A CASE STUDY OF MOTIVES AND METHODS OF MASS MURDERERS AND WHETHER THEY RELATE TO MENTAL ILLNESS

By

Gregory C. Towe

An Abstract
of a thesis submitted in partial fulfillment of the requirements for the degree of Master of Science in the Department of Criminal Justice
University of Central Missouri

November, 2015
ABSTRACT

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Mass murder has gained attention as a crime in our society, with an ever-growing presence in the media and in the public’s interest. With such attention comes the desire to place blame on what causes or contributes to these attacks, and many choose to blame the mental health of the offenders. This study performs a case study of 25 mass murders, their motives and methods, with the intention to answer three questions: whether mental illness is a significantly contributing factor to mass murder, if so what illnesses are most prevalent, whether the killer shows delusional or psychotic features, and whether other variables might indicate a pattern among mass murderers. The study showed that 56% of the sample was suspected or had a mental illness, showing a moderate relationship between mass murder and mental illness. Only 24% of the sample had a mental illness that had psychotic or delusional features, establishing that the majority of mass murderers do not have breaks with reality.
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CHAPTER 1
NATURE AND SCOPE
OF THE STUDY

Few crimes carry the weight of attention or shock factor as mass murder. Also referred to as a mass killing or mass shooting, mass murder is described as a killing where multiple people are killed in a rampage of violence in one time and place (Holmes & Holmes, 2001). These killings are performed with a variety of weapons, such as firearms, explosives, and knives. As the killings become more bizarre or extreme, they gain shock value and increase the chance that the massacre will be covered by national news networks. This process keeps the murders in the public focus for a few months, but eventually interest fades.

In recent years, mass murders in the United States (U.S.) have seemed to become a recurring phenomenon, one that has increased in both regularity and coverage. These events plaster images and death tolls across the front page of every newspaper, media source, and social media outlet in existence, leaving the public to ask themselves “How could this happen, and what can we do to stop it in the future?” With that question, people look for someone or something to blame; something to rationalize the pain and to prevent it from happening again.

A poll by Gallup in 2011 surveyed the U.S. population, and of those who answered, 48% believed that the “failure of the mental health system to identify individuals who are a danger to others” was a factor that contributed a great deal in causing mass shootings. This survey came in the wake of the shooting in Tucson, Arizona on January 8th, 2011, by Jared Loughner, in which U.S. Representative Gabrielle Giffords was injured. Other answers discussed in the poll included the ease shooters had gaining access to guns (46%), the prevalence of drug use (42%), and violence in movies, video games, and music track lyrics (31%), among many others. Gallup revisited this survey after the Navy Yard Shooting by Aaron Alexis on September 16th, 2013, and
tracked the changes in public opinion. The results showed that the “failure of the mental health system” held steady at 48%, with the majority of other top factors dropping anywhere from 3% to 6% in the poll, with the exception of violence in pop culture which gained 1%. The factor of ease of access to guns dropped to 40% over the two years, leaving the failure of the mental health system as the top and unchanging factor (Saad, 2013). This reflects that the public believes that mental illness is a factor in mass murder.

These survey results raise questions as to why the public believes the mental health system is responsible for mass murder. In addition to this, public studies and researchers have implied that mental illness is a significant factor in mass murder (Central Florida Intelligence Exchange, 2013; Liebert, 2014). Mass murder, as a whole, does not have an abundance of research describing it. However, mass murder has existed for over a century, but only resurged in the 1960’s (Duwe, 2007), and since mass murder is particularly rare as a brand of homicide, it can be difficult to research. Some studies and authors have done this with emphasis on many areas, but few have focused on mental illness.

**Purpose of the Thesis**

The purpose of this thesis is to confirm or dispute the claim that mental illness is a significant factor that contributes to mass murders in the U.S. The current study is designed to thoroughly examine 25 cases studies of mass murder in the U.S. This study will perform a comparative analysis of a variety of factors in each of the cases in the search for relevant factors, with a special emphasis on whether or not mental illness is a significant factor in mass murders.
Definitions

Mass murder has had varying definitions in the criminal justice field and in the public sphere. The FBI defines mass murder as the killing of four or more victims in one location at one place in time (Morton, 2005; Fox & Levin, 2005, p. 157). Others hold that mass murder is three victims; while others say five (Holmes & Holmes, 2001; Lester, 2004, p. 9). Some studies even suggest that the victims do not need to actually be killed for an event to qualify as a mass murder, but rather an attempt needs to be made to kill the victims (Lester, 2004, p. 10). For the purposes of this study, an event of mass murder shall be defined as the assault by an individual or group of individuals with the intent to kill or maim their target group or population at a single point in time and place, having at least three victims who are either killed or wounded in the attack. This definition gives the researcher the ability to observe a wider group of killers, as poor execution of the attack does not always exclude them from being capable or actually having attempted to commit mass murder.

The American Psychiatric Association (2013) defines mental disorders in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), as “a syndrome characterized by a clinically significant disturbance in the individual’s cognition, emotional regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning” (American Psychiatric Association, 2013, p. 20) Synonymous terms include mental illness, mental instability, and mentally deficient. Different mental disorders exist within the DSM-5 including the Schizophrenic Spectrum, Bipolar and similar disorders, the Autism Spectrum, and many others. Further definitions of relevant disorders will be included in Appendix A.
In 2001, a typology was developed by Holmes and Holmes that covers the majority of mass killings in the U.S. These consist of the Disciple Mass Murderer, the Ideological Mass Murderer, the Disgruntled Citizen Mass Murderer, the Disgruntled Employee Mass Murderer, the Family Annihilator Mass Murderer, the Set-and-Run Mass Murderer, and the Psychotic Mass Murderer (Holmes & Holmes, 2001). This typology is the most comprehensive of any in the literature and is cited many times. Detailed descriptions of the aforementioned types will be included Appendix B.

**Procedural Overview**

The researcher will begin with an overview and summary of various research on the topics of mass murder and mental illness. From this summary, the reader should gain a better understanding of both concepts. At which point, a set of 25 cases of mass murder will be collected. Aspects of the murders will be reviewed and common factors will be compared across all cases. This study will focus on whether mental illness is a contributing factor to mass murder. The researcher will conclude by interpreting the results of the study, and give possible suggestions for further research.
CHAPTER 2
LITERATURE REVIEW

Literature on mass murder does exist, but compared to topics like serial murder or murder for hire, mass murder research is rather sparse. The crime of mass murder has only existed since the 1950’s (Ramsland, 2005), but the act of mass murder can often be traced back to as early as the turn of the 20th Century (Duwe, 2007). Mass murder literature can be confused with genocide or political killings by rulers who kill their captives, such as with Hitler and the Jews of Europe (Bellamy, 2012). While these do technically involve the murder of people in mass, that is not the subject of the research at hand. The killers involved in this study usually act alone, and go against the rule of law.

The frequency of mass murder has been exaggerated. For a long period of time, researchers believed that mass murder was a rather new crime that had only started in the mid-1960’s. Further studies have shown that this is incorrect. While the first defined case of mass murder was performed by Howard Unruh on January 21, 1949, in Camden, New Jersey (Ramsland, 2005; Shipkowski, 2009), the crime characteristics, as defined by one of the definitions described in Chapter 1 the concept of one person killing many, has existed for centuries. The act, however, can be traced back much farther. The concept of “devotio” was when a Roman soldier crossed enemy lines, killed as many enemy soldiers as he could, and then would commit suicide. “Amok” is the ancient Malaysian term describing a man of myth who would kill anyone he came across until his rage subsided (Auxemery, 2015). From around 1900 to the early 1940’s, mass murder was common but not defined as a single great crime, in a similar way to the modern era.
In reality, 909 mass murders were found in the 20th Century. However, these mass killings have not been with regularity. From the turn of the century to around 1940, mass murders were committed at similar rates as to today, with a spike in attacks around the 1920’s. From the 1940’s to the mid-1960’s, mass murders become very rare. Researchers suspect that this is because of the pro-social behaviors happening at the time such as the creation of families, the booming economy, and the creation of stable jobs with stable income. The mid-1960’s marks the beginning of the modern era of mass murder, and returns to the earlier rates held at the beginning of the century (Duwe, 2007).

In the present day, there are on average 29 mass murders per year, with an average of 147 victims per year. The current impression is that the number of mass murders has increased in recent years, when in fact it has been stable around this number for many years (Welch & Hoyer, 2013). The main reason the public gets this impression is because of the increase of coverage and inaccurate reports by the media.

The mainstream press is the medium by which the public hears about and understands events that happen in the world today. However, when it comes to the media and any report of mass murder or any attack of similar nature, errors happen. One of the best examples of this was the coverage of the Navy Yard Shooting in September of 2013, in which two major networks named the wrong person as a suspect, but later retracted their report (Rieder, 2013, p. 1), and this is by far not the only instance. One study even showed that the media preferred to categorize the mentally ill as “monsters” or “mentally disturbed,” rather than specifically detail what was wrong with the individual (Rapley, McCarthy, & McHoul, 2003). Therefore, the literature reviewed suggests that the media has little to no positive effect on educating the public about mental illness, and only reports on murders with mental illness for the sensationalization and the
sales that comes with it (Broadwell, 2003). One study examined the accuracy of media coverage on mass murders (Huff-Corzine, et al., 2013) and found that media coverage was wrought with errors, even after the attack happened. Even more so, other reports show that the media provides a warped perspective of the mass killer and the victims (Duwe, 2007).

Other studies on the media’s coverage following mass murders held that the media’s coverage was to push political agendas. There is some debate over whether media coverage positively or negatively affects public opinion on the need or effectiveness of gun control (Metzl & MacLeish, 2015; McGinty, Webster, & Barry, 2013). However, there is no debate that media coverage negatively affects those who are mentally ill. Many articles show a pattern of negative impressions for those who have mental illness when shown by the media in the context of a mass murder (McGinty, Webster, Jarlenski, & Barry, 2014) despite the lack of evidence to establish a stable link between mass murder and mental illness (Aitken, Oosthuizen, Emsley, & Seedat, 2008). The public assumption then becomes that mental illness causes gun violence and that it can be predicted by psychiatric care or diagnoses (Metzl & MacLeish, 2015). Even beyond that, while policy has been made to try and counteract mass murder on multiple fronts such as gun control, mental health system improvements, and even restrictions on violence in video games, these efforts are small or ineffective at stopping mass murder (Fox & DeLateur, 2014; Faria, 2013).

After the Sandy Hook Elementary Shooting, many began to take a much closer look at the mental health system as it relates to mass murder. According to a survey by the World Health Organization, the U.S. ranked first out of seventeen countries for the highest rate of mental illness. Tom Insel, Director of the National Institute of Mental Health, noted several key factors about mental illness in a US Senate hearing on January 24, 2013. The first being that mental
illness is the third most expensive health related condition to medically treat. This is only outdone by heart disease and physical injury. (Shern & Lindstrom, 2013) Insel also pointed out that “people with untreated initial episodes of psychosis are fifteen times more likely to be involved in violence than those whose conditions are treated” (Shern & Lindstrom, 2013, p. 448). Prevention of mental illness is sometimes sought by political and media figures as a way to stop mass murders. This produces a few problems. Science’s understanding of mental illness has drastically changed in the last fifteen years, forcing us to look further into adolescence for diagnostic material, as the median age for diagnoses is around fourteen years old (Shern & Lindstrom, 2013). Therefore, recognition of what is a symptom of mental illness and not something less serious like mood swings typical of pubescence, is difficult and needs better testing methods.

**Possible Motivations**

The literature, at certain points, suggests that paranoia may be an active element in those who commit mass murders. Individual case studies show that many mass murderers feel socially persecuted, feeling envious of those who are not persecuted, and seek revenge on whom they believe to be their tormentors. (Knoll & Meloy, 2014). The reasoning behind this suggests that all mass murderers fit on the paranoid mass murder spectrum, displaying traits from slight paranoia to psychotic delusions. Early recognition of these symptoms can lead to the prevention of a mass murderer’s attack (Knoll & Meloy, 2014).

Among researchers, there is also a notion that narcissism may be behind the desire to murder innocent people in mass. The idea behind this concept is that media attention to these sorts of attacks makes them famous, helping them achieve a sense of martyrdom (Aitken,
Researchers suggest that narcissism and social rejection are risk factors that produce aggressive behavior, and that “narcissism is the classic American pathology” (Knoll J. L., 2013).

The literature notes that mass murderers feed off the attention of the general public. After the mass murder, there is always shock and awe among the community. Local media will always report the murders. Only extreme cases, such as an alternative method of killing or high body count, will attract the attention of the national media. After a short time, attention is drawn away from the killing and the nation moves on. The event simply fades, but the local community remembers the events. This pattern exists with almost all mass murder cases in recent history (Holmes & Holmes, 2001).

Literature on the topic of mass murder nearly always examines reasons why mass murders are prevalent in today’s society, but the answers vary widely. Some pieces of literature suggest mental health may be to blame; others blame easy access to firearms, or violence as depicted in video games and movies (Saad, 2013). Motivations vary among the killers, as Holmes and Holmes (2001) demonstrate in their different typologies. Therefore, it is likely that no one factor is the cause of all mass murder, but rather these elements may help encourage mass murders as an aggregate.

**Annotations**

**Welch & Hoyer, 2013**

This is a database set up by USA Today detailing recent mass murder cases. The reasoning for the creation of such a database as opposed to using the FBI’s Supplementary Homicide Data is because USA Today found that the FBI’s data was wrought with
inconsistencies as to what was a mass killing, even by their own definition. Cases were included in this new database if four or more people were killed, not including the killer, from 2006 and on. USA Today was able to classify mass murders into three categories: “public massacres, family violence, and deaths that are linked to other crimes” (Welch & Hoyer, 2013). Further study of the data showed that mass murders attract a significant amount of attention, but only account for around 1% of murders in the US and that they are not on the rise.

**Rapley, McCarthy, McHoul, 2003**

The authors of this study take on the idea of how society members identify and categorize themselves. Instead of looking at theories for methods that people categorize, the authors looks to how the people as a whole categorize events such as a mass murder. This is done by examining media articles describing particular cases. The one for this article is Martin Bryant, who in 1996, killed 35 people in Port Authur, Tasmania. The authors look at the media coverage and how the event was reported, specifically what labels the media chooses to use and the context they frame for the killing (Rapley, McCarthy, & McHoul, 2003).

**Broadwell, 2003**

Broadwell published a short analysis that looks at the media’s desire to demonize those with mental illness. The author examines several points in his article, such as pointing out the difference between psychosis and a psychopath, and that the media prefers to spin stories to keep sales up. Different cases are described in each case, varying from individual cases to the state of the United Kingdom in general. His study also shows that because of negative media coverage, the situation could deteriorate to where people who may have a mental illness would not get
treatment. This is despite mental illness cases being very rarely involved in homicides in the U.K (Broadwell, 2003).

**Huff-Corzine, et. Al, 2003**

The authors of this study chose to look at the data source of media, as it is used by researchers today, with regards to its validity. This study compares databases with media sources as its core versus official statistic sources, with additional comparison between the Supplementary Homicide Reports and the National Incident-Based Reporting System. Comparisons along with contrasts are made between the media-based databases and official databases (Huff-Corzine, et al., 2013).

**Metzl & MacLeish, 2015**

Metzl & Macleish discuss in their article the different assumptions the media and the public make in the aftermath of a mass shooting. These being “(1) that mental illness causes gun violence, (2) that psychiatric diagnosis can predict gun crime, (3) that shootings represent the deranged acts of mentally ill loners, and (4) that gun control ‘won't prevent’ another Newtown (Connecticut school mass shooting)” (Metzl & MacLeish, 2015). They come to these assumptions by studying articles of different kinds of social research in psychiatry, psychology, public health, and sociology, specifically ones that address mental illness and gun violence. They examine this literature and how opinions of mental illness and gun violence are tied to public opinion and legislative politics (Metzl & MacLeish, 2015).
McGinty, Webster, & Barry, 2013

McGinty, Webster, & Barry explore the effects that media has on the public’s perception of those who are mentally ill and gun control policy support. The authors exposed a nationwide sample of people to one of three news articles or were in a control group and were not given an article to read. Sorting into these groups was done at random, and the sample size was 1797 subjects. One of the articles was in regard to a mass shooting in which the shooter was mentally ill. The second article involved the same mass shooting but was about a law proposal that would increase restrictions for a mentally ill person to obtain a firearm. The third article involved the same mass shooting but with a proposal to ban high-capacity magazines. After the subjects had read their article or were in the control group and lacked an article, the authors surveyed the sample as to how the subjects felt about working with or living near someone who had a serious mental illness. They also measured whether or not the subject supported gun or high-capacity magazine restrictions (McGinty, Webster, & Barry, 2013).

McGinty, Webster, Jarlenski, & Barry, 2014

McGinty, Webster, Jarlenski, & Barry complete a content analysis on media reports involving gun violence that involved perpetrators from the years 1997 until 2012 that had serious mental illnesses. The authors used a 25% random sample from a population of almost 5200 news stories about gun violence and mental illness. This sample was further refined to make sure the stories that were used were on topic and over 100 words, resulting in a sample of 364 news articles and news editorials. The study conducted looked for whether “news stories focused exclusively on a specific act of gun violence by a person with a serious mental illness (SMI), or on the general problem of gun violence by persons with SMI” (McGinty, Webster, Jarlenski, &
Barry, 2014). The authors first measured and talked about any one of five facts that are supported by previous research:

1. “People with SMI are often stigmatized;
2. negative public attitudes about SMI can lead to reluctance to seek treatment among persons with SMI;
3. negative public attitudes about SMI can lead to public desire for social distance (e.g. reluctance to live near or work with) persons with SMI;
4. most people with SMI are not violent; and
5. predicting violence among persons with SMI is difficult” (McGinty, Webster, Jarlenski, & Barry, 2014).

Then, the authors measured whether the article mentions any specific kind of diagnoses in the new story, such as Schizophrenia, Bipolar Disorder and several others. Finally, the authors measured whether the news story mentioned additional factors that implied the subjects had violent tendencies with their serious mental illness. All three of these measures independently represent stories that can impact and shape how the public understands people with serious mental illnesses. Similarly, the authors looked at policy implications that news stories presented as well, as these too shape how the system responds to gun violence and how the mental health system operates. These stories were compared against each other for similarities, especially those stories that happened in the wake of mass shootings. This range specifically is limited to the two weeks after the event happened. The authors also used logistic regression models to take a closer look at the correlations between gun violence cases being mentioned and gun violence prevention policies being mentioned. This was done with mental health problems as well, and shown in table form (McGinty, Webster, Jarlenski, & Barry, 2014).
Aitken, Oosthuizen, Emsley, & Seedat, 2008

Aitken, Oosthuizen, Emsley, & Seedat look at the feasibility of predicting mass killings via biological and psychological factors. The authors look at mass murderers as a case, and describe the factors that affect his willingness to kill. Following this, the authors show how psychiatry relates to mass murder, and that while psychosis exists in some cases, it is not everpresent as the media describes. The authors then bring up the social context of these killings, with topics such as media coverage of the attacks, how literature has changed the social environment, and how gun control has been shown to be an effective measure against mass shootings. The authors conclude by talking about mental health professionals and the difficulties that go with diagnosing individuals, as they describe the sensitive balance between over and under diagnosing patients.

Fox & Delateur, 2014

Fox & DeLateur examine several myths that exist surrounding mass shootings and whether policy is effective at reducing attacks. Beyond these myths, the authors show the reality of the case. The authors also look at policy concepts ranging from increased gun control, increasing security at certain locations, and the effectiveness of mental health services as well as how accessible they are. The authors end the article by making the case for increased policy, while still explaining its inconsistent effectiveness.

Holmes & Holmes, 2001
Holmes and Holmes published a book entitled “Mass Murder in the United States.” This is the expanded publication version of previous publications (Holmes & Holmes, 1992) that describes how mass murder varies from other kinds of multicide and sorts mass murderers by their methods, behavior, and victim. The typology has been cited by many other authors (Duwe, 2007; Ramsland, 2005; Lester, 2004) and can be viewed in greater detail in Appendix B.

**Faria Jr., 2013**

Faria looks at the gun control debate that is often ignited in the wake of mass shootings. The author provides an editorial of other publications to determine whether guns are to blame for these violent crimes. Faria points to the large discrepancies with both argument for and against gun control, but ultimately asserts that gun control is not feasible in the U.S. Moreover, he points to the mental health system and the way the media sensationalizes murder. The author also gives several policy suggestions involving improving the mental health system, while improving the criminal justice system and removing frivolous legislature supporting gun control.

**Shern & Lindstrom, 2013**

Shern & Lindstrom wrote an article discussing mass murders in the context of mental illness. The authors discuss what the state of the current mental health system is in the U.S., along with how it is changing and improving with programs like the Affordable Care Act. The authors show the mental health systems failures as the reason for the increase in mass murders. The authors wrap up the article by explaining what will and will not work in terms of policy to make the system more effective.
Saad, 2013

Saad along with Gallup polls conducted a research project into what the public holds as the responsible factor contributing to mass shootings today. The survey was conducted by telephone interviews of a random sample of 1023 adult individuals in the days following the Navy Yard Shooting in September of 2013. Samples were weighted to correct for unequal selection probability to get the results closer to matching US demographic information. The proctor would ask the subject whether one of seven factors would be considered responsible “to blame for the shootings” (Saad, 2013). The sample test subject would then state whether they thought the factor contributed a “great deal, fair amount, or not much/not at all” (Saad, 2013). The seven factors were:

1) “Failure of the mental health system to identify individuals who are a danger to others
2) Easy access to guns
3) Drug use
4) Violence in movies, video games and music lyrics
5) Insufficient security at public buildings including businesses and schools
6) The spread of extremist viewpoints on the internet
7) Inflammatory language from prominent political commentators” (Saad, 2013)

These factors were read in a random order to the test subjects. This study was done in a similar manner in 2011 after the Tuscon, AZ shooting with similar methods. The results were compared in the report. Additionally, the report included the gun violence study that Gallup has been conducting since the early 1990’s, which asks whether gun laws should be more restrictive, less restrictive, or kept at the level they are now. Sampling for this study is done in the same manner as the former. (Saad, 2013)
Knoll & Meloy, 2014

Knoll & Meloy recognize in their article that the media believes that mass murder is the violent byproduct of those with serious mental illnesses and rejects the notion in favor of suggesting that paranoia and paranoid delusions may be more culpable. The authors provide analysis of pre-offense writings of Kipland Kinkel, who killed his parents and two young students. This analysis demonstrated forensic psycholinguistics, a tool that can be used to look for individuals who would be more prone to violence by examining their state of mind. These writing were taken before Kinkel committed the attack, and the authors display how his paranoia and fears of social rejection lead to his violent outburst. The authors close the article and reinforce the need for recognition and prevention of those who are capable of mass murder (Knoll & Meloy, 2014).
CHAPTER 3
RESEARCH DESIGN

This study is a qualitative case study examining 25 cases of mass murder, breaking them down by killer demographics, time, place, whether they were mentally ill, and comparing them against one other. By using a case study, the researcher is able to look for similarities between the killers on a qualitative basis. The researcher aims to determine whether mental illness and mass murder are significantly related, and whether a specific mental illness is more responsible than others. If no single mental illness is responsible, the question then becomes whether similar symptoms or traits are present among the mentally ill killers. This study will collate the results and look for correlations among the variables, while examining current research on the subjects of mass murder and mental illness to understand what other researchers have produced on such topics.

Literature for the study was collected from a variety of sources. The majority of physical literature was collected from the University of Central Missouri’s James C. Kirkpatrick Library and from the St. Charles City-County Library system. Literature was selected on the available literature with relation to the topics of “mental illness,” “mass murder,” and “biological criminology.” Mass murder textbooks were used to better convey the nature of mass murder to the reader. The Diagnostic and Statistical Manual of Mental Disorders was consulted to further define relevant mental illnesses and to give clarity to the reader as to what the relevant disorders entail in terms of symptoms and behaviors. Academic articles were collected from University of Central Missouri’s James C. Kirkpatrick Library’s database system, which includes SAGE publications, ProQuest, NCJRS, and EBSCO Host. Google searches for articles were also conducted with relevant keywords with limited success. The keywords used were “mental
illness,” “mental disorder,” “mass murder,” “mass killing,” and “mass murderer.” The articles that showed the most relevance to the subject of this thesis were included.

The 25 cases for this study were collected from a list compiled by psychiatrist Dr. Jon Liebert from Arizona, who published it to a Criminal Justice Specialists page on LinkedIn. This list was in discussion of policy that would add regulation of guns for those who are mentally ill by creating state reporting requirements, and it provided a list of approximately 63 cases of mass murder. This list was published around the same time as research began for this study, and represented the most readily available, up-to-date list. This was a departure point for the research. This list was only used as a convenience list from which to start from, and the 25 cases selected from it were the first 25 the researcher could verify met the requirements set forth in the research questions. The researcher chose 25 cases for the size of the sample to establish statistical reliability. To verify the cases met the requirements, a Google search for the killer’s name plus words like “murder,” “shooting,” and “killing” was conducted. The requirement for the case to be selected was that the mass murderer kills or wounds at least three people in their rampage, along with the killings taking place in one location and within a 24 hour period. These requirements were created to align with literature that defines mass murder (Holmes & Holmes, 2001; Duwe, 2007; Fox & Levin, 2005). All killings that were included had to happen within the 24 hour period. This means that the killings by the Tsarnaev brothers that were committed in the escape three days after the attack were not included, but as they’re initial attack still meets the definition, the researcher chose to include their initial attack. As for location, Holmes and Holmes defined locations broadly, as wide as being committed in the community (Holmes & Holmes, 2001). As such, the researcher operationalized this to limit the killings to the same town or metropolitan area. Thus, killers like Adam Lanza and Charles Whitman, who both killed their
close family and significant others before the mass murder, were included and those kills counted.

If the case met the requirements set by the study, collection of the qualitative data was completed from news sources and official reports that were used to verify the incident. Such sites varied from large national news organizations like USA Today, the Huffington Post, and Fox News, to more local news organizations that focused on the attack in their hometown. From these sites, data about the killer was collected. This included information on his or her method in the killing, locations the killings took place, details about the killer’s mental status, specific mental illnesses they may have including if they received treatment, whether he or she had prior criminal history, what their weapon of choice was and whether they obtained it of choice legally, as well as pedigree information such as race and age of the killer. Additionally, time and day statistics were gathered as well as how effective the killers were at killing their victims by including the number they wounded and the number they killed, and whether the killers themselves survived the attack and were captured by police. These variables show the method of the killers, and were compared against each other, with a specific emphasis on whether or not mental illness is a significant factor in mass murder cases.

Research Questions:

1. Is mental illness a significant contributing factor to mass murder?
   a. What mental illnesses are most common?
   b. What common traits do those with mental illness share?

2. Are psychotic and delusional features present in the mental illness cases of this study?

3. What other variables are significantly linked?
Frequency tables were formed out of each of the variables, and the study included the variables that showed statistics of interest. Frequency tables display the variation among the sample well, and were chosen for this reason. After the initial screening was complete, a more detailed analysis was taken of those who were suspected of being mentally ill. Additionally, a correlation table was formed to look for other significant relationships between variables. Correlations show statistical relationships between variables, specifically dependence of the variables upon each other. A correlation table was included to look for and show variables that may be connected to one another. Only variables that outputted significant relationships to the .05 level were included to conserve size. Coding of ratio level variables such as “Number Killed,” “Age”, and “Number Wounded”, were done numerically. Nominal variables were coded into a number system to aid in the process. The variable “Weapon Used” was coded as 1= “Pistol,” 2= “Shotgun,” 3= “Multiple Guns,” 4= “Assault Rifle”, and 5= “Bomb.” The study did this to align with the potential destructiveness of the weapon. As the coding number goes up, the weapon is likely more lethal. Variables that involved mental illnesses were coded as 0= “No,” 1= “Yes,” 3= “Unknown.” Inferences made by the researcher about the correlation table and its reliability are discussed following the table.
CHAPTER 4
FINDINGS

The following pages reflect case studies conducted by the researcher of 25 cases of mass murder. These cases fit the definition and restrictions of mass murder cases and were selected as described in Chapter 3. The chapter will then summarize the findings and similarities of these cases. Full descriptions of the cases used are available in Appendix C.

Common Traits

After the SPSS analysis was complete, the variables showed a few frequent occurrences. First, the researcher compared demographic, gender, and age information to look for common elements. The results show in Table 1-3.

Table 1
Gender of the Killer

<table>
<thead>
<tr>
<th>GENDER</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>25</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 2
Race of the Killer

<table>
<thead>
<tr>
<th>RACE</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arabic</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>Asian</td>
<td>2</td>
<td>8.0%</td>
</tr>
<tr>
<td>African American</td>
<td>2</td>
<td>8.0%</td>
</tr>
<tr>
<td>Latino</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>19</td>
<td>76.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Table 3

Age of the Killer Statistics

<table>
<thead>
<tr>
<th>AGE STATISTICS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>33.08</td>
</tr>
<tr>
<td>Median</td>
<td>32</td>
</tr>
<tr>
<td>Mode</td>
<td>22\textsuperscript{a}</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>12.843</td>
</tr>
</tbody>
</table>

\textsuperscript{a} Multiple modes exist. The smallest value is shown.

From the 25 cases the study found that the majority of our cases were predominantly white males in their early 20’s to mid-30’s. Since the Tsarnaev brothers are two people, the researcher chose to make them one entry and average their ages together and round, resulting in 23. This tracks similarly with past research that holds that male killers take up the majority if not almost the entire sample (Duwe, 2007). The same goes for white killers.

Tables 4-6 display month, day, and time information about the killings.

Table 4

Month of the Mass Murder

<table>
<thead>
<tr>
<th>MONTH</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>February</td>
<td>2</td>
<td>8.0%</td>
</tr>
<tr>
<td>March</td>
<td>2</td>
<td>8.0%</td>
</tr>
<tr>
<td>April</td>
<td>3</td>
<td>12.0%</td>
</tr>
<tr>
<td>May</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>June</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>July</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>August</td>
<td>4</td>
<td>16.0%</td>
</tr>
<tr>
<td>September</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>October</td>
<td>4</td>
<td>16.0%</td>
</tr>
<tr>
<td>November</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>December</td>
<td>5</td>
<td>20.0%</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 5
Frequency and Statistics of Day of the Week of the Mass Murder

<table>
<thead>
<tr>
<th>DAY OF THE WEEK</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
<th>DAY OF THE WEEK STATISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sunday</td>
<td>2</td>
<td>8.0%</td>
<td>Mean</td>
</tr>
<tr>
<td>Monday</td>
<td>9</td>
<td>36.0%</td>
<td>Median</td>
</tr>
<tr>
<td>Tuesday</td>
<td>2</td>
<td>8.0%</td>
<td>Mode</td>
</tr>
<tr>
<td>Wednesday</td>
<td>3</td>
<td>12.0%</td>
<td></td>
</tr>
<tr>
<td>Thursday</td>
<td>3</td>
<td>12.0%</td>
<td></td>
</tr>
<tr>
<td>Friday</td>
<td>2</td>
<td>8.0%</td>
<td></td>
</tr>
<tr>
<td>Saturday</td>
<td>4</td>
<td>16.0%</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0%</td>
<td></td>
</tr>
</tbody>
</table>

Table 6

Statistics on the Time of the Attack

<table>
<thead>
<tr>
<th>TIME OF DAY STATISTICS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>10:45</td>
</tr>
<tr>
<td>Median</td>
<td>10:45</td>
</tr>
<tr>
<td>Mode</td>
<td>9:30a</td>
</tr>
<tr>
<td>Std. Deviation</td>
<td>4 Hours, 7 Minutes</td>
</tr>
</tbody>
</table>

a. Multiple modes exist. The smallest value is shown
b. Times are presented in a 24 hour, ex: 6:00PM is 18:00

Table 4 reflects that while certain months show higher numbers of attacks than others, no one single month is dominated by mass murderers. While certain periods of time do show surges such as December of 2012, where four mass murders happened within the same two week period, it is not clear as to why this surge occurred, and no other comparable surges happened in the sample.

The results also show that attacks in the sample had an abnormal amount of attacks on Mondays with three times the amount of attacks as the rest of the days. This may be caused by Monday being the beginning of school and work week, and therefore a stressor on the mass murderer’s life.
Table 5 also confirms Monday as the unusually high mode. Table 6 reflects the median and average time of day between the attacks, which was approximately 10:45 AM and a mode of 9:30 AM, suggesting early morning is the most popular time for mass murder. One case, Guy Heinze Jr., was not given a time because the investigators could not determine at what time the attack happened. Heinze was the reporting party, who called in at around 8:05 AM, but it is unknown at what time the attack occurred and therefore it was excluded.

The frequency analysis also reflects the majority of cases took place after 2007, as shown in Table 7.

Table 7

<table>
<thead>
<tr>
<th>YEAR</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1966</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>2007</td>
<td>2</td>
<td>8.0%</td>
</tr>
<tr>
<td>2008</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>2009</td>
<td>4</td>
<td>16.0%</td>
</tr>
<tr>
<td>2011</td>
<td>2</td>
<td>8.0%</td>
</tr>
<tr>
<td>2012</td>
<td>11</td>
<td>44.0%</td>
</tr>
<tr>
<td>2013</td>
<td>4</td>
<td>16.0%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>25</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

The only outlier was the case of Charles Whitman in 1966. This indicates that the majority of cases reflect modern mass murder trends and methods because the sample is largely from the current era.

The weaponry used was fairly consistent around firearms, often multiple firearms, as reflected in Table 8.

Table 8

| Weapon Used in Mass Murder |
As reflected by Table 8, nearly all of the killers used a firearm in their crime. The one exception to this trend is the Boston Bombing performed by the Tsarnaev Brothers. The table was broken down to reflect what kind of firearms were used, and if there were various firearms of different types used, they would fall under the “Firearms, Multiple” category. The majority of killers used several different kinds of firearms; the most popular among these were pistols.

One case in particular is noteworthy. Guy Heinze Jr. used a shotgun, but as a bludgeon rather than its intended purpose as a firearm. All other cases of firearms involved the death of their victims by the intended use of the manufacturer.

The output for Table 9 shows whether the weapons mentioned above were obtained legally.

Table 9

<table>
<thead>
<tr>
<th>WEAPON OBTAINED LEGALLY?</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>9</td>
<td>36.0%</td>
</tr>
<tr>
<td>No</td>
<td>13</td>
<td>52.0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>12.0%</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
52% of the weapons used were obtained illegally. As the one case of a bomb with the Tsarnaev brothers was conducted with pressure cookers, and are not subject to any regulation. The firearms that were obtained illegally were obtained by various means from theft to illegal sales over the internet. However, this is slightly dissimilar to Table 10, which describes the number of subjects that had previous encounters with police.

Table 10

Whether the Killer had a Criminal History before Attack

<table>
<thead>
<tr>
<th>PAST CRIMINAL HISTORY</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5</td>
<td>20.0%</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>76.0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 10 shows that 19 of the 25 offenders had no previous criminal history or negative encounters with the legal system, such as restraining orders. This disparity between Tables 9 and 10 would suggest an error as thirteen killers obtained their weapons illegally, yet only five had previous criminal history barring them from obtaining their weapon. Table 9 measures whether it was legal for the killer to obtain the weapon at the time of purchase. Table 10 measures any kind of criminal history that would bar them from obtaining a weapon such as a firearm. Some of the killers illegally obtained their weapons by methods such as stealing or killing the owner of the weapon. This action would help the killer avoid a negative contact with the legal system, but is illegal. Another way this can be achieved is by lying on the documentation for the purchase of a firearm. While criminal history is recorded and reviewable by law enforcement officials, mental
illness has no such database that is available nationwide. An individual could lie about his mental health on the form and would have no one to dispute this, thus still making the obtainment of a firearm illegal while not possessing a criminal record.

The effects of mental illness on mass murder are shown in Tables 11-13.

Table 11

Suspicion of Whether the Killer was Mentally Ill

<table>
<thead>
<tr>
<th>SUSPECTED MENTALLY ILL</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>14</td>
<td>56.0%</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>32.0%</td>
</tr>
<tr>
<td>Unknown</td>
<td>3</td>
<td>12.0%</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Table 12

Mental Disorder Breakdown

<table>
<thead>
<tr>
<th>Disorder Name</th>
<th>Yes</th>
<th>No</th>
<th>Percent Yes</th>
<th>Percent of Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>5</td>
<td>9</td>
<td>35.7%</td>
<td>20%</td>
</tr>
<tr>
<td>Schizoaffective Disorder</td>
<td>2</td>
<td>12</td>
<td>14.3%</td>
<td>8%</td>
</tr>
<tr>
<td>Bipolar</td>
<td>1</td>
<td>13</td>
<td>7.1%</td>
<td>4%</td>
</tr>
<tr>
<td>Autism Spectrum</td>
<td>2</td>
<td>12</td>
<td>14.3%</td>
<td>8%</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>2</td>
<td>12</td>
<td>14.3%</td>
<td>8%</td>
</tr>
<tr>
<td>Anti-Social Personality Disorder</td>
<td>2</td>
<td>12</td>
<td>14.3%</td>
<td>8%</td>
</tr>
<tr>
<td>Suicidal</td>
<td>1</td>
<td>13</td>
<td>7.1%</td>
<td>4%</td>
</tr>
<tr>
<td>Insomnia</td>
<td>1</td>
<td>13</td>
<td>7.1%</td>
<td>4%</td>
</tr>
<tr>
<td>Borderline Personality Disorder</td>
<td>1</td>
<td>13</td>
<td>7.1%</td>
<td>4%</td>
</tr>
<tr>
<td>Depression</td>
<td>4</td>
<td>10</td>
<td>28.6%</td>
<td>16%</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
<td>14</td>
<td></td>
<td>25 Cases</td>
</tr>
</tbody>
</table>
Table 13
Whether the Offender Received Treatment for Mental Disorder

<table>
<thead>
<tr>
<th>TREATMENT RECEIVED</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
<th>PERCENT OF MENTALLY ILL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committed, Released</td>
<td>2</td>
<td>8.0%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Medicated</td>
<td>2</td>
<td>8.0%</td>
<td>14.3%</td>
</tr>
<tr>
<td>Medicated, off medication</td>
<td>2</td>
<td>8.0%</td>
<td>14.3%</td>
</tr>
<tr>
<td>No</td>
<td>7</td>
<td>28.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Receiving Treatment</td>
<td>1</td>
<td>4.0%</td>
<td>7.1%</td>
</tr>
<tr>
<td>N/a</td>
<td>11</td>
<td>44.0%</td>
<td>N/a</td>
</tr>
<tr>
<td>Total</td>
<td>25</td>
<td>100.0%</td>
<td>100%</td>
</tr>
</tbody>
</table>

*Cases with N/a indicate those not mentally ill.

Table 11 shows us that 14 of the 25 cases were suspected or confirmed as mentally ill, or that a mental diagnosis was made of the killer’s health while he was still alive, or a family member had sufficient evidence to believe they were mentally disturbed. This constitutes the majority of the cases in the study. Table 12 reflects the breakdown of those who were mentally ill. It is worth noting that many of the murderers in these cases had multiple disorders, hence the overlap. Schizophrenia had the most cases with five cases. Table 13 reflects whether or not those who were considered to be mentally ill were receiving any kind of treatment for their illness. Of the fourteen cases, seven were not receiving nor had ever received treatment of any kind. Only two were committed, but both were released. Four were on prescribed medication for their illness, but two were off their medication at the time of the attack, and one other case was receiving treatment of a nondescript nature.

Other statistics produced some interest as well, as displayed on Tables 14 and 15.
Table 14

Disposition of the Killer

<table>
<thead>
<tr>
<th>DISPOSITION</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Captured</td>
<td>8</td>
<td>32.0%</td>
</tr>
<tr>
<td>Killed by Police</td>
<td>5</td>
<td>20.0%</td>
</tr>
<tr>
<td>Killed by Police/Captured</td>
<td>1</td>
<td>4.0%</td>
</tr>
<tr>
<td>Suicide</td>
<td>11</td>
<td>44.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Table 15

Type of Location Where Mass Murder Took Place

<table>
<thead>
<tr>
<th>LOCATION</th>
<th>FREQUENCY</th>
<th>PERCENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital/Care Facility</td>
<td>3</td>
<td>12.0%</td>
</tr>
<tr>
<td>Military Compound</td>
<td>2</td>
<td>8.0%</td>
</tr>
<tr>
<td>Public Place</td>
<td>9</td>
<td>36.0%</td>
</tr>
<tr>
<td>Residence/Neighborhood</td>
<td>4</td>
<td>16.0%</td>
</tr>
<tr>
<td>School</td>
<td>7</td>
<td>28.0%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>25</strong></td>
<td><strong>100.0%</strong></td>
</tr>
</tbody>
</table>

Table 14 reflects what happened to the killer after their attack. Suicide was the most common outcome among mass murderers. Additionally, the one result of “Killed by Police/Captured” refers to the Tsarnaev Brothers, in which case Tamerlan was killed by police and Dzhokhar was captured by police.

Table 15 shows the different kinds of locations in which the attacks took place. It is worth noting that universities, schools, military compounds, and hospitals all have restrictions concerning weapons on the premises. These constitute 12 of the 25 cases. Similar restrictions also exist in some malls and movie theaters, although it is unclear whether these specific locations had those restrictions in place. Further research is encouraged on this topic.
From the data, a correlation table was conducted to look for variables that were significantly linked. Only variables that showed statistically significant relationships were included. The results are displayed in Table 16 on the following page.
Table 16

Correlation Table of Variables

<table>
<thead>
<tr>
<th></th>
<th>Age</th>
<th>Weapon Used</th>
<th>Number Killed</th>
<th>Number Wounded</th>
<th>Mental Illness</th>
<th>Schizo-Affective Disorder</th>
<th>Autism</th>
<th>PTSD</th>
<th>ASPD</th>
<th>Suicidal</th>
<th>Insomnia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>Pearson’s Correlation</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>N</td>
<td>25</td>
<td></td>
<td></td>
<td></td>
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<td>Weapon used</td>
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<td>Number Wounded</td>
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<td>.490*</td>
<td>-.031</td>
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*, Correlation is significant at the 0.05 level (2-tailed).
**, Correlation is significant at the 0.01 level (2-tailed).
a. Cannot be computed because at least one of the variables is constant.
This table displays several variables that show a significant relationship. The first significant relationship is between the number of victims wounded in an attack and the weapon used. The number of victims wounded was a continuous variable noting how many people were wounded at the scene and weapon used was coded as 1=Pistol, 2=Shotgun, 3=Multiple Different kinds of Guns, 4=Assault Rifle, and 5=Bomb for the weapon that the killer used. The result showed a significant positive correlation between the two variables. This correlation shows that as the destructiveness of the weapon increase the number injured increased as well. This correlation exists due to the Boston Bombing by the Tsarnaev Brothers, which had 264 wounded, more victims wounded than all of the other mass murder attacks in the sample combined. This case is an outlier, but it shows the unfortunate effectiveness of the pressure cooker bomb to maim as opposed to kill its victims.

The next set of significantly related variables is between mental illness and age. Age is a continuous variable measuring how old the offender was at the time of the attack, while mental illness was coded as 0=No, 1=Yes, and 3=Unknown, representing whether or not the offender was mentally ill. All yes/no variables were coded in this way. These two variables are positively correlated, meaning as the age of the offender goes up, the higher the likelihood that the offender is mentally ill.

Other variables, such as Anti-Social Personality Disorder (ASPD) and Suicidal Behavior disorder were linked with Number Killed, a continuous variable representing the number of people who were killed in an attack. The other two, ASPD and Suicidal, are yes/no variables that represent the killers in the sample with those mental illnesses. This result indicates that those with these mental illnesses killed more victims than other killers with mental illness. This
Statistic is an interesting one, but lacks reliability because of the very few cases that exist in the sample of those with ASPD and Suicidal Behavior Disorder.

Some variables showed significant negative relationships, such as Autism and Age. Autism was coded in the same manner as other yes/no variables, and represents whether the killer was diagnosed with a disorder on the Autism spectrum. The correlation suggests that as the age of the offender increases, the less likely it is that the killer will be on the Autism Spectrum. This correlation is realistic, as the two killers from the sample who had Autism were Lanza and Reyes, two of the youngest killers of the sample. However, Autism was only involved in two cases, and therefore while this is a significant relationship, the sample size is too small to be fully verified.

This was a problem with many of the variables. With such small numbers across the board on cases for each of the variables, many cases showed significant relationship, such as the relationship between Insomnia and PTSD, and between Suicidal and Schizo-Affective Disorder, all of which were yes/no variables. All of these variables had no more than two positive cases and therefore were likely to correlate. Despite this, the results are more reliable as there are so few cases.
CHAPTER 5
DISCUSSION & CONCLUSION

The findings presented by the researcher confirm that mental illness is a significant influence in mass murders. 14 of the 25 cases presented the researcher with evidence that the killer was mentally ill in some fashion, but the breakdown of the common symptoms and traits shows the researcher a slightly different picture.

One such set of symptoms included the emotions that were closely tied to these killings. Aggression was found to be the most common character trait among the mental illnesses found by the researcher. Individuals with Schizophrenia and Schizoaffective Disorder both can display aggression as part of the illness, but cases of Bipolar Disorder, PTSD, and Anti-social Personality Disorders show cases of anger as a symptom of the illness. This constitutes 10 of the 14 cases, and makes up 40% of the overall sample. Additionally, tendencies for self-destruction were also found. These exist in those with Bipolar Disorders, those who are suicidal, those with Borderline Personality Disorders, and those with depression. Four of the fourteen mentally ill killers were found to exhibit this trait, two of whom belong to the previous list and two who were not. Among the two killers who are not on either list is Jose Reyes who was Autistic. In addition to the Autism, Reyes was depressed and suicidal from the bullying he experienced at school, which he cites as the motivation for the killing. The other is Ian Stawicki, who was urged to seek help but never did and had been cited for domestic violence. This shows Stawicki had a temper, thus fitting in with the rest of the previous assumption. From these two symptoms, we can look at the killings through emotions that are familiar to society, rather than resort to the notion of the mass murderers becoming disconnected from reality.
It is often assumed by both the media and the public that mass murderers have a break from reality. This is often the easiest of explanations, as no one in their right mind would ever commit such a heinous act. Holmes and Holmes described this killer as the Psychotic Mass Murderer (Holmes & Holmes, 2001, p. 106). Of those with mental illness in the sample, Schizophrenia and Schizoaffective Disorder are the only two disorders in which people experience delusions or hallucinations that would cause them to have a break with reality. This only makes up six cases in the sample with these illnesses, as Cho was suspected of either Schizophrenia or Schizoaffective Disorder. Within the sample, this is only 24% of all cases, and therefore fits the analysis by Holmes and Holmes: that psychotic mass murderers are in the minority. While this does agree with the definition, this study does not support the conclusion by the media that all mass murders are mentally ill. This aggregation leads to generalization about the population that is not true and only exists in a section of the sample.

The study does show that mental illness is present in mass murder and has a moderately significant presence in it, but it does not back the other claim by media outlets that mass murderers are psychotic killers, ones who have breaks with reality. The majority of cases show little to no potential for a loss of ability to perceive what is real and what is delusional. In reality, those with serious mental illnesses only make up 4.1% of the U.S. population as of 2012, whereas Schizophrenia itself only makes up 1.1% of the U.S. population and is not part of the former statistic. (National Institute of Mental Health, 2013). Compared to the six cases which make up 24% of the sample of mass murderers this population remains overrepresented. However, only one of these six was receiving the treatment that he needed to get better, Kazmierczak, and he not taking his medication at the time of the attack. Two of these cases were committed but eventually released, Shick and Cho. The remaining three were captured and
diagnosed after their assault. This means that all of cases from the sample that were schizophrenic were not given the care they needed.

A review of the rest of the mental illness cases shows a similar story. 5 of the 14 mental illness cases from the sample were receiving treatment in some way, but two of those cases were off their medication during the attack. Therefore, 11 of the 14 cases did not receive treatment or rejected their treatment, and with the other three cases, the treatment may have not been enough.

With so many in the sample failing to receive needed treatment, it is highly likely that the suspicion of the public that the mental health system fails to identify those who need treatment is an accurate assumption. The reason the system is failing could be caused by a number of problems. The first is the diagnosis period for some illnesses can be extremely long. For example, according to the DSM Schizophrenia has a diagnosis period of six months, with a one month period where the symptoms must be directly present (American Psychiatric Association, 2013, p. 100). This is an extremely long period for the patient to simply wait to be diagnosed, thus delaying the needed care. Additionally, mental health professionals only have interactions when the patient has a run in with the law or is self-reported for the most part. Further research into better diagnosing patients would be a prudent measure to help fix the system.

Limitations

This study was a case study of 25 cases from the list Jon Liebert posted online (Liebert, 2014). This list was the most readily available and was posted near the beginning for the collection of research. This sample is representative of this list, and the results are significant only to this sample.
One item the researcher notes is that the sample was based on news and media reports, as well as official reports made available to the public. As the question of reliability of the media to report the facts (Huff-Corzine, et al., 2013; Rieder, 2013), the researcher does note that there is a possibility that the reports may not be completely accurate. If they are not accurate, then the results show that the public’s perception of mental illness is based purely on the media’s misrepresentation of mass murder. However, the researcher is confident in the accuracy of these reports to reflect the facts and resulting statistics.

It is worth noting that while the research does confirm a connection between mental illness and mass murder, it is not predictive, and the result is not significant to for this sample. Further research of larger quantitative samples can provide more reliability. Beyond that, a lack of proper treatment can be suspected as the real problem. With so many individuals in the sample failing to be diagnosed or receive proper treatment, the warning given by Insel (Shern & Lindstrom, 2013) about the untreated patients can be suspected as a credible one. Therefore, untreated mental illness is a good place to look for policy improvements.

**Policy Recommendations**

Creating policy that better detects mental illness in young adults and children would seem to the researcher as a good place to start. Even if the policy is made and it has no effect on mass murder rates in the U.S. (Fox & DeLateur, 2014), it will help get treatment to those who need it. Additionally, making self-report options more available and friendly will increase the number of people that may seek help, making it easier for them to receive treatment.

One idea that is stated in the literature is a national database of those who are mentally ill to prevent them from having access to firearms. There are certain killers that this could help
prevent such as Shick who was diagnosed in one state and bought a gun in another. The Gun Control Act of 1968 prohibits the mentally ill from purchasing a firearm, but because of doctor-patient confidentiality reporting is a problem (Gun Control Act of 1968, 1968). In this case for the law to be effective there would have to be a workaround in the creation of such legislation. However, it borders on criminalizing the mentally ill and will further discourage those who have mental illness from seeking help. Therefore, if policy makers are to proceed with policy along these lines, it must be done with great care for those who are mentally ill.

Much of the literature suggests that the best way to overcome mass murder is for the community to come together and overcome the actions. Community efficacy counts for a lot in this case, but it also requires the community to reach out to those who separate themselves from society. Often these types of killers isolate themselves and then lash out at society, so if the community brings them into the fold it may reduce such attacks. This also requires the media to demonstrate self-control when it comes to examples of mass murder, like not covering the killing every waking hour of the day.

Further research is encouraged to look at anger and self-destructive attitudes, even in those who are not considered mentally ill, as a possible factor in mass murder psychology. Another area that would be highly encouraged would be into the locations themselves. The researcher came across several points that suggested strict gun regulation in the target location, but felt it was a departure from the purpose of this study. Finally, a larger sample with similar parameters will produce a more robust, reliable result as to the nature of mental illness and mass murder that may be more reflective of mass murder as a whole.
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APPENDIX A
MENTAL ILLNESSES

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, (DSM-V) is a manual created by the American Psychiatric Association to help practitioners diagnose patients more reliably and with better validity, and is the best representation of the terms and definitions classified by the APA that both researchers and practitioners use in regards to mental illness. This book will be used to define the various mental illnesses that are seen throughout this thesis.

Schizophrenia is a mental disorder that involves “a range of cognitive, behavioral, and emotional dysfunctions, but no single symptom is pathognomonic of the disorder” (American Psychiatric Association, 2013, p. 100). Symptoms include delusions, hallucinations, disorganized speech, disorganized or catatonic behavior of a severe nature, and other negative symptoms, such as a lack of emotional expression or avolition. Diagnosis requires at least two of the aforementioned symptoms, must exist in a major area such as work or social life, and must exist for a period of six months with a least one month where the symptoms are directly present. It is also distinguished from other mental disorders such as Schizoaffective Disorder, Bipolar Disorder, and depression. Schizophrenia can be diagnosed in those with Autism if prominent delusions or hallucinations are present. Aggression and hostility can be related to Schizophrenia, but usually exists only in young males and those with a history of violence. Onset is typically around the mid-20’s for men and late-20’s for women.

Schizoaffective Disorder is an illness on the Schizophrenia Spectrum, in which there is an uninterrupted period where there is a major mood episode. Delusions and hallucinations take the place of the major mood episode for a minimum of two weeks during the lifetime of the illness, although these can exist for a longer period of time. Major mood episode symptoms must be
present for the majority of the time, and cannot be attributed to properties of a substance, such as a drug or prescription, or another condition. Those with Schizoaffective Disorder can also be sorted into two subtypes: Bipolar type, if a manic episode is displayed as part of the symptoms, and Depressive type, if major depressive episodes are the only symptoms. This disorder can also exhibit catatonia. This illness differs from Schizophrenia because it lacks the social dysfunction requirement and exclusion of an autism spectrum disorder prerequisite (American Psychiatric Association, 2013, pp. 105-107).

Post-Traumatic Stress Disorder, is a Trauma/Stressor related disorder, in which the person was exposed to “actual or threatened death, serious injury, or sexual violence” (American Psychiatric Association, 2013, p. 271) by either experiencing them directly, witnessing the events as it happened to someone else, learning about the event happening to a family member or close friend (this case must be either violent or accidental), or by extreme repeated or extreme exposure to details of traumatic events, usually found in first responders (American Psychiatric Association, 2013, p. 271). At which point, one of the following intrusion symptoms that are related to the traumatic event must be present:

“recurrent, involuntary, and intrusive distressing memories of the traumatic events, recurrent distressing dreams in which the content and/or effect of the dream is related to the traumatic events, dissociative reactions, in which the individual feels the traumatic events were recurring, intense or prolonged psychological distress at exposure of internal or external cues that resemble an aspect of the traumatic events, and marked by physiological reactions to internal or external cues that symbolize or resemble an aspect of a traumatic event” (American Psychiatric Association, 2013, p. 271).
Along with these intrusive symptoms, people with PTSD will avoid stimuli that remind them of the traumatic event, and will have negative changes to their personality, such as amnesia, anger, negative beliefs, or reckless behavior. These symptoms must exist for more than a month for it to be diagnosed as PTSD. Effects vary from adults to children under the age of six.

Bipolar Disorder is a set of disorders that exists as a bridge between schizophrenic/psychotic disorders and depressive disorders. They are typically divided into Bipolar I and Bipolar II disorders, along with various other subtypes, but for the purposes of this study these will be the two primarily examined. Bipolar I is characterized by a manic episode, a clear period where the person experiences a change in their normal behavior. The subject may feel a boost in self-confidence, lack of need for sleep, an increase in talkativeness, racing and brief thoughts of a subjective nature, easily distracted, a rise in goal directed activity, and an increase in activities that are considered high risk or can lead to harm. This period has to be at least one week long, and occur nearly every day. Three of these symptoms are required for diagnosis. These behaviors are taken to such an extreme that it causes the subject to be incapable of functioning normally in their occupation or social setting. Hospitalization may be prudent to prevent them from hurting themselves or others. The manic episode must not be attributed to any substance or treatment, with the exception of antidepressant treatment if it persists. The manic episode can be preceded or followed by hypomanic or major depressive episodes.

Bipolar II however requires both a hypomanic episode and major depressive episode in either order. A hypomanic episode displays the same symptoms listed above in the manic episode, but the required time is shorter: only four days for the episode with symptoms each day. Major depressive episodes require five of the following symptoms and must be present for at least two weeks: depressed mood for the majority of the day, lack of interest or diminished
pleasure from life’s activities for most if not all of the day, decrease or increase in weight or appetite, a significant loss or gain of sleep, fatigue every day, “psychomotor agitation or retardation” (American Psychiatric Association, 2013, p. 133), lack of concentration or indecisiveness, lack of self-worth, repeating or constant thoughts of death. This too impairs the person’s ability to function socially and occupationally. A stipulation for Bipolar II disorders includes that there has been no manic episode, as it would classify it as a Bipolar I disorder, and must not be better explained by other disorders such as a disorder on the Schizophrenia Spectrum. To clarify, Bipolar II is not a lighter form of Bipolar I, just with a shorter manic period.

Anti-social Personality disorder is part of the Personality disorders under Cluster B. It is described as “a pervasive pattern of disregard for and violation of the rights of others” (American Psychiatric Association, 2013, p. 659) since the individual was fifteen years old. They also must have at least three of the following behavioral symptoms. They either fail to conform to social norms in regards to how to behave lawfully, typically displayed by multiple arrests, they lie repeatedly or are choosing to be deceitful, are impulsive, irritable, reckless disregard for self and others, constantly irresponsible, or a lack of remorse for one’s actions against another person. To diagnose the person, the individual must be eighteen years of age, with an onset at age fifteen, and the antisocial behavior is not exclusive to another disorder such as Schizophrenia or Bipolar Disorder. This pattern is used to describe psychopathy, sociopathy and dissocial personality disorders, and is much more common than most other disorders (American Psychiatric Association, 2013, p. 659).

Borderline Personality Disorder is another type of personality disorder in Cluster B along with Antisocial Personality disorder. Borderline Personality Disorder is described as “a pervasive
pattern of instability of interpersonal relationships, self-image, and affects, and mark impulsivity” (American Psychiatric Association, 2013, p. 663). It typically presents itself in early adulthood and must have 5 of the following traits: desperate efforts to avoid abandonment, either real or imagined, unstable or intense relationships, unstable portrayal of self-image, self-damaging impulsive actions, chronic suicidal actions or behavior, affective behavior instability sometimes characterized by reactivity of mood, feelings of hollowness or an empty feeling, strong feeling of rage or anger or a difficult time controlling the anger, or paranoia related to stress (American Psychiatric Association, 2013, p. 663). Those with the disorder may be easily bored and may use extreme sarcasm, bitterness, or outburst. This too has a high prevalence rate in the population, like the antisocial personality disorder (American Psychiatric Association, 2013, pp. 664-665).

Suicidal Behavior Disorder is characterized by a suicide attempt made by the individual in the previous 24 months. The suicide must have been initiated by the individual and at the time of the attempt the person expected to die. It also cannot meet the requirements for non-suicidal self-injury. These actions must not have happened as a result of delirium or confusion, and cannot be motivated for political or religious reasons. The diagnosis also does not apply to suicidal ideation or preparatory acts (American Psychiatric Association, 2013, p. 801). This disorder can be seen in combination with other disorders, such as those on the Schizophrenia Spectrum.

Insomnia Disorder falls under the Sleep-Wake disorders of the DSM-V (2013). It is described as a person who does not get the amount of sleep he or she desires. This can either be in the form of difficulty starting sleep, difficulty maintaining it, or inability to return to sleep after waking up too early. This in turn causes distress on the individual to the point that it affects
their everyday life. To meet the requirements for diagnosis, the sleep difficulty must happen at least three nights per week and be present for at least for three months, despite ample opportunities to sleep. The insomnia must also not be better explained by another sleep-wake disorder or to the effects of a substance such as drugs or medication, and that other mental disorders that the patient may have do not better explain the insomnia. This disorder is relatively common as one in three adults report symptoms of insomnia, with about 6-10% actually having symptoms meeting the criteria of the disorder (American Psychiatric Association, 2013, pp. 362-368). It can exist alongside other disorders such as Bipolar Disorder or Depressive Disorder.

Autism Spectrum Disorder is when an individual has a deficiency in social communication and interaction in many different settings and presents in the form of the deficiencies in social-emotional reciprocity, in nonverbal communication behaviors, and in developing, maintaining, and understanding relationships (American Psychiatric Association, 2013, p. 50). Additionally, restricted repetitive behavior patterns, interest patterns and activity patterns must manifest, and must be demonstrated by two of the following:

“Stereotyped or repetitive motor movements, use of objects, or speech; insistence on sameness, inflexible adherence to routines, or ritualized patterns of verbal or nonverbal behavior; highly restricted, fixated interests that are abnormal in intensity or focus; hyper- or hyporeactivity to sensory input or unusual interest in sensory aspects or the environment” (American Psychiatric Association, 2013, p. 50).

These deficiencies range in severity, and are based on how impaired the individual is at social communication, and on the range of repetitive behavior by the subject. These symptoms can show themselves in early stages of development, but may not fully manifest until the social demand exceeds the individuals capacity, and the symptoms will impair the subject socially,
occupationally, and in many other areas of function but on a clinically significant level (American Psychiatric Association, 2013, p. 50). In order to diagnose someone as autistic, the individual’s disturbances must not be better explained by an intellectual disability or global development delay. Often, the diagnoses will specify an accompanying intellectual or language impairment, along with any medical or genetic condition if one exists. The same goes for other disorders or if the patient is catatonic. Severity is often ranked as Level 1, or the lowest end as “requiring support,” to Level 3, the highest level “requiring very substantial support” (American Psychiatric Association, 2013, p. 52).

Asperger’s disorder, another mental disorder from the previous edition of the DSM, is also known as Pervasive Developmental Disorder. Asperger’s has been regrouped under the autism spectrum disorder. Those who match the social communication symptoms but lack the other symptoms of autism spectrum disorder are now evaluated for social (pragmatic) communication disorder. (American Psychiatric Association, 2013, p. 51)

Depression is a condition where the individual feels sad, empty, or lonely about their life, or a disinterest or lack of pleasure about their life. Depression can be just episodic, but in extreme cases, it may need the attention of a medical professional for evaluation and possible treatment. The most serious form of depression is the Major Depressive Disorder, which requires five or more of the following symptoms along with either the depressed mood or loss of interest or both:

“Depressed mood most of the day; markedly diminished interest or pleasure in all, or almost all, activities; significant weight loss when not dieting or weight gain, or decease or increase in appetite nearly every day; insomnia or hypersomnia nearly every day; psychomotor agitation or retardation nearly every day; fatigue or loss of energy nearly
every day; feelings of worthlessness or excessive or inappropriate guilt nearly every day; diminished ability to think or concentrate, or indecisiveness, nearly every day; recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide” (American Psychiatric Association, 2013, pp. 160-161).

These symptoms must be present for two weeks to make the diagnosis of Major Depressive Disorder, and must cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning” (American Psychiatric Association, 2013, p. 161). It also cannot be attributable to the physiological effects of another disorder or substance. These all make up a major depressive episode, which is indicative of the disorder. These symptoms should not be better explained by another disorder, such as one on the Schizophrenia Spectrum, and there should be no manic or hypomanic episodes present or in the patient’s recent history.
APPENDIX B
MASS MURDERER TYPOLOGY

Typology on mass murders has been briefly debated, but one set of authors, Ronald and Stephen Holmes, created a typology of mass murderers. Their typology covers the majority of mass murderers and why the killer commits murder in this particular fashion, as well as victim typology, motivation, spatial mobility and many other components. The typology is cited by multiple authors in mass murder literature (Ramsland, 2005; Lester, 2004) and is now the basis for understanding mass murder as a type of multicide.

The Disciple Mass Murderer is a killer who follows a typically charismatic leader of a group varying in ideology from political to religious. The motivation for this type of killer is extrinsic and is dependent on the relationship between the leader of the group and the disciple. The expected gain for him or her is expressive or psychological to the killer and he or she “wants to have something realized by their acts of murder” (Holmes & Holmes, 2001, p. 42). The killer typically has no preference when picking the victims, as they tend to be strangers to the disciple killer but can be chosen by the leader. Spatial mobility for the disciple mass murderer is fairly transient, with the only constraint being the funds available to make travel possible. Like the victim selection, the victim traits are nonspecific. An example of a Disciple Mass Murderer group is the Charles Manson Family.

The Family Annihilator Mass Murderer kills those who are closest to them: their family. While the motivations of the Family Annihilators vary, they are always intrinsic to the personality of the killer. The anticipated gain is expressive or can be psychological. Victim selectivity is nonrandom, as the victim’s relationship to the killer is always a family member or someone of close relation. Some Family Annihilators can kill other nonrelated victims, but the first victims will always be a family member. Family Annihilators tend to be long-term residents
of the community and are less transient than other killers. They usually grow up in that community and are well known there. Very rarely does a family annihilator kill his or her family outside the confines of the community or their household. The physical traits of the victim give no partiality on the killer, only that they are related to him or her. “The Family Annihilator is the most common type of mass murderer” (Holmes & Holmes, 2001, p. 60) with many different possible motivators, but always having a significant relationship with the victim. The text gives a few examples; the most famous being the mass murderer Captain Jeffrey MacDonald, who in 1970 murdered his wife and two children in Fort Bragg, North Carolina, and blamed it on a group of “hippies” [sic].

The next type of mass murder is the Disgruntled Employee Mass Murderer. The Disgruntled Employee Mass Murderer is an individual who kills at his or her current or former place of work. Motivation for the killer is intrinsic to the personality of killer, and the reasoning is only important to the killer. The Disgruntled Employee Mass Murderer’s expected gain is expressive. Usually the killer feels that they have been wronged and that by killing the people who are responsible, attention will be brought to the actions of those who wronged them. This type of killer is geographically stable and lives and works in his or her community. As for the victims, they are randomly selected, victim traits have no meaning to the killer, and the only relationship that the victims have to the killer is that they either work or are doing business at the place where the killer works. These types of killers are hard to predict, as the killers randomly select their victims for a number of reasons. Possible solutions to prevent this type of killing include a reporting system inside businesses to allow other employees to report possible violence.
The Ideological Mass Murderer is a killer, typically a leader of a cult or group that will kill his or her own group as a display of power and control, and will blame the system. The group is typically that of a political or religious nature. Motivation for this killer is intrinsic to the personality of the killer, who is searching for control. There is no control for him or her like the ability to end the lives of the followers in the group or cult as a display of power. The anticipated gain is typically a mixed bag of both expressive and instrumental actions. The deaths of his followers are meant to convey the control that the leader has ultimate power. Spatial mobility for the leader can be high, as the leader can move around to flee the law or recruit new followers. The killer’s victims are not random and are not strangers to the killer, as the only victim group the ideological mass murderer kills is his or her own cult. Victim traits are not as important to the killer. Holmes and Holmes (2001) cite the Jonestown killings in which Reverend Jim Jones ordered his over 900 followers to kill themselves.

The next type of mass murderer is the Set-and-Run Mass Murderer as defined by Holmes and Holmes. The Set-and-Run Mass Murderer is a killer who is not present for his killings. They are noted as the least understood of all mass murderers, and that they often overlap with other types of mass murderers. This killer has no desire to be caught or die during his killings. Motivation is intrinsic to the killer. Likewise, the anticipated gain is intrinsic and personal to the killer. This killer’s spatial mobility tend to be, as the text describes it, “nomadic” (Holmes & Holmes, 2001, p. 91) as the killer does not reside in the place he kills. As for the victims, they are completely random to the killer, with no relationship or specific traits that the killer is looking for. The given examples are Timothy McVeigh, who was responsible for the Oklahoma City Bombing, and the Tylenol Mass Murderer.
The Disgruntled Citizen Mass Murderer is the next kind of mass killer. This type of killer is angry at their society and does share many traits with other mass killers. Motivation for the Disgruntled Citizen Mass Murderer is intrinsic to the killer, as they feel as though society has wronged them in some way and the only solution is to inflict massive casualties upon the society’s citizens. The anticipated gain is personal to killer and expressive. Like the Disgruntled Employee Mass Murderer or the Ideological Mass Murderer, the killings can be meant to demonstrate the wrongs of society, but are always psychologically linked to the killer’s mind. This killer is geographically stable, meaning they are members of their communities, and will typically start the killing in that same area. Victims are selected at random by the killer, with no particular traits or relationship to the killer. Early identification is the best solution, along with early intervention with mental health professionals.

The final type of mass killer is the Psychotic Mass Murderer. This type of killer has a mental condition of some sort that alters the killer’s perception of the world around him, causing a break with reality. These murderers aren’t just neurotic; they have a condition that impairs them from interacting normally with society on a day to day basis. However, they are not psychopaths and don’t have character disorders as defined by Cleckley. Psychopaths and sociopaths can kill, but only because they have a disregard for life. This is different from psychosis which is a break from reality. By far, the Psychotic Mass Murderers show up in the minority, according to the authors. Because of the graphic nature of these killings, many who report these killings will automatically turn all mass murderers into psychotic killers, while the rates of actual psychotic mass killers is very low. Motivation for the psychotic mass killer is intrinsic to the mind of the killer. He or she is out of touch with reality, to the point where they may hear voices or see visions compelling them to kill. These delusions only exist in their mind;
however, their mind may be influenced by their surroundings to allow the mind to arrive at such conclusions, such as psychological trauma or biological stimuli. The anticipated gain is also psychological and individual to the killer. The killer usually wants some sort of psychological gain, such as appeasement of the “voices.” For spatial mobility, this killer is geographically stable. This killer prefers the known and the familiar, and therefore is likely to live with family or alone and is not likely to move except to preserve that familiarity. Victims of this mass murder are completely random, with no particular type of characteristic or relationship. The victims simply happen to be in the same location as the killer when the psychotic break happens. People of this killer’s category are likely to be well known for mental deficiency, and therefore proper treatment by mental health professionals is essential in preventing this type of killer from having a break with reality.

Holmes and Holmes additionally provide a look at the rise in school shootings over the late 1990’s and early 2000’s. From this, they generate a working profile for school shooters, a killer who commits his mass murder in a school. While some school shooters do not fit into the whole profile, it matches the majority. The profile is: white males, a student of the school where the killings are performed, along with the school being located in a rural or suburban area. The student will typically belong to the middle class socioeconomically, is disenfranchised, and is in the “out” crowd. Additionally they have an interest in video games and weaponry. They will foretell their deadly plans to fellow students before the killings, as well as keeping their daily actions secret. Motivations vary widely, but are intrinsic to the killer.
APPENDIX C
EXAMINED CASES OF MASS MURDER

On March 8th, 2012, a lone gunman entered the lobby of the Western Psychiatric Institute and Clinic of UPMC with two semiautomatic pistols and began opening fire. The attack killed a therapist, Michael Schaab, 25, who worked at the clinic, and wounded four more. The shooter was killed by police before he could be captured (Sheehan, 2012a).

The shooter was identified as John Shick, 30, a student who lived in Oakland, PA, described by neighbors as very functional. In high school, Shick was heavily involved in student organizations and extra-curricular activities. He also earned a co-author position in an article published in Experimental Psychology while still in high school. Shick graduated from Carlaton University with a degree in Chemistry and Columbia University with a degree in Computer Science in 2004 (Thomas, 2012). After receiving his degree, Shick held a variety of jobs in New York. At one job, his employer failed to note a single time where he had been violent or having aggressive tendencies (Thomas, 2012). In April 2009, Shick moved to Portland, Oregon in an effort to work at Portland State University. While attending school there, he was accepted into the doctoral program on Chemistry and was working in a lab. A few coworkers noted Shick having odd conversations with students and other coworkers. Shick was also described as being anti-social during this period of time and began to cause problems. Multiple run-ins with security were noted, to the point that PSU rescinded its offer. Additionally, Shick legally changed his name to “Willim Hahnpere Scolskan,” but later changed it back (Thomas, 2012). On December 29, 2009, Shick had a very serious encounter with the police after he harassed a Budget Car Rental attendant at Portland International Airport. Shick resisted arrest, kicking and biting the arresting officer. Shick was committed by the testimony of the officer, and was diagnosed with Schizophrenia while in his commitment (Brandolph, 2013).
After his release and around July 2011, Shick moved back to Oakland, PA, in an effort to try and get his academic career back on track at Duquesne University in the biology department. Complaints ensued against Shick for harassing several women on the campus. He was barred after a hearing found him responsible of harassment. (Thomas, 2012)

The months before the shooting consisted of a 911 call placed by Shick, claiming he was vomiting blood. He was transported to the later shooting site, UPMC Presbyterian. Neighbors reported strange behavior and a reclusive nature from Shick. On March 7th, 2012, the day before the shooting, Shick called 911 again, claiming he was vomiting blood. He was released the next day. That afternoon, Shick returned to the lobby. Shick entered the lobby of UPMC Presbyterian and opened fire with two semi-automatic handguns at 1:42PM, wounding 4 people (Sheehan, 2012a). Shick had purchased these guns through a gun dealer in Albuquerque, New Mexico in April 2011 (Sheehan, 2012b). Shick then left the lobby and proceeded down one of the hallways where he killed Michael Schaab. Minutes later, six police officers entered the building; confronting Shick in a hallway where a gunfight ensued that ended the shooter’s life (Sheehan, 2012a). While it is illegal to sell a firearm to a person with a declared mental illness, Oregon does not report their mentally ill citizens nationally, so Shick’s mental illness never came up in the background check.

On Saturday, August 29, 2009, seven people were found dead and two critically wounded, one dying later from his wounds, in a trailer home in Glynn County, Georgia (Mach, 2009). The perpetrator, Guy Heinze Jr, 26, called 911 himself and reported to authorities that his entire family was dead. Autopsies of the victims show 220 wounds on the victims, resulting in head and brain injuries that caused their deaths. The weapon used, according to police, was a shotgun barrel used as a bludgeon. Heinze was high at the time of the murder on crack cocaine
and was attempting to steal pain medication. To avoid being caught, he attacked the occupants of
the trailer home (Crimesider Staff, 2013). Heinze was found guilty of eight counts of malice
murder, one count of aggravated assault, and two drug charges (Dickson, 2013). He was
sentenced to life in prison without the chance for parole on October 30, 2013. (Bynum, 2013)

On April 16, 2007, Seung-Hui Cho entered the campus of Virginia Tech University and
proceeded to shoot students and faculty. Cho, a student at Virginia Tech, began his rampage at
7:15AM by shooting the first two victims in a residential building and then proceeding back to
his room. The police reportedly were investigating the crime at this point, but were unaware that
Cho was responsible and were pursuing another lead. At 9:01AM, Cho mailed a package to NBC
News in New York, with pictures of him with the weapons he would use, a Walther P22 and a
Glock 19, along with a document eluding to the massacre he was about to commit. From
approximately 9:40AM to 9:51AM, Cho began shooting the students and faculty in Norris Hall.
Cho chained the entrance doors to the Hall to prevent law enforcement from gaining access.
During this rampage, Cho killed 32 students and faculty and wounded 17 before taking his own
life, making it the single deadliest mass shooting in the U.S. to date (Virginia Tech Review
Panel, 2007).

Cho was described as a deeply troubled individual. Cho was diagnosed at an early age
with extreme social anxiety, and was even admitted to a hospital in college after making threats
of suicide, but was never formally diagnosed. (Virginia Tech Review Panel, 2007). Several
studies have performed posthumous diagnoses on Cho. The end result of the studies resulted in a
myriad of possibilities. Some suggest that Cho was suffering from major depression issues with
“Psychotic Features” (Dombeck, 2007) along with an anti-social disorder, and that the
environmental factors, such as being bullied and having emigrated from South Korea further led
to Cho’s mental state the day of the shooting. (Dombeck, 2007) Others suggest that he was psychotic, and that he was living in the delusions of his own mind by Schizophrenia (Dombeck, 2007). Others suggest that he displayed psychopathic tendencies (Cullen, 2007). While there still is no universal opinion of Cho’s mental state, most agree that he was experiencing a depression of great magnitude and lacked the social skill to find help or someone to talk to.

Cho’s behavior before his death corroborates the reports of his antisocial nature reports and shows potential warning signs, such as the multiple stalking reports by women from the campus (Cho, 2014). One of these reports led Cho to tell one of his suitemates that he was suicidal. On December 13th, 2005, Cho was taken by Virginia Tech Police Department to their station for a pre-screen process. The pre-screen indicated he was mentally ill and was a danger to himself. He was ordered by a magistrate to see a psychiatrist. This psychiatrist did confirm that Cho was mentally ill, but stated that he “does not present an imminent danger to himself or others” (Virginia Tech Review Panel, 2007, p. 47). Cho was then released as an outpatient. To this day, the motives of Cho are unknown (TriData Division, System Planning Corporation, 2009).

On July 20th, 2012, James Holmes, 24, entered midnight release of the movie *The Dark Knight Rises* at the Century Aurora 16 theater in Aurora, Colorado. Holmes initially bought a ticket and propped open a nearby emergency door. Holmes exited shortly after the film began and went to his vehicle to arm. At approximately 12:38AM, Holmes reentered the theater in heavy body armor, wearing a gas mask and carrying “an AR-15 assault rifle, a Remington 12-gauge shotgun, and a .40 caliber Glock handgun” (Johnson, 2012, p. 3). Holmes released two devices that dispensed smoke and then opened fire on the occupants of the theater. During this, Holmes killed 12 people and wounded 58. Holmes exited the theater and was detained by Aurora
Police Department shortly thereafter. Police later found in Holmes’ apartment, which was booby trapped, “30 homemade grenades, 10 gallons of gasoline and IEDs” (Ferner, 2013).

Holmes is currently awaiting trial on 166 counts of murder, attempted murder, and other various offenses. A diagnosis has been made of Holmes’ mental state, which determined he was schizophrenic. Holmes has entered a plea of not guilty for reasons of insanity (Gurman, 2013; Muskal, 2014).

On September 16th, 2013, Aaron Alexis, a contractor and military veteran, entered the Washington Navy Yard at approximately 8:17AM and proceeded to shoot several individuals who worked there. Alexis, 34, proceeded to move through the base, armed with a Remington 870 shotgun and a 9mm semiautomatic pistol he took off the body of a Security Guard (Hermann & Marimow, 2013). Alexis was eventually gunned down by police and NCIS agents. Alexis killed thirteen people and wounded at least eight more (Morello, Hermann, & Williams, 2013).

Alexis had served in the U.S. Navy from 2007 until 2011 as an Aviation Electrician’s Mate 3rd class. He received an honorable discharge for a “pattern of misconduct” (Carter, Lavandera, & Perez, 2013). Alexis had several incidents that required the attention of law enforcement. Most of these incidents were anger related, which according to his father was due to Post-Traumatic Stress Disorder. This was never diagnosed, however Alexis was seen by the VA for insomnia (Fox M., 2013). The Department of the Defense provided a review of shooting and determined that the events were looked at by investigators individually, which would not be alarming, but as an aggregate should raise alarms (Under Secretary of Defense for Intelligence, 2013). Alexis’ motives for the attack are not clear.

On August 1, 1966, a 25 year old architectural student and ex-Marine named Charles Whitman killed his mother and then his wife before climbing the UT Tower at the University of
Texas in Austin, Texas at approximately 11:50AM (Whitman, 2014). Whitman brought an arsenal with him: a .35 caliber Remington rifle, a 6mm Remington rifle with a scope, a .357 Magnum Smith & Wesson revolver, a 9mm Luger pistol, and a Galesi-Brescia pistol (Macleod, 1999, p. 5) to commit the act. Whitman initially started his assault on the ground in an attempt to get to the tower, and then barricaded himself into the UT tower where he continued his assault. In the following 96 minutes, Whitman shot 43 people, of which 13 died. Two Austin police officers were able to break the barricade to the tower’s top floor, ambush Whitman and kill him before he could return fire. The massacre ended at around 1:24PM (Macleod, 1999).

Whitman’s case is strange in several aspects. Whitman was regarded by many as an outstanding character in the community. He was a model student; had completed his Eagle Scout award with the Boy Scouts of America. His father was abusive, which led to Charles leaving the home (Macleod, 1999). After high school, Whitman had served in the United States Marine Corps, where he was trained as a sniper. He complained regularly of headaches, to which Whitman himself was concerned for his own mental health. This was the primary reason for his discharge from the Corp in 1963. Whitman even requested in one of his death notes that he would like to have his brain examined for possible mental illness upon his impending death. Doctors completed an autopsy on Whitman, and found he had a brain tumor, though there is some debate over whether or not it affected Whitman’s actions (Whitman, 2014).

On December 14th, 2012, Adam Lanza, 20, entered the Sandy Hook Elementary School and killed twenty students and six faculty members and wounded twelve others. Lanza started his massacre by killing his mother in his own home and then proceeded to Sandy Hook Elementary at approximately 9:30AM. (Sedensky, 2013) The first 911 calls began around 9:35AM, and police arrived on scene at 9:39AM. (Gray R. H., 2013) Lanza was armed when he
entered the school with “a Bushmaster Model XM15-E2S rifle, a Glock 20, 10 mm pistol and a Sig Sauer P226, 9 mm pistol and a large supply of ammunition” (Sedensky, 2013, p. 9). Lanza gained access to the building by shooting his way into the glass patio windows at the front of the building with the rifle. Lanza entered the front office and shot several members of staff. At the same time, someone in the office triggered the PA system, which alerted the rest of the school to the situation. This resulted in the school being placed into lockdown. He then proceeded to Rooms 8 & 10 of the building. This is where the majority of the killing occurred. At 9:40AM, Lanza took his own life with the Glock 20 in Room 10 of Sandy Hook (Sedensky, 2013).

Adam Lanza was a disturbed individual. At an early age, Lanza was diagnosed with Asperger’s syndrome, a variant of Autism. Lanza had received this diagnosis, but refused to admit he had Asperger’s, going so far as to refuse treatment multiple times. On top of this, Lanza was hypersensitive and anti-social (Solomon, 2014). Lanza was living with his mother Nancy at the time, who was by many accounts very protective of him. She even shielded Adam from his own father whom his mother divorced when Adam was nine. She was the first of Adam’s victims. (Solomon, 2014) The motive for the killings is still not conclusively known.

On March 29, 2009, Robert Stewart, 45, entered the Pinelake Health and Rehab nursing home in Carthage, N.C. Stewart entered the nursing home at 10:00AM, killing seven residents and one nurse (WRAL.com, 2009). During the shooting, Stewart used primarily a Winchester 1300 12 gauge shotgun, in addition to .357 magnum revolver and a .22 magnum semi-automatic pistol (Kaminski-Leduc, 2013). In addition to the dead, Stewart wounded three others including the police officer who first responded. This officer was able to wound Stewart and take him into custody. Stewart was charged with eight counts of felony murder and one count of felony assault on a law enforcement officer (Sulzberger & Binker, 2009). Stewart was convicted of second
degree murder on September 4th, 2011. This was a downgrade from first-degree murder charges because the jury believed he lacked the “premeditation and deliberation” (Breen, 2011, p. 1) required for the aforementioned charge. Stewart was sentenced to an indeterminate sentence by the judge ranging from 141 to 177 years in prison (Breen, 2011).

Stewart had only one connection to the nursing home. Wanda, his wife whom recently separated from him, worked as a nurse’s assistant in the nursing home and was present the day of the shooting in the section reserved for Alzheimer patients. It is possible that he was looking for her the day of the shooting, as some reports have insinuated (Associated Press, 2009). Stewart’s legal defense held that Stewart was suffering from “mental illnesses including Depression and Borderline Personality Disorder” (Breen, 2011, p. 2) and that his use of sleep medication in combination with anti-depressants led to the shooting. Stewart is still currently serving his sentence.

On December 24th, 2012, William H. Spengler, a 62 year old convicted felon, set fire to his home in Webster, New York, and shot at first responders. Spengler was armed with a Bushmaster semiautomatic rifle, a .38 special revolver, and a 12 gauge shotgun (Goldman, 2012). At 5:30AM, Spengler set fire to his own car and house and then waited for first responders in a nearby perch. When firefighters arrived, he opened fire on them with the Bushmaster rifle, killing two firemen and wounding two more. Police showed up on scene and returned fire, eventually bringing in an armored vehicle and rescued those in the area, including the firefighters. The resulting blaze burned down seven other houses. Spengler ended up killing himself before police could apprehend him (Nye & Zennie, 2012).

Spengler was a former prisoner, convicted of killing his grandmother with a hammer for which he spent seventeen years in prison (Collins, 2012). The mere fact that he was in possession
of the guns put him in violation of the law. When Spengler was released, he stayed with his sister. Police believe that she was killed by Spengler either prior to or by the fire set in the home, making her the third victim. Spengler left behind a death note, stating his intention to burn down the neighborhood and “do what [he] likes doing best, killing people” (Nye & Zennie, 2012, p. 1). Mental health issues were cited after Spengler’s death, but not with specificity (Freile & Stanglin, 2012). The true reasoning behind Spengler’s rampage is unknown.

On October 12th, 2011, a gunman later identified as Scott Dekraai went into the Salon Meritage on the Pacific Coast Highway in Seal Beach, California. Armed with three pistols, “a Springfield 9mm semiautomatic handgun, a Heckler & Koch .45 caliber semiautomatic handgun, and a Smith & Wesson .44 Magnum revolver” (Cruz & Sahagun, 2011, p. 3) and wearing body armor, Dekraai killed eight people in the salon and wounded one other. The first 911 calls were received around 1:20PM when the shooting started. (Lovett & Nagourney, 2011) Dekraai fled the scene after the crime, but was pulled over in his vehicle and was arrested without incident. Dekraai was charged with 8 felony counts of special circumstance first-degree murder and one felony count of attempted murder (Cruz & Sahagun, 2011). Dekraai pled guilty to the 8 counts of felony first degree murder on May 2nd, 2014 (Jolly & Hartley, 2014).

Dekraai chose this location because of his ex-wife, Michelle Fournier, with whom he was having a heated custody battle over their 8 year old son. Fournier worked at the salon and was Dekraai’s first victim (Cruz & Sahagun, 2011). Dekraai was a violent man by many accounts, with such actions as holding a gun to Fournier’s head shortly after their wedding. Shortly after this in 2006, she left him and eventually divorced him (Flaccus, 2011). Dekraai had also been diagnosed with Post-Traumatic Stress Disorder in 2007 after a boating accident almost removed his legs (Barboza & Cruz, 2011). Shortly after this, Dekraai attacked his step-father who was...
asking for rent. The step-father placed a restraining order on Dekraai, which provided that he must surrender all firearms, making the ones he had on him during the shooting illegally owned (Flaccus, 2011). Thus, the domestic dispute between Dekraai and his wife may have been the motive, but the factors of the PTSD and anger issues may have led him to take more drastic measures. Dekraai has pled guilty to the eight felony murder charges and is currently awaiting sentencing, where he will likely plead insanity (Cruz & Sahagun, 2011).

On January 8th, 2011, Jared Loughner, 22, attended a public political meeting called “Congress on Your Corner” being held by Representative Gabrielle Giffords at the local Safeway in Tucson, Arizona. Loughner approached Giffords at the event at around 10:10AM and shot her in the head (Gillum, 2011). Loughner then proceeded to shoot into the crowd, killing six and wounding fourteen others (Lacey & Herszenhorn, 2011). Loughner used a Glock 19 9mm semiautomatic pistol with an extended magazine (DeGregory, 2011). Loughner was ambushed by the crowd while he was attempting to reload and was detained until police could arrive (Dolak & Weaver, 2011). Giffords lived to survive her injuries.

Loughner was charged with 49 different federal counts, 19 of which he pled guilty to in exchange for not facing the death penalty (Gray M., 2012). Loughner is currently serving a life sentence. Loughner was diagnosed as a schizophrenic by experts handling his court case. Additionally, he has been kept on a psychotropic dosage for a little more than a year. The forensic psychologist handling his case, Christina Pietz, was able to determine that Loughner was aware of his actions and of their consequences (Gray M., 2012, p. 3). It is suspected that Loughner’s motivation for the shooting was because of his anti-government attitude (Anglen, 2011); however whether this is his true motivation for the shooting is still unknown.
On April 15, 2013, Dzhokhar and Tamerlan Tsarnaev, two Chechen brothers, used two pressure cookers to bomb the Boston Marathon in Boston, Massachusetts at approximately 2:49PM, killing three people and wounding 264 (Kotz, 2013). The Tsarnaev brothers were not apprehended at the scene, prompting a nationwide manhunt. The FBI successfully identified the Tsarnaev’s on April 18. That same day, the brothers killed an MIT campus police officer (Ngowi, Jakes, & Apuzzo, 2013). On April 19, 2013, police tracked down the brothers, killing Tamerlan, 26, and successfully capturing Dzhokhar, 19, the following day. Dzhokhar has been charged with “using a weapon of mass destruction and one count of malicious destruction of property” (Al Jazeera, 2013, p. 1) and is currently awaiting trial.

Both Tsarnaev’s had a connection to radical Islam, but Tamerlan more than his brother. In the year prior to the attack, Tamerlan traveled to Russia, supposedly to train with Chechen rebels (CNN Staff, 2013). It is worth noting that no terrorist group ever claimed responsibility for the attacks, making the brother “lone wolf” actors and acted alone (Bernkowitz & Kerber, 2013). No mental illness history was apparent or available. The motive for the killing may have been political, but it is yet unclear.

On December 15, 2012, Jason Letts, 38, entered the St. Vincent Hospital in Birmingham, Alabama and wounded 2 hospital employees and an officer. Letts entered the hospital at around 4:00AM with a handgun and then forced a security guard to take him to the 5th floor of the hospital where his wife, who was a patient at the hospital, was staying (Robinson, 2012). Someone called 911 when they saw Letts enter with a handgun, and police showed up shortly thereafter. When the officers confronted Letts, a gunfight ensued. Letts wounded three people, one of them being one of the officers, before being killed by the officers (Global Post News Desk, 2012). Sources claim that Letts was dissatisfied with the care that his wife had been
receiving and that he had been removed from the hospital the previous evening. The Birmingham Police chief attributed quick response times to the prevention of loss of life (Robinson, 2012).

On November 5, 2009, Maj. Nidal Hasan opened fire inside the army base known as Fort Hood in Killeen, Texas. Hasan opened fire at around 1:23PM that afternoon when the first 911 calls were received. He was using a FN Herstal 5.7 tactical pistol to carry out most of the carnage and had a .357 magnum revolver as well (Cuomo, Friedman, Netter, & Esposito, 2009). Two civilian police officers were able to rush Hasan, wounding him with gunfire. The shootout was over four minutes after it started (McCloskey, 2009). The final death toll was 12 dead and 31 wounded, with Hasan placed in custody (NBC News, 2009). Hasan was paralyzed from his wounds but survived to be court marshalled. He was charged with 13 counts of premeditated murder and 32 counts of attempted murder (Cooper, Rowlands, Starr, & Todd, 2009). Hasan was found guilty of all counts on August 23rd, 2013, and was sentenced to death (Associated Press, 2013).

Hasan was considered mentally sound by a panel of the Army’s “sanity board” (Christenson, 2011). Hasan claimed that his religion, Islam, was his sole reasoning for committing the murders, as he described himself as a “Soldier of Allah” and was a critic of the American political system (Herridge & Browne, 2013). Hasan purchased the guns legally from “Guns Galore,” a gun shop in Killeen, Texas and owned the guns legally (Stairrett, 2010). Hasan is still awaiting execution.

On October 21st, 2013, 7th grader Jose Reyes, 12, went to his middle school, Spark Middle School in Sparks, Nevada and killed one of teachers and wounded two others before committing suicide. Reyes had taken his family’s Ruger SR9C 9mm semiautomatic pistol (Reno
Gazette-Journal Staff, 2014) to school that day and shot his victims at around 7:16AM, just before the beginning of first period (McAndrew, 2013). According to police, Reyes was teased and bullied while at the middle school by his peers, but not to the extent that warranted action by supervisory faculty (Associated Press, 2014). Additionally, it was determined that Reyes showed signs of being autistic and that he had been prescribed a 10mg regular dosage of Prozac, a common antidepressant. The autopsy confirmed that Reyes had been taking his medication as prescribed (Reno Gazette-Journal Staff, 2014). Finally, the police admit that Reyes took his motives as to why he committed the crime to his grave, but he left behind a series of letters clueing that the bullying and teasing may have been largely responsible for his resort to violence (Associated Press, 2014).

On February 14, 2008, Steven Phillip Kazmierczak, 28, went onto the campus of Northern Illinois University in Dekalb, Illinois, and proceeded to shoot his classmates. Kazmierczak entered his classroom at around 3:05PM at the beginning of one of his scheduled classes. Kazmierczak brought with him a Remington Sportsman 48 12-guage shotgun, a Glock 19 9mm pistol, a Sig Sauer P232 9mm pistol, and a HiPoint .380 caliber Model CF380 pistol (Northern Illinois University Department of Public Safety, 2008). Kazmierczak was able to get the shotgun on campus by bringing it in a guitar case and hid the other gun in his coat (Friedman, 2008). He was able to kill five people and wound 21 others. Kazmierczak took his own life before police arrived. Kazmierczak was diagnosed with Schizoaffective Disorder in 2000 (Northern Illinois University Department of Public Safety, 2008) and was taking Xanax, Ambien, and Prozac by prescription (Boudreau & Zamost, 2008). He was not taking his medication at the time of the shooting. All guns were purchased from a local gun shop legally.
and were owned legally by Kazmierczak (Associated Press, 2008). The true motives of the shooter are still unknown.

On December 5th, 2007, Robert Hawkins entered the Westroads Mall in Omaha, Nebraska and began shooting those in the mall at around 1:42PM. Hawkins killed 8 people with his fire and wounded 6 more before turning the gun on himself (CNN, 2007). Hawkins used an AK-47 assault rifle to carry out the shooting (Kaminski-Leduc, 2013). Hawkins had stolen it from his ex-stepfather’s house while he was home alone (Cantor, 2007). Hawkins had been experiencing depression at the time of the shooting. Hawkins was in therapy for the depression and for a drug problem. Additionally, he had reportedly broke up with his long-term girlfriend and lost his job not two weeks prior to the shooting (Weaver, 2007). The suicide note left behind by Hawkins apologized to his friends, stating he wouldn’t be a burden anymore (Associated Press, 2007). Hawkins’ motive for the shooting is still unclear.

On August 4th, 2009, George Sodini walked into the aerobics class at the LA Fitness gym in Bridgeville, Pennsylvania, and opened fire on the participants at around 8:00PM that evening. Sodini, 48, shut off the lights in the gym before going through and beginning the spree. He killed three of the participants and wounded nine others before killing himself (Mandak & Dobbin, 2011). For the attack, the shooter wore blackout gear and used two 9mm semiautomatic handguns, a .45 caliber revolver, and a .32 caliber pistol that remained in his pocket (Candiotti, 2009). Sodini expressed in a journal that was found in the investigation that he was having a hard time meeting women and that he didn’t understand why they didn’t like him (Tatton, 2009). No mental health issues were ever discovered in Sodini’s case.

On May 30th, 2012, Ian Stawicki killed five people in the Café Racer Espresso in Seattle, Washington’s University district around 11:00AM. Stawicki, 40, opened fire in the coffee shop
killing four of the victims, wounding only one person, and then fleeing in a stolen car, the driver of which he shot and killed. Stawicki was found several miles outside downtown Seattle, having committed suicide (Vojtech, Newcomb, & James, 2012).

Stawicki carried out the shooting with two .45 caliber handguns. One of these guns he used to kill himself. The guns were purchased legally, along with two others not involved in the shooting (Dahl, 2012). Although Stawicki had a history with police, including a domestic battery charge, he was never convicted. Stawicki, according to his family, suffered from mental illness but could not be convinced to seek the help needed. The family also described that his behavior had worsened over his final months with several misdemeanor domestic charges that were later dropped (Associated Press, 2012). Stawicki was also removed from the Café where the shooting took place before (McNerthney & Gutierrez, 2012). However, Stawicki’s motive is not readily apparent.

On April 2, 2012, at around 10:30AM, One L. Goh, 43, entered the campus of Oikos University in Oakland, California. Goh entered the building that housed the University and went room to room, lining up students and executing them. Goh killed seven and wounded three before driving off in one of the victim’s cars (Crimesider Staff, 2012). He surrendered to police at a supermarket a few miles from the campus.

Goh confessed to his crimes and was charged with “seven counts of murder, three counts of attempted murder, weapon enhancements and two special circumstances: committing multiple murders and murdering in the course of a kidnapping” (Lee, 2014b, p. 1). However, Goh was diagnosed with Paranoid Schizophrenia in a court ordered evaluation and ruled unfit to stand trial at that time. Goh’s case has been suspended, pending Goh’s treatment at Napa State Hospital,
which he is still receiving. The case recently resumed in August 2014, but it is still unclear as to whether he will be able to stand trial.

Goh’s firearm, a .45 caliber semiautomatic pistol, was legally bought from a California dealer two months before the shooting occurred (Dahl, 2012). Goh’s motive, according to witness testimony, was a former student at the University and was targeting an administrator, who incidentally no longer worked there (Lee, 2014a). Goh remains interned at Napa State Hospital pending the outcome of his trial.

On February 28, 2012, T.J. Lane, 17, attended his high school Chardon High School and at 7:45AM began shooting his fellow students in the high school’s cafeteria (Horton, 2012). In the fray, Lane killed two and mortally wounded a third, bringing the death count to three. Lane also managed to wound 3 others before fleeing the school. Lane was detained by police a little ways from the school (Horton, 2012).

Lane was charged with three counts of aggravated murder, two counts of attempted murder and one count of felonious assault, and was tried as an adult even though he was a juvenile when he committed the murders (Achladis, Jovic, Dabrowski, & Taylor, 2012). Lane eventually pled guilty to all charges and is now serving 3 life sentences (Ng, 2014). Lane managed to escape Allen Oakwood Correctional Institution in Lima, OH, on September 11th, 2014, and was caught 6 hours later (Payne & Lenz, 2014).

Lane carried out the shooting with a .22 Ruger pistol; however, it has not been released where he obtained the gun because of a gag order on the case placed by the judge (Dahl, 2012). Lane’s reasoning for the shooting is not known nor has Lane actually said why he did it.

On August 13th, 2012, Thomas Caffall shot an officer who approached his home in College Station, Texas, close to Texas A&M University. The officer was there to serve a notice
to appear in court, as Caffall was two month behind on rent. Caffall killed him and then took the
gun from the officer’s body. He then started shooting at other bystanders on the street, killing
one more. Dispatchers received the first 911 calls at 12:11PM. Authorities arrived shortly
thereafter, and Caffall began shooting at them. Caffall was eventually fatally wounded and
secured by officers (Lozano, 2012). The final body count was three dead, including Caffall, and
four wounded.

Caffall, 35, had a mental illness of some variety, according to his family. One family
member stated that he may have been suffering from Bipolar Disorder, but it was never
confirmed and he never received treatment (Falls, 2012). Caffall was according to the family a
gun enthusiast (Falls, 2012), whose collection included a Czech vz.58 and a Russian Mosin-
Nagat. It is unclear whether these guns were used in the shooting or not (Bowen, 2012). Caffall’s
motive for the shooting may have simply been to buck authority when the officer presented the
notice to appear, but at this time it’s not readily apparent as to why he started shooting.

On December 11th, 2012, at around 3:30PM, Jake Roberts entered the Clackamas Town
Center Mall and began shooting with an AR-15 at the mall’s patrons (Spross, 2012). Roberts, 22,
wore a hockey mask at the time of the shooting and killed two people and wounded a third
before taking his own life (Karlinsky & Curry, 2012).

Supposedly, Roberts was moving to Hawaii. He had begun selling all his things, was
telling his friends that he was leaving, and even broke up with his girlfriend. Many describe this
as a shock and not characteristic of Roberts (Karlinsky & Curry, 2012). Roberts used an AR-15
in the attack that according to authorities he had stolen from a friend (Lohr, 2012). Roberts’
motive for the shooting is unknown.
On October 21, 2012, at approximately 11:09AM, Radcliffe Haughton entered the Azana Salon and Spa in Brookfield, Minnesota and proceeded to shoot at the employees and patrons. Radcliffe carried out his attack with a .40 caliber semiautomatic handgun, killing three and wounding four, and then using a flammable liquid to fuel a fire. Haughton then committed suicide (Ramde, 2012).

Haughton’s wife Zina worked at the Salon where the shooting took place. Zina had been abused by Radcliffe and she had obtained a restraining order against him two weeks before the shooting after he slashed her car’s tires (CNN Wire Staff, 2012). The pistol that Haughton used was bought illegally through a site called Armslist.com, a site used to sell guns to those who can’t legally buy handguns, like Haughton who had a restraining order against him (Durkin, 2012). Zina was the first killed by Radcliffe in the rampage. Thus, it is likely that the motive to the shooting was related to domestic violence between the couple.

On October 26th, 2013, around 9:00AM, Michael Guzzo burst into his next door neighbors, the Moore’s, with a pump-action shotgun and killed all four residents and their two dogs. Guzzo had recently complained about the Moore’s dogs barking, hence the reason for the dog’s death. Guzzo then proceeded out across a large courtyard in the apartment complex, shooting at other residents, before returning home and committing suicide (Pearce, 2013).

Guzzo had expressed multiple times to his neighbors that the barking from the dogs aggravated him (Skoloff, 2013). This is likely the motive for the shooting, but whether the dog’s barking is what sparked the killing is unknown. Guzzo’s ex-wife, Janet, said that he had anger issues, possible from a mental illness but it was never confirmed or treated (Watkiss, 2013).