studies have concluded that the lack of cognitive and executive capacities usually cannot be overcome in the case of persons with severe psychological dysfunctions, reason for which this category of individuals does not represent a significant vulnerable population in risk of radicalization. In case of terrorists affiliated to a group, psychopathology did not prove itself a factor of radicalization, while in the case of lone actor terrorism, mental disorders seem to play

a certain role. At the same time, from the range of mental illnesses, psychoses and autism are more common among terrorists (Bhui, 2018).

Professionals in the field have agreed that radicalized individuals need to be apporached in a comprehensive program, in which inter-disciplinary cooperation (psychological, legal, social, education etc.) plays a central role. While criminal justice actions are not considered particularly efficient in prevention, public health interventions provide an efficient approach, when implememnted from young ages (Bhui, 2013; 2018). The promotion and protection of people's mental health has been suggested as a necessary ongoing preoccupation (WHO, 2018). Many studies emphasize the high level of vulnerability in case of migrants (Bhui, 2013), youngsters (Bhui, 2015; Bhui, 2013; Schuurman et al., 2019; RAN (02)) and foreign fighters (Schulten et al. (2019). Therefore, it is important that any preventing or countering action be focused on avoiding stigmatization (Holden, 2017).

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Chapter 3

Lone actors experiencing mental health disorders

Definition

There is a variety of definitions for lone actor terrorism. Most of them focus on the modus operandi of lone actors, and usually define lone actors as individuals that operate in isolation from organized networks (Spaaij 2012) (Crisismanagement 2007). Other definitions emphasize that lone actors are individual terrorists executing attacks on their own, but maintaining contacts with organized extremists during the radicalization process. The analysis unit of the Danish Police Intelligence service, CTA, introduced a distinction between lone actors and solo terrorists, the former operating in isolation, without having any connection to a terrorist organization, and the latter having ties to violent extremist or terrorist networks (Spaaij 2010), but acting individually under direct instructions (Graaf 2011). As a consequence, a number of authors have distinguished between lone actors acting under no direction from a terrorist group, but this does not necessarily imply an absence of links, and individual actors acting under the instructions of a terrorist organization (Nesser 2010) (Pantucci 2011) (Spaaij 2010).

Jessica Stern defines lone actor terrorists as "small groups who commit terrorist crimes, inspired by a terrorist ideology, but do not belong to established groups" (J. Stern 2003). Other authors focus specifically on individuals, excluding attacks committed by small cells even where they act in isolation from a broader terrorist network (Randy Borum 2012) (S. C. Jeff Gruenewald 2013) (Spaaij 2010). Pantucci even suggests that such small groups form their own subset and named this typology "lone wolf packs" (Pantucci 2011).

A more detailed definition of lone actor terrorism is offered by the CLAT Project: „The threat or use of violence by a single perpetrator (or small cell), not acting out of purely personal material reasons, with the aim of influencing a wider audience, and who acts without any direct support in the planning, preparation and execution of the attack, and whose decision to act is not directed by any group or other individuals (although possibly inspired by others)" (Clare Ellis 2016).

For the purpose of this study we will retain that lone actors are persons who "(a) operate individually, (b) do not belong to an organized group or network; and (c) whose modus operandi is conceived and directed by the individual without any direct outside command or hierarchy" (Spaaij 2010).

The characteristics of lone-actor terrorists

The general consensus in the specific literature is that it is not possible to profile terrorists. Accepting this limitation, we can still notice some patterns/ characteristics of lone actor perpetrators. A literature analysis provided certain characteristics of lone actors as respects gender, age, ideological drivers of lone actor terrorism, education and relationship status. Another characteristic is the prevalence of mental health disorders. However, the results indicating a mental health disorder need to be compared to benchmarks of local, national or international health organizations. Moreover, it is important to consult mental health experts to

judge the findings. Therefore we will analyze the literature results in a separate paragraph in the following.

To begin with, most of the studies indicate that the lone actor "profile" is heavily **male** oriented (S. C. Jeff Gruenewald 2013) (J. H. Paul Gill 2014) (Clare Ellis 2016). The percentage of male lone actors is over 85%. In a study by Jeanine de Roy van Zuijdewijn and Edwin Baker, 96% of perpetrators are male (Baker 2016).

According to Gill, Horgan and Deckert, the **average age** of lone actor perpetrators is 33 years. The number exceeds the Colombian militants that have an average age of 20 years, the Provisional Irish Republican Army at 25 years or Al-Qaida-related terrorists at 26 years (J. H. Paul Gill 2014). The lone actors in Gruenewald, Chermak and Freilich's study were found to be in their late thirties (S. C. Jeff Gruenewald 2013).

However, it seems that with the increasing use of the Internet and social media, the average age of lone actors began to decrease as a reflection of the user base of social media. (Michael Wolfowicz 2017). More recent studies indicate that **males in their 20's** are most likely to turn from belief to action (Michael Wolfowicz 2017).

Regarding **ideology**, there are **three dominant ideological drivers** that can be identified: right-wing, jihadist ideology and idiosyncratic, self-developed ideologies. Daesh has repeatedly advocated the use of lone-actor-style attacks through its propaganda.

While it may appear contradictory, most recently, far-right extremists are taking inspiration from Islamist terror groups, molding their own ethno-nationalist ideology and using the reach of social media and other online platforms to spread it across borders, targeting a younger, more tech savvy audience, who it hopes to mobilize for what it sees as a long-term struggle against radical Islam.

However, these ideologies have very different age profiles. When correlating age with ideology, it seems that most of the older perpetrators are right-wing and few of them religiously-inspired. The younger perpetrators are mostly religiously inspired (Baker 2016). In their dataset, Jeanine de Roy van Zuijdewijn and Edwin Baker, found that the youngest group, aged less than 25 years, was in a high percentage religiously inspired (47 %) (Bakker 2016).

In contrast, among the perpetrators aged over 40 years, 47 % were right-wing extremists and 21% religiously inspired (Bakker 2016).

The media, and consequently public attention, is largely focused on violent Islamist extremists. Despite this, it seems that right-wing extremists are **responsible for** substantially more **fatalities**. Within the CLAT dataset, including the attack by Breivik, right-wing attacks caused 260 injuries and 94 fatalities, while religiously-inspired attacks killed sixteen and injured 65 people. These findings clearly indicate that right-wing extremists represent a substantial aspect of the lone-actor threat and must not be overlooked (Clare Ellis 2016).

Regarding **prior convictions**, half of the far-right terrorists examined in Gruenewald, Chermak and Freilich's study had "evidence of prior arrests" (S. C. Jeff Gruenewald 2013). It seems there is a prevalence of previous convictions among lone actors (Fredholm 2011): 41.2 % of lone-actor cases had previous criminal convictions (J. H. Paul Gill 2014) - of this subset 63.3% had served time in prison and whilst in prison 32.3% experienced radicalization that ultimately led to an attack.

A misconception questioned by the research regards the general belief that lone actors are **socially isolated persons**. Studies indicate the opposite (Eby 2012): they are "relatively well educated and relatively socially advantaged" (Spaaij 2012). Eby points out that "lone wolf terrorists are not necessarily lower-class residents with no prospect of social mobility … [and are] as likely to be employed as unemployed" (Eby 2012). In the religiously inspired group, the percentage of those socially isolated is very low (9%) (Baker 2016).

In the CLAT dataset, the youngest group, aged younger than 25 years old, showed the highest percentage of social isolation at 36 %. The percentage of social isolation at those aged 25–39 years was of 25%, whilst those aged at over 40 years old presented the lowest figure of 11%. In line with this, the youngest age group (younger than 25 years old) manifested the highest percentage of suggested mental-health disorder (40%) (Bakker 2016).

Regarding **the education of lone actors**, the data are distributed relatively evenly: in Gill, Horgan and Deckert's study, 24.7 % of actors attained the lowest level of education of high school or equivalent; 20.8 % achieved the highest level of graduate school and the remaining actors completed a level between the two (J. H. Paul Gill 2014). **Employment** data suggest a higher rate of deprivation after completing education. Within the same study's sample of 112 individuals, 40 % were unemployed.

In assessing the threat posed by an individual, the research suggests that previous military training or experience and weapon choice are potentially important factors. A 26% level of **military experience** is noteworthy within Gill, Horgan and Deckert's sample (J. H. Paul Gill 2014) since the general population percentage is 13 %.

Gill, Horgan and Deckert's dataset also highlights the potential significance of the perpetrator's **relationship status** as 50 % of lone actors were single and had never been married (J. H. Paul Gill 2014).

From the above mentioned we can conclude that unlike we expected, lone actors are not socially isolated persons. Another important detail is that those **aged under 25** have the highest percentage (40%) of mental-health disorders (Bakker 2016) and their attacks are mostly religiously inspired (45%) (Bakker 2016). In the following we will highlight the link between violence and mental disorders on one side, and between mental health disorders and lone actor terrorism, on the other.

Lone actors and violence

The research results obtained by Schuurman et al. (2019) propose the reconsideration of the "lone wolf" or "lone actor" typology, in relation to the factors of radicalization. Their empirical efforts have proved that the motivation and behavior susceptible to radicalization and criminal acts are correlated to radical milieus, both in online and offline environments. Attackers described as "lone wolves" result to have connections with certain groups, according to their interests – political, operational etc.. Schuurman et al. (2019) have studied lone actor extremism in Europe and United States, in case of 125 attackers who have been active between 1978 and 2015. The researchers consider that the term "lone wolf" implies a certain degree of cunning, which is not necessarily available, so they propose the use of the term of "lone actor". Factors like peer-pressure, polarization or leader-influence are not available in the case of this type of attackers. The loneness of the lone actors most often results after social changes - they cannot integrate, or just because of their lack of sociability or mental health disorders. Some lone actors experience the exit from certain terrorist groups, sometimes on a non-voluntary basis, so they act by themselves. The involvement of lone actors in radical networks offer them access to role models and also a frame for a justification of their terrorist acts; being exposed to extremist ideologies and authority figures contribute to the process of overcoming guilt. The results obtained by Schuurman et al. (2019) indicate that 78% of the lone actors they have studied were influenced by external figures to use violence, and under a third of the sample has received assistance by external sources in preparing the attacks.

The lone actors have also been analyzed in relation to possible extremists returning from Syria's civil war; these individuals pose a threat in the context of their paramilitary training, war experience and previous interactions with terrorist networks. Schuurman et al. (2019) suggest analyzing this threatening possibility through a multi-disciplinary collaboration between academics, practitioners and policymakers.

Schuurman et al. (2019) found that most often the **lone actors** connect to other groups or persons starting from the process of radicalization, to the planning of the terrorist act itself, fact which makes them detectable for the law enforcement agencies or intelligence services. Also, they seem to act by themselves after having attempted to recruit followers and have failed, because of their lack of social skills, or mental disorder. The analysis of lone actors' profiles indicate that they usually don't have operational skills, auto-evaluate themselves as very important and despise the potential partners. Also, they tend to give hints of their intentions long before starting the terrorist act. It is the case of 86% of the sample analyzed by Schuurman et al. (2019), who shared their convictions with others long before committing attacks, and 58% provided actual indications.

Studies on lone actors (Schuurman et al., 2019); Andres and Pisoiu, 2016) have outlined a series of typical actions and behaviors that may indicate violent intentions:

- expressing the admiration for murderers;
- sustaining the activity of people who facilitate abortion;

- expressing online a racial discourse;
- disseminating execution videos;
- critically addressing the Government's activities and decisions;
- expressing the desire to act radically, violently, or threatening persons or properties;
- ignoring operational security and not keeping the secret of their intentions or actions;
- being exposed to mental or physical abuse.

Mental health disorders comprise a broad range of problems, with different symptoms. They are generally characterized by a combination of abnormal thoughts, emotions, behaviour and relationships with others. Examples are schizophrenia, depression, intellectual disabilities and disorders due to drug abuse (World Health Organization 2019).

Violence in the context of mental disorder can be especially sensationalized, which only deepens the stigma of the patients (M. E. Welton 2008). Mental disorders may increase the likelihood of committing violence in some individuals, but only a small part of the violence in society can be ascribed to mental health patients (M. E. Welton 2008).

Violence and mental disorders share many biologic and psychosocial aspects. Individuals with mental disorders, when appropriately treated, do not pose any increased risk of violence over the general population. Violence may be more of an issue in patients diagnosed with personality disorders and substance dependence (M. E. Welton 2008).

Multiple different disorders have been linked to violence and criminality.

The diagnoses associated with violence are substance abuse disorders, psychotic disorders, affective disorders, Cluster B personality disorders, conduct and oppositional defiant disorders, delirium and dementia, dissociative and posttraumatic stress disorders (M. E. Welton 2008).

Holcomb and Ahr found that patients with alcohol or drug use had more arrests over their lifetime than patients with schizophrenia, personality disorders, or affective disorders (Holcomb W 1988). Steadman and colleagues determined that patients with concomitant mental disorders and substance abuse were 73 percent more likely to be aggressive than were nonsubstance abusers, with or without mental disorders (Steadman HJ 1998).

Swanson, et al., found that the rate of violence among those with a mental disorder was twice that of those without one, but violence was not more prevalent in persons with schizophrenia than among those with other disorders (H. C. Swanson JW 1990).

Brugha et al. highlight that weighted prevalence of psychosis in prisons was over ten times greater than the general population (52 per thousand compared to 4.5 per thousand) (Traolach Brugha 2005).

Elbogen and Johnson statistically demonstrated that schizophrenia, bipolar disorder and major depressive disorder were only reliable predictors of violence when there was substance abuse/dependence co-morbidity (Johnson 2009).

In a cross sectional survey of disorder prevalence across nonviolent men, violent men, and gang members, Coid et al. noted prevalence differences across six disorder groups (psychosis, anxiety, depression, alcohol dependence, drug dependence, anti-social personality disorder) (Jeremy W. Coid 2013). Gang members bore the highest prevalence across all disorder groups. Prevalence differences between violent men and gang members ranged between 11.2 percent for depression, and 56.6% for anti-social personality disorder.

Fazel, Doll, and Langstrom performed a systematic meta-analysis of 25 surveys concerning mental disorder prevalence in juvenile detention settings, observing gender differences in prevalence of four disorder groups (Seena Fazel 2009). Psychotic illness and conduct disorder held equal prevalence across genders, however, major depression (29.2 % compared to 10.6 %) and attention deficit hyperactivity disorder (ADHD) (18.5 % compared to 11.7 %) were more frequently identified in females.

Mental health disorders and lone actors

Mental health disorders include a wide range of disorders, from depression to paranoid schizophrenia. It is necessary to distinguish these types of disorders to understand the role of mental illness in lone-actor terrorism. The reporting of clinical diagnoses among lone-actor perpetrators is rare. It should be distinguished between cases where a clinical diagnosis has been made and those which rely on proxy indicators (such as news reporting that alludes to mental health disorders), as it might not be possible to find accurate information about diagnoses in many cases (Bjornsgaard 2015).

Much of the research points to a strong link between mental disorders and lone-actor violent extremists rather than group actors (O'Driscoll 2018).

Gruenewald, Chermak and Freilich found that 40 per cent of the lone actors in their dataset experienced mental disorders, which was significantly higher than the 7.6 per cent among the group-based actors (S. C. Jeff Gruenewald 2013). Recent work by Emily Corner and Gill concluded that a lone actor is 13.49 times more likely to have a mental disorders than an actor within a terrorist group (P. G. Emily Corner 2015).

In a research project conducted by the Centre for Terrorism and Counter terrorism at the Leiden University in the Netherlands focusing on the mental health aspect of lone actor terrorism, in 32% of cases there was some indication reported of a mental health disorder whereas this percentage decreased to 23% in terms of an actual clinical diagnosis of such a mental health disorder. However, for 62% of the cases a clinical diagnosis was unknown. In some of these cases, it meant that the direct environment of the perpetrator - family, friends, colleagues – indicated that the perpetrator was allegedly receiving some kind of treatment for a mental health disorder. In other cases, it meant that the direct environment reported that they were aware of the fact that the perpetrator had been suffering from mental health disorders.

The same research project found a significant difference in the score obtained by ideological groups with regard to mental health disorders. For all clearly defined ideologies (religiously-inspired, right-wing and single issue), the authors found scores below the overall average (respectively 24%, 28% and 33%). The score that highly deviated from the average was found in the group "other", where we found a figure of 70%.

The group "other" is inherently different from that of individuals asherring to established ideologies: it is the group with the least well-defined ideology, with perpetrators who often "cut and paste" from different sources to form their own particular subset of ideological influences (Baker 2016).

In a study of Islamic State-influenced attacks, it was found that the occurrence of mental disorder was comparable to the global average, however those that were inspired by the Islamic State rather than directed by them had a higher occurrence of mental disorders than the global average (P. G. Emily Corner 2016).

Alongside studies of mental disorders, personality issues are also examined in the scientific literature. Individuals who become lone-actor terrorists tend to exhibit social problems to varying degrees (Spaaij 2010). As the ICCT concisely summarises, "one common characteristic among lone wolves is that they do not "work and play well with others"' (Graaf 2010). These difficulties can result in social alienation, which Gill found to be prevalent within his database of 119 offenders (P. Gill 2013). Literature suggests that social problems can act as a barrier to joining wider terrorist groups (Spaaij 2010).

It was also revealed that significant personal events or grievances can play a central role in the radicalization process. In Clark McCauley and Sophia Moskalenko's study, there are identified four common characteristics, which include grievance and "unfreezing" (defined as "a situational crisis of personal disconnection and maladjustment") (Moskalenko 2014). Nesser similarly concluded that "personal frustrations appear to have been an important factor behind the ideological radicalisation" (Nesser 2010).

Mental disorders that have a substantially higher prevalence in the lone-actor

Early studies highlighted very specific mental disorders like psychopathy or personality disorders such as narcissism (C. Lasch 1979). Later, highly influential literature reviews were correct to question the data quality, assumptions, and methodological rigor of many of these early "studies" (J. Horgan 2005) (J. Victoroff 2005) (A. Silke 1999). These reviews illustrate a lack of evidence to suggest that very specific forms of mental disorders are caused terrorism.

Schizophrenia:

Schizophrenia is a mental disorder that is characterized by hallucinations (auditory, visual, olfactory, or tactile) and delusions. Because these delusions and hallucinations feel as real as the world around them, a person with untreated schizophrenia can sometimes have trouble distinguishing actual reality from this altered reality that their brain is telling them. It is usually treated with a combination of antipsychotic medications and psychotherapy (Grohol 2019).

People with schizophrenia suffer from some of the greatest prejudice, stigma, and discrimination associated with any mental disorders (National Institute of Mental Health 2019).

Schizophrenia has long been accepted as having a contentious link to violent behavior (P. G. Emily Corner 2016).

In a study of 140 radical Islamists from the Netherlands whom were suspected of joining or planning to join the fight in Syria the prevalence of schizophrenia was 2%, which is double that of the general population (Weenink 2015).

Delusional disorder:

Delusional disorder is characterized by the presence of either bizarre or non-bizarre delusions which have persisted for at least one month.

Non-bizarre delusions typically are beliefs of something occurring in a person's life which is not out of the realm of possibility. All of these situations could be true or possible, but the person suffering from this disorder knows them not to be (e.g. through fact-checking, third-person confirmation, etc.).

Delusions are deemed bizarre if they are clearly implausible, not understandable, and not derived from ordinary life experiences. Delusions that express a loss of control over mind or body are generally considered to be bizarre and reflect a lower degree of insight and a stronger conviction to hold such belief compared to when they are non-bizarre.

People who have this disorder generally don't experience a marked impairment in their daily functioning in a social, occupational, or other important setting. Outward behavior is not noticeably bizarre or objectively characterized as out-of-the-ordinary.

The lifetime prevalence of delusional disorder has been estimated at around 0.2%. (Bressert 2018).

Delusional disorders also hold a litigious link with violence. Those with delusional disorders hold stringent beliefs, seen by others as inconceivable. Parallel to this, lone-actors show high preponderance of single-issue ideologies; highly personal grievances linked to political aims (P. G. Emily Corner 2016).

Autism spectrum disorders (ASD):

Autism spectrum disorder (ASD) is a developmental disorder that affects communication and behavior (National Institute of Mental Health 2018).

According to the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*, people with ASD have:

Difficulty with communication and interaction with other people;

Restricted interests and repetitive behaviors;

Symptoms that hurt the person's ability to function properly in school, work, and other areas of life (ASP 2013).

Autism is known as a "spectrum" disorder because there is wide variation in the type and severity of symptoms people experience. ASD occurs in all ethnic, racial, and economic groups (National Institute of Mental Health 2018).

People with ASD have difficulty with social communication and interaction, restricted interests, and repetitive behaviors (National Institute of Mental Health 2018).

ASD show a higher than expected prevalence in the lone-actor sample. Although individuals with ASD are not linked to violent behaviors, social interaction deficits impair an individual's ability to maintain functional relationships. However, these individuals often foster intense online relationships, a trait noted in lone-actors with ASD (P. G. Emily Corner 2016).

Conclusions

Significant criticism has been brought to research that links mental disorders to violent extremism. Most invoked reasons include the fact that it does not traditionally involve interviews with perpetrators to assess mental health, it has not historically disaggregated the data across actors and mental disorders, and it does not examine the temporal ordering of risk factors across those engaged in violent extremism.

It is argued that no mental health disorder appears to be a predictor of terrorist involvement and is rather just one of the many risk factors that push and pull individuals towards terrorist engagement. However, research studies clearly show a link between cases of lone actor perpetrators and some mental health disorders, such as schizophrenia, ASD and delusional disorders. It could be noticed from the above mentioned studies that these mental health disorders are more prevalent to those individuals aged below 25 years and religiously inspired.

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Chapter 4

Youth and children returnees and refugees that have been exposed to severe trauma

Although youth and children returnees and refugees are a category of individuals potentially most vulnerable to radicalization, research on children and violent extremism is still in its initial stages. Most research studies are focused on the recruitment and radicalization of children recruited by the Islamic State and on the associated range of consequences resulting from this: trauma treatment, family relations, security risk assessment issues, and less on rehabilitation and reintegration.

Most available research studies on youth radicalization focus on the causes why immigrant youth radicalize. Robinson et all. suggest that one possible cause for immigrant youth radicalization is an identity crisis (Robinson, et al. 2017). Muslim youth in Britain, for example, face a unique set of challenges related to cultural identity and acculturation. Because of perceived discrimination and frequent identity issues, they are often considered at risk for radicalization (Robinson, et al. 2017).

Other authors advance as a cause the need to embrace multiple identities, so that if one is threatened, another one could fill this void (Knapton 2014).

Doosje, Loseman and Van den Bos state the idea of economic marginalization for immigrant youth radicalization. They hypothesize that this process is driven by three main factors: (a) personal uncertainty, (b) perceived injustice, and (c) perceived group threat (L. A. Doosje B 2013).

Paulussen, Nijman and Lismont indicate that individuals with behavioral problems and disorders are overrepresented among terrorist (Paulussen 2017), while Rink A. And Sharma K. indicate religious indoctrination to explain why some individuals radicalize along religious lines (Rink 2018).

Poor integration of the Muslim community in socio-economic and political domains reflects the perceived discrimination of Muslims at macro level (Tinka Veldhuis 2009). It seems that in times of economic deprivation, the likelihood of terrorism increases. This was further explained by Veldhuis and Staun as relative deprivation may be the cause for radicalization, in other words the subjective perception of being unfairly disadvantaged in relation to groups of reference (Tinka Veldhuis 2009). This might be the case of refugees since they are an economically marginalized social group, at least at their arrival in the host countries. Sude, Stebbins and Weilant's study concluded that in all reviewed cases in which radicalized groups emerged from refuge situations, the receiving countries pursued inconsistent, at times punitive, policies in dealing with the refugee population. The longer refugees are confined to camps and the lower the likelihood that the initiating crisis will be resolved quickly, the greater the risk of radicalization and waning host country commitment appears to become (Sude 2015).

Eleftheriadou (2018) provides **a model for understanding radicalization within a refugee environment**. The article proposes a composite model that enriches our understanding of radicalization drivers with insights from refugee militarization studies. The model demonstrates that not only do some radicalization drivers present different dynamics in refugee populations, but that there are also other important factors, such as refugees' cause of flight or prior political organization, which are absent in traditional radicalization models.

Another implication is that the possibility of refugee radicalization is not the same for every refugee population and in every (European) country. Thus, the policies that either the European Union or specific states adopt should be tailored to the specific needs of each community and state (Eleftheriadou 2018).

Lynch (2016) looks at how to handle PTSD and trauma in child returnees from conflict zones (therapy methods for dealing with trauma). To mitigate the impact of trauma upon engaging in interaction with support services it is essential to meet the following conditions: have **a family system approach** (whereby the family is seen as one emotional unit), implement **a dedicated key worker system** and focus interventions **on key issues such as education, employment, psychological coping and identity**. Toxic stress as a result of exposure to ongoing trauma is cumulative in that it has a dose response effect; the greater the exposure, the greater the negative outcomes (Lynch n.d.).

However evidence has demonstrated that children are equipped to recover from trauma and develop resilient coping strategies when the appropriate environment is created and maintained. Building resilience through creating such an environment should be the key focus for any

intervention strategy. As an intervention, trauma informed Cognitive Behaviour Therapy (CBT) has been shown to be effective for both children and their families in overcoming trauma related difficulties (Steel and Malchiodi 2010).

Experiences within the refugee camps:

Milton, Spencer and Findley's study finds that **refugee flows significantly increase the likelihood and counts of transnational terrorist attacks** that occur in the host country, even when controlling for other variables. Given the prominence of refugee flows and populations worldwide, the result suggests that states with significant refugee populations and the international community at large should take measures to address the conditions in refugee camps, as well as the treatment of refugees by host states in order to prevent transnational terrorism (Milton, Spencer and Findley 2013). Host communities offering a sense of belonging, economic opportunities, friendly schools and counselling to the traumatized may be less prone to radicalization and terrorism (Aubrey 2016).

The existing literature on radicalization in crisis situations typically identifies three drivers of radicalization: the existence or pervasiveness of an Islamic education; the ability to find gainful employment; and the ability to have freedom of movement (encampment vs. open camp policies) (2010).

Martin-Rayo (2011) suggests in his study on countering radicalization in refugee camps that access to a well-rounded education is a powerful tool in order to reduce radicalization and recruitment. The author suggests that access to education is the most important factor for reducing radicalization, even if of mediocre quality and even if the student can attend classes only for a few years. This can be achieved by ensuring acces to educational programs that have a lasting effect on the refugee population during the displacement and upon the return home. Crisis situations are seen as an opportunity to educate a population with little or no access to education prior to its displacement (Martin-Rayo 2011).

Drivers of radicalization in youth and children returnees and refugees

The pathway to radicalization of youth and children returnees and refugees is a more complex process than it seems at first glance. It involves many drivers and factors that lead to radicalization. One of these factors is social **marginalization.** Economic, social and political marginalization of ethnic or religious groups enhances the risk of violent extremism. Additionally, the perceived victimization of fellow members of the wider group can be used by violent extremist groups in order to gain supporters (Allan, et al. 2015).

In conflicts involving violent extremism, marginalisation is often a factor in extremist groups being able to recruit in large numbers. Blocked participation creates grievances that can be harnessed to promote extremist violence, however they do not necessarily lead to violent extremism and are rather a factor. It is suggested that the lack of civil liberties is the most reliable predictor of terrorism. This includes civil or political society turning to violence when faced with political failure or repression (Allan, et al. 2015).

Identity-formation is important in radicalisation, as it can become 'maladaptive' and make some individuals more vulnerable to radicalisation. Radicalisation is also a social process and identity can play a key factor in individuals becoming involved in violent extremism and religion and ethnicity are strong elements of individual and group identity (Allan, et al. 2015).

Poverty and **deprivation** can play a role in pathways to violent extremism, particularly outside of the West and in areas involved in civil war. However, as poverty is often linked to other drivers, it is important to examine the wider context. Additionally, extremist groups often recruit from the unemployed and underemployed groups, including the well-educated (Allan, et al. 2015). Studies at the individual level of analysis failed to find a direct connection between poverty and the decision to take part in terrorist attacks. Krueger and Malečková acknowledged that poor countries produce more terrorists (Krueger and Malečková 2003).

Migrants represent a special category vulnerable to radicalization, because of the changes they experience, such as cultural, religious, even in relation to their ethnic identity. Bhui (2013) considers that these factors represent a risk of mental disorders, especially in the case when migrants cannot integrate into the new society and become isolated. Experts within RAN have also highlighted the impact of the journey to Europe on the migrants' and refugees' mental health state, which can be exploited by extremist groups (RAN (01)).

The Internet and marketing actions are seen as two major risk components of the process of radicalization. The two can be used as channels for "influence and manipulation", by offering possibilities to be a part of groups or movements that they identify with, and by making them think that it is a choice or an opportunity: "An individual's vulnerability will lead them [the young] to terrorist websites that propagate messages of hatred and violence, to make repeat visits and to engage in dialogue in order to be persuaded" (Bhui, 2013, p. 26).

The role of schools and social workers in detecting deviant behavior

Schools have a critical role in promoting democratic values, nurturing diversity, tackling discrimination, fostering media literacy and building religious literacy. Research on terrorism is equivocal on the role of education. Although an individual's level of education isn't a cause for radicalization, the democratic quality of education can make a difference.

Reynolds and Crea discussed about the importance of social position within the school environment and integration of immigrants (Sieckelinck, Kaulingfreks and De Winter 2015). They hypothesized that if "immigrant youth occupy similar positions in school social structures to their native peers", they will have a higher propensity for integration and therefore would be part of a resilient community and identity (Reynolds and Crea 2017). Teachers and social workers are on the frontline of detecting the deviant behavior.

Stanley et al. studied the role of social workers dealing with cases of children in radicalized settings (practical tools and intervention methods for dealing with families and radicalized children) (Stanley, Guru and Gupta 2018).

Interventions with children returnees

As far as interventions with children are concerned, the psychological and psychiatric guidelines must be observed. As a general guide, children under the age of 12 - 13 are considered pre-teens and above the age of 12-13 would be adolescent children. Adolescent interventions are only possible if a child has reached a certain cognitive level (Theodore 2016).

Adolescent children that have returned from Daesh territory have witnessed extreme violence and abuse. The main concern about these children is that they are less open to intervention and less capable of change. In addition, there should be significant concern about the spread of radical ideas amongst peers (Fergusson, Swain-Cambell și Horwood 2001).

Furthermore, children should be treated in accordance with their age and developmental level. They should not be included in adult services (RAN COE 2017).

Although the experience in working with children that have returned from Syria and Iraq is still very limited in the EU (RAN COE 2017), there is, however, a large body of experience and research on working with children who have been exposed to combat situations (e.g. child soldiers) as well as on severe trauma and extremist ideology in general.

In addition, there are guiding conventions and international frameworks that shape policies establishing the rights and protection of children in vulnerable situations and that can provide guidelines when designing policies and interventions in this area.

Children living/growing up in conflict areas are particularly vulnerable because of the abuses they face, as well as the violence they witness, and because of the fact that their normal social, moral, emotional and cognitive development is interrupted and corrupted by the experience of war (Kohrt, Jordans and Koirala 2014). In addition to trauma related to living in a conflict zone, the process of resettlement (returning to the EU) may be a cause of further trauma. This is even more pronounced when families are separated, or when children have travelled alone.

Children exposed to armed conflict are highly likely to face multiple and ongoing trauma (Kohrt, Jordans and Koirala 2014) related to interpersonal/interfamilial violence, sexual abuse, hunger, malnutrition, neglect and abandonment. Exposure to multiple and repeated trauma represents a significant risk for a child's development and overall functioning (Kohrt, Jordans and Koirala 2014) In addition, further trauma as a result of the resettlement and integration processes is a distinct possibility (Fazel, et al. 2012) This may be caused by discrimination, social exclusion, instability, parental unemployment and the absence of peer networks of support.

When children have been involved in violence, psychological evidence demonstrates an inability to adequately consent to involvement in violent activity and a lack of capacity to fully understand the consequences of this involvement. A child's upbringing, as well as his/her biological development, will determine at what age he or she can be expected to understand and oversee the consequences of his/her actions. Like child soldiers, child returnees can be seen as victims and, in some cases, perpetrators at the same time.

Even though back in Europe and away from the conflict zone, practitioners should be aware that children might still be in a transitional environment. This is especially the case when their parents

are incarcerated and they are, for example, living in foster care. This can be an impediment to dealing with trauma and rebuilding resilience.

Final remarks

Although it is apparent that age matters when it comes to child returnees (as well as the length of time they have been exposed to a conflict situation, and the level of their engagement in conflict), there is no clear-cut guidance on age groups when it comes to responses.

The Daesh ideology and their carefully orchestrated community infrastructure have created the foundations of an identity for children that also serves as a protective factor, allowing them to remain resilient while living in those circumstances. Interventions aimed at addressing the ideology/worldview of child returnees should take into account that deconstructing the foundation of their identity and transitioning to a new identity is a complex, long-term process. These kinds of interventions should therefore take place in the context of broader reintegration and rehabilitation processes and/or measures.

Once returned, the social environment of the child (family, community and peer groups) will have a great influence on the success of rehabilitation and resocialization. Practitioners should be aware that some returnees were in the public/local spotlight and are therefore stigmatized or celebrated amongst certain communities and groups. Children of different ages may become future targets of bullying and intimidation or, on the other hand, recruited back into extremist circles.

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Conclusions

The four studies included in this selective literature survey in the field of radicalization and mental disorders have been drafted in the context of the project based approach with the aim to provide to policy makers and practitioners a better understanding and perspective on the risks posed by individuals with mental health disorders showing signs of radicalization.

As stated in the introduction, the survey aimed to summarize findings that could help answer a set of relevant questions for both policy makers and practitioners. Each of the four distinct chapters of the study addressed a distinct set of research questions and, as it became apparent, attempted to provide insight into the complexities and interdependencies that characterize the psychological and social process of radicalization, especially when placed in the context of a mental disorder. As the survey emphasizes, there is no simple set of lessons learnt or good/promising practices that can be without doubt associated with early identification, risk assessment and management of risks posed by individuals that are vulnerable to radicalization and that struggle with a mental disorder. And although early research attributed mental disorders to terrorists, now it has become all too apparent that these studies have been disconfirmed. On the contrary, what can be stated with satisfactory certainty is that mental disorders do not represent an independent risk factor for radicalization and hence no direct causality can be established. Nevertheless, when occurring, and if combined with favoring factors – such as emotional trauma, exposure to radical content, indoctrination, substance abuse etc. – mental disorders increase the likelihood of radicalization.

Psychiatric disorders among radicalized individuals remain however rare and there is no scientific evidence to support the idea that individuals with certain diagnoses are at high risk of perpetrating violence and posing threat to the public. Hence, when designing public policies and interventions aimed at managing risks, policy makers should also take note of the need to avoid stigmatization and discrimination. An early detection program built within communities, easy and rapid access to mental healthcare and a multilevel, converging approach to intervention at state level, including healthcare, education, social services, local authorities, security and police, might be of significant help in containing the risk and increasing chances for successful integration.