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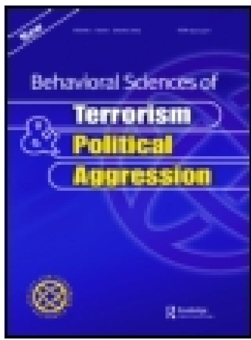

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"Between the self and the other": clinical presentation of male supremacy in violent extremists

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ABSTRACT

This paper examines the relationship between gender and violent extremism (VE) among individuals engaged in VE clinical services in Montreal, Quebec (Canada). We use mixed methods to understand the experiences and characteristics of individuals who express support for male supremacist ideologies. Study participants include 86 patients enrolled in VE clinical services and 7 clinical practitioners providing services. We conduct a retrospective chart review to identify clinical and sociodemographic characteristics of male supremacists. A focus group was conducted with members of the clinical team. Integrating quantitative and qualitative findings provides an opportunity to draw meta-inferences on male supremacist violent extremists, including a typology of the phenomena as well as clinical characteristics and social dynamics. Clinicians articulated that many of the harmful attitudes and beliefs of male supremacists were not marginal, but rather reflected in everyday forms of misogyny, homophobia, and transphobia that were activated by their personal experiences. Our findings suggest the importance of clinicians remaining attentive to the underlying gendered grievances which shape a range of extremist beliefs. Finally, we explore the value of training practitioners who work on VE on diverse domains of gendered violence which may intersect with VE participation.

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Gender; violent extremism; Quebec; Canada; clinical services; mixed methods

Introduction

During the past decade, a scholarship on violent extremism (VE) has seen a rapid growth of work which explicitly focuses on gender, alongside a growth of work on interventions for VE. While increasing attention has been paid to how gender shapes the ideology of

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violent extremists, their pathways into violent networks, and their actions, either solitary or within armed groups, and some early work on prevention, we know little about how clinicians perceive the role of gender. The rise of Incel-related attacks and attempts to embed gender-sensitive policy and programmatic responses to VE creates an opportune moment for comparison between the characteristics and clinical needs of those who support ideologies that explicitly center on male supremacy and those for whom the role of male supremacy, although potentially present, appears as rather invisible. This paper explores the perceptions of clinicians regarding the role of gender in shaping individuals who express affiliation with Incel and other primarily misogynistic ideologies in comparison to other extremists who are in their care, with the goal of identifying trends relevant to best practices in clinical interventions.

This mixed-method study uses quantitative and qualitative methods to understand the experiences and characteristics of individuals who express support for male supremacist ideologies as their main focus (male supremacy for short in this paper). By 'male supremacy' we mean an ideology which centers primarily on the sexual accessibility of women for cis men, as well as a cluster of related grievances identified by scholarship on Incel such as the dissolution of norms around premarital sex, decreasing expectations of women's monogamy, and women's increased sexual agency (Glace et al., 2021; O'Donnell & Shor, 2022). This is not to suggest that other forms of violent ideology don't also endorse male supremacy, or that controlling women's sexuality isn't a central goal, as Roose and Cook (2022) argue these tend to be common traits of a range of groups they categorize as Jihadist, Far Right, and Male Supremacist. Similar findings have been found by others such as the findings from Pruden et al. (2022) which show a high degree of convergence between manifestos they code as White Supremacist and Violent Male Supremacist. However, we believe the central focus on these factors by the participants who this study focuses on means that the terminology of male supremacy can serve as a shorthand to create distinction to other clusters.

Male supremacist ideology and VE

To understand the clinical presentation of male supremacy in violent extremists it is key to first outline the existing scholarship on the relationship between misogyny, male supremacy, and VE. While misogyny is a contested concept with scholarly debate on how it should be used, it can be understood as 'a political phenomenon whose purpose is to police and enforce women's subordination and to uphold male dominance' (Mann, 2017, p. 33). Misogyny is linked to VE in several ways ranging from normalizing hate speech to motivating terrorist attacks specifically targeting women (United Nations Development Programme, 2021). A particular concern in research scholarship has been the role of misogyny in fostering support for VE across the ideological spectrum, with groups ranging from Boko Haram to far-right groups focusing on messaging that center male supremacy for the purpose of attracting both men and women (Agius et al., 2022). Indeed, misogyny has been described as 'the extremist gateway' that connects the ideologies of otherwise disparate extremist groups (United Nations Development Programme, 2021). While attention to the link between misogyny and VE has increased over the past decade, the link is not new and there has been feminist scholarship trying to highlight this far earlier than work within terrorism studies or policy (Diaz & Valji, 2019; Gentry, 2022).

Related to this study, there have also been concerted efforts to link everyday forms of misogyny, mainstream violence against women, and VE that have often received little attention from mainstream terrorism scholarship until recently (Pain, 2014).

This scholarship can also result in difficulties drawing distinctions as it often highlights the close links between mundane forms of misogyny, such as catcalling or sexual harassment, and extreme forms of violence perpetrated by violent extremists. To address this, scholars like Nicholas and Agius (2018, p. 5) have tried to codify sets of particularly gendered ideology, such as masculinism which they define as 'an underlying ethos or totalizing worldview that implicitly universalizes and privileges the qualities of masculinity, and in doing so subordinates and 'others' alternative ways of understanding, knowing, and being.' Within the context of VE, many different groups reinforce hierarchical binaries and supremacism. For VE, Agius et al. (2022) argue that masculinism can act as a 'translation point' between broader misogynistic sociopolitical attitudes and more explicitly male supremacist ideologies like Incel.

Male supremacist ideologies can be distinguished from other violent extremist ideologies (which are often misogynistic, anti-feminist and contain direct messaging about how the gender order should be arranged) due to how they center the rearrangement of the gender order and control of women as *their primary goal* (DeCook & Kelly, 2021; Ging, 2019). Not all of those who endorse male supremacist ideology would be categorized as violent extremists (though they often endorse forms of gender-based violence which is deemphasized in terrorism studies) as Ging (2019, p. 644) argues the five main hubs of the male supremacist manosphere are 'men going their own way (MGTOW), pick up artists (PUAs)/game, traditional Christian conservatives (TradCons), and gamer/geek culture.' While few of these endorse the publicly violent tactics of Incel, all remain preoccupied with overthrowing the current gender order, placing women back in more resolutely subordinate positions in relation to men and punishing infractions on gendered behavior (Preston et al., 2021). Male supremacist ideology is often linked to broader trends of anti-gender ideology (which entails rejection of feminism, gendered analysis, and gender equality), but not all who espouse anti-gender ideology focus on the (sometimes violent) reassertion of a mythologized vision of patriarchy (Agius et al., 2022; Sosa, 2021; Zaremberg et al., 2021). What this means for those undertaking clinical interventions to VE is that it may be difficult to clearly distinguish between those who espouse misogynistic views due to participation in mainstream patriarchal culture, those who espouse misogynistic views due to support for one of the many VE ideologies that contains messaging about gender relations, and those who espouse misogynistic views because they subscribe to an explicitly male supremacist ideology.

Clinical interventions to address VE

To date, there is limited data to develop best practices for clinical programs that address VE (Brouillette-Alarie et al., 2022; Hassan et al., 2021; Rousseau et al., 2021). Recent systematic reviews of research on secondary and tertiary prevention and intervention initiatives found a lack of quality data and weak experimental research designs (Hassan et al., 2021). Other shortcomings include poorly defined program objectives and lack of clear logic models linking intervention components to outcomes (Brouillette-Alarie et al., 2022; Hassan et al., 2021). Notably, within international initiatives, there is an

overwhelming focus of studies on programs targeting Islamic extremism, and limited information on far-right, far-left, and single-issue (for example, misogyny) extremist intervention services (Brouillette-Alarie et al., 2022; Hassan et al., 2021).

There has been growing interest in understanding the relationship between mental disorders and VE and what role mental health practitioners should play in VE intervention. In a recent systematic review, Gill et al. (2021) found prevalence of mental disorders at 33.47% among violent extremists in studies where clinical examinations took place. Information on specific mental disorders is limited, with evidence for a diverse array of diagnoses including severe mental illnesses (for instance, schizophrenia), mood disorders (depression, anxiety), stress-related disorders, personality disorders, and attention deficit hyperactivity disorder (ADHD) (Gill et al., 2021). In an online survey of 272 Incels, Speckhard et al. (2021) observed that despite the high prevalence of depression, a majority of the subjects who had looked for professional help found it to be ineffective. A high prevalence of autism spectrum disorder (ASD) has also been reported in the literature (Faccini & Allely, 2017; Walter et al., 2021). In a narrative review on Incels, violence, and mental disorder, Broyd et al. (2022) suggest that the association between Inceldom and ASD may have important implications for practice, while acknowledging the lack of empirical data on effective interventions in this domain.

In Quebec, Canada, clinical services to address VE were developed in 2016 based on a provincial mandate (Gouvernement du Quebec, 2015). Services were launched in five regions of Quebec, including Montreal. The Montreal team works with radicalized individuals with a suspected or proven risk of extremist-related violence, families and significant others of radicalized individuals, and victims of extremism. This multi-disciplinary team is composed of psychiatrists, clinical psychologists, social workers, and a psychoeducator and attached to a mental health and primary care institution. Clinical expertise includes transcultural psychiatry, ASD, first episode psychosis, trauma, and multilevel interventions (individual, family, community) (Rousseau et al., 2022). The Quebec service model is structured around three pillars: (1) multiple access points to services to facilitate outreach and decrease stigma; (2) assessment and treatment based on existing best evidence in forensic, social, and cultural psychiatry; and (3) collaboration with other services to promote social integration and long-term management and follow-up (Rousseau et al., 2022). Extremist individuals are referred to the program primarily by community partners (schools, police, health services) and family members, and have a suspected or proven risk of violence (Rousseau et al., 2022). The Quebec clinical intervention model focuses on five broad treatment principles, including alleviating psychological distress, promoting family and social networks and support, addressing issues of identity and belonging, promoting a sense of purpose and positive future, and enhancing cognitive flexibility of patients (Rousseau et al., 2021). The majority of individuals are referred to services because of the mental health expertise and focus of the clinical team, resulting in prevalence of mental disorders among patients much higher than not just the general population, but of individuals engaged in other VE intervention programs (Rousseau et al., 2021; Rousseau et al., 2022).

Current study

This current study focuses on clinicians and patients delivering and receiving clinical VE services from this specialized team in Montreal, Quebec. Our central research question

is, what are the experiences and characteristics of individuals who express support for male supremacist ideologies? To answer this, the research explores the following quantitative questions from the perception of clinicians as documented in the medical charts of violent extremists engaged in services: (1) What are the sociodemographic characteristics, social experiences, and clinical characteristics, as identified by clinicians, for individuals with a male supremacist ideology; and (2) How do clinicians compare the characteristics of these individuals to those who don't center male supremacy in their professed ideology? Our qualitative research aim is to use thematic content analysis and narrative analysis to better understand how clinicians characterize male supremacist ideologies and dynamics of working with these individuals in a clinical setting. The qualitative questions this paper asks are: (1) How do clinicians understand male supremacist VE expressed and acted on by individuals engaged in services?; and (2) What social grievances and life experiences are associated with male supremacist individuals referred to a clinical team? Information on this subgroup of patients and clinician perspectives is informative and useful in its own right. In addition, we include a comparative component to explore potential trends and variations in VE patients for the purpose of developing clinical interventions and best practice guidelines. We should not assume that VE clinical interventions are a 'one size fits all' model; interventions may need to be tailored and adapted based on the kind of extremist ideologies of patients in order to be effective.

Materials and methods

Participants

Quantitative

Study participants are patients of specialized clinical services in Quebec (Canada) designed for working with individuals identified as violent extremists. The inclusion criterion is having received services from this team at some point between 1 January 2016 and 31 December 2021. A total of 86 individuals received services during this time period, and all were included in this study.

Qualitative

Study participants are practitioners and clinical supervisors in Montreal who provide services to individuals identified as violent extremists. The inclusion criterion is providing services at the time of qualitative data collection in March 2022. A total of seven individuals participated in the group, including three women and four men.

Procedures

The study was approved by the Psychosocial Research Ethics Committee (REC) of CIUSSS (Centre Integré Universitaire de Santé et de Services Sociaux) West-Central Montreal Research Ethics Board (REB).

Quantitative

A team of researchers and clinicians developed a quantitative assessment battery with domains related to sociodemographic characteristics, social integration/grievances, and

clinical characteristics of clients engaged in services. These domains and variables were chosen based on clinical expertise and relevance for research purposes. Data were extracted from paper medical charts and transferred into REDCap by two research assistants (RAs) using the following process (Harris et al., 2009). First, a research team member with experience in medical chart review extracted data from five charts. Next, the two RAs extracted data from the same charts, and results from all three were compared and assessed for alignment. Disagreements were discussed and resolved as a group. Next, RAs independently extracted data from the remaining charts. Research team members met regularly to review results and resolve questions that arose during the chart review process, including consultations with the clinical team.

Qualitative

A 90-minute focus group was held with members of the Montreal clinical team to explore their experience and perception of providing services to individuals presenting gender-based extremism. Recruitment was done on a voluntary basis and without incentive, creating a convenience sample of seven participants. The focus group was facilitated by the second author, and participant-observation was also carried out by the second and third authors. The focus group discussion guide covered the following themes: characteristics of male supremacist individuals, clinical presentation of male supremacy, links between male supremacy and life experiences and social grievances, clinical strategies and challenges, and the impact of clinical work on practitioners. A hybrid modality was used for the focus group. Eight individuals were brought together through a Zoom meeting: four participants connected from separate locations, and three participants and a researcher were gathered in a room and connected to the same Zoom meeting.

Integration

Integration of qualitative and quantitative data during the data collection process was achieved in two ways: expanding and matching (Fetters, 2019). Specific to expanding, qualitative interview questions were designed to provide more detailed information on clinical dynamics and expression of male supremacist VE, while quantitative data provide information on client sociodemographic characteristics and clinical diagnoses. In terms of matching, both qualitative and quantitative data are collected on the phenomenon of male supremacist VE for the potential for comparison.

Measures

Sociodemographic characteristics

Sociodemographic information includes age (continuous variable), sex (male or female), marital status (single, married/has partner, separated/widowed), and highest level of education (high school or lower, college, university). Additional information includes school enrollment (yes/no) and current employment (yes/no). Sources of referral is a categorical variable capturing pathways into clinical services, which including self-referral, friends/family, youth protection services, community organizations, security agencies, schools, and health services.

Clinical characteristics

Clinical information includes history of mental health care (yes/no), history of involvement in the criminal justice system (yes/no), and current substance abuse (yes/no). Psychiatric diagnosis is a categorical variable including ASD, intellectual disability, stress-related disorder, mood/anxiety disorder, psychotic disorder, personality disorder, ADHD, oppositional defiance disorder/conduct disorder, other, and not applicable. Number of psychiatric diagnoses is a categorical variable ranging from 0 to 4. For the purposes of analysis, number of psychiatric diagnoses was recoded as a binary variable (1 or less vs. 2 or more). To test our hypothesis, type of psychiatric diagnoses was recoded as a binary variable focused on ASD (yes/no).

Extremist ideology

Ideological categories include far-right, far-left, religious, male supremacist (including Incels), nationalism, conspiratorial, and non-ideological violence. Categories were chosen based on existing literature on categories of radical ideologies (Doosje et al., 2016), this current study's focus on male supremacy ideology, and the expertise of the clinical team. Individuals may align with one or more ideology; for instance, a person associated with the far-right can also support a male supremacist extremist ideology (Doosje et al., 2016). Number of types of extremism is a categorical variable (1–3). For the purposes of analysis, number of types of extremism was recoded as a binary variable (1 vs. 2 or more).

Social grievances

There are eight social grievances, each measured as a categorical variable (yes/no). These include past or current trauma experience, discrimination, harassment/bullying, break-up of a romantic relationship, social isolation, family grievances, work grievances, and school grievances.

Social integration

There are nine measures of social integration. Eight are measured as a categorical variable (yes/no). These are contact with family, romantic relationship, work integration, school integration, community involvement, involvement in sports, frequenting places of worship, and use of internet/social media. One variable, friendships, is measured as a categorical variable with three options – none, few, and many. For the purposes of analysis, this variable was recoded as a binary variable (none/few vs. many).

Data analysis

Quantitative

We use univariate statistics to present a descriptive epidemiology of individuals engaged in VE services. Mean and standard deviation are reported for continuous variables (age). Frequencies and proportions are reported for categorical variables. We use Fisher's exact test to assess differences between individuals with male supremacist extremist ideology and others enrolled in services. Given the number of tests performed, we use a Bonferroni correction with statistical significance of $p < .002$ (Armstrong, 2014).

Qualitative

The focus group was video recorded, transcribed verbatim, and analyzed following a rigorous, systematic approach based on principles of thematic content analysis and qualitative research scientific rigor (Boyatzis, 1998; Braun & Clarke, 2006; Creswell & Miller, 2000). First, the transcript was anonymized by assigning codes to participants and annotated to indicate when certain narratives provoked non-verbal reactions from other participants, indicating agreement or disagreement with the statements made. Second, the transcript was read multiple times to allow for a phenomenological immersion in the data along with inductive analytical notetaking. Third, the material was coded using NVivo by going back and forth between the transcript, a priori, and emerging codes. The final set of themes was reviewed by coauthors to check that themes accurately reflected the content. Finally, key themes and sub-themes were identified, and the content of the participants' discourses was compared in their dialectical tension to highlight convergences, complementarities, or divergences around these themes. The second author conducted this analytical process, and the results were collaboratively produced, refined, and interpreted among coauthors. To ensure the confidentiality of research participants, all information that could result in identifying a professional or a specific institution was slightly modified in the results section. Quotes were translated from French to English for publication purposes.

Mixed methods integration

Integration of quantitative and qualitative during the data analysis process was achieved via corroborating, enhancing, and merging (Fetters, 2019). In terms of corroboration, we assessed if findings from the qualitative and quantitative data confirmed/reinforced each other. Specific to enhancing, we identified ways and places where qualitative and quantitative findings diverged from each other or provided additional insight into the phenomenon of male supremacist extremism. Finally, we merged qualitative and quantitative data using joint displays to create meta-inferences.

Results

A total of 22 (25.6%) of individuals engaged in services had a male supremacist extremist ideology. Of these 22, a total of 9 (40.9%) also supported a far-right extremist ideology. All 22 were male, with 20 (90.9%) identifying as single. Half (50%) had a college or university degree, and over half (55.6%) were employed at some point while engaged in services (see Tables 1 and 2).

The prevalence of ASD was 63.6%, followed by mood/anxiety disorders at 50% (see Table 2). The majority of individuals were characterized as being socially isolated ($n = 16$, 72.7%), with social integration occurring primarily via contact with family members (90.9%) and through the use of online social media (90.9%) (see Table 4).

Compared to others, male supremacists were more likely to affiliate with two or more extremist ideologies ($p < .001$) (see Table 3). They were more likely to have a diagnosis of ASD ($p < .001$) than others in services. There were no differences between the two groups in terms of prevalence of social grievances or social integration, these being very high for both groups (see Table 4).

Table 1. Sociodemograhic characteristics of individuals enrolled in VE clinical services in Montreal, Quebec, 2016–2021 ($N = 86$).

	Male supremacist extremism ($n = 22$)	Other extremism ($n = 64$)	Total ($N = 86$)
Age			
Mean (SD)	26.1 (8.27)	25.0 (14.6)	25.3 (13.2)
Sex			
Male	22 (100%)	59 (92.2%)	81 (94.2%)
Female	0 (0%)	5 (7.8%)	5 (5.8%)
Marital status			
Single	20 (90.9%)	50 (78.1%)	70 (81.4%)
Married/In a relationship	0 (0%)	10 (15.6%)	10 (11.6%)
Separated/Widowed	2 (9.1%)	4 (6.3%)	6 (7.0%)
Currently in school			
Yes	9 (40.9%)	36 (56.3%)	45 (52.3%)
No	13 (59.1%)	28 (43.8%)	41 (47.7%)
Highest education			
High school or under	9 (40.9%)	33 (51.6%)	42 (48.8%)
College	5 (22.7%)	11 (17.2%)	16 (18.6%)
University	6 (27.3%)	9 (14.1%)	15 (17.4%)
Missing	2 (9.1%)	11 (17.2%)	13 (15.1%)
Currently employed			
Yes	10 (55.6%)	8 (25.0%)	18 (36.0%)
No	8 (44.4%)	24 (75.0%)	32 (64.0%)
Not applicable	4	32	36
Referral sources			
Self-referral	2 (9.1%)	11 (17.2%)	13 (15.1%)
Friends and family	4 (18.2%)	11 (17.2%)	15 (17.4%)
Youth protection services	0 (0.0%)	7 (10.9%)	7 (8.1%)
Community organization	2 (9.1%)	4 (6.3%)	6 (7.0%)
Security agencies	10 (45.5%)	13 (20.3%)	23 (26.7%)
School	3 (13.6%)	9 (14.1%)	12 (14.0%)
Health services	6 (27.3%)	19 (29.7%)	25 (29.1%)

Table 2. Clinical and VE characteristics of individuals enrolled in VE clinical services in Montreal, Quebec, 2016–2021 ($N = 86$).

	Male supremacist extremism ($n = 22$)	Other extremism ($n = 64$)	Total ($N = 86$)
History of mental health care			
Yes	17 (77.3%)	42 (65.6%)	59 (68.6%)
No	5 (22.7%)	22 (34.4%)	27 (31.4%)
Criminal offense history			
Yes	6 (27.3%)	14 (21.9%)	20 (23.3%)
No	16 (72.7%)	50 (78.1%)	66 (76.7%)
Substance abuse			
Yes	4 (18.2%)	15 (23.4%)	19 (22.1%)
No	18 (81.8%)	49 (76.6%)	67 (77.9%)
Number of extremist ideologies			
1	10 (45.5%)	57 (89.1%)	67 (77.9%)
2	6 (27.3%)	4 (6.3%)	10 (11.6%)
3	6 (27.3%)	3 (4.7%)	9 (10.5%)
Extremist ideologies			
Far-right	9 (40.9%)	18 (28.1%)	27 (31.4%)
Far-left	0 (0%)	3 (4.7%)	3 (3.5%)
Religious	5 (22.7%)	13 (20.3%)	18 (20.9%)
Gender	22 (100%)	0 (0%)	22 (25.6%)
Nationalism	1 (4.5%)	4 (6.3%)	5 (5.8%)
Conspirational	3 (13.6%)	8 (12.5%)	11 (12.8%)
Non-ideological violence	0 (0%)	28 (43.8%)	28 (32.6%)

(*Continued*)

Table 2. Continued.

	Male supremacist extremism ($n = 22$)	Other extremism ($n = 64$)	Total ($N = 86$)
Number of psychiatric diagnoses			
0	0 (0%)	2 (3.1%)	2 (2.3%)
1	6 (27.3%)	39 (60.9%)	45 (52.3%)
2	7 (31.8%)	18 (28.1%)	25 (29.1%)
3	8 (36.4%)	4 (6.3%)	12 (14.0%)
4	1 (4.5%)	1 (1.6%)	2 (2.3%)
Psychiatric diagnosis			
Autism spectrum disorder	14 (63.6%)	10 (16.1%)	24 (28.6%)
Intellectual deficiency	3 (13.6%)	2 (3.2%)	5 (6.0%)
Stress-related disorder	3 (13.6%)	27 (43.5%)	30 (35.7%)
Mood & anxiety disorder	11 (50.0%)	20 (32.3%)	31 (36.9%)
Psychotic disorder	3 (13.6%)	6 (9.7%)	9 (10.7%)
Personality disorder	4 (18.2%)	14 (22.6%)	18 (21.4%)
Attention deficit hyperactivity disorder	4 (18.2%)	5 (8.1%)	9 (10.7%)
Oppositional/conduct disorder	3 (13.6%)	4 (6.5%)	7 (8.3%)
Other	3 (13.6%)	3 (4.8%)	6 (7.1%)
Not applicable	0	2	2

Service providers articulated that, although not always central in clinical presentation, issues of gender identity and sexual orientation permeate their work. As one individual said,

> In this type of [clinical] work, there is a lot more thought given to gender issues than in other [clinical] work contexts. I think that the question arises from the moment of the arrival of the referral as to who would be a credible interlocutor [therapist] for this person who makes harsh comments whether it be anti-women, anti-immigrants, or anti something else.

Table 3. Mixed methods integration of findings on typology of male supremacist VE.

	Quantitative			Qualitative	Meta-inferences
Item	Male Supremacist VE n (%)	Other VE n (%)	Fisher's Exact test		
Identify with far-right VE	9 (40.9)	18 (28.1)	–	'There are those who are clearly associated with a group, like Incels […]. Then there are those who are more right-wing but make masculinist statements. […] Then you have a third group who are neither one nor the other, they can be a bit of religious radicalization, but mixed with a misogynistic discourse. It's a whole continuum. Then maybe there's a fourth group, which is people who use gender to express their distress. There you have more what we call gender diverse.'	Male supremacist VE is a ***multidimensional sociocultural marker.***
Identify with far-left VE	0 (0)	3 (4.7)	–		
Identify with religious VE	5 (22.7)	13 (20.3)	–		
Identify with nationalistic VE	1 (4.5)	4 (6.3)	–		
Identify with conspiratorial VE	3 (13.6)	8 (12.5)	–		
Identify with two or more extremist ideologies	12 (55.5)	7 (11)	.11 $p < .001$		

Table 4. Mixed methods integration of findings on male supremacist VE clinical characteristics and social dynamics.

Domain	Item	Quantitative			Qualitative	Meta-inferences
		Male supremacist VE n (%)	Other VE n (%)	Fisher's Exact test		
Clinical characteristics	Prior mental health treatment	17 (77.3)	42 (65.6)	1.76 $p = .43$	• Male supremacist VE as explanation for social rejection and exclusion among patients with ASD	Male supremacist VE can be understood as a strategy to enact '***protection of the self***' in relationship to personal identity distress and social exclusion and difficulties with intimacy.
	Two or more psychiatric diagnoses	16 (72.7)	23 (50.4)	.21 $p = .006$	• Male supremacist VE and belonging to an extremist group or identity as protection against external threats among patients with ASD	
	ASD diagnosis	14 (63.6)	10 (16.1)	9.12 $p < .001$*		
Social grievances	Trauma history	9 (40.9)	18 (28.1)	1.76 $p = .29$	• Patients with male supremacist VE report negative social experiences and lack of satisfaction related to romantic relationships and contentious family dynamics, particularly with women • Patients with male supremacist VE frequently express anxiety related to gender identity, sexual orientation, and/or sexual performance	Male supremacist VE exists and is expressed at an ***intersection of individual, relational, and sociopolitical distress***.
	Discrimination	3 (13.6)	13 (20.3)	.62 $p = .75$	• Male supremacist VE as manifestation of social polarization of gender in the current sociocultural and historical context	
	Harassment/ bullying	10 (45.5)	27 (42.2)	1.14 $p = .80$		
	Break-up of romantic relationship	6 (27.3)	13 (20.3)	1.46 $p = .56$		
	Social isolation	16 (72.7)	29 (45.3)	3.18 $p = .05$		
	Family grievances	18 (81.8)	38 (59.4)	3.04 $p = .07$		

(*Continued*)

Table 4. Continued.

Domain	Item	Quantitative: Male supremacist VE n (%)	Quantitative: Other VE n (%)	Quantitative: Fisher's Exact test	Qualitative	Meta-inferences
	Work grievances	6 (27.3)	5 (7.8)	4.33 $p = .03$		
	School grievances	6 (27.3)	26 (40.6)	.55 $p = .31$		
Social integration	Contact with family	20 (90.9)	57 (89.1)	1.23 $p = 1$		
	Romantic relationship	3 (13.6)	17 (28.1)	.41 $p = .25$		
	Work integration	8 (36.4)	6 (9.4)	5.38 $p = .006$		
	School integration	3 (13.6)	16 (25)	.48 $p = .38$		
	Community involvement	3 (13.6)	4 (6.3)	2.34 $p = .37$		
	Sports	3 (13.6)	4 (6.3)	2.34 $p = .37$		
	Worship	5 (22.7)	14 (21.9)	1.05 $p = 1$		
	Internet/social media	20 (90.9)	57 (89.1)	1.23 $p = 1$		
	Friendships	3 (13.6)	15 (23.4)	1.52 $p = .57$		

Participants talked about gender as a way to identify and define individuals and groups of individuals, at times with regards to the self and the in-group, and at times as a way to identify and target 'the other' who can become 'the enemy' in terms of a target of extremist beliefs and behaviors. A participant summarized this idea by saying, 'Between the self and the other, which is often split and at the heart of our work, when does gender define me and when does it define the other? […] When does it define the relationship with the therapist?'

Interestingly, the providers' reaction to the focus group opening question further illustrated this multidimensional and difficult-to-categorize aspect of gender-related VE. When participants were asked to talk about what distinguishes those who had been identified as following a 'gender-related' VE ideology from others, the question proved to be more complex than anticipated. Focus group participants had difficulty providing an answer and asked for clarification as to whom the term 'gender-related VE' includes. A participant then proposed the following categorization:

> There are those who are clearly associated with a group, like Incels […]. Then there are those who are more right-wing but make masculinist statements. […] Then you have a third group who are neither one nor the other, they can be a bit of religious radicalization, but mixed with a misogynistic discourse. It's a whole continuum. Then maybe there's a fourth group, which is people who use gender to express their distress. There you have more what we call gender diverse.

In this last group, clinicians explained that the gender identification was not driving the violence, but rather reflecting a feeling of global disarray and of not belonging to mainstream society.

Participants discussed male supremacist ideologies of clients including misogyny or anti-women extremism, Incels, homophobia, and anti-LGBTQ discourses and highlighted the high prevalence of far-right ideologies among this population, and to a lesser extent co-occurrence of religious extremism and far-left ideologies.

Characteristics of patients referred for 'gender-related' VE: individual differences and social grievances

According to the service providers, not being satisfied in an intimate relationship is a common trait among patients referred for 'gender-related' VE. A 'suffering related to intimacy' represents a central grievance, and many patients have experiences of rejection, failure, and disappointment in this domain, resulting in a wounded and vulnerable self-image and generating a great deal of anger and rage. Contentious family dynamics are also common, with anger towards women sometimes linked to anger towards 'the mother' or those who 'take care of you and thus prevent you from becoming independent and self-sufficient'. Many patients also have experiences of bullying and trauma. As one participant noted, 'Most of them have a lot of relational trauma problems'. Another stated about a client, 'He was bullied [about his physical appearance], he felt rejected, and that increased his anger in general'.

Male supremacist VE ideology was viewed as a strategy for explaining social rejection. One participant said, 'people in masculinist groups or in the Incel movements have a rigid explanatory model as of why they can't have relationships, so "it's not really my fault"'. Stereotypical views of gender roles and heterosexual relationships thus transform

being part of a couple into an almost impossible or unattainable goal, and become a means to explain difficulties in this domain as opposed to attributing them to personal failure. As one participant explained, patients may be thinking that 'It's better that it's impossible [being in a relationship] and that I'm enraged than to try to hurt myself again'.

Some patients, to explain social and relationship difficulties, harness male supremacist extremist beliefs; in other instances, these ideologies, by providing a rigid and unquestionable certainty in terms of gender definition and roles, can sometimes protect clients from their own gender identity-related questioning and relieve anxiety and distress related to sexual orientation or sexual performance, especially when they are not aligned with cultural expectations. Based on observations, a participant wondered whether the anxiety caused by a dread of being gay in a homophobic context could contribute to a defensive reaction expressed through the adoption of masculinist and anti-LGBTQ discourses. This is the case in particular for patients that are members of families or social groups where homosexuality is very taboo.

Participants also noted a link between male supremacist VE and autism. Providers observed that many of their patients who present with male supremacist VE are young men with autism who have experienced a lot of rejection. These individuals often 'have to explain why they have so much difficulty in their interpersonal relationships' and are very angry about it. Belonging to a group – whether it be Incels or the trans and non-binary communities for example – can alleviate a feeling of social alienation, for as one participant paraphrased,

> It's not because I'm autistic that I have difficulty relating to others, it's because I'm non-binary or because I don't fit the norm. [...] I feel different. And maybe I feel better with other people who, like me, feel different in other differences.

One individual also noted that when a patient says, 'I'm a masculinist', or 'I'm trans', they are not only talking about themselves but more so about a group they wish to join, maybe perceiving that group as a protection against actual threats, aggressions or rejections that they have experienced in the past.

With respect to sexuality, the role of pornography was discussed in terms of the fact that the consumption of this type of online content (especially violent pornography) can generate unrealistic expectations and a distortion of the reality of sexual intercourse in patients. Participants noted performance anxiety among some patients, linked to narcissism. It was reported that some patients make very raw and degrading sexual comments about women, even entertaining rape fantasies. However, some of these men are also very dependent on women in their real lives. Important to note is also that among some far-right misogynist and masculinist patients, a 'traditionalist view' of gender identities and relations is sometimes combined with an anti-pornography stance, arguing that 'pornography degrades the natural relationship that there should be between men and women' and that pornography might contribute to 'prevent white males from reproducing'.

Male supremacist VE in sociocultural and historical context

Interestingly, participants framed and understood gender-related VE within a broader sociocultural, political, and historical context in which gender is an increasingly contentious construct. Participants highlighted that we are living in a time of rapid changes in

representations and experiences related to gender identities and sexual orientations, particularly among young people. As noted by participants, not only are representations rapidly changing, but they also tend to be increasingly polarized 'particularly among youth on the Internet', and concentrate around the extremes of the right-wing and left-wing political spectrum. This polarization not only makes it difficult to adopt more nuanced and 'centralized' ideological positions related to gender, but also runs the risk of 'fueling the troops' on both sides and being harnessed by radical groups for online recruitment purposes. As one individual said,

> We are in an era of very polarized discourses about gender. So, it's as if we are pushed to adhere to very [extreme positions]. [...] The extreme right proposes very rigid models with a clearly delineated distribution of power and where men would be the poor victims, or on the contrary a vision called woke, for lack of a better term, and of social constructionism that prevents the questioning of certain positions.

The persisting presence of misogyny and heteronormativity in the social space was also highlighted, including the significant increase in feminicides in recent years. Participants noted a potential tension between misogyny and what they termed 'traditional' views of gender in that some patients do not perceive themselves as misogynistic but have very stereotypical discourses about women. A traditionalist and essentialist perspective on gender, with clear and predictable social and relational roles – e.g. victim, aggressor, protector – can have a very reassuring effect for some people. As one participant mentioned,

> I think [this patient] doesn't consider himself misogynistic. He has a very essentialized idea of women who would be confined to the domestic domain, so a very traditionalist narrative, and it's as if with this discourse, he is trying to reassure himself that the world could be predictable like that.

Discussion

We found an association between male supremacist extremist ideology and patient identification with other extremist ideologies, such as the far-right, as well as an association with a diagnosis of ASD. The 'co-occurrence' of male supremacist extremist ideology with other extremist ideologies is not surprising, and supports the body of research that has explored this dynamic among religious extremism and far-right ideologies in particular (Pearson, 2020; Pearson et al., 2021). This however does lend further evidence to the claim within existing scholarship that addressing other forms of extremist ideology may require more direct attention to male supremacist extremist ideology even when it is not interpreted as the 'primary' grievance. The lack of association between male supremacist extremist ideology and engagement in, and grievances related to, romantic relationships may be somewhat surprising, especially given the focus of these issues among some male supremacist groups, such as Incels (Collins, 2019; Palma, 2019). Although Incels have been on the forefront of media and policy makers attention, these results suggest that their predicament (absence of romantic and sexual relations), represents only a part of male supremacist VE, and that attention should also be given to the less dramatic form of misogyny associated with alt-right and anti-system ideologies. However, these findings may also be understood by the fact that social grievances and social isolation, including those focused on romantic relationships,

is a pervasive issue among individuals involved with VE, regardless of ideology (Miconi et al., 2022).

Specific to our findings regarding the association between a diagnosis of ASD and male supremacist extremist ideology, we urge caution in interpretation of these results and stigmatization of individuals with ASD. Overrepresentation of ASD diagnoses in clinical services more broadly and within this subgroup more specifically may be an artifact of the increased likelihood of individuals with ASD to be referred to, and accept engagement in, services as opposed to an increased likelihood of individuals with ASD to be involved with VE (Chown et al., 2018; Faccini & Allely, 2017; Speckhard & Ellenberg, 2022). This finding however emphasizes the need to pay attention to individuals with autism related to difficulties associated with establishing intimate relationships, and to provide support in those areas. If individuals with ASD could be more vulnerable to recruitment by extremist groups and forums (Broyd et al., 2022), considering them an at risk group may further isolate and stigmatize them if an adapted intervention is not proposed. The clinicians of the Montreal team reported being successful at engaging over the short and medium term this clientele, which is promising. But more research is needed to see if these gains are maintained over time, and to determine what are the key elements of a successful intervention.

Qualitative study findings provide insight into the expression of, and actions related to, gender-related VE. Service providers identify a typology of male supremacist VE that includes those who affiliate with a single-issue group, as well as those with masculinist and misogynistic beliefs intertwined with other extremist ideologies. Specific to social grievances and life experiences, providers articulated gender-related VE acting as both an explanation for social exclusion among individuals, as well as protection against external threats. Patients with male supremacist VE were also characterized as experiencing problematic romantic and familial relationships, and, at times, experiencing anxiety related to gender identity and sexuality. Findings related to an anti-pornography stance of patients fit within broader trends contesting the role of pornography and masturbation in shaping contemporary masculinity from far-right figures in the manosphere whereby self-pleasure has been seen as a failure of self-governance and control (Hartmann, 2021).

Integrating quantitative and qualitative findings provides an opportunity to draw meta-inferences on the phenomena of male supremacist VE. In terms of typology, male supremacist VE is a multidimensional sociocultural marker. It can be defined categorically in terms of an issue relevant to VE, either as a ‘single-issue’ form of VE, such as identification as an Incel, or co-occurring with other extremist ideologies. A second dimension pertains to sociopolitical beliefs and worldviews related to gender and power, captured by concepts such as misogyny, masculinism, and anti-gender. A third dimension focuses on male supremacist VE as a behavioral response to distress (see Table 3).

There are two meta-inferences related to clinical characteristics and social dynamics relevant to male supremacist VE. First, male supremacist VE can be understood as a strategy to enact ‘protection of the self’ in relationship to personal identity distress and social exclusion and difficulties with intimacy. Although patients with male supremacist VE may not differ quantitatively from those affiliated with other extremist ideologies in terms of social grievances, dynamics related to intimate relationships in

particular may have different meaning for this group. Second, male supremacist VE exists and is expressed at an intersection of individual, relational, and sociopolitical distress. A polarized sociopolitical context in regards to gender identity and expression may fuel individual-level anxiety related to these constructs. This individual-level distress may lead to and exacerbate contentious and unsatisfactory social relationships that center around gender dynamics, and vice versa. Additionally, gender stereotypes may pave the way for representations and or fantasies of regaining power in the intimate sphere for those individuals who feel disempowered or without a voice (see Table 4).

Study limitations

Our quantitative findings are based on cross-sectional data obtained from a retrospective chart review. As such, we cannot make causal claims regarding the relationship between study variables. Furthermore, the relatively small sample size means that we do not have the statistical power to detect relationships between study variables that may in fact be important. Relying on chart review also has shortcomings in that it does not include data based on self-report of patients engaged in services. Additionally, charts are completed and maintained by different practitioners who themselves vary in gendered perceptions and biases regarding their patients. Shortcomings specific to the qualitative data include findings were limited to one focus group conducted with a single team of service providers. Finally, caution is needed regarding the generalizability of study findings to other settings and patient populations. Dynamics related to VE are very context specific, and our findings must be situated and understood within the sociocultural setting of Quebec and Canada. Additionally, the study population is unique and biased in that almost all individuals referred to services have a psychiatric diagnosis; this may not be representative of the larger group of individuals engaged in VE intervention services.

Implications for secondary and tertiary VE intervention

Despite these limitations, our findings have implications for VE interventions. Thoughtfulness is required when considering implications for secondary and tertiary prevention services. Practice recommendations related to working with individuals with a male supremacist ideology can be problematic (Jones et al., 2020; Van Brunt & Taylor, 2020). As DeCook and Kelly (2021) write, suggesting that clinicians are in a position to 'treat' ideology is not only misguided, but also harmful in that it pathologizes and exceptionalizes gender-related hatred as a problem of particular individuals, as opposed to a symptom of larger systemic social issues that need to be addressed. The observation of study participants regarding the larger context of polarization around gender issues that foster male supremacist extremism supports this view.

Clinicians can reduce the risk of violence among individuals engaged in services by paying close attention to diverse forms of gender-related extremist beliefs, addressing the underlying grievances and minimizing the associated distress and despair. Practically, this means that beyond taking engagement with male supremacist (Incels or others) seriously, it is important to elicit and understand patient representations of gender relations and relational implications in familial and intimate settings to protect the welfare of women.

Homophobic utterances and hostility toward gender diverse individuals and groups are also significant, as patients often express that these groups represent a threat to the masculinity of an individual or group, increasing the risk that they become a potential target of hate discourses or attacks. In each of these instances, our findings indicate that responses consider the structural contexts in which gender-related extremist beliefs emerge. While the participants certainly expressed ideas or supported practices that are outside of the mainstream, many of the aspects they wished to address are reflected in everyday forms of misogyny, homophobia, and transphobia (True & Eddyono, 2021).

Our results suggest that models for training practitioners in the field of VE should include a variety of violence domains (extremist, gang related, and others) and the evolution of misogynistic representations in the social realm and appropriation by specific extremist online and offline groups. Beyond training, partnering with gender-based violence intervention programs and service providers is warranted given their expertise in misogynistic, masculinist, and anti-gender beliefs and behaviors (DeCook & Kelly, 2021). Findings also indicate the importance of having specialized clinical teams that work with this patient population. More mainstream mental health services tend to focus on working with victims of gender-based violence perpetrated by violent extremists; the identified aggressor is instead more frequently handled by security and justice systems. In the case of violent extremists who have a mental health diagnosis, this approach may increase despair and risk of perpetrating violence if distress is not addressed. Specialized clinical teams may play a role in augmenting and supporting primary care services that are often reluctant to engage those individuals in services.

Conclusion

Our findings indicate that consideration of male supremacist ideology in clinical work with violent extremists requires a nuanced lens. Violence risk reduction includes exploration, identification, and awareness of anti-female, homophobic, and anti-gender diverse sentiment among patients engaged in services. In the era of equity, diversity and inclusion policies, and of sensitivity to sexual violence, practitioners may be reluctant to engage with this clientele. Training and supporting clinicians to move beyond a moral condemnation of these attitudes and beliefs to address the distress of patients is urgently needed, but not easy. A cross-disciplinary effort that integrates knowledge and expertise from the fields of mental health, violence prevention, security, justice systems, and the social sciences is warranted to adequately respond to and prevent acts of gender-related VE.

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