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

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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

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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

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