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Short communication

Comparison of patients who were violent, victimized and violent–victimized during the first year after discharge from emergency psychiatry

John Olav Roaldset [a,b,c,*], Stål Bjørkly [c,d]

[a] Psychiatric Department, Ålesund Hospital, Møre & Romsdal Health Trust, 6026 Ålesund, Norway
[b] Faculty of Medicine, The Norwegian University of Science and Technology, Trondheim, Norway
[c] Centre for Research and Education in Forensic Psychiatry, Oslo University Hospital, Norway
[d] Institute of Health and Social Sciences, Molde University College, 6402 Molde, Norway

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ABSTRACT

This prospective observational study included 345 (70%) of 489 patients discharged from an emergency psychiatric hospital during one year. Episodes of offending and victimization were recorded during first year after discharge. Forty-eight persons (14%) committed violent offenses only, 27 persons (8%) were violence victims only, and 42 persons (12%) were both offenders and victims. Significant differences in demographic and clinical variables were found between the three groups. The results pointed to two distinct groups of victims: one group with a robust offender–victim overlap and another group without offender–victim overlap. The latter group was difficult to distinguish from other discharged patients.

1. Introduction

Despite higher rates of both violent offending and violent victimization (Khalifeh et al., 2015; Maniglio, 2009) among psychiatric patients compared with persons without mental illness, there is a scarcity of investigations of the overlap between violent behavior and violent victimization in the mentally ill. A recent review on the violence–victimization overlap identified 37 studies (Jennings et al., 2012). Only three of the studies were conducted in psychiatric settings (Hiday et al., 2001; Silver, 2002, 2011). In the MacArthur study on patients discharged from acute psychiatry, Silver found that 13% of the patients had performed a violent offense and 19% were victims of violence during the first 10 weeks after discharge (Silver et al., 2011). Nearly 6% were both offenders and victims. This study identified several risk factors that were predictive of both offending and victimization, and the correlation between violent offending and violent victimization remained robust after controlling for demographic, clinical and social risk factors.

Findings by Silver et al. (2011) suggested that violence and victimization may be linked directly through processes like provocation, retaliation or chronic relationship conflict. This is in line with sociological theories of the violence–victimization overlap emphasizing that opportunity structures and risky lifestyle increase the likelihood for committing an offense or experiencing victimization, and also, that this overlap is associated with low self-control and certain subcultures (Jennings et al., 2012). Studies have shown a significant correlation between childhood victimization and adult adversities, including violent behavior (Forsman and Långström, 2012; Watts and McNulty, 2013). A recent study found this victimization–violence overlap significant for patients with cholesterol levels below mean value, but not for patients above the mean (Asellus et al., 2014). Deviations in cholesterol levels have been associated with violence, suicidal behavior and depression (da Graça Cantarelli et al., 2014; Roaldset et al., 2011a; Woods et al., 2012). However, we failed to find any studies on lipid levels and victimization in our literature search.

The current research was conducted on a one-year cohort of patients admitted to a psychiatric emergency department in Norway. The main aim was to explore prospectively associations between different inpatient measures and subsequent violent and suicidal behavior during inpatient stay and the first year after discharge. Previous publications reported on predictive validity testing of a violence risk screening tool (the V-RISK-10) and the MINI Suicidal Scale concerning violence and self-harm, respectively (Roaldset et al., 2011b, 2012b). Other publications from the same cohort analyzed patients' own statement of their risks of violence and self-harm (Roaldset and Bjørkly, 2010), characteristics of violence repeaters (Roaldset et al., 2013) and self-harm

* Corresponding author at: Psychiatric Departement, Ålesund Hospital, 6026 Ålesund, Norway.
E-mail address: johnolr@gmail.com (J.O. Roaldset).

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repeaters (Roaldset et al., 2014).

The aim of this article was (i) to explore the extent of victimization during the first year after discharge, and (ii) to explore and compare characteristics typical of victims, offender-victims and offenders.

2. Methods

The research was conducted as a prospective follow-up study at the emergency psychiatric unit at Ålesund Hospital in Norway. The unit covers a catchment area of approximately 130,000 inhabitants in a combined small-town and semirural population. The target population was a one-year cohort of 489 patients who had been admitted and discharged during 2006–2007. The final study population consisted of 345 patients (70%) having complete follow-up data.

Violence was defined in accordance with other studies (Monahan et al., 2000).

The violence and victimization record form was designed as a checklist and contained detailed scoring instructions for each violence and victimization category. Prior to the study, the staff at all sites was trained to use the form for recording violent behavior. Possible responses were "No," "Yes," or "Don't know." "Don't know" answers in the recording schemes were recorded as missing and excluded.

Patients were followed-up by staff at 3, 6, 9, and 12 months after discharge to document episodes of violent behavior and victimization occurring in the community or in community psychiatric facilities; based on information from patients, outpatient records, and other people when possible (general practitioners, community nurses, family, etc.). Information about violence was also gathered from police records.

Data were analyzed using SPSS 22.0. Chi-square tests and t-tests were used to examine demographic variables, and multinomial logistic regression was employed to discriminate among groups.

More detailed methodological information can be found in previous publications (Roaldset et al., 2011b, 2012a). The project was approved by the Regional Committee for Medical Research Ethics and the Norwegian Ministry of Health and Care.

3. Results

In the first year after discharge, 90 patients (26%) committed a violent act ($n=46$) or violent threat ($n=44$). Sixty-nine patients (20%) had been victimized, and of these, 32 were exposed to violent threats and 37 were exposed to violent acts. Forty-two patients (12%) were both violent offenders and victims, 48 patients (14%) were offenders only, and 27 patients (8%) were victims only.

To explore the relationship between offenders and victims, the study sample was divided into four categories: offenders only (O-group), both offenders and victims (OV-group), victims only (V-group), and patients with no violence or victimization (the remaining patients). Table 1 shows the results from a multinomial logistic regression comparing the O, V and OV groups with the remaining patients.

Table 1
Comparison of "other patients", "offenders only" (O-group), "victims only" (V-group), and "both offenders and victims" (OV group) in univariate multinomial logistic regression analyses.

	Other patients $n=249$	O-group $n=48$ OR (95% CI)	V-group $n=27$ OR (95% CI)	OV-group $n=42$ OR (95% CI)
Age	Reference	1.0 (0.99–1.0)	0.99 (0.96–1.0)	0.97 (0.95–0.99)*
Men	"	3.0 (1.5–6.1)**	0.50 (0.22–1.2)	1.6 (0.84–3.2)
Involuntary admitted	"	7.1 (3.6–14)***	0.75 (0.21–2.6)	2.7 (1.3–5.7)**
Hospital stay days	"	0.99 (0.97–1.0)	0.99 (0.97–1.01)	1.0 (0.98–1.01)
Re-hospitalizations	"	1.6 (1.3–2.1)***	1.3 (0.86–1.9)	2.0 (1.5–2.5)***
Inpatient self-harm	"	0.68 (0.08–5.6)	1.2 (0.15–10)	2.5 (0.61–9.9)
Outpatient self-harm	"	1.5 (0.73–3.0)	1.5 (0.61–3.8)	3.9 (1.9–7.8)***
Feeling of hopelessness	"	1.0 (0.4–2.8)	1.6 (0.6–4.1)	2.5 (0.9–7.0)
Main diagnoses				
F1X Substance abuse	"	1.5 (0.66–3.4)	0.52 (0.12–2.3)	2.0 (0.90–4.5)
F2X Psychoses	"	3.4 (1.7–6.7)***	1.3 (0.45–3.6)	1.5 (0.67–3.5)
F3X Affective disorders	"	0.31 (0.14–0.67)**	0.47 (0.19–1.1)	0.14 (0.05–0.41)***
F4X Anxiety disorders	"	0.29 (0.09–0.98)*	2.2 (0.92–5.2)	0.73 (0.29–1.8)
F6X Personality disorders	"	0.36 (0.05–2.8)	2.1 (0.56–7.9)	3.4 (1.3–9.0)*
Violence risk screening–10 (V-RISK-10), total score and single items				
V-RISK-10 score (0–20)	"	1.2 (1.1–1.4)***	1.0 (0.92–1.2)	1.2 (1.1–1.3)***
Violent acts, ever	"	6.4 (3.1–13)***	1.8 (0.7–5.0)	10 (4.6–24)***
Violent threats, ever	"	4.2 (2.1–8.6)***	1.4 (0.6–3.2)	8.6 (3.7–20)***
Substance abuse, ever	"	1.8 (0.96–3.5)	0.9 (0.4–2.3)	4.1 (1.9–9.0)***
Psychosis, ever	"	2.0 (1.0–4.0)*	0.9 (0.4–2.1)	0.9 (0.5–1.8)
Personality disorders, ever	"	1.6 (0.8–3.2)	1.7 (0.7–4.7)	2.0 (0.98–4.2)
Lack of insight, present	"	3.3 (1.7–6.5)***	2.3 (0.98–5.6)	2.2 (1.1–4.5)*
Suspiciousness, present	"	3.1 (1.6–5.8)***	1.3 (0.5–3.1)	1.3 (0.7–2.8)
Lack of empathy, present	"	2.5 (1.3–5.0)**	1.6 (0.6–4.1)	4.0 (2.0–8.2)***
Unrealistic plans, present	"	2.4 (1.2–4.6)*	2.7 (1.1–6.9)*	2.0 (1.0–4.1)*
Stress vulnerability, present	"	5.2 (2.2–12)***	0.8 (0.3–2.0)	2.0 (0.95–4.0)
The MINI Suicidal Scale, total positive items and single items				
MINI suicidal scale (0–6)	"	0.87 (0.73–1.0)	1.1 (0.90–1.3)	1.0 (0.88–1.2)
Suicidal ideation last month	"	0.7 (0.3–1.6)	1.5 (0.6–3.8)	1.2 (0.5–2.5)
NSSI[a] ideas last month	"	0.3 (0.1–0.8)*	1.6 (0.7–3.9)	1.2 (0.6–2.4)
Suicide attempt last month	"	1.0 (0.4–1.6)	1.8 (0.6–5.2)	0.8 (0.4–1.7)
Suicide attempt ever	"	0.6 (0.3–1.3)	1.5 (0.6–3.5)	1.7 (0.8–3.4)
Lipid values				
Total cholesterol	"	0.7 (0.4–1.1)	0.8 (0.5–1.4)	0.5 (0.3–0.9)**
HDL	"	0.5 (0.2–1.6)	0.4 (0.1–1.6)	0.1 (0.02–0.5)**
LDL	"	0.6 (0.3–1.1)	1.5 (0.7–3.6)	0.9 (0.5–1.8)
Triglycerides	"	1.0 (0.5–2.1)	1.3 (0.6–2.4)	1.2 (0.7–2.2)

[a] Non-suicidal self-injury.
* $p \leq 0.05$.
** $p \leq 0.01$.
*** $p \leq 0.001$.