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HEALTH

03/11/2021

CONCLUSION PAPER

RAN event - Mental health practices and interventions in P/CVE
22-23 September 2021, Online

Mental health practices and interventions in P/CVE

Key outcomes

A growing number of programmes and interventions aimed at preventing and countering violent extremism (P/CVE) programmes and interventions are being implemented across the European Union (EU). Many of these P/CVE interventions also include psychosocial aspects. This raises the question of what makes an intervention successful and how this relates to the role of mental health professionals. The main aim of this meeting was to exchange on existing practices, skills, experiences and tools that include mental health practices. The underlying question of the meeting was: How can these intervention or practices be best applied to individuals at risk with specific mental health problems.

This meeting of the RAN Mental Health Working Group on 'Mental health practices and interventions in P/CVE' took place in a digital setting on 22 and 23 September 2021. Mental health practitioners discussed P/CVE interventions and practices by exploring different case studies. The following key points were discussed:

- **Cultural mediators, mentors or family members** may help by reaching out to the at-risk individual and help with the referral to a psychologist or psychiatrist. The cultural mediator should have a similar cultural background as the radicalised person.
- Mental health professionals should have a **broad perspective** on radicalisation and violent extremism, combining the clinical perspective with psychosocial and ethno-cultural perspectives. Interventions need to be integrated in an approach that also considers the lifeworld of the individual by exploring problems at a local, national and global level.
- A **follow-up plan** should include job search, leisure time, social support and family engagement. These are considered essential to prevent relapse/recidivism following treatment or therapy.
- It is crucial for **multi-disciplinary mental health teams** to have access to the necessary information as a mental health practitioner in P/CVE and to discuss which intervention methods (ethno-psychiatry, cultural psychology or family therapy) are best suited.

This paper summarises the main conclusions following the three anonymised case studies discussed during the meeting. Consequently, this paper describes the reoccurring challenges with diagnosis, the terrorism label and (lack of) information. This is followed by practical recommendations on outreach, context, treatment methods, multi-agency and multi-disciplinary working. Follow-up and inspiring practices are also outlined.

Highlights of the discussion

Participants at the meeting formed small groups to discuss three case studies. Short, anonymised descriptions of each case study, as well as a summary of the main points discussed, are outlined below.

Case Study 1

A man in prison is deemed a threat due to his apparent Islamic extremist ideas. He shared his idea for an attack with a fellow inmate. He is always aggressive towards the prison guards. There are concerns that his overall mental state of mind and his extremist beliefs may result in an attack after his release from prison.

Mental health issues and challenges identified:

- As a child, he was sexually abused but never received therapy to recover from this traumatic experience. Also, the sexual abuse was known by members of his family but not addressed or talked about.
- He witnessed his mother being beaten by his father. He does the same to his girlfriends. He is obsessed about his masculinity and doesn't trust women.
- He sees ghosts/spirits/djinns and talks in a 'psychotic' way about spiders in the room talking to him. He has been diagnosed with schizophrenia.
- Most of his social contacts are from or within a criminal environment. His sister, who is his only social support, is the one who convinced him to seek help.
- He suffers from drug addiction(s). He uses self-medication (alcohol, drugs, opiates) to deal with the hallucinations.

Case Study 2

The individual was placed in police custody for planning violent attacks and for being in contact with Islamist extremists. He does not have much family around him and has no social contacts. He had an unhealthy physical condition because of sitting in front of his computer for long periods. He was obsessed with violent videos.

Mental health issues and challenges identified:

- The person lacks peer relationships and social contact. He is not interested in contact with his peers. He has never been in a relationship and lived with his father who has Alzheimer. This person was continuously stressed about his father's health situation.
- He was cooperative but also reserved. He preferred talking about superficial subjects and not about his life and events that happened to him. He was happy in prison with the attention from the guards and psychologists. While he respected the authority of the prison guards, he distrusted fellow inmates.
- He lived in a virtual fantasy world because he acted like he was in an internet story/video. He socialised only in the virtual world.
- He had attempted suicide three times, once in custody, because of his anxiety, acute stress, adjustment disorder and bizarre behaviours. For instance, he always carried with him to show around the biography of the Spanish king.

Case Study 3

Arrested for vandalism, this individual has now made Islamic (radical(statements and threatened politicians. He has a short fuse and there is a rapid escalation leading to high emotional reactions and aggressive behaviour. This eventually resulted in a physical attack. Fortunately no one was injured. He is now in prison.

Mental health issues and challenges identified:

- He is frustrated because he wasn't able to travel to a Islamic country due to restrictions imposed to stop the spread of the coronavirus. He wants to move to an Islamic country because he doesn't trust the system and authorities in his home country and wants to live in an Islamic country.

- There has been an escalation of negative behaviours over time. However, no one was in a position to give sufficient support to prevent the negative behaviours from escalating further. The individual did not want to cooperate or accept any support.

- The only information available is about his behaviour under stress and even here there are numerous inconsistencies. This made it difficult to pinpoint the exact reasons for his behaviour.

- His aggressive behaviour is instrumental, a method, to avoid any type of assessment, help or interference from authorities. The aggression doesn't seem to be a results of any underlying mental illness. He hasn't been diagnosed with a mental illness and there is no information about his cognitive or intellectual functioning.

- Staff at the psychiatric ward, as well as his brother (the only family member he has contact with), believe he is not mentally ill. They consider him to be a manipulative person who likes to play games.

Reoccurring challenges

One challenge that was repeatedly mentioned during the breakout sessions in all three case studies is the impact of labelling someone as **radicalised** or a **terrorist.**

- Sometimes the violent or aggressive behaviour is a result of someone's life experiences and/or mental illness rather than ideology. Mental health issues are often closely interlinked. A combination of mental health issues and identity crisis can make a person vulnerable to a call-for-action by violent extremist groups. In these cases, there is very little ideological conviction.

- Labelling an act as terrorism might dissuade practitioners (mental health professionals) from providing support. Also, it could require lengthy discussions in order to decide whether a case is related to violent extremism or extremism. On the other hand, sometimes labelling it as such is needed to be able to intervene or escalate the case handle it within a bigger and multi-disciplinary team of professionals.

- Multi-agency partnerships may result in diverging opinions as regards the necessary measures and the actions needed to address radicalised individuals with mental health problems. While mental health professionals consider the personal and social situation of the individual, security professionals (such as the police chief) view the individual within a public order perspective.

Another reoccurring challenge is whether **diagnosis is essential or harmful for intervention**.

- Involuntary confinement in a psychiatric hospital is not always possible. However, when the individual is not cooperating, it becomes difficult to formulate a diagnosis. A lot of time may be spent discussing a diagnosis, but the intervention might be the same, nonetheless.

- In many EU Member States, a diagnosis is necessary in order for an individual to receive mental health support. Without a diagnosis, mental health professionals can only provide support if the intervention is not integrated in the mental health system.

- Sometimes therapy depends on the diagnosis of the individual (e.g. with cognitive behavioural therapy). Diagnostic interviews are the first step to setting goals together at the start of each trajectory.

Lastly, it is usually the case that not one person holds all the pertinent information or has the proper background to assess all the information. This results in a **limited amount of information** on someone's background and mental state.

- Multi-agency cooperation is often stressed as key in P/CVE. When cooperation is weak, information is split between different departments. Some mental health professionals, as well as other professionals, face difficulties resulting from this lack of cooperation and trust between the relevant stakeholders. When important information is missing, it is difficult to decide on the best suited intervention.

- Mental health professionals often do not know where to focus their attention due to lack of experience in P/CVE (ideology, mental disorders). They may also be unsure about how to interpret manifestations of different disorders (e.g. spirits or djinns have different cultural components and meanings). Information is therefore perceived through the lens of the given professional. As such, pivotal information for an intervention could be missed.

Recommendations

Outreach

- When a person rejects offers of support, it is advised to reach out to the family. There might be a family member or a close friend through which contact may be established.
- Enlist the help of a cultural mediator to make contact and keep in touch with the individual. This mediator should be someone the individual trusts and who is considered a prominent figure in the immediate community and the local society.
- Work together with a mentor with whom the individual can relate to and trust. When a trusting relationship is in place, the mentor can help to refer the person to a psychologist. It is important this mentor is supported by a team of professionals.
- Mental health professionals should avoid ideological issues. Instead, they should consider the everyday needs to understand the individual better.

Take context into account

Early prevention

- Diagnosis might be stigmatising. For this reason, it is advisable to consider the traits instead of the diagnoses which may result in problematic behaviour and/or violence. Clinical assessment and psychological evaluation are the first steps preceding any intervention.
- Practitioners should look for connected violent behaviours like stalking and alcohol and drug abuse. They should also try identifying mediators like alcohol and drugs.
- The social structures, social systems and groups of the individual should be identified. If these social structures and systems are present, contact with risk groups (friends supporting radical ideas) should be avoided.
- Identify unintended negative effects of treatment in risk populations. Identifying the failures of the intervention can help to improve future mental health interventions.

Local, national and global context

- Sindemia/syndemic is the concentration of problems, interaction between disorders and social factors. This concept is relevant for the prevention of radicalisation. For instance, P/CVE is not only about individual problems but about how local, national and global problems relate to the individual's lifeworld.
    - Interventions should be part of an integrated approach considering the sindemia.

- Adopt a broad perspective of radicalisation. There is not just one factor, but a broad range of factors and topics that come into play and can have significant influence. For this reason, it's important to combine the clinical perspective with psychosocial and ethno-cultural perspectives.

- When treating young people, screening the individuals' use of the internet and (social) media is highly recommended since new developments on social media may trigger (new styles of) violence.

Cultural context

- All cultures have their own experiences and beliefs regarding psychological disorders and their treatment. **Ethnopsychiatry** is the study of mental illness in a cross-cultural perspective. It's a methodology that considers all cultural and therapeutic practices and theories relevant to treating individuals (particularly immigrants):

    - Consider all the psychological, social, political, religious and cultural information that may help better understand the individual's process of radicalisation.

    - In addition to focusing on the usual concepts of psychology, psychiatry and psychoanalysis, it's important to also consider concepts like The Apocalypse in Islam and other religions, Spirits and Djinns, purity and stain, death and ancestors. For example, schizophrenia is a Western understanding of the individual's perception of reality. In some Islamic cultures, however, it's perceived as being possessed by a djinn. Violent or negative manifestations are due to the djinn possession. Understanding this difference is key for treatment or planning an intervention.

- The **ethno-clinical mediator** plays an important role in ethnopsychiatry. The mediator speaks the language of the individual's family, knows the cultural treatment methods, as well as the political, economic and social situation of the individual's country of origin.

- Consider the radicalising person from a **course of life** perspective, surrounded by his/her relatives, socio-cultural collective/community and their trans-generational history. In ethnopsychiatry, the individual is seen as being in search of knowledge and intelligence about themselves and the world. Meaning making is an important aspect ([1]).

- **Culture specific diagnosis** takes into consideration the family's cultural origin as a source offering effective tools in the process of deradicalisation.

Therapy and methods

- In some cases, it is necessary for the individual to receive **medication** before further treatment is possible (e.g. when someone is dealing with hallucinations, medication might help that person to be more self-aware and receptable to treatment).

- Increase engagement by asking **open-ended questions (motivational interviewing)**. This will help practitioners to better understand the individual's problems and to create a meaningful connection. It's important to avoid stigmatisation and confrontation.

- When an individual is socially isolated but does not show a schizotypal disorder, **group therapy** (peer group) can help lift this person out of isolation.

    - Young men working together on a certain task to stimulate group-building. This focus on nonverbal forms of therapy can make the individual feel a part of a group and by combining this nonverbal method with verbal forms of therapy, it can stimulate the individual to talk about feelings and emotions.

- **Family therapy** is an intervention that works with families to nurture change and development. This entails changes and development in terms of how family members interact. For instance, when the individual is young, family therapy can be provided through school, and always followed up by social workers.

[1] More info: RAN H&SC Conclusion paper, 3 June 2019.

- **Aggression replacement training (ART)** is a cognitive behavioural intervention where a person is encouraged to express what he/she wants in another way than with aggression. The therapy focuses on improving social skill competence and providing a person with other possibilities to express needs. The aim is to replace the aggression with verbal solutions for the problem ([2]).

- **The syndemic theory** is a proper framework to analyse causes and consequences, integrating several mental health and social factors in the analysis, and developing integral models for explanations and interventions.

- **Cognitive behaviour therapy (CBT)** is a type of psychotherapy that focuses on changing unhealthy, unreal or catastrophic ideas and thoughts that underly negative feelings and behaviour. It also aims to teach a person techniques and skills to alter negative and destructive behaviours.

- **Cognitive interviewing (CI)** is a method of interviewing to recover the individual's memory and gain information on their feelings, emotions and life. It helps to reflect on their behaviour, and to be more aware in terms of its causes, factors involved and consequences.

- In ethnopsychiatry, conversion to radical Islam can be seen as an attempted solution to a social symptom of disaffiliation with the family's original culture/group. **The reaffiliation process** is an intervention based on providing the radicalised (convert) individual access to his/her biological, cultural, religious and social origins. This is done by strengthening family ties, strengthening the social, cultural and religious affiliation of the parents, and involving grandparents and other family members in the intervention.

Practitioners should use flexible and dynamic methods in their intervention to find out what works and what doesn't. It is necessary to review the design of intervention programmes and other treatments to adapt the treatment to the characteristics of the target group.

Multi-agency and multi-disciplinary working

- Treatment is only useful when the follow-up plan includes the following: job search, use of leisure time, social support and family engagement. Its recommended to establish a system in which the individual is supported in tackling daily problems (especially for those suffering mental illnesses) and gains access to a normalised life.

- To handle challenging cases, mental health practitioners need support from a multi-disciplinary team to find the best suited intervention. As such, it's advised to set up a multi-agency structure where essential information can be shared between different professionals involved in a case.

    - In France, for example, each district has a platform where major institutions have a representative. When handling a difficult case, practitioners can turn to the platform for additional background information in order to better understand the person's trajectory and problems.

[2] More info on: http://www.episcenter.psu.edu/ebp/ART

Relevant practices

1. **Centre Georges Devereux** (France): a clinical ethnopsychiatriac centre providing clinical interventions and trainings and conducting research on the subject of ethnopsychiatry. Since 2014, the team has been involved in P/CVE, working with at-risk youth and their families, with support from the French government. More information here.

2. **Dianova Spain Association** (Spain): a non-governmental organisation (NGO) dedicated to the well-being and general interest of vulnerable populations. They work according to the syndemic theory. The association offers addiction follow-up and treatment services. Also, they provide educational programmes for minors with behavioural disorders. More information here.

Follow up

- With so many psychological intervention methods and practices identified, an important next step is to disseminate relevant information needed for mental health practitioners in the field of P/CVE.

- One important development would be the continuous exchange of knowledge and experiences on this topic between mental health practitioners in EU Member States. This would ensure making use of the knowledge already present in the network.

Further reading

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