EDITORIAL

Violent Acts and Being the Target of Violence Among People With Mental Illness—The Data and Their Limits

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Evidence has accumulated over the last 40 years indicating increased rates of violent perpetration and being the target of violence among people with mental illness. Landmark data collected in the early 1980s by the Epidemiologic Catchment Area study found a 12-month prevalence of 12% for any type of violence among people with mental disorders, which dropped to 7% if people with comorbid substance abuse (*DSM-III*) were excluded, compared with 2% in the general population.[1] Similar magnitudes of increased risk have been found in subsequent studies[2] and meta-analyses,[3] although the absolute rates of violence vary, probably because of differences in the populations sampled, outcome measures, and means of ascertainment.[4] However, despite the greater risk associated with mental disorders, the proportion of violence accounted for by mental disorder is small, with 1-year attributable risk estimated at 4% in the Epidemiologic Catchment Area analyses.[1]

Related article page 359

Being targeted by violence also has been shown consistently to be elevated among people with mental disorders, with most studies focusing on severe mental disorders.[5,6] Vulnerability may be enhanced by factors particularly associated with psychotic disorders, including homelessness and substance use, along with symptoms that may provoke violence by others, such as delusions and hallucinations.[6] Studies also confirm an association between being a perpetrator and being a target of violence, with a pooled sample from 5 studies showing that either status led to an 11-fold increase in the likelihood of the other.[7] However, findings on the degree of increased risk of being targeted by violence compared with people without mental disorders vary across studies.

In this issue of *JAMA Psychiatry*, Sariaslan and colleagues[8] report being targeted by violence and violence perpetration data from a 20-year Swedish birth cohort of more than a quarter million people, comparing people with diagnoses of mental disorders with a comparison group without diagnoses from the general population and their own siblings without diagnoses. With a mean of 7.3 years of follow-up data after onset, overall rates of being targeted by violence and perpetration were low (approximately 7 per 1000 person-years), but the mentally disordered group was at elevated risk of being a target and perpetrator of violence. Without adjusting for confounders, the hazard ratios reflecting increased risk for being a target of violence and perpetration were approximately 7 and 11, respectively. However, in contrast to previous studies, the authors controlled not just for confounders that included sex, birth year, and parental characteristics, but also histories of violent involvement and unmeasured familial factors, the latter by means of the sibling comparisons. The fully controlled models indicated a 3- to 4-fold increased risk of both outcomes compared with unaffected siblings, who presumably were exposed to similar environments during their formative years.

Given the large sample, limited attrition, and careful statistical controls, this study underscores the robustness of the positive associations between mental disorders and being targeted by violence and perpetration, which are now demonstrated in multiple studies with different populations and methods. However, notwithstanding the strengths of this study, it is important to underscore the limits of the conclusions that can be drawn. First, the mental disorder diagnoses that led to inclusion in the affected group included alcohol and drug use disorders along with personality disorders. People with these diagnoses had the highest crude rates of being targeted by violence and (along with schizophrenia) perpetration, with the rates for drug use disorders far and away the highest. Because it is likely that many members of the general public, and even many mental health professionals, do not think of these categories as being encompassed by the category of psychiatric disorders, as they are referred to by the authors, citation of the rates of the outcomes found in this study will need to be accompanied by a careful explanation of the diagnoses included.

A second caveat deals with potential comparisons between the rates of being targeted by violence and perpetration. As the authors note, previous literature has supported the conclusion that people with mental disorders are more likely to be targets of rather than perpetrators of violence.[7] In contrast, the rates of both outcomes appear to be roughly equivalent in these data. However, it is critical to note that the definitions of the 2 categories in this study are quite different. Violent perpetration occurred when a member of the cohort was convicted of homicide, assault, robbery, violence against an officer, arson, or a sexual offense. However, being targeted by violence required the episode to have involved an outpatient visit (excluding primary care), inpatient admission, or death of the individual. Thus, a member of the cohort could have been classified as violent after having been convicted of an assault against another cohort member, but unless the latter sought medical treatment from someone other than a primary care clinician, he or she would not have been considered a target of violence. It seems quite likely that many people targeted by violence, especially those with serious mental illnesses, would not have sought medical attention. The different criteria for measuring perpetration and being targeted by violence preclude any valid assessment of their relative frequencies based on these data. Moreover, this restrictive definition of being a target of violence could account for the

lower rates of being targeted by violence reported in this study compared with the prior literature.

Third, it cannot be assumed that either the unadjusted rates of being a target of and perpetrating violence or the adjusted hazard ratios observed in Sweden will necessarily be the same in other countries. Societies in which treatment is more difficult to access and social benefits are fewer may leave people with mental disorders more vulnerable to both outcomes, resulting in higher rates of being targeted by violence and violent behavior than was observed in this study. For example, homelessness and untreated psychosis are risk factors for being targeted by violence and perpetration among people with severe mental illness[9,10] and both may be elevated in countries that lack Sweden's universal health coverage and strong social safety net. Higher rates of homelessness among people with mental disorders would be expected to elevate the base rates of both outcomes. In addition, data from countries with higher (or lower) overall rates of violence may result in different hazard ratios associated with mental disorders if people with and without these conditions are differentially affected by the factors associated with the increase in the prevalence of violence.

To their credit, the authors acknowledge many of these limitations, none of which should detract from the findings of the study. Whatever the absolute rates and relative risks of being a target of violence and perpetration among people with mental disorders, which in any case are likely to vary by jurisdiction and change over time, it is important not to lose sight of the major conclusion on which almost all studies agree: there is an increased risk of both outcomes for people with a range of mental disorders. Although violence perpetrated by people with mental disorders accounts for only a small proportion of violent incidents, to the extent that the frequency of such events can be diminished, people with the potential to be targeted by violence and incipient perpetrators will benefit. Similarly, reducing the rate of being a target of violence of people with mental disorders will benefit them directly and is likely to make it easier for them to reintegrate into the community. Thus, our focus going forward should be on identifying factors in the causal pathways to violence and being targeted by violence (not merely identifying correlates), testing interventions to find effective answers, and mustering the will and the resources to implement them.

ARTICLE INFORMATION

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