2019
HANDBOOK
RAN H&SC

EXTREMISM, RADICALISATION & MENTAL HEALTH:
HANDBOOK FOR PRACTITIONERS

PRODUCT OF THE RAN CENTRE OF EXCELLENCE AND THE RAN H&SC WORKING GROUP.
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Introduction to the Handbook

The current handbook is designed as a research- and theory-informed aid for clinical forensic practitioners working with individuals who present with extremism risk/vulnerability and mental illness. It was authored by Dr Zainab Al-Attar, University of Central Lancashire, United Kingdom and produced by the Radicalisation Awareness Network: Health & Social Care subgroup.

There is no empirical evidence to suggest that terrorism is predominantly committed by mentally ill individuals, and where mental illness is present, it may not be relevant to risk. Wherever it has some relevance, it may not be causal, and if it is partly causal, it is likely to interact with a range of political, social, environmental, situational and biological factors at any given time. Therefore, the current handbook does not seek to explain terrorism through mental illness but instead provides guidance on which aspects of mental illness may be considered and how, whenever an individual exhibits both mental illness and terrorist offending or extremist behaviours. It is designed to assist practitioners to unpack the complex impact of mental illness and test hypotheses on its possible role in an individual's extremism vulnerability and risk.

This handbook is not meant to be used as a risk assessment methodology, nor does it seek to offer a quantitative measure of risk and vulnerability. It also does not seek to offer a position on the medico-legal implications of mental health contributors to extremism vulnerability/risk. Its sole purpose is to aid in qualitative assessments, formulation and intervention planning and it is designed to be used as an adjunct to the appropriate, existent risk-assessment methodologies, intervention and therapeutic approaches, and mental health and counter-extremism frameworks and processes.

It is important that the work that mental health practitioners undertake with extremists does not operate in isolation and all efforts should be made to operate within a multidisciplinary framework. Such frameworks may involve security and law enforcement agencies as well as social and mental health services. Given that extremist behaviour may be covert or overt and contextualised by both operational and psychological factors,

the clinical forensic practitioner provides one piece in a broader jigsaw of expertise, assessment, intervention and decision-making. It is important where possible that the operational and clinical experts inform each other's insights. Clear lines of communication and information-sharing between professionals and agencies are important. Each country, state, organisation and professional group will have its own protocols on multi-disciplinary working and information-sharing and this handbook should only be used to inform practice within the confines of such existent protocols.

The structure of this handbook is as follows: It will firstly present an introduction to key concepts on which extremism risk/vulnerability formulation builds. Secondly, the handbook will provide a section on each of a number of mental illnesses or clinical diagnoses, with a consideration of how the symptoms may be relevant to extremism risk/vulnerability and what approaches could mitigate such risk/vulnerability. Finally, it will provide a reading list, which may be of assistance to practitioners wanting to develop or refresh their knowledge of relevant theory and clinical practice.

Introduction to key concepts that impact working with extremists with mental illness

THE CONCEPTS OF RISK & VULNERABILITY

There are several complexities that need to be acknowledged when devising guidelines for both practitioners working with extremists with a known history of extremist offending and those working preventatively with individuals who may be suspected of becoming vulnerable to radicalisation and extremism. The first area of work requires assessing **'known risk'** whilst the latter requires assessing **'potential vulnerability'.** Not only does this generate a conceptual distinction and a need for careful linguistic distinction, but it also raises the scientific question, "Can we simply use the retrospective proxies of known risk in offenders to predict potential future extremist offending in those who have not yet offended?" Caution is advocated in using such an approach and practitioners should draw clear distinctions between known 'risk' in those who have offended and potential 'vulnerability' in those who have not offended, even when using a similar research and evidence base to inform practices with both. Throughout the current handbook, risk and vulnerability will be presented together under each section, for brevity. Nevertheless, it is advised that practitioners applying the current handbook draw distinctions between risk and vulnerability, in the way they interpret and communicate their findings.

Furthermore, when assessing risk and vulnerability, practitioners need to be clear about the distinction between general risk/vulnerability to violence/crime ('criminogenic risk') and specific risk/vulnerability to radicalisation and extremist acts ('extremogenic risk'). Whilst some individuals will be impacted by both types of factors and present a risk/vulnerability of both generic crimes/violence as well as extremism and terrorism, others will only pose a risk of the latter. In cases posing extremism risk, practitioners need to further distinguish the specific types of terrorism risk/vulnerability, where possible, as terrorism encompasses such a broad spectrum of behaviours. For example, both the acts of downloading a terrorist publication online and committing

mass murder in the name of an extremist group or cause would constitute terrorist acts and may be preceded by radicalisation, but decision-makers and service providers clearly need to adopt different measures for each of the two. Therefore, practitioners addressing such general and broad areas of risk and vulnerability as 'terrorism' need to be as specific as possible in their opinions and recommendations to contribute to effective, reasonable, proportionate, and ethical decision-making. Overall, clear definitions of risk/vulnerability and specificity about types of harmful behaviour being assessed will strengthen such decision-making. In addition, a balance should be struck between using practice proven to be effective in similar situations in the broader population and an in-depth knowledge of the individual's case. Effective practice often hinges on applying the general principles of tried and tested approaches tailored to the individual's idiosyncratic, specific and dynamic needs.

THEORY AND RESEARCH-INFORMED PRACTICE

The clinical research field of extremism and terrorism is a relatively young and fairly fragmentary field, incorporating both small-scale quantitative studies that lack in-depth clinical insight and qualitative studies of individual cases without a broader empirical baseline to compare them against. There is little if any work published on specific mental health drivers for extremism and the effectiveness of approaches to address them. Therefore our modern-day practice in this field may not necessarily be evidence-based in the strictest sense, although it can be theory- and research-informed. It is thus important for practitioners to remain up to date in the theory and research of the terrorism field as well as of other fields that may come to bear on this area of work (e.g. mental illness, assessment methodologies and therapeutic approaches).

Overall, there appears to be a pattern of findings suggesting that most individuals who commit terrorism are not mentally ill, and when mental illness is present, it tends to be more prevalent in specific sub-groups (e.g. lone actors compared to members of organised terrorist groups). The links between terrorism and mental illness are neither empirically well-established, nor are their nuances well understood.

Furthermore, there are variations in how the problem of risk and vulnerability is approached. Some research focuses on systemic risks/vulnerabilities and seeks to devise broad predictive models of threat. Other research focuses on individuals and the idiosyncratic factors that drive them, an approach that is of greater relevance to practitioners and hence adopted in the current handbook. When researching individuals, some experts have focused on identifying individual risk factors whilst others have postulated broad pathways to terrorism. There is also a tradition of organising the factors and their pathway into 'push' factors – aspects of an individual's mindset or life that push them towards terrorism – and 'pull' factors, or aspects of the terrorist cause/ideology/group/modus operandi that appeal to an individual and pull them in. Essentially, the shifting balance of push and pull factors, influenced by

a range of personality, social, political and operational factors, lead to the decision to plan and implement a terrorist act. Some individuals may endorse extremist beliefs and actions (become radicalised) and commit to terrorism whilst others may be incentivized to commit acts of terrorism for a range of psychological or even materialistic motives. In most cases, an individual's goals and needs are met by terrorism/extremism, with each push and pull factor possibly varying in its influence at different points in that pathway.

In reality, all the above-mentioned areas of theory and research could be of value, but they should be considered comprehensively and in relation to the specific individual in question. Research has consistently shown that those who exhibit extremist markers and terrorists are a very heterogenous and diverse population and their behaviour is shaped by a complex array of interacting psychological, social, political, operational and biological drivers. There is no 'one size fits all' blueprint or prototype, even though there may be general patterns or groups of factors that may bear on our understanding of risk/vulnerability.

Whilst practitioners should use international research to inform some of their hypotheses, they must always maintain an open mind and develop as in-depth an understanding of an individual as possible, using as many different sources of information as possible, alongside their clinical experience. The role of the practitioner is not to fit the individual to a research-informed typology but to understand the individual's overall needs and then to identify what could potentially make them vulnerable to radicalisation or extremism, and under what circumstances. Mental illness is therefore examined in this individualised context, when it is present. The practitioner should adopt an open mind as to whether 'present' mental illness is 'relevant' to extremism vulnerability and if so, how.

The aim of the current handbook is to use theory and research to guide practitioners to develop an understanding of the individual, and help them to develop hypotheses on how mental illness may contextualise their vulnerability to extremism and test such hypotheses using their clinical and operational expertise. It is not designed as a prescriptive guidance on what constitutes vulnerability to extremism, but instead offers suggestions to explore, based on the broad research field. The sources of information used in the current handbook include the clinical and academic research base on terrorism, radicalisation factors and pathways, lone actor terrorists, fixated threat offenders, and links between mental illness and violence/offending. This handbook advocates the individualised case formulation approach, which is supported by research and commonly endorsed in clinical forensic practice.

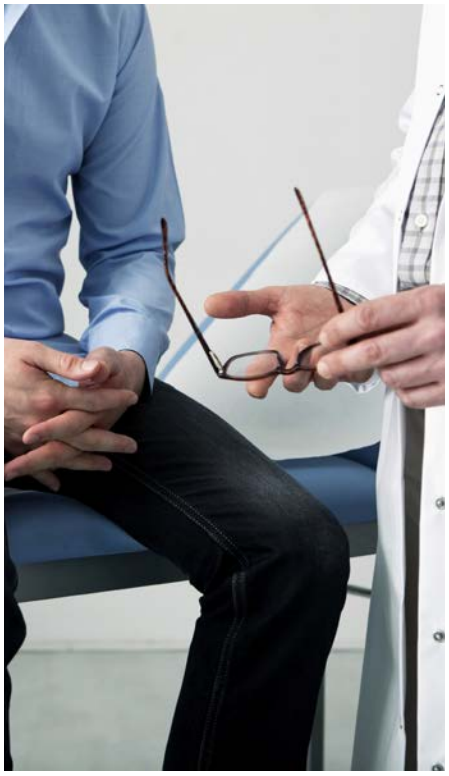
INDIVIDUALISED CASE FORMULATION

Individualised case formulation is the preparation of an evidence-based explanation of an individual's difficulties – their form, their origins, and their development and maintenance over time. A forensic mental health case formulation process is thus applied to provide an understanding of the nature of the individual's mental health needs and the ways some, if any, relate to vulnerability/risk. Whilst there is a broad evidence base on the links between mental illness and violence/offending, practitioners should pay particular attention to the complex and often idiosyncratic (individual) relationships between different aspects of mental illness and different aspects of risk. For example, one aspect of one symptom may contribute to a predisposition to engage in risky behaviour, but another may precipitate or trigger the decision to act in a violent way. Yet another aspect may contribute to the maintenance of such behaviour. In all instances, the symptom may interact with a range of other social and situational factors to drive the vulnerability/risk. Inversely, some aspects of mental health may act as protective factors against risky behaviours.

It is worthy of note that wherever both mental illness and extremist/terrorist behaviours are witnessed, practitioners should not only maintain an open mind about whether the former causally contributes to the latter but should also consider the reverse causal influence, namely if any of the mental health problems have arisen as a result of engagement in extremist or terrorist acts. Alternatively, both may be driven by a third factor and simply co-vary. Additionally, the effects of the aftermath of arrest and detention must also be considered, to fully delineate the drivers for the current needs and vulnerability. Finally, it is important that practitioners' understanding of mental illness is informed by the individual's own subjective experiences alongside any objective diagnostic classifications. The subjective experience of one's symptoms, and one's perceived ability to cope with them, are as important as their clinical interpretations by professionals, where forensic case formulations are concerned. Therefore, the current handbook will seek to provide guidelines on how subjective as well as observable aspects of a particular mental illness may contribute to vulnerability to extremism.

In the current handbook, a number of mental illnesses and psychological and neurodevelopmental disorders will be addressed, with consideration of how aspects of each may come to shape vulnerability to extremism in some individuals. It is very important to emphasise that ***these aspects of mental illness are not risk factors for extremism in the general population***, and may only be relevant for individuals who already present with both extremism risk/vulnerability and mental illness. The current handbook should only be used in this context, to explore the possible contextual links between mental illness and extremism risk/vulnerability in individuals who present with both.

MENTAL ILLNESS: ASSESSING CONTEXTUAL LINKS BETWEEN MENTAL ILLNESS & EXTREMISM RISK/VULNERABILITY



In many terrorism and extremism cases, mental illness will not be a relevant consideration. In some cases, however, mental illness may be present and a practitioner will need to consider if and how it may be relevant to risk and vulnerability. Such cases may include severe, enduring and debilitating mental illness (e.g. acute psychotic episodes that are part of an enduring schizophrenic disorder) as well as mild symptoms that may not impair the individual's overall functioning (e.g. mild anxiety or depression). They may be either recent/episodic (e.g. panic attacks) or lifelong/pervasive (e.g. autism spectrum). Practitioners should neither assume that mental illness is causally relevant to extremism risk/vulnerability nor discount its relevance, before they conduct a thorough formulation. Nor should practitioners assume a correlation between the level of severity of mental illness and its degree of causality in shaping extremism risk/vulnerability. Mild symptoms may be strongly causal of risk/vulnerability and severe symptomatology may be weakly causal, in some, whilst the reverse may be true in others. Only a thorough individual case formulation can elicit such information.

To assist with such individual formulations, the next section of this handbook will consider a number of mental illnesses and psychological and neurodevelopmental disorders that are commonly encountered in mental health practice. It is not an exhaustive list, nor does each individual diagnosed with the listed disorders necessarily experience all or only the symptoms mentioned. It is, nevertheless, a broad guide to alert practitioners to the possible contextual role played by each mental illness in shaping extremism risk/vulnerability.

For each mental illness or diagnostic category, specific symptoms or subjective aspects of the condition that could contribute to extremism vulnerability and risk will be summarised (referred to as '*Potentially relevant features*'), and '*Recommended support and intervention approaches*' will be suggested. It will be assumed that users of this handbook will have good basic knowledge of each mental illness/diagnostic category addressed or else have access to advisors with such knowledge, hence for brevity's sake the diagnostic criteria and detailed descriptions of each condition will not be provided. It is also assumed that users of this handbook will already have clinical interviewing and forensic formulation skills and therefore this handbook does not seek to prescribe a methodology for interviewing and formulation. The handbook is no substitute for clinical forensic training and it is important that its users operate within the boundaries of their clinical competence, operational roles and ethical regulations.

Practitioners may often find that individuals they work with present with a number of conditions and these will most likely interact to impact experience and behaviour. Needless to say, many aspects of mental illness may be 'present' but not 'relevant' to extremism vulnerability and risk, and in some instances may even protect against it. Therefore, features of mental illness that are assessed to be relevant, and their interactional effects, should be the focus of individual case formulations. These factors should be considered alongside the range of other important factors that may impact the individual's experience and behaviour, such as age and developmental stage, gender and gender identity, culture, religion, and any relevant socio-demographic and socio-political factors. Learning difficulties, traumatic brain injury and neurological disorders should also be ascertained. The aforementioned factors not only help determine experience and behaviour but also define appropriate norms against which we appraise the individual and which we try and accommodate when devising support and interventions. Thus, mental illness is one complex area of a much more complex array of factors that shape an individual's vulnerability and risk, as well as our approaches to negate those.

Mental illnesses & psychological disorders

AUTISM SPECTRUM DISORDER (ASD)

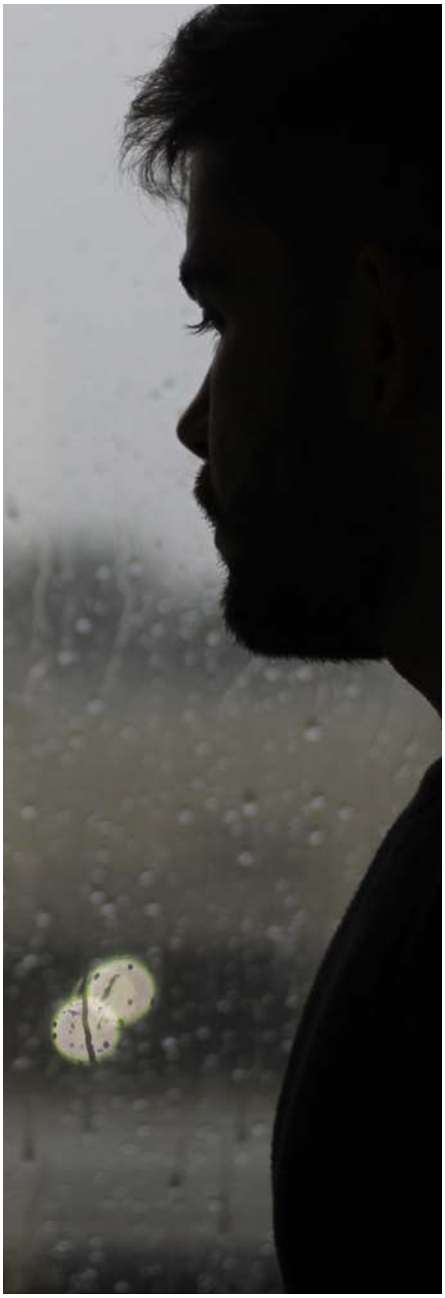
Potentially relevant features

A number of features associated with autism may shape vulnerability and risk to extremism, in the following ways:

Restricted interests: Individuals with ASD may develop intense, obsessional interests that come to serve a range of psychological functions, including providing positive emotional states and alleviating negative emotional states. Interests may become a primary source of identity, purpose, focus, excellence/mastery and creativity. An interest may also be the only topic that the individual feels confident to talk about, relate to others through and function at their best in its pursuit. Whilst such interests may be a healthy source of well-being and achievement, they may be heightened and intensified at times of stress, anxiety and change or uncertainty. At times of depression and anger, interests may take on morbid or destructive themes, with more intense negative rumination. Restricted interests are often researched in great detail and the individual often collects associated information and items, often without a long-term purpose and with a sole focus on the short-term rewards. Restricted interests may develop in any topic; given the salience of terrorism and other forms of high-profile crimes, such as mass shootings, serial killings or political assassinations, it is not surprising that in some individuals restricted interests in terrorism, terrorist groups or mass killings and political assassinations may emerge. Interests may also emerge in technical topics such as explosives, hacking and cyber-espionage, and these could take on illegal pursuits. Where such interests become all-consuming and obsessional, the individual may take increasing risks in researching them, as they become all-absorbed in their details and immediate rewards and less focused on their consequences. They may indeed overlook the consequences all together. Some individuals with ASD process the world in a highly compartmentalised manner and struggle to see the links in cause-and-effect of their behaviour, leading to the pursuit of dangerous and harmful interests that are completely isolated from their otherwise law-abiding daily lives. 'Research' of terrorism-related interests may of course reach a point of violating the law or at the very least raising the alarm for security services. When an individual starts to act out their terrorism-related interests, risk may be heightened. Where such interests are longstanding and obsessional, an arrest is unlikely to diminish their intrinsic appeal and hence they may continue to contextualise risk, irrespective of detection. Furthermore, the same targets may be pursued repeatedly due to the obsessive repetitive

nature of interests, and hence vulnerability/risk may also be repetitive and intense, in spite of detection and mitigation attempts.

Fantasy: Individuals with ASD may experience a very rich and vivid fantasy life, often based on visual imagery they have been exposed to (photographic memory) rather than on hypothetical abstract ideas (social imagination). Some individuals may have a very strong visual processor and find certain visual imagery very compelling. Fantasy built on images that have sensory and psychological appeal can be highly rewarding and addictive, especially at times of stress. In some instances, fantasy may include aversive imagery too, that drives distress and anger (e.g. images of people injured or killed, in terrorist propaganda). Fantasy can shape vulnerability and risk if terrorism-related fantasy develops that is highly rewarding and addictive. Where habituation to the fantasy occurs, the individual may need to intensify its content or eventually act it out, to derive an intense reward. Alternatively, distressing imagery can become intrusive and fuel anger and threat, which then lead to extremist solutions that are then seen as addressing the upset caused (e.g. attacking those who are blamed for causing the upsetting scenes).



Social and communication difficulties: These aspects of autism often make the social world exhausting, stressful and anxiety-provoking. The online world may provide a safe haven where communication can be done visually and explicitly (e.g. in pictures and in writing), remote from the stressors of social and sensory overload, giving the individual more confidence, control and optimising their communication skills. The online space and community may come to serve particular needs when the offline world is overwhelming and distressing for the individual and when it leads to social isolation and loss of confidence. Whilst online activity is not in itself problematic, it may become a vulnerability if the individual accesses extremist websites and establishes online links with extremists who come to exploit them or inspire them to commit acts of terrorism. An individual with ASD may not always recognise others' agendas or see 'the bigger picture' and the consequences of what they are being encouraged to do, and take extremist propaganda literally, as facts. Furthermore, when an online extremist community encourages their restricted interests and validates them and their skills, it can become socially and emotionally reinforcing.

Need for order, routine and predictability: Individuals with ASD tend to have a heightened need for order, justice and predictability. The social and political world rarely afford these, and both personal experience of injustice as well as constant news coverage of injustice, moral disorder and uncertainty are likely to generate anxiety and anger. Extremist narratives and groups often purport to explain the moral and social chaos in the world and allege to provide solutions that sift the world back into a neat order, with absolutist justice and concrete certainty. Furthermore, extremist groups often brand themselves as organised, systematic, and orderly, engaging in ceremonial rituals and displaying neat visions of a social order, stage-managing a depiction of a predictable, safe, organised, structured and orderly world. They often also adopt neat categories in their ideology and theories of society (e.g. a hierarchy of races or religious groupings that need to be neatly demarcated). These messages and brands may appeal to an individual with ASD, more for their heightened need for order and predictability than for their philosophical underpinnings, especially when the 'real world' comes across as chaotic, shifting in its categorisations and benchmarks of right/wrong, and full of grey areas and uncertainties. ASD

can be associated with high systemizing and low empathizing, which means that the world makes clearer sense when it is explained in categories, facts and systems, overlooking the social and emotional nuances of people's lives. Extremist narratives are often systemizing in their depictions of political/social problems and solutions, and deliberately avoid empathizing with their enemy and the social complexities and grey areas of their own group. They may thus appear more logical and persuasive to individuals with ASD due to their neurocognitive resonance and not because of their moral philosophy.

Cognitive styles & information processing: Even in the absence of explicit extremist contacts and online terrorist materials, an individual may be easily exposed to radicalising material if they stumble on online or offline narratives of threat and injustice that seek to blame an 'out-group' or section of society and purport conspiracies (e.g. by governments) to maintain such threats and injustice. In an online world where such salient topics as terrorism and immigration are never far from any discussions of day-to-day concerns and events, it is easy for an individual with ASD to come across such online narratives without recognising the biased agenda behind them or their link with broader extremist ideologies or groups. This is because individuals with ASD may not only have difficulty in appraising others' implicit agendas but may also struggle to connect events and information into a larger picture. They may take information literally and focus on its details, whilst lacking the ability to compare and contrast it with other sources of information. They may also have attention-shifting difficulties that makes it hard for them to mentally 'let go' of certain information. Furthermore, as mentioned above, wherever such narratives sift the social and emotional world into factual categories and tangible systems, they may resonate strongly with individuals with ASD by appearing 'logical' and providing reassuringly clear answers to confusing abstract questions about the world.. Thus, how information is processed, in addition to its content, may shape vulnerability.

Sensory sensitivity: Finally, individuals with ASD may experience both sensory hypersensitivity and hyposensitivity. The former leads them to avoid certain sensory stimuli and environments that overwhelm them, whilst the latter may lead them to seek out certain stimuli that offer them reward and satiate their sensory needs. The former may lead to vulnerability if they are overwhelmed by the sensory environment in such a way that leads them to underachieve and to find education, the workplace and the social world aversive and exhausting. They may retreat and become immersed in an online space that exposes them to extremist forums, offers them extremist forms of escapism, or furthers their pursuit of terrorism-related interests. Alternatively, terrorism-related stimuli may themselves have sensory reward value. For example, colourful imagery, insignia and uniforms, the colour, brightness, sound and smell of explosives and the aesthetic reward of weapons, may trigger and maintain terrorism-related interests.

When ASD is combined with mental health problems such as severe depression, heightened anxiety, Obsessive-Compulsive Disorder, Post-Traumatic Stress Disorder and psychosis, it may generate significant distress, subjective threat, and confusion. Terrorism-related materials, forums and interests that serve to alleviate threat/anxiety and restore positive emotional states, may become especially potent at such times of heightened mental health difficulties.

Recommended support & intervention approaches

Once the precise relationship between the specific aspects of ASD and vulnerability/risk are established, strategies can be put in place to increase resilience. ASD is a lifelong condition and hence the aim is never to 'reduce the ASD' but instead should be to support the individual to manage the difficulties that the ASD and co-existing mental health problems may generate, and to optimise the strengths that come with ASD. The ultimate outcome should be to enable the individual to attain success/well-being as well as relief from distress by using their strengths and abilities, and to self-monitor and manage their vulnerability/risk and seek support when that state is heightened.

More specifically, where terrorism-related restricted interests develop, there are at least three strategies that can be deployed to increase resilience. First, to nurture and facilitate existent healthy interests (and associated fantasy) that serve similar psychological functions and offer comparable levels of reward/relief as the terrorism-related interests. Second, to nurture the legal pursuit of safe offshoots of terrorism-related interests, whenever the individual does not have any unrelated interests that meet their needs. A detailed history of the origin and divergence of the terrorism-related interest may reveal safe, legal variants and subsidiaries that could be capitalised on. Third, to develop strategies that the individual could use to monitor and regulate their terrorism-related interests by managing their compulsion to pursue it physically and where possible distracting themselves from associated fantasies. Where the interest in terrorism themes is unshakable, at the very least healthy legitimate platforms for the discussion of the interest (e.g. with professionals) could act as a 'harm reduction' approach. Additionally, where stress, anxiety and depression may heighten the focus on and compulsion to pursue terrorism-related interests, support and therapy should be provided to assist the individual to manage those triggers and to restore their overall well-being and emotional health. It should be borne in mind that all the above-mentioned intervention approaches should maintain a focus on managing the 'here-and-now' rewards of interests, be it the terrorism-related interests being managed or the healthy alternatives being encouraged. Wherever extremist ideology has itself become a restricted interest, the focus of interventions should include the here-and-now rewards of the interest and not focus on abstract discussions on the philosophical flaws and long-term harm and ineffectiveness of such ideologies, as the latter is not the driver for the individual and will have little effect.

Where terrorism-related fantasy has developed and become repetitive, durable and psychologically rewarding and addictive, several approaches may assist to diminish risk. Firstly, the functions served by the fantasy (e.g. to generate positive emotions or alleviate negative emotions) need to be established and healthy, alternative means to meet such functions developed. Secondly, the individual needs to be supported to manage and reduce the internal triggers (e.g. negative thoughts or states) as well as the external triggers (e.g. visual imagery and reading materials) to the fantasy. Where fantasies persist and become intrusive, healthy distraction strategies alongside the nurturing of other healthy fantasies may be helpful. Where there are no healthy compelling or rewarding fantasies to capitalise on, safe offshoots of the terrorism-related fantasies may be developed, as a last resort. This may for example include non-violent elements of the fantasy. Where this is not psychologically plausible, and violent elements of the fantasy persist, support could focus on reducing the pull or appeal of the fantasies by helping the individual to critique

the sources of such fantasies. For example any nostalgic and romantic depictions in the source material can be critiqued and its deliberate staging and deceptive agenda may be explored, so as to reduce the appeal of the fantasy. Furthermore, the real life sequelae of such violence can be reflected on, in order to help the individual to see the real life, negative consequences of the violent acts. Overall, the individual needs to be supported to report and enlist support to manage harmful fantasy, especially when its self-management becomes difficult. It is important that fantasy life is not pathologised and where-ever possible, healthy fantasy life is encouraged, as it may be a critical source of well-being and rich experience.

Where social and communication difficulties contextualise vulnerability and risk, it is important to firstly examine if any 'reasonable adjustments' can be made to remove barriers to educational, employment and social opportunities (e.g. educational provisions, employee guidance, assistance to join social clubs that are autism-friendly). Secondly, the individual may benefit from social skills therapies and internet-safety awareness to help them build relationships they find rewarding whilst also navigating the dangers of online and offline exploitation and influence.

When an individual's vulnerability/risk is heightened by their need for order and predictability, it is important to support them to first of all navigate and make orderly sense of the disorder in the world, as well as to cope with inevitable uncertainties in their life. When practical solutions to uncertainty in their lives are not feasible, psychological support to make the unpredictable predictable (or at least manageable and bearable) may become more important. For example, providing them with healthy forums and information that enable them to make theoretical sense of disorderly social and political behaviours, as well as helping them to devise orderly theories of the uncertainty in the world, may alleviate anxiety and restore some sense of order in their lives. It is also important to nurture healthy routines, structured activity and healthy interests and healthy sources of sameness and predictability in the individual's personal life, in order to make them less sensitised to external social or political uncertainties. Finally, as well as reducing the push factors in their lives, it is important to also reduce the pull of extremist theories and groups by helping the individual to recognise the disorderly reality and outcomes of extremism/terrorism.

Where cognitive styles may heighten vulnerability and risk, support can be provided to help the individual to see the 'bigger picture', to link the cause-and-effect of their behaviours and indeed those of others, to de-compartmentalise any terrorism-related interests from their effects on the individual and those they care about, and to critique extremist narratives in order to recognise their non-factual nature and identify the biased agenda of their sources. Such work can still adopt a systemising approach and use theoretical, factual and categorical concepts, in order to make it more logical and resonant. It is obviously important that all support and interventions are delivered in an autism-friendly manner that is responsive to the individual's specific ASD and neurocognitive profile.

Whenever sensory hypersensitivity and overload contextualise vulnerability/risk, the individual can be helped to plan their life in a way that minimises the overload where possible (e.g. by adjusting routines or routes or by agreeing with education institutions and employers to make reasonable adjustments).

Wherever sensory hyposensitivity plays a role and terrorism-related stimuli come to have sensory reward value, the individual can be helped to identify safe, alternative stimuli or safe offshoots that afford comparable levels of sensory reward. Wherever possible such rewards, along with safe rewarding interests, can be used as reinforcers and general sources of well-being, in all forms of support and therapeutic interventions. Sensory well-being may be key to reducing anxiety and increasing resilience, generally.

Finally, when ASD is accompanied by co-existing mental health problems, it is important to ensure that support does not become short-sighted and focus solely on the ASD but instead tackles the associated mental health difficulties that may either play a primary role or at the very least accentuate the primary role that ASD may play in shaping vulnerability. This is particularly relevant when the ASD and accompanying mental health difficulties result in mood regulation difficulties, whereby the individual experiences intense distress and negative mood states and feels a loss of control. This area of vulnerability/risk is addressed in the next section, but may also be relevant to working with individuals with ASD wherever mood regulation difficulties are indicated.

MOOD DISORDERS

Potentially relevant features

Depression: The symptoms of depression, as well as those of Adjustment Disorder and Persistent Complex Bereavement Disorder may shape vulnerabilities to certain narratives that offer escapism, hope, redemption and meaning. Individuals experiencing and intensely ruminating over their deep anguish, suffering, dejection and psychological pain may find relief in extremist narratives that help them attach meaning to such intense pain (e.g. through social, political and religious explanations). Those whose anguish fuels anger may find angry vengeful narratives resonant and normalising of the feelings they may otherwise feel are pathologised by society and those around them. Extremist narratives may resonate with their anger and redress their despair at the world which is ignoring their anger. Extremist acts may be viewed as the only means to 'make the world listen' and acknowledge their suffering (due to the high profile of such acts and their ability to gain attention). Those who experience self-loathing, self-blame and guilt may find narratives of redemption and forgiveness resonant with their need for atonement (contingent on carrying out acts of violence) and also find narratives that blame and condemn those who choose inaction impactful and guilt-provoking. Those who have lost their sense of purpose, identity and are struggling to find meaning after experiencing a major loss, could find solace in a new life purpose or else a way to be reunited with their loved ones through death. Finally, those individuals who reach a point of hopelessness and feel too emotionally fatigued to continue may find solace in narratives of heroic death, perceiving this as a noble source of relief and an honourable way to end their life. Self-destructive and suicidal ideation may clearly provide generic 'push' factors for harmful acts of self-destruction, whilst anger and vengefulness may act as further push factors for violence. The individual may at the very least not be inhibited by the fear of dying (as they have 'nothing to lose') or at most be seeking to die, albeit a meaningful and heroic death. In some instances they may be driven by a need to be killed but in a way that provides meaning (e.g. 'suicide by cop', as part of a noble or symbolic act). Those who do not feel worthy and feel that they have let others down may frame their own death or destruction as a 'corrective' act. Those who feel angry at others for failing them or tormenting them may frame others' death or destruction as a corrective or restorative act and frame their own death as an act of restoring control and dignity. Thus, depression (especially when severe) may generate a range of push factors and allow some extremist narratives of suffering, death, atonement and revenge to exert a greater pull. The 'trigger' that shifts the individual from thought/fantasy to action may vary from individual to individual but may for example include agitation, an additional accumulative stressor or be as simple as an opportunistic event, access to the means or external encouragement from other parties.

Mania: Expansive emotions and intensified goal-directed behaviour could make coincidental events that the individual sees/hears about (e.g. internet or news coverage of a terrorist incident or political event) a trigger to an emotional over-reaction and a grandiose sense of needing to and being capable of addressing the event. This could trigger grand gestures of defensive or revengeful violence, which could be accentuated by the increased risk-taking and loss of social inhibitions that are associated with mania. Irritability may also drive anger and its impulsive expressions through extremist aggression. Mania could

either bring about a sudden, new focus of one's expansive energy/motivation and impulsive behaviour on terrorism, or else lift inhibitions on an already existent focus on terrorism. It could therefore trigger a new vulnerability/risk or accentuate an existent one.

Recommended support & intervention approaches

Wherever depression is implicated as a vulnerability, the specific experiences that acted as push factors need to be identified and healthy means to address those be developed through therapy and support. It is important to ensure that professionals are careful not to exacerbate feelings of guilt, shame, failure and hopelessness (e.g. by solely emphasising the harmful effects of terrorism and the individual's actions) but to support the individual to manage perceptions of failure brought about by detection, arrest or imprisonment. The range of well-researched pharmacological and psychological interventions for depression may be helpful for individuals whose vulnerability is shaped by depression. When depression is likely to re-occur or be a chronic feature, long-term therapeutic support may need to be considered. Similarly, standard therapeutic approaches to adjustment disorders or unresolved grief can be effective for individuals whose vulnerability to extremism is compounded by these conditions.

Wherever mania drives vulnerability and the episodes of mania have a rapid onset and short duration, risk may obviously increase rapidly and just as quickly subside. In such cases, it is more important to assess and mitigate the quick escalation of risk than to focus intervention on more stable or static variables such as ideology or political injustices. The manifestation of risk may also vary with circumstantial triggers and hence predicting risk (during future manic episodes) needs to take into consideration the dynamic nature of ideation and the circumstantial nature of its external triggers and its forms of expression. Thus, assessment and support need to consider the dynamic and changing nature of risk/vulnerability. The range of well-researched pharmacological as well as psychological methods used in clinical practice to manage the onset, severity and relapse of mania and to build insight and a healthy lifestyle that negate some of its risks may all be helpful in reducing risk in such cases.

PSYCHOSIS & SCHIZOPHRENIA

Potentially relevant features

Psychosis is too general a clinical construct to be considered as a general vulnerability/risk for extremism, and specific facets of it need to be examined separately and collectively, with research linking different symptoms to various forms of violence. Furthermore, terrorism is one of the most salient topics today and social media and constant newsfeeds inevitably expose people to quite distressing accounts of terrorism on a regular basis. Not surprisingly, this exposure can preoccupy and disturb a psychotic individual with chaotic thinking, anxiety and loss of touch with reality. Hence psychotic individuals may frequently make references to terrorism that may not necessarily link to heightened extremism vulnerability/risk. It is therefore important to examine specific aspects of psychosis and identify when and how they may link to extremist action (rather than just ideation), which is the focus of this section. Most of the potential push factors and how they are experienced by the individual are notably acute 'positive symptoms' of psychosis, although the role of some neurocognitive impairments in lifting inhibitions may also be worthy of consideration.

Delusions: Delusional ideas relating to terrorist group membership or threat from a hostile 'enemy' who can only be removed through terrorism, can have a direct role in shaping vulnerability/risk. Delusional Misidentification Syndromes in which an individual or group are believed to be someone else, often hostile and the source of threat, may contextualise risk. This is especially so when they are associated with intense perceptions of threat and loss of a sense of control over the threat (symptoms labelled 'threat control override' or TCO symptoms). This may be more likely when they are accompanied by high levels of anxiety, delusional distress, anger, and irritability, as such additive factors have been reported by research to increase vulnerability/risk of violent acts that serve to remove the perceived threat. Apart from persecutory and paranoid delusions that generate a sense of threat, other forms of perception that may create vulnerability could include delusions of grandeur, where the individual believes they have an important role to play or duty to eradicate a threat or enemy by engaging in terrorism or indeed unofficial violent 'counter-terrorism'. Alternatively, delusions of reference could mean that messages and news coverage about terrorism/counter-terrorism may be believed to be personally addressed to the individual. Somatic delusions may lead an individual to believe that a group of people has physically harmed or interfered with them physically. In all these instances the delusional belief may drive vulnerability to violence if the individual believes that violence will remove the threat or danger. As well as the nature and intensity of perceived threat, practitioners need to explore the intensity of the delusional fixation, the delusional distress it generates and the subject(s) it attributes blame to, in order to appraise the drivers of the vulnerability/risk and potential targets of any violence that may be enacted.

Hallucinations: Whilst in rare cases, command hallucinations to commit acts of terrorism may drive vulnerability/risk, command hallucinations on their own are rarely sufficient drivers for violence. Other interacting factors should be

considered in formulations, such as the existence of delusional beliefs and other hallucinatory experiences (e.g. visual hallucinations) that are consistent with and strengthen the power of the command hallucinations. The patient's perceptions of the voices or sources of the command hallucinations is important to assess, with particular attention being paid to their trust in, fear of and relationship with the source/voice, their personal appraisal of what will happen to them if they don't comply with the command and their perceived ability to refuse the command. The effects of the commands and any other comments made by the commanding voice on emotional state should also be assessed (e.g. does the voice generate anxiety, anger or distress). Overall, the individual is more likely to comply with a command if they experience threat and distress caused by the command hallucination, if it is strengthened by other congruent symptoms, if the individual feels that they can't cope with the threat and either trust or fear the commander and if they believe there will be bad consequences if they don't comply. Hence all these subjective features of command hallucinations and associated symptomatology may shape vulnerability/risk.

Neurocognitive impairments: The aforementioned positive symptoms may create push factors for extremist violence or make some forms of violent extremist groups and acts more resonant, and hence may act as direct vulnerabilities. However, such push factors may not be sufficient to drive action without the cognitive, social and behavioural impairments that arise from other neurocognitive symptoms of psychosis. Psychosis may be accompanied by reduced frontal inhibitions and a number of frontal executive impairments. This may include an impaired ability to monitor and control one's behaviours, as well as attention difficulties and disorganised thinking that make it difficult for the individual to filter relevant information, process it objectively, identify its sources, and link it with its likely consequences. There may also be 'state' (rather than trait) impairments in theory-of-mind and social cue processing, making it difficult for the individual to recognise their own thoughts and motivations, those of others and the link between the two. The result of the aforementioned neurocognitive features may be chaotic thinking and behavioural disinhibition that generate erroneous conclusions, confusion/fear, poor impulse control, difficulty with social interactions, poor conflict resolution skills, impaired problem-solving, and a general sense of inefficacy and threat. All the aforementioned consequences of psychosis may add to vulnerability by accentuating mental confusion, threat/fear, social difficulties and impulsive behaviour. These consequences could also generate secondary vulnerabilities. For example, loss of social and occupational capital, isolation, depression and possible anger and irritability may increase vulnerability, especially when the individual lacks insight into their difficulties. Furthermore, impaired social functioning, bizarre behaviour and loss of behavioural inhibition may elicit hostility from others and the psychosis may indirectly create a vulnerability by generating secondary factors in the social environment that then give rise to threat, distress, anger and grievance in the already vulnerable psychotic individual. Thus, not only could positive symptoms create terrorism-related ideation and threat, but the negative symptoms may add to the threat and diminish one's ability to cope with it.

Suggestibility/susceptibility: Should an individual experiencing the above symptomatology and impairment of functioning then be exposed to radicalisers online or offline, they may be in a vulnerable state and ill-equipped to critique

their agenda and recognise their own vulnerability. Whilst such acute distress, chaotic thinking and lack of behavioural inhibition may by definition deter more organised clandestine terrorist groups (that rely on self-disciplined and dormant recruits) from enlisting such individuals, modern-day online recruitment often preys on such individuals. Such vulnerable individuals are seen as dispensable lone actors whose erratic behaviour would not endanger the security of the group. Hence, much of online and remote recruitment does not hinge on self-discipline and clarity of thought; on the contrary, the lack of such functions may be seen as making the recruits amenable to persuasion and control and therefore open tor exploitation.

Shifting & idiosyncratic ideation: Even without deliberate exploitation, psychotic individuals may be vulnerable to narratives and imagery online and offline, especially when graphic visual imagery feeds into their ideation and sense of threat. Self-radicalisation may occur – often rapidly and unexpectedly – but when it does, it is important that practitioners remain mindful that psychotic ideation could take on a specific and idiosyncratic focus unrelated to any generic terrorist group objectives and targets (e.g. a political theory veering into an obsession with individual politicians), and it may keep changing. Such specific and idiosyncratic pathways could divert the individual from a general terrorist focus to a more specific theme or target that becomes the object of fixated threats, harassment and violence. Alternatively, it may steer them towards shifting their targets and types of harmful behaviours. Therefore, it is important to develop a nuanced understanding of the thinking of the psychotic individual (instead of relying on terrorist group ideology, for example), in order to identify the path of their vulnerability and risk. Given such individuals' cognitive and mental instability, disorganisation and idiosyncratic view of the world, practitioners need to explore their subjective, unstable and changing worldview to track vulnerability, instead of relying only on external indicators such as documents or images accessed by the individual.

Co-morbidity: Psychosis may be compounded by other symptoms to drive vulnerability (e.g. in cases of schizoaffective disorders), co-existing and interacting, for example, with depression, substance misuse, impulsivity or personality disorder. This is especially true where the combination heightens levels of acute distress, fear and threat, confusion and chaotic thinking, anger, irritability, and restlessness, alongside hopelessness and loss of cognitive, behavioural, social and moral inhibitions.

Recommended support & intervention approaches

It is important that practitioners establish a detailed history of past and present psychotic symptoms as well as co-morbid illnesses. With psychotic symptoms, it is important to explore the specific content, nature, intensity & perception of the symptom, particularly subjective experience of threat-control-over-ride (TCO), distress and attributions about commanding voices/sources and the individual's perceived ability to cope with them. Neurocognitive correlates of psychosis also need to be assessed as does their impact on cognitive, emotional and social vulnerability and behavioural disinhibition. Links between psychotic symptoms and vulnerability may be direct or indirect, or indeed non-existent. Practitioners should remain open-minded even to psychosis acting as a protective factor against extremism in individuals who may be generally involved in extremism but who cease to engage during psychotic episodes.

Furthermore, individuals with chronic psychosis and vulnerability during acute phases may show reduced vulnerability when transitioning into residual negative symptomatology. Despite this protective effect, however, negative symptoms continue to warrant generic clinical support, to enhance well-being.

Regardless of the existence and nature of the links between psychosis and vulnerability, support and interventions should seek to enhance self-management of the illness, coping and wellbeing and to reduce distress, TCO, confusion and of course all forms of risk, including risk to self and risk of non-extremist forms of violence. Well-researched approaches to the treatment of psychosis should be used, as per standard clinical practice, and functional links between psychosis and risk should be reviewed as the symptoms subside. When the psychotic symptoms are better managed, assessments can be revisited to assess for any residual risk.

POST-TRAUMATIC STRESS DISORDER (PTSD)

Potentially relevant features

Helplessness and distress arising from trauma could heighten the resonance and comfort derived from extremist narratives, by assigning deeper meaning and nobility to such experiences and seeking to restore control or avenge those who inflict trauma and suffering on others (e.g. through war, military attacks, civil war, sectarian and racial violence, and abuses of power). Anger, irritability, aggression and blame of others for one's traumatic experiences may accentuate the push factors of PTSD, making violence an outlet for tension and anger whilst also giving revenge narratives a stronger pull. Dissociation and detachment may contribute to the lifting of inhibitions where the individual feels removed from and emotionally numb in response to the consequences of extremist violence. Extremist groups and causes could also become a form of avoidance and escapism from one's traumatic experiences. Extremist causes may further offer a resolution for guilt through redemption narratives. Finally, risk-taking, recklessness and self-destructive tendencies are now accepted features of PTSD and in some individuals may either act as a push factor towards dangerous and destructive endeavours or else strengthen the pull effect of the dangerousness and risk of terrorism.

The aforementioned features of PTSD (or Acute Stress Disorder) may arise from sexual, physical or emotional trauma of any kind, including those experienced during war and civil conflict. The impact of trauma varies across individuals, and its manifestation may depend on developmental stage, gender, culture and time of onset (e.g. with a delayed onset of symptomatology that may be triggered by further trauma). Violence and traumatic loss in a combat zone may bring on a range of sequelae, including anger and grievance. These should not be pathologised or automatically assumed to constitute vulnerability and risk. Where an individual has themselves been involved in combat or perpetrated acts of violence, they may exhibit PTSD symptomatology after they are removed from the combat zone and start to process their experience from a different moral and social frame of reference. Once again this may not necessarily signal vulnerability and risk, and being traumatized by one's acts of violence may create an opening for resilience. For example, the negative impact of war and violence on the individual themselves could create a natural aversion to violence and an empathy for its destructive consequences. Inversely, where an individual is desensitized to violence in a specific combat zone, this too may not necessarily translate into a propensity for violence beyond that combat zone and practitioners should remain open-minded and appreciative of the complex link between trauma, de-sensitisation to combat/violence and risk. Practitioners should particularly remember there is currently no research evidence to causally link exposure to trauma/violence in combat with engagement in extremist violence. They should consider cumulative vulnerabilities and risks (e.g. substance misuse, further traumatisation, depression) and consider opportunities for post-traumatic growth as well as vulnerability.

When an individual has engaged in extremist activity and presents with PTSD, practitioners should consider the possibility that PTSD may be secondary to the engagement, even when the individual has not participated in violent combat.

Exposure to extremist materials, engagement in violent acts, and capture and detention by the authorities or rival groups (especially where torture is involved), may all trigger the PTSD symptoms. Practitioners should therefore remain open-minded about the direction of causation when considering extremist involvement and PTSD. PTSD symptoms may not necessarily signal a further vulnerability/risk if they arose from the extremist engagement, for example; on the contrary, they may serve protectively against further engagement. Wherever these symptoms exacerbate vulnerability/risk, they may do so by creating other risk factors that did not previously contribute to extremism but may do so now: for example, through a new grievance or sense of threat driving extremist engagement now that was previously driven by other factors. Thus, PTSD could either be secondary and unrelated to extremism or it could add to the complexity of the risk of extremism.

Finally, the relationship between PTSD and extremism may be multi-directional, with PTSD both preceding and arising from engagement in extremism. In some cases, pre-existing PTSD may be re-activated by extremist activity, leading to heightened vulnerability as the individual continues to engage as a way of escapism, release of negative emotions or an attempt to regain control. It is important that a detailed chronology and description of all traumatic events and reactions is elicited to unpack the aforementioned complexity and links. Furthermore, the presence and role of other mental health difficulties that may be secondary to PTSD, such as depression and substance misuse, need to be assessed as these may heighten push factors, especially where suicidality is present.

Recommended support & intervention approaches

An in-depth clinical assessment of PTSD symptomatology, how it is subjectively interpreted and responded to and its chronology is needed, alongside an assessment of secondary mental health problems. When any aspects if PTSD are acting as push factors or strengthening the pull power of extremist causes/groups/violence, support and intervention should focus on alleviating the PTSD symptoms, reducing push factors and providing alternative sources of relief to reduce the pull of extremism. Well-researched clinical approaches to treating PTSD may be helpful in alleviating the symptomatology; if complex, multiple traumatic events have been experienced, longer-term forms of multi-modal therapy may be considered. The effects of engagement in extremist activity on psychological health need to be addressed. Once the emotional distress associated with such effects is managed and intellectual insight is developed, this could be cultivated into a protective factor, helping the individual recognise the adverse effects of extremism on themselves and others. Any opportunity for post-traumatic growth should be capitalized on. Finally, co-morbid mental illnesses that may exacerbate the role PTSD plays in shaping vulnerability need to be assessed and treated using well-established clinical interventions.

PERSONALITY DISORDERS

There would appear to be four personality dimensions mediating vulnerability and risk of general violence that are worth considering, as these may, in some instances, come to bear on extremist violence. These are i) poor impulse control, ii) impaired affect regulation, iii) narcissism or a grandiose sense of self and entitlement, and iv) a paranoid cognitive personality style. Furthermore, Antisocial or Dissocial personality disorder is strongly linked to violence and offending and may add to risk when it co-exists with any other mental illness.

Whilst the above features and types of personality disorder (PD) may create general vulnerabilities for all types of violence and offending and hence this may include extremist offending, there may be other features of particular personality disorders (or personality traits) that create specific vulnerabilities to extremism, which will be discussed below. It is important to note that therapeutic interventions for personality disorders is an in-depth, broad and much researched field and should be consulted when devising support and intervention approaches. The guidelines below simply touch upon the broad considerations of each personality type when examining extremism vulnerability/risk; a more detailed intervention approach should be informed by the relevant clinical and research base.

Antisocial/dissocial personality

Potentially relevant features

Individuals with such traits are focused and driven by a need to meet and gratify their immediate physical, financial, social and emotional needs, preferably with as little effort as possible. They are not deterred by harm to others or danger/risk and might, on the contrary, seek danger and risk. They do not have a respect for authority and rules and will often violate and resist these. Their decisions may be impulsive in the sense of gratifying their immediate needs as opposed to seeking long-term objectives or calculating long-term consequences. If their needs are not met, they feel a sense of entitlement and hence frustration and anger towards others and society overall.

Extremist causes, violence and groups may appeal to such individuals when they are perceived as self-serving and exciting opportunities to gratify one's needs in the short-term. They may be seen as an opportunity to regain one's status and avenge perceived failure by society, to rebrand oneself from a social failure or criminal to a morally superior, noble 'soldier', to derive excitement, intensity and the 'thrill of the chase' from clandestine high-risk terrorist involvement, and to derive a sense of status and power without the responsibility of earning it (e.g. instant elevation to a 'heroic warrior' without training, effort or responsibility). Extremist groups may also appeal to antisocial personalities because they resonate with the individual's natural inclination to fight authority and to resist rules. They may also provide a noble rationale for discharging one's natural anger and frustration at society, especially when extremist narratives help the individual to reframe and attribute their failures

to an oppressive, conspiratorial society/group. At a more basic level, the individual may view engagement in extremism as a pragmatic way to gain financial, material or criminal rewards (e.g. be paid or else be permitted to control criminal territory and markets). They may be 'hired guns' themselves or act as a criminal capability for extremists (e.g. by involving themselves in narco-terrorism or protection rackets), or they may ingratiate themselves in an extremist group by 'talking the talk' of the ideological cause but without believing in it or having an internal motivation to defend it.

Recommended support & intervention approaches

Support and intervention approaches for such individuals need to focus on the individual's immediate, egocentric needs. They need to help reduce the perceived rewards of extremism and increase the perceived rewards of healthy, legal alternatives. Identifying the 'risks' and 'harm' of extremism will be ineffective or even counter-productive, as such individuals may even be attracted to risk and harm. Instead, the 'costs' of extremism to themselves should be identified, in order to reinforce a high-cost/low-benefit' perception of extremism.

Narcissistic personality

Potentially relevant features

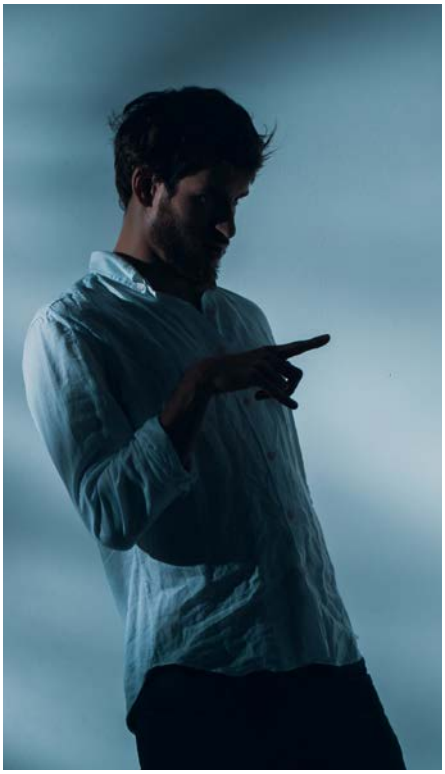
Individuals with such traits see themselves as inherently superior, deserving of great admiration, worthy of status and power, and entitled to special treatment. They see others as mere vehicles to serving their interests. They naturally dominate others and if others do not serve their needs or if they dare question their superiority or challenge them, this will typically lead to rage, angry and grandiose outbursts and revenge ideation. They may feel aggrieved with individuals and society who they feel have not recognised and respected their 'greatness' or deservedly met their needs. Their lack of achievement, success and status is attributed to others' failings. Such individuals will often feel unsatisfied with what life has to offer them, as roles that lack dominance and status are viewed as unrewarding. Thus, they may often feel frustrated and angry and resort to conspiracy theories and even retribution over such feelings. Extremism will appeal to such individuals if it meets the aforementioned needs, offers a means of restoring power, dominance and status and affords notoriety and fame. Alternatively, if they experience narcissistic rage, extremism can offer an avenue to exact revenge in a demonstrative and high-profile way that they feel befits their significance in the world and is proportionate to their intense feelings of indignation and rage.

Extremist narratives may appeal to narcissistic individuals due to their references to the 'in-group' having superior status, nobility and a moral high ground. They often denigrate the 'out-group' and classify them as inferior, blaming them for one's failure. They purport to offer powerful positions of dominance over the out-group and may assign leadership roles that allow the individual to dominate the ingroup. Some offer armed roles where dominance, humiliation and violent demonstrations of power are permitted and indeed celebrated. Narcissistic individuals may be attracted to both the symbolic power and superiority as well as the inter-personal opportunities for dominance, offered by extremist

groups. They may thrive on opportunities to dominate, instruct, indoctrinate and lead, online and offline, and feel strongly affirmed by their position of power and the symbolism that goes with it (e.g. titles, honorary position, narratives of nobility and courage). Furthermore, extremist groups often justify revenge as 'noble' and a sign of power, which appeals to the grievant narcissist. Thus extremist narratives and groups feed many narcissistic needs through both their symbolism and the roles they assign recruits. They enable an individual to reframe their failure into superiority and justify dominance and revenge. Once the individual is pulled in by such seductive narratives, their needs continue to be met through glorification and admiration by comrades. Terrorism itself may be seen as the ultimate form of power over the system and others, as it is the most feared and highest-impact crime. It may also be seen as the ultimate way of gaining notoriety and unprecedented 'recognition' without having to invest huge effort or develop a significant skill base.

Recommended support & intervention approaches

Individuals with narcissistic traits need to be supported to question the actual superiority and grandiosity of the extremist group, to recognise that extremist groups use people like them to gain glory for themselves and do not in fact recognise and value them and that their engagement with extremism does not portray superiority or status to society. An individual may be encouraged to desist by realising how little respect the group has actually shown them and how little status it affords its members. Instead, the individual needs to be supported to derive recognition, status, worth and value from legal and prosocial alternatives. It is important that professionals do not reinforce the appeal of notoriety by emphasising the individual's dangerousness, high profile and significance, whilst also ensuring that the individual does not feel that the 'system' is criticizing, demeaning or belittling them. The individual needs to be supported to conclude that terrorism/terrorist groups do not provide them any real significance whilst prosocial/legal alternatives do. They need to be supported to recognise that walking away from extremism symbolizes the ultimate strength of character and show of their power, control and unique status and that they are in effect 'better' than and 'above' extremism..



Paranoid personality

Potentially relevant features

Individuals with such traits see the world as a dangerous place full of persecution and malicious 'traps'. They often interpret innocuous events and behaviours as threatening, and are receptive to conspiracy theories and threat 'stories' and narratives. They attribute their failings to 'persecution' and feel angry and at times vengeful. They may develop the belief that in order to safeguard themselves from persecution and harm they need to 'pre-emptively strike' in order to remove threat and send out a message to persecutors.

The appeal of extremism may be in its narratives of threat and persecution, which resonate with the individual's belief that the world is inherently dangerous and unfair to the weak, hence one needs to fight this and show strength. Extremist narratives justify violence and revenge by whipping up the sense of threat and

exacerbating and generalising it, whilst also whipping up anger at such threat continuing unchallenged. Extremist narratives attribute the threat to a target group and justify their harm as the only, necessary means to remove the threat. If the out-group has not committed acts of harm against the in-group, extremist narratives fuel conspiracy theories about the subversive and insidious nature of the out-group and emphasise the importance of fending off their dormant threat. They then present the in-group as guarantors of safety and protection and as the only side one can trust, while being suspicious of everyone else. Such narratives isolate members and accentuate their sense of threat and need for the in-group. An individual with paranoid personality can very quickly find such narratives resonant and ironically may become less suspicious of those who propagate them, seeing them as the only ones who understand their fears and who can protect them against harm. They therefore succumb to a shared, collective sense of threat and illusion of safety promulgated by the in-group. They are easily persuaded that any negative accounts of the extremist group in mainstream information sources are lies and part of the conspiracy, preventing them from critiquing the extremist group, reinforcing their isolation in an echo chamber of paranoia and tunnel vision of the in-group as the only place of safety.

Recommended support & intervention approaches

It is important for practitioners to recognise the intensity of the individual's perceived threat/danger and their mistrust for professionals and to manage this so the professional can be seen as a credible helper instead of a persecutor and part of the threat. Transparency and honesty between practitioner and the individual are key. Such issues as the consequences of disclosure by the individual and the duty of the practitioner to share information on risk with the authorities need to be openly and transparently addressed at the start. If they are not and the practitioner then reports disclosures to the authorities, they will lose the trust of their patient and reinforce their mistrust and conspiratorial mindset. Inversely, the true benefits of engaging with professionals are important to discuss – i.e. benefit to society as well as to the individual – so that practitioners are seen to be honest and frank. The practitioner may face intense scrutiny (e.g. the individual may demand to view the practitioners' notes and reports) and they need to be prepared to manage such scrutiny, within their organisational and professional protocols.

Once the individual is able to build enough trust to engage with professionals, the practitioner may then help them to recognise the untrustworthiness of extremist groups and their exploitation of individuals like them. When the individual feels generally threatened, they may also be offered support to develop a sense of safety and security and, where amenable, may engage in therapeutic work to tackle the origins and daily triggering and manifestation of their 'dangerous world' view. Thus, reducing perceived threat, establishing feelings of safety and supporting the individual to critique the exploitation of extremist groups, alongside trust-building with the practitioner, may all be essential components of working with individuals with paranoid PD, whose traits shape their extremism vulnerability.

Borderline personality

Potentially relevant features

An individual with these traits commonly experiences an unstable and diffuse identity which leads to rapid fluctuations in their sense of who they are, going from one extreme to another: e.g., seeing themselves as a model citizen and then seeing themselves as a bad, destructive person. The individual has an excessive need for care, affection and reassurance and over-attaches to and idolises others in a frantic attempt to secure their love and commitment and to ensure that it is permanent and unshakable. However, they are plagued by a chronic fear of abandonment, which leads them to become suspicious and angry towards their attachment figures and to constantly test their commitment and affection. They switch from idolising and intensely attaching to them to pre-emptively rejecting and angrily pushing them away to avoid the pain of their anticipated rejection, often resulting in others leaving them or withdrawing. This then cyclically accentuates their feelings of abandonment and anger at being abandoned. Such self-destructive cycles typically lead to self-loathing, dejection, low mood, anger, and destructive behaviours. Emotions are normally very intense, fluctuate rapidly, are experienced as loss of control and are juxtaposed with an intense feeling of emptiness and dissociation, leading to intense distress and suicidality. Individuals with such traits can be volatile, manipulative and very intense to be with and their traits are self-perpetuating and self-defeating, often leading to the rejection and abandonment they intensely fear. This often leads to isolation, loneliness and anger, along with a desperate need to belong, develop an intense sense of identity and feel 'something' (rather than emptiness). They may experience both chronic suicidality as well as acute states of self-destructiveness and suicidality, which clearly correlate to general risk to self.

Extremist groups can appeal to such individuals if they purport to offer them a secure group to belong to that will not abandon them, and if they offer an intense, concrete new identity that makes them 'a good person' and redeems their 'badness'. Extremism can also offer a channel to vent their overwhelming anger by channelling it at the 'enemy', who is reframed as the cause of their misery and abandonment. Membership in extremist groups is often rewarded by affection, intense and total wrap-around support from the group, lessening the perception of the abandonment members fear and building an illusion of the permanency of support they crave. For those who feel self-loathing and guilty/defective, extremist narratives and groups offer redemption and a newly found moral high ground. The group also offers a sense of emotional containment through its structure, rules, predictability, and illusion of safety, all things that this personality needs to feel emotionally regulated, supported and grounded. The leader and comrades are often idolised, channelling the borderline personality's need for a safe and secure attachment figure, whilst the out-group are demonised, channelling their need to demonise and vent their anger at others. Thus, the extremist group and its cause offer a way for the split emotions/needs to find their expression, structure and meaning. The individual's membership may be maintained by their fear of abandonment by the group. However, their emotional volatility and lack of stable attachments or loyalties may soon generate conflict with the group and they may turn their anger towards the group. Thus, vulnerability and risk are as volatile and dynamic as the individual's emotions, attachments and identity.

Some individuals with borderline PD may not engage in extremist groups but instead express extremist ideas and intent in order to vent their anger and distress and signal their need for care and containment from professionals. Such individuals often seek to attract the attention of health and even criminal justice system professionals by committing destructive acts or threatening to do so. At a time of heightened terrorist threat, it is easy enough for individuals with borderline PD to realise that the most effective and rapid way of securing professional interest is to make claims of being radicalised or to claim intent to commit terrorist acts. The 'function' as well as the 'content' of the communication of individuals with borderline PD are thus both important to appraise. In some individuals with such traits, behaviour is heavily shaped by the borderline needs (e.g. to secure care and vent anger at being abandoned), and the extremist content is opportunistic and secondary. In some cases, detection and professional involvement may not deter the behaviour but encourage the idea that such behaviour does indeed secure professional care, thus reinforcing the behaviour. It is only when the borderline needs are met through alternative means that the behaviour may cease.

An individual with chronic suicidality may find death narratives of a group or cause appealing, although this may happen more so at times of acute self-destructiveness and suicidality. Times of acute vulnerability may correspond to periods of acute suicidality, where the risk to self may be heightened. When acute self-destructiveness is coupled with anger and impulsiveness, the risk to others may also be heightened. Thus, whilst some aspects of borderline PD may shape vulnerability to engaging with extremist group members and causes, others may shape vulnerability/risk of violence or violent self-destructive acts (including suicide), which may take on extremist forms of expression.

Recommended support & intervention approaches

Support and interventions that are commonly used to manage and treat borderline personality are helpful in such cases, including supporting the individual to meet their needs in healthy ways, and providing them with safe channels for venting and grounding techniques. The professionals themselves may become attachment figures whom the individual may alternate between idolising and demonising. This may lead to inconsistent and fluctuating engagement with professionals and the authorities. Further confusing the matter may be that the borderline individual comes to use extremist narratives more when they are angry at professionals and want to vent their anger as well as when they over-attach to the professional and want to stop them from leaving them. In such instances, the more the individual is angry and the more they attach to professionals, the more they may disclose extremist leanings and intent. Thus, vulnerability and risk are complex and their activation and manifestation may vary with the individual's emotional changes and attachments to the professional. Engagement with professionals as well as engagement with extremism are both dynamic and driven by impulsive, reactive, and at times opportunistic factors.

The individual with borderline disorder is often in severe distress and fearful and struggles through the emotional roller-coaster that is daily life. Hence much of the support and intervention needs to focus on managing and alleviating their distress, whilst also building their lifestyle resilience and facilitating healthy opportunities and sources of identity, emotional expression/venting,

acceptance, belonging, intimacy and predictability. Focusing on alleviating extremist ideology is unlikely to be effective. Focusing resources on building structure, predictability, boundaries and rules may be more beneficial. Professional and personal relationships may also require clear boundaries; if family are ill-equipped to manage the needs of the borderline individual, family counselling may be helpful. Realistically, borderline traits are unlikely to subside without long-term therapies, and the short-term focus may be to detach extremism from meeting borderline needs and to develop the individual's emotional and social resources to contain them in the short-term, rather than attempting to significantly reduce their traits. It is important that the dynamic nature of vulnerability and risk are reviewed regularly whilst also putting plans in place for the expected regular fluctuations in mood/identity/behaviour (including fluctuating engagement in extremist ideas/groups).

Other personality traits: sadistic, histrionic, avoidant, dependent, compulsive/obsessive & schizoid/schizotypal

Potentially relevant features

There are numerous other personality traits that may shape vulnerability, alone or combined. Examples may include:

Sadistic traits: Whilst dropped from some diagnostic classifications due to their overlap with antisocial and narcissistic PD, sadistic tendencies themselves may play an important role in driving violence and dominance that seeks to subordinate, humiliate and instil fear in victims. Some extremist groups offer a platform for the intimidation, subordination and humiliation of the out-group. Graphic images of violence, torture and rape are often circulated by some extremist groups. Brutal violence is celebrated as noble and when sadistic individuals join such groups they may be attracted to roles that involve torture, fear and humiliation of both members of the out-group and members of the in-group who may be viewed as deserving of punishment. Thus, the appeal of extremist groups and causes may be in their celebration of and license to commit acts of harm towards subordinates. Mitigation approaches may need to include taking away access to graphic materials of harm as well as reducing the opportunities to dominate and instil fear through terrorist identities, which may limit access to and the appeal of terrorism. Ultimately, when the individual is receptive to more in-depth evidence-based therapeutic approaches that help them to gain insight into and manage their sadistic tendencies (e.g. psychotherapy), this would be an ideal approach to adopt, in the long term, so as to help them reduce their sadistic tendencies and their triggers.

Histrionic traits: For individuals who have a heightened need for theatrical displays and demonstrative identities, terrorism may be the highest profile

event/identity that they come across. Whilst such individuals may create a lot of drama by making extremist statements and displaying extremist identities, it is important for professionals not to reinforce the drama of their extremist vulnerability by reacting strongly. Instead, their extremist behaviour needs to be de-dramatised and they need to be offered healthy alternative means to meet their needs.

Avoidant traits: Individuals with avoidant traits may feel anxious about getting close to others and fear being hurt or failing, which makes the virtual space a safer place to conduct relationships and socialise. They may find it easier to adopt virtual roles and engage in virtual relationships. This may create a vulnerability if they engage in online extremist forums. They need to be supported to develop their healthy sources of relationships and to manage their fear and anxiety about getting close to others, whilst also being afforded the opportunity to engage in safe/remote (virtual) roles that are non-extremist.

Dependent traits: Individuals who are dependent may fear losing others and comply with them in order to avoid being alone. When they have formed a relationship with extremists, their fear of losing those relationships and sense of vulnerability when alone could maintain their commitment to both the group and its causes and give the group more control over them. They need to be supported to break away from those individuals and groups and to develop healthy relationships and circles of support. They may also benefit from developing strategies to manage their anxieties in relationships and to develop a healthy sense of autonomy and self-efficacy.

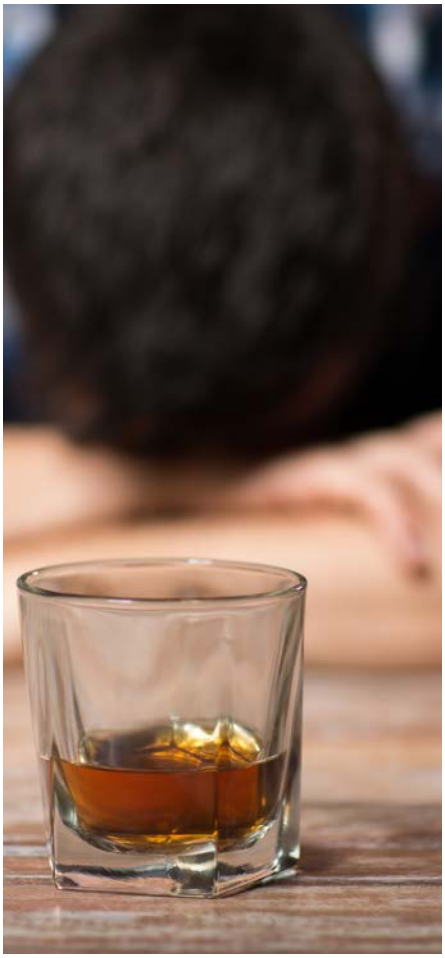
Obsessive-compulsive traits: Individuals with such traits are typically perfectionist and self-critical, fearing failure and often tormenting themselves with self-criticism. They may be prone to guilt that is brought on by any perceived moral, social, emotional or academic/occupational failure. Such individuals may be receptive to narratives of redemption due to their guilt and need for redemption. They may also be receptive to guilt-tripping tactics used in extremist propaganda whereby an individual is made to feel guilty and a failure for their inaction and lack of strong support for the cause. Such individuals need to be supported to manage and reduce the unrelenting standards they impose on themselves, to manage guilt and their sense of failure and to recognise their vulnerability to extremist narratives. They typically work hard in any rehabilitative intervention, because of their very desire to do well and correct errors; whilst this is positive, therapists need to ensure that referrals or interventions do not in themselves create a perception of having failed or done something wrong. When the individual can channel a healthy level of perfectionism in safe domains in their life – e.g. to excel academically or in their job – this could enhance resilience and divert vulnerability.

Schizoid & schizotypal traits: Such individuals may find 'odd' or taboo topics appealing and be attracted to conspiracy theories and idiosyncratic explanations of the world. They may also appear odd to others and be rejected by mainstream social groups. Whilst this is not problematic in itself, if the individual is satisfied with their life and engages in safe pursuits and alternative social groups, it can become a vulnerability if they find extremist groups, causes and explanations appealing or find acceptance in extremist social groups. In such instances, their personality traits may increase the

resonance of extremist causes or groups, especially if they lack the healthy social networks to question and steer them away from extremism. It is important to support such individuals to adopt healthy interests and pursuits that they find rewarding, however socially unconventional these may be, and to meet like-minded individuals or co-enthusiasts. They may also benefit from support to recognise the risks and true agendas of extremists.

ALCOHOL & DRUG USE & OTHER ADDICTIONS

Potentially relevant features



The use of alcohol, illicit drugs, and possibly some prescription drugs may play variant roles in shaping extremism vulnerability/risk. Firstly, alcohol, drugs and other addictive activities may play a role in creating vulnerability and triggering the pathway to extremism. Secondly, they may sustain the vulnerability and increase risk. And thirdly, alcohol and substances may lift behavioural and mental inhibitions at the later stages of the pathway when the individual is considering committing an extremist offence. Of course, there is also the fourth possibility that the individual may be involved in narco-terrorism, whereby they engage in the trafficking of drugs in order to fund terrorist activity, however this is rarely of relevance to mental health practitioners and may simply be a consideration for operational disruption and security agencies. Thus, the first three roles that substances may play in shaping vulnerability warrant consideration by mental health practitioners.

Creating vulnerability: The individual's own substance misuse or indeed any kind of addiction and dependency – including that of a loved one such as a parent or partner – may significantly add to their distress, confusion and sense of losing control. It may exclude them from social success, lead to rejection and of course to anxiety and low mood. It may reduce their sense of purpose and meaning in life and lead to social isolation, lifestyle instability and uncertainty, and exposure to harmful and toxic environments and groups that exploit them. Collectively, these adverse circumstances may generate a sense of injustice, anger, fear, threat, guilt and helplessness, which the person feels they are unable to overcome. Such consequences of substance misuse often self-perpetuate the very need for substance use, until life spirals out of control. As a result, the individual's substance misuse (and indeed their loves one's) may generate intense distress, a sense of threat, grievance, loss of meaning, identity purpose and belonging, and a heightened need to escape or restore control and redeem one's self. All these factors may constitute vulnerabilities to extremism, which extremist causes and groups may purport to resolve.

Sustaining vulnerability: For some individuals, extremist identities, activity or groups could become means of escaping from their life's problems and emotional pain and serve a similar function to substance use. Therefore engaging in substance use and extremism co-vary with a third factor such as psychological distress, and may reinforce one another by continuing to provide dysfunctional means of escapism from such distress, exacerbating and maintaining it in a vicious cycle. Alternatively, in individuals who have a heightened need for risk, stimulation or intensity, both substance misuse and extremism may fulfil these needs while being mutually reinforcing. Thus, substance misuse and extremist activity may be two parallel areas of vulnerability that are underpinned by a common need.

Lifting inhibitions: Individuals may opt to use substances to lift their inhibitions and overcome anxiety/guilt, hesitation or cognitive controls, when they need to commit acts of harm or take risks associated with extremism. Some terrorist groups routinely use substances as disinhibitors or energisers for this reason,

even when their purported values (e.g. religious or moral beliefs and goals) discourage substance use, rationalising that they do so for the greater good and as a means to a noble end. Regardless of whether substance misuse is chosen by the individual or group as a disinhibitory or energizing aid, it can heighten and intensify an individual's intent to offend by lifting barriers that could otherwise prevent them or slow them down. Such barriers and inhibitions may include anxiety, fear, guilt, hesitation to harm others, themselves or abandon and impact loved ones, and complex reasoning and deliberation. Substances could therefore act to heighten intent and increase capability to offend once the individual has engaged in extremism and has either considered or been assigned to carry out an offence or a violent act.

Recommended support & intervention approaches

If substance misuse shapes the extremism vulnerability/risk, it is important to address both the misuse and its current and historical drivers, as well as to ensure that the needs met by extremism (e.g. escapism, sense of control/efficacy, redemption, etc) can be fulfilled by alternative, healthy means.

When substance misuse co-varies with, serves the same function as and reinforces extremist engagement, it is important to address the underlying factor that generates the need for both substance use and extremism – be it heightened distress generating a need for escapism or a heightened need for stimulation that generates a need for intensity and risk.

Finally, where substance misuse acts as a disinhibitor to extremist offending, it is important to mitigate its access, develop the individual's insight into their pathway to extremism and nurture existent inhibitions that prevented them from offending in the absence of substance misuse (e.g. the fact that they needed to use substances to lift inhibitions meant that they had healthy inhibitions and these can be nurtured and strengthened). Where the individual's substance misuse initially constituted a mere deliberate disinhibitor for actions but has since become addictive, support should be provided to address this emergent problem, to ensure that substance misuse is not sustained beyond and independent of their extremist pathway.

OTHER MENTAL HEALTH & PRACTICE CONSIDERATIONS

The above list of mental illnesses and disorders is not exhaustive and there may be other diagnostic considerations as well as sub-diagnostic-threshold problems that present which may have relevance to vulnerability and risk for a given individual at a given time.

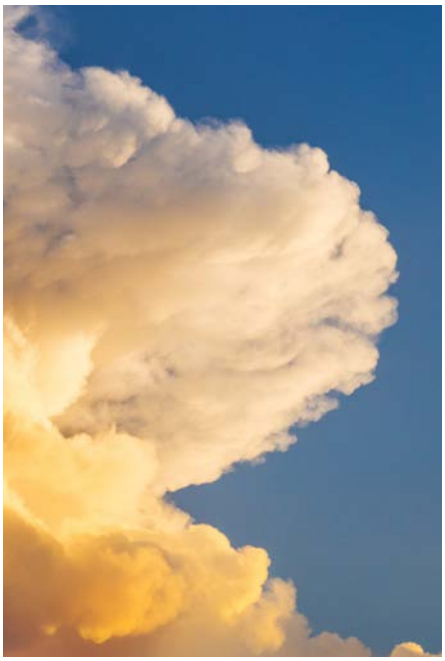
Some psychological states and sensitivities contributing to vulnerability/risk may cut across several of the above diagnostic categories, either as primary features or secondary problems that arise from it. These include 'anxiety', 'anger' and emotional dysregulation. These are of potential interest because research has shown that a sense of 'threat' and/or 'grievance/injustice' may act as a driver for engaging in extremism. Additionally, psychological conditions associated with behavioural and cognitive impulsivity and low frustration tolerance (e.g. substance misuse, ADHD, frontal dysexecutive syndrome, traumatic brain injury) that may act as general vulnerabilities for wider offending, may also be worthy of consideration as generic vulnerabilities. Furthermore, identity and attachment disorders heightening identity confusion and the need to belong and secure support are also worth considering, as they may render the individual susceptible to groups and leaders who promise to meet such needs in return for engagement in violence or other extremist activity. Finally, cognitive vulnerabilities that accentuate 'suggestibility' and 'susceptibility to influence', including learning difficulties and cognitive impairment, are important to consider in formulation, as research has shown that susceptibility to group influence and radicalising agents (e.g. individuals or ideas) can increase risk of extremist engagement. This is especially pertinent if the individual is exposed to extremist materials, contacts and peers which they are ill-equipped to critique. Whilst emotional, behavioural and cognitive frailties may be selected out by many traditional terrorist recruiters who see such characteristics as posing an operational liability, modern day online recruitment and self-radicalisation have meant that some recruiters overlook such frailties and may even deliberately seek and exploit such individuals.

In addition to psychological states, biological, social, environmental and situational/practical factors must always be considered in any formulation of vulnerability and risk. It is important to address mental illness and mental well-being within a holistic framework whilst also attending to its specificity and medical drivers. Examples of biological factors that may impact an individual may include physical illness, injury, and disability. Social factors may include loss of social capital, economic adversity, and difficulties in psycho-social adjustment to a new culture or social environment. Social-environmental factors may include political conflicts, injustices and narratives that are normative and adaptive for a given group at a given time. Such biological, social and environmental factors may contribute to and interact with an individual's mental health, to shape their vulnerability and risk. It is therefore important to avoid reductionist formulations of mental health as a vulnerability. Similarly, the 'remedies' to impaired well-being should include all types of support, intervention and capital that are meaningful to that individual in particular, and not just general medical/psychiatric support and interventions. For example,

social support, faith and pastoral support and personal capital that the individual deems to be important for their well-being are important to consider, alongside traditional Western mental health services and approaches. Overall, practitioners should endeavour to maintain sight of an individual's holistic needs and remain mindful of their developmental, cultural and environmental context. Where possible, they should familiarise themselves with the norms that shape the individual's frame of reference – including age, gender, cultural and religious norms – and ensure support and intervention can respond to such frames of reference.

It is important to recognise that vulnerability and risk are dynamic and their relationships with mental illness are not static. Therefore, vulnerability and risk formulations should be reviewed regularly. Practitioners need to develop the skill and confidence to communicate clinical formulations and appraisals of risk reduction to non-clinicians tasked with operational decisions. Whilst terrorism is a broad and long-term risk in many countries, this does not mean that all individuals engaging in terrorism pose a long-term and broad risk, and clinicians play an important role in delineating and communicating such realities to audiences that may be understandably very risk-averse. Extremism and terrorism are socially feared and politically sensitive and authorities are naturally circumspect when dealing with such risk. Practitioners should therefore be thorough and clear in their clinical formulations and recommendations relating to risk in order to enable and equip their colleagues to make proportionate operational decisions about the individuals in question.

It is important for professionals to endeavour to reduce the social demonization of individuals referred for support for extremism vulnerability/risk and to ensure that mental illness is not stigmatized and seen as an inevitable sign of risk. They need to ensure that their own judgements are objective and clinically sound and not skewed by societal stereotypes or political pressures and fears. Mental health professionals may also need to consider the impact of such complex, sensitive and often challenging work on their own health and well-being and to ensure that they have the support they need to maintain resilience and to develop the relevant skills and knowledge. This is a challenging area of work in terms of the complexity of the issues being managed by the practitioner and it is always advisable that practitioners in this field are supported properly and, where possible, operate as part of a multi-disciplinary team.



Summary

When extremist behaviours and mental illness are both present in an individual, practitioners would benefit from using individualised case formulations that are evidence-informed to identify any specific aspects of mental illness that contribute to extremism vulnerability or risk. Mental illness may be present but not relevant to shaping vulnerability to extremism and may in some instances be protective against it or a secondary effect of extremist engagement. Wherever mental illness is present and relevant, it may play a direct or indirect role in shaping vulnerability, often by interacting with social, environmental, and biological factors that impact the individual.

There is no simple formula for the role mental illness may play in shaping extremism vulnerability across individuals, nor may its greater severity simply infer greater causality. Symptoms often interact with a range of factors that impact an individual at a given point in time, while co-morbidity may increase general vulnerability and add complexity to the role mental illness may play in shaping extremism vulnerability. Different aspects of mental illness may contextualise 'push' factors or aspects of the individual's life and experience leading them towards extremist causes/groups, as well as 'pull' factors or aspects of extremist causes/groups appealing to them and pulling them in. A thorough individual case formulation can be used to identify the contribution that each symptom may make to push and pull factors, and on this basis, inform effective, nuanced mitigation strategies. Additionally, protective factors should be enhanced, whilst general resilience and well-being should be maximized.

Once push and pull factors that shape the pathway to extremism and the protective factors that divert from it are identified, support and therapeutic strategies can be put in place. Support and interventions may vary and should build on evidence-based practice and well-researched intervention approaches for mental illness whilst also taking into consideration non-psychiatric approaches that enhance resilience for that individual. Regardless of the intervention and support approach taken, the common principle needs to be to help the vulnerable/at risk individual to recognise the functions and needs that extremism met for them and to either alleviate the factors that exacerbate that need or else to meet those needs in healthy alternative ways.

The current handbook provides suggestions for how different mental illnesses may play a role in shaping extremism vulnerability/risk by impacting push and pull factors. It suggests approaches to mitigating such vulnerability/risk and building resilience. The current handbook only addresses a small number of mental health conditions and hence is not exhaustive in its coverage. Practitioners are encouraged to adopt an open mind about mental health and examine all diagnoses that are relevant for an individual as well as to consider presenting difficulties that don't fit a diagnosis. As well as difficulties, it is as important that practitioners examine the strengths and sources of resilience that an individual exhibits and nurture those. Vulnerability and risk are dynamic, as are the links between mental illness and extremism. Therefore, by understanding and supporting the individual to reduce vulnerability and risk and to enhance their resilience, forensic clinical practitioners can make a significant contribution to protecting the public and reducing the terrorist threat. The current handbook was produced to provide an accessible aid to assist practitioners to perform this important and complex role.

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HANDBOOK

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EXTREMISM, RADICALISATION & MENTAL HEALTH:

HANDBOOK FOR PRACTITIONERS

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