

Anders Breivik: Extreme Beliefs Mistaken for Psychosis

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The case of Anders Breivik, who committed mass murder in Norway in 2011, stirred controversy among forensic mental health experts. His bizarrely composed compendium and references to himself as the “Knights Templar” raised concerns that he had a psychotic mental illness. Beliefs such as Mr. Breivik’s that precede odd, unusual, or extremely violent behavior present a unique challenge to the forensic evaluator, who sometimes struggles to understand those beliefs. Psychotic disorder frequently is invoked to characterize odd, unusual, or extreme beliefs, with a classification that has evolved over time. However, the important concept of overvalued idea, largely ignored in American psychiatry, may better characterize these beliefs in some cases. We discuss the definitions of delusion and overvalued ideas in the context of Anders Breivik’s rigidly held extreme beliefs. We also review the British definition of overvalued idea and discuss McHugh’s construct, to introduce the term “extreme overvalued belief” as an aid in sharpening the forensic evaluator’s conceptualization of these and similar beliefs.

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The 2011 case of Anders Breivik, the man responsible for the bombing and shooting deaths of 77 mostly young people in and near Oslo, Norway, rekindled the controversy of how forensic psychiatrists evaluate violent criminal behavior.^{1–5} The first team of forensic evaluators (Team One) issued a diagnosis of paranoid schizophrenia and opined that Mr. Breivik was legally insane. Their opinion reverberated negatively throughout Norway, such that the Oslo district court then appointed a second pair of psychiatrists to evaluate Mr. Breivik. This second team (Team Two) found him to be nonpsychotic and held that he was sane at the time of his crimes.^{1,4,5}

In this case, both teams of psychiatrists agreed that Mr. Breivik did not have grossly disorganized behavior, hallucinations, a natural history consistent with a severe mental disorder, or a serious cognitive impairment affecting his daily life.^{4–6} Further, a media account of the trial revealed that Mr. Breivik defended

his behavior and clearly relished being the center of what he believed was a political opportunity to further his agenda.⁷ Absent other evidence, it then appears that the nature of his beliefs, most of which were mass distributed by e-mail just hours before his attacks, is the major basis on which this distinction was made.^{1,4,5}

For this discussion, we first looked briefly at Mr. Breivik’s beliefs as he shared them with others just before he committed his crimes. We then reviewed the historical context of the term “psychosis” to help understand and better define the scope of psychotic disorder as it is used in modern forensic evaluations. As part of our consideration of psychosis, we also considered the American and British notions of delusion. We looked at the concept of an overvalued idea. We now propose a new term, “extreme overvalued belief,” for future consideration in cases such as Breivik’s.

We acknowledge that there are ethics-related challenges regarding the controversial Goldwater rule, proclaiming that it is unethical for a psychiatrist to offer a professional opinion about an individual’s mental condition unless that psychiatrist has conducted an examination of the individual and has been granted proper authorization (§ 7.3 of the

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American Psychiatric Association's Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry).⁸ However, given the large volume of information that is publically available about Mr. Breivik, including data from some of the professionals who examined him, and considering the professional and social interests that may be served by an analysis of his case and discussion of new perspectives on forensic assessment in cases such as his, we believe we are within the boundaries of ethics.¹

Mr. Breivik's Beliefs

On July 22, 2011 hours before the attacks, Mr. Breivik e-mailed a 1500-page compendium to several thousand people. Entitled "2083: A European Declaration of Independence," the compendium opposed multiculturalism, Marxism, and the Norwegian Labor Party. Mr. Breivik wrote that he was a "savior of Christianity" and claimed that he was part of an order called the "Knights Templar."^{4,5} Ensuing investigations by Norwegian and other international law enforcement agencies found no convincing evidence that the Knights Templar, a medieval order that was disbanded centuries ago, was in existence in 2011.^{1,4,5}

Although Mr. Breivik created his compendium over several years, there is general agreement that he copied large sections from other sources, such as the manifesto of the Unabomber (Theodore John "Ted" Kaczynski). In addition, he has been reported to have included some of the espoused ideas of Karl Marx, Tony Blair, Osama bin Laden, and George W. Bush. Further, he selectively altered single words and phrases in some of the copied passages.^{1,4}

Recall that both teams of evaluators assessed Mr. Breivik as having no gross disorganization or auditory hallucinations. However, they agreed that he had pathological grandiosity. Team One opined that the ramblings in his online manifesto represented neologisms and disorganized thoughts. Team Two believed that his so-called ramblings actually were copied and then carefully edited by him to emphasize his extremist views. Team One also pointed out that he had shown symptoms of social withdrawal before the attacks, which they interpreted to be negative symptoms of schizophrenia. However, Team Two regarded his behavior as surreptitious planning for the attacks. The evaluation teams also offered differing interpretations of Mr. Breivik's espoused beliefs

regarding the Knights Templars and his duty as a "foot soldier."^{1,4,5}

Team Two attributed Mr. Breivik's grandiosity to a severe narcissistic personality disorder combined with *pseudologia fantastica* (compulsive or pathological lying). They opined that he was not psychotic during their interviews, during the six months of observation, or at the time of his crimes, thus making him ineligible for a finding of criminal nonresponsibility under Norwegian law.^{1,4,5} The court ultimately concurred with Team Two's opinion,⁴ referencing Chapter 3, § 44, of the General Civil Penal Code of Norway, which states:

A person who was psychotic or unconscious at the time of committing the act shall not be liable to a penalty. The same applies to a person who at the time of committing the act was mentally retarded to a high degree [Ref. 6].

As the *Breivik* case suggests, current clinical guides may inadequately equip modern forensic psychiatrists to agree with sufficient reliability upon what constitutes delusions versus nondelusions. Classifying disorders only by symptoms and examiner interpretations of observable behaviors may account for some of this discrepancy. A different approach to understanding Mr. Breivik's beliefs may have simplified matters at the outset. Dietz discusses the use of his threshold for finding psychosis: "I draw a crisp line between psychotic mental illness and other disorders such as pedophilia or anti-social personality disorder" (Ref. 9). The challenge is to provide new contours for this line.

Therefore, we proceed to offer what we believe will allow for a crisper line to be drawn by discussing some of the kinds of extreme, odd, or unusual beliefs encountered in psychiatry. We then suggest a method by which forensic psychiatrists might more thoughtfully tease apart beliefs that generate odd or extreme violent behavior. We begin by looking at the kinds of beliefs associated with what are currently recognized to be the most severe mental illnesses, the psychoses.

Odd, Unusual, or Extreme Beliefs

Psychosis

The term psychosis has historically encompassed a confusing array of interchangeable constructs such as narcissistic neuroses, psychoses, dementia praecox, and schizophrenia. For example, Waelder¹⁰ considered a narcissistic personality to be a muted variant of

schizophrenia. Regardless, delusions are one of the fundamental characteristics of the psychotic mental illnesses.¹¹

In the last half of the 20th and into the 21st century, the Diagnostic and Statistical Manual of Mental Disorders (DSM) arguably began to place psychotic illnesses along a spectrum of disturbances. First published in 1952, DSM-I¹² featured descriptions of disorders referred to as reactions. This term offered the psychobiological view that mental disorders represent reactions of the personality to psychological, social, and biological factors. Among these reactions, the DSM included psychotic disorders characterized by fundamental disturbances in reality, relationships, and concept formations, with affective, behavioral, and intellectual disturbances of varying degrees and mixtures. DSM II,¹³ essentially extended the work of the original DSM.^{14,15}

Subsequently, a group of psychiatrists at Washington University in St. Louis began deriving more objective criteria based on descriptive and epidemiological considerations. In 1967, at the urging of then-resident John Feighner, the group began meeting with the initial goal of writing a review of prior contributions to psychiatric diagnosis. In their meetings over the next year, the task soon shifted to the development of a set of new diagnostic criteria. Their work, then, gave rise to DSM-III.¹⁶ DSM-IV and DSM-IV-TR^{17,18} essentially continued to use similar criteria, but added more diagnoses and further emphasized familial and other causes of or contributions to the major mental disorders.^{14,15}

The chapter, "Schizophrenia and other Psychotic Disorders," in DSM-5¹⁵ includes abnormalities in one or more of the following domains: delusions, hallucinations, disorganized thinking (speech), grossly disorganized or abnormal motor behavior (including catatonia), and negative symptoms. DSM-5 further organizes the psychotic disorders along a spectrum: schizotypal (personality) disorder, delusional disorder, brief psychotic disorder, schizophreniform disorder, schizophrenia, and schizoaffective disorder. This spectrum continues to classify these disorders by symptom- and sign-based criteria, not the underlying putative causes. (As used in Norway, the International Classification of Diseases and Related Health Problems (ICD)-10 has a similar section on psychotic disorders).¹⁵ Thought disorder has also been described as an important topic in severe psychopathology. Blatt and Auerback¹⁹ differenti-

ated three major types of thought disorder according to degrees of boundary disturbance and demonstrated that the types form a continuum of severity. For example, patients with borderline personality disorder often have cognitive distortions and an unstable affect, and they may alternate between idealizing and then devaluing others.

While not specifically intended for forensic use, the DSM and ICD are regularly used to describe conditions seen in civil and criminal forensic psychiatric cases,¹⁵ including Mr. Breivik's. Eastman²⁰ pointed out that the two traditions of law and psychiatry combine with differing models of the mind to determine essential disjunctions when the disciplines are drawn into an apparently common purpose. We believe that psychotic spectra, which may be helpful in clinical settings to make a differential diagnosis, may unintentionally contribute to confusion for the forensic psychiatric examiner, and, ultimately, for the legal system.

The psychotic spectrum of disorders also does not yet have rigorous scientific data supporting a definitive line between schizophrenia and some types of personality disorders. Schizophrenia is a neurodegenerative disease with a growing body of genetic, biochemical, and anatomic marker research.^{21,22} However, putative endophenotypes do not necessarily reflect genetic origin, as these biological markers may be environmental, epigenetic, or multifactorial in origin.^{23,24} For example, people with schizotypal personality disorder share phenomenological, genetic, and cognitive abnormalities with people who have chronic schizophrenia.²⁴ Temporal volume reductions appear to be common to both groups, although there may be a preservation of frontal lobe volume in schizotypal personality disorder compared with schizophrenia.²⁵ Psychosis may also result from a brain injury, a metabolic condition, anabolic steroids (Mr. Breivik reportedly had used these¹), or an infectious disease.^{11,15} Therefore, the current nosology of a spectrum of psychotic disorders leaves open the possibility for rigidly held non-delusional beliefs to be regarded as evidence of psychosis, as opposed to extreme beliefs, as seen in some personality disorders.

Obsessions

Obsessions consist of unwanted (once called *ego alien*) intrusive thoughts, which the person himself recognizes as odd, unusual, or extreme, and which he

actively resists. For example, such thoughts may lead the afflicted individual to go out of his way to resist recurrent thoughts of killing others. Although their thoughts may appear odd, unusual or extreme to some observers, those persons who have obsessions typically do not present a threat to others.²⁶

Political, Cultural, Religious, and Spiritual Beliefs

Although not to be equated one with the other, politics, culture, religion, and spirituality are some of the important ways in which many people organize their understanding of the world. Each forms a configuration of ideology, ritual, and practice that profoundly affects the way lives are led and experienced.²⁷ In addition, some people feel so strongly about their associated beliefs that they are moved to take extreme actions based at least in part on their beliefs. In most cases, it can be relatively straightforward to make a distinction between psychotic phenomena and political, cultural, religious, and spiritual beliefs, but sometimes making such a distinction can be quite challenging. We believe this occurred in the *Breivik* case.

Parker²⁸ reviewed the literature, case law, and information obtained from both the Southern Poverty Law Center and the Anti-Defamation League to trace the origins and history of “sovereign citizens.” Its followers believe that the existing government in the United States is illegitimate, and they seek a minimalist government. Sovereign citizens wage war against the government and those in authority by using harassment, refusal to pay taxes, and intimidation tactics, and they occasionally resort to violence. Parker explains that so-called sovereign citizens “present with a variety of idiosyncratic legal theories and political beliefs that may appear delusional” (Ref. 2828, p 346). He then discussed this somewhat heterogeneous population as persons who vehemently hold extreme beliefs, but the “beliefs are shared by a large group of adherents, so they are best understood as an extremist political philosophy and not as a psychotic belief system” (Ref. 2828, p 346). He went on to advocate that a useful framework for evaluating such defendants is to view the evaluation in cross-cultural terms. We believe such an interpretation applies, by extension, to the case of Mr. Breivik.

Further, with respect to religious beliefs, Sims²⁹ has put forth a practical guide, in which psychiatric

morbidity of those religious beliefs would be suggested by the following:

Both the subjective experience and the observed behavior conform to psychiatric symptoms—i.e., the self-description of this particular experience is recognizable as being the symptomatology of a known psychiatric illness (for example, it has the form of a delusion)

There are other recognizable symptoms of mental illness in other areas of life, such as other delusions, hallucinations, mood disturbances, thought disorders, and so on.

The lifestyle, behavior, and direction of the personal goals of the individual subsequent to the event or religious experience are consistent with the natural history of a mental disorder rather than with a personally enriching life experience.

The personality is disordered when assessed on evidence other than the manifestation of religious behavior²⁹.

We believe that Sims’ guidelines also could be applied to assessing the potential of psychopathology with other extreme beliefs, such as those espoused by Mr. Breivik. However, we also would underscore that related functional impairment preceding and unrelated to the act itself must be present in a manner consistent with Sims’ criteria but well before the commission of the act. The use of a narrative to formulate forensic cases builds on McHugh and Slavney’s idea that mental disorders can arise from biological insult, dimensional attributes, maladaptive behaviors and the patient’s own life story.¹¹

Drawing a Crisper Line

Mr. Breivik’s rigidly espoused beliefs were ultimately thought to be the source of his extreme violence. Similar rigidly espoused beliefs resulting in violence have been seen in Islamic, antiabortionist, and proenvironmental terrorism. The violence committed by Timothy McVeigh and Terry Nichols, whose homemade fertilizer bomb blew up the Murrah Federal Building in Oklahoma City, is another example. In 2012, FBI Director Robert Mueller stated: “Over the past few years, we have seen increased activity among extremist individuals. These individuals have no typical profile; their experiences and motives are often distinct. But they are increas-

ingly savvy and willing to act alone, which makes them difficult to find and to stop” (Ref. 30). With the increasing prevalence of such violent behavior, a better understanding and definition of nondelusional but rigidly held beliefs is critical. In the next section, we reintroduce and then expand upon the notion of “overvalued idea,” first used over a century ago, which we believe can help forensic psychiatrists to draw a sharper line.

Overvalued Idea

Carl Wernicke (1848–1905) was a German neuropsychiatrist who is best known for his work with discrete brain lesions that cause aphasias. He was honored by having syndromes named after him, such as Wernicke’s (receptive) aphasia and Wernicke-Korsakoff syndrome. He also tried to identify many different clinical psychiatric concepts by using his patients as examples. He proposed the concept of *überwertige Idee* (overvalued idea) in 1900.³¹ This term is mentioned only in passing in British textbooks and is largely ignored by American psychiatrists.³²

Veale³² has extensively reviewed the various historical definitions of an overvalued idea, which he points out have evolved over time and are not universally accepted. The DSM-5 definition states that it is “an unreasonable and sustained belief that is maintained with less than delusional intensity (i. e., the person is able to acknowledge the possibility that the belief may not be true). The belief is not one that is ordinarily accepted by the other members of the person’s culture or subculture” (Ref. 15, p 826). The British definitions are quite different. The *Oxford Textbook of Psychiatry* states that it is “an isolated, preoccupying belief neither delusional, nor obsessional in nature, which comes to dominate a person’s life for years and may affect his actions” (Ref. 33, p 267). McKenna, at Cambridge, stated that it is a preoccupying abnormal belief which often appears following a key event and which comes to single-mindedly preoccupy an individual, often indefinitely.³⁴ Sims,²⁹ in London, wrote that an overvalued idea is a solitary, abnormal belief that is neither delusional nor obsessional in nature, but which is preoccupying to the extent of dominating the sufferer’s life. It is usually associated with abnormal personality. A highly abnormal religious belief could sometimes be regarded as an overvalued idea. For example, an individual repeatedly desecrated

churches because he believed they displayed images of which he disapproved.²⁹

In the wake of the 9/11 terrorist attacks, McHugh at Johns Hopkins used Wernicke’s concept of overvalued idea to describe the ideology behind the attacks:

An overvalued idea differs from an obsession in that, although it dominates the mind as an obsession does, the subject does not fight an overvalued idea but instead relishes, amplifies, and defends it. Indeed, the idea fulminates in the mind of the subject, growing more dominant over time, more refined, and more resistant to challenge [Ref. 35, p 243].

This description appears to be an accurate portrayal of the right-wing, anti-Muslim extremist views of Mr. Breivik, who boastfully asserted that he was a knight dedicated to stemming the tide of Muslim immigration into Europe.^{1,4,5} Overvalued ideas are also described in literature pertaining to anorexia nervosa, where the desire to be slim is the result of beliefs that are shared by others in society (that slimness is desirable). However, these individuals have extreme beliefs that fulminate and dominate their minds to the point of starvation.^{31,32} In addition, overrideational, obsessive-compulsive, and paranoid features have long been described in severe pathological personality disorders.^{15,19}

Taken in historical context, overvalued ideas may be seen as paving the way for something “good” or just. For example, the founders of the United States are among the most proudly celebrated people in America. However, at least some of the founders arguably broke the English law of high treason. Assuming current legal standards, were George Washington or Thomas Jefferson charged with treason today, they probably would be found competent and criminally responsible. Similarly, the abolitionist John Brown and the prohibitionist Carrie A. Nation used unconventional and often violent means to further their respective causes.

By contrast, on a much darker side, Adolf Hitler wiped out millions of Jews. Islamic extremists such as Osama bin Laden have recruited terrorists to carry out violent plots. Mr. Breivik, referring to Mr. bin Laden in his own compendium, hoped to inspire his readers to become knights who would carry out independent operations with the help of the detailed information he provided about acquiring weapons, body armor, poisons for hollow bullets, and preparation of explosive charge.¹ Durkheim, describing his concept of collective conscience stated that we must

not say that an action shocks the common conscience because it is criminal, but rather that it is criminal because it shocks the common conscience. We do not reprove it because it is a crime, but it is a crime because we reprove it.³⁶

Psychiatrists have sometimes referred to people who espouse overvalued ideas as fanatics.^{35,37} Winston Churchill³⁸ stated “A fanatic is one who can’t change his mind and won’t change the subject.” According to most definitions, the overvalued idea is solitary; it is not accompanied by delusions of reference, other delusions, or misinterpretation of reality. However, any definition of an overvalued idea or delusion is problematic. The DSM series has definitions of terms such as delusion and overvalued idea in its glossary; however, when taken in the context of the current forensic analysis, those definitions may fall short. One problem is that there are no essential elements to a delusion (it is a problem of epistemology). Discussing such concepts then becomes a problem of semantics. However, in a forensic framework, the evaluator arguably has the responsibility of offering something more substantial than a semantic debate. For example, the federal definition of insanity calls for examiners to assess whether a defendant was unable to appreciate the nature and quality or the wrongfulness of his acts. Each of these terms (e.g., unable, appreciate, nature, and quality) has both legal and common meanings; the courts look at only the legal meanings. Given what is known about the case, we argue that Mr. Breivik’s extremely violent behavior perhaps can be better understood to be a manifestation of his overvalued ideas that take the form of fanaticism. We believe that such fanaticism is better explained by dimensional models of personality disorders,^{11,15} which assert a spectra of normal and abnormal personality function. Personality traits such as “pathological narcissism” in the *Breivik* case might be better explained by extremes of character and temperamental traits. These traits do not fit easily into diagnostic categorical systems such as the DSM. They tend to require formulations and a narrative³⁹ or life story¹¹ assessment, and this necessity renders forensic work performative and inherently more complicated than merely recounting the findings elicited during psychiatric examinations.³⁸ Such checklist styles of psychiatric formulations have gained popularity among

psychiatrists, but may tend to blur important natural diagnostic distinctions.⁴⁰

Extreme Overvalued Belief

The court ultimately had to draw a line with respect to Mr. Breivik. It concluded that Mr. Breivik’s grandiose beliefs were not bizarre or delusional, noting that the evaluators who opined that he was not criminally responsible should have consulted experts on right-wing ideologies before concluding that his grandeur was culturally implausible.^{4,5} This finding is consistent with the original European meaning of overvalued idea.

To describe the beliefs seen in the *Breivik* case (and similar cases discussed herein), we propose the term “extreme overvalued belief” to convey Wernicke’s original concept of a nondelusional, strongly held belief. We believe this term helps avoid confusion with the DSM-5 glossary’s definition of overvalued idea.¹⁵ It conveys, as British psychiatrists have emphasized, a belief separate from either a delusion or an obsession. We go further by adapting from McHugh a proposed definition for future discussion of this term:

An extreme overvalued belief is one that is shared by others in a person’s cultural, religious, or subcultural group. The belief is often relished, amplified, and defended by the possessor of the belief and should be differentiated from a delusion or obsession. The idea fulminates in the mind of the individual, growing more dominant over time, more refined, and more resistant to challenge. The individual has an intense emotional commitment to the belief and may carry out violent behavior in its service. It is usually associated with an abnormal personality.

We believe that Mr. Breivik’s behavior is an example of violence stemming from extreme overvalued beliefs. The evidence suggests he had vehement emotions regarding Muslims, immigrants, and liberal political parties. It appears to have dominated his mind. Based on our review of the data, Mr. Breivik’s beliefs were unaccompanied by other cardinal symptoms seen in severe mental illness, and his beliefs were not considered bizarre by the court, especially in the context of right-wing ideologies. His manifesto was not a form of disorganized speech, but rather a series of beliefs that he had sought out, copied, selectively altered, and incorporated and thereby “relished, amplified, and defended”³⁴ throughout his trial.

Conclusion

The case of Anders Breivik illustrates the importance of considering extreme overvalued beliefs when conducting a forensic evaluation. The DSM places the psychoses on a spectrum that can lead to the misidentification of rigidly held, nondelusional beliefs as being delusions. American forensic psychiatrists may be unaware of the European concept of the overvalued idea as being distinctly separate from an obsession or delusion. We propose a definition of extreme overvalued belief, which conveys this important concept of rigidly held nondelusional beliefs. Although forensic psychiatrists may not always agree on a particular individual's motives, this concept may help to sharpen their differential diagnosis in challenging cases such as Mr. Breivik's. Forensic psychiatrists should be aware of the powerful and destructive forces that extreme overvalued beliefs can unleash in any culture, subculture, political affiliation, or religion. They also should be aware of the differences in interpreting the diagnostic significance of such beliefs.

We believe that the DSM-5 may prove to be important in characterizing odd, unusual, or extreme violent behavior. The more rigid multiaxial system has been eliminated, allowing for the use of revised personality functioning criteria defined across disorders by typical impairments in personality functioning and the presence of pathological presentations of personality traits in individuals who are not optimally described as having a particular personality disorder. These DSM-5 innovations, coupled with the definition of extreme overvalued beliefs described herein, allow the examiner to provide a personality narrative for the rigidly held beliefs seen in cases such as Mr. Breivik's. Future cases will undoubtedly require a similar analysis of such extreme beliefs. The fact that a defendant committed a crime because of a delusional belief is a common basis for an insanity defense. It is therefore critically important that forensic psychiatrists properly identify a defendant's belief as either a delusion or as an extreme overvalued belief.

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References

1. Leonard C, Annas D, Knoll J, *et al*: Breivik: extreme ideologist or mentally deranged? Presented at the 44th Annual Meeting of the American Academy of Psychiatry and Law (AAPL), San Diego, CA, October 2013
2. Taylor M: Do cases like that of Anders Breivik show that fanaticism is a form of madness? Yes. *BMJ* 345:e4612, 2012
3. Fahy T: Do cases like that of Anders Breivik show that fanaticism is a form of madness? No. *BMJ* 345:e4647, 2012
4. Melle I: The Breivik case and what psychiatrists can learn from it. *World Psychiatry* 12:16–21, 2013
5. Roth WT, Dager SR: Psychiatry on trial: the Norway 2011 massacre. *J Nerv Ment Dis* 202:181–85, 2014
6. The General Civil Penal Code, Act of 22 May 1902, No. 10, with Subsequent Amendments, the Latest Made by Act of 21 December 2005, No. 131. Available at <http://www.ub.uio.no/ujur/ulovdata/lov-19020522-010-eng.pdf>. Accessed on April 18, 2014
7. Lewis M: The Breivik trial: Norway's self-flagellation for a horrific crime. *Time Magazine* April 19, 2012. Available at <http://content.time.com/time/world/article/0,8599,2112515,00.html>. Accessed March 20, 2014
8. American Psychiatric Association's Principles of Medical Ethics With Annotations Especially Applicable to Psychiatry. Available at: <http://www.psychiatry.org/psychiatrists/practice/ethics>. Accessed March 20, 2014
9. Keiger D: The dark world of Park Dietz. *Johns Hopkins Magazine* (Electronic Edition). November 1994. Available at <http://www.jhu.edu/~jhumag/1194web/dietz.html>. Accessed March 20, 2014
10. Waelder R: The psychoses, their mechanisms and accessibility to influence. *Int J Psycho-Anal* 6:259–281, 1925
11. McHugh PR, Slavney PR: *The Perspectives of Psychiatry*. Baltimore: Johns Hopkins University Press, 1998
12. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*. First Edition. Washington, DC, American Psychiatric Association, 1952
13. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*. Second Edition. Washington, DC, American Psychiatric Association, 1968
14. Tartakovsky M: How the DSM developed: what you might not know. Available at <http://psychcentral.com/blog/archives/2011/07/02/how-the-dsm-developed-what-you-might-not-know/>. Accessed March 20, 2014
15. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders (DSM-5)*. Arlington, VA: American Psychiatric Press, 2013
16. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*. Third Edition. Washington, DC, American Psychiatric Association, 1980
17. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition. Washington, DC: American Psychiatric Association, 1994
18. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association, 2000
19. Blatt SJ, Auerback JS: Differential cognitive disturbances in three types of borderline patients. *J Personality Disord* 2:198–211, 1988
20. Eastman N: Psychiatric, psychological, and legal models of man. *Int J Law Psychiatry* 15:157–169, 1992
21. Siever LJ, Davis KL: The pathophysiology of schizophrenia disorders: perspectives from the spectrum. *Am J Psychiatry* 161: 398–413, 2004
22. Pearlson GD: Neurobiology of schizophrenia. *Ann Neurol* 48: 556–566, 2000

23. Ripke S, O'Dushlaine C, Chambert K, *et al*: Genome-wide association analysis identifies 13 new risk loci for schizophrenia. *Nat Genet* 45:1150–1159, 2013
24. Thangadurai P, Gopalakrishnan R, Kurian S, *et al*: Diagnostic stability and status of acute and transient psychotic disorders. *Br J Psychiatry* 188:293, 2006
25. Gottesman II, Gould TD: The endophenotype concept in psychiatry: etymology and strategic intentions. *Am J Psychiatry* 160: 636–645, 2003
26. Booth BD, Hatters Friedman S, Curry S, *et al*: Obsessions of child murder: underrecognized manifestations of obsessive-compulsive disorder. *J Am Acad Psychiatry Law*. 42:66–74, 2014
27. Cook CH, Powell A, Sims A, *et al*: Spirituality and secularity: professional boundaries in psychiatry. *Ment Health Relig Cult* 14:35–42, 2011
28. Parker G: Competence to stand trial evaluations of sovereign citizens: a case series and primer of odd political and legal beliefs. *J Am Acad of Psychiatry Law*. 42:338–49, 2014
29. Sims A: *Is Faith Delusion? Why Religion is Good for Your Health*. London: Continuum, 2009
30. Mueller III RS: Statement Before the Senate Committee on Homeland Security and Governmental Affairs (September 19, 2012) [Testimony of Robert S. Mueller, III]. Available at <http://www.fbi.gov/news/testimony/homeland-threats-and-agency-responses>. Accessed December 6, 2013
31. Wernicke C: *Grundriss der Psychiatrie in Klinischen Vorlesungen* [Foundation of Psychiatry in Clinical Lectures]. Leipzig, Germany: Fischer & Wittig, 1900
32. Veale D: Over-valued ideas: a conceptual analysis. *Behav Res Ther* 40:383–384, 2002
33. Gelder M, Gath D, Mayou R, *et al*: *Oxford Textbook of Psychiatry* (ed 3). New York: Oxford University Press, 1996
34. McKenna, PJ: Disorders with overvalued ideas. *The British Journal of Psychiatry* 145(6): 579–585, 1984
35. McHugh PR: *The Mind Has Mountains: Reflections on Society and Psychiatry*. Baltimore: Johns Hopkins University Press, 2006
36. Durkheim E: *The Division of Labor in Society* [1893 English Translation]. New York: The Free Press, 1984
37. Freudenreich O: *Psychotic Disorders: A Practical Guide*. [Practical Guides in Psychiatry series]. Philadelphia: Lippincott Williams & Wilkins, 2008
38. Halle K: *Irrepressible Churchill: A Treasury of Winston Churchill's Wit*. New York: World Publishing Company, 1966
39. Griffith EEH, Stankovic A, Baranoski M: Conceptualizing the forensic psychiatry report as performative narrative. *J Am Acad Psychiatry Law* 38: 1:32–42, 2010
40. McHugh PR, Slavney PN: Mental illness: comprehensive evaluation or "Checklist"? *N Engl J Med* 366:1853–55, 2012