EMILY CORNER

MENTAL DISORDER IN TERRORISM, MASS MURDER AND VIOLENCE: MOVING AWAY FROM PATHOLOGISING GRIEVANCE.

On the night of October 1st 2017, Stephen Paddock opened fire from the 32nd floor of the Mandalay Bay hotel in Las Vegas onto a crowd of concert goers below. His actions led to the deaths of 58 and injuries to over 800. It was the deadliest mass shooting conducted by a single individual in United States history.

Despite the flurry of activity on social media to categorise Paddock's actions as either terrorism or mass murder, Paddock's motives continue to elude law enforcement. Within a week of the attack, investigators publicly stated that they had not yet uncovered any insights into Paddock's motivations from his personal life, political affiliations, social behaviours, or economic situation. As the investigation continued, one overarching assumption began to infiltrate the media; that the violence was caused by an undiagnosed mental disorder.

This assumption snowballed when evidence emerged of Paddock's father's history of psychopathy, suicidal tendencies, and criminal behaviour.

The assumption of mental disorder causing violent behaviour has instinctive appeal: It offers a clear-cut and simple explanation of why people choose violence. By attributing Paddock's record act of violence to mental disorder (as understood by the general public), as opposed to a political aim, it fits with the popular image of a crazed killer.

The case of Paddock is not isolated. Media coverage of many recent mass killings has shown the desire to attribute motivation to mental illness. The cases of Dylann Roof, Esteban Santiago-Ruiz, Michel Zehaf-Bibeau, Mohamed Lahouaiej-Bouhlel, and Omar Mateen have all attracted wide media coverage, mainly because of the discussion surrounding how their actions should be labelled due to their suspected mental disorder.

Nowhere was this debate more evident than at the inquest following the Sydney Siege, an attack carried out by Man Haron Monis. During the attack, Monis had claimed allegiance with the Islamic State, and following the siege, the Islamic State praised his actions in it's propaganda. Monis also had an extensive history of mental health issues. During the inquest, many expert witnesses reasoned that Monis' history of mental disorder best explained his actions and that, although he declared commitment to a political ideology, he should not be considered a terrorist.

Despite improvements in research which examines mental health in terrorism, the public and political reactions to large scale acts of violence, where the attacker's motivation remains elusive, draw us back to the question of whether the development of a political grievance and experiencing a mental health problem are mutually exclusive?

This question is predominately fuelled by four common assumptions:

- Being a 'loner' automatically means you have a mental health condition.
- All terrorists are the same.
- There is a clear difference between terrorists and mass murderers.
- The risk of violence across mental disorders is the same.

LONE ACTORS AND MENTAL HEALTH

Research continually shows that prevalence of mental disorders in terrorist groups is lower than would be expected in a general population. This is thought to be due to rigorous selection techniques during terrorist recruitment, which helps to screen out unsuitable individuals, particularly those with a mental health problem. Given this (and evidence showing the higher than expected prevalence of mental disorders in the lone actor population) it is readily assumed that individuals acting alone who do profess an ideological motivation have not been able to join a terrorist group because of a mental health problem. This then feeds into the belief that individuals who act alone, whose motivation is not readily identified, must have a mental health problem.

However, on interviewing and examining the writings of terrorist recruiters, these assumptions have proven to not hold weight. Terrorist recruitment is highly fluid. Terrorist recruiters do sometimes look for specific qualities in recruits, but this is highly dependent on the current aims and needs of the group, the area that they are recruited from, and the political situation.

No recruiter mentioned, or could recall, a situation where they would reject an individual with an overt mental health problem, or held that an individual with a mental health problem would be unsuitable. Interviewed recruiters also questioned whether it would always be possible to tell if a potential recruit had a mental health problem if it was not disclosed.

'THE TERRORIST'

Related to the assumption that terrorist groups screen out individuals with mental health problems is the assumption that 'the terrorist' is a single entity. The above identified low prevalence rates of diagnosed mental disorders within terrorist groups has helped fuel this misconception. It is now readily assumed that terrorists within a group will not have a mental health problem.

However, terrorists are in fact highly diverse, with different beliefs, roles, functions, and experiences. These experiences, occurring before becoming involved in terrorism, during involvement, and following disengagement can have a psychological impact.

Terrorist writings and interviews have highlighted that undiagnosed mental health problems in those involved in terrorist groups are higher than currently expected: Psychological distress before engagement is 23.1%, during engagement is 45.9%, and following disengagement is 41.9%. The writings and interviews have shown that negative experiences, and the way individuals cope with such events during engagement may have longstanding psychological effects.

TERRORIST OR MASS MURDERER?

Solely focusing on those who engage in violence on behalf of a political or religious cause unduly narrows our understanding of the relationship between mental health and extreme violence. Answers may also be found in the scientific study of mass murderers. Much like lone actors, mass murderers carry out large scale acts of violence alone and their mental state has been continually discussed. However, to date, the difference lies in the motivation behind their violence. Mass murderers are not seen to have a political motivation.

Mass murderers are seen to irrationally act on impulse, primarily because of psychiatric conditions. The evidence, however, is that most conduct predatory, rather than impulsive, violence – even when there is evidence of mental disorder. In fact, much like lone actors, evidence shows there to be very little difference in 'rational' planning and attack behaviours between mentally ill and non-mentally ill mass murderers.

VIOLENCE IN THE MENTALLY ILL

Media portrayals of large scale acts of violence consistently imply that mental disorder (as a single entity) is a cause of violence. This unnuanced view is broadly consistent with how mental health problems are perceived within public opinion.

The use of general terms such as 'mentally ill' neglect to consider the range of different disorders, each with a different combination of symptoms, that interact differently with different environments. In search for the role of mental disorder in acts of mass violence, the answer is likely to differ wildly from case to case depending upon the individual's diagnosis and symptoms, prior life experiences, co-existence of other stressors and vulnerabilities, and lack of protective factors.

Importantly, improvements in this area can only be made with empirically sound research. Researchers must have a mature response which will then feed into practice and public discussion. Just because a factor (such as mental disorder) is present in a case of mass violence, does not make it causal. Nor is it always facilitative. It may be completely irrelevant. We must be comfortable with this complexity; understand that where mental health problems are present, they are usually one of several aspects in a risk profile; and by doing so, not stigmatising the vast majority of people that suffer from mental health problems while remaining non-violent, non-radicalised, and in need of care.

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