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Comorbidity Between Abuse of an Adult and DSM-III-R Mental Disorders: Evidence from an Epidemiological Study

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Abstract

Objective—To report the prevalence, risk and implications of comorbidity between partner violence and psychiatric disorders.

Method—Data were obtained from a representative birth cohort of 941 young adults using the Conflicts Tactics Scales and Diagnostic Interview Schedule.

Results—Half of those involved in partner violence had a psychiatric disorder; one-third of those with a psychiatric disorder were involved in partner violence. Individuals involved in severe partner violence had elevated rates of a wide spectrum of disorders.

Conclusions—Mental health clinicians may treat victims and perpetrators before injury occurs.

Studies of partner violence reveal that 35–50% of young adults are involved in some level of physical abuse (1). Accordingly, the mental health field has made partner violence a “focus of clinical attention” with its creation of the category “Physical Abuse of Adult” in the DSM-IV. Acknowledging that partner violence may represent a clinical condition raises the possibility that abusive relationships may co-occur with other clinical disorders (i.e., comorbidity). This study aimed to estimate the base rates of psychiatric disorders among women who are victims and men who are perpetrators of partner violence because these persons are most frequently treated in mental health facilities.

Previous studies found that women victims of partner violence have an increased incidence of depression, anxiety, personality disorders, schizophrenia, and drug and alcohol abuse and that men perpetrators of partner violence have an increased incidence of depression, personality disorders, and drug and alcohol abuse (2–7). However, these studies relied on samples from shelters (2,4), medical settings (3), treatment programs (5,6,7) and correctional facilities (5). Such samples are biased by factors associated with treatment seeking or adjudication. Therefore, epidemiological studies such as this one are needed to identify rates and patterns of comorbidity in the age segment of the general population that is at greatest risk for partner violence (8). Such knowledge can inform theory about relations

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between these conditions and can inform clinicians who treat partner violence about what other disorders they should assess and treat.

Method

Participants were members of the Dunedin Multidisciplinary Health and Development Study, a representative birth cohort (N=1037; 52% males, 48% females) studied since birth in 1972–73. We report data gathered at age 21, when 92% of the living study members provided data about their intimate relationships and mental health. Sample, design, and data are described extensively elsewhere (9, 10, 11, 12).

Partner violence in the previous 12 months was measured using the Conflict Tactics Scales (CTS) (13). We examined Any Physical Violence, which referred to any of three minor or six severe violent behaviours in the CTS (minor: throw object at partner, push/grab/shove partner, slap partner; severe: kick/bite/hit with fist, hit with object, beat up, choke/strangle, threaten with a knife/gun, use a knife/gun) and Severe Physical Violence, which referred to any of the six severe violent behaviours in the CTS.

The Diagnostic Interview Schedule (14) was used to obtain diagnoses of 15 DSM-III-R disorders in the previous 12 months: a) six Anxiety Disorders: Generalised Anxiety Disorder, Obsessive-Compulsive Disorder, Panic Disorder, Agoraphobia, Social Phobia, Simple Phobia; b) three Mood Disorders: Major Depressive Episode, Manic Episode, Dysthymia; c) two Eating Disorders: Anorexia Nervosa, Bulimia Nervosa; d) two Substance Disorders: Alcohol Dependence, Marijuana Dependence; e) Antisocial Personality Disorder; and f) Non-Affective Psychosis, consisting of the positive symptoms for Schizophrenia and Schizophreniform Disorders. Rates of partner violence (10) and mental disorders (11) in the Dunedin Study are comparable to national rates for young adults in the United States.

Results

Table 1 shows the prevalence and risk of psychiatric disorders among women victims and men perpetrators of any and severe partner violence. (Tables reporting findings for each of the 15 specific disorders are available from the authors.) Over half of the women victimised by violence suffered a DSM-III-R disorder; they had statistically significant elevated rates of Mood and Eating disorders. Two-thirds of the women victimised by severe partner violence met criteria for one or more disorders, with elevated rates of Mood, Eating and Substance Disorders, as well as Antisocial Personality Disorder and symptoms of Schizophrenia. Over half of the men perpetrators of partner violence met criteria for some type of disorder, with elevated rates of Anxiety and Substance Disorders, and Antisocial Personality Disorder. Virtually all men perpetrators of severe partner violence met criteria for one or more of a wide spectrum of psychiatric disorders.

Discussion

This study provides evidence that abusive relationships co-occur with other clinical disorders. Women victims and men perpetrators of mild forms of partner violence showed significantly higher rates of disorders which mirror gender differences in the general population: greater depression and eating disorder among women and greater substance dependence and antisocial personalities among men. In contrast, both women and men involved in severe partner violence showed elevated rates of a wider spectrum of psychopathology. The most severe forms of partner violence are likely to be experienced and performed by individuals with very poor mental health. This study probably underestimates the true extent of comorbidity because not all DSM disorders were assessed.

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These epidemiological findings about comorbidity between partner abuse and psychiatric disorder underscore the need to screen for partner violence in mental-health clinics. Recent discussions have focused on how general practitioners can screen for partner violence in medical facilities (15). The advantage of screening for partner violence in mental-health facilities, in addition to medical facilities, is that medical practitioners see only the victims, after an injury, whereas mental-health clinicians may see both victims and perpetrators, in time to prevent injury. Findings about comorbidity may also inform treatment programs for partner abuse. Some cases of partner violence could be resistant to treatment because comorbid psychiatric disorders complicate the clinical picture. For example, our findings showed that among men perpetrators of severe violence, 48% met criteria for at least two or more psychiatric disorders. In attempting to change a batterer's behaviour, health professionals may also have to treat disorders such as substance disorders or paranoid delusions for behavioural change to occur. The present findings suggest a need to reconsider institutional practices that separate services for victims and perpetrators of partner violence from services for persons suffering psychiatric disorders.

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References

1. Fagan, J.; Browne, A. Violence between spouses and intimates. In: Reiss, AJ., Jr; Roth, JA., editors. Understanding and preventing violence, vol. 3, Social Influences. Washington, DC: National Academy Press; 1994.
2. Gleason UJ. Mental disorders in battered women: An empirical study. Viol & Vict. 1992; 8:53–68.
3. Rounsaville BJ. Theories in marital violence: Evidence from a study of battered women. Victimology. 1978; 3:11–31.
4. West CG, Fernandez A, Hillard JR, Schoof M, Parks J. Psychiatric disorders of abused women at a shelter. Psychiat Quart. 1990; 61:295–301. [PubMed: 2103013]
5. Miller, BA. Drugs and violence: Causes, correlates and consequences. Washington, DC: Government Printing Office; 1990. The interrelationships between alcohol and drugs and family violence. National Institute on Drug Abuse Research Monograph Series #103.
6. Dinwiddie SH. Psychiatric disorders among wife batterers. Comprehensive Psychiat. 1992; 33:411–416.
7. Barnett OW, Fagan RW. Alcohol use in male spouse abusers and their females partners. J Fam Viol. 1993; 8:1–25.
8. Bureau of Justice Statistics: Violence against women: Estimates from the redesigned survey. Washington, DC: US Dept. Of Justice, Office of Justice Programs; 1995.
9. Silva PA. The Dunedin multidisciplinary health and development study. Paediatr Perinat Epidemiol. 1990; 4:96–127.
10. Caspi A, Moffitt TE, Newman DL, Silva PA. Behavioral observations at age 3 years predict adult psychiatric disorders: longitudinal evidence from a birth cohort. Arch Gen Psychiatry. 1996; 53:1033–1039. [PubMed: 8911226]
11. Magdol L, Moffitt TE, Caspi A, Newman DL, Fagan J, Silva PA. Gender differences in partner violence in a birth-cohort of 21-year-olds: Bridging the gap between clinical and epidemiological approaches. J Consult Clin Psychol. 1997; 65:68–72. [PubMed: 9103736]

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12. Newman DL, Moffitt TE, Caspi A, Magdol L, Silva PA, Stanton W. Psychiatric disorder in a birth cohort of young adults: Prevalence, comorbidity, clinical significance, and new case incidence from age 11 to 21. J Consult Clin Psychol. 1996; 64:552–562. [PubMed: 8698949]

13. Straus, MA. Measuring intrafamily conflict and violence: The Conflict Tactics (CT) Scales. In: Straus, MA.; Gelles, RJ., editors. Physical violence in American families: Risk factors and adaptions to violence in 8,145 families. New Brunswick, NJ: Transaction; 1990.

14. Robins LN, Helzer JE, Croughan J, Ratcliff KS. National Institute of Mental Health Diagnostic Interview Schedule: Its history, characteristics, and validity. Arch Gen Psychiatry. 1981; 38:381–389. [PubMed: 6260053]

15. Alpert EJ. Violence in intimate relationships and the practicing internist: New “disease” or new agenda? Ann Intern Med. 1995; 123:774–781. [PubMed: 7574196]

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Table 1

Risk of DSM-III-R mental disorders among women victims and men perpetrators of partner violence

	% with disorder											
	any partner violence			severe partner violence			any partner violence			severe partner violence		
	non-victims (N=346)	victims (N=115)	Odds ratio[a] (95% CI)	non-victims (N=407)	victims (N=54)	Odds ratio (95% CI)	non-perpe-trators (N=386)	perpe-trators (N= 94)	Odds ratio (95% CI)	non-perpe-trators (N=455)	perpe-trators (N=25)	Odds ratio (95% CI)
Any DSM-III-R Diagnosis	38.4	55.7	2.01 (1.31–3.08)	39.8	64.8	2.79 (1.54–5.04)	34.2	58.5	2.71 (1.71–4.30)	36.3	88.0	12.89 (3.80–43.7)
Anxiety Disorder	26.3	33.0	1.38 (.88–2.18)	26.5	38.9	1.76 (.98–3.18)	10.9	24.5	2.65 (1.50–4.69)	12.7	28.0	2.66 (1.07–6.65)
Mood Disorder	21.7	35.7	2.00 (1.27–3.17)	22.6	44.4	2.74 (1.53–4.92)	11.9	13.8	1.19 (.61–2.30)	11.2	32.0	3.73 (1.53–9.07)
Eating Disorder	1.2	6.1	5.54 (1.59–19.29)	1.7	7.4	4.57 (1.29–16.17)	0.3	1.1	4.14 (.26–66.8)	0.4	0.0	NA
Substance Disorder	7.8	12.2	1.64 (.83–3.24)	7.6	18.5	2.76 (1.27–6.00)	19.7	38.3	2.53 (1.56–4.12)	20.9	68.0	8.05 (3.37–19.23)
Antisocial Personality Disorder	0.0	2.6	NA	0.2	3.7	15.62 (1.39–175.2)	4.4	11.7	2.88 (1.30–6.37)	5.1	20.0	4.70 (1.62–13.64)
Non-Affective Psychosis	2.6	6.2	2.45 (.89–6.74)	2.7	9.4	3.71 (1.24–11.14)	4.2	6.4	1.57 (.60–4.12)	4.0	16.0	4.6 (1.43–14.81)

NA - statistical tests could not be performed because one or more cells were empty.

[a]Statistical significance for the odds ratio is conveyed by a 95% confidence interval that does not include 1.