Treating the 'Disease of Disconnection'

Would a Public Health Approach to Preventing and Countering Violent Extremism and Radicalization Work?

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About the Authors

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Author's Note

The previous <u>paper</u> by this author, while addressing the broader concerns and implications of Daesh for the Indian context, built on theoretical insights from multidisciplinary domains in pursuit of a possible counter-narrative to the violence, hate and prejudice suffused by the extremist master-narrative in what is essentially emerging as a 'war of, and for ideas'. This paper, in continuation of preceding efforts, attempts to view the challenge of radicalization and violent extremism through the prism of the 'epidemiological metaphor'. While diagnosing radicalization as the 'disease of disconnection' it draws, primarily, from research in the fields of human psychology, neuro-psycho pathology and epidemiology to examine the suitability of a public health approach which affirms systematic immunity against the spread of virulent extremist ideologies and their politico-economic support structures.

Among the many metaphors that are invoked while referring to terrorism, the most prominent and frequently used has been that of a 'disease' – the *'public health epidemiological metaphor'*[1] which works on the assumption that terrorism must be contained through efforts which liken its spread to a social epidemic. This analogy claims to shift focus towards complex variables which may cause an individual to descend into the unfathomable abyss of violent radicalization – *the 'constellation of factors that may have engendered terrorism in the first place'*[2] – something that could be ignored by schemes of analysis which are keen on attacking the manifestations, or rather the symptoms. The metaphorical approach to counter-terrorism, in addition to this quasi-biological narrative, may feature other categories of comparison, including war or law enforcement, but none of them are absolutely perfect. Each functions from a position of convenience by exclusively playing up some aspects of the phenomenon, while moderating the others.

The significance of metaphors goes beyond poetic fluidity or rhetorical extravagance. They are crucial in deciding and framing some of the most banal aspects of social life and interactions, and their pertinence has effected linguists and philosophers to describe them as 'concepts we live by'. With reference to terrorism research, the language employed serves a purpose far greater than merely putting across details of action – it is a subtle declaration of the intent and ethos which guide individual and collective behaviour and response; a crucial propaganda tool which has significant bearing on the shaping of popular perceptions. The metaphorical

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[1] AW, Kruganski *et al.* "What Should This Fight Be Called? Metaphors Of Counterterrorism And Their Implications." *Psychol Sci Public Interest.* (2007): n. pag. Web.

[2] Ibid.

comparison between terrorism and biological diseases, therefore, must be taken with a pinch of salt, for it is far more complex than its purported packaging.

If the talk is about the significance of language and the meaning conveyed thereof, it may perhaps be useful to ponder over the esoteric divergence between the concepts of 'radicalization' and 'terrorism', two terms that been used far too interchangeably, and which from an academic perceptive is a grave anomaly. Radical beliefs may be influencers, or precursors for terrorism, but it would be problematic to draw a relationship of equivalence between the two. Most people who possess radical ideas may not engage in terrorism, and many who do, may not be firm ideologues or believers in a nuanced, extremist doctrine. Between the opinion and action models of radicalization, it is the act of committing violence which confirms terrorist intent, else the individual floats somewhere in the preceding stages of radicalization. Unfortunately, these differences are conveniently ignored, and theoretical precepts morphed beyond recognition, often with latent but significant consequences. Figure 1 offers valuable insight in relating Countering Violent Extremism (CVE) efforts to radicalization and counter-terrorism phases.
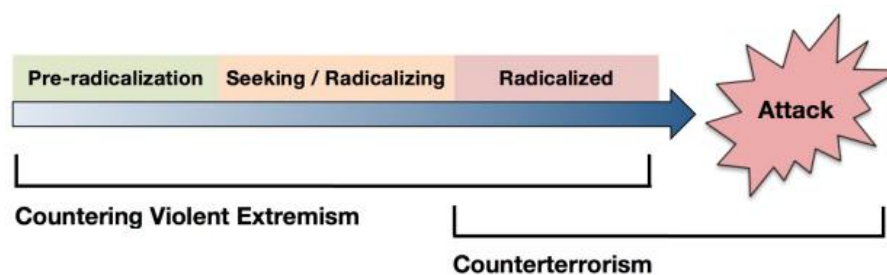

Figure 1: CVE as related to counter-terrorism and radicalization phases[3]

In 2015, President Obama termed terrorism as a "cancer that has no immediate cure"[4]. Without doubt, this has emerged as one of the most frequently visited analogies to bring out possible resemblances between acts of terror, and the disease. At an apparent level, this comparison may not seem misplaced at all. But upon deeper introspection one may conclude that perhaps a more suited parallel could be drawn between the disease as mentioned, and radical beliefs, which invade the social fabric in the same way as cancer attacks the fundamental constituents of the human body. Like cancer, radical ideas may lay dormant for many years without any definite tell-tale signs of the disease, until the phenomenon manifests explosively (in the presence of congenial catalysing conditions) through acts of terrorism. The process of metastasis is rapid, at times restricted loco-regionally, while in other instances it may attempt at seizing control of the organism as a whole.

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[3] *Challgren, Jonathan et al. Countering Violent Extremism: Applying The Public Health Model, 1st ed. Georgetown University, Center for Security Studies, National Security Critical Issues Task Force, 2016, Web.*
[4] *Robinson, Eugene. "Obama's Brave Admission About Terrorism". Washington Post. N.p., 2015. Web.*

Importantly, the severity of the disease, its presumed incurability and high rates of mortality are treated as justifications for the inevitability of drastic, often unmeasured action. The problem with an exclusive focus on this analogy is that it assumes the irrelevance of political context, historical processes, foreign policy errors, and human intention to the conceptualization of an intrinsically social process. By harping exclusively on ideological fundamentals, it dangerously absolves numerous actors of the responsibility of creating and sustaining the phenomenon, and searches straitjacketed solutions for a deeply complex process. Radicalization into terrorism is often described as a process which 'occurs between the ears of the individual', facilitated by sociological vectors. Pinning the blame on a pre-assumed villain while disregarding factors which construct the crucible is an approach flawed in its logic - and the results shall be no different. Recognizing the agency of and establishing causality between various 'push and pull factors' which guide the process of radicalization is crucial towards building a perspective which is comprehensive and equitable.

This paper attempts to understand radicalization into violent extremism as a 'disease of disconnection', caused and propelled by a diabolic but nebulous mosaic of psychological, sociological, geographic, cultural, ethnic, sectarian and geopolitical factors. In investigating this argument through the epidemiological triad, it seeks to analyse the feasibility of institutionalising the public health model in building structural resistance against radicalization and violent extremism.

Radicalization and the Epidemiological Triad

There are significant benefits which the epidemiological approach can lend to the study of 'thought contagions' like violent radicalization and terrorism. In making this argument it is essential to acknowledge that the 'contagion' analogy is less than perfect, probably even ticklish for some. Ideas, unlike viruses and bacterium, are intangible, nebulous, volatile, and contextual concepts, whose ability to invade an organic body is contingent upon its systemic receptiveness. People, typically, contract illnesses unwittingly and unwillingly, but agency and wilful intent on part of the individual to execute violence is essential in case of acts of terror. These caveats notwithstanding, it cannot be ignored that the virus of hate and savagery seems poised at the brink of a massive outbreak, lending the situation 'epidemic-like' qualities. This analogy may be contentious because ideas lack the clinical features of a biological disease, yet the increasingly 'infectious' appeal of the extremist master-narrative cannot be negated.

Before delving into the specifics it would be useful to understand the standard design employed by epidemiologists to deconstruct disease outbreak into its dynamically interrelated constituent factors. Figure 2 depicts the interacting triad of causal factors for the classic epidemic model:
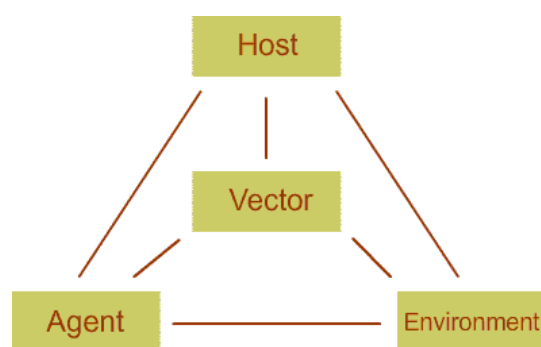
Figure 2: The Classic Epidemic Model

(Source hyperlinked)

The model explains that the spread of the disease occurs through interactions between external agents, susceptible hosts, through vectors, and in the presence of an environment which brings the various constituents together. In this scheme developed by Paul B. Stares and Mona Yacoubian (2006), the *"agent refers to the pathogen (e.g., a virus or bacterium) that causes disease. The host is the person infected by the disease (the "infective"), while the environment refers to a variety of external factors which affect both the agent and host. At the center of the triad are the vectors, the key pathways, or conduits that help propagate the disease."[5]*

Raiding the tool-chest of epidemiologists to understand the processes of radicalization into terrorism has several advantages which transcend the façade of the public health approach's metaphorical appeal. The triad of merits which stand out, as noted by Stares and Yacoubian (2006) include the critical insight gained from an intelligible analysis of the "origins and geographical and social contours of any outbreak: where the disease is concentrated, how it is transmitted, who is most at risk or "susceptible" to infection, and why some portions of society may be less susceptible or, for all intents and purposes, immune." These meticulous standards of enquiry aid the assimilation of knowledge relating to the "derivation, dynamics and propagation of a specific disease." Additionally, it is recognized by epidemiologists that "diseases neither arise nor spread in a vacuum," rather "emerge and evolve as a result of a complex dynamic interactive process between people, pathogens, and the environment in which they live." This approach nuances the debate by suggesting that the "epidemiological concept of a "cause" is rarely ever singular or linear but is more "akin" to a web of direct and indirect factors that play a lesser or greater role in differing circumstances." Relatedly, because epidemiologists emphasize upon the complexity and protean nature of disease, public health officials are careful to design approaches which aim at "controlling and rolling back an epidemic" through

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[5] *B. Stares, Paul, and Mona Yacoubian. Rethinking The "War On Terror": New Approaches To Conflict Management And Prevention In The Post-9/11 World. 1st ed. 2006. Web.*

"carefully orchestrated, systematic, prioritized, multipronged" efforts in the spirit of comprehensive enquiry.[6]

Extrapolating this understanding to the realms of radicalization and violent extremism yields some fascinating results. Little contestation can be put to the fact that the study of the processes of radicalization must be an exercise in trying to dig out the individual and collective causes, as much as the geographical, economic, social, and other contextual contours which impact the phenomenon. Organizations like Daesh or al Qaeda haven't emerged out of thin air, and nor has the ideology they espouse. Importantly, funding mechanisms which provide critical sustenance fuel to ensure the survival of this ideology and its adherents/propagators require investigation. As seen through the epidemiological prism, the web of interconnections so created requires deconstruction through dynamic analytical procedures which are cognizant of the multiple forces at play. Seeking solutions in practices which curb outward manifestations is an approach which reeks of desperation and shall do little good in the longer term. Treating the disease shall require a systemic approach which takes on board all relevant stakeholders, and is willing to initiate an open-ended and broad-based dialogue in search of remedies which address distinctive and exoteric concerns. Wisdom to sift surgical techniques from ongoing procedural interventions undertaken at the systemic and sub-structural levels is critical to orchestrate a dynamically effective CVE programme.

Applying the epidemiological model to the study of radicalization is a process influenced by peculiarities of the context in which it is being invoked; attempting a one-size-fits-all model is a futile exercise. The *agent* which can be identified as the cause of this infection is any strain of thought which positions itself at the extremes, espouses or legitimises the use of violence for the attainment of self-serving goals, is radically intolerant of countervailing opinions, exclusionary, exclusivist, and therefore intrinsically 'radical' or 'extreme'. Importantly, while the 'injection' of this strain into the 'bloodstream' by itself may not be sufficient to propel radicalization, the narrative it creates against those it identifies as the 'enemy other', and the perception (particularly of being threatened, targeted, wronged, isolated or alienated) it generates within the social structure is what may trigger the phenomenon. The *host* may be an individual or group which finds its beliefs (however shallow or perfunctory may they be) resonating with the concerned strain. Lack of 'systemic immunity' to the disease automatically increases chances of contracting the infection. The *vectors* which cause the spread of the agent are pathways or conduits which facilitate group interactions, physically or virtually, and may include (amongst several others) social networks, group organizations or

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[6]*Ibid.*

outfits, semi-organized movements, vigilante anarchists, ideologically motivated media platforms, and prominently the internet. The *environmental factors* which create the conditions for optimum interaction between other agents cannot be fixed or generalized but may broadly be driven by varying political, personal, economic, social, cultural, demographic, ethnic, linguistic, sectarian, (and other)conditions or forces.

The model of epidemiology survives on inter-connectivity. Any factor taken in isolation may not be sufficient to give rise to radical tendencies. Analogously, the human body, under normal conditions, is believed to host numerous disease-causing agents which, should appropriate conditions arise, manifest symptoms of the ailment. The presence of catalysts and attainment of the 'tipping point' evinces characteristics and forces, which until then, engaged latently.

The 'Disease of Disconnection'

Radicalization into extremism is a clear and impending threat, and meeting the challenge requires a shift from a business-as-usual approach to a dynamic and flexible model that escapes the banality of platitudes. It is therefore critical for academics and policy-makers to better understand the puzzle of why and how some people may appreciate ideas and practices which are shunned by the society at large. Violent extremism is not limited to actions within any single faith community. It is a broad term that applies to threats emanating from a range of organizations and movements which use violence to pursue ideological, social or political goals.[7] The appeal of violent ideologies transcends the rhetorical flourish propagated and proliferated by extremist groups; an individual on the path of radicalization finds himself caught in a vortex of individual and collective 'push and pull' factors which motivated and facilitated his journey into violence. Alienation and isolation therefore disconnect the individual from the social realities which surround his existence cultivating a psychological state of cognitive dissonance at which the individual is most susceptible to fall prey to extremist narratives and the actions they ask of individuals to prove their loyalty and commitment to the meta-cause. Appropriately, radicalization surfaces as the disease of 'disconnection', through which the individual loses connect with a rationalistic interpretation of the world, and fixates his frame of reference in accordance with an ideology which best suits his current 'worldview'.

Radical behaviour develops through a series of stages which strengthen an individual's belief system, and contrary to common perception, is not the result of a sudden, overnight decision by the attacker to use violence for the attainment of his objectives. Of the many models which seek to describe the process of radicalization,

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[7] *Lyons-Padilla, S., Gelfand, M. J., Mirahmadi, H., Farooq, M., & van Egmond, M. (2015). Belonging nowhere: Marginalization & radicalization risk among Muslim immigrants. Behavioral Science & Policy, 1(2), pp. 1–12.*

of relevance here may be the one proposed by the forensic psychologist, Randy Borum[8] (see figure 3).

The Process of Ideological Development

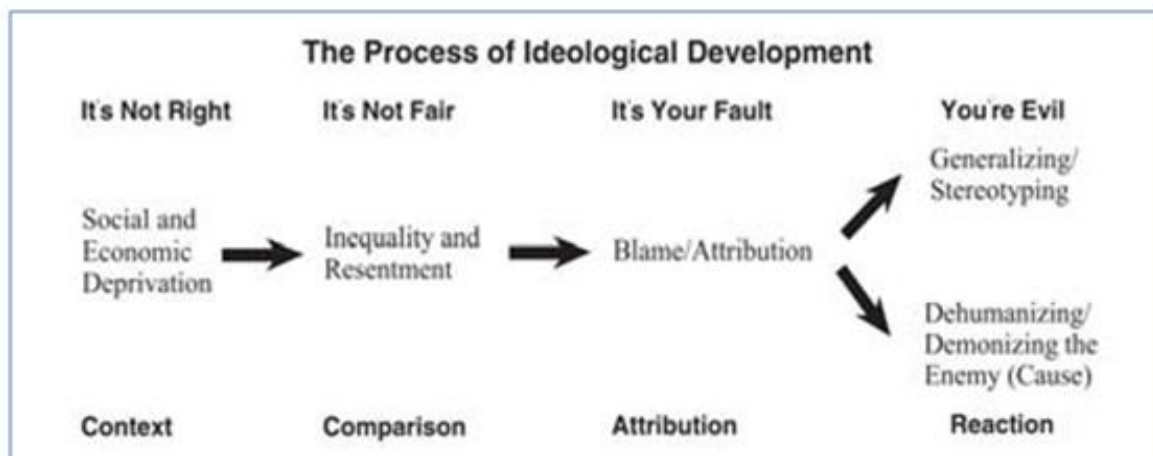| It's Not Right	It's Not Fair	It's Your Fault	You're Evil
Social and Economic Deprivation	Inequality and Resentment	Blame/Attribution	Generalizing/ Stereotyping / Dehumanizing/ Demonizing the Enemy (Cause)
Context	**Comparison**	**Attribution**	**Reaction**

Figure 3: Borum's Pathway to Radicalization

A perception of relative deprivation justifies the context which the individual is beginning to frame in his mind, the emotion of being wronged – it's not right - creating the 'cognitive opening' to the receptiveness of anti-normative opinions. This comparison confirms his mistrust of a system which he holds responsible for the injustices being meted out against him. The third stage is when the target of this resentment acquires a definite form, such that the individual develops adequate reasoning to hold others responsible through a discernible externalization of hatred. At the last stage, the demonization and dehumanization of the perceived 'out-group', the enemy is complete. Violence against the 'out-group' is normalized and legitimized, to an extent that the individual draws comfort from his aberrant behaviour. As the individual progresses through each stage, his disconnect with the environment that surrounds him consistently increases. A sense of isolation sets in, which may be self-induced, through the development of an attitude sympathetic of ideologies which favour the self-styled perceptions of the individual, or may be a by-product of actual or professed political alienation of the individual himself, or the group to which he claims ideological affiliation. The individual may either retreat unto himself, or chose to surround himself with people who reinforce and encourage his beliefs to sustain the process of socialization towards extremism.

'Isolation' is a fairly slippery term. Varying and often conflicting research on the substance of its contribution towards radicalization has caused researchers to distance themselves from expressly favouring or denying its role. The multi-dimensionality of the term necessitates a careful assessment of its usage in defining

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[8] *Borum, Randy. "Radicalization Into Violent Extremism I: A Review Of Social Science Theories". Journal of Strategic Security 4.4 (2011): n. pag. Web.*

threat scenarios. Individuals may choose to isolate themselves in pursuit of creative, spiritual or other constructive reasons. But a sense of forced isolation is responsible for creating dastardly consequences, of which extremist interpretations/outlook may be one. Additionally, the various types of isolation – social, emotional or perceived – may produce different results in different individuals. While social isolation is defined as "social connectedness or an objective measure of contacts with other people, emotional isolation represents the "gap between one's ideal level of social relationships and their actual level of relationships – the subjective degree to which an individual feels emotionally connected with others. An emotionally isolated individual may feel distanced and disconnected, and maintain difficulty in relating to others." Perceived isolation is a "subjective lack of social support related to the extent one feels isolated." The various correlations between these concepts provide significant insight for addressing the dynamics and human behaviours that impact radicalization[9].

Another concept inextricably intertwined with this discussion is the psychoanalytical construct of 'identity' and 'cognitive dissonance'. The complexity of the identity question is often lost in the din of polarized debates which seek answers in simplified deconstructs that assume causality rather than investigating it. Recent studies support the claim that some people who join violent extremist movements are on a quest for significance, a sense that their lives have purpose and meaning. The pursuit of one's identity is fundamental to defining one's self-worth. Personal trauma, humiliation, shame, perceived maltreatment by society and other acute negative events such as job loss, financial struggles, victimization, domestic discord etc. can cause people to feel a loss of self-worth, or better termed as 'significance loss'. Such individuals fit in the personality profile of those most vulnerable to be attracted to any opportunities to restore a sense of self-worth and clear identity. Existing research on the propaganda and recruitment material released by terrorist organizations like Daesh or al Qaeda reveals the frequent use of the arguments of the 'humiliation and suffering of Muslims' throughout the world, which can resonate with people who relate to a collective experience of significance loss. For instance, Daesh's slick propaganda videos often refer to jihad as a route to regaining significance, which aligns with the 'identity' principle and the 'narcissistic-rage' hypotheses often referred to in these cases. For such wayward individuals, suspended at the cross-roads of mental and emotional conflict, the route of gaining fame through the barbarity and savagery espoused by such organizations becomes a source of belonging, purpose and in-group status. The consequences of a perception of 'fitting in nowhere' and 'collective rejection' leading to a sense of alienation from

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[9] C. Hug, Erin. *"The Role of Isolation in Radicalization: How Important It Is?"*. Dtic.mil. N.p., 2013. Web.

and disconnect with the society at large can thus be deadly[10]. An interesting perspective to this context is offered by Olivier Roy in his much acclaimed article 'France's Oedipal Islamist Complex'. Nearly all French jihadis, comments Roy, belong to two precise categories: they are either second-generation French, or they are native French converts. The common thread which unites the two is a sense of generational revolt – both seem to have ruptured with their parents, or more precisely, what their parents represent in terms of culture and religion, but they also do not represent a culture which is rebelling against Westernization. The appeal of any 'moderate' interpretations of Islam fails to align with their interests, for it is the "radicalism which attracts them in the first place. Salafism is not only a matter of sermonizing financed by Saudi Arabia — it's also the product that suits these youth, who are at odds with society." The idea of this generational revolt stems from a fundamental urge to envisage a grandiose exaltation of self. Therefore, writes Roy, "these youth do not hide anything, but rather display their new conviction on Facebook. They exhibit their new almighty selves, their desire for revenge for their suppressed frustrations, the pleasure they derive from the new power lent them by their willingness to kill, and their fascination with their own death. The violence that they subscribe to is a modern violence; they kill in the manner of mass shooters in America or Anders Breivik in Norway — coldly and calmly. Nihilism and pride are profoundly tied to each other." Their radicalization stems from an alternate reality created around imaginations of heroism, violence, and death, not (exclusively) of Sharia or utopia. They assert, thus, to be "reclaiming, on their own terms, an identity that, in their eyes, their parents have debased."[11]

Going back to Borum's model, while the stages may appear self-explanatory, a closer look brings forth curious details which appear to sit inconsistently with contemporary realities. Therefore, it would be useful to note that these process(es) are not uniform for all, and as tempted one may be to put data profiles into neat boxes defined on the basis of linear trajectories of radicalization, such an effort will ultimately be counter-productive. Models which delineate the processes of radicalization must be treated for the descriptive aids that they are, and not prescriptive tools that they are made out to be. Attempts at fixing a generalized profile of a potential 'terrorist' based on the findings of such models must be balanced with an understanding of the peculiarities which frame the unique social, cultural, political, religious, economic, regional contexts of the individual. Another take-away from this section would be the understanding that while 'isolation' is a fairly individualistic term defined by personal undercurrents, the term 'disconnection' implies an acknowledgement of and engagement with reciprocal

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[10] *Lyons-Padilla, S., Gelfand, M. J., Mirahmadi, H., Farooq, M., & van Egmond, M. (2015). Belonging nowhere: Marginalization & radicalization risk among Muslim immigrants. Behavioral Science & Policy, 1(2), pp. 1–12.*
[11] *Roy, Olivier. "France'S Oedipal Islamist Complex". Foreign Policy. N.p., 2016. Web.*

social processes to which the individual responds, and which shape his perceptions. The use of the latter is therefore preferred to underline the psychological and sociological factors which influence the process.

The Public Health Model

Public health research seeks to enquire into foundational questions which can better inform preventive strategies and interventions against violent radicalization whose contemporary appeal bears epidemic-like qualities. Central to this approach is the shift in social perceptions towards violence – from a reactive policy to one that acknowledges the behavioural, sociological, cultural, demographic and environmental causes of violence. By building on a scientific substructure, it weaves a narrative which brings to the table the benefits of methodological coherence, dynamism and the ability to evolve with the changes in the external circumstances.

Public health is defined as "The science and art of promoting and protecting health and well-being, preventing ill health and prolonging life through the organized efforts of society[12]." Therefore, an approach which is collective and communitarian in its intent and practice is deemed important, as is the task of building lasting partnerships with all agents who contribute towards the health of the population.

The public health model involves multiple steps, each informing and reinforcing the other. Each level involves the participation of multiple individuals, organizations and systems to evaluate, address, and mitigate the wide-ranging dynamics of violent extremism. This paper shall build on the framework provided by the World Health Organization's (WHO) Violence Prevention Alliance (see figure 4) to investigate into the causes of radicalization.
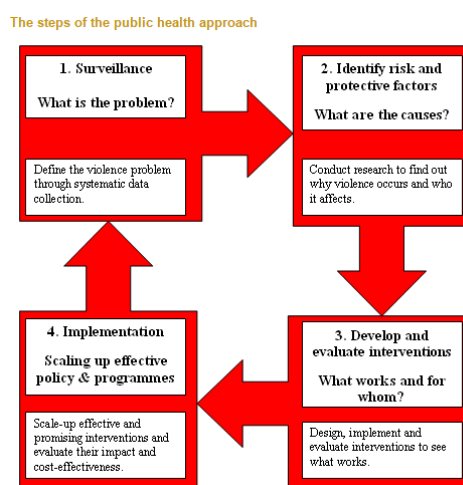

Figure 4: The Public Health Model (as applied to CVE)

(Source: hyperlinked)

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[12]*Acheson, 1988; WHO.*

The *first step* deals with defining the problem. This is done through a systematic collection of data pertaining to the magnitude, scope, characteristics and consequences of violence. In the spirit of scientific enquiry, this step builds the edifice which determines the "who", "what", "where", "when" and "how" of the issue under consideration.

The *second step* looks at establishing the probable causes (and correlates) of violence. Systematic research methods are employed to investigate factors which increase the risk for violence (risk factors), and factors that may buffer against these risk factors - protective factors – which decrease the likelihood of violence in the face of risk. The goal of violence prevention, as defined in the underlined document issued by the National Center for Injury Prevention and Control, Division of Violence Prevention, is to decrease risk factors and increase protective factors.

The goal of *step three* is to develop prevention strategies, and to rigorously test their workability by sampling the implementation of interventions.

Step four is where the actual operationalization of the programme takes place. The strategies which qualified through the preceding steps are disseminated and implemented in a wide range of settings. Technical assistance and training is offered to practitioners when implementing these strategies and programmes to ensure that the execution of the plan is as intended. Additionally, the effects of these interventions on risk factors and the target outcome is monitored, and their cost effectiveness evaluated to assure that all components of the strategy fit within the context for which they have been designed.

The CDC document[13] presents draws a rather interesting analogy to this model: that of a relay team for prevention (see figure 5). The prevention practitioner may take up the baton in the fourth step, but the overall success of the system depends upon the team as a whole and how each teammate runs their leg of the race[14].
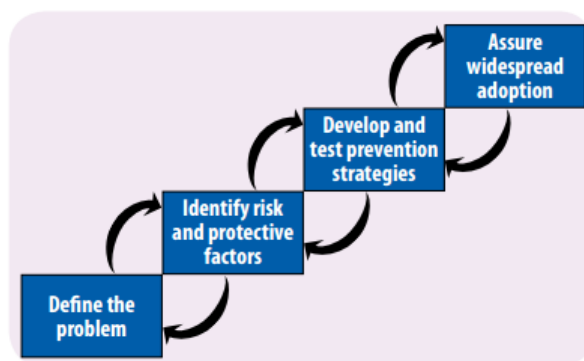

Figure 5: Stages in the public health approach
(Source: hyperlinked)

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[13] "*The Public Health Approach To Violence Prevention| Violence Prevention| Injury Center| CDC". Cdc.gov. Web.*

[14] *Ibid.*

Public health approaches which attempt at building a proactive and positive paradigm to address violent extremism through "non-coercive means in the pre-criminal space"[15] are read through a framework which collates a broad spectrum of measures which can be categorized into *primary, secondary and tertiary* preventions. In the language of 'public health', primary approaches are directed towards preventing injury and disease before it occurs by preventing exposure to the causes and promoters of injury and disease. They generally target specific causes and factors which heighten the risk of disease degeneration, but may also aim to promote healthy behaviours, improve host resistance, and foster safe environments that reduce the risk of disease. Secondary prevention detects and treats the "pre-clinical" changes that occur before the disease manifests and progresses. And, tertiary prevention comes into the picture once the disease sets in and the goal now is to reduce its impact on longevity and quality of life. [16]

This can be explained by taking the example of the 'Metabolic Syndrome (MS)' which is essentially defined as "a cluster of biochemical and physiological abnormalities associated with the development of cardiovascular disease and type 2 diabetes." The primer contents created for clinicians by the Association of Faculties of Medicine of Canada (AFMC) suggests that primary prevention strategies for MS may include nutrition and exercise counselling, smoking cessation, and efforts at building common infrastructure which promotes active transport, among other initiatives. Secondary prevention interventions include community level weight loss and exercise programs to control symptoms and regular screening procedures for diabetes. Tertiary interventions, which are comparatively drastic in their approach, require referral to cardiac rehabilitation clinics following a myocardial infarction, moderate and alter behaviours to reduce the likelihood of a re-infarction, thereby softening the impact caused by the disease on the patient's function, longevity, and quality of life[17].

Applying this model to the CVE domain involves the aggregation into a common stream of the efforts and initiatives which address the multiple dynamics of the perceived 'disease'.

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[15] *Weine, Stevan, and David Eisenman. "How Public Health Can Improve Initiatives To Counter Violent Extremism | START.Umd.Edu". Start.umd.edu. N.p., 2016. Web.*
[16] *Ibid.*
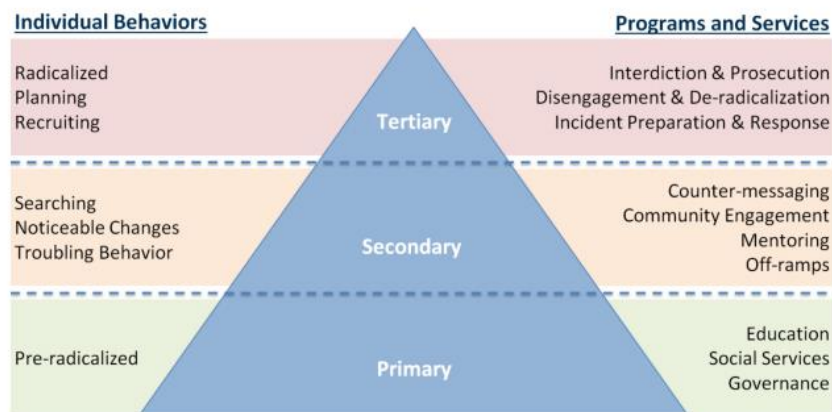[17] *"The Stages Of Prevention". Phprimer.afmc.ca. Web.*

Figure 6: Public Health Model for Countering Violent Extremism
(Source: hyperlinked)

The bottom of the pyramid (refer to figure 6) is reserved for the primary intervention strategies which attempt to target the society as a whole through community level initiatives which address "socio-political, group and community factors for violent radicalization[18]". Assigning the broadest segment of the triad to these strategies is indicative of their encompassing nature and closest association with symptoms at the grassroots. The target factors at this stage are those with a "modifiable degree of risk[19]" and that are "empirically or theoretically associated with violent extremism[20]". The idea behind such initiatives is to tackle the causes of threat through "a holistic approach which has a low risk of stigmatizing communities since it avoids targeting specific groups of people[21]." Examples of primary prevention tools include education programmes (including critical thinking courses, extracurricular programmes, ethics and civic engagement courses), cultural awareness initiatives (such as inter and intra faith dialogues, cross-cultural engagement, sensitization programmes), social engagement initiatives (involving policy and grassroots schemes aimed at reinforcing democratic tenets, local governance initiatives and criminal justice reform), and importantly, health services which seek to improve quality and access to affordable mental healthcare systems. Initiatives which rely on family networks to identify individuals at the risk of radicalization into violent extremism and design strategies to wean them away from the path of violence, are also included under this head.

Secondary prevention strategies are aimed at individuals and groups which have been identified as 'at-risk' for violent extremism. Characteristically, individuals belonging to this category may have been previously exposed to extremist ideologies

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[18] *Challgren, Jonathan et al. Countering Violent Extremism: Applying The Public Health Model. 1st ed. Georgetown University, Center for Security Studies, National Security Critical Issues Task Force, 2016. Web.*
[19] *Weine, Stevan, and David Eisenman. "How Public Health Can Improve Initiatives To Counter Violent Extremism | START.Umd.Edu". Start.umd.edu. N.p., 2016. Web.*
[20]*Ibid.*
[21]*Ibid.*

or radical social networks[22]. It is at this stage that the role of 'bystanders' and close contacts within the social network of such individuals assumes importance for they are often the first ones to notice perceptible behavioural changes in the attitudes and actions of individuals who may be at the risk of radicalization. Therefore, while taking care to not breach the line of coercive/intrusive action, law enforcement has to devise strategies to build partnerships by gaining the trust of communities such that they are encouraged to report aberrant behaviour as soon as possible. Specialist driven community education and sensitization programmes which enable members to accurately identify possible red-flags are crucial for the success of interventions at this stage. Other measures include mentorship, counselling, training on warning signs, mediation, CVE education centres, CVE support hotlines, and community resilience programs. Counter messaging tactics which aim at taking down the violent rhetoric proliferated by extremist narratives, and building positive counter-narratives, are also incorporated within the ambit of secondary prevention strategies.

Tertiary prevention programmes are intervention strategies targeted towards individuals who may have already been radicalized, adopted extremist ideologies, or are in contact with violent extremists, but are not engaged in planning or carrying out acts of violence.[23] At the tertiary level, initiatives must be tailored to meet specific ends, and their effective implementation requires that significant law enforcement, community and intelligence assets be committed to each individual in the net. Tertiary prevention tools include "disengagement, de-radicalization, isolation and redirection" initiatives aimed at altering extremist beliefs, emphasising mitigation efforts, and preventing individuals from carrying out attacks and influencing others.[24]

Each level of the program targets a particular stage in the process of radicalization. If one were to draw a line of connection between the *Public Health Model* and *Borum's Pathway to Radicalization*, it would be appropriate to say (notwithstanding minor changes suiting specific requirements) that primary intervention programmes may deal with the first *(It's not right)* and second *(It's not fair)* stage when the individual is grappling, emotionally and psychologically, to define the context of his perceptions. Secondary strategies may be more suitable at the 'blame attribution stage', once a certain degree of receptiveness is established. And tertiary programmes are effective once the beliefs cultivated over time have been strengthened to the effect that the 'reaction stage' associated with the dehumanization/demonization of the enemy is reached.

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[22]*Ibid.*

[23] *Ibid.*

[24] *Challgren, Jonathan et al. Countering Violent Extremism: Applying The Public Health Model. 1st ed. Georgetown University, Center for Security Studies, National Security Critical Issues Task Force, 2016. Web.*

Discerning these stages, however, is an act easier said than done. The need therefore to shed compartmentalized programmes which deal with the malaise and its symptoms in silos, for the adoption of a 'whole of society' and 'whole of government' approach which institutionalises the operation of targeted programmes at multiple levels cannot be emphasized enough. Public health approaches seek to engage with the population to foster connect with a larger proportion of the critical mass which might be at the risk of radicalization into violence. The approach is appropriately seized of the concern that not all individuals who proceed to the end state of committing a terrorist act may reflect homogenous symptoms, or indicate identical profiles. In its attempt to prevent stigmatization, public health research delves into variables drawn from social and behavioural sciences and emphasises upon an understanding of "individuals' and groups' biographies, identities and stories, the cultural influences on socialization and successful resettlement, and public and community support for counter-radicalization[25]."

Towards Evolving a Public Health Model to Prevent and Counter Radicalization and Violent Extremism

One of the most favoured definitions of violent extremism explains it as a social and psychological process, often facilitated by recruitment and training, by which an individual becomes increasingly committed to politically motivated violence, especially against civilians[26]. Such an individual may or may not indulge in actual acts of violence, but is behaviourally conditioned to believe in its plausibility. Pre-existing models rooted exclusively in the criminal justice system assume generalities which, in addition to posing ethical dilemmas, may by themselves be insufficient or unsuccessful in preventing or dealing with the dynamism of the challenge. The public health approach supplements the objectives of traditional prosecutorial and law enforcement techniques by functioning at multidisciplinary intersections to institutionalise preventive strategies which build collective immunity against such (opinion or action driven) violence. In doing so, it advances certain fundamental principles which serve to nuance the debate and put into perspective the guiding conceptual frame within which embarkation on the fine print is carried out. Adherence to these principles is crucial when the fields of operation exhibit intricate, complex, delicate and diverse social structures.

To cure a disease it is, at first, essential to acknowledge and come to terms with its existence. Denial risks exacerbation of the problem to a point of no recovery – an undesirable end for all relevant stakeholders. It might be valuable take a step back, revaluate and realign priorities in accordance with the cardinal principle of

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[25] *Bhui, Kamaldeep et al. "A Public Health Approach To Understanding And Preventing Violent Radicalization". BMC Medicine (2012): n. pag. Web.*
[26] *Ibid.*

prioritising 'prevention' over 'cure', or preventing the issue from snowballing into a terminal catastrophe. Once, if the onset of disease is confirmed, **early warning and response** can make all the difference.

Treatment (primary, secondary, or tertiary) is based on diagnosis – of the mainspring and not the symptoms – which aid in identifying the fundamentals of the ailment. Privileging predetermined notions while disregarding (due to actual or feigned ignorance) the wider social, geopolitical and historical circumstances shall lead to glib, inept and amateurish solutions, if at all. Assigning priorities and fixing responsibilities through an understanding of the local drivers of radicalization and violent extremism may better analytical accuracy. Some of the risk factors identified in <u>existing research</u> on this theme include grievances (real or perceived), surrounding cultures of war and conflict, perceived threat to family or cultural identity, a perception of discrimination, exclusion, marginalization, and relative deprivation, and/or a sense of alienation or disconnect from the immediate or extended social context. Approaches such as the one under discussion question the theoretical and empirical conventions which define the radicalization process by asserting that "the motivation for an individual or group to commit extremist violence or terrorism is not grounded in a single ideology, but selectively demonstrate their commitment from different clusters of belief systems[27]."

Importantly, the Hippocratic Oath – 'Do No Harm' - is as relevant to conflict situations as it is to medical practice. Diagnosis is followed by procedures which aim to deescalate the momentum and impact of resulting consequences. Should intractability of a conflict situation be confirmed, palliative care which attempts to limit negative repercussions must be put in process. But at no stage should interventions worsen an already precarious situation. Timing operational priorities is as important as framing them, for even the most well-intentioned policies when introduced out of context may end up in disastrous results.

Progressing towards the schematics of the plot, in January 2016, the United Nations' Secretary General presented a Plan of Action (PoA) to Prevent Violent Extremism to the General Assembly (UNGA) [28] , and in July 2016, through resolution A/RES/70/291 [29] , the UNGA recommended by consensus that Member States consider the implementation of the suggestions put forth in the Plan of Action as applicable to the national context. Caveat being that while a national policy framework to deal with social manifestations of radicalization and violent extremism

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[27] *Labilles, Ulysses. "Significance Of Public Health Approach On Violent Radicalization". O.N.E. – One Nation's Echo. N.p., 2016. Web.*

[28] *"Plan Of Action To Prevent Violent Extremism | Counter-Terrorism Implementation Task Force". Un.org. N.p., 2016. Web.*

[29] *The United Nations Global Counter - Terrorism Strategy Review | A /RES/ 70/291. United Nations General Assembly, 2016. Print.*

might be desirable, experts suggest that the best way to proceed is by hyper-localising the content which is co-created with individuals and communities in the target audience to ensure that the message does not stray too far from the social and cultural identities of native milieus.

Within the PoA, the seven priority areas include: *Dialogue and Conflict Prevention; Strengthening Good Governance, Human Rights and the Rule of Law; Engaging Communities; Empowering Youth; Gender Equality and Empowering Women; Education, Skill Development and Employment Facilitation; Strategic Communications, the Internet and Social Media.* Most of these interventions can be mandated under the primary and/or secondary strategies of the public health triad. This calls for the active involvement of multiple constituents – the government, security, law enforcement and intelligence agencies, civil society, inter-governmental and non-governmental organizations, international organizations, educational institutions, think-tanks, academics, informational and communication technology experts, media (traditional and social) specialists, religious and community leaders, and families. The aim of such broad-based (perhaps informally institutionalized) measures is to enhance the firewalls of *protective factors* to guard individuals/communities against the sway of radicalizing tendencies. Essentially, it boils down to building means and mechanisms for social support, social cohesion, social capital and trust in institutions, integrated cultural identity, access to democratic means for negotiating needs and opinions and access to critical religious leadership that can moderate and inform on legitimate religious perspectives[30]. It is important to bear in mind that the malaise of radicalization into extremism in its capacity of being a deeply personal problem feeds on self-induced or socially constructed perceptions of alienation and disconnection. Addressing this aspect is vital.

Reinforcing these requires committed and sustained efforts in reaching out to those who may at greater risk of isolation and alienation, (which make them more vulnerable to recruitment by violent extremists), through positive outreach programmes. Engagement activities must entail informed strategies to identify and detect susceptible individuals/groups, and follow up on their concerns through "intensive mentoring, tailored risk reduction, and behaviour change strategy" by optimizing the utilization of available" resources and network linkages." However, identification of the population sample most vulnerable to radicalization must be based on scientifically determined approaches which are unbiased and unprejudiced to avoid the pitfalls of furthering isolation through stigmatization.

It is often stated that individuals who are radicalized to either join extremist outfits or commit ideologically motivated individual acts of terror display a marginal or

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[30] *Bhui, Kamaldeep et al. "A Public Health Approach To Understanding And Preventing Violent Radicalization". BMC Medicine (2012): n. pag. Web.*

misguided knowledge of religion or the fundamentals of the cause to which they seem to have committed their life, or perhaps afterlife. Prevention strategies, particularly at the primary level, must endeavour to impart services which address these critical gaps to pre-empt further mobilization. In this domain, the role of media platforms, particularly social media with its the prototypically town hall-like characteristics, deserve attention. Specialized social media technologies can be brought into play to identify persuasive warning signals in the radicalization process or/and recruitment of connected users, monitor trends in sentimental expression (and probable calls to action) in response to geopolitical occurrences and shifts, and as a powerful medium to proliferate strategic counter messages/narratives against the violent rhetoric churned out by the extremists' propaganda machinery.

Programs working at the tertiary level are more targeted in their designs and implementation given that the focus now shifts (in the epidemiological terminology) from preventive and protective measures towards containment and remedial strategies. Individuals/groups earmarked at this stage include those already at advanced stages of radicalization, including those involved in planning for or recruitment into terrorist organizations. The role of criminal justice and traditional law enforcement systems is now pronounced, in addition to skilled community members, psychologists, religious authorities, and deradicalized former extremists who continue to be crucial influencers.

At each stage, employing credible messengers is pivotal to the success of the programme. For interventions to achieve intended results, it is important for the message to resonate with the target audience. Organic models which rely on a grassroots approach to involve individuals, organizations and communities in building, sustaining and broadcasting a discourse which is sensitive to their peculiarities have the maximum potential of creating a lasting cognitive imprint. Public health approaches aim to engage with populations to build awareness regarding warning signs of an impending (biological/social/psychological) disorder, and educate the community to rise to the challenge by aggregating and implementing shared knowledge and practices. This strengthens communitarian zeal in contributing towards cultivating what is often termed as 'herd immunity', and is tipped as one of the more effective tactics to deal with shared vulnerabilities.

Approaching the phenomenon of terrorist radicalization through the prism of the epidemiological metaphor mainstreams some oft-ignored but increasingly relevant perspectives. Counter radicalization or CVE activities aim at transforming the nigh 'unknowable' among diverse and disparate individuals and groups. Pursuing a systematic but flexible approach which balances considerations of standardization and individualization, and is able to adapt, calibrate and prioritize measures accordingly, is pivotal. Interestingly, thought contagions of violence mutate at a dangerously fast pace, and the inability of the 'good guys' to keep up with emerging

trends seals the prospects of their success. Even in societies which pride on the assertion that such tendencies are yet to have significantly influenced or impacted their populations, the threat is visible and potent. The public health model with its reliance on three key elements – detecting and interrupting behaviour before it happens or before it can spread; changing the thinking of the highest risk; and changing overall norms –is uniquely aligned to prevent/counter violent radicalization without taking recourse to the stereotypical targeting of entire communities or groups.

Testing Theory in Practice[31]

Counter/De-radicalization programmes must take into consideration the peculiarities of the context of their implementation. Generalized approaches may be as ineffective as they are undesirable, given their inability to strike a chord with key demographic elements at the grassroots.

Countries in the past have experimented with their own "soft" counter terrorism programs[32] designed to forestall or undo the radicalization process by investigating individuals' original reasons for radicalizing and seeking to undo the radicalization process by engineering their return to moderate society. Measuring the success of such programs continues to be a challenge due to the methodological dependency on rates of recidivism (which, derived from behavioural data, are characteristically indeterminate). But, given the nature of contemporary security threats, the criticality of such programs and the necessity to bolster their efficacy and efficiency cannot be debated. This section dwells on some of the 'best practices' in the field of CVE (entailing activities and interventions which can be placed under the primary, secondary and/or tertiary tier) and de-radicalization, while building the case for the feasibility and possibility of implementing some of these practices in the Indian context within the 'public health' triad.

In the analysis of various de-radicalization approaches, significant attention has been accorded to the model under implementation in *Saudi Arabia*, deemed as among the "most high-profile of its kind."[33] The Saudi initiative, a two-stage government-run program started in 2005, is coordinated primarily through three sub-committees which deal with the religious, psychological and social and the security aspects of the initiative. The thrust of the program is to evaluate the individual causes of radicalization, and factor in community organizations, social groups and families into the process of de-radicalization. Prior to release from the program, individuals

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[31] *This section alludes in brief to the various counter/de-radicalization programs institutionalized in different states. Detailed analysis of various 'best practices', including their applicability to the Indian context, and suggestions for an indigenous model to prevent and counter radicalization and violent extremism shall be covered in an upcoming paper.*

[32] *Hoeft, Gabriel. 'Soft' Approaches To Counter - Terrorism: An Exploration Of The Benefits Of De-radicalization Programs. 1st ed. International Institute for Counter-Terrorism, 2015. Web.*

[33] *A New Approach? De-radicalization Programs And Counterterrorism. 1st ed. International Peace Institute, 2010. Web.*

are required to successfully complete a "pre-release care program" which aims at promoting moderate interpretations and discrediting the extremist ideology, integrated with courses on self-development. Post release, beneficiaries of the program are encouraged to remain in contact with tutors, and continue to receive welfare assistance which facilitates their integration into the social structure.

Criticisms of this program, however, run aplenty. It is contended that the apparent ineffectiveness of the Saudi model may be in its excessively soft approach, which fails in sifting the hardliners from relative novices. Additionally, the 'prevention element' is conspicuous by its absence. Major chunk of the approaches, apart from certain one-off initiatives, can at the most be considered at the tertiary stage, but may be of little relevance in situations where the focus in on strengthening the primary and secondary prevention interventions.

Singapore's model comes across as better equipped in dealing with some of these issues. Here, the safety net is in the form of a security assessment process – having determined the soundest approach to a potential beneficiary's de-radicalization, assessment regulates a review by psychologists and cognition experts to determine the possibility of an individual's integration with society. Bringing families into the operational fold is crucial at the prevention, and rehabilitation and reintegration stages. At the same time, community based 'religious rehabilitation groups' are tasked with challenging and reforming radicalized beliefs. A key feature of Singapore's approach is its stated and explicit focus on questioning and undermining the extremist ideology: *"If we can challenge the ideology, get voices out there, we can ultimately turn the tide."*[34]

Another model whose relative successes are toasted within the strategic community is that of *Indonesia*. This program functions on an approach which begins by determining the prospective participant's commitment to de-radicalization before tailoring the steps that need to be taken to achieve it. The many facets of the program employ dialogic intervention strategies between program beneficiaries, professors, clerics, families, to ensure that the individual has a sound social support structure beyond the apparent perceptions of terrorist network kinship. A balance between non-kinetic measures and astrong rule of law approach has been positively received. The crux of the Indonesian program is in its efforts to rehabilitate, reintegrate and re-educate potential beneficiaries, and empower the generation and dissemination of counter-narratives through the involvement of ex-radicals, psychologists, religious leaders and scholars, among others.

The uniqueness of *Morocco's* model lies in its ability to incorporate various de-radicalization and counter-radicalization measures into the state's policy agenda.

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[34]*Ibid.*

Simultaneously, it encourages various civil society organizations to develop their own procedures and priorities. The state has mandated the operationalization of initiatives which aim at countering extremist interpretations of religion, even reorganize religious structures to guard civilians against the sway of radical tendencies. The Moroccan model functions by exploiting the leverage offered by traditional and new media systems in popularising and propagating counter messaging campaigns which challenge vitriolic extremist narratives. Reforms in education policies and curriculum infrastructure, coordinating youth outreach and income generation programs are some other flagship interventions which have been prioritized under Morocco's counter-radicalization strategy.

The hallmark of *Malaysia's* counter-radicalization model is an emphasis on promoting inclusivity and respect for universal human rights through reforms in its education system. The country's much-acclaimed de-radicalization strategy adopts a four-point model built around discussion, debate, continuous assessment and evaluation of beneficiaries, welfare assistance, and eventual rehabilitation and reintegration into the social framework. Experts within the state prefer the term 'disengagement' over 'de-radicalization' for it better conveys the thrust of their programme.

With incidences of terrorism-related violence on an upswing in its territory, *France* has been forced to revisit its counter-radicalisation strategy. The French model speaks in favour of balancing upstream and downstream approaches to refine the methods of detection and management of radicalization. France's counter-radicalization policy relies on a three-stage model focusing on detention, prevention and de-radicalization. Initiatives have sought the active involvement of family and community networks, civil society organizations, psychoanalysts, subject experts and law enforcement agencies. Rates of success are not overwhelmingly positive and efforts are underway to plug the loopholes the program is fraught with.

The *Canadian* model regionally contextualises the implementation of counter-radicalization and de-radicalization interventions which are emphatically executed as grassroots ventures. Local involvement in projects, according to program coordinators, is sacrosanct, and federal assistance is welcomed so long as it is "administered sensitively and does not crush the local zeal."[35] The project mandates its exercises to take on opinion and action radicalization in its many manifestations – religious, "neo-Nazis, skinheads, ultra-leftists and single-issue radicals." [36] Community-led flagship projects take in "many forms of extremism" and their "aim is to nip extremist thinking in the bud rather than simply wait and react once it is in full flower." Interventions are coordinated through the involvement of parents,

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[35]*"From Therapists To Imams To Cops, Canada Seeks Many Antidotes To Terrorism". Economist.com. N.p., 2016. Web.*

[36]*Ibid.*

social workers, police agencies, schools, health institutions, psychoanalysts, psychotherapists, and a host of other voluntary organizations.

Within the broader mandate of CVE programs in the *United States*, the 'public health' model is particularly relevant to three pilot projects: the Boston, Minneapolis and Los Angeles Frameworks[37]. Of the three, the Boston Framework places high emphasis on primary prevention, while also encouraging communities to consider secondary and tertiary strategies. Solutions identified seek to address perceived alienation and isolation, grievances and lack of cultural sensitivity through measures which include (but are not limited to) the development of personal and interpersonal skills; increasing access to mental health services; developing engagement networks through mentorship; community education and media engagement on violent racial and religious narratives etc. Contrary to the Boston Framework, the Los Angeles Framework for CVE is primarily focused on tertiary activities through the three pillars of *Prevention, Intervention, and Interdiction*. This model concentrates on strategies designed to serve as 'off-ramps' – "described as the process of deflecting a radicalizing individual away from violence through a full-scope application of community resources". Prominently, the *interdiction* pillar involves efforts to arrest and potentially prosecute unrepentant individuals *when other prevention efforts have failed.* The Minneapolis Framework is specifically focussed at countering radicalization within the Somali community. Majority of the initiatives, beyond the scope of primary and secondary interventions, are targeted towards at-risk population segments, and are aimed at "building better law enforcement and community engagement."

Another significant case study for the application of the 'public health' model to counter violent extremism and radicalization is *Denmark's* Aarhus Model. The program is admired for its success at stemming the outflow of individuals bound for Syria to 'fight' at the behest of Daesh. The program's coordinators involve teachers, social workers and youth clubs, who are trained to identify the early signs of radicalization. Admittedly, the goal of the program is not *"to persuade them* (potential beneficiaries) *to give up their religious conviction, but to help them balance that religious perspective with school, work, and family – with life. To be able to see questions from a different angle, to have a more … nuanced understanding. A broader horizon."*[38] Through such initiatives, the program functions to create trust between the authorities and the social circles identified at the risk of radicalization, and create opportunities for rehabilitation and reintegration.

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[37] *Challgren, Jonathan et al. Countering Violent Extremism: Applying The Public Health Model. 1st ed.Georgetown University, Center for Security Studies, National Security Critical Issues Task Force, 2016. Web.*

[38]Henley, Jon. *"How Do You Deradicalise Returning Isis Fighters?". the Guardian. N.p., 2014. Web.*

Some of the more vociferous suggestions which emerge through the analysis of multiple models speak converge to against, as stated earlier, taking a cookie-cutter approach to the phenomenon of radicalization and violent extremism. Contextualising trends assumes significance; a one-size-fits-all approach shall prove unsustainable and counterproductive over time. Also, none of these models/approaches are infallible. Challenges exist, perhaps abound. But so do the opportunities. An emphasis on the latter shall secure desired outcomes in the short and long term.

The possibility of coordinating India's counter/de-radicalization policy through the prism of the 'public health' approach requires detailed analysis given its immense and promising potential. The model's inherent flexibility and dynamism allows for the customisation of interventions in accordance with specific determinants and socio-cultural peculiarities, thereby enhancing its appeal in the Indian context. It goes without saying that the customisation process will have to factor in the local social and family traditions and influences to make the module workable.

Public health models derived from an epidemiological study of contributing situations highlight the susceptibility to violent rhetoric, of unimmunized populations coalesced within a broad sentiment pool which feeds on consensual support for dominant ideological meta-narratives. In identifying factors which cause the induction of individuals into violent ideologies during critical periods of progression, the approach seeks to enhance social inclusion and justice to the effect of neutralising the impact intended by divisive forces. Instead of confining itself to the "proximal 'here and now' of terrorist activities"[39], the epidemiological metaphor transcends towards the "long-term motivational, cognitive, and social/organizational processes" [40] which have a bearing on the likelihood of terrorism, and its relevance therefore to build a multi-sector and non-discriminatory model which involves relevant stakeholders at multiple levels, and creates space for the emergence of local, context-specific solutions, is immense and noteworthy.

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[39]*AW, Kruglanski et al. "What Should This Fight Be Called? Metaphors Of Counterterrorism And Their Implications.". Psychol Sci Public Interest. (2007): n. pag. Web.*
[40]*Ibid.*

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