

RAN HEALTH

28/11/2023

CONCLUSION PAPER

RAN HEALTH Working Group meeting

23-24 October 2023, online

RAN HEALTH: Psychotic disorders and the implications for P/CVE

Key outcomes

On 23 and 24 October, the RAN Mental Health Working Group meeting on 'Psychotic disorders and the implications for P/CVE' took place online, via WebEx. During this meeting, mental health practitioners, social workers and prison staff discussed the role of psychotic disorders and their symptoms in the process of radicalisation as well as their impact on the disengagement, rehabilitation and reintegration process. There is some research evidence that psychotic disorders and disorders from the schizophrenia spectrum seem overrepresented in lone-actor terrorists⁽¹⁾. Since the presence of psychotic symptoms can complicate preventing and countering violent extremism (P/CVE) work, it is crucial to examine the specific aspects of psychosis and if, when and how they may relate to extremist behaviour rather than ideation⁽²⁾. Participants of the meeting discussed implications by means of case studies and formulated practical needs and recommendations:

- Looking at the links between psychosis and terrorism, there are four scenarios that each have a different treatment approach.
- Dependent on whether there may be a direct link between psychosis and terrorism, an indirect link, no link or it is the case of no psychosis. Treating psychotic symptoms may or may not reduce risk.
- It is important to know the medical history of an individual and the sequence of the symptoms that are present when formulating conclusions. The role of the family in this can be very important.
- There is still a lot of stigma around persons with severe mental illness and who are radicalised. It is important that practitioners are aware of this stigma and not contribute to it. This gets in the way of offering the right treatment and for persons to overcome their illness.
- Information sharing and trust between parties (medical, police, criminal justice services, social services, immigration) remain a challenge. This makes it hard to identify risk and set the right diagnosis and treatment plan and also creates challenges in the rehabilitation process.

⁽¹⁾ Schulten, N., Doosje, B., Spaaij, R., & Kamphuis, J. H. (2019). *Radicalization, Terrorism & Psychopathology: State of affairs, gaps and priorities for future research*. Commissioned by the Research and Documentation Centre/Dutch Ministry of Justice and Security. University of Amsterdam.

⁽²⁾ RAN e-learning: *Extremism, radicalisation & mental health: Guidance for practitioners*, via EU Academy.

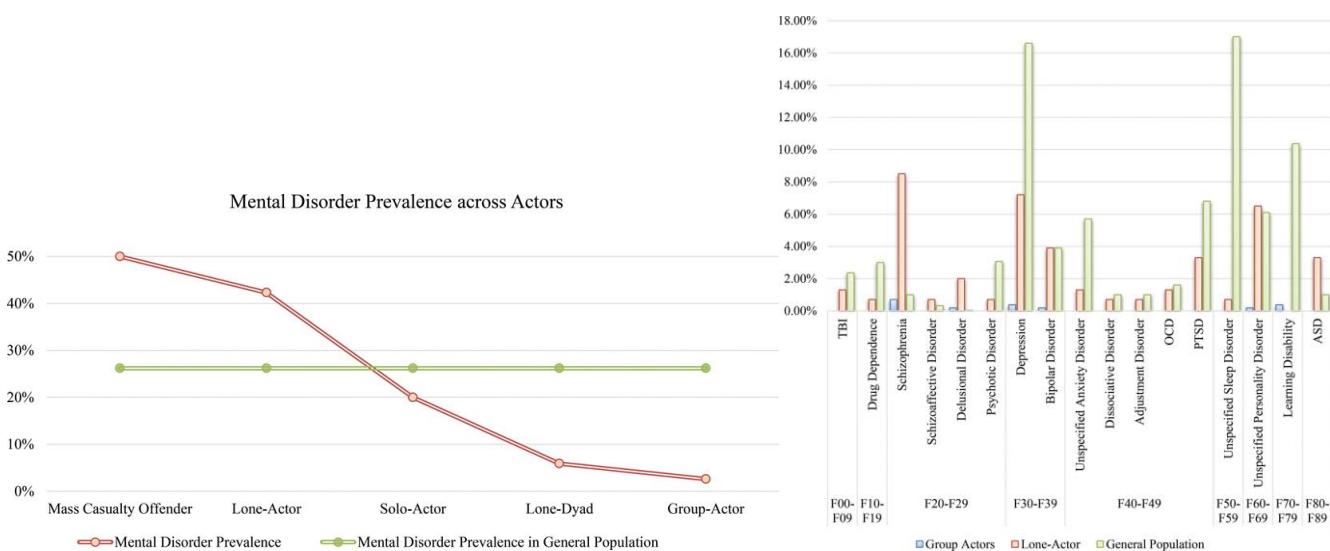
This paper summarises the main conclusions following the discussions and presentations.

Highlights of the discussion

Psychosis and radicalisation in research

Prospective and retrospective studies have found raised risk of violent crime perpetration for people diagnosed with schizophrenia. A study among prison inmates observes a higher probability of violent acts for people with severe mental illness compared to people not diagnosed with a functional psychosis. However, the association between lack of formal education and committing violent acts is almost three times higher⁽³⁾. Research about radicalisation and mental health has caveats. Most research is cross-sectional and it is impossible to make causal inferences. Also, research often compares the terrorist population to the general population, rather than to other perpetrators.

Overall, most individuals who commit terrorism are not mentally ill⁽⁴⁾. When mental illness is present, it tends to be more prevalent in specific subgroups compared to the general population. There is evidence that the more isolated the individual is in terms of the number of co-offenders and support networks, the more likely it is that this individual will also have mental health problems⁽⁵⁾. The same research found that schizophrenia and delusional disorder are more common in lone actors than in the general population⁽⁶⁾.



Graphs from: Corner, Gill & Mason (2016)

Psychotic experience

Individuals with psychotic disorders have a hard time in differentiating between their perceptions and reality. The disorder affects their functioning by altering thoughts, beliefs or perceptions and can be accompanied by hallucinations (i.e. seeing or hearing things that nobody else experiences) or delusions (i.e. having intense false beliefs that are not shared by others). The following experiences may be present:

⁽³⁾ Saavedra, J., López, M., & Trigo, E. (2017). Association between violent crimes and psychosis in men serving prisons terms. *Spanish Journal of Psychology*, 20, 1-11.

⁽⁴⁾ RAN H&SC Handbook: *Extremism, radicalisation and mental health*.

⁽⁵⁾ Corner, E., Gill, P., & Mason, O. (2016). Mental health disorders and the terrorist: A research note probing selection effects and disorder prevalence. *Studies in Conflict & Terrorism*, 39(6), 560-568.

⁽⁶⁾ Ibid.

- Ontological insecurity, which results in searching for meaning to explain situations and experiences, but also in seeing patterns or connections in random or meaningless perceptions.
- A state of tension and uncertainty, the feeling that an apocalypse is about to happen with an alteration in awareness of the world around oneself can further drive persons to search for meaning.
- A loss of the sense of self, which may lead to self-destructive tendencies.
- An alternation of bodily experiences and of continuity in time and a feeling of disconnection from the world.

Untangling psychosis – terrorism links

The first line of treatment that is often considered when an individual has a psychotic episode is medication. This may reduce stress and might be needed to be able to start treatment, but it is not clear if it will reduce terrorism risk. Every individual is different and psychosis–terrorism links and their treatment need complex, dynamic and individual formulation. In general, it could be said that there are four different possible scenarios when a radicalised individual has psychosis. Treatment and support approaches that reduce terrorism risk could vary with each scenario.

1. There is a direct link between (some aspects of) psychosis and terrorism: reducing symptoms is reducing the risk

Someone talking about terrorism does not equate them with being a terrorism risk. We need to get past the assumption that terrorism talk signals risk. A lot of symptoms are bio-psycho-social, hence impacted by social salience. For example, after 9/11, stories about the attack were all over the news and also became the subject of many conversations. Some psychiatric patients suddenly started to talk about al-Qaeda and their ideation changed into terrorism themes. In rare cases psychotic symptoms link directly and causally to risk. If there is a causal link present, there might be clusters of symptoms that could activate violence, rather than one specific symptom. For example, hallucinations congruent with delusions:

- For example, delusional belief system and supporting hallucinations that generate an intense sense of threat from an enemy outgroup (threat-control-override). This is a perceived threat but feels real to the patient, giving them the idea that they have to defend themselves.
- For example, delusional ideation and supporting hallucinations that created a perception that the person is a member of the terrorist group and they have a grand role to re-enact. Delusion of grandeur with a sense of moral duty.

Treatment implications: consider treating persons medically to reduce stress and where required psychologically with cognitive behavioural therapy to address risk causal symptoms (conducive ideation and threat-control-override).

2. Indirect links: reducing other risk factors that interact with psychosis and terrorism reduces the risk

The second scenario may be indirect links between aspects of psychosis and terrorism, which are probably a more common scenario than direct links. Examples of this scenario could be:

- The **consequences of psychosis**, for example anxiety, stress, social decline, isolation, helplessness, dejection and stigma, may create “push” factors for terrorism. Extremist narratives can act as “pull” factors because they play into the sense of threat by providing relief, meaning, belonging or a solution for the sense of threat and injustice.
- **Side effects of anti-psychotic medication**, for example weight gain, sexual dysfunction, cognitive deficits and physical health problems, can create vulnerabilities that act as push factors for terrorism.

- Psychosis **interacts with other conditions** (personality disorder, substance use disorder, mood disorder, neurodevelopment disorders, complex PTSD) to create push & pull factors for terrorism:
 - For example, psychosis alone may have no forensic primacy (not a primary driver for risk), but maybe antisocial or narcissistic personality disorder has forensic primacy and psychosis adds to the vulnerability and reduces resilience.
 - For example, psychosis alone may have no chronological primacy, which means the risk emerges first and psychosis is the end point. It may lift inhibitions on existent risk.
- Psychosis **unmasks or accentuates another condition** that may shape push/pull factors
 - For example, undiagnosed autism (autism spectrum disorder (ASD)) which is often missed. Psychosis may be induced by ASD-congruent stressors such as change, social sensory crisis or overload.
- Psychosis could mask and **overshadow pre-existing risk or temporarily reduces** it. In that case you need to deal with the psychosis before dealing with the risk.

Treatment implications: in the case of indirect links, consider addressing other factors that interface with psychosis to shape risk. You could make use of intervention sequencing, look at what has primacy for risk to be able to reduce risk.

3. No links: address separate risk factors (unrelated to psychosis) to reduce risk

The third scenario may be that psychosis is present but entirely unrelated to risk. Examples of this scenario could be:

- Psychosis is experienced more recently and has triggered professional help but risk had developed prior to this point. The risk might have preceded psychotic episodes or operates independently of the psychotic episodes and therefore does not influence the risk.
- Psychosis could mask and replace pre-existing risk or temporarily reduce it. In that case you need to deal with the psychosis before dealing with the risk.
- Psychosis and terrorism may be independently linked to a third variable:
 - For example, terrorism could be linked to trauma and psychosis could be linked to trauma, but psychosis and terrorism are not linked.
 - For example, ADHD symptoms like impulsiveness and intensity seeking could be a risk for terrorism and drug use, which may trigger a psychotic episode.

Treatment implications: in the case of no links, consider looking at the illness and risk separately and be aware not to assume that treating one "risk" reduces the other risks.

4. No psychosis

There may be a diagnosis of psychotic illness, but this turns out to be a misdiagnosis or a case of malingering. Misdiagnosis:

- It is a myth that psychosis is the most clear-cut, reliably diagnosed mental illness. Many symptoms may be ambiguous and trans-diagnostic. Unless a lot of time is spent with the individual and their pre-psychosis history is known, it is hard to tell the difference between different symptoms.
- The connection between ideation and "reality" may not be as easy to delineate.

- For example, delusional disorders could be a misdiagnosis of autistic-restricted interests with idiosyncratic beliefs.
- For example, pseudopsychosis. When individuals with ASD, mood disorder or personality disorder become stressed, they can become a more chaotic version of themselves which might be seen as a psychotic disorder.

Treatment implications: mental health care practitioners could first consider all other diagnoses. Especially when extremist ideation precedes positive symptoms and continues after treatment with anti-psychotics. Also, one could consider if “pseudopsychosis” is triggered by stressors (ASD challenges).

Malingering, when the psychosis is feigned by the person, may need to be considered in cases where a psychosis diagnosis and its assumed links to risk are questionable:

- The individual could overplay the role of psychosis in risk, blame symptoms, emphasises “pathology” and lack of responsibility, he or she could be malingering for secondary or pragmatic gains.
- Where malingered symptoms may deploy culture-specific references (e.g. Jinn, invisible beings created by Allah (?)), clinicians may be hesitant to critically evaluate the meaning and evidence of the symptom(s), due to assumptions that to do so would be culturally insensitive. The experience of symptoms should be explored for an individual, in order to appraise their authenticity.

Implications for P/CVE

Working with radicalised individuals with psychotic disorders poses clinical and operational challenges. To discuss the complexity of working with radicalised individuals (clinical challenges) and the significance of information sharing (operational challenges), the participants discussed cases during the meeting. Below are descriptions of cases and examples of discussion points among the group of participants during case discussions. Lastly, participants of the meeting also discussed that working in a field with a lot of stigma adds to the challenges. Therefore, some recommendations about this topic were formulated by the participants.

Clinical challenges

- Non-compliance with medication and/or treatment is common for individuals with psychotic disorders. This may pose a problem for treatment and risk. The individuals that mental health practitioners encounter are already success stories since they went to the therapy. As a practitioner, one cannot have a conversation with a person with acute psychosis.
 - Practitioners could try to get through to the individual by recognising the delusions and their feelings. Establish an open dialogue, so the individual can also understand and recognise their own delusions.
 - Psychoeducation focuses on developing knowledge and understanding of the individual’s own situation. This could help to make the individual feel more empowered and less helpless, which in turn could increase their engagement in therapy.
- It is sometimes difficult to gather insights into the illness, the risks, their links and relapse warning signs. This formulation of links and risks are underlying the treatment plan.
- A family approach, where a practitioner works for a longer time with the family of the individual with psychotic symptoms can help to build an image of the individual and the mental health history. It can also help in creating the right support for the individual in their daily life, or during rehabilitation.

(?) Lim, A., Hoek, H. W., & Blom, J. D. (2014). The attribution of psychotic symptoms to jinn in Islamic patients. *Transcultural Psychiatry*, 52(1), 18-32. DOI: 10.1177/1363461514543146.

Case description

X is a 37-year-old Christian Syrian refugee now living in Belgium. There are concerns about his obsessive hate towards Muslims. He expressed to social workers that he knows things about Muslims that no one else knows and that this information should be reported to the media and the mayor. He has a delusional belief system: all Muslims everywhere are connected to each other and are working together. He is one of the agents who sees through it and is here to warn the Belgian society about it. He is diagnosed with schizophrenia and complex trauma and needs medication and therapy. However, working with him poses risks for practitioners. X drinks a lot of alcohol alone in his apartment. When agitated he threatens, shouts and starts throwing things. He shows sexually transgressive behaviour (sexual frustration). This in combination with the lack of self-insight and refusing medication lead the psychological team to stop working with him. The doctor explains that he needs to hit rock bottom before he can receive help. The biggest concern is that he may become dangerous before he hits rock bottom.

Highlights and recommendations from the case discussion

- The different symptom clusters of X have to be formulated with granularity and specificity to establish the link between psychosis and risks:
 - it may be a direct link where his delusional system and threat-control-override induces risk;
 - it may be an indirect link where his isolation, social oddness and lack of normal healthy feedback make him more obsessed and psychosis is the end-point;
 - it may also be the case of other links that may explain the risk, for example ASD, developmental issues or immaturity that imposes risk.
- A timeline is needed, not a diagnosis. This way a baseline can be established for when he is not symptomatic. What is X's "default" setting and what triggers him?
- It is important to keep in mind that X has a **delusional belief system** and that when his ideas are invalidated, he gets very agitated. As a practitioner you could respond to his ideas by validating with the starting point "I can see how you have that conclusion, Daesh pretend to represent all Muslims" and provide more information "but statistically they have murdered a lot of Muslims".
- Feeling traumatised could cause the sense of being in danger. **Trauma** makes X more easily dysregulated and less predictable. You may consider working with the family to compare whether they responded differently to similar trauma or have similar symptoms.
 - In Syria where there was a lot of violence, some of his ideas might not be irrational. It could be the case of **moral injury**, a form of trauma, where his core values were violated. He talked about Daesh coming to where he lives, destroying everything and even killing babies. It is possible that he could not deal with this happening in the world. It can be a push factor for certain ideologies that correct moral transgressions.
- Compare him to his own cultural norm. You may not expect an average Syrian to drink alone and have no social connections. This shows that he is more odd than "default" and his odd beliefs might have been there a long time. His **alcohol use** might be a way of self-medicating for a long time already.
- Ask X's family about **neurodevelopmental conditions**; in what way was he different from his family before the trauma? If he already got frustrated if others didn't understand his "special knowledge" before the psychosis and trauma, then there may be ASD present.
 - When a person with ASD has an obsession with a certain topic, like injustice, it may get stuck in their head. In times of stress, they can become more obsessive with the topic and look for evidence for their beliefs. This can be online, but also mainstream media can fuel the obsessions.

- Individuals with ASD have a hard time with seeing other peoples' views and like to talk with people with the same obsessions. Therefore, going against their views may not help. Instead, try to help them to shift the world with logic and put their theory in the (political) context. Make the world more predictable. This approach does not harm anyone, even when someone does not have ASD.

Operational challenges

There are several operational challenges when it comes to dealing with mentally ill radicalised individuals:

- Information sharing (medical, police, criminal justice services, social services, immigration) remains a challenge. During the meeting there seemed to be a consensus that mental health practitioners should only inform the police when there is an imminent threat. However, when different agencies/people have only one part of the information, no one has the full picture. This makes it extra difficult to decide on the right diagnosis and decide when there is a risk and information needs to be shared. If one practitioner does not think someone is acting out or poses a risk, this might be because he/she did not have all the needed information. What someone does on, for example, social media can influence the risk assessment. This emphasises the need for closer collaboration between mental health and the security field.
- Non-mental health care practitioners are not trained to diagnose and detect subtle diagnostic symptoms. It is important to train and sensitise them to these signals, so they know how to act when mental illness symptoms are present. When mental health practitioners use clinical jargon, they have to be very specific for non-clinicians and provide information about what mental health issues look like.
- Psychosis is more medicalised than other disorders. Therefore, there is an assumption that doctors hold the decision to share information or not. Practitioners should decide among themselves when medical and operational interventions are needed.

Case description

B is imprisoned at 22 for funding a jihadist network. He has a cannabis addiction, tends to parrot the phrases of other radicalised individuals and refuses medical care. With the imprisonment, no information about a medical history or information about the family was shared. However, a hypothesis of incipient schizophrenia was made. B got transferred to another prison, where he accepts therapy with a psychologist, and a psychiatrist who confirmed the diagnoses of schizophrenia, with mostly negative symptoms (seemed a form of ASD). After a couple of years B has almost served his sentence and therefore his release needs to be prepared. Given his medical symptoms there is a necessity for social assistance and for curatorship (he isn't good at handling money), but the medical staff working in the prison have conflicting opinions about sharing medical information with the needed parties from the judiciary. Furthermore, just before his release it turns out that his mother also has schizophrenia, with whom he is going to live after his imprisonment.

Highlights and recommendations from the case discussion

- It is very hard to help a person with schizophrenia with mostly negative symptoms (e.g. blunted affect, avolition, alogia, asociality) because medication may not be sufficient to alleviate symptoms. Therefore, the family is an important asset to help B reintegrate outside prison.
- Not sharing (medical) information and information about the medical history poses many issues in this case:
 - It made creating a timeline and coming to the right diagnosis harder.
 - His mother having schizophrenia would have been crucial information in the assessment of B's symptoms. Because of this he is likely to have a genetic predisposition. B might have experienced trauma in his home environment, which might have triggered the symptoms of schizophrenia.

- This is also important to know because B planned on living with his mother after release. Given her psychiatric symptoms, she is not able to offer him the guidance that he needs. This impacts the rehabilitation and reintegration planning.
- Sharing medical and psychological information before release is necessary for providing the right psychological and social assistance after release.
- There is a lot of stigma around people who are in prison and are radicalised. Not all mental health professionals are familiar or comfortable with dealing with persons who are radicalised and have a mental health disorder, like schizophrenia. This makes offering the right treatment harder. It is essential to train mental health professionals about this topic.

Stigma

Being a psychiatric patient is stigmatising, especially if it is psychosis. Public stigma is an obstacle for people to overcome their mental illness and is even harder when the link between severe mental illness and violence is being drawn. As a (mental health) practitioner, consider the following to not contribute to the stigma:

- Do not only focus on psychopathology and symptoms, but emphasise the role of biographical and social factors that affect the risk. An example is social failure in the context of marginalisation, lack of education, lack of medical attention or substance misuse.
- Avoiding mentioning psychiatric disorders in relation to violence altogether also does not help. Not talking about the topic of radicalisation as a psychologist or psychiatrist adds to the stigma. They need to talk about the topic to be able to nuance it and provide the proper mental health care.
- Terrorism, like other serious but rare offences, may be portrayed by “mad” or “bad” individuals, creating stigma and misinformation about mental illness.
- This has changed in the last few years for the better. The media started to think more about comorbidity and the police played a role in training the media on how to discuss cases and how and when information needs to be shared. Also focusing on not sensationalising someone by giving them the publicity they aimed for.
- When individuals do not want the disorder and do not want treatment due to stigmatisation, extremism/terrorism can be an alternative to psychiatric treatment.

Follow-up

- This event can be followed up by a joint event with RAN Mental Health and RAN Rehabilitation, to focus on the stigmatisation of (radicalised) persons with psychotic symptoms and the impact this has on the reintegration and rehabilitation process of a person outside prison.
- The need for information sharing will be further addressed during the RAN cross-cutting event with practitioners, policymakers and researchers on ‘Prevention of violent extremism: A shared responsibility between mental health care and the security domain’

Further reading

- Campelo, N., Oppetit, A., Thompson, C., Cohen, D., & Louet, E. (2022). A clinical and psychopathological approach to radicalization among adolescents. *Frontiers in Psychiatry, 13*, Article 788154.
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