



## Differentiating Delusional Disorder From the Radicalization of Extreme Beliefs: A 17-Factor Model

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Threat assessment professionals and forensic mental health experts face a challenging differential in determining whether a potential violent actor or postviolence defendant suffers from a delusional disorder or is simply radicalized in his extreme religious or political beliefs. No published model for analysis (i.e., structured professional judgment, SPJ) is available to aid in systematically distinguishing these cases or promoting transparency in associated reports and testimony. In the model of analysis (SPJ) proposed herein, 7 primary arenas of analysis were distilled from scholarship regarding features of delusions and delusional disorder: belief content; belief style; subjective distress and social dysfunction associated with the belief; social influences in belief formation, maintenance, and behavior; social inclusion; prodromal factors; and behavioral or action factors. Seventeen factors are specified for operationally defining and qualitatively describing the 7 primary arenas of analysis. Within each factor, features may be specified that further disaggregate the analysis. This SPJ tool is termed: Model of Analysis for Differentiating Delusional Disorder from the Radicalization of Extreme Beliefs–17 Factor (MADDD-or-Rad-17).

### ***Public Significance Statement***

Violence having social or political motivations, particularly when perpetrated by lone actors, may variously stem from delusional constructions or from radicalized beliefs. Threat assessment professionals and mental health experts have faced marked challenges in differentiating between these offenders, with no systematic model available. A structured professional judgment tool, reflecting 7 dimensions and encompassing 17 factors, is proposed to inform this important differential.

**Keywords:** delusions, delusional disorder, extreme beliefs, radicalization, terrorism

Differentiating delusional disorder from the radicalization of extreme religious or political beliefs importantly informs threat assessment and management before violence, law enforcement investigation after a violent act having apparent social or political implications, and forensic evaluations relevant to adjudication and disposition. This differential

is quite challenging, as reflected by the sharply divergent findings among mental health experts in a number of high-profile cases. Such divergent findings characterized the evaluations of Brian Nichols,<sup>1</sup> Christo-

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<sup>1</sup> Brian Nichols was on trial in Atlanta for the rape, kidnapping, and assault of a former girlfriend in March 2005 when he overpowered an escorting officer and, shortly after, shot to death his presiding judge and court reporter. Fleeing the courthouse, Mr. Nichols fatally shot a sheriff's deputy. He took refuge in a residence under construction where he shot and killed the homeowner, a federal agent. First author was retained by the defense and testified in the 2009 guilt-phase regarding mental state at time of offense, opining that the defendant suffered from a delusional disorder. Mr. Nichols was convicted, but sentenced to life in prison rather than the death penalty.

pher Monfort,<sup>2</sup> and Anders Breivik.<sup>3</sup> In each of these cases, determination of the defendant's mental state was made more challenging by the apparent absence of generalized psychotic disorganization or hallucinations.

Indeed, in both Nichols and Monfort, defense-sponsored testimony asserted the presence of a delusional disorder; a diagnosis characterized by delusions in the absence of other significant psychopathology (*Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition-Text Revised [DSM-IV-TR]*, see [American Psychiatric Association, 2000](#); *Diagnostic and Statistical Manual of Mental Disorders-Fifth Edition [DSM-5]*, [American Psychiatric Association, 2013](#)). In the Breivik case, the first team of mental health evaluators diagnosed paranoid schizophrenia, but found that "Mr. Breivik did not have grossly disorganized behavior, hallucinations, a natural history consistent with a severe mental disorder, or a serious cognitive impairment affecting his daily life" (p. 28, [Rahman, Resnick, & Harry, 2016](#)). Given this symptom description, delusional disorder appears to have been an alternative diagnostic option in this case as well.

A second team of Breivik psychiatric evaluators (see [Rahman et al.](#)), as well as state-retained experts in Nichols and Monfort, opined that the respective defendant was not psychotic, rather exhibited abnormal personality features and expressed a political agenda (i.e., extreme but nonpsychotic beliefs) in his offense conduct. Similar diagnostic controversies (i.e., delusional disorder vs. abnormal personality expressing the radicalization of extreme beliefs) are likely to characterize future cases involving violent acts having political or social implications, particularly those perpetrated by lone actors.

## Diagnostic Divergence Among Experts

### Factors Contributing to Diagnostic Divergence

That equally well-intentioned and well-credentialed mental health experts arrived at fundamentally different diagnostic destinations in these cases is hypothesized as attributable to five factors.

First, delusions are the sole distinctive feature of delusional disorder, with these occurring in

the absence of other significant psychopathology; without history of schizophrenia or prominent hallucinations; in a person who may be quite functional and who does not display odd or bizarre behavior, excepting when the delusional belief is discussed or acted on (see *DSM-IV-TR*, *DSM-5*). A differential in the absence of more generalized psychopathology is understandably more controversial.

Second, even when acting on the belief, a mentally ill offender may exhibit planning and rationality. Gill asserted that the dichotomy between lone actors who are politically motivated and those who are mentally ill, that is, lone wolves versus lone nuts (see [Burton & Stewart, 2008](#)) is a false one. Gill described:

... it is also often incorrectly assumed that just because there is a history of mental illness, the offender is "completely irrational and incapable of planned or self-interested behavior" ([Borum, 2013](#), p. 107). Research demonstrates however that the supposed "irrationality" experienced by the mentally ill is not as debilitating as previously thought ([Borum, Fein, & Vossekuil, 2012](#); [Fein & Vossekuil, 1999](#); [Gill, Horgan, & Deckert, 2014](#)). For example, [Gill et al. \(2014\)](#) illustrate that lone-actor terrorists diagnosed with mental illness frequently display rational motives. Similarly, [Borum \(2013\)](#) highlights a number of terrorists with mental illness who were capable of sophisticated attack planning. In an operational study of assassins, attackers, and near-lethal approachers, [Fein and Vossekuil \(1999\)](#), highlight cases of mentally ill individuals planning and executing behaviors as effectively as those lacking diagnoses (p. 106).

A one-way differential is, thus, implicated. Psychological disorganization when acting on a delusion may point to a delusional disorder. However, both types of offenders may exhibit rationality and planning in the attack.

Third, the delusions characterizing a delusional disorder may reflect content that is within

<sup>2</sup> In October 2009, Christopher Monfort firebombed Seattle police vehicles parked in a city maintenance yard. Nine days later, he assassinated a Seattle police officer and wounded another. When apprehended, Mr. Monfort was shot and paralyzed. First author was retained by the defense and testified in the 2015 guilt-phase regarding mental state at time of offense, opining that the defendant suffered from a delusional disorder. Mr. Monfort was convicted, but sentenced to life in prison rather than the death penalty. Mr. Monfort died in prison in January 2017.

<sup>3</sup> In July 2011, Anders Breivik killed eight people by detonating a van bomb in Oslo, then shot to death 69 students at a summer camp on the Norwegian island of Utøya.

the realm of possibility or is “nonbizarre” (*DSM-IV-TR*, *DSM-5*), rendering these less face-distinguishable from extreme beliefs. This differential is particularly challenging when the delusions or extreme beliefs have political or social ideology themes.

Fourth, *DSM-IV-TR* and *DSM-5* provided very limited guidance on the differential between delusional disorder and extreme beliefs:

The distinction between delusion and strongly held belief is sometimes difficult to make and depends in part on the degree of conviction with which the belief is held despite clear or reasonable contradictory evidence regarding its veracity (*DSM-5*, p. 87).

Various rating scales for assessing delusions are available, but these are clinical in focus, often fail to distinguish between delusional presentations in schizophrenia as opposed to delusional disorder, and are not easily applied to a forensic context (discussed subsequently). As a result of diagnostic ambiguity and the absence of available structured clinical judgment tools, the analysis undertaken by a forensic mental health professional may lack range and structure in parsing the dimensions that could illuminate this differential.

Fifth, incidents of extreme violence with sociopolitical overtones are particularly shocking to social consciousness. They disturb our sense of order, safety, and reciprocal community. Intense media coverage brings these events and their aftermath psychologically close, and holds them in psychological proximity for days or weeks. As these cases are adjudicated, they are subject to particularly vigorous adversarial advocacy. These social-emotional-interpersonal factors impact mental health experts, as well as courts, attorneys, jurors, and the public at large. Arguably, the press of such forces makes it more challenging for mental health professionals to dispassionately consider the diagnostic differential in a systematic fashion.

### Limitations of Clinical Rating Scales and Simplistic Conceptualizations

**Clinical rating scales.** Various clinical rating scales for delusions have been proposed.<sup>4</sup> Most include delusions with fantastic content and other psychotic symptoms occurring in schizophrenia, as opposed to the conceivable, but false, delusions or beliefs typifying a forensic differential. Some scales also provide ratings

for the intensity of delusion-type symptoms, a consideration that may inform a differential analysis regarding where a belief lies on the continuum of belief to delusion. The extant rating scales, however, are limited in scope and, if applied without reflection, may function more as checklists than bases for deeper analysis. None were designed to make differentials in a forensic context between delusions that are not fantastic and radicalized extreme beliefs. These scales illuminate, however, features of delusions or delusional disorder for which there is scholarly consensus or at least conceptual support. Features that are repeatedly reflected in these rating scales are incorporated into the model of analysis proposed herein (MADDD-or-Rad-17).

**Extreme overvalued ideas.** Rahman et al. (2016) offered the conceptualization of “extreme overvalued idea” (citing McHugh, 2006; Veale, 2002; and Wernicke, 1900) and a synonymous variation, “extreme overvalued beliefs (EOB)” (Rahman, 2018; Rahman et al., 2016). McHugh (2006) offered the overvalued idea as an explanatory construct for the motivations of the 9/11 terrorists. Similarly, Rahman and colleagues proposed the extreme overvalued belief as a nonpsychotic alternative to “delusion” in Anders Breivik and as a more appropriate formulation in terrorism cases (e.g., Oklahoma City bombers Timothy McVeigh and Terry Nichols). Incorporating conceptualizations of Wernicke (1900); Veale (2002), and McHugh (2006); Rahman (2018) operationally defined the extreme overvalued belief as:

An extreme overvalued belief is one that is shared by others in a person’s cultural, religious, or subcultural group. The belief is often relished, amplified, and defended by the possessor of the belief and should be differentiated from an obsession or a delusion. The

<sup>4</sup> For example, *Dimensions of Delusional Experience* (Kendler, Glazer, & Morgenstern, 1983), *Characteristics of Delusional Experience—CODE* (Garety & Hemsley, 1987), *The Positive and Negative Syndrome Scale—PANSS* (Kay, Opler, & Lindenmayer, 1989), *Maudsley Assessment of Delusions Schedule—MADS* (Wessely et al., 1993), *Belief Rating Scale* (Jones & Watson, 1997), *The Brown Assessment of Beliefs Scale* (Eisen et al., 1998), *The Psychotic Symptom Rating Scales—PSYRATS* (Haddock, McCarron, Tarrier, & Faragher, 1999), *Peters et al. Delusions Inventory—PDI* (Peters et al., 1999, 2004), *Green et al. Paranoid Thought Scale—GPTS* (Green et al., 2008), *Simple Delusion Syndrome Scale—SDSS* (Forgáčová, 2008).

belief grows more dominant over time, more refined and more resistant to challenge. The individual has an intense emotional commitment to the belief and may carry out violent behavior in its service.

The concept of the “extreme overvalued idea” or “extreme overvalued belief” acknowledges that an extreme belief may take on an organizing function for the individual, with identity, attitudinal investment, and preoccupation aspects. A change in terminology, though, does little to advance a diagnostic differential, except perhaps to state the obvious, that is, that some beliefs may occupy a central role in the individual’s life without reflecting delusion.

Illustrating this limitation, Rahman et al. (2016) and Rahman (2018) provided little guidance in how to differentiate an extreme overvalued idea from a delusion—Rahman et al. (2016) vaguely proposed “the use of a narrative to formulate [such] forensic cases” (p. 31). Inconsistent with ruling out delusions through life narrative, though, Ernst Kretschmer (1888–1964) hypothesized that biography and personality traits could grow into delusional states (see Hoff, 2006). Even with a well-developed life narrative, then, making a differential between delusion and extreme beliefs could prove quite challenging. Rahman (2018) elaborated that the extreme overvalued belief was “shared by others in a person’s culture or subculture,” as opposed to the idiosyncratic nature of the delusion. Rahman’s proposed sequence of steps in the development of the extreme overvalued belief provided some additional illumination:

(1) There are a core set of beliefs normally shared by others in their culture/subculture; (2) as the individual is exposed to progressively more extremist information and perceives a lack of contradictory information, reinforcement and refinement of the extreme beliefs occur; (3) additional amplification is acquired and coupled with the use of harm to self and/or others in its service.

Problematically, delusional content often reflects some shared cultural component (e.g., political and/or religious themes), persons with delusional disorder also seek confirmatory information and ignore contradictory data, and “amplification” may be manifested in the idiosyncratic features and compulsions to act characterizing delusional disorder (subsequently discussed). Further, in the literature, the conceptualization of the “overvalued idea” is not limited to reality-based beliefs. Veale (2002), to

whom the conceptualization of overvalued idea is attributed by Rahman et al., included among such overvalued ideas a belief that one or more limbs do not belong to the afflicted person (apotemnophilia), with solicitation of surgical amputation. According to Veale, overvalued ideas can then represent a serious breach in reality testing. Finally, Rahman et al.’s references to delusion were both vague and did not appear to contemplate delusions with a tenuous reality anchor as may be reflected in delusional disorder.

### Rationale for a Structured Professional Judgment Tool

There is a need, then, for a structured approach for making the differential between delusional disorder and the radicalization of extreme beliefs that would make this analysis more systematic. Structured professional judgment (SPJ) tools have gained wide acceptance in violence risk assessment (e.g., HCR-20, SARA, SAVRY, RSVP, B-SAFER, etc.), as have structured and semistructured tools for diagnostic interviewing (e.g., SCID, see First, Spitzer, Gibbon, & Williams, 2002). Beyond the obvious applications such an SPJ tool would have to mental health experts making diagnostic findings for adjudication, disposition, or both, threat assessment teams working in corporate, government, or education settings could also benefit from a systematic method of analysis to better frame the risk assessment of a specific person in advance of any violence. In such traditional threat assessment scenarios, an SPJ tool for this differential could be used to direct or focus information gathering activities, to make recommendations about risk intervention or threat management strategies, or generally structure a more comprehensive analysis of the case.

Despite the advantages of systematically guided judgments for threat assessments and forensic mental health evaluations, no structured analysis has been published for differentiating delusional disorder from the radicalization of extreme beliefs. This article seeks to address that void in the literature by articulating a 17-factor analysis for differentiating delusional disorder from radicalized extreme belief (i.e., Model of Analysis for Differentiating Delusional Disorder from the Radicalization of



Extreme Beliefs–17 Factor, MADDD-or-RAD-17, see [Appendix](#)).

## Orientation to Delusional Disorder

### Historical Perspectives

A historical framework regarding delusional disorder may be helpful as a back-drop for making the differential between delusional disorder and extreme beliefs. In 1838, Jean-Étienne Dominique Esquirol, a French psychiatrist, drew on Pinel's scholarship and conceptualized "monomania" (i.e., partial insanity) as distinct from the main body of insanity (i.e., schizophrenia; see [Hoff, 2006](#)). Esquirol observed that these patients were in touch with reality on most things. He further described monomania as characterized by an intact sensorium: that is, logical thought processes, accurate memory, and lively curiosity. Where their ideas were odd or eccentric, these monomania patients supported them by appeals to evidence. Subsequently Karl [Kahlbaum \(1863\)](#) opined that "paranoia" should be used to distinguish one type of partial insanity, characterized by a coherent, encapsulated delusional system.

In the late 1800s and early 1900s, Emil Kraepelin, a German psychiatrist, conceptualized paranoia as a distinct illness characterized by a chronic, unshakable system of nonbizarre delusions (i.e., delusions with content that could occur, such as poisoning, conspiracy, etc.). Unlike *dementia praecox* (i.e., schizophrenia), *dementia paranoides* were without thought disorder, and with few changes in affect or volition (see [Tamburello, Bajgier, & Reeves, 2015](#)). As these authors detail, Kraepelin observed that the delusions comprising this disorder were largely confined to "diseased" interpretations of real events, often extending to include events of recent date. Contradictions and objections were recognized and explained by patients exhibiting this disorder. [Munro \(1995\)](#) similarly noted the encapsulated nature of delusional disorder:

Perhaps the most unique feature of delusional disorder is the way in which a patient can move between delusional and normal "modes." In the former, the individual is overalerted, preoccupied with the delusional theme and often driven remorselessly by it. In sharp contrast, the normal has relatively calm mood, neutral

conversation, and some ability to pursue everyday activities. The contrast is striking and often difficult for the lay person to understand (p. 203).

These conceptualizations describe an encapsulated delusional pathology in a context of largely preserved mental functioning.

### Diagnostic Acceptance

Delusional disorder was embraced in modern diagnostic nomenclature in *DSM-III-R* in 1987 and has continued through *DSM-IV* and *DSM-5*. Diagnostic features remained relatively consistent from *DSM-IV-TR* and *DSM-5*. Both editions specified the presence of delusions: in the absence of other significant psychopathology; among persons never having met criteria for schizophrenia and not exhibiting marked hallucinations, who had the capacity to be quite functional, and tended not to display odd or bizarre behavior outside of the delusion context. The primary diagnostic evolution from *DSM-IV-TR* to *DSM-5* was an expansion to allow bizarre as well as "nonbizarre" (i.e., reflecting content that could conceivably occur) delusions in the criteria for delusional disorder (for a discussion of reliability issues in differentiating "bizarre" and "nonbizarre" delusions, see [Bell, Halligan, & Ellis, 2006a](#)). *DSM-5* defined delusions as:

Delusions are fixed beliefs that are not amenable to change in light of conflicting evidence. Their content may involve a variety of themes (e.g., persecutory, referential, somatic, religious, grandiose; p. 87).

International Statistical Classification of Diseases and Related Health Problems (ICD-10; [World Health Organization, 2018](#)) classified a presentation of encapsulated delusional psychosis as "persistent delusional disorder" (PDD), where delusions constitute the most conspicuous or only clinical characteristic. In ICD-11 ([World Health Organization, 2018](#)), "persistent delusional disorder" and "induced delusional disorder" have been collapsed into a single classification: delusional disorder (for a discussion, see [Gaebel, 2012](#)).

### Prevalence

Accurately quantifying the community prevalence of delusional disorder is difficult, as "individuals with isolated delusions are often able

to function unnoticed in the community” (Tamburello et al., 2015, p. 82) and *infrequently* present themselves for mental health treatment. Acknowledging that caveat, lifetime prevalence is estimated as 0.2% and point prevalence as 0.03 in the community, and 1–2% among psychiatric inpatients (Tamburello et al. citing *DSM-IV-TR*, *DSM-5*). The prevalence rate in a correctional population, though, appears substantially higher (i.e., eightfold in one study); Tamburello et al. reported a point prevalence rate of 0.24% among inmates in state corrections custody.

### Psychological Disorders Among Lone Actor “Socio-Political” Offenders

Significant psychopathology is not unusual among lone actors engaging in offenses having sociopolitical elements (see Gill, 2015), with estimates ranging from 20–60%. Unfortunately, rates of delusional pathology and/or disorder among these offenders are not typically systematically reported in a way that would allow meaningful comparisons. That said, Fein and Vossekuil (1999) reported that 61% of lone assassins had received mental health services. Hewitt (2003) reported a 22% prevalence rate of psychological disturbance among lone actor terrorists. Gruenewald, Chermak, and Freilich (2013) reported a 41% rate of mental illness among lone homicide offenders with far right agendas. Corner and Gill (2015) found that lone actor or lone dyad offenders had significantly higher rates of mental illness than group terrorists. Gill (2015) studied 111 lone actors perpetrating attacks having sociopolitical elements 1990–2014, reporting that 41% had “a history of mental health problems” (p. 107). A single study, Corner, Gill, and Mason (2016), detailed the disaggregated prevalence of mental disorders among lone-actor terrorists, finding an over-representation of schizophrenia, delusional disorder, and autism spectrum disorder. The presence of psychological disturbance of some sort among persons acting violently on political or social themes is not unusual. The prevalence of the mental disorder being principally manifested by the *beliefs* of these offenders is unknown.

### Model of Analysis for Differentiating Delusional Disorder From the Radicalization of Extreme Beliefs—17 Factor (MADDD-or-Rad-17)

In the sections that follow, a model for differentiating delusional disorder from persons who have become radicalized in their extreme beliefs is outlined. Seven primary arenas of analysis were distilled from scholarship regarding features of delusions and delusional disorder. These seven primary arenas are:

- A. *Cognitive content of the belief* (What is believed?)
- B. *Cognitive style of the belief* (How is it believed?)
- C. *Distress and social dysfunction associated with beliefs* (What are the repercussions of the belief?)
- D. *Social influences* (How is the belief inspired, maintained, and/or operationalized into action by a social context?)
- E. *Social inclusion* (To what extent is the adherent integrated and productive in the community?)
- F. *Prodromal symptomatology* (What indications of emerging psychosis have been present?)
- G. *Behavioral/Action factors* (What disturbance accompanies acting on the belief?)

Seventeen factors are specified for operationally defining and qualitatively describing the seven primary arenas of analysis. Within each factor, features may be specified that further disaggregate the analysis. These are not intended as a checklist or scoring paradigm, and it is not expected that all factors will be present or absent in a particular case. Rather, these factors are intended to prompt more systematic analysis and consideration of rival perspectives. This method of analysis also supports a more organized, descriptive, and transparent discussion of findings in forensic reports and testimony.

Each factor is accompanied by a brief discussion of scholarly and conceptual support for the respective consideration. These references are intended to reflect an orientation to the associated literature and are by no means exhaustive. Distinguishing features of *delusional pathology* are emphasized, as the heterogeneous nature of

lone actors (see Gill, 2015) renders it impractical to specify features of “normal” persons who have become radicalized into acting in the service of extreme beliefs. That said, normal persons acting on extreme beliefs are hypothesized as being heavily motivated by factors in the social influence arena (see Horgan, 2008, discussed subsequently).

### Criterion A: Cognitive Content of the Belief (What Is Believed?)

The content of the belief in a delusional disorder must, by definition, be delusional (*DSM-5*), that is, a fixed, false belief. Idiosyncrasy, improbability, and grandiosity are useful lenses for assessing the content of the belief(s).

1. Idiosyncrasy: Idiosyncrasy is conceptualized as a continuum on which:
  - a. Some elements of the belief are *not* commonly held by others; and/or
  - b. The *integrated totality* of the belief is unique.

*Caveat:* Idiosyncrasy is not considered to be a dichotomous determination of whether anyone else shares any element (theme) of the belief.

*Discussion—Factor 1:* Idiosyncrasy is a face obvious feature of a delusion. This feature was noted in the definition of delusion in *DSM-IV*: “The belief is not one ordinarily accepted by other members of the person’s culture or subculture” (American Psychiatric Association, 1994, p. 765). This idiosyncrasy is to be expected: as a delusional belief is the product of the psychosis of the individual, it is unlikely to extend beyond a folie à deux or small group of acolytes. Consistent with the unique character of delusion, idiosyncrasy is identified as one of the core characteristics of delusional content (see Taylor, 2006; Taylor et al., 1994). That is not to say that the content of a delusion is *unrelated* to common cultural experiences, quite the contrary. Cummings and Mega (2003) noted: “the content of delusional disorders varies across cultures and reflects the social and cultural setting of the delusional individual” (p. 62). For this reason, it is expected that idiosyncrasy will be relative, that is, unique interpretations resting on more broadly accepted themes. The content of a delusional disorder, then, may reflect an idiosyncratic systemization of more common cultural themes or political beliefs. That said, an ideology may be sufficiently shared that it does not represent a delusion (for applications to the Sovereign Citizen Movement, see Parker, 2014; Pytyck & Chaimowitz, 2013). The relationship of extreme overvalued beliefs and delusions to the context of shared extreme beliefs in a culture or subculture is reflected in Figure 1.

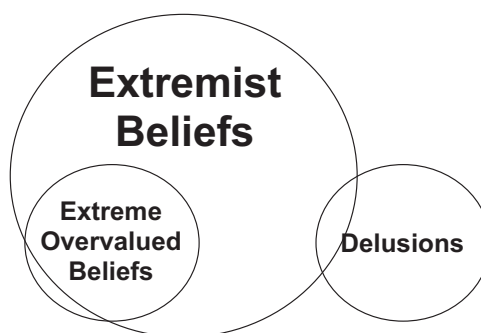


Figure 1. Non-overlap reflects idiosyncratic aspects of the beliefs or delusions.

2. Improbability: Improbability is operationalized to mean the extent to which the beliefs reflect:
  - a. Historical inaccuracy or erroneous linkage to historical events;
  - b. Faulty interpretation of current events; and/or
  - c. Inflated confidence in associated actions having the desired impact.

*Caveat:* Improbability does not require that the belief be impossible.

*Discussion—Factor 2:* Improbability is a core element of the “conceivably plausible but false” delusion. It is one of three characteristics asserted by Karl Jaspers in his 1913 text: that is, the “content of delusion is objectively wrong or impossible” (p. 244, Hoff, 2006). The *DSM-IV* definition of delusion as “false belief . . . despite what constitutes incontrovertible and obvious proof to the contrary” (p. 765) operationally expresses this same concept.

3. Grandiosity: In its more subtle forms, grandiosity may be implicated by:
  - a. Special insight into the problem;
  - b. Special recognition of the action needed;
  - c. Perceived right to take that action;
  - d. Expectations of profound influence; and/or
  - e. Heroic identification;
  - f. Publicly claiming responsibility for the act (see Gill, 2015).

*Caveat:* Grandiosity as a subtext does not require that the person overtly claim to be someone of special importance.

*Discussion—Factor 3:* Grandiosity is often demonstrated in delusional beliefs, either as a prominent feature or a subtext. When this grandiosity is a prominent feature, it is relatively straightforward to identify

a delusional disorder. A more difficult differential occurs in differentiating grandiosity as a subtext in delusional disorder from the narcissism that may co-occur as a personality feature in a person who has simply become radicalized in his extreme beliefs. In making this differential, grandiosity may be implicated by beliefs and actions reflecting various combinations of the above features.

### Criterion B: Cognitive Style of the Belief (How Is It Believed?)

Delusions are identifiable not just in their content, but also in *how* they are believed. These features are termed their noncontent dimensions (see Appelbaum, Robbins, & Roth, 1999). Peters (2010) cogently observed: "Form may be more important diagnostically than content: it is not what you believe, but how you believe it" (p. 134; see also Peters, Joseph, & Garety, 1999), finding that conviction, preoccupation, and distress better differentiated delusion than content. Consistent with these observations, Pierre (2001) described that the delusional is not only determined by "the content of a belief per se, but to the manner in which the belief is held (i.e., with excessive preoccupation, conviction, emotional valence, and resulting in functional impairment)" (p. 170). Several factors can be useful in understanding the noncontent dimensions of a belief.

4. Rigid adherence to belief despite disconfirming evidence: (This may also be considered to reflect the conviction or strength of the belief), as reflected by:
  - a. Difficulty articulating disconfirming evidence;
  - b. Difficulty specifying alternative hypotheses;
  - c. Difficulty mentally manipulating alternative hypotheses;
  - d. Unsubstantiated claims of broad social agreement;
  - e. Irritability/agitation when challenged; and/or
  - f. Failure to incorporate disconfirming evidence following challenge.

*Caveat:* Standing alone, claims of being open to disconfirming evidence do not controvert rigid adherence to belief.

*Discussion—Factor 4:* The noncontent dimensions of strength of conviction and imperviousness of the delusional beliefs have been recognized for more than a century. To illustrate, Karl Jaspers in his 1913 text

specified two pragmatic criteria of *how* delusions are believed: "1. Unparalleled degree of subjective feeling of certainty; and 2. Cannot be influenced by experience or arguments ('incurability')" (p. 244, Hoff, 2006). Similarly, Spitzer (1990) elaborated that the delusion is held with a degree of subjective certainty that is typically reserved for one's inner experiences (see Hoff, 2006). Clinical rating scales such as the Maudsley Assessment of Delusions Schedule (MADS; Wessely et al., 1993), subsequently adapted as the MacArthur-Maudsley Assessment of Delusions Schedule (MMADS; Appelbaum et al., 1999) specify the strength of the conviction as a consistently observed feature of delusions.

5. Suspension of critical judgment: This may also be considered as thinking and processing errors, as reflected by:
  - a. Theory of mind deficit;
  - b. Confirmation bias;
  - c. Personalizing bias;
  - d. Externalizing bias;
  - e. Jumping to conclusions (JTC); and/or
  - f. Social reality testing deficits.

*Discussion—Factor 5:* Persons holding delusions often exhibit a number of errors in the way they think about their beliefs (Bentall & Taylor, 2006; Jasper, 1913 cited by Hoff, 2006; Wessely et al., 1993). Jasper (1913, cited by Hoff, 2006) described delusional beliefs as being held with a subjective feeling of certainty that was not influenced by experience or arguments. The MADS (Wessely et al., 1993) also noted the degree and idiosyncrasy of the conviction with which the beliefs are held, as well as belief maintenance factors. A hasty reasoning style and associated vulnerability to jumping to conclusions have been observed to be common among delusional persons (Bentall & Taylor, 2006; Taylor & Felthous, 2006). Borum (2014) provided a cogent review of the research on thinking errors that while not restricted to delusions, are often involved in the development and maintenance of delusional beliefs. As Borum categorized and defined (a–e.), such errors include:

*a. Theory of mind deficit:* Persons with persecutory delusions may have difficulty accurately recognizing and interpreting the emotions and cognitions of others (see Bentall, Corcoran, Howard, Blackwood, & Kinderman, 2001; Bentall & Taylor, 2006; Garety & Freeman, 1999; Taylor & Kinderman, 2002). Other scholars (e.g., Frith, 1992; Frith & Frith, 1999; Hoff, 2006) have also observed that deluded persons exhibit deficits in recognizing how they are perceived by others and what the future actions of others will be.

*b. Confirmation bias:* Confirmation bias is characterized by attending to information that is consistent with a preexisting belief, with failure to incorporate readily available disconfirming information regarding the accuracy, prevalence, scope, severity, and/or social primacy of the belief. Borum (2014) identified this process as "one explanatory mechanism for how people



maintain delusional beliefs” (p. 296, citing Freeman, 2007; van Dael et al., 2006).

*c. Personalizing bias:* This is one of two errors of attribution, involving a broad disposition toward viewing others, rather than circumstances, as being responsible for and/or causing negative events. This thinking error may be widely applied, as well as serve to support the delusion (see Bentall & Taylor, 2006; Hoff, 2006; Penn, Sanna, & Roberts, 2008).

*d. Externalizing bias:* This is a second attributional error, involving a broad tendency to avoid viewing self as responsible for negative events, with readiness to blame others or circumstances. Persons exhibiting paranoid delusions are more susceptible to externalizing bias (see Bell, Halligan, & Ellis, 2006b; Bentall et al., 2001; Bentall & Taylor, 2006; Garety & Freeman, 1999; Hoff, 2006; Kaney & Bentall, 1989, 1992; Langdon et al., 2006; but see Fear, Sharp, & Healy, 1996), particularly in implicating the intentions of others (Kinderman & Bentall, 1997). Carlin, Gudjonsson, and Rutter (2005) reported that external attribution style was more often present in a forensic sample among individuals with psychosis, and was not specific to persecutory delusions.

*e. Jumping to conclusions (JTC):* JTC is characterized by substantial generalization or elaboration from limited or erroneous historical or current anecdotal data (Colbert & Peters, 2002; van Dael et al., 2006). Hoff (2006) similarly observed that deluded persons need less information to arrive at definitive conclusions, even on issues apart from delusions. JTC bias may contribute to the maintenance as well as formation of delusions (see Bentall & Taylor, 2006; Borum, 2014; Dudley, Taylor, Wickham, & Hutton, 2016; Fine, Gardner, Craigie, & Gold, 2007; So et al., 2016; Taylor & Felthous, 2006; van Dael et al., 2006).

*f. Additionally, I hypothesize a social reality testing deficit* as another type of thinking error. This error is characterized by the failure to utilize the *absence* of shared belief and/or the lower intensity of belief by others for reality testing purposes (e.g., If the belief is true, why are others not as concerned as I am?).

6. Preoccupation with the belief: This may be operationally demonstrated by:
  - a. Relative predominance of the belief;
  - b. Spontaneous digressions to the belief;
  - c. Recurrent “scripts” in discussing the belief;
  - d. Emotional energy accompanying discussion of the belief;
  - e. The primacy and affect surrounding the belief coming to the attention of others.

*Caveat:* The ability to discuss other topics does not negate preoccupation.

*Discussion—Factor 6:* Preoccupation with the belief has been a recurrently observed feature of delusional thinking. Wessely et al. (1993; MADS, 1994) specified

“preoccupation” as a characteristic of delusions. Similarly, delusions were characterized as pervasive and intrusive by Taylor and Felthous (2006). Junginger (2006) observed that the content of delusions was persistent and recurrent. Five features that may prove useful in qualitatively assessing preoccupation are detailed above.

### Criterion C: Distress and Social Dysfunction Associated With Beliefs

7. The distress and functional impairment associated with the belief.

*Discussion—Factor 7:* Subjective distress and functional impairment may be another dimensional (as opposed to content) feature of delusions. Peters et al. (1999) observed that as beliefs are associated with greater distress, they are more likely to be delusional in nature. Pierre (2001) noted that emotional valence (i.e., distress) and extension (i.e., functional impairment) were among dimensional factors that were more likely to be observed in religious delusions than faith. Also consistent with dimensional features of distress, Pillmann, Wustmann, and Marneros (2012) reported that at the first psychiatric hospitalization of patients with delusional disorder, 55.8% experienced depressed mood and 16.3% exhibited anxiety.

8. Extent to which the beliefs have constituted a social difficulty.

*Discussion—Factor 8:* Both the content and dimensional features of a delusional disorder have a marked likelihood of resulting in social problems. By contrast, radicalized extreme beliefs may only be strategically expressed, and then to a like-minded subculture who offer affirmation.

### Criterion D: Social Influences (How Are the Beliefs Inspired, Maintained, and/or Operationalized Into Action by a Social Context?)

Horgan (2008) emphasized the central role played by social context in the pathway of ostensibly nonmentally ill persons from radicalization into terrorism. Three primary sources of social influence can be distilled from Horgan’s discussion and are reflected in Criteria 9, 10, and 11. These factors have been observed to have belief structuring and motivational salience in nonclinical actors. Further, persons expressing beliefs that are not socially congruent (i.e., idiosyncratic, improbable delusions) are unlikely to be socially accepted/assimilated or viewed as operationally reliable for recruitment (see Horgan, 2005; Spaaij, 2010). Consis-

tent with this hypothesis, Gruenewald et al. (2013) reported that mental illness was almost six times more likely in far-right lone offenders (40.4%) than group offenders (7.6%). These findings lend inferential support to a metric that the more extensive and organized the social context of the beliefs and the social support for acting on them, the less likely the beliefs reflect a delusional disorder (see Pytyck & Chaimowitz, 2013).

As Factors 9–11 are operative, delusional disorder is less likely.

9. Interaction with a community of like believers: This reflects the extent to which the individual has extensive interactions and close relationships with persons sharing the belief, as reflected in a:
  - a. Virtual community; and/or
  - b. Actual community.
10. Social motivators: This reflects the extent to which the beliefs arise and/or continue in a social context of like believers, where the person with the belief gains:
  - a. Structure;
  - b. Identity;
  - c. Role/purpose/meaning;
  - d. Affiliation; and/or
  - e. Status.
11. Social facilitation/tangible support: That is, the extent to which the group has provided:
  - a. Selection/recruitment;
  - b. Training;
  - c. Planning;
  - d. Targeting;
  - e. Resources; and/or
  - f. Sanctuary.

#### **Criterion E: Social Inclusion (To What Extent Is the Adherent Integrated and Productive in the Community?)**

As the social inclusion of the adherent increases, delusional disorder is less likely.

Reduced social inclusion is observed in many psychological disorders, including psychosis (Killaspy et al., 2014). Killaspy et al. conceptualize social inclusion as consisting of two factors or expressions: social integration and productivity. These authors observed that both decline in the presence of psychosis, with psychotic persons becoming less socially

integrated and less productive. To the extent that the adherent is ostracized, even among others who hold grossly similar beliefs, the potential for delusion is increased. Similarly, the differentiating factors in delusional disorder described herein are likely to be inconsistent with ongoing occupational or broad life-productivity.

12. Social inclusion.
  - a. Social integration; and/or
  - b. Productivity.

#### **Criterion F: Prodromal Factors (What Indications Have There Been of a Developing Psychosis?)**

No developmental or family history characteristic can be considered pathognomonic for delusional disorder. Pillmann et al. (2012) reported on sociobiographical characteristics of 43 inpatients with persistent delusional disorder (PDD, see ICD-10). All of these also met *DSM-IV* diagnostic criteria for delusional disorder. The relatively small number of cases limits applications. Developmental characteristics were: 9.3% birth complications and 9.3% developmental disturbance, and 32.6% broken home environment. Education level reported: 7% less than 8 years or special education, 41.9% 8–9 years, 27.9% 10–11 years, 23.3% 12 years or more. Family characteristics included: 23.3% any mental illness/alcohol dependency in first degree relatives, 9.3% major affective disorder in first degree relatives, 2.3% schizophrenia in first degree relatives. Munro and Mok (1995, see below) found a positive family history of psychiatric disorder in 18.7% of combined male and female cases of delusional disorder.

Delusional disorders also do not have a clear etiology, age of onset, or typical prodromal course (i.e., gradual or acute). With that caution, Munro (1995) descriptively observed:

Many patients are unmarried, divorced, or widowed and the premorbid personality often seems asocial, but the condition is sometimes compatible with marriage and continued employment. Even so, many of these individuals are regarded as eccentric or fanatical (p. 203).

Munro and Mok (1995) reviewed approximately 1,000 articles on paranoia or delusional disorder 1961–1994, accumulating 257

cases. Of 103 male cases, approximately one third was married and 14.7% had histories of organic brain disorder or head injury or substance abuse. [Manschreck and Khan \(2006\)](#) updated this review by seeking published reports of delusional disorder 1994–2004, identifying 224 cases. Premorbid factors were not disaggregated by sex. Depression was the most common premorbid condition (23%). In contrast to Munro and Mok, only 2.2% had suffered organic brain disorder or head trauma, and only 1% had a known history of substance abuse. The newer cadre of articles did not report family psychiatric histories.

Prodromal factors for psychosis (see [Møller & Husby, 2000](#)) and associated rating scales (see [Maurer, Zink, Rausch, & Häfner, 2016](#)) have been proposed. These, however, have been developed on the emergence of schizophrenia. Whether such prodromal symptoms generalize to the more encapsulated syndrome of delusional disorder is uncertain. The ERI scales developed by Maurer et al. have utility, despite these cautions, as structured inquiries across a spectrum of premorbid functioning. Arguably, to the extent that broader evidence of psychological deterioration or decremented functioning is present, delusional disorder as opposed to radicalization is implicated (see [Golding, 2007](#); [Pytyck & Chaimowitz, 2013](#)).

### 13. Prodromal Symptomatology

*Caveat:* This is a unidirectional metric: prodromal symptoms of psychosis support the presence of a delusional disorder, but the absence of these is not contraindicative.

## Criterion G: Behavioral/Action Factors (Is the Belief Acted on? How Is the Belief Acted on or Exhibited? What Disturbance Accompanies That Action?)

### 14. Willingness to act on the belief.

*Discussion—Factor 14:* In a forensic evaluation context, a violent act has been committed—whether emanating from a delusional disorder or the radicalization of extreme beliefs. Action alone, then, is not a conclusive differential. That said, because a delusional disorder constitutes a strong motivational catalyst to act, having acted violently on a belief raises the index of suspicion for delusion. An inextricable linkage between belief and behavior in delusional disorder has

been described by a number of scholars. To illustrate, [Taylor and Felthous \(2006\)](#) observed:

This fits well with the theme that one of us (Taylor) embraces, the nature and impact of interaction about delusions. It is one in which Mullen [[Mullen & Lester, 2006](#)] is also interested: The pathology [delusional disorder] does not lie exclusively in the patients' mental state, but also in their behavior and impact on themselves and others. (p. 237).

Consistent with this belief-behavior linkage, the MADS ([Wessely et al., 1993](#)) identified “assertive action” as a recurrent feature of delusions. [Bentall and Taylor \(2006\)](#) described that 60% of deluded patients reported acting on their beliefs, with those suffering from paranoid delusions being at increased risk of committing violent acts toward others. Taylor noted that these patients tended to view the violent act as protection from perceived threat and appropriate. [Junginger \(2006\)](#) reported that the presence of delusions increased violence risk 2.6-fold. Junginger further characterized the delusional content as blueprint that established the parameters of the violence (i.e., motivating conduct consistent with the delusion).

### 15. Compulsion to act on the belief, as reflected by:

- a. An increasing subjective press or tension to act on the belief;
- b. An idiosyncratic sense of personal responsibility to take action;
- c. A sense of special obligation to act;
- d. Perception of an acute necessity or imminent harm;
- e. Framing action as defining of representations of self (e.g., If I fail to act, I am no better than the oppressors; I am not an authentic citizen if I remain passive);
- f. Grandiose identification with historic or heroic figures who took action; and/or
- g. Ill-conceived planning, particularly for follow-on actions (e.g., the first action is well-planned, but subsequent actions are hasty and improvised).

*Discussion—Factor 15:* As can be inferred from linkage between belief and behavior in delusional disorder, delusional persons may feel internally compelled to act on their beliefs. This is differentiated from persons acting on extreme beliefs, whose behavior may be more strategic than driven.

## 16. Rigid moral distinctions in acting on the belief.

*Discussion—Factor 16:* Terrorists, guerilla groups, and even governments may target particular property or persons, but accept “collateral damage” and civilian casualties as an unfortunate but realistically necessary cost in achieving a desired political or military outcome. By contrast, the parsing of moral distinctions and the unwillingness to accept a certain amount of “collateral” damage or “noncombatant” casualties in acting on the beliefs may point to these beliefs being delusional rather than simply extreme. At times, persons acting on delusions may jeopardize the entire “campaign” by assiduously remaining within the rule boundaries the delusional beliefs impose.

## 17. Psychological disorganization associated with the belief, e.g.:

- a. Inconsistency in planning and execution in acting on the belief;
- b. Pressured and/or socially inappropriate verbalizing about the belief;
- c. Act-related factors symbolizing the belief that draw attention to the individual and/or increase likelihood of apprehension.

*Caveat:* Psychological disorganization as conceptualized herein is not typically manifested by grossly disorganized speech/thought, nor is planning or organized activity in the execution of the attack a contraindication of delusion.

*Discussion—Factor 17:* Psychological disorganization (i.e., a marked change in psychological equilibrium) when thinking about or discussing an extreme belief is often observed in a delusional disorder, as the psychotic capsule containing the delusion is breached. This would be less evident in a person who is simply radicalized. Evidence of topic-specific psychological disorganization, then, can be an important factor in differentiating delusional disorder from the radicalization of extreme beliefs. More important, psychological disorganization is often *not* evident in the motive, sophistication of planning, or execution of the attack itself by a mentally ill person (see Borum, 2013; Fein & Vossekuil, 1999; Gill, 2015; Gill et al., 2014).

## Applications and Cautions

The MADDD-or-Rad-17 is offered as a structured professional judgment tool for systematically and qualitatively analyzing whether potential or completed offending is the product of a delusional disorder or, alternatively, reflects the radicalization of extreme beliefs. The MADDD-or-Rad-17 is not a test that can be scored or checklist lending itself to item totaling. Its best application is seen as encouraging a wide-

ranging, careful review of empirical and clinically observed factors that may illuminate this differential. These factors support systematic threat assessment investigations, as well as mental health reports and testimony that give rich, well-organized descriptive detail to the trier of fact, who ultimately is faced with dichotomous determinations (e.g., criminal responsibility or insanity, death-penalty sentencing).

More important, a forensic determination that a delusional disorder is the contextual or motivating condition, as opposed to the radicalization of an extreme belief, is only a threshold prong in an evaluation of adjudicative competence, criminal responsibility, or sentencing. A subsequent analysis of the role and influence of this disorder on the defendant’s relevant psycho-legal capabilities must follow. Similarly, as threat assessment or forensic mental health professionals illuminate these issues, a nuanced approach is recommended. Gill (2015) emphasized that the distinction of “mad or bad” may be a false dichotomy, suggesting: “Instead, we should be looking at how a multitude of variables and experiences (mental illness being one) crystallize within the offender at the same time” (p. 106).

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(Appendix follows)

## Appendix

### Outline of The Model of Analysis for Differentiating Delusional Disorder From the Radicalization of Extreme Beliefs-17 Factor (MADDD-or-RAD-17)

#### Content, Style, Distress/Dysfunction, Social Influences, Social Inclusion, Prodromal Factors, Action

#### Criterion B: Cognitive Style of the Belief (How Is It Believed?)

#### Criterion A: Cognitive Content of the Belief (What Is Believed?)

1. Idiosyncrasy: Idiosyncrasy is conceptualized as a continuum on which:
  - a. *Some* elements of the belief are *not* commonly held by others; and/or
  - b. The *integrated totality* of the belief is unique.

*Caveat:* Idiosyncrasy is *not* considered to be a dichotomous determination of whether *anyone* else shares *any* element (theme) of the belief.

2. Improbability: Improbability is operationalized to mean the extent to which the beliefs reflect:
  - a. Historical inaccuracy or erroneous linkage to historical events;
  - b. Faulty interpretation of current events; and/or
  - c. Inflated confidence in associated actions having the desired impact.

*Caveat:* Improbability does not require that the belief be impossible.

3. Grandiosity: In its more subtle forms, grandiosity may be implicated by beliefs and actions reflecting:
  - a. Special insight into the problem;
  - b. Special recognition of the action needed;
  - c. Perceived right to take that action;
  - d. Expectations of profound influence; and/or
  - e. Heroic identification; and/or
  - f. Publicly claiming responsibility for the act.

*Caveat:* Grandiosity does not require that the person *claim* to be someone of special importance.

4. The rigid adherence to belief despite disconfirming evidence (i.e., strength of the belief), as reflected by:
  - a. Difficulty articulating disconfirming evidence;
  - b. Difficulty specifying alternative hypotheses;
  - c. Difficulty mentally manipulating alternative hypotheses;
  - d. Unsubstantiated claims of broad social agreement;
  - e. Irritability/agitation when challenged; and/or
  - f. Failure to incorporate disconfirming evidence following challenge.

*Caveat:* Standing alone, claims of being open to disconfirming evidence do not controvert rigid adherence.

5. Suspension of critical judgment, that is, the extent to which the beliefs reflect:
  - a. Deficits in theory of mind (i.e., difficulty accurately recognizing and interpreting the emotions and cognitions of others);
  - b. Confirmation bias, that is, selectively attending to information that is consistent with the belief, with failure to incorporate readily available disconfirming information regarding the accuracy, prevalence, scope, severity, and/or social primacy of the belief;
  - c. Personalizing bias: the tendency to view others rather than circumstances as being responsible for and/or causing negative events;
  - d. Externalizing bias: the tendency to avoid viewing self as responsible for negative events, with readiness to blame others or circumstances;

(Appendix continues)



- e. Jumping to conclusions: Substantial generalization or elaboration from limited or erroneous historical or current anecdotal data; and/or
  - f. Social reality testing deficits, that is, not utilizing the absence of shared belief and/or the lower intensity of belief by others for reality testing purposes (e.g., If the belief is true, why are others not as concerned as I am?).
6. Preoccupation with the belief, as may be demonstrated by:
- a. Relative predominance of the belief;
  - b. Spontaneous digressions to the belief;
  - c. Recurrent “scripts” in discussing the belief;
  - d. Emotional energy accompanying discussion of the belief; and/or
  - e. The primacy and affect surrounding the belief coming to the attention of others.
11. Social facilitation/support, that is, the extent to which the group has provided:
- a. Selection/recruitment;
  - b. Training;
  - c. Planning;
  - d. Targeting;
  - e. Resources; and/or
  - f. Sanctuary.

*Caveat:* The ability to discuss other topics does not negate preoccupation.

#### **Criterion C: Distress and Social Dysfunction Associated With Beliefs**

- 7. Distress and functional impairment associated with the belief.
- 8. Extent the beliefs have constituted a social difficulty.

#### **Criterion D: Social Influences (How Are the Beliefs Inspired, Maintained, and/or Operationalized Into Action by a Social Context?)**

As Factors 9–11 are operative, delusional disorder is less likely:

- 9. Interaction with a community of like believers:
  - a. Virtual community; and/or
  - b. Actual community.
- 10. Social motivators, that is, the extent to which the beliefs arise and/or continue in a social context of like believers, where the person with the belief gains:

#### **Criterion E: Social Inclusion (To What Extent Is the Adherent Socially Integrated and Productive?)**

- 12. Social inclusion.
  - a. Social integration; and or
  - b. Productivity.

#### **Criterion F: Prodromal Factors (What Indications Have There Been of a Developing Psychosis?)**

- 13. Prodromal symptomatology.

*Caveat:* This is, thus, a unidirectional metric: prodromal symptoms of psychosis support the presence of a delusional disorder, but the absence of these is not contraindicative.

#### **Criterion G: Behavioral/Action Factors (Is the Belief Acted on? How Is the Belief Acted on or Exhibited? What Disturbance Accompanies That Action?)**

- 14. Willingness to act.
- 15. Compulsion to act on the belief, as reflected by:
  - a. An increasing subjective pressure or tension to act on the belief;
  - b. An idiosyncratic sense of personal responsibility to take action;
  - c. A sense of special obligation to act;

(Appendix continues)

- d. Perception of an acute necessity or imminent harm;
  - e. Framing action as defining of representations of self (e.g., If I fail to act, I am no better than the oppressors; I am not an authentic citizen if I remain passive);
  - f. Grandiose identification with historic or heroic figures who took action; and/or
  - g. Ill-conceived planning, particularly for follow-on actions (e.g., the first action is well-planned, but subsequent actions are hasty and improvised).
16. Rigid moral distinctions in acting on the belief.
  17. Psychological disorganization associated with the belief, e.g.:
    - a. Inconsistency in planning and execution in acting on the belief;
    - b. Pressured and/or socially inappropriate verbalizing about the belief; and/or
    - c. Act-related factors symbolizing the belief that draw attention to the individual and/or increase likelihood of apprehension.

*Caveat:* Psychological disorganization as conceptualized herein is not typically manifested by grossly disorganized speech/thought nor is planning or organized activity in the execution of the attack a contraindication of delusion.

Received July 3, 2018

Revision received August 8, 2018

Accepted August 9, 2018 ■