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Trends. Terrorism, Terror Management, and Faking Mental Disorder

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According to The New York Times, two psychiatrists and a psychologist have opined that a defendant accused of complicity in the bombings of United States embassies in Kenya and Tanzania is faking mental disorder. They also have posited that the defendant is able to understand and assist in the legal proceedings. The three mental health professionals maybe correct, however, their opinion can be significantly challenged.

The defendant's lawyers stated that he did not recognize them or that he had a family in the United States. The implications of this might then be that some sort of memory disorder would preclude understanding of and assistance with the legal proceedings. Unfortunately, the diagnostic tools to rule out or support these hypotheses are problematic. Mental health professionals usually depend on nomothetic theory and data to make idiographic decisions. They depend on overt and covert theories of human nature and individual functioning--including the existence of signs, symbols, and symptoms--that often have not stood up to rigorous empirical and experimental scrutiny. (And some of these theories may be operative but not in even in the awareness of the professionals.) In addition, they are bereft of pertinent, multicultural data. Moreover, they are knowingly and/or unknowingly supporters of politically engendered norms of right and wrong behavior hopelessly conflated with clinical lore.

So, what are our options? The alleged terrorist may be validly characterized by a memory-related diagnosis or other clinical diagnosis. The alleged terrorist may be intentionally feigning disorder. The alleged terrorist may be engaged in terror management--e.g., a disorder might arise as a means to optimally control the dread of death. Yet other hypotheses include the mental health professionals as grinding political axes, satisficing the task of evaluation, and even engaging in their own version of terror management to ward off awareness of the death of self-identity based on their profession's limitations. (See Frey, R. G., & Morris, C. W. (Eds.). Violence, terrorism, and justice. Cambridge University Press; Gutheil, T. G., & Sutherland, P. K. (1999). Forensic assessment, witness credibility and the search for truth through expert testimony in the courtroom. Journal of Psychiatry and Law, 27, 289-312; Holloway, H. C., & Norwood, A. E. (1997). Forensic psychiatric aspects of terrorism. In R. G. Lande, & D.T. Armitage (Eds). Principles and practice of military forensic psychiatry. (pp. 409-451). Charles C. Thomas; Lees-Haley, P. R. (1997). MMPI-2 base rates for 492 personal injury plaintiffs: Implications and challenges for forensic assessment. Journal of Clinical Psychology, 53, 745-755; Weiser, B. (December 12, 2000). Defendant in bombings case is feigning mental illness, court-hired doctors say. The New York Times, p. C24.) (Keywords: Faking Mental Disorder, Mental Disorder, Terror Management, Terrorism.)