The Association Between Mass Shootings and Mental Illness in American Society

Posted on September 19, 2018

Abstract

Public discussion of mass shootings in the United States frequently attributes violence to mental illness. This explanation is appealing because it offers a seemingly identifiable cause, but the relationship is far more complex. Most people living with mental disorders are not violent, and mental illness alone is a weak predictor of rare acts such as mass shootings. Risk is shaped by multiple factors, including access to lethal weapons, previous violence, domestic abuse, grievance, substance misuse, social crisis, suicidal intent, and situational opportunity. Overemphasizing psychiatric diagnosis can stigmatize millions of people while diverting attention from more useful prevention strategies. This paper examines the evidence concerning mental illness and mass shootings, distinguishes population-level violence from targeted public attacks, analyzes the limitations of prediction, and evaluates policy responses. It argues that prevention should combine responsible firearm policy, threat assessment, domestic-violence intervention, suicide prevention, accessible mental healthcare, and careful public communication. Mental-health services are important because suffering deserves treatment and because some crises involve elevated risk, but psychiatric care should not be treated as a substitute for broader violence-prevention policy.

Introduction

Mass shootings generate fear, grief, and an urgent demand for explanation. After a highly publicized attack, political and media commentary often turns immediately to the perpetrator's mental state. The phrase "mental illness" may be used as though it provides a complete cause. Yet this framing creates several problems. Mental disorders include a wide range of conditions and levels of severity. Diagnosis does not explain why one person becomes violent while millions of others with similar symptoms do not. Furthermore, many people who commit serious violence have never received a diagnosis that would have enabled preventive intervention.

The debate also contains a moral risk. Associating mental illness with spectacular violence can reinforce the stereotype that psychiatric patients are inherently dangerous. Such stigma may discourage help-seeking, increase discrimination, and misrepresent the people most likely to experience victimization rather than commit it.

This paper argues that mental illness should be understood as one possible component within a multifactorial risk environment, not as the primary general explanation for mass shootings. Effective

prevention requires attention to behavior, circumstances, weapon access, and threats, while also improving humane mental-health services.

Defining Mass Shootings

Research is complicated by the absence of one universally accepted definition of a mass shooting. Definitions may vary according to the number of victims, whether deaths or injuries are counted, whether the perpetrator is included, whether the incident occurred in public, and whether crimes connected with domestic violence, gangs, or other criminal activity are included.

A broad definition captures more events but combines incidents with different motives and contexts. A narrow definition focused on indiscriminate public attacks may better match common public understanding but produces a much smaller sample. Researchers and journalists should therefore state their definitions rather than compare statistics that count different phenomena.

This distinction matters for mental-health analysis. A public attack motivated by grievance may have a different risk profile from a family annihilation, robbery-related shooting, or conflict between criminal groups. Treating every incident as one category can obscure the factors that prevention must address.

What Mental Illness Means

Mental illness is not a single condition. It includes mood disorders, anxiety disorders, psychotic disorders, trauma-related conditions, personality disorders, and many other diagnoses. Symptoms vary over time and may be mild, severe, treated, untreated, or in remission.

A diagnosis alone says little about violent risk. Relevant questions include whether the person has a history of violence, is experiencing persecutory beliefs linked to a specific target, is abusing substances, has recently made threats, is suicidal, or has access to weapons. Even these factors do not create certainty; they change probability.

Metzl and MacLeish (2015) argue that public narratives frequently exaggerate the causal role of mental illness and overlook the social and political context of gun violence. Their analysis does not deny that some perpetrators experience psychiatric symptoms. It cautions against turning exceptional cases into a stereotype about an entire population.

Mental Illness and General Violence Risk

Research indicates that serious mental illness may be associated with a modest increase in violence under some conditions, but the relationship is heavily influenced by other variables. Substance

misuse, prior victimization, social instability, and previous violence often account for a substantial part of the risk.

Elbogen and Johnson (2009), using data from a national epidemiological survey, found that severe mental illness alone did not predict future violence after other factors were considered. Risk increased when mental illness occurred together with substance abuse, environmental stressors, and a history of violence.

These findings illustrate why diagnosis-based exclusion is an imprecise prevention tool. It may restrict large numbers of people who present no danger while failing to identify individuals without a formal diagnosis who exhibit escalating violent behavior.

Mass Shootings as Rare Events

Mass shootings are statistically rare relative to the number of people who experience distress, anger, or mental illness. Rare events are difficult to predict accurately because even a tool with reasonable sensitivity can generate many false positives. If authorities attempted to identify future mass shooters from psychiatric symptoms alone, they would wrongly classify enormous numbers of people.

Prediction should therefore focus less on identifying a supposed personality type and more on observable pathways toward violence. These may include fixation on a grievance, communicating intent, researching previous attackers, acquiring weapons, testing security, escalating threats, or signaling a desire for fame or revenge.

Behavioral threat assessment is not a diagnostic process. It examines whether a person is moving toward violence, the seriousness of communications, available means, protective factors, and opportunities for intervention. This approach can involve mental-health professionals, educators, law enforcement, employers, and family members without assuming that unusual behavior or diagnosis equals dangerousness.

Suicidality and Mass Violence

Suicidal intent is an important dimension of many mass attacks. Some perpetrators expect to die during the event, kill themselves afterward, or view the attack as a final act. This connection suggests that suicide prevention can contribute to violence prevention.

However, suicidality should not be interpreted as evidence that suicidal people generally pose a threat to others. Most do not. The relevant concern arises when suicidal despair combines with grievance, hostility toward specific targets, violent planning, and weapon access.

Intervention may include crisis support, temporary separation from firearms, treatment, social

stabilization, and direct assessment of threats. Families and professionals should take statements about self-harm or harming others seriously rather than dismissing them as attention-seeking.

Domestic Violence and Prior Aggression

Prior violence is a stronger and more direct warning factor than psychiatric diagnosis. Domestic abuse, stalking, coercive control, threats, and cruelty may indicate a pattern of entitlement and aggression. Some mass shootings originate in domestic incidents or include intimate partners and family members among the victims.

Prevention strategies should therefore enforce firearm restrictions connected to qualifying domestic-violence orders and convictions, improve reporting, support survivors, and respond to stalking and threats. A system focused primarily on hospitalization records can miss perpetrators whose danger is visible through abusive conduct.

Access to Firearms and Lethality

A violent intention becomes more lethal when the person has rapid access to highly effective weapons and ammunition. Mental-health treatment cannot replace policies governing access. Even excellent psychiatric systems cannot identify every crisis in advance, and not all people planning attacks are seeking care.

Policies commonly discussed include background checks, safe-storage requirements, licensing, waiting periods, domestic-violence restrictions, and risk-based temporary removal procedures that include due process. The effectiveness and constitutional design of particular measures require careful evaluation, but the central point is that weapon access is an independent policy variable.

Means safety is also relevant to suicide. Creating time and distance between a person in crisis and a firearm can allow an acute episode to pass and create an opportunity for intervention.

The Effects of Stigma

When news coverage repeatedly links mental illness with mass murder, the public may generalize fear to people with depression, bipolar disorder, schizophrenia, post-traumatic stress, or other conditions. This can lead to discrimination in employment, housing, education, and relationships.

Stigma also damages prevention. People may avoid treatment because they fear being labeled dangerous or losing rights automatically. Families may conceal symptoms. Policymakers may fund coercive responses while neglecting voluntary, community-based care.

Responsible communication should avoid speculative diagnosis and person-first labels. Journalists

should distinguish verified evidence from rumor, provide context showing that most people with mental disorders are nonviolent, and avoid presenting one condition as a sufficient cause.

Mental Healthcare as Part of Prevention

Rejecting simplistic explanations does not mean mental healthcare is irrelevant. Accessible services can reduce suffering, support people through crises, treat psychosis or severe mood disturbance, address substance misuse, and help families respond to warning signs.

Effective systems require more than emergency hospitalization. They include affordable outpatient treatment, crisis lines, mobile crisis teams, school and workplace support, housing, continuity of care, and services adapted to culture and language. Treatment should be available before a person reaches a catastrophic crisis.

Clinicians also need clear procedures for assessing threats and coordinating with appropriate authorities when law and ethics permit. At the same time, confidentiality remains essential to therapeutic trust and should not be abandoned through vague demands that clinicians predict rare violence.

Behavioral Threat Assessment

Threat-assessment teams evaluate concerning behavior in context. They gather information from multiple sources, determine whether a threat is transient or substantive, identify stressors and capabilities, and create a management plan. The objective is not simply to punish or remove the person. It is to reduce risk through interventions such as conflict resolution, monitoring, mental-health support, changes in access, or law-enforcement action when necessary.

Factor	Why it matters	Possible response
Specific threat or violent communication	May indicate intent, target, or planning	Document, assess credibility, protect potential targets
Weapon acquisition linked to grievance	Increases capability	Review legal options and access controls
Prior violence or stalking	Shows behavioral history	Enforce orders, support victims, increase monitoring

Factor	Why it matters	Possible response
Suicidal crisis	May create urgency and reduced concern for consequences	Crisis care and temporary means separation
Major loss or humiliation	Can intensify grievance but is not sufficient alone	Support, mediation, and continued assessment
Protective relationships	May provide support and information	Engage trusted people where appropriate

Policy Implications

A comprehensive approach should avoid two extremes: claiming that mental illness has nothing to do with any mass shooting, or treating mental illness as the dominant cause of all such events. The evidence supports a layered strategy.

First, communities need accessible and non-stigmatizing mental healthcare. Second, institutions need trained multidisciplinary threat-assessment processes. Third, domestic violence, stalking, and communicated threats require early action. Fourth, firearm policies should address access during periods of demonstrated danger. Fifth, media organizations should avoid sensational coverage that rewards perpetrators with notoriety.

Research should use transparent definitions and distinguish among types of incidents. Policy claims should not be based on one exceptional case or retrospective speculation.

Conclusion

The association between mass shootings and mental illness is real in some individual cases but misleading as a general explanation. Mental illness is common, while mass shooting is rare. Diagnosis alone has poor predictive value, and most people with mental disorders are not violent.

Risk emerges from interactions among behavior, grievance, past violence, crisis, substance misuse, suicidal intent, opportunity, and access to lethal means. Prevention is therefore strongest when it focuses on observable warning behavior and reduces opportunities for harm rather than relying primarily on psychiatric labels.

Mental-health services remain an essential public good. They should be expanded because people deserve effective care and because timely intervention may reduce some crises. But meaningful

prevention also requires domestic-violence policy, suicide prevention, threat assessment, responsible firearm regulation, and accurate communication. Replacing stigma with evidence is both more ethical and more likely to improve public safety.

References

Appelbaum, P. S. (2013). Public safety, mental disorders, and guns. *JAMA Psychiatry, 70*(6), 565–566. https://doi.org/10.1001/jamapsychiatry.2013.315

Elbogen, E. B., & Johnson, S. C. (2009). The intricate link between violence and mental disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 66*(2), 152–161. https://doi.org/10.1001/archgenpsychiatry.2008.537

Metzl, J. M., & MacLeish, K. T. (2015). Mental illness, mass shootings, and the politics of American firearms. *American Journal of Public Health, 105*(2), 240–249. https://doi.org/10.2105/AJPH.2014.302242

Skeem, J. L., & Mulvey, E. P. (2020). What role does serious mental illness play in mass shootings, and how should we address it? *Criminology & Public Policy, 19*(1), 85–108. https://doi.org/10.1111/1745-9133.12473

Swanson, J. W., McGinty, E. E., Fazel, S., & Mays, V. M. (2015). Mental illness and reduction of gun violence and suicide: Bringing epidemiologic research to policy. *Annals of Epidemiology, 25*(5), 366–376. https://doi.org/10.1016/j.annepidem.2014.03.004