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CONCLUSION PAPER

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Personality disorders and mental illnesses with implications in preventing violent extremism

Key outcomes

Personality disorders and mental illnesses present amongst radicalised individuals bring additional challenges to prevention of violent extremism (PVE) efforts. On 20-21 June, the RAN Mental Health (HEALTH) Working Group convened 22 participants in Helsinki and discussed with (both clinical or forensic) psychologists, psychiatrists, local authorities and experienced rehabilitation practitioners the underlying dynamics of specific personality disorders and susceptibility to radicalisation leading to violent extremism. The general aim of the meeting was to create a deeper understanding of the challenges practitioners face when dealing with radicalised individuals with personality disorders, which are: a lack of understanding on the interplay between these specific disorders and radicalisation, how this could lead to violence, and what this means for prevention efforts and treatment options. The meeting addressed this on the practical level through analysis of real case studies, which resulted in practical recommendations on how to prevent those with specific disorders from being drawn/groomed into violent extremism and to increase our understanding of which violence-supporting factors these disorders may or may not be associated with. Particular attention was paid to the mechanisms and underlying dynamics of antisocial personality disorder (ASPD) that contribute to the vulnerability for radical opinions and extremist action that has the potential to lead to violence and subsequently to the interventions that address these underlying dynamics. Some of the key outcomes include:

- The underlying dynamics of personality disorders that lead people to violent extremism are associated with specific traits/symptoms of the personality disorder. The diagnosis of personality disorders therefore is not always helpful and sometimes stigmatising. Mental health practitioners in PVE benefit from focusing on the underlying dynamics to better address and treat the specific symptoms of the disorders.

- Challenges regarding the treatment of personality disorders are multiple. In specific cases like ASPD, there are no evidence-based treatments available. Practitioners also have to deal with the frustration of working with uncooperative individuals and the fact that improvement is at times short-lasting. Additionally, with hostile attribution bias being one of the symptoms, practitioners find extreme difficulty in the precondition for treatment, which is building trust.

This paper summarises the main conclusions following the discussion on a range of personality disorders (especially those in Cluster B) with a particular focus on ASPD. Consequently, this paper describes the main (mental) health issues within specific cases, recommendations on how to deal with these, relevant practices and some possible follow-up on this topic.

Highlights of the discussion

Underlying dynamics of antisocial personality disorders

Within the current conceptualisation of ASPD in the DSM-5-TR, there are many different profiles of ASPDs. The way to approach these individuals can vary a lot. Also, there is conceptual confusion with the construct of psychopathy. Lastly, there is a lot of comorbidity with other disorders (ADHD, Cluster B personality disorders, borderline personality disorder, substance use disorder).

In therapy, the context of the behaviour is often neglected. In poor neighbourhoods, ASPD is more likely to be diagnosed. Violence is a survival mode in some neighbourhoods where the street code is: you are not safe, no one can be trusted (this also fuels conspiracy beliefs and anti-government sentiments). Youngsters who are not inclined to be violent may think it necessary to live according to this street code even if they grew up in stable and loving families (also influenced by the idealisation of a criminal/extremist lifestyle, fuelled by social media and certain music). This demonstrates how social structures shape behaviour and guides us in what we can learn regarding deradicalisation from the disengagement processes of other groups like gangs, religious movements, etc. ([1]).

Pathways to antisocial behaviour and radicalisation

To understand why people behave antisocially, you can start with the question why people behave prosocially. This is explained by a collective survival strategy, namely reciprocal altruism. The preconditions for reciprocal altruism are trust and reciprocal ability (knowing what the needs of another person are).

1. **Lack of trust:** trauma and affective neglect are common in childhood in ASPD. The current social milieu in which individuals with ASPD live is often competitive and hostile, and some of the people with ASPD are hypervigilant to threat: **hypermentalisation**. These individuals often show a lot of aggression. Pathway to radicalisation:
    - Because of trust issues, they are more susceptible to conspiracy beliefs. They feel that something is not right, someone is scheming against them. They generally have no trust in government, institutions, psychologists, psychiatrists, teachers, police, and/or the justice and penitentiary system.
    - Due to hypermentalisation and hypervigilance, they are susceptible to conspiracy beliefs and ideas.
    - They assume a "survival of the fittest" lifestyle and think they have to protect themselves. Because they are looking for allies in a world they cannot trust, they are susceptible to extremist networks.
2. **Lack of reciprocal abilities:** emotional neglect is common in the life history of individuals with ASPD and leads to poorer mentalising ability: **hypomentalisation**. Preliminary results from research show these individuals look at all kinds of irrelevant cues when looking at people showing emotion and therefore miss important information to assess someone's emotions (attention bias). Pathway to radicalisation:
    - These individuals cannot correctly assess emotions and find it difficult to regulate their own behaviour. They do things without thinking and this results in impulsive rule breaking behaviour.
    - Lack of reciprocal abilities is often related to sensation seeking — e.g. the case of a young man with behavioural problems, who met friends from an extremist group and impulsively decided to go to Syria and fight, but when he arrived he was disappointed. He does not know much about the Quran, and he was mostly driven by a need for sensation.

([1]) Harris, K. J., Gringart, E., & Drake, D. (2018). Leaving ideological groups behind: A model of disengagement. *Behavioral Sciences of Terrorism and Political Aggression, 10*(2), 91-109. https://doi.org/10.1080/19434472.2017.1299782

3. **Psychopathy:** a disorder that has a biological basis. These individuals do recognise emotions in others, but do not (emotionally) respond to it. They lack empathy: **callous-unemotional facet**. This is a small part of the population. They display instrumental aggression and criminal behaviour. Pathway to radicalisation:

    - They are determined to achieve self-centred goals.
    - They may enjoy torture and violence.
    - They are more likely to be a leader or a recruiter.

Syndemic theory

The idea that the social context needs to be considered when dealing with ASPD/radicalisation aligns with syndemic theory ([2]). The core concept of this theory is the concentration of problems and the interaction between disorders and social factors. It was discussed that syndemic theory could be a suitable framework to analyse causes and consequences, integrating mental health and social factors in analyses to develop integral models for interventions.

Disorganised attachment

During the meeting it was repeatedly mentioned how attachment styles matter in understanding the pathway to radicalisation (adding to the argument of social structures), and in relation to Cluster B personality disorders, how disorganised attachment styles matter. Disorganised attachment is fear-based (see survival of the fittest) and has both emotional and cognitive effects:

1. a confused emotional bond to the source of fear (e.g. extremist leaders/groomers) in a failed attempt to seek comfort;
2. cognitive dissociation, that is, the inability to think about one's feelings.

Fear or stress without escape derails a person's ability to think logically and clearly about the situation and therefore to take action to resolve it. As a result, the person is more susceptible to being isolated from former friends and family, establishing the group as the sole perceived safe haven and eliciting chronic stress and fear. More information can be found under 'Relevant practices' (see GAP-model).

Case studies

Participants at the meeting formed small groups to discuss four case studies. Short, anonymised descriptions of each case study as well as a summary of the main points discussed regarding the mental health issues and challenges are outlined below.

([2]) This was discussed in an online RAN Mental Health meeting that took place on 22-23 September 2021, online. The link to the conclusion paper can be found here.

Case study 1: PTSD, borderline traits, obsessive-compulsive disorder and general anxiety

A 40 year old woman born and raised in Denmark and converted to Islam in adulthood. Her mother was part of a cult with strict hierarchy. Her father has a drinking problem. She divorced her husband whom she accused of physical abuse and harassment and lost custody of her three children. She then married a much younger man, possibly to get a higher status in a very extreme Salafi environment in Denmark. Now she is sentenced to prison for supporting IS and terrorism. From her medical records, she is diagnosed with PTSD, personality disorder with borderline traits, obsessive-compulsive disorder (OCD) and general anxiety.

- When she divorced her first husband, she started to live more strictly and isolated herself from her network. This is when she became obsessed with some extreme Islamist ideas. The loss of custody over her three children resulted in her withdrawing from any contact with the system.

- It seems as if she has (ambivalent) attachment issues. She needs control and security.

- What is most persevering in her case is her difficulty in finding a "ego-syntonic identity" and stability. Religion, strict rules, and obsessive ideas and convictions serve as tools for distraction from her heavy thoughts and overwhelming emotional responses, which formerly led to substance abuse and broken relationships and a chaotic lifestyle in general.

- There is a lot of uncertainty about why she is so rigid in her way of thinking and what her motives are. The target of intervention is creating a space where stability is demonstrated, the rigid thoughts are slowly becoming more nuanced and help is offered, when needed. The collaboration is based on flexibility, easy access, no timelines, and no restrictions or demands per se.

Case study 2: Borderline personality traits and dependent traits

An Italian women who converted to a strict branch of Islam and travelled to Syria. Her mother was absent and depressed during her childhood, her father is an adamant atheist and her grandmother embraced a feminist vision of women. She dealt with social exclusion from her peers and relational problems in her childhood. Her borderline personality traits manifested during adolescence. Self-harming was a way to release her stress and she met her husband on a self-harm forum. They both converted to Islam. He suffered from severe OCD with a psychotic personality structure. He was convinced his problems were caused by social trappings like money and personal documents and this is why they moved to Syria. It is suspected that he is no longer alive. During this relationship she over-idealised him and developed dependent traits. She is accused of supporting a terrorist organisation, but not of any violent crimes.

- Self-harm as an expression of her borderline traits might be the start of her radicalisation process. On the internet, she created her whole (social) identity around this. On a forum she found people who understood her, which she did not experience from the people around her.

- The dependent traits relate to her psychologically binding herself to her husband. She has no social networks; her husband was her entire world. The strict branch of Islam provided her the perfect role of a woman contained and de-responsibilised. She claims she hates IS because they are not "real Muslims".

- She did not dislike prison, because it imposed and structured her daily routine and she could live isolated from other inmates. She is currently in an enclosed small community where the goal is to attempt to resocialise her.

- This case is more about personality traits and social aspects. She is not a violent person. Therefore, a general intervention to work on social skills, emotions and creating a network might be best suited to deal with her.

Case study 3: Autism spectrum disorder, antisocial traits

A Dutch boy (17 years old) accused by his mother of becoming a right-wing extremist. His parents divorced when he was 12 and he is living with his mother. His mother has a lot of problems with other people and new relations. His father is living abroad and is a "psychopath" according to the mother. The police tapped the boy's conversations about drug deals, buying a gun and killing enemies. In his computer they found a plan to make a bomb and maps with all synagogues in the Netherlands. In his phone were many images and texts of extreme right wing movements, hate messages, and images about jews, gays and left-wing politicians. He was diagnosed with autism in the past. He is a smooth talker and pathological liar. There is no feeling of responsibility for his deeds. He downplays his deeds and the consequences.

- It is very difficult to identify what really happened because the boy was lying a lot to different people and organisations. Was there really a threat? Therefore it is difficult to pinpoint whether this is a healthcare matter or a police matter.

- He is still a teenager in search of his identity, making it hard to distinguish between what is role play and what is becoming a personality disorder.

- His family was very unstable and he was deserted by many. He has a high need for order and clear guidance on what is right and wrong (very black and white) to solve the uncertainty in his life.

- When he turns 18 this will limit the means professionals can have to support him. There are worries about his psychological capacity, educational plans and his income later on as well as fears he will end up being a criminal in the future.

- There is clearly a need for long-term contact and a case manager in order to build a network around this young man.

Case study 4: (Paranoid) schizophrenia, psychosis and drug abuse

A Kurdish man, former combatant for the Kurdish forces in Iraq, and currently a refugee in Germany. Although uncertain without a diagnosis, the man seems to suffer from schizophrenic paranoia and psychosis with religious delusions (Allah commands him). He had a long history of cannabis abuse. He stopped abruptly after Allah told him to. He frequently expresses that all need to follow Allah, otherwise you go to hell. He was relatively new to Islam and it is suspected that he is being influenced by a Salafi teacher based outside of Germany. Furthermore, he expresses some sense of grandeur, "being" the messenger or chosen one of Allah. He has been very violent, with numerous offences in a short period of time that include vandalism and assault — especially since the occurrence of psychotic episodes with religious content. In the past he was in the care system with paranoid psychotic episodes without religious content. The care system is unable to handle him and it took a judge to get him into a forensic ward.

- His drug addiction is possibly a coping mechanism. Besides his schizoid paranoia and psychosis, there might be PTSD and other (war) trauma. He refuses medication, and fixation is necessary at times to keep him constrained. This requires hourly evaluation.

- The religious delusions from his psychosis are often given different roles, either instructed as a messiah, chosen by god, or a victim to Satan/djinn.

- The multi-agency structure does not suffice for this case. Most of the focus is on risks, but there is confusion whether to treat him as a radicalised case that could be dealt with federally or as a psychiatric patient case that would be dealt with locally in the healthcare system. This leaves a potentially dangerous individual between care and security approaches, which increases the risk of violence.

- It is troubling that institutions have not been sharing information. This leaves practitioners handicapped to deal with the case adequately.

- It was reported by the care system that development of the psychotic content did not start with religious content but with paranoid content, which resulted in first contacts with the care system and/or security authorities. If the psychosis is not treated sufficiently, religious content is often added to the psychosis content. This development seems to enhance the probability of violence, especially when the person receives "commands", so-called imperative phonemes.

Recommendations

Lessons learned from gang disengagement

- Focus on disappointing experiences with (gang) members of the group, for example agitators within the group using extreme violence towards innocent people or other relevant conflicts inside the group.

- Make sure there is something else to live for next to the extremist network, for example family ties, work, income and status. Someone can only leave a gang/extremist group if they are sure there is an alternative.

General recommendations

- Use motivational interviewing for violence disengagement: focus on acceptance, avoid discussion or persuasion. Create discrepancy with regard to (new) life goals.

- Do not expect the individuals you treat to show vulnerability and/or openness quickly and do not pressure them into doing so. It might feel like contempt or having a total lack of consideration towards them.

- Be apprehensive about labelling. Saying that someone has a mental disorder can be very stigmatising. Find complexity in the label, try to deconstruct it and look at the individual. The underlying dynamics give directions to the treatment.

Borderline and dependent traits

- People with borderline and dependent traits need respect, the feeling of being understood and attention, and that is why they are attached to the professional. That happens with individuals both diagnosed with borderline disorder and convicted as terrorist offenders. The first step is to help them understand the way they attach to other people. If they understand how they are functioning, this will resolve a lot of stress.

    - You can use functional analysis to understand the structure of their functioning. A functional analysis examines the antecedents and consequences of behaviour.

    - A functional analysis of behaviour is often used as part of cognitive behaviour therapy that considers the antecedents, thoughts, actions and consequences that make up behaviour ([3]).

- It is important to not project your personal perspective on the client. Consider whether someone is (still) a threat and, if not, if they want to receive help. If this is not the case, always examine whether it is beneficial to provide therapy or deradicalisation/disengagement programmes.

Antisocial behaviour/personality disorder

- Oftentimes people are diagnosed with ASPD, but the social context plays a crucial role in shaping their behaviour and therefore it is important to take this social context into account. Both therapeutical and social interventions are needed.

Lack of trust – hypermentalisation

- When someone believes in conspiracy narratives and/or has psychotic feelings, the **LEAP method** may be helpful. The aim of this method is to go along with the problem definition and connect by the following steps: **L**isten to the individual, **E**mpathise with the feelings he/she experiences, **A**gree on the part you have in common, **P**artner by doing something to help them ([4]).

- Focus on traumas that affect trust (see, for example, disorganised attachment) and empathise with the generalisation of mistrust. **Trauma therapy** might also reduce the lack of trust to some extent. For this it

([3]) See: https://positivepsychology.com/functional-analysis-cbt/#theory
([4]) Amador, X., & Johanson, A.-L. (2000). *I am not sick, I don't need help! Helping the seriously mentally ill accept treatment*. Vida Press.

is important not to put all people with ASPD together in a group, but really focus on individuals who experienced some traumatic episodes in their past.

Lack of reciprocal abilities – hypomentalisation

- Attention bias can be reduced by some extent with trauma therapy but also with **psycho-education**: help them become aware that they might come across as aggressive for their environment, which increases aggressive responses.

- **Impulsive lifestyle counselling**: the aim of this programme is to offer people with ASPD an opportunity to talk about their problems and support them in awareness raising and reflection and to find other strategies for their thinking and behaviour ([5]).

- Another intervention is to create a protective, healthy social network. Provide them with work-appropriate reference figures, work, a home and financial support.

- The risk is not only radicalisation but also crime. Keep monitoring them for years on drugs and friends.

Lack of empathy

- There are some first indications that individuals with psychopathic traits have no idea what the effect of their behaviour on their surroundings is. When they learn how to recognise emotions in others, they do respond appropriately.

Schizophrenia

- When a person with psychosis reacts with religious delusions, there are generally many different manifestations and you have to understand the cultural background of the individual. One practitioner observed that you also have to understand the role of the individual in the delusion to get access and potentially build trust.

- It is also very important to evaluate the risk. When there is a clear risk of violence, action is needed and capacity needs to be increased to support and protect both the individual and society. Labelling the psychiatric disorder or whether we are speaking of a radicalised individual might not be of high importance. The heavy focus on risk might consequently add to the risk when you are dealing with a person with schizophrenia, adding to paranoid delusions. A needs analysis could potentially address further escalation of both radicalisation and the psychiatric condition.

Relevant practices

1. **LEAP method** – LEAP (Listen, Empathise, Agree, Partner) is an evidence-based communication programme. This programme enables mental health practitioners to build relationships with people with a serious mental illness to accept treatment.

2. **GAP-model** – Based in Germany and aimed at exit work for the extreme right, JUMP has developed the GAP-model based on attachment theory. Attachment theory was developed by John Bowlby with thousands of studies across a range of social relationships providing a rich evidence base. The model seeks to help practitioners understand the formed attachment with an authoritative individual or group and how to form new attachments leading to the exit out of violent extremism*.

3. **National Support Center for Extremism –** LSE is a Dutch support centre that provides family support, individual counsel and group contact for people dealing with radicalisation and extremism.

([5]) Thylstrup, B., & Hesse, M. (2016). Impulsive lifestyle counselling to prevent dropout from treatment for substance use disorders in people with antisocial personality disorder: A randomized study. *Addictive Behaviors, 57*, 48-54. https://doi.org/10.1016/j.addbeh.2016.02.001

* More information about this model is yet to be published online

The multidisciplinary team consists of professionals experienced in radicalisation, youth care, crisis care and intercultural work.

Follow-up

- During the corona pandemic, mental health practitioners noticed an increase in conspiracy believers in their practice. Especially in the Cluster B population, there is an increasing distrust towards government institutions and policies that leads to practical implications for practitioners, like refusal of treatment or difficulty in building trust (e.g. refusing to wear a facemask). The follow-up meeting of RAN Mental Health on the fragmentation of ideologies and single-issue radicalisation could address such practical issues and how such societal developments impact effective treatment.

- Particular attention was paid to ASPD, and to a lesser degree the other Cluster B personality disorders. Expert meetings should address the other relevant Cluster B personality disorders (each disorder in its own meeting) and pay attention to the gendered dimension of personality disorders and, consequently, the gendered dimension of radicalisation pathways.

Further reading

Alexandra Stein in her article The Role of Disorganized Attachment in Extremist Organizations describes the common features of totalitarian — or totalist — groups, and discusses how the manipulation of attachment relationships drives the hyper-credulity and uncritical obedience of followers and how understanding this can help guide our prevention and intervention efforts.

The book Code of the Street, by Elijah Anderson, describes how people adopt violence even if not inherently violent. The inclination to violence springs from the circumstances of life amongst the ghetto-poor — the lack of jobs that pay a living wage, the stigma of race, the fallout from rampant drug use and drug trafficking, and the resulting alienation and lack of hope for the future. Thus, the social structure shapes the behaviours of individuals, families and communities. There is a higher chance of being diagnosed with ASPD if you are from a "bad" neighbourhood, begging the question whether ASPD is not in fact a societal issue and the context of behaviour is too often neglected.

Nils Duits, Daphne Alberda and Maaike Kempes, in their article Psychopathology of Young Terrorist Offenders, and the Interaction With Ideology and Grievances, examined whether and to what extent psychopathology is related to a violent ideology, to grievances and anger about perceived injustice.

Zainab Al-Attar describes in her article Severe Mental Disorder and Terrorism: When Psychosis, PTSD and Addictions Become a Vulnerability that when terrorist acts are planned or executed by individuals with mental disorder, possible functional links between the two need to be explored in order to delineate risk and inform approaches to risk management and reduction. This paper explores such functional links, their complexities and implications for clinical interventions.