Findings from the National Comorbidity Survey on the frequency of violent behavior in individuals with psychiatric disorders

Patrick W. Corrigan*, Amy C. Watson

Center for Psychiatric Rehabilitation at Evanston Northwestern Healthcare, 1033 University Place, Suite 450, Evanston, IL 60201, USA

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Abstract

Previous studies using probability samples have found a noticeable, but small association between violence and psychiatric disorder. In this article, we analyze data from the National Comorbidity Survey (NCS) to further examine this question. Psychiatric diagnosis of survey responses was based on a modified version of the Composite International Diagnostic Interview. The NCS study also included items that permitted self-report of violent behaviors in the past year. People with 12-month diagnoses of anxiety disorders, dysthymia and major depression were three to four times more likely to admit violent behaviors than those with no disorders. People with bipolar disorder or drug and alcohol abuse were eight times more likely to report violent behaviors. People with co-occurring non-substance and substance abuse disorders were more likely to report violence than those with only non-abuse disorders. Adjusting violence rates by population base rates shows demographics including ethnicity and gender to be a better predictor of violent behavior than psychiatric diagnosis. The NCS findings approximate those in other probability studies and echo the conclusions of the 1996 Consensus Statement by Advocates and Researchers on violence and mental illness; namely, mental illness is only a weak predictor of violent behavior.

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1. Introduction

Regardless of where people stand on the issue of psychiatric disorder and violence, most agree that it is a major source of prejudice and discrimination against people with mental illness. Results of a nationwide probability survey showed that as much as 75% of the public view people with mental illness as violent (Link et al., 1999; Pescosolido et al., 1999). A separate analysis of these data found that twice as many Americans in 1996 viewed people with mental illness as violent than did so 40 years ago (Phelan et al., 2000). Why do so many members of the general public think mental illness is strongly linked to a
potential for violence, and why is this perception on the rise? Some view rising public concern in this area as an accurate reflection of increased violence by people with mental illness that has resulted from diminished institutional care (Torrey, 1994). Others argue that media portrayals of people with mental illness as violent, especially in the entertainment industry, contribute to the widespread misperception that mental illness and violence go hand in hand (Wahl, 1995). Several studies with varying methodological rigor have addressed this question. The National Comorbidity Survey (NCS) (Kessler, 1994) provides a rigorously collected set of data from a probability sample that provides additional perspective on this issue.

Members of the Treatment Advocacy Center (TAC) have cited statistics that suggest mental illness is strongly associated with a potential for violence. The TAC, for example, estimates that persons with serious mental illness commit approximately 1000 homicides per year in the United States (Treatment Advocacy Center, 2002). The TAC findings are echoed by other research. A 1979 review of research comparing offenses of people with mental illness to other community residents found ratios varied from as low as 1.16 to as high as 15 (Rabkin, 1979). Rabkin’s summary was mirrored by subsequent studies in which people with mental illness were consistently more likely to be arrested for violent crimes compared with non-psychiatric samples (Harry and Steadman, 1988; Holcomb and Ahr, 1988; McFarland et al., 1989; Shore et al., 1990). Finally, a body of practice-based evidence seems to provide empirical support for the perception of a strong link between mental illness and violence. For example, reviews of records of admissions to inpatient units have found that between 18% and 41% of patients had been violent (e.g., struck others) before admission (Johnstone et al., 1986; Humphreys et al., 1992).

Several research groups have criticized the studies on which these conclusions are based (Link et al., 1992, 1999; Wahl, 1995). In summarizing the state of research on mental illness and violent behavior, Monahan (2002) said answers to this issue can only be advanced by studying probability samples that were unselected for treatment status in the community at large. Several studies have been completed using probability samples; that is, groups of people with mental illness that were randomly selected from geographic areas in stratified formats so that key demographics relevant to crime and violence are appropriately distributed. Comparison groups were also drawn from the general population and are representative of all key variables. This line of research suggests that people with mental illness are more likely to commit violent crimes than are comparable samples of people without mental illness in the general population. Research completed in the United States and Britain show a two- to six-fold increase in the rate of violence in samples of people with mental illness compared with samples of people without mental illness drawn from the general population (Link et al., 1992; Stueve and Link, 1997; Swanson et al., 1997; Steadman et al., 1998). The prototypic study of this kind was the analysis conducted on the data set from the Epidemiological Catchment Area (ECA) survey (Robins and Regier, 1991). Conducted between 1980 and 1983, the ECA survey was the largest study of psychiatric disorders conducted in the United States to that date. ECA analyses completed by Swanson et al. (1990) showed a four-fold increase in violent behavior for some mental illnesses (e.g., schizophrenia) compared with no disorder, and a 10-fold increase for substance abuse disorders.

We seek to extend and advance ECA findings using the NCS data set. The NCS was a congressionally mandated survey designed to study the comorbidity of substance use and non-substance use disorders in the United States. It was designed to take the next step beyond the ECA study. Two main advances are noteworthy. First, NCS diagnoses are based on DSM-II-R (American Psychiatric Association, 1987) rather than DSM-III (American Psychiatric Association, 1980) criteria. Questions are also included in the interview that allow some comparisons with DSM-IV (American Psychiatric Association, 1994) and with the International Classification of Diseases (ICD-10) Diagnostic Criteria for Research (World Health Organization, 1991). Second, the NCS yielded a national probability sample and was the first nationally representative data set that can be used in the current debate about health care policy in the United States.

Using the NCS data set, we have three goals in this article: (1) We seek to contrast findings from the NCS sample with those reported by Swanson et
Corrigan and Cooper (2005) attempted to make sense of the effect size of the ECA findings on violent behavior and mental illness diagnosis by juxtaposing frequency of violent behaviors by diagnostic groups and by demographic subgroups of the general sample against base rates of those groups in the population. Results showed that demographic variables including gender and age are significantly stronger correlates of violence than psychiatric diagnosis. This kind of base-rate analysis will be repeated in our NCS data analysis.

2. Methods

All aspects of the NCS have been discussed in detail elsewhere (Kessler, 1994, 1995; Kessler et al., 1994). Briefly, the NCS is based on a stratified, multistage area probability sample of persons aged 15–54 years in the non-institutionalized civilian population in the 48 coterminous states. The survey was administered by the Survey Research Center at the University of Michigan between September 14, 1990, and February 6, 1992. The response rate was 82.6%. A total of 8098 respondents participated in the survey. A subset of the whole (n=5865) completed an additional survey on items that included proxies to violent behavior; data from the subsample are used in this analysis. Adjustment weights were used to adjust for nonresponse, variation in probabilities of selection both within and between households, and national population distributions of the cross-classification of age, sex, race/ethnicity, marital status, education, living arrangements, region, and urbanicity as defined by the 1989 U.S. National Health Interview Survey.

Psychiatric diagnoses reported in this article are based on the DSM-III-R (American Psychiatric Association, 1987). The diagnostic interview used to generate these diagnoses is a modified version of the Composite International Diagnostic Interview (CIDI) (World Health Organization, 1990), a state-of-the-art structured diagnostic interview based on the Diagnostic Interview Schedule and designed to be used by trained interviewers who are not clinicians (see Robins et al., 1988, for a discussion of the CIDI). NCS diagnoses used in this study represent those made in the last year and lifetime diagnosis.

The goal of this study was to determine the relationship between “last year” or “lifetime” diagnoses of mental illness, and recent violent behavior. Consistent with the ECA analysis (Swanson et al., 1990), violent behavior was defined as one of two items from the NCS survey. 1. In the past 12 months did you have serious trouble with the police or the law? This item was included in a scale on recent life events. Survey participants answered yes or no to the item. 2. During the past 12 months, how many times have you been in a physical fight in which you or someone else was injured and had to be treated by a doctor or a nurse? This item was included in a scale on health. Interviewers coded the number of times the person reported a fight in the past 12 months. For purposes of the analysis reported in this article, individual survey participants were coded positive for violent behavior if they responded yes to item 1 or admitted one or more occurrences of physical fights in item 2.

The items used in the analyses have some limitations worth noting. The NCS items are not specific in severity, are limited in frequency, and vary in their relevance to violence, per se. In fact, the first item was more a measure of crime involvement than of violence; hence the focus of this article is on violent behavior rather than violence. As a result, we are left with a relatively blunt measure of the presence or absence of violent behavior in association with psychiatric diagnoses. Note, however, that this limitation is common to the kind of post hoc methodological decisions that are made when analyzing epidemiological data sets. Definition of violence in the ECA analysis conducted by Swanson et al. (1990),
for example, included items that were conflated by concurrent alcohol use (thereby perhaps artificially inflating the rate of violence in comorbid individuals) and by parenting habits (Swanson and Holzer, 1992). Moreover, the ECA analysis did not include any markers of violence that did not involve bodily harm (e.g., harm to property, threatening, or arson). Implications of these methodological decisions are discussed more fully in Section 4.

3. Results

3.1. One-year prevalence of violent behavior

Of the survey participants responding to item 1, 158 (2.7%) people reported trouble with the police in the past year. For item 2, 88 (1.5%) reported one physical fight that led to injury in the past year, 46 (0.8%) had such fights two or three times in the past year, nine (0.1%) reported four to five incidents, and 10 (0.2%) reported more than five. This yields a total of 157 (2.6%) people reporting fights in the past year. Interestingly, combining the two items together to yield a single index of violence behavior yields little overlap; 272 survey participants reported positively to one of the two violent behavior items (4.6% of the weighed sample).

3.2. Violent behavior by demographics

Gender, age, and ethnicity were all shown to be associated with the overall index of violent behavior. In terms of odds ratio, men were 4.4 times more likely to report violent behavior than women (5.8% compared to 1.4%). A similar striking effect was found for age. The prevalence of violent behaviors by age group was 10.3% for 15 to 24 years of age, 2.1% for 25–34 year olds, 0.9% for 35–44 year olds, and 1.0% for 45–54 year olds. Being in the youngest group increased the odds of violence by 5.5 times over the next age group. As outlined in Table 1, a noticeable interaction was found between gender and age. Males age 15–24 were almost five times more violent than any other gender by age group in the table.

A noticeable effect was also observed for ethnicity: 3.2% of European Americans reported violent behavior, 3.8% of African Americans, 7.3% of Hispanic Americans and 2.1% of others. Odds of violent behaviors in Hispanic Americans were twice those of African Americans and European Americans, with odds ratios of 2.0 and 2.3 respectively. Unlike gender and age, however, the interaction between gender and ethnicity does not seem to increase violent behaviors across demographic groups.

3.3. Violent behavior and diagnosis in the past year

The second and third columns of Table 2 list the NCS prevalence rates of self-reported violent behavior by lifetime and past year diagnosis. Each cell in that column includes the number of people who met the diagnostic criterion for the single disorder in the corresponding row, the subset from this group who also reported violent behavior, and the corresponding frequency ratio expressed as a percentage. The first row of Table 2 represented the prevalence of violent behavior in people who did not meet diagnostic criteria for any psychiatric disorder in the past year; this was 2.0%. The fourth column of Table 2 represented findings from the ECA where diagnoses corresponded across studies. Swanson et al. (1990) also reported a rate of violent behavior equal to 2.0%. One might wonder whether these scores are low because survey participants are unwilling to report their violent behavior in the past year. Data from federal archives, however, suggest these rates may be accurate. The 2000 U.S. Census (U.S. Bureau of the Census, 2002) reports a violent crime rate of 0.51% and the Bureau of Justice Statistics data for 2001 indicates that 2.9%

<table>
<thead>
<tr>
<th>Percent violent behavior</th>
<th>Age</th>
<th>Ethnicity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15–24</td>
<td>25–34</td>
</tr>
<tr>
<td>Male</td>
<td>16.6%</td>
<td>32.7%</td>
</tr>
<tr>
<td>Female</td>
<td>3.8%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
of the American adult population was involved in some type of correctional supervision (e.g., jail, probation, prison, parole).

Consistent with other studies that used probability surveys, NCS data showed psychiatric diagnosis was associated with increased violent behavior. Survey participants with anxiety disorders, dysthymia, and depression were more likely to report violent behaviors than the “no disorder” group, with odds ratios of 3.4, 4.8, and 3.8, respectively. A much higher rate was found for bipolar disorder; the odds ratio for violence for this group was 9.5. Survey participants who were dependent on alcohol or other drugs in the past year showed similar odds ratios. The one surprising finding was the low rate of violent behavior in the non-affective disordered group with psychosis (e.g., people in the schizophrenia spectrum). Of that group, 3.2% reported violent behavior, just 1.65 times higher odds than the “no disorder” group. However, this percentage only represented data from 18 participants in the entire survey, so this finding may have been muted because of small sample size.

Note that a disorder-by-disorder comparison of the rate of violent behaviors in NCS and ECA samples yields some similarities, but many differences. Most notable of the differences can be seen in the affective disorders, non-affective psychosis, and alcohol abuse disorder. Rates of violent behavior in people diagnosed with depression were more than 4% lower in the NCS sample. However, the difference in rates for bipolar disorder was reversed; participants in the ECA sample were almost 5% lower. A large difference was noted in non-affective psychosis with the NCS sample being almost 10% lower. Finally, violent behavior rates for alcohol abuse were almost 15% lower in the NCS sample.

3.4. Violent behavior and lifetime diagnosis

Data from the NCS study yielded lifetime diagnoses and helped to address the question whether it is recent symptoms and associated disabilities (i.e., diagnosis in the past year) or presence of diagnosis (diagnosis in lifetime) that is more strongly associated with violent behaviors. Interestingly, column 2 in Table 2 shows that use of lifetime diagnostic criteria yielded almost the same rate of violent behavior in the “non-disordered” group: 1.9%. Comparing the remaining frequencies in column 2 shows some interesting trends. In all cases except one, 12-month diagnoses yielded higher rates of violent behavior than lifetime diagnoses.

3.5. Violent behavior and multiple diagnoses

Previous research suggests that the rate of people with violent behaviors increases with multiple diagnoses (Swanson et al., 1990). NCS data were examined to answer this question in two ways. First, Fig. 1 represents the percentage of survey participants reporting violent behavior by number of concurrent diagnoses.
Data Fig. 1 represent 12 months and lifetime diagnoses from the NCS data as well as 12 months of diagnosis from the ECA data (Swanson et al., 1990). Note that the ECA data showed a significant increase in people reporting violent behaviors as diagnoses increased from none to more than three; e.g., people with three or more diagnoses were almost four times more likely to report violent behavior than survey participants with only one diagnosis (odds ratio 3.9). Patterns for 12-month diagnosis from the NCS data represented the same increase from no diagnosis to more than three diagnoses, though the curve was not nearly so steep. NCS participants with more than three diagnoses were only twice more likely to report violent behaviors than individuals with only one diagnosis. The same pattern was found for lifetime NCS diagnosis; those with three or more diagnoses were about 4.5 times more likely to report violent behaviors than individuals with only one diagnosis.

Previous research has been especially concerned with the impact of substance abuse, co-occurring with a non-substance disorder, on violent behavior (Steadman et al., 1998). Table 3 lists the percentage of survey participants who met diagnostic criteria for one of the non-substance abuse disorders and who were also diagnosed with co-occurring alcohol or other substance abuse (with or without dependence). Cells in these columns include two sets of values. The first ratio represents the number of people with the co-occurring disorder by the total number of people with the corresponding non-substance abuse disorder. In some cases, less than 4% of people who met criteria for the non-substance abuse disorder also reported a co-occurring alcohol or other substance abuse disorder. In these cases, small sample size would preclude an accurate determination of the percentage with violent behaviors so we did not report the frequency of violence here. In the remaining cases, each cell lists the percentage of people with corresponding dual diagnosis that reported violent behavior.

In cases where dual diagnosis yielded a sufficient sample, combining alcohol or some other substance abuse with a non-substance abuse disorder generally increased the number of people reporting violent behavior. This pattern appeared for both 12-month and lifetime diagnoses. Depending on the disorder, odds increased from 1.1 to 2.4 times. The only exception to this rule among the 23 dual diagnoses with these scores in Table 2 was people with a 12-month concurrent diagnosis of social phobia and alcohol abuse.
3.6. Violent behavior and base rates

Results reported in this article suggest that risk of violence for people with a single 12-month diagnosis can be 2 to 10 times higher than that for the no-disorder sample, depending on the diagnosis. This ratio, however, does not clearly suggest the size of the problem because it neglects base rates of various groups. One way to appreciate the size of the relationship is to use the NCS data to examine how mental illness compares with various demographics that also are related to violence. The second column of Table 4 repeats the percentage of people in each diagnostic group that reported violent behaviors (from Table 2). Note that diagnoses are presented in two groups: a selection of substance abuse disorders and non-substance abuse disorders. The third column lists the prevalence rates for the various diagnoses also gleaned from the NCS data set. The fourth column represents the number of people in a hypothetical community of one million who would be expected to exhibit violent behaviors based on their diagnoses (determined as the product of the % violence risk, the % of the general population, and the total community population (N=1,000,000)). The sum of correct identifications across the five non-substance abuse groups is 19,054, though this number is inflated because many NCS respondents met criteria for more than one disorder. This number suggests 1.9% of one million would show violent behaviors because of mental illness. Correct identifications for the substance abuse group equals 3859. Combining total number of correct identifications for non-substance abuse and substance abuse groups is 22,913, representing 2.3% of this hypothetical community.

How does this finding compare to numbers of violent people identified by key demographics included in Table 1: age, gender, and ethnicity? Table 4 lists the percentages of Hispanic, young (age 15 to 24), and male respondents who reported violent behavior and

| Table 3 |
|------------------|------------------|------------------|------------------|------------------|
| Relationship between co-morbidity (substance abuse plus an additional psychiatric diagnosis) and “violent behavior” |
| Psychiatric diagnosis | Co-morbid alcohol abuse with 12-month diagnosis | Co-morbid drug abuse with 12-month diagnosis | Co-morbid alcohol abuse with lifetime diagnosis | Co-morbid drug abuse with lifetime diagnosis |
| Simple phobia | 16/515* | 4/515* | 215/654 7.6% | 117/654 9.7% |
| Social phobia | 22/474 5.6% | 6/474* | 267/295 9.6% | 155/795 16.4% |
| Agoraphobia | 6/214* | 0/214* | 113/386 11.3% | 74/386 13.0% |
| Generalized anxiety disorder | 2/171* | 4/171* | 106/294 6.2% | 77/294 7.9% |
| Panic disorder | 2/129* | 0/129* | 69/200 9.2% | 53/200 6.9% |
| Posttraumatic stress disorder | 8/223* | 3/223* | 145/429 11.8% | 104/429 7.9% |
| Dysthymia | 4.148* | 3/148* | 134/382 6.8% | 80/382 9.4% |
| Major depression | 18/586* | 7/586* | 333/992 8.5% | 203/992 10.3% |
| Bipolar disorder | 2/71* | 2/71* | 55/93 14.5% | 35/93 13.2% |
| Non-affective disorder psychosis | 1/18* | 0/18* | 24/20 20.3% | 9/20 23.0% |

* The ratio of people with dual diagnosis that corresponds to a specific mental illness was less than 4%; hence, frequency of violence score was not determined for that dual diagnosis.

Table 4

Rates of violent behavior in 12-month diagnostic groups and two key demographics

<table>
<thead>
<tr>
<th></th>
<th>% Violent in NCS data</th>
<th>% General population</th>
<th>Correct identifications in community of 1,000,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simple phobia</td>
<td>5.8</td>
<td>8.8*</td>
<td>5104</td>
</tr>
<tr>
<td>PTSD</td>
<td>7.5</td>
<td>3.5</td>
<td>2625</td>
</tr>
<tr>
<td>Panic disorder</td>
<td>8.4</td>
<td>2.3</td>
<td>1932</td>
</tr>
<tr>
<td>Major depression</td>
<td>7.1</td>
<td>10.3</td>
<td>7313</td>
</tr>
<tr>
<td>Bipolar disorder</td>
<td>16.0</td>
<td>1.3</td>
<td>2080</td>
</tr>
<tr>
<td>Alcohol abuse w/wo dependence</td>
<td>9.1</td>
<td>2.5</td>
<td>2275</td>
</tr>
<tr>
<td>Drug abuse w/wo dependence</td>
<td>19.8</td>
<td>0.8</td>
<td>1584</td>
</tr>
<tr>
<td>Substance abuse subtotal</td>
<td></td>
<td></td>
<td>3859</td>
</tr>
<tr>
<td>Hispanic</td>
<td>7.3</td>
<td>12.0</td>
<td>8760</td>
</tr>
<tr>
<td>Age (15–24)</td>
<td>10.3</td>
<td>14.1*</td>
<td>14,523</td>
</tr>
<tr>
<td>Male</td>
<td>5.8</td>
<td>49.1</td>
<td>28,478</td>
</tr>
</tbody>
</table>

* Diagnoses represent prevalence rates from the NCS for 12-month diagnoses.

b Demographic data determined from the 2000 U.S. Census.
the third column lists U.S. Census figures for the base rates of each demographic in the general American population. Using these ratios, 8760 Hispanics in a community of one million would be expected to report violent behavior, a result that is higher in numbers than any generated by a single psychiatric diagnosis. Indeed, 14,523 young adults would be correctly identified, nearly twice the number identified by a single psychiatric disorder. Finally, 28,478 males would be correctly identified, almost 125% more than the sum of all the people identified by psychiatric diagnoses in Table 4. Note that our goal here is not to prove that young Hispanic males are violent. Assuming so would lead to many false positives. Rather, we present this information to place in perspective the putative connection between mental illness and violence.

4. Discussion

This article used the NCS data to address the question about violent behavior in people diagnosed with single and multiple psychiatric disorders. In many ways, findings from this study mirrored the results found in Swanson et al. (1990) on the ECA data. People with 12-month single diagnoses in the anxiety or depressive spectrum will have a three to almost four times greater likelihood of reporting violent behaviors than those with no 12-month disorder. People with bipolar disorder will have a 9.5 times greater likelihood. Similarly, high rates were found for people with alcohol and other substance abuse disorders. Inconsistent with other studies, however, was the low rate of violent behavior in people with psychosis not due to affective disorders; a rate of 3.2% in the NCS study compared with 12.7% in the ECA data. This difference may in part be due to the different ways in which the two studies defined these categories. The ECA data limited this category to the DSM-III definition of schizophrenia while the NCS data concerned the schizophrenia spectrum. This distinction, however, does not seem to account for the relatively small sample of people of the schizophrenia spectrum found in the NCS (0.3% of the entire sample). Moreover, the NCS score for non-affective psychotic disorder seems much lower than that in other epidemiologic studies of disorders in the schizophrenia spectrum (Jablensky, 1995). This disparity and the low sample size suggest that data on violence in the sample of people with non-affective psychotic disorder may be underestimated.

Results from this study also examined the impact of multiple co-occurring disorders on violent behaviors. Like those in other probability samples, the results suggest that self-reports of violent behavior are much more frequent in people with more than one co-occurring disorder, with the rate increasing progressively with the number of co-occurring disorders. Findings from this NCS analysis also suggest that the presence of a co-occurring substance abuse disorder can double the frequency of violent behaviors compared with that in people with the non-substance abuse disorder alone.

Unlike earlier studies, we also examined the relationship between lifetime diagnosis and violent behavior. Two interesting results were found. First, 12-month diagnosis was generally associated with higher rates of violent behavior than lifetime diagnosis. This finding suggests that recent symptoms and disabilities, rather than mere presence of the disorder, better account for violence. Note, however, that people with lifetime-only diagnoses of alcohol and drug abuse still show a four to six times higher rate of violent behavior than people with no disorder. This finding suggests characteristics of substance abuse other than recent symptoms and disabilities account for violent behavior. Among the likely candidates is the illegal lifestyle that some drug and alcohol users must adopt for their habits.

Let us revisit the methodological limitations discussed earlier in the article; namely, defining violence based on existing NCS items may limit the clarity and strength of findings. As we remarked earlier, our data, like the ECA findings, are limited by the way in which violence was operationalized. Moreover, proxies taken from the ECA were different from those taken from the NCS, making direct comparisons more difficult. In particular, the NCS analysis focused on violent behaviors (which included criminal behavior), while the ECA items focused on violence (i.e., behavior leading to bodily harm). Nevertheless, convergence of findings across the NCS and ECA samples using slightly different definitions of violence and violence adds to the strengths of our assertions. In some ways, the NCS analysis might be viewed as a triangulated data set that supported the conclusions of Swanson et al. rather than cross-validation of the ECA data.
We opened this article by returning to the often asked question of whether people with mental illness are more violent than the rest of the population, making psychiatric diagnosis an important predictor of violent behavior. We attempted to address this question by juxtaposing the frequencies of people with violent behavior per disorder against base rates of the disorder in the population. We then compared these products to similar indices determined by demographic variables including age, ethnicity, and gender. Results of the analyses showed that demographic variables, especially gender, are far better predictors of violence than psychiatric diagnosis of either substance abuse or non-substance abuse disorders. Hence, our answer to the question about violence and psychiatric disorder, based on these analyses of NCS data, echoes the 1996 Consensus Statement by Advocates and Researchers: “only a weak association between mental disorders and violence exists in the community” (Monahan and Arnold, 1996). Assertions about any kind of association are further qualified by the high frequency of false positives yielded by psychiatric diagnosis as a predictor of violent behavior. Hence, research summaries that stress the connection of violence and psychiatric disorder may be exacerbating the stigma of mental illness.

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