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A mental health approach to understanding violent extremism

The field of preventing and countering violent extremism (P/CVE) has seen increasing calls for multi- and cross-agency coordination in multidisciplinary partnerships. The area of mental health is no exception: more and more, practitioners, policymakers and researchers are beginning to explore the interplay between mental health and radicalisation. Cross-agency approaches to mental health must recognise that mental ill-health encompasses not only confirmed, current diagnoses, but also conditions that represent areas of potential vulnerability despite not warranting diagnoses (i.e. subclinical cases). A functioning mental health paradigm/approach for the field of P/CVE must address these risk factors. It should also include evidence-based knowledge of the individual, group and societal protective factors that nurture resilience in multicultural contexts. There is growing acknowledgement that there are no simple causes or 'easy fixes' regarding mental health and violent extremism. The misunderstanding or misquoting of research findings on the presence of mental health diagnoses or impairments among some individuals involved in terrorism has had negative consequences for those living with mental health stigmatisation as well as for prevention (primary, secondary and tertiary): presence is not the same as relevance. These challenges call for continued collaborative and coordinated efforts, in order to generate agreed term definitions, assessment tools, treatment protocols with cultural and gender competencies across diverse contexts, ongoing monitoring and evaluation processes and multi-layered communications across agencies, disciplines, regions and other 'borders' including the translation of research findings into practice.

Mental health and radicalisation

This paper offers guidance for practitioners and policymakers developing or revisiting mental health approaches to radicalisation and violent extremism. The discussion begins with a brief exploration of the mental health preconditions and precursors that may be linked with radicalisation and violence, and the challenges in detecting them. Readers are then invited to consider the relationship between abnormal and normal psychological functioning; how this relationship is conceptualised will shape both policies and practices. The discussion turns next to diagnoses and treatment, considering how to do both responsibly. The paper concludes with an exploration of the need for and challenges to multi-agency working (MAW) in this area.

Over the years, several RAN working groups, particularly Health and Social Care (RAN H&SC), **have explored the role of mental health in P/CVE** among adults, youth, and children, while also exploring models and experiences of MAW coordination. The RAN H&SC working group was formed with the conviction that 'the problem was part of the solution': mental health diagnoses and subclinical concerns can function in certain conditions as risks and in other conditions as protective factors for radicalisation. It is commonly agreed (with some exceptions) that **the role of mental health concerns and mental health disorders cannot be ignored in multi-agency, coordinated prevention and treatment strategies**. However, the practicalities of translating this insight into policy and practice differ across and within countries.

Possible mental health **precursors** and **preconditions** for radicalisation involve the **interplay of diagnoses, psychosocial impairments, trauma, other personal factors, social dynamics and environmental stressors**. This variability is compounded by an additional **challenge** to coordinate strategies and responses: non-universal **understandings of mental health and mental ill-health,** which are always, to some degree, **culturally shaped** and built on explicit knowledge and context limits as well as implicit and explicit values. This diversity calls for explicit acknowledgement of the conceptual frames/paradigms/approaches used when selecting and implementing resources in response to questions about prevention (primary, secondary and tertiary), assessment and treatment.

Psychosocial impairments refer to dysfunctional and/or maladaptive family and/or peer relationships and poor school/work performance involving, for instance, disregard for others, lack of empathy, uncontrolled emotional reactions and low life quality. Although psychosocial impairments may occur in individuals who have been clinically diagnosed, often they are not associated with a mental health condition.

Overall, *whether* **mental ill-health and mental health disorders play a role in violent extremism has ceased to be considered a pertinent question; rather, the emphasis is on when and how this occurs.** Notwithstanding the important distinction that presence does not necessarily mean relevance, mental health issues and radicalisation have been observed to intersect in at least three ways, as follows:

1) **Diagnoses**: as explored in earlier RAN papers ([1]), certain diagnoses, such as the neuropsychiatric disorders of schizophrenia or autism spectrum disorder (ASD), are over-represented in individuals involved in violent extremism or at risk of violence, whether as lone actors or otherwise.

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1 For instance: Radicalisation Awareness Network (RAN). (2019). Understanding the mental health disorders pathway leading to violent extremism. RAN H&SC ex post paper, 13 March 2019. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/about-ran/ran-h-and-sc/docs/ran_h-sc_understanding_the_mental_health_190313_25_en.pdf;
Radicalisation Awareness Network (RAN). (2019). *Multi-problem target group: the influence of mental health disorders and substance abuse on Exit work*. RAN HSC & RAN EXIT ex post paper, 7 November 2018. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/exit_hsc_paper_joint_meeting_vienna_07112018_en.pdf

2) **Psychosocial impairments**: recent research ([2]) has found psychosocial impairment among those supportive of violence or carrying out violent acts; this finding is drawn from studies of general (non-clinical, non-diagnosed, subclinical) populations.

3) **Trauma**: several RAN papers ([3]) have noted that trauma *may be* a **risk factor** for violent extremism. The risk is not associated with the trauma experience itself but rather with the causes of the trauma and the resulting psychosocial impairments. Another factor is the capacity of the practitioners to offer trauma-informed interventions that identify and work with individuals' specific needs, hopes and resources, and to employ a person-centred perspective that reinforces the therapeutic alliance (i.e. the practitioner-client relationship) ([4]).

Diagnoses, psychosocial impairment, trauma and radicalisation and violence can be linked, but only when numerous other individual, social, political and operational factors are involved. An individual's experiences may fall under one or more of these categories, something which can — but does not necessarily — increase risk. **Each category can function as a risk, or occasionally, as a protective factor.** For example, a diagnosis or psychosocial impairment may result in treatment that is protective against violent extremism — or that increases risk if clinically mishandled, with the possibility for subsequent social stigmatisation and further isolation. Similarly, trauma could lead to post-traumatic stress disorder (PTSD), or in certain circumstances and conditions, to post-traumatic growth (PTG) ([5]). And while these categories of mental health issues may **intersect** with violent extremism, they also intersect with violence in general and with social inequalities ([6]).

'INVISIBLE' PRECONDITIONS

Lone actors and the role of mental ill-health/disorders have been the focus of much research. A large proportion of lone actor violent extremists show aversive (i.e. antisocial) behavioural patterns; a subgroup, specifically those on the periphery of society, have **abnormal functioning** as a majority characteristic. However, **mental health issues *may* be a precondition for *any* violent extremist actor**, not only for lone actors or those with diagnoses. Empirical studies carried out on the general population indicate that individuals who support violence or carry out violent acts tend to have relationship, school and/or work difficulties ([7]). However, those with psychosocial impairments are often not identified until an acute crisis occurs that involves local mental and/or physical health services, social work, criminal justice, education and/or others.

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2 For instance, Gøtzsche-Astrup, O., & Lindekilde, L. (2019). Either or? Reconciling findings on mental health and extremism using a dimensional rather than categorical paradigm. Journal of forensic sciences. doi: 10.1111/1556-4029.14014

3 For instance, Radicalisation Awareness Network (RAN). (2016). Child returnees from conflict zones. RAN issue paper, November 2016. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/issue_paper_child_returnees_from_conflict_zones_112016_en.pdf;
Radicalisation Awareness Network (RAN). (2019). Multi-Agency Working and preventing violent extremism: Paper 2. RAN H&SC position paper. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/about-ran/ran-h-and-sc/docs/ran_hsc_policy_mawr_report_sarma_26032019_en.pdf;
Radicalisation Awareness Network (RAN). (2018). Enhancing the resilience of victims after terrorist attacks. RAN Issue paper, March 2018. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/about-ran/ran-rvt/docs/enhancing_resilience_victims_after_terrorist_attacks_032018_en.pdf

4 Christenson, A. B. (2019, May). Prevention of Trauma Among Refugees: Components and findings from a trauma treatment project in four Danish municipalities'. Paper presented at RAN meeting, Paris.

5 Gøtzsche-Astrup, O., & Lindekilde, L. (2019). Either or? Reconciling findings on mental health and extremism using a dimensional rather than categorical paradigm. *Journal of forensic sciences*. doi: 10.1111/1556-4029.14014;
Sapach, M. J. T., Horswill, S. C., Parkerson, H. A., Asmundson, G. J., & Carleton, R. N. (2019). Centrality of Traumatic Events: Double Edged Sword or Matter of Valence?. *Cognitive Therapy and Research*, 43(2), 374-386. https://doi.org/10.1007/s10608-018-9983-9.

6 Weine, S., Eisenman, D. P., Kinsler, J., Glik, D. C., & Polutnik, C. (2017). Addressing violent extremism as public health policy and practice. *Behavioral sciences of terrorism and political aggression*, 9(3), 208-221. doi: 10.1080/19434472.2016.1198413;
Weine, S. M., Stone, A., Saeed, A., Shanfield, S., Beahrs, J., Gutman, A., & Mihajlovic, A. (2017). Violent extremism, community-based violence prevention, and mental health professionals. *The Journal of nervous and mental disease*, 205(1), 54-57.

7 Gøtzsche-Astrup and Lindekilde (2019) Either or? Reconciling Findings on Mental Health and Extremism using a Dimensional Rather than Categorical Paradigm. J Forensic Sci,2019doi: 10.1111/1556-4029.14014

Key actions to inform mental health approaches in the midst of these complexities:

- identify appropriate **support mechanisms** to **strengthen protective factors** and **reduce risks**;
- develop appropriate **intervention and rehabilitation strategies** for those individuals already involved in violence;
- formulate **culturally and gender-informed** effective interventions for individuals with special needs;
- put in **place ongoing monitoring and evaluation** processes to identify gaps and best practices in existing public mental health promotion, prevention, intervention, rehabilitation and assessment processes.

RECOGNISED PRECURSORS

There is strong evidence indicating that chronic and severe stress resulting from multi-trauma experiences contributes to mental health imbalances later in life ([8]), increasing vulnerability generally, including radicalisation and violent extremism. Mental health imbalances may be linked to the use of alcohol or other drugs, which is also associated with radicalisation and violent extremism ([9]). However, **none** of these links **are absolute or necessary**. Despite the real risk, not all traumatised children have mental health problems ([10]). Resilience and other protective factors (personal and/or community-based) **can compensate for risk**, facilitating a positive final outcome. Very few traumatised young people turn towards violent extremism, even with the extra risk of online recruitment ([11]).

To become radicalised, an individual made vulnerable by early trauma must be exposed to ideological propaganda combined with direct or indirect group influence or pressure. In the short term, ideological extremism can operate as a kind of protective factor, offering a sense of purpose and protection against other mental health problems, while working as a type of 'cure' for post-traumatic stress and depression. Individuals with relationship issues may experience extremist groups as caring communities, view the group leaders as surrogate father figures, and experience the group social norms as accepting rather than rejecting of antisocial or narcissistic tendencies ([12]). In these cases, **multi-agency practitioners and policymakers** need to determine when and how to oversee, carry out, and **monitor the disengagement of these individuals from radicalisation and extremism, in ways that provide appropriate alternative protective factors** (as well as identify who will be responsible for doing this). It is equally important to determine how the appropriate protective factors will be identified, as well as by whom and with which criteria. Careful leadership of the cross-agency planning and monitoring of the process will not only help to avert failed or counter-productive disengagement efforts but will also prevent them from inadvertently compounding wider community problems.

ABNORMAL VERSUS NORMAL PSYCHOLOGICAL FUNCTIONING

As mentioned at the beginning of this paper, the practical, 'how'-type questions must address large contextual differences, such as **the relationship between 'abnormal' and 'normal' psychological functioning**. This is not an academic question. **The relationship between the two categories will shape prevention and treatment practices and policies.**

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8 Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C. H., Perry, B. D., ... & Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. *European archives of psychiatry and clinical neuroscience*, 256(3), 174-186. Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2013). *Violence, crime, and abuse exposure in a national sample of children and youth*: An update. JAMA pediatrics, 167(7), 614-621.

9 Radicalisation Awareness Network (RAN). (2018). *Multi-problem target group: the influence of mental health disorders and substance abuse on Exit work.* RAN HSC & RAN EXIT ex post paper, 7 November 2018. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/exit_hsc_paper_joint_meeting_vienna_07112018_en.pdf

10 Personality disturbances can be related to early childhood trauma paired with disorganised attachment (Lyddon et al., 2001). However, social impairment is not necessarily the result; in fact, sometimes it is the opposite. See Greenberg, D. M., Baron-Cohen, S., Rosenberg, N., Fonagy, P., & Rentfrow, P. J. (2018). Elevated empathy in adults following childhood trauma. PLoS one, 13(10). https://doi.org/10.1371/journal.pone.0203886).

11 Radicalisation Awareness Network (RAN). (2018). Developing counter- and alternative narratives together with local communities. RAN C&N issue paper, 15 October 2018. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/about-ran/ran-c-and-n/docs/developing_counter_and_alternative_narratives_together_with_local_communities_en.pdf

12 Lundesgaard, A. & Krogh, K. (2018). From Childhood Trauma to Violent Extremism: Implications for prevention. In G. Overland, A. J. Andersen, K. E. Førde, K. Grødum & J. Salomonsen (Eds.), *Violent extremism in the 21st century: International perspectives* (pp. 180-188). Newcastle-upon-Tyne: Cambridge Scholars Publishing.

Two commonly used models ([13]) are shown in Figure 1: Model 1 (*top*) shows a dimension with 'normal' and 'abnormal' at either end, while Model 2 (*bottom*) shows discrete categories.
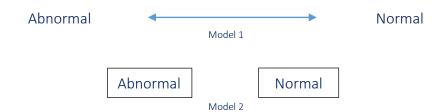
Abnormal ←——————→ Normal

Model 1

| Abnormal | | Normal |

Model 2

Figure 1. Two models of relationship between abnormal and normal functioning (source: authors, drawing on Gøtzsche-Astrup & Lindekilde, 2019).

While only a very small percentage of individuals being radicalised, **abnormal functioning** *can* **increase risk and/or vulnerability to recruitment.** It is therefore vital to evaluate existing (multi-agency) prevention and treatment strategies to ascertain whether they help individuals move towards or away from **'normal' functioning,** and whether such strategies are built on an underlying assumption that each individual inhabits one or the other category throughout their lifetime. Since psychosocial impairment and disorder may remain undetected until radicalisation occurs, the scope of prevention and treatment strategies may need to be expanded to include the wider populace, but the goal of the strategies will vary according to the chosen model (one of the models in Figure 1) ([14]).

Diagnoses

It is generally agreed that there is a need to enhance **protective factors** for mental health patients who might be particularly attracted to **violent extremist messages**, e.g. those with ASD, psychosis and schizophrenia. **Each case needs to be treated individually, and treatment carefully planned so as to avoid unintentionally triggering reactions that increase rather than reduce risk.** For example**, specific aspects of autism like fixation, social naivety or social impairment can render individuals vulnerable** to becoming radicalised, especially **through online recruitment tactics**. Supporting someone with ASD during disengagement will involve compensating for what is lost via alternative initial and sustainable rewards and incentives. Similarly, if someone with schizophrenia is not offered or is unable to access mental health treatment, the risk of radicalisation may increase. All treatment strategies need to be adapted to and made accessible across ethnic groups and cultures, to include rewards for engagement and include long-term strategy planning to satisfy the felt needs that render radicalisation attractive.

> The social stigmatisation of diagnosis and treatment can increase isolation and the risk of radicalisation. Public communications, including those with the media, need careful handling. For example, the media may highlight the presence of a mental health disorder in a terrorist act without considering its relevance to the terrorist act. If media attention focuses on diagnoses rather than the multidimensional, individualised nature of a person's involvement with violence, the social stigma attached to mental health disorders will increase. As a result, the social consequences of treatment will cause some to shun the help needed to prevent radicalisation.

The complexity of mental ill health and other concerns that need to be taken into account when assessing vulnerability for violent extremism is illustrated by the following example. Of all the individuals who committed recognised terrorist criminal acts in France, none had a history of known schizophrenia, ASD or bipolar disorder. Rather, past juvenile delinquency seemed to represent a more significant risk factor, with a very difficult life course leading to the development of dysfunctional attachment patterns and a lack of emotional regulation, characterised by repeated failures to deal with these difficulties. Preventive and anticipatory treatment will involve the close study of an individual's life course (using all available information, e.g. family member interviews, cross-agency files and judicial records) in order to identify how radicalisation fulfilled their needs.

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13 See discussion in Gøtzsche-Astrup, O., & Lindekilde, L. (2019). Either or? Reconciling findings on mental health and extremism using a dimensional rather than categorical paradigm. Journal of forensic sciences. doi: 10.1111/1556-4029.14014.

14 See discussion about the interplay between mental health disorder functioning and push/pull factors leading to radicalisation; if one accepts that the risk factors are many and varied, then MAW coordination is required – to improve the mental health of all as well as for effective prevention at all levels. RAN Ex Post paper Taking mental health insights into account in local P/CVE

Policy considerations for mental health planning through an inter-agency and societal perspective

Member States continue to face many **dilemmas centred on mental health concerns and human rights**. These include identifying how interventions involving sensitive data are best coordinated across agencies, whether individuals with mental health concerns can be separated from radicalised or violent extremist groups without their consent or against their will, and whether **prevention strategies for mental health issues** should be used population-wide, given the 'invisibility' of both existing and potential mental health concerns. **Additional challenges for practitioners** active in law enforcement, criminal justice, youth work, health and social care, mental health services, education and others include the following areas:

- The identification of appropriate short- and long-term assessments for use with all individuals who engage with mental health services:
  - o ensuring that **assessments identify and monitor the presence of protective factors** (e.g. social and emotional intelligence, resilience, emotion regulation, trustworthy relationships and access to safe environments), **as well as risk factors** (including dysfunctional or maladaptive attachment — 'attachment' refers to how an individual responds in relationships when hurt, separated from loved ones or perceives threat);
  - o **putting in place regular training for and monitoring of assessment tools along with ongoing evaluation.**
- Cross-agency acceptance that there are no quick, simple clinical solutions:
  - o some diagnoses, psychosocial impairments and traumas may be associated with radicalisation and violent extremism, but any association is complex and hinges on many other factors. A diagnosis or impairment may be a contributing cause of radicalisation, but it is always non-predictive and is never an isolated cause operating separately from other factors. The role of mental health concerns must be understood within the larger acknowledgement that a **turn towards violent extremism is indeterminate.** Rather than 'pathways' (which imply a linear route or progression), practitioners should identify intersections, exits, re-entries, circles, and overlapping factors and dimensions ([15]).
- The large but crucial task of tackling stigmas, stereotypes and other prejudices attached to mental health concerns:
  - o these can 'cast a **cloak of invisibility**' over problems, and prevent early intervention, as well as reinforce vulnerability to radicalisation through physical and relational isolation. The experience of stigmatisation can also contribute to anger and/or depression, that for some may become a vulnerability to radicalisation ([16]).
- **Creating the right conditions for professionals** to support those with mental health concerns:
  - o in the long-term, **establishing practical and functional multi-agency-frameworks** with durable support for public mental health promotion strategies across multicultural communities and across prevention and intervention activities (primary, secondary and tertiary).
- Determining appropriate protocols for engaging with those whose mental health improves initially with radicalisation:
  - o careful cross-agency management and coordination are needed in order to avoid causing mental health damage, by providing alternative contexts to meet **identity and belonging needs**. One method is to develop social media apps and forums offering safe 'spaces' where youth can engage sustainably in activities focused on identity, belonging and 'meaning-making' (defined below).
- The prerequisite for meeting all these challenges is a public health framework spanning national and local levels — strategies, action plans, guidelines and protocols — to help guide responsible practitioners in long-term P/CVE interventions. Such policies entail continuous development (an iterative process) and ongoing evaluation ([17]).

Carefully maintaining the distinctions between different kinds of mental illnesses and different kinds of violent extremism will help prevent the indiscriminate justification of all terrorism using a few mental

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15 Radicalisation Awareness Network (RAN). (2016). The Root Causes of Violent Extremism. RAN issue paper, 4 January 2016. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/issue_paper_root-causes_jan2016_en.pdf.
16 Also noted in RAN Ex Post paper Taking mental health insights into account in local P/CVE
17 Ibid.

illness categories ([18]). Consider the following example: Two individuals join a violent extremist group. The one, with pathological narcissism and a lack of empathy, may be adept socially and may discover that a violent extremist group is a receptive environment for their specialised social skills in manipulation ([19]). The other, with psycho-social impairment and an anti-social personality profile, may experience a sense of belonging with the extremist group and feel that they share a common world-view. For both individuals, psychological functioning plays a role in their decisions to join this type of group, but each of their different mental health profiles (one with a diagnosis and one without) requires a different prevention/intervention strategy for maximum effectiveness. In other words, the **possible background role of a psychiatric diagnosis cannot be equated with the possible background role of psycho-social impairment.** Practitioners should identify protocols to **avoid minimising or erasing these differences**. **Failure to do so exposes their work to ineffectiveness, unintended negative consequences and increased risks** ([20]).

THE ROLE OF SOCIAL DYNAMICS

A predisposition to **mental health concerns can be triggered or exacerbated through chronic adverse environmental conditions,** shifting individuals (and groups) towards 'abnormal' functioning, and possibly finding expression through violent extremism. These shifts often occur through social dynamics. Protective factors such as **personal** *and* **community resilience**, within and across communities, should be assessed and strengthened. This involves addressing the social polarisations that such individuals might consider appealing ([21]). **A focus on *either* social dynamics *or* mental health issues** results in **'a blind spot in counter violent extremism practices and increases the risk of not identifying threats in time for effective intervention'** ([22])**.** Given the interplay of social dynamics and mental health, prevention policies and practices need to include the wider population.

THE ROLE OF MEANING AND SIGNIFICANCE

An **underlying rationale** for considering radicalisation and violent extremisms alongside the abnormal-normal dimension or categories is recognition among practitioners of the role of the human **desire for meaning and significance as a motive for joining radical and extremist groups** ([23]). Anticipatory prevention, intervention and treatment approaches can include the development of skills for 'meaning-making': the creation and maintenance of health-promoting personal and collective narratives, symbols and rituals for sustainable mental health. These **'meaning-making' processes** can be taught and learned, and are attracting a large amount of international attention across public health and mental health frameworks ([24]). These practices bestow confidence, a positive self-identity and a sense of belonging, all protective against radicalisation. Incorporating meaning-making into mental health approaches offers an antidote to quick-fix prevention and intervention strategies. It is in line with a 'life-embeddedness' approach, based on **life psychology**, that targets young people at risk of violent extremism, as employed by the Aarhus model in Denmark ([25]). Constructing meaning-making strategies is identified as one of the keys to success at the Sabaoon residential centre in Pakistan for deradicalising and rehabilitating adolescent and pre-adolescent males (where there is zero recidivism, to date). Every resident **designs a life trajectory** for meaningful social, civic and economic

18 For an example of good practice see: RAN H&SC 2019, https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/about-ran/ran-h-and-sc/docs/ran_h-sc_understanding_the_mental_health_190313_25_en.pdf

19 Bath, H. (2008). The three pillars of trauma-informed care. Reclaiming children and youth, 17(3), 17-21.

20 Romaniuk, P. (2015). Does CVE work? Lessons learned from the global effort to counter violent extremism. Global Center on Cooperative Security. September 2015. Retrieved from https://www.globalcenter.org/wp-content/uploads/2015/09/Does-CVE-Work_2015.pdf

21 Radicalisation Awareness Network (RAN). (2017). RAN Polarisation Management Manual RAN ex post paper, 6 July 2017. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/ran_polarisation_management_manual_amsterdam_06072017_en.pdf

22 Gøtzsche-Astrup, O., & Lindekilde, L. (2019). Either or? Reconciling findings on mental health and extremism using a dimensional rather than categorical paradigm. *Journal of forensic sciences.* doi: 10.1111/1556-4029.14014

23 DeMarinis, V. (2018). Countering violent extremism: Public mental health promotion in a public health paradigm. In G. Overland, A. J. Andersen, K. E. Førde, K. Grødum & J. Salomonsen (Eds.), *Violent extremism in the 21st century: International perspectives* (pp. 271-281). Newcastle-upon-Tyne: Cambridge Scholars Publishing.

24 Lloyd, C. S., af Klinteberg, B., & DeMarinis, V. (2017). An Assessment of Existential Worldview Function among Young Women at Risk for Depression and Anxiety—A Multi-Method Study. *Archive for the Psychology of Religion*, 39(2), 165-203. .

25 Ozer, Simon, Bertelsen, Preben Peace and Conflict: Journal of Peace Psychology, May 02 , 2019, No Pagination Specified. E-print, ahead of print. Countering radicalization: An empirical examination from a life psychological perspective;
Lindekilde, L., Bertelsen, P., & Stohl, M. (2016). Who goes, why, and with what effects: The problem of foreign fighters from Europe. *Small Wars & Insurgencies*, 27(5), 858-877.

participation following community reintegration, with ongoing psychosocial support and monitoring ([26]). Cultural and social differences will influence whom policymakers identify as responsible for teaching meaning-making ([27]) to young people (e.g. particular individuals, social groups, agencies and/or institutions). Responsibility might be shared across agencies, or alternatively, one agency could take the lead. Importantly, responsibility might be shared among prevention practitioners as part of the existing counter-narrative practices.

TRAUMA-INFORMED CARE

Three protective factors are key for traumatised children who might be at risk of radicalisation**: safe environments, trustworthy relationships and adequate support in learning to cope with and regulate negative emotions** ([28]). With **trauma-informed care for prevention, intervention or rehabilitation, the child's unique experiences are assessed, and the effects of trauma are treated individually and/or in collaboration** with caring adults ([29]).The family, group or an even wider network needs to be involved in the trauma-informed care. Many children, young people, and adults in one family group or community may be affected by the same trauma, and may also be at risk of radicalisation through comorbidity and secondary trauma. This necessitates **a holistic approach, to address the needs of various family members** ([30]). In all situations, it is crucial to take into account how past individual and collective traumatic experiences have affected family dynamics. Police, criminal justice, education, social care, mental health, and physical health services need to consider how they will coordinate trauma-informed care for personal, familial, and community resilience in the above three key protective factor areas.

Trauma-informed interventions are necessary as a matter of good practice for very different populations likely to have PTSD or other traumas, such as returnees, war veterans and refugees. When trauma exists in the background (personal, familial and/or communal) of an individual turning towards radicalisation, it is easy to focus on the trauma rather than the structural issues associated with the trauma ([31]). **Yet these structural issues could be greater risk factors for radicalisation than the resulting trauma itself. Many individuals with trauma have themselves been traumatised by terrorists. To understand the sequela (i.e. consequences) of multiple-trauma experiences, practitioners must attend to the possible iatrogenic (i.e. system-induced) consequences of problematic healthcare and social interventions that further traumatise the individual or group**. For refugees and asylum-seekers, post-destination trauma is an established area of concern (see previous RAN papers [32]).

26 Khan, R.R. & Peracha, F.N. (2017). Deradicalizing, Rehabilitating and Reintegrating Violent Extremists. Peace Brief, United States Institute of Peace. Retrieved from https://www.usip.org/publications/2017/11/deradicalizing-rehabilitating-and-reintegrating-violent-extremists;

Peracha, F. N., Khan, R. R. & Savage, S. (2016). Sabaoon: Educational Methods Successfully Countering and Preventing Violent Extremism. In S. Zeiger (Ed.) Expanding Research on Countering Violent Extremism (pp. 85-104). Hedayah and Edith Cowan University. Retrieved from http://www.hedayahcenter.org/Admin/Content/File-410201685227.pdf;

Macdonald, S. (2016). Terrorist Narratives and Communicative Devices: Findings from a Study of Online Terrorist Magazines. In S. Zeiger (Ed.) *Expanding Research on Countering Violent Extremism* (pp. 127-141). Hedayah and Edith Cowan University. Retrieved from https://www.researchgate.net/publication/309031804_Terrorist_Narratives_Communicative_Devices_Findings_from_a_Study_of_Online_Terrorist_Magazines;

Azam, Z., & Fatima, S. B. (2017). Mishal: a case study of a deradicalization and emancipation program in Swat Valley, Pakistan. *Journal for Deradicalization*, (11), 1-29. Retrieved from http://journals.sfu.ca/jd/index.php/jd/article/view/97

27 Encompassing both narrative- and ritual/symbol components as well as aspects of identity and belonging. This component is climbing high on the agenda in mental health circles in the very secular contexts of both Sweden and Norway, not only around P/CVE, but as part of the wider discussion about how to respond to increasing mental ill health among youth in general.

28 Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming children and youth*, 17(3), 17-21. See also Dalgaard-Nielsen, A., & Schack, P. (2016). Community Resilience to Militant Islamism: Who and What?: An Explorative Study of Resilience in Three Danish *Communities. Democracy and Security*, 12(4), 309-327, as noted in RAN. (2018). *Developing counter- and alternative narratives together with local communities.*

29 Radicalisation Awareness Network (RAN). (2016). *Child returnees from conflict zones.* RAN issue paper, November 2016. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/issue_paper_child_returnees_from_conflict_zones_112016_en.pdf

30 Kiser, L., & Figley, C. R. (2013). *Helping traumatized families*. New York: Routledge.

31 See similar point in RAN Ex Post paper Taking mental health insights into account in local P/CVE

32 See Radicalisation Awareness Network (RAN). (2018). PTSD, trauma, stress and the risk of (re)turning to violence. RAN H&SC ex post paper, 10-11 April 2018. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/ran_h-sc_ptsd_trauma_stress_risk_re-turning_violence_lisbon_10-11_04_2018_en.pdf;

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Coordinating across agencies and professions

Fostering trust among agencies is key to developing or strengthening structures and systems **for cross-agency P/CVE information-sharing. Action points to support this include:**

- Design frameworks that also allow for situations where information-sharing is less helpful (e.g. during prosecution).
- Build relationships in order to produce strategies that can be monitored and evaluated.
- Put in place information-sharing guidelines with rigorous safeguards against misuse, and rectify the problem swiftly when this occurs.
- Use positive incentives for information-sharing, giving credit to all involved when communication goes well.
- Develop multi-agency teams from the bottom up and support local initiatives through national training programmes.

Information-sharing can support the development of **risk assessment tools**. Appropriate assessment in a MAW context requires a **shared lexicon of terms and definitions that can prevent cross-agency misunderstandings**. Tool evaluation is essential. **Without evaluative monitoring processes to ensure fidelity of use, assessment tools can be misused — to confirm assumptions and maintain current practices rather than to uncover unrecognised risks and protect vulnerable individuals.** Evaluations should cover practitioner experiences of tool use, confidence during use, and identification of new information discovered as a result (e.g. benefit gained from using the tool, that would otherwise be lacking).

Ongoing training supports fidelity of use and increases confidence. **Similarly, ongoing assessment of individuals for protective as well as risk factors enables targeted strategies for prevention and rehabilitation. Ongoing individual assessment also increases the likelihood of supporting and redirecting individuals who, while not mental health patients, display behaviours indicating psychosocial impairments that could increase the appeal of violent extremist rhetoric and ideologies.** For example, in Bosnia, commonalities and possible patterns among lone actors include broken families, abusive parents, trauma transfer across generations and untreated mental health problems.

Social and health care providers and services in diverse agencies need to accept the principle that 'practitioners cannot address what they cannot see'; all providers can benefit from being equipped with prevention and intervention strategies appropriate for use with all individuals presenting with mental health disorders. At the same time, mental health providers can 'reclaim' and apply their existing professional training and expertise to support all clients in ways that reduce risk and enhance protective factors, while working to reduce social stigma and the social isolation and marginalisation that it entails. **A working 'therapeutic alliance' is an essential part of health and social care interaction. Gaining access to the individual's own interpretation of the situation, and assessment of problems as well as possible resources, hopes and aspirations, is facilitated by instruments such as the Cultural Formulation Interview (CFI)** [33]. In international studies, the CFI has contributed to an improved therapeutic alliance with challenging patients/clients, and has increased rates of compliance [34].This free instrument is available for use internationally [35].

Supporting the disengagement of individuals with multiple mental and physical health needs from violent extremist groups requires **multi-agency communication** and coordination, so as to assess the needs, risk and protective factors and life-course story of every individual identified as radicalised. For example, RAN EXIT practitioners consult a network of trusted mental health specialists who support referrals as needed (Diagnostic-Therapeutic Network Extremism (DNE)). **Appointing a central coordinator** for each individual involved in disengagement can help to overcome some of the communication challenges around information-sharing.

Multi-agency information-sharing is also crucially important for the **joint formulation of communication strategies and policies with the media (and wider public) on the topic of mental health and radicalisation**. This may

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33 The Cultural Formulation Interview (CFI) is a free-standing instrument found in: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (DSM-5®). (5th ed.) Washington DC.

34 Lewis-Fernandéz, R., Aggarwal, N. K., & Kirmayer, L. J. (2016). Introduction, I. In R. Lewis-Fernandéz, N. K. Aggarwal, L. Hinton, D.E. Hinton, & L. J. Kirmayer, (Eds.), *DSM-5 Handbook on the Cultural Formulation Interview*. Washington DC: American Psychiatric Publishing.

35 See the American Psychiatric Association Cultural Formulation Interview online. A link to the PDF version of the CFI is automatically provided.

warrant cultivating partnerships and regular meetings with media and other public representatives, to discuss challenges. All parties can be enlisted to prevent and redirect public discourse that further stigmatises and marginalises those with mental health issues.

RAN papers for further reading

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Radicalisation Awareness Network (RAN). (2018). *Transforming schools into labs for democracy: A companion to preventing violent radicalisation through education*. RAN Centre of Excellence policy paper. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/about-ran/ran-edu/docs/ran_edu_transforming_schools_into_labs_for_democracy_2018_en.pdf

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Radicalisation Awareness Network (RAN). (2017). *A holistic local approach to preventing radicalisation in Helsinki*. RAN ex post paper, study visit Helsinki, 8-9 June 2017. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/ran-papers/docs/ran_paper_holistic_local_approach_to_preventing_radicalisation_8-9_06_en.pdf

Radicalisation Awareness Network (RAN). (2019). *Monitoring & Evaluating counter- and alternative narrative campaigns*. RAN C&N ex post paper, 21-22 February 2019. Retrieved from https://ec.europa.eu/home-affairs/sites/homeaffairs/files/what-we-do/networks/radicalisation_awareness_network/about-ran/ran-c-and-n/docs/ran_cn_ex_post_evaluating_campaigns_berlin_210219_22_en.pdf