Extremism, Terrorism, and Mental Disorder

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The nexus between mental disorder and terrorism has long confounded both clinicians and researchers. Data indicate that approximately one-third of lone-actor terrorists will be diagnosed as having a mental disorder on clinical interview, but members of a terrorist group typically have neither more nor less mental disorder diagnoses than the general population. Other notable problems for the psychiatrist are distinguishing between symptoms of mental disorder and extremist beliefs, discerning radicalization and a pathway to violence in a psychiatric patient, and identifying the proximal warning behaviors that suggest a heightened probability of violence toward a targeted individual or group. Steps toward clarification of these various issues through measurement and mitigation of risk are offered.

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Clinical psychiatry has had a vexed relationship with extremism and terrorism. On the one hand, the probability of a patient espousing an extreme ideology that advances him on a pathway to violence is highly unlikely; on the other hand, if such a case—rarely the focus of psychiatric training or clinical practice—should present itself and pose a threat to the community, the potential violence, often a mass attack, will be catastrophic. Such low-frequency and high-intensity events are considered targeted violence (1), and the risk assessment and management of such patients, when motivated by extremist ideology, has matured into an empirically robust discipline (2).

Data indicate that approximately one-third of lone-actor terrorists will have a diagnosable mental disorder when clinically interviewed (3). These are individuals who plan and prepare for a terrorist attack without any external command and control, although research also indicates that they are typically embedded within a network of like-minded true believers, often online, and aspire to be identified with a particular extremist belief system or global terrorist movement (4). Studies of terrorist organizations and their group members, however, indicate that the prevalence of mental conditions and diagnosed mental disorders among them is the same as among the general population (5). There are no specific diagnoses that predict radicalization and movement on a pathway toward terrorist violence; however, predisposing conditions, such as autism, depression, and psychosis-proneness, can create vulnerabilities to extremist beliefs that warrant attention (6).

FIXATION, DELUSION, AND EXTREME OVERVALUED BELIEFS

Eighty percent of targeted attackers will evidence a pathological fixation—a preoccupation with a person or a cause that results in deterioration of social and occupational functioning—in the months or years prior to an attack (7). However, fixations are very common and by themselves do not predict an attack. This pattern of thought, however, is an early warning sign that has one of three cognitive-affective drivers: an obsession, a delusion, or an extreme overvalued belief. The first two are readily diagnosable symptoms within psychiatry, and often medically treatable, but without extreme overvalued beliefs and their historical provenance within psychiatry, clinical discernment suffers (8).

Extreme overvalued beliefs are *shared by others* in the person's culture or subculture, are relished and amplified, and over time grow more dominant, refined, and resistant to challenge. The beliefs are simplistic, binary, and absolute. The patient will develop an intense emotional commitment to the belief and may carry out violent behavior in its service (7, 8). Recent research has both validated and refined the understanding of extreme overvalued beliefs, drawing from nineteenth century French and German clinical psychiatry, especially the work of Carl Wernicke (9, 10).

The practical application to contemporary psychiatry is that, unlike obsessions and delusions, there is currently no medical treatment for extreme overvalued beliefs as drivers of a pathological fixation, and the psychiatrist will need to engage more readily with both familial and social resources to alter a clinical course that may portend a commitment to an eventual act of violence. Deepening the clinical quandary is that such beliefs can be accelerated in online communities of "violent true believers" (11) wherein there are no countervailing opinions, and the online behavior may be concealed from others until the patient has progressed onto a pathway toward violence.

Here is a social media posting by a young man who subsequently carried out a mass attack and killed nine members of a church prayer group in Charleston, South Carolina, in 2015:

> I have no choice. I am not in a position to, alone, go into the ghetto and fight. I chose Charleston because it is the most historic city in my state, and at one time had the highest ratio of blacks to Whites in the country. We have no skinheads, no real KKK, no one doing anything but talking on the internet. Well someone has to have the bravery to take it to the real world, and I guess that has to be me (12).

The shared beliefs in this case were racism and White supremacy, with a simplistic, binary, and absolute commitment to violence on behalf of the neo-Nazi community with which he identified.

RADICALIZATION AND THE PATHWAY TOWARD VIOLENCE

The patient who radicalizes will typically show changes in their interpersonal behaviors, their internal life, and their felt emotions toward those whom they consider the enemy (13), often incubated by online extremist websites. Berger (14) notes that extremist groups share two characteristics. First, they identify an outgroup who poses an imminent existential threat; such groups could range from political parties, the federal government, immigrants, people of color, Jews, LGBTQIA+, and other minorities to delusional groups and other unusual conspiratorial enemies. Second, they believe that the threat is such that violence toward the outgroup is necessary. Such hostility toward outgroups is embedded in the online cultures that patients sometimes inhabit, and membership need only be an aspiration. The more vulnerable the patient's mental state, the greater the likelihood that they could begin to radicalize. For example, the patient with paranoid schizophrenia may come to believe that the somatic delusions that haunt him have actually been implanted by lizard people, fully "explained" in the 2022 documentary film *Lizard People: The Truth about Reptilians* (15). Subcultural online support for his delusions may motivate him to believe that such lizard people pose an imminent existential threat to his well-being, and hostile action is necessary against these alleged shape-shifting creatures, now believed to inhabit the bodies of his parents with whom he lives. Delusional misidentification syndrome emerges in the clinical setting (16). The clinical task, however, is to not only diagnose the condition and the online activity of the patient that is exacerbating his new symptoms, *but also to determine whether there is a nexus between such symptoms and a motivation to be violent,* and then to take whatever steps are necessary to mitigate the risk.

Medical schools and psychiatric residency curricula rarely teach about targeted attacks such as those that occur in the context of extremism and terrorism. Instead, they often teach violence risk assessment with an emphasis on intense anger and a loss of control. In the context of extremism and terrorism, however, the nature of the violence, should it occur, is different: it is planned, purposeful, predatory, and emotionless (17). Such violence is usually the result of movement on a pathway wherein thoughts and feelings change over time, typically weeks or months, and follow a fairly predictable pattern: it begins with a personal grievance, characterized by a loss, humiliation, anger, and blame; moves to the contemplation of violence as the only means to address the personal grievance; progresses to the intent to be violent; further coalesces as the patient makes decisions concerning the target, tactics, and weapons he will use; crystallizes in specific planning and preparation for the attack; and culminates in the implementation of his attack (1, 18). This thoroughly researched pattern of movement is often heralded by the patient becoming *less* emotional, calmer, and more controlled as they put their secret plan into action. The bad news is that much of this pathway behavior can now occur online, and the patient does not need to do anything on the ground until he is mobilizing for the violent action itself. The good news is that most targeted attackers, whether motivated by ideology or not, will communicate their intent to attack to a third party (19). This again compels the treating psychiatrist to engage with the patient's close friends and family members to discern whether or not such an intent to attack has been communicated by the patient, either in person or through concerning online behavior. Such "leakage" communication usually mandates contact by the psychiatrist with local law enforcement, depending on the legal duty to warn and protect in the jurisdiction in which the psychiatrist practices.

Can a psychiatric patient, especially one who has a psychotic disorder, engage in planned and purposeful violence? Absolutely. Junginger discussed "psychotic action" and the concept of rational planning within an irrational state of mind (20). Others have argued for the clinical focus for assessment of targeted risk to be at the level of symptoms rather than diagnosis (21). The paradox is that the delusion may bring a resolve and commitment to the violent plan that would be suffused with ambivalence and anxiety if the delusion were absent.

Other diagnoses can also provide vulnerabilities to both recruitment and targeted violence. For example, a jihadist recruiter online may target a patient who is clinically depressed, convincing them that their current suicidal thoughts and feelings can be positively redefined as an act of martyrdom for the global cause to destroy the *kaffir,* those unbelievers who threaten the Islamic faith.

THE PROXIMAL WARNING BEHAVIORS FOR A TARGETED ATTACK

There is now substantial research on eight proximal warning behaviors that precede a targeted attack (2, 22): pathway,

fixation, identification, novel aggression, leakage, energy burst, last resort, and directly communicated threat. On average, a targeted attacker will manifest *five* of these patterns of behavior. These proximal warning behaviors are defined in Box 1.

The warning behaviors are apparent among attackers regardless of the target and whether an extreme ideology has played a primary role. Research indicates that all public mass shooters are more alike than different in both their offender and offense characteristics (23), and a significant proportion of such attackers will hold extremist interests or will be motivated by such beliefs (24). For example, the perpetrator of the attack on Marjory Stoneman Douglas High School in 2018, which resulted in the deaths of 17 people, was drawn to ideologies of hatred, including Nazism, Satanism, and White supremacy. He also evidenced a misanthropic state of mind. There was suggestive evidence that he was both suicidal and depressed (25, 26).

Research also supports that four of these proximal warning behaviors in particular—pathway, identification, energy burst, and last resort—may indicate imminent risk (27–29).

Pathway is the most obvious, particularly any later stage markers, such as securing the means to carry out a targeted attack. A Federal Bureau of Investigation study found that one-half of the active shooters assessed prepared between 24 hours and 1 week before their attack, and 33% prepared between 1 week and 2 months before implementation (30). Telltale behaviors could include the purchase of multiple firearms and ammunition from different retail outlets or of ingredients to construct a bomb. The Oklahoma City bomber had to secure over 4,000 pounds of ammonium nitrate fertilizer over the course of several months from multiple dealers to not attract attention (J.R. Meloy, unpublished data).

Identification as a proximal warning behavior is seeking a new self-identity that embraces weapons, admires previous targeted attackers, or, in the case of a lone-actor terrorist, signals that he has become a soldier or warrior for a particular cause. It is a shift from what the patient thinks about all the time (the fixation) to whom he becomes (the identification). For example, the patient may post on his social media admiring comments about the Islamic State, a militant jihadist organization with roots in Iraq, and then one day he posts an image of himself and the comment, "I'm a soldier for ISIS." This new dark identity, often with both conscious and unconscious determinants, may be a prelude to mobilization for violence. Such deeply felt emotional shifts often compensate for a blighted day-to-day life. As the journalist Tom Friedman (31) so aptly put it, "he's never held a job or a girl's hand." For the young patient, immersion in such an aggressive identity will often burnish self-esteem as he grandiosely links himself with a global cause, and if done in a religious context, it adds religious sanctification to his desire to avenge his angers and humiliations.

Energy burst occurs among slightly less than one-half of targeted attackers (32) and is simply an increase in on-the-ground behavior often related to the attack, accompanied by a decrease in online behavior (26). This information is difficult for the treating psychiatrist to discern and usually is noted by third parties close to the patient. The discovery of such important data is most easily facilitated by securing consent from the patient to be able to freely converse with family and friends during the course of treatment—*before* there is any indication of radicalization or movement on a pathway to violence. Although consent to view the online postings of a patient that can be viewed by the general public is legally unnecessary because there is no reasonable expectation of privacy, the treating psychiatrist should seek consent to minimize the risk of disruption of the treatment (33).

Last resort is the four-alarm fire in threat assessment and management and is simply the extreme overvalued belief: "I must be violent, and I must be violent now." It can manifest as either words or behavior and is captured in a posting by the attacker of the Tree of Life synagogue in Pittsburgh in 2018 who killed 11 men and women. He posted the following comment on the Christian nationalist website gab.com just before he carried out his killings: "[Hebrew Immigrant Aid Society] likes to bring invaders in that kill our people. I can't sit by

BOX 1. The proximal warning behaviors for a targeted attack

1. *Pathway* warning behavior is research, planning, preparation, or implementation of an attack.
2. *Fixation* warning behavior indicates an increasingly pathological preoccupation with a person or a cause, accompanied by a deterioration in social and occupational life.
3. *Identification* warning behavior indicates a psychological desire to be a pseudo-commando or have a warrior mentality, closely associate with weapons or other military or law enforcement paraphernalia, identify with previous attackers or assassins, or identify oneself as an agent to advance a particular cause or belief system.
4. *Novel aggression* warning behavior is an act of violence that appears unrelated to any targeted violence pathway and is committed for the first time.
5. *Energy burst* warning behavior is an increase in the frequency or variety of any noted on-the-ground activities related to the target, usually in the hours, days, or weeks before the attack. Online activity usually diminishes.
6. *Leakage* warning behavior is the communication to a third party of an intent to do harm to a target through an attack.
7. *Last resort* warning behavior is evidence of a "violent action imperative" and/or "time imperative." It is often a signal of desperation or distress.
8. *Directly communicated threat* warning behavior is the communication of a direct threat to the target or law enforcement beforehand.

and watch my people get slaughtered. Screw your optics, I'm going in." There is always time compression and a foreshortened future in last resort as a proximal warning behavior, but the offender may choose to act rather than to speak: debts are settled, goodbyes are communicated, important documents are destroyed, and living possessions are given away; all these behaviors are similar to those in preparation for suicide, and in the case of mass attackers, there is often both a homicidal and a suicidal intent (27, 34).

Assessment of Risk

For decades, the use of assessment instruments to assess violence risk has been shown to be superior to subjective clinical judgment (35). They are referred to as structured professional judgment (SPJ) instruments and provide an evidence-based organizing template for the psychiatrist to arrive at an opinion of risk. In fact, the absence of use of such instruments and sole reliance on the clinician's past experience as the benchmark for determining risk may be *prima facie* evidence of substandard practice in subsequent civil litigation.

The most validated SPJ instrument for assessing lone-actor terrorism risk appears to be the Terrorist Radicalization Assessment Protocol (TRAP-18) developed by the author (13). It codes the eight proximal warning behaviors, as well as 10 distal characteristics, to determine whether the case only needs to be monitored or should instead be actively managed. TRAP-18 has been shown to have excellent inter-rater reliability and concurrent, postdictive, and discriminant validity in comparative studies (36). Case studies have also illuminated its usefulness, which have ranged from the jihadist who attacked a German Christmas market (37), a U.S. Coast Guard extremist (38), and the Oklahoma City bomber (39) to the Christchurch mass murderer (40) and the Capital Gazette mass attacker (26). Generalizability across various ideologies and their cultural influences has also been demonstrated (41). The instrument's license and use requires online training through Multi-Health Systems, Inc. (mhs.com).

Mitigation of Risk

There are common mistakes made by treating clinicians in the management of a patient who is radicalizing on a pathway to potential violence. Addressing the following mistakes can help to mitigate the risk:

1. They interpret the clinical data from a binary perspective: it is either the patient's mental illness or his radicalization that is the problem. The correct clinical question is how and to what extent are the extremist ideology and the mental disorder interacting to aggravate risk? And is there a useful psychiatric intervention?
2. They attempt to manage the case without consultation and help from other allied professionals, such as those in law enforcement, psychology, social work, education, and the legal system, as well as from other local community service professionals with skills in this area. For example, school counselors and administrators often have valuable insights into a young patient's behaviors and often provide critical information to the treating psychiatrist for treatment planning. A collaborative team approach, ideally a threat assessment and management team, should determine the overall management and safety plan. Nevertheless, clinicians may find that such a team is not available, or there is resistance among local allied professionals to help manage the case. Outside consultation should be sought, most readily through the Association of Threat Assessment Professionals, a national nonprofit organization with active chapters throughout the United States (atapworldwide.org) and sister organizations on other continents.
3. They prematurely terminate treatment or transfer the case because of their anxiety and perceived professional risk, or they completely refuse to take such cases on referral.
4. They do not learn the elements of the extreme ideology that is being adopted because it is foreign to their culture and upbringing, personally disliked, or evokes feelings of disgust.
5. They do not attempt to understand their own counter-transference reactions to the radicalization and how such insight can help with treatment. A significant problem is that the clinician, due to a lack of experience of such cases, overestimates the actual violence risk.
6. They remain ignorant of the online or on-the-ground behavior of the patient when the patient is not physically in front of them. This is especially challenging if collateral resources are absent or uncooperative, and the clinician is pressed for time due to a busy schedule.
7. They reify and rigidify their initial risk assessment and do not consider subsequent clinical and behavioral data that may change their original determination, what is referred to as both an anchoring effect and a confirmation bias (42). This is especially common when unstructured clinical judgment is the only metric and when the clinician is not using a validated risk assessment instrument.
8. The treating psychiatrist conducts his own formal threat assessment without any other evaluator. This should *always* be done in concert with a forensic psychiatrist or psychologist trained in such work. The most common unintended consequence is that the therapeutic alliance will distort the risk assessment findings of the treating clinician and will likely be damaged if the assessment is conducted by the treating doctor. In some scenarios, especially if there are very few outside resources, a treating clinician may effectively be forced into playing a central role in the risk assessment; if such is the case, the treating clinician should have the prior training and knowledge to conduct a thoughtful, informed risk assessment for targeted violence.
9. Clinicians do not seek the widely available continuing education in targeted violence prevention, threat assessment, and radicalization to extreme beliefs.

The Bottom Line

With these limitations and caveats in mind, psychiatric care of the patient who may be radicalizing toward violence depends on recognition of the proximal warning behaviors; assessment of risk by using an SPJ instrument such as TRAP-18 (13); avoidance of overpathologizing an ideology; management of comorbid psychiatric disorders; involvement of other threat assessment professionals, particularly law enforcement if there is an imminent threat; maintenance of the therapeutic alliance if at all possible; and knowledge of the legal and ethical parameters that apply to the psychiatrist's jurisdiction and the facts of the case.

As Brutus spoke, "Between the acting of a dreadful thing and the first motion, all the interim is like a phantasma or a hideous dream: The genius and the mortal instruments are then in council; and the state of man, like to a little kingdom, suffers then the nature of an insurrection" (43).

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Dr. Meloy reports deriving income from the training and licensure of the Terrorist Radicalization Assessment Protocol (TRAP-18).

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