

Analysing Personal Characteristics of Lone-Actor Terrorists: Research Findings and Recommendations

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Abstract

This Research Note presents the outcome of a project that looked at the personal characteristics of lone-actor terrorists. It is part of the larger Countering Lone-Actor Terrorism (CLAT) project. The project described here aimed to improve understanding of, and responses to, the phenomenon of (potentially) violent lone-actors based on an analysis of 120 cases from across Europe. The Research Note focuses on the personal characteristics of lone-actor terrorists.[1] First of all, it presents the main findings of the general analysis of the study into personal variables of lone-actor terrorists. Subsequently, the authors outline a set of recommendations based on the key findings. In the beginning, we present the main research questions of the CLAT project and the working definition of lone-actor terrorism.

Keywords: *Lone actor; lone wolf; personal variables; terrorist profile*

Research Questions and Definition

What drives an individual to commit acts of violent extremism? Is the process of radicalisation towards violent extremism and terrorism for a lone-actor different from group-based radicalisation? Can we identify indicators that signal whether an individual is going down the path of violent extremism, and, if so, how can we prevent and counter lone-actor terrorism? So-called “lone wolves” have become an increasing concern for governments across Europe, certainly since the massacre caused by Anders B. Breivik in Norway in 2011. Concern has risen in the light of foreign fighters returning to their home countries. The Countering Lone-Actor Terrorism (CLAT) project aimed to answer these questions through analysis of data pertaining to attempted plots and successful cases of European solo terrorists.

For this project, lone-actor terrorism was defined as

‘The threat or use of violence by a single perpetrator (or small cell), not acting out of purely personal-material reasons, with the aim of influencing a wider audience, and who acts without any direct support in the planning, preparation and execution of the attack, and whose decision to act is not directed by any group or other individuals (although possibly inspired by others).’[2]

Examples of individuals who fall under this definition are “classical” terrorists such as jihadists or right-wing extremists. In some cases, school shooters were also included, but only in those cases when they had a broader societal goal, and aimed to influence a wider audience.

The research involved the construction of a database on perpetrators of lone-actor terrorism within the European Union for the years between 2000 and 2014. To that end, a codebook was developed, establishing how incidents should be categorised and recorded in the database. Data were collected from open sources (court proceedings, media reports).[3] This resulted in the identification of 120 perpetrators of lone-actor terrorism; they were involved in 98 plots and 72 actual attacks. These were coded on a wide range of variables. These cases were studied from four particular angles: attack planning and preparation, law enforcement, online and political engagement and personal characteristics. In this Research Note, we will report on personal characteristics found[4] and briefly present the main findings as also outlined in the analysis paper.[5]

Personal Characteristics of Lone-Actor Terrorists

Prior to this project, a few scholars have conducted some exploratory research into this area[6] but due to a lack of reliable empirical data, no clear answer about the personal characteristics of perpetrators could be given. Nevertheless a number of unproven assumptions and claims about a presumed “lone-actor terrorist personality” have circulated in the public domain. The media’s favourite term “lone wolves” invokes the idea of a single actor who is a recluse, detached from society, hungry for action and willing and able to strike out of the dark at any moment. Another often-mentioned personality trait of the lone-actor is that he (less frequently: she) is supposed to have serious mental health problems – these being the key triggers for violent, irrational and immoral acts. A number of questions raised address differences between “group” and “lone-actor” terrorists. Is the lone-actor preferring a strategy of solitary action, or is he forced to do so after failing to be accepted by a terrorist network (perhaps as a result of certain personality or behavioural traits that are deemed to be a risk for the group’s security)? Alternatively: are terrorist organisations deliberately employing them as part of a strategy of “acting alone” – in a framework of “leaderless jihad” – so as to minimise the risk of detection by authorities?

In order to answer such questions, we have collected data on biographical variables that allow us to confirm or falsify various claims. We have looked at the following variables incorporated in our codebook: age, gender, education and school drop-out, employment, relationship status, having children, indication of successful sibling, indication of social isolation, previous criminal sanction, indication of previous physical violence, evidence of drug use, indication of a mental health disorder[7], diagnosis and treatment, indication of a noteworthy life event.[8]

Analysis

Age and Ideological Profiles

The average age of the 120 perpetrators was found to be 29.7 years at the time of attack or arrest, with the youngest perpetrator being fifteen and the oldest seventy-four. The standard deviation was 9.9, indicating a large variance between the different perpetrators. Age was also contrasted with ideology. Not surprisingly, school shooters were found to be younger (20.5) than the overall average in the database. It is also notable that religiously inspired perpetrators are on average almost five years younger (27.3) than those driven by a right-wing ideology (32.3). Moreover, there is less variation among this religiously inspired group, with a standard deviation of 7.69 in contrast to 11.88 for right-wing extremists.

These disparities were investigated further. Religiously inspired and right-wing perpetrators comprised more than 70 per cent of cases in the database; however, despite a comparable number of cases (46 and 40 respectively), these ideologies resulted in very different age profiles. Among the youngest group aged less than twenty-five years, it was found that almost half of the perpetrators were religiously inspired (47 per cent); in contrast, among the perpetrators aged forty years or older, only 21 per cent were religiously inspired while 47 per cent were right-wing extremists.

Variations between age groups were also evident in relation to social isolation and mental-health disorders. The youngest group (younger than twenty-five years old) showed the highest percentage of social isolation at 36 per cent; fewer perpetrators aged 25–39 years old exhibited similar signs (25 per cent); while those aged at least forty years old presented the lowest figure at 11 per cent. In line with this, the youngest age group (younger than twenty-five years old) manifested, with 40 per cent, the highest percentage of suggested mental-health disorder.

Similarly, ideological categories presented strikingly different results in relation to social isolation. Across the entire database 29 per cent of perpetrators were in some way socially isolated; this rose slightly to 33 per

cent for right-wing extremists, but dropped drastically to only 9 per cent for religiously inspired lone-actor terrorists. As indicated earlier, the highest figure could be found among school shooters at 75 per cent.

The prevalence of “noteworthy life events” also varied substantially between different ideological groups. While such events were noted in 43 per cent of cases across the data-set, the figure was higher within the single-issue subset at 67 per cent, and among the school shooters at 88 per cent. Upon examining the latter group, it was established that in many cases the event related to bullying. In contrast to these elevated figures, only 37 per cent of religiously inspired perpetrators and 28 per cent of right-wing cases suggested the prior occurrence of a noteworthy life event. These findings suggest that a noteworthy life event should not be considered a consistent trigger leading to a process of radicalisation and mobilisation towards violence.

Mental-Health Disorders

In 35 per cent of cases there was an indication of a mental-health disorder based on news media reporting. However, in order to interpret the significance of this result, it is crucial to have a benchmark. In examining the EU, Norway, Iceland and Switzerland, the World Health Organization (WHO) found that ‘27 per cent of the adult population (18–65) had experienced at least one of a series of mental disorders in the past year (this included problems arising from substance abuse, psychoses, depression, anxiety and eating disorders)’.^[9] Although the WHO uses a broad definition, this offers an appropriate comparator, given the low threshold used by the corresponding CLAT variable that records any “indication of” mental disorder. The finding of a potential mental-health disorder in 35 per cent of lone-actor terrorists therefore does not suggest a substantial deviation from the broader population. Moreover, the WHO also states that “[about] two-thirds of people suffering mental disorders will never seek help because of discrimination and the stigma attached to such conditions” indicating that the general population figure may even be higher than indicated.^[10]

Indications of mental-health disorders were also examined within ideological sub-groups. The most striking finding comes from school shooters where there was an indication of mental-health disorder in 63 per cent of all cases. Interestingly, the mental health percentage was lowest among religiously inspired lone-actor terrorists where it stood at 24 per cent. Some caution must be required in interpreting these findings. Reporting bias may influence whether or not journalists investigate and/or report the possibility of mental-health disorders; for example, questions regarding the psychological state of a perpetrator are perhaps more prominent in the case of school shooters. Some communities are also reluctant to speak with journalists, some cultural backgrounds also make people unwilling to openly discuss mental-health issues. Nevertheless, the finding that 63 per cent of school shooters exhibited some form of mental-health disorder should be a clear warning signal for those in charge of prevention.

In cases where there was an indication of a mental-health disorder, 50 per cent of perpetrators were also socially isolated, in contrast to only 17 per cent where there were no suggestions of mental health problems. Similarly, examination of socially isolated perpetrators found that in 62 per cent of cases there was an indication of mental-health disorder. These findings suggest a clear link between these two variables.

Finally, where legally owned firearms were the weapon of choice for an attack (fifteen cases), there was an indication of mental-health disorder for 53 per cent of all perpetrators.

All in all, these findings demonstrate the importance of looking at different sub-groups. Overall, the data do not suggest support for any stereotype of lone-actor terrorists or a “lone-actor terrorist profile”. There simply is no typical lone-actor terrorist. However, combining results on different variables and looking at subgroups can offer directions for preventive measures and policy-recommendations.

Policy Recommendations: Sub-Groups and Benchmarking

Our database contains information of 120 perpetrators from different EU countries, who have very different backgrounds and often act out of very different motivations. While it is useful to start from the aggregate data, we feel the most relevant conclusions can be drawn when comparing our data to benchmarks.

Mental health disorder

As indicated earlier, we found that in 35% of the cases, some reference was made to a mental health disorder. It must be noted that this does not mean that the perpetrators were officially diagnosed by authorised medical authorities. In some of these cases, it meant that the direct environment of the perpetrator – family, friends, colleagues – indicated that the perpetrator was allegedly receiving some kind of treatment for a mental health disorder. In other cases, it meant that the direct environment reported that they were aware of the fact that the perpetrator had been suffering from mental health disorders. Thus, this should not be interpreted as an official diagnosis of a mental health disorder; rather it indicates whether or not the direct environment of the perpetrator had (retrospectively) received signals about a mental health disorder.

How should we interpret this figure of 35%? This particular number can be interpreted in different ways. Some might claim that this finding reflects the simple fact that in 35% of 120 cases we have found evidence pointing at a mental health disorder while in the other 65% of all cases we were unable to find such evidence. However, whereas it is conceivable that the real percentage is higher, the opposite statement could also be made: the real rate might have been lower. To some extent it could also be comforting or logical for relatives or acquaintances of the perpetrator to say that they “knew it all along” that “something was seriously wrong” with this particular person. Thus, the figure of 35% cannot be taken as a hard fact, but it can be taken as an estimate reflecting that about one third of all lone-actor terrorists might have mental health problems.

What then, does a percentage of 35 tell us about the population of lone-actor terrorists: are they more confronted with these kind of problems than others, or not? As already explained, there is a need for an accurate benchmark to compare to our findings. The data most appropriate for a comparison is compiled by the World Health Organization (WHO). The WHO stated that ‘27% of the adult population (18-65) had experienced at least one of a series of mental disorders in the past year (this included problems arising from substance abuse, psychoses, depression, anxiety, and eating disorders)’.^[11] This includes a wide range of disorders. It must be noted that not all of them can be linked to violence. The Institute of Medicine notes that ‘[m]ost patients with stable mental illness do not present an increased risk of violence’. It also adds that ‘[m]ental illness may increase the likelihood of committing violence in some individuals, but only a small part of the violence in society can be ascribed to mental health patients’.^[12] Therefore, we should refrain from making any causal claims about a direct relation between mental health disorders and violence. Clinicians have also noted that we should not adopt ‘the simplistic notion that (...) mental illness could act as a marker for potential assassins, when psychotic illnesses affect nearly 1% of the population (i.e. are relatively common [in medical terms]) and assassins are extraordinarily rare’.^[13] Whereas there might be a few exceptional cases where mental health disorders might have indeed contributed to the violent act, the above-mentioned statements clearly warn us not to approach the question of lone-actor terrorism from a mental health perspective. To put it simply, we should not regard those who are seeking mental help as a “pool” of potential lone-actor terrorists. Similarly, it would also be rather absurd to start identifying potential lone-actor terrorists by screening or paying close attention to the entire male population within the European Union (as 96% of the lone-actor terrorists are male). Focusing simply on those who are seeking mental help would not only be inaccurate and probably yield little results, but it could also have serious social ramifications. It could stigmatize those being in therapy and deter people who need help from seeking it, which could have serious consequences for the individual and his or her environment. To sum up: the benchmark of the WHO does enable us to judge the correlation between mental health disorders and lone-actors in comparison to the general population. When comparing our figure of 35% with the 27% provided by the WHO, we do not see

a large difference. Another finding is that there are wide differences between the ideological groups – right-wing extremist, left-wing and anarchist, single issue, religiously-inspired, and other. This raises the following two questions:

- What is the difference between “mental health cultures” in the different countries in our database?
- What is the difference in “mental health cultures” between the different sub-groups in our database?

These are just two particular questions that we think should be asked by those interpreting the results with the aim of formulating certain policies or strategies to deal with the issues. We can already point to the previously quoted figure from the WHO that ‘[a]bout two-thirds of people suffering mental disorders will never seek help because of discrimination and the stigma attached to such conditions.’[14] This last point is particularly relevant when looking at the data within particular sub-groups. We found, for instance, that the percentage of mental health disorders within the religiously-inspired group (24%) is even a bit lower than the figure presented by WHO.

Other variables

Some other areas also showed interesting results when focusing on particular sub-groups instead of the aggregated data. The average age of all perpetrators was 29.7 years old. This effectively refutes the idea that perpetrators of lone-actor violence are very young and can often still be found in (high) schools. When focusing more closely on sub-groups within the database, we find some interesting results. For instance, the combination of certain age groups and ideologies showed a clear pattern: the older perpetrators (40+) in our database were in almost half of the cases (47%) motivated by a right-wing ideology whereas the younger perpetrators were in almost half of the cases (47%) religiously-inspired.

In sum, in order to be able to accurately interpret and work with the data, it is important to have appropriate benchmarks and also to identify relevant sub-groups where results might be more specific and thus relevant for policy measures.

Policy Recommendations: Trust and Embeddedness

In the previous section we outlined why we need benchmarks to compare to our data. Our data on mental health disorders, combined with the observations by the WHO, and some comments received by mental health practitioners during the workshops of this project, helped us to identify the area of trust and transparency. When looking at the sub-groups, we found a large difference between the ideological groups and the score on the indication of a mental health disorder. For all clearly defined ideologies (religiously-inspired, right-wing and single issue) we found scores below the overall average (respectively 24%, 28% and 33%). The score that highly deviated from the average was found in the group “other”, where we found a figure of 70%. The group “other” is inherently different from the other ideologies listed: it is the group with the least well-defined ideology, with perpetrators who often “cut and paste” their worldview from different sources to form their own particular subset of ideological influences. As indicated before, 63% of the school shooters within this group were reportedly suffering from a mental health disorder. Based on this one might reach several different conclusions. It could be argued that those with a more vague ideology (or a mix of different ideologies) are perhaps more often motivated by personal frustrations. To some extent, this shows similarities to what researchers from the Fixated Threat Assessment Centre called a ‘highly personalised quest for justice.’[15] Secondly, it could also be said that these differences are perhaps not really reflecting differences within the actual prevalence of mental health disorders within different sub-groups, but rather reflect different “mental health cultures”. For instance, it is widely known that within certain communities, there is a taboo on openly speaking about mental health problems. Especially in some religious communities as well as many extremist scenes, this is simply seen as “not done”. This is not surprising, given the fact that the World Health Organization reported that two-thirds of those with a mental health disorder never seek

help, which could also mean that people are less prone to speak about mental health problems to their friends and family. Also, national differences should be taken into account here as well.

Social Isolation and Lower Barriers to Mental Health Services

It is interesting to look at this also in light of the figures on social isolation. Contrary to some of the widespread notions about “lone-actors”, such as that they are lonely, reclusive, and living detached from society, we found that the majority is far from being isolated. In the religiously-inspired group, we saw that the percentage of those socially isolated was very low (9%). Especially when these perpetrators were part of a religious community, they often have strong ties to their fellow believers. It is then also this group that is most likely to notice any change in behaviour, or mental health problems. It is thus not only desirable from an ethical point of view to lower barriers to mental health services. The existence of mental health services that are culturally and religiously sensitive is an important step towards building trust and lowering the threshold for troubled persons to seek help. This should first and foremost be a goal in itself, as improving the accessibility of mental health clinics for those in need is a noble effort and much needed as the WHO noted. This does not mean, however, that it could not also be beneficial in light of countering lone-actor violence. Removing taboos on certain issues such as mental health problems also increases the chances of “suspicious” cases being noticed or notified, although it must again be stressed that this should not be the starting point to approach the issue. This could both mean that mental health practitioners have the opportunity to help those who would normally not have crossed their way. It could also result in families and relatives feeling safe to speak out if they pick up signs of potentially violent behaviour. In some cases, those acquaintances might have had been able to alert mental health services.

Although focusing on removing taboos and encouraging openness and transparency about mental health problems is one of the areas where progress could be made, we should keep in mind that the figures we have found do not seem to point at an unusually high prevalence of mental health disorders among lone-actors. Ultimately, the most important and best equipped “detectors” are not mental health practitioners or local police officers, but family, friends, and colleagues who can judge whether or not a person is “at risk”. Against this backdrop, it is also relevant to briefly highlight the role that social care and social workers could play. They could also serve as sensors in communities to detect where individuals might cross the line into any type of violent behaviour. It must be noted here that there are also clear limits to what can be expected in this regard since many lone-actors are not known to either social care or mental health services.

Policy Recommendations: Multi-Agency Approach for Preventing and Identifying Potential Lone-Actors

An often-mentioned recommendation in many domains of counterterrorism policy is the need for a multi-agency approach. Few would doubt that this is an important step but it is rarely specified what this exactly means and how this should be attained. Recording and exchanging every piece of information about every individual within certain services would probably do more harm than good: it would be an unfeasible approach and it raises ethical questions about the right to privacy of individuals. Still, some areas can be identified where perhaps more effort should be focused on improving these information-exchange procedures. A striking observation in our dataset was that out of the fifteen perpetrators who legally possessed fire-arms, eight of these 15 individuals were also said to have suffered from a mental health disorder. Two different conclusions can be drawn from this. The first is that these eight perpetrators who were positively identified as having suffered from a mental health disorder might not all have been known to mental health services. This again reaffirms the plea made for more openness and trust within certain communities, which could have resulted in those perpetrators being noticed. Secondly, for those who were known to mental health services: this raises questions about the effectiveness of information-exchange between those responsible for issuing legal gun permits and those within the mental health sector. Rather than having a broad approach of focusing on everyone within the mental health sector, specifically focusing

on those with a known history of mental health issues who also aim to obtain a gun permit is perhaps more beneficial. It is precisely in such areas where we might have the highest chance of detecting and preventing lone-actor terrorism.

Some agencies and services in a number of countries could serve as a good example or best practice of designing such a multi-agency approach. The earlier mentioned Fixated Threat Assessment Centre (FTAC) in the UK brings together police and social and mental health practitioners, e.g. psychiatric nurses who work on both separate and shared servers to both guarantee privacy as well as information-sharing. The “Team Threat Management” (Team Dreigingsmanagement) of the Dutch National Police also seeks to bring together these different kinds of expertise in order to accurately assess the risk of certain individuals. It must be noted that both examples relate to a multi-agency approach of agencies involved in cases of individuals who are already seen as posing a potential threat.

Conclusion

In this Research Note, we have formulated some overall recommendations relating to our data on personal variables derived from 120 perpetrators of lone-actor terrorism. We feel it is more appropriate for the professionals working in the different sectors, such as the mental health sector, to design and evaluate concrete policies. Nevertheless we hope to have been able to pinpoint some areas where improvements can be made, or areas that should be taken into account when trying to interpret data. We have specifically outlined the importance of benchmarking and of focusing on at different sub-groups. We also stressed that trust and openness is important as is a multi-agency cooperation approach.

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*Recent publications include: [The Hofstadgroup Revisited](#). In: *Terrorism and Political Violence* 27 (5), 2015; [EU Counter-radicalization Policies: A Comprehensive and Consistent Approach?](#) In: *Intelligence and National Security* 30 (2-3), 281-305, 2015; [Reintegrating jihadist extremists: evaluating a Dutch initiative, 2013–2014](#). In *Behavioral Sciences of Terrorism and Political Aggression*, 1-20, 2015; [Terrorism and Counterterrorism Studies. Comparing Theory and Practice](#). Leiden University Press, 2015.*

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Notes

- [1] The second Research Note in this issue of *Perspectives on Terrorism* presents the results on the processes of lone-actor terrorism, see Clare Ellis et al, "Analysing the Processes of Lone-Actor Terrorism: Research Findings", *Perspectives on Terrorism* Vol. 10, No. 2 (2016).
- [2] Edwin Bakker and Jeanine de Roy van Zuijdewijn, "Lone-Actor Terrorism. Definitional Workshop", *Countering Lone-Actor Terrorism Series* No. 2 (Royal United Services Institute for Defence and Security Studies, 2015), https://rusi.org/sites/default/files/201512_clat_definitional_workshop.pdf.
- [3] For more information about the data collection process, see Sebastien Feve and Kelsey Bjornsgaard, "Lone-Actor Terrorism: Database Workshop", *Countering Lone-Actor Terrorism Series* No. 3 (Royal United Nations Service Institute for Defence and Security Studies, 2015), http://www.strategicdialogue.org/wp-content/uploads/2016/02/Database_Workshop.pdf.
- [4] For the other three focus areas, see Simon Palombi and Benoît Gomis, "Policy Paper 2: Attack Methodology and Logistics", *Countering Lone-Actor Terrorism Series* No. 6 (Royal United Services Institute for Defence and Security Studies, 2016); <https://www.chathamhouse.org/sites/files/chathamhouse/publications/research/2016-02-29-lone-actor-terrorism-attack-methodology-logistics-palombi-gomis-final.pdf>; Melanie Smith, Sabine Barton and Jonathan Birdwell, "Policy Paper 3: Motivations, Political Engagement and Online Activity", *Countering Lone-Actor Terrorism Series* No. 7 (Institute for Strategic Dialogue, 2016); <http://www.strategicdialogue.org/wp-content/uploads/2016/02/CLAT-Policy-Paper-3-ISD.pdf>; Clare Ellis and Raffaello Pantucci, "Policy Paper 4: 'Leakage' and Interaction with Authorities", *Countering Lone-Actor Terrorism Series* No. 8 (Royal United Services Institute for Defence and Security Studies, 2016), https://rusi.org/sites/default/files/201602_clat_policy_paper_4.pdf.
- [5] Ellis et al., "Analysis Paper", *Countering Lone-Actor Terrorism Series* No. 4 (Royal United Services Institute for Defence and Security Studies, 2016), https://rusi.org/sites/default/files/201602_clat_analysis_paper.pdf.
- [6] For an overview of the body of literature on lone actor terrorism, see, Raffaello Pantucci, Clare Ellis and Lorien Chaplais, "Literature Review" *Countering Lone-Actor Terrorism Series* No. 1 (Royal United Services Institute for Defence and Security Studies, 2015), https://rusi.org/sites/default/files/201512_clat_literature_review_0.pdf.
- [7] According to the National Alliance on Mental Illness, a mental illness or mental health disorder can be defined as "... a condition that impacts a person's thinking, feeling or mood and may affect his or her ability to relate to others and function on a daily basis". This can include a variety of different disorders, such as ADHD, anxiety disorders, autism, bipolar disorder, borderline personality disorder, depression, dissociative disorders, eating disorders, obsessive compulsive disorder, posttraumatic stress disorder, schizoaffective disorder and schizophrenia; see <https://www.nami.org/Learn-More/Mental-Health-Conditions#sthash.aG8AULXP.dpuf>, accessed on February 4, 2016.
- [8] A 'noteworthy life event' is defined as an event so significant – either positive or negative – that it was cited as altering the life of the perpetrator: for example, the loss of parents at a young age.
- [9] World Health Organization, Regional Office for Europe, 'Data and Statistics', 2016, <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-statistics>, accessed 22 February 2016.
- [10] Ibid.
- [11] World Health Organization, *Data and Statistics*, accessed on December 4, 2015, <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-statistics>.
- [12] Marie E. Reuve and Randon S. Welton, "Violence and Mental Illness", *Psychiatry (Edmont)*, Vol. 5, No. 5 (May 2008); <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2686644/>.
- [13] It should be kept in mind that this statement was made in the context of those who threaten dignitaries in the United Kingdom. See: James, D.V., Farnham, F.R. & Wilson, S.P. "The Fixated Threat Assessment Centre: Implementing a joint policing and psychiatric approach to risk assessment and management in public figure threat cases". In: J. Reid Meloy & J Hoffman (Eds.) *International Handbook of Threat Assessment* (New York: Oxford University Press, 2014), p.9.
- [14] World Health Organization, *Data and statistics*, accessed on December 4, 2015, <http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/data-and-statistics>.
- [15] Farnham & Wilson. "The Fixated Threat Assessment Centre", p.9.