Correlates of violence and victimization typologies among adults with serious mental illness

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Introduction

Though the belief persists that adults with serious mental illness (SMI) are often dangerous, they are more likely to be victims than perpetrators of violence (Teplin et al., 2005). The research literature also reflects a focus on dangerousness; three times as many publications exist on the link between mental illness and violence as on mental illness and victimization (Choe et al., 2008).

In the general population, in contrast, the victim-perpetrator overlap has been examined extensively and supported widely (cf., Jennings et al., 2011). While adults with SMI are at heightened risk of both outcomes, few studies have examined the overlap in this population. The presence of one is frequently acknowledged as a risk factor for the other (cf., Swanson et al., 1999), yet we are aware of only three studies that have examined both violence and victimization in the same sample of adults with SMI (Silver et al., 2011; Brekke et al., 2001; Hiday et al., 2001). When both outcomes have been measured in the same study, analyses (and conclusions) have been limited due to small, non-representative samples.

The Present Study

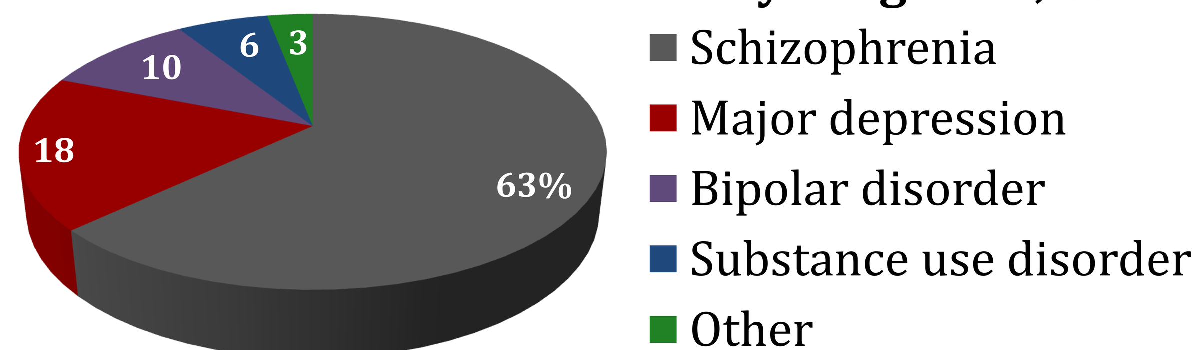
We examined the overlap between and selected risk and protective factors for violence and victimization in a large, heterogeneous sample of adults with SMI. We examined sociodemographic (i.e., age, sex, race/ethnicity) and clinical characteristics (i.e., primary diagnosis, psychotic symptoms) as possible distinguishing factors across four groups: non-victims/non-perpetrators (NVNP), victims only (VO), perpetrators only (PO), and victim-perpetrators (VP).

Methods

Baseline data were pooled from the: (1) MacArthur Mental Disorder and Violence Risk Study (*n* = 1,136; Steadman et al., 1998); (2) Schizophrenia Care & Assessment Program (*n* = 404; Swanson et al., 2004); (3) Clinical Antipsychotic Trials of Intervention Effectiveness Study (*n* = 1,460; Lieberman et al., 2005); (4) MacArthur Mandated Community Treatment Study (*n* = 1,011; Monahan et al., 2005); and (5) Psychiatric Advance Directive Study (*n* = 469; Swanson et al., 2006).

Participants. Studies included broad inclusion and minimal exclusion criteria, enrolling a range of participants, from exacerbated inpatients to partially remitted outpatients. A total of 4,460 participants were recruited across studies.

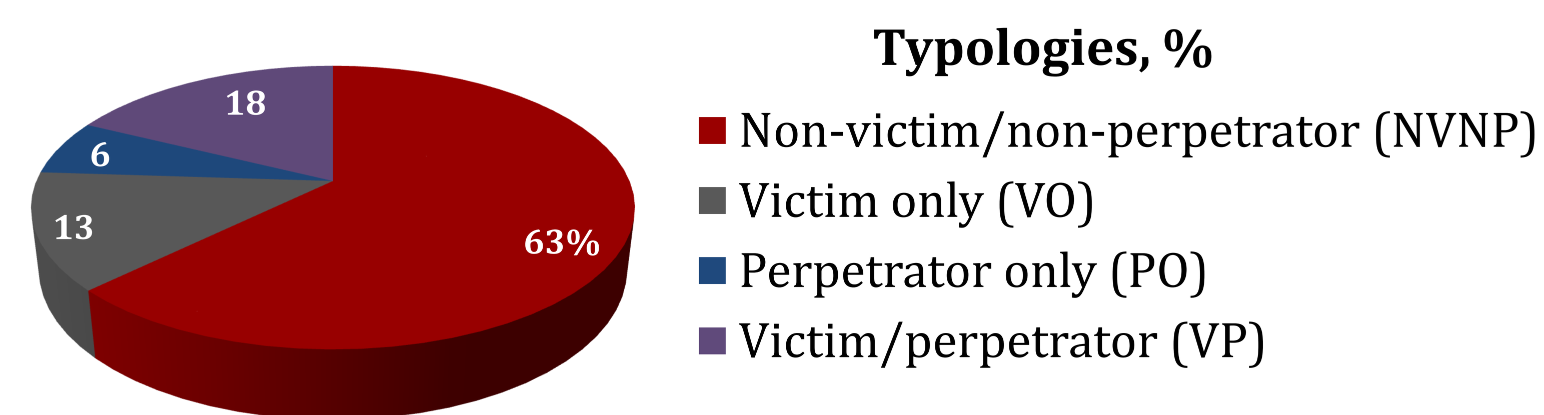
Primary Diagnosis, %



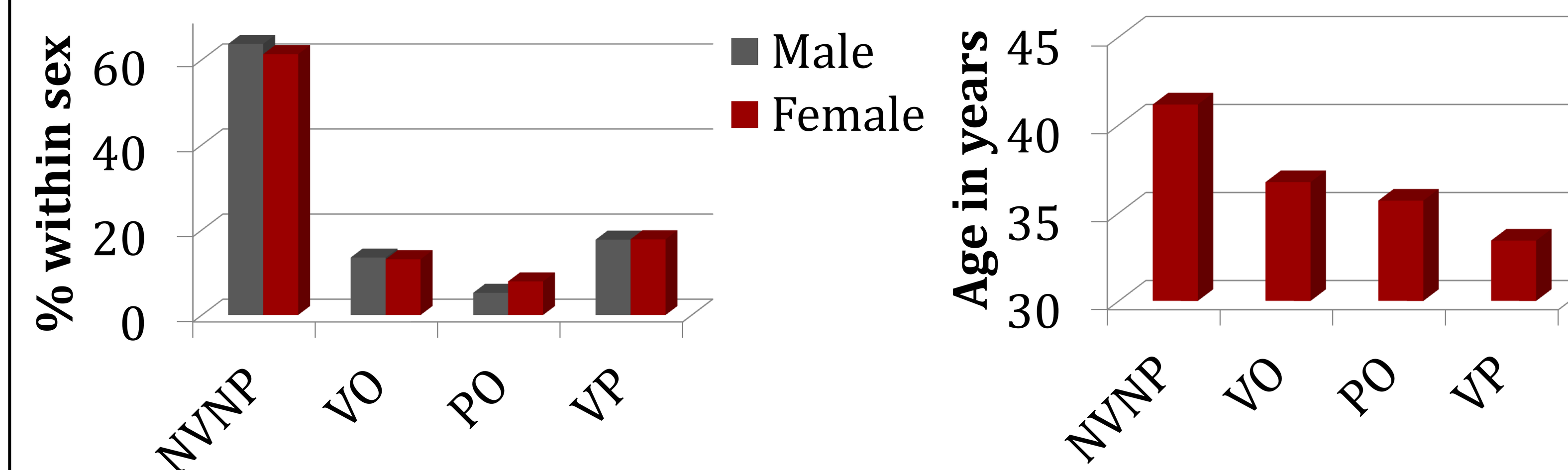
Measures and Procedures. Prevalence of violence and victimization were assessed using the MacArthur Community Violence Inventory (Steadman et al., 1998). Psychotic symptoms were assessed in interviews using the Positive and Negative Syndrome Scale (Kay et al., 1987) and the Brief Psychiatric Rating Scale (Overall & Gorham, 1962). Sociodemographic and diagnostic data were gathered through research interviews and medical chart reviews.

Results

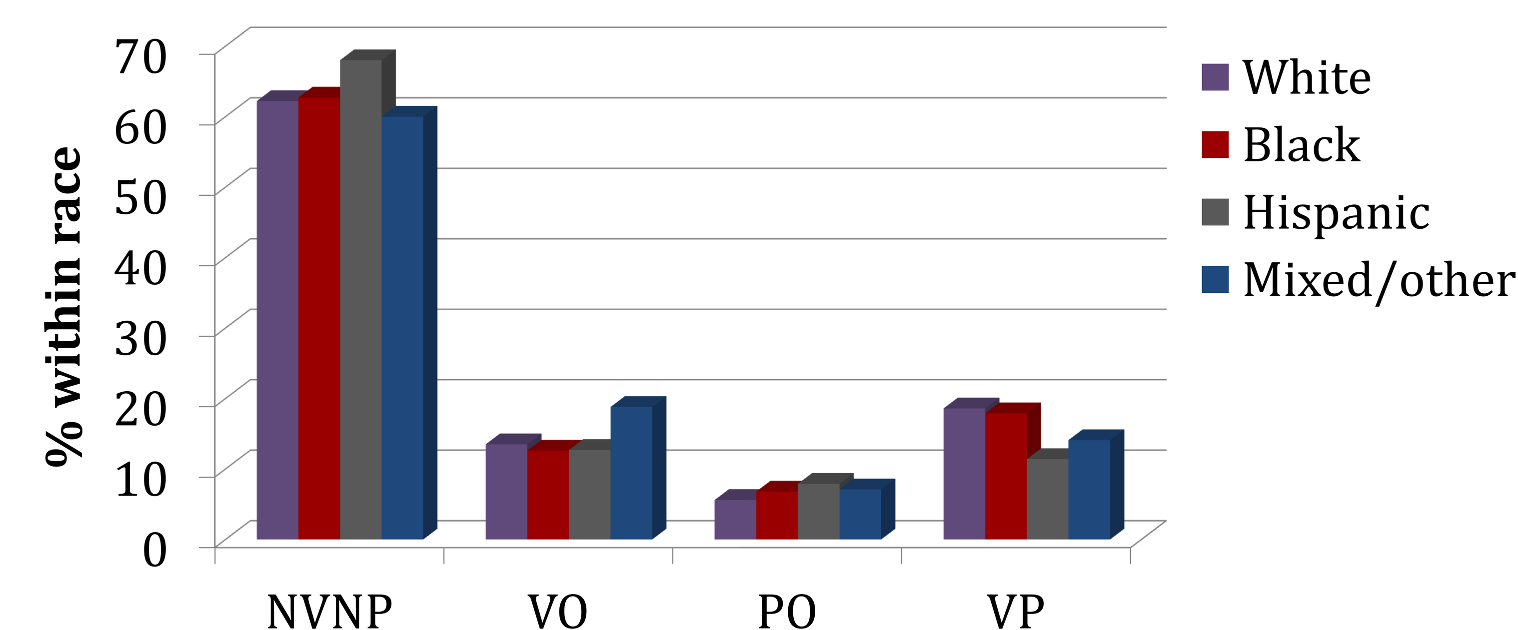
Typologies, %



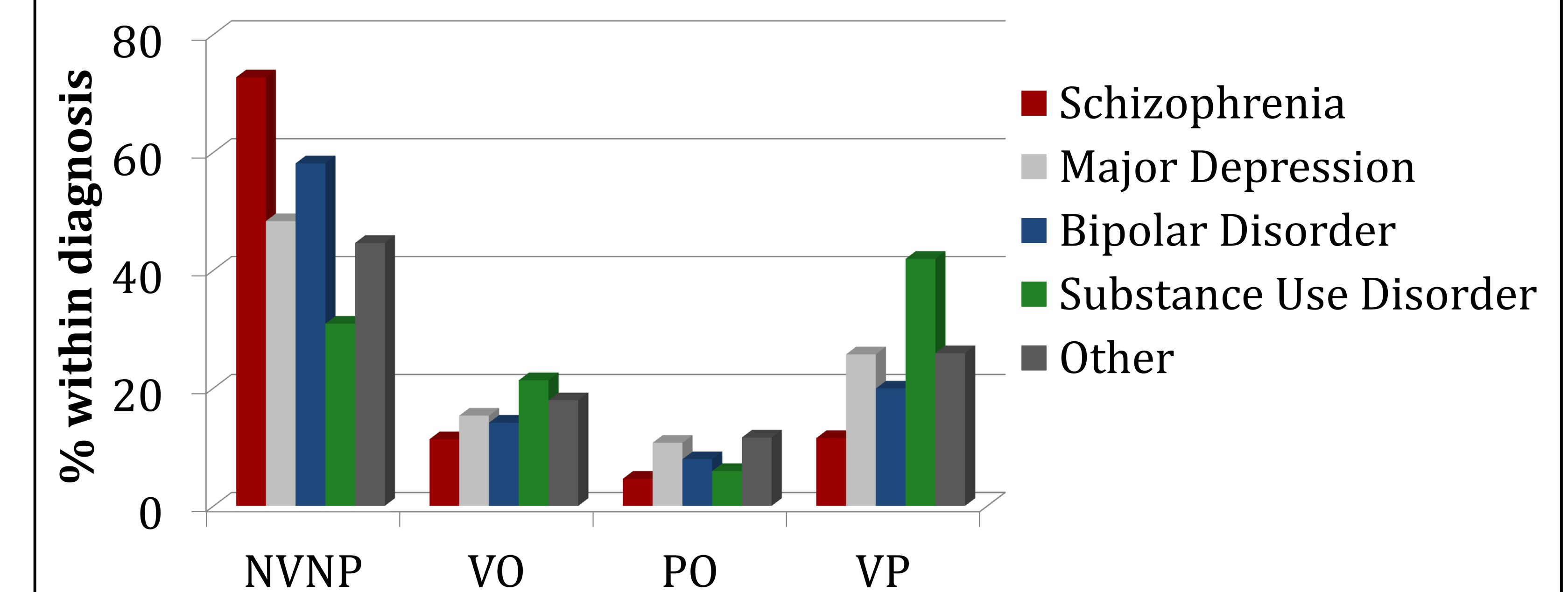
Demographic Characteristics. The distribution of male and female participants differed significantly across typologies, $\chi^2(3, N = 4{,}459) = 13.19$, $p < .01$. Post hoc z-tests indicated that the PO typology deviated significantly from the 2:1 male ratio reflected in the other typologies, and in fact had a greater representation of females than of males. Age also differed significantly across typologies, $F(3, 4{,}448) = 127.38$, $p < .001$. Post hoc comparisons showed that mean age for each typology differed significantly from one another in all cases except between VO ($M = 36.75$, $SD = 10.51$) and PO ($M = 35.70$, $SD = 10.46$).



Race/ethnicity also differed across typologies, $\chi^2(9, N = 4{,}454) = 19.88$, $p < .05$. Post hoc z-tests indicated that Hispanic participants were significantly more likely to identify as NVNPs and less likely to identify as VPs.



Clinical Characteristics. Primary diagnoses differed significantly across the four groups, $\chi^2(12, N = 4{,}452) = 436.86$, $p < .001$. Post hoc z-tests showed that, with the exception of bipolar disorder ($p = .25$), the distribution of each disorder differed significantly across typologies.



Psychotic symptoms also differed significantly across typologies (*ps* < .05 except for excitability, *p* = .65, and hallucinations, *p* = .08). Post hoc comparisons showed that mean symptom severity for the NVNP group was significantly lower for symptoms of anxiety, depression, and guilt feelings compared to the other typologies, and higher for blunted affect. The NVNP group was higher than VO and VP groups for disorientation and emotional withdrawal, and higher than PO and VP groups for mannerisms and posturing and conceptual disorganization. Meanwhile, VPs reported greater levels of depression than individuals in PO and VO groups, and higher guilt feelings than those in the VO group.

Discussion

Sex, race/ethnicity, age, primary diagnosis, and psychotic symptoms differed between the four typologies. These findings suggest unique profiles of sociodemographic and clinical correlates associated with each typology. For instance, in the PO typology, there was a greater representation of females than of males – a deviation from the 2:1 male ratio reflected in the other typologies. In cases of significant differences, members of the NVNP and VP typologies typically reported either the highest or lowest levels of symptom severity.

These profiles may assist in identifying those most at risk of violent outcomes and tailoring preventive interventions to reduce risk of future violence and victimization. We examined bivariate associations only; future research should include multivariable analyses to determine the relative importance of demographic and clinical characteristics.

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