

# Event report | Between Convictions and Psychiatric Labels: Beliefs, Polarisation and Mental Health in a Changing Europe

Wednesday 6 May 2026 | 11:00 - 11:40 AM CET

Webinar organised by EPHA & The University of Sheffield

## Background and context

At a time of severe polarisation, misinformation, and rapid social change, human beliefs do not emerge in a vacuum. Instead, they are deeply shaped by social identity and the wider socio-political climate, which frequently blurs the boundary line between shared collective convictions and clinical psychiatric presentations. Strongly held political convictions and severe clinical manifestations can look surprisingly similar; both systems of thought are highly resistant to change in the face of contradictory evidence and are intimately bound up with fear, identity, or an existential need to make sense of a confusing world.

To open a compassionate conversation about the complex grey area between these spaces, the European Public Health Alliance (EPHA) co-organised a 40-minute interview-style webinar linked to the IN-MIND project, a Horizon Europe Marie Skłodowska-Curie Action. The event brought together leading psychological researchers and public health experts to evaluate when an extreme political belief shifts into clinical pathology, how human groups form identity networks, and how evidence-driven psychological frameworks can guide real-world intervention strategies.

The session was moderated by Dr Jaisalmer de Frutos Lucas, Policy Manager at the European Public Health Alliance.

## Opening remarks

The webinar opened with words of welcome from Dr Jaisalmer de Frutos Lucas, who reintroduced the guest speakers and set the stage for an interactive session, preparing the audience to engage directly via the Wooclap platform. She emphasised that the

overarching goal of the webinar was to deepen our public health and policy frameworks regarding how different variations of strongly held beliefs relate to mental health within a rapidly changing European context.

## Expert presentations

Speakers Professor Richard Bentall and Dr Almudena Trucharte initiated the core discussion with a retrospective analysis of the 22 July 2011 Norway attacks carried out by Anders Behring Breivik, utilising his profile to illustrate the profound legal and medical debate regarding the border between mental illness and political extremism.

Breivik detonated a powerful homemade car bomb within the government quarter of Oslo, instantly killing 8 people and wounding 209, before travelling disguised as a police officer to a youth summer camp held by the Norwegian Labour Party on the island of Utøya. On the island, he carried out a mass shooting that killed 69 individuals and wounded 66 others. Prior to executing the attacks, Breivik circulated a 1,518-page online manifesto titled "2083: A European Declaration of Independence," which heavily recycled far-right conspiracy ideas, centred primarily on the "Great Replacement Theory". This is the belief that a secret cabal of European elites is deliberately conspiring to replace the white Christian population of Europe with black or dark-skinned populations from Africa and the Middle East. Following his arrest, Breivik was evaluated by two distinguished Norwegian psychiatrists who applied the Positive and Negative Syndrome Scale (PANSS) and concluded that his extreme, paranoid worldview was indicative of paranoid schizophrenia, which would render him legally non-culpable and steer him toward clinical care rather than prison. This evaluation provoked an immediate public uproar, intense media pushback, and a massive international debate among mental health professionals regarding whether his horrific acts were born of cold political extremism or clinical madness. Ultimately, the court found him legally sane and guilty, issuing the maximum possible sentence of 20 years under Norwegian law.

Key insights included:

- The legal, clinical, and medical challenge of cleanly separating extreme political convictions from severe psychiatric delusions remains an active international debate.

- Extremist manifestos frequently rely on copied-and-pasted material from broader online ecosystems, masking specific personal psychological profiles behind shared socio-political narratives.
- Standardised psychiatric interview procedures require extraordinary contextual and cultural sensitivity when applied to individuals operating within radicalised political movements.

## Pathological themes and the continuum of belief

Dr Trucharte then outlined the precise clinical definition of delusions, categorising them as pathological beliefs that are exceptionally difficult to alter and are completely unshared by other members of an individual's culture. She identified the five most common delusional themes observed in clinical practice, emphasising that while up to 60% of individuals experiencing severe psychosis or schizophrenia present with these themes, a significant minority (3% to 7%) of the general population also experiences them along a psychological continuum.

- **Persecution/Paranoia:** Driven by deep interpersonal anxiety and existential safety concerns ("Who can I trust?").
- **Grandiosity:** Centered on distorted social hierarchies and overinflated comparative worth ("How do I compare to others?").
- **Reference:** The fixed conviction that entirely random external occurrences carry targeted, highly personal significance ("Which events matter to me?").
- **Control:** The belief that one's personal thoughts, physical movements, or structural autonomy are being manipulated by outside forces ("Do I have autonomy?").
- **Religious:** Unwavering ideas regarding a unique cosmic role, spiritual duties, or a supreme destiny ("What is my life's purpose?").
- **The Continuum Principle:** Mild symptoms of suspicion, tracking eye contact, or assuming others are laughing occur routinely across the healthy general population; it is the frequency, severity, and resulting emotional distress that dictates when a belief crosses into pathology.

## The "Wrong Comparator Problem" and identity dynamics in human groups

Professor Bentall introduced the concept of the "Wrong Comparator Problem," asserting that psychiatrists have traditionally mischaracterised delusions by contrasting them with mundane, everyday beliefs (such as believing a train will arrive at a specific time). While mundane beliefs shift seamlessly when disproving evidence is introduced, clinical delusions remain completely rigid, highly emotionally salient, multi-propositional (comprising an interconnected network of complex ideas), and tightly bound to existential dilemmas. However, when delusions are contrasted against extreme political or religious ideologies, the structural differences vanish entirely.

- **The Transmissibility Divider:** The true distinguishing hallmark separating a clinical delusion from an extreme political conviction is transmissibility. Ideologies are co-produced by human groups and propagate across communities, whereas clinical delusions are fiercely idiosyncratic and held strictly by a single, socially isolated individual.
- **Imagined Communities:** Based on Benedict Anderson's theories of nationalism, human beings scale social groups far beyond basic animal interactions by forming vast abstract "imagined communities" (such as global religious groups or political parties) that link individuals who will never meet, providing structural psychological resilience.
- **Identity Fusion Profiles:** Human belief configurations can be mapped along an identity architecture:
  - **The Deluded Individual ("Only I"):** Experiences a total absence of a collective "We." They are locked entirely within their own minds, entirely alone in the world.
  - **The Healthy Individual ("I" and "We"):** Maintains multiple, flexible social identities, navigating smoothly between the personal self and various collective communities.
  - **The Extremist Individual ("Only We"):** Undergoes a severe phenomenon known as "identity fusion," where the boundary between the personal "I" and the collective "We" is erased, crushing personal autonomy and

cultivating group narcissism that drives extreme self-sacrifice or outward violence if the group is perceived as disrespected.

## Interactive audience exploration and evidence-driven intervention strategies

To demonstrate the structural parallels between these frameworks, the webinar conducted an interactive experiment via Woodclap, prompting audience members to evaluate 11 statements collected from both psychiatric cases and conspiracy/political sources (covering topics such as aircraft contrails, covert night-time surveillance, hidden government bases, and obscure historical facts). The extreme difficulty in immediately distinguishing clinical output from extremist political manifestos highlighted the need for nuanced psychological frameworks. The speakers concluded by addressing specific strategies for media figures, educators, and influencers tasked with communicating with individuals or radicalised youth holding deeply polarised convictions.

- **Avoid Adversarial Preaching:** Confronting an individual with a combative “you are wrong and I am right” stance immediately hardens extremist alignments and terminates open communication.
- **Acknowledge the Functional Need for Meaning:** No matter how bizarre or destructive an extreme belief appears, it represents the core cognitive framework that the individual has constructed to make sense of a threatening, confusing, or unstable world.
- **Deploy “Radical Love” and Grievance Empathy:** Interventions must utilise active listening and kindness to address an individual’s underlying personal anxieties or systemic grievances (such as severe social isolation) before attempting to dismantle the toxic political or ideological program attached to those anxieties.
- **De-escalate Threat Perceptions:** The primary goal of intervention should not be the forced imposition of absolute ideological uniformity, but rather the reduction of perceived external threats and the active restoration of multiple, flexible social identities.

## Key takeaways

- **Socio-Political Blurring:** The line between shared social convictions and clinical psychiatric labels is heavily blurred by modern socio-political polarisation and digital misinformation ecosystems.
- **The Wrong Comparator Problem:** Traditional clinical models fail by comparing delusions to mundane everyday beliefs; extreme beliefs mirror clinical delusions in rigidity, emotional salience, multi-propositional networking, and existential focus.
- **Transmissibility as the Boundary:** Transmissibility and collective group co-production serve as the foundational dividing line separating idiosyncratic clinical delusions from widely shared political extremism.
- **Isolation Drives Fusion:** Extreme social isolation acts as a massive driver for radicalisation, pushing vulnerable individuals toward “identity fusion” where a singular, absolute collective “We” completely overrides and replaces the personal “I”.
- **Empathetic Intervention Frameworks:** Successful de-escalation requires shifting away from adversarial debunking and preaching toward empathetic dialogue and “radical love” that addresses foundational human anxieties and structural grievances first.