

# A Comparison of Youthful Inmates Who Have Committed Violent Versus Nonviolent Crimes

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The incidence of violent crimes committed by youthful offenders in the United States is increasing. In this report, 150 inmates in a prison for youths (ages 14 to 24 years) who were treated by a psychiatrist were compared with 150 control subjects on several parameters including those who had committed violent crimes (V) versus those who had committed nonviolent crimes (NV). There were more similarities than differences between those who had committed V versus NV crimes. There was no statistically significant difference between the V and NV groups in most diagnostic categories, the Beck Hopelessness Scale, the IQ scale, the MMPI scores, job stability, and whether they were treated by a psychiatrist or not. There were, however, some significant differences. The V group was younger than the NV group; those with a diagnosis of paranoid schizophrenia disorder had committed V crimes, while those with a diagnosis of dysthymic disorder had committed NV crimes.

The number of people incarcerated is growing rapidly in the United States, with one of the fastest growing segments comprising those convicted of violent offenses, which increased 34% between 1980 and 1992.<sup>1</sup> Youthful offenders between the ages of 17 and 25 commit the majority of violent crimes after a history

of less serious, nonviolent infractions of the law.<sup>2</sup> Inevitably, if the law is broken, prisons become the receiving center for both the social misfit as well as those with mental and emotional illness.

Psychiatric patients are often viewed by society as being more unstable, violent, and dangerous than patients with no such difficulties. A study performed in Sweden showed that men with major disorders such as schizophrenia or affective disorder were actually 2.5 times more likely to commit crimes and 4 times more likely to commit violent crimes, and women with major disorders were 5 times more likely to commit crimes and 27

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times more likely to commit violent crimes than men and women with no major disorder.<sup>3</sup> Somewhat similar studies have been reported based on data collected in Denmark<sup>4</sup> and Finland.<sup>5</sup> This information suggests a correlation between violent behavior, emotional disorder, and the sex of the individual.

However, is this the case in the United States? Are inmates with a psychiatric disorder more violent than inmates with no such diagnosed disorder? Are violent inmates any different in background or in personality characteristics than nonviolent inmates? These are questions that we investigated in this study. Other aspects of this study have been reported previously.<sup>6</sup>

### Methods

In a prison for youthful male offenders 14 to 24 years of age, the records of 150 inmates with diagnoses of mental or emotional problems (profile designation S-III) were reviewed at the time they were interviewed by the psychiatrist for consideration for psychotropic medication.\* A team made up of a psychiatrist and a psychologist either made or confirmed the diagnoses according to DSM-III-R diagnostic criteria. A second group of 150 inmates with no currently diagnosed disorder and at least average prison adaptive functioning (profile designation S-I) was selected by matching to the S-III group on the variables of age, race, and sex. A profile was developed for each inmate by

recording: age, sex, race, offense, IQ (determined by the Beta IIR exam<sup>7</sup>), Beck Hopelessness Scale, family history of emotional disorder, previous history of psychiatric inpatient and/or outpatient care, use of psychotropic drugs, substance abuse, treatment for substance abuse, employment, highest level of education, special education classes for the learning disabled or the emotionally handicapped, diagnosis, and nature of their crime: violent (V) versus nonviolent (NV). Examples of crimes considered to be violent by the Department of Corrections (DOC) are the following: armed robbery, aggravated battery, sexual battery, and manslaughter (i.e., crimes against people); examples of nonviolent crimes are grand theft, dealing with drugs, uttering forgery, and dealing in stolen property (i.e., crimes against property). All inmates, including minors, had been tried and sentenced in adult courts. The S-III and S-I groups were compared on all variables, the chi-square test, *t* test, or Fisher Exact Test, as appropriate.

Additionally, a sample of 16 valid MMPI scales from the S-I inmates were drawn. The data consisted of *t* scores for 13 MMPI subscales obtained from each of eight NV offenders and each of eight V offenders. Mean *t* scores for each of the basic scales were compared between the NV and V groups using the independent sample *t* test, and a 95 percent confidence interval was computed for the true difference between each pair of group means. An analogous nonparametric comparison of *t* scores between the NV and V groups was carried out using the Wilcoxon rank sum test.

\*This group is given the psychiatric profile designation of S-III by the Department of Corrections and is defined as having an Axis-I disorder (DSM-III-R) and having emotional behavioral problems resulting in moderate adaptive functioning difficulties.

## Young Inmates and Types of Crimes

**Table 1**  
**Mean Age (years) of S-I and S-III Inmates**  
**Committing Violent Versus**  
**Nonviolent Crimes**

	Violent	Nonviolent	<i>t</i> Test <i>p</i> Value
S-I	18.78	19.69	0.005
S-III	18.81	19.54	0.022

Most of the IQ scores were determined by the Beta IIR exam. The Beta IQ test was initially designed to measure the intelligence of Army recruits, particularly non-English-speaking and illiterate recruits. As a performance IQ test, it is accurate in the mid-range of IQ.<sup>5</sup> In the DOC, if the Beta IIR score was below IQ 76, the appropriate Wechsler intelligence test was given to provide greater accuracy.

### Results

**Violence Comparisons** The mean age of all the subjects was 19.2 years, but those who had committed violent crimes were significantly younger than those committing nonviolent crimes, regardless of psychiatric (S-III) versus nonpsychiatric (S-I) category (see Table 1). Sixty-one of the 150 inmates in the S-III category (40.7%) but only 74 of the 150 inmates in the S-I category (49.9%) were found to have committed violent crimes ( $p = .118$ ). Although this is not a large difference, it reveals a trend toward fewer psychiatric patients than nonpsychiatric patients committing violent crimes leading to imprisonment. Large differences were not found between inmates who had committed either violent or nonviolent crimes and who had been diagnosed as having

adjustment disorder (all types combined) and depressive disorder. However, all five patients with dysthymic disorder had committed nonviolent crimes ( $p < .07$ ), whereas all four paranoid schizophrenics had committed violent crimes ( $p < .03$ ). Also, there were nearly twice as many nonviolent as violent patients with bipolar disorder and adjustment disorder with mixed disturbance of emotions and conduct (see Table 2). Many subjects' criminal records were sufficient to warrant a diagnosis of conduct disorder or antisocial personality disorder, depending on their age, in addition to their axis I diagnosis.

As may be clinically expected, a high level of feelings of hopelessness (scores of 9 or higher on the Beck) appears more related to mental disorder than to types of crime. Far more S-III (21%) than S-I (3%) inmates showed significant feelings of hopelessness ( $p < .001$ ). When sorted for violence, there was no significant difference between the V and NV groups. Overall, more inmates expressed higher degrees of hopelessness if they were diagnosed with an affective disorder and had been incarcerated for a nonviolent crime. Stability of work behavior measured by months on a job prior to incarceration tended toward nonviolent inmates staying longer on a job than the violent (NS). There was no significant difference between the V and NV groups in the parameters of family history for prior psychiatric treatment. MMPI scores showed no difference between the V and the NV group on any of the 13 MMPI subscales ( $p = .248$  to  $.960$ ) (see Table 3). There were no significant differences

Table 2  
Diagnoses Made on S-III Inmates<sup>a</sup>

	Total N = 150	V n = 61	NV n = 89
Adjustment disorder with depressed mood	23	11	13
Adjustment disorders (all other types)	18	5	13
Depressive disorder, NOS <sup>b</sup>	14	6	8
Bipolar disorders <sup>b</sup>	17	6	11
Major depressive disorders <sup>b</sup>	11	5	5
Major depressive disorder with psychosis <sup>b</sup>	5	4	1
Dysthymic disorder <sup>b</sup>	5	0	5 <sup>c</sup>
Psychotic disorder, NOS	23	11	12
Schizophrenia, paranoid type	4	4 <sup>d</sup>	0
Intermittent explosive disorder	8	3	5
Tourette's disorder	1	0	1
Schizoaffective disorder	3	1	2
Attention deficit hyperactivity disorder	2	1	1
Conduct disorder	1	1	0
Polysubstance-related disorder	1	0	1
Personality disorder, NOS	1	0	1
Panic disorder	2	0	2
Impulse control disorder, NOS	2	0	1
Schizotypal personality disorder	1	0	1
Generalized anxiety disorder	3	2	2
Schizophrenia, undifferentiated type	2	0	2
Deferred	3	1	2

<sup>a</sup> V, violent; NV, nonviolent; NOS, not otherwise specified.

<sup>b</sup> 52 of 150 had affective disorder, 21 V and 31 NV.

<sup>c</sup> Fisher's Exact Test,  $p < .07$ .

<sup>d</sup> Fisher's Exact Test,  $p < .03$ .

between the NV and V group  $t$  score means for any of the MMPI items. Correspondingly, none of the 95 percent confidence intervals for the true differences between group means excluded 0. Non-parametric analysis of the NV and V group  $t$  scores also indicated no significant differences for any of the items. The composite configural profiles of the V and NV groups displayed some similarities and some differences. Both validity indices suggest low ego strength and inadequate defense mechanisms. Both the NV and V composite scales suggest an-

gry, sullen, resentful, demanding men with severe social maladjustment.

The large majority (more than 90%) of both the V and NV groups abused drugs, and there was no significant difference in this area between those two groups.

**Treated (S-III) Versus Nontreated (S-I) Comparisons** The number of S-III inmates with a family history of mental illness and a personal history of previous psychiatric hospitalization, outpatient psychiatric treatment, and use of psychotropic medicine is considerably greater than that of S-I inmates ( $p < .001$ ). Non-

**Table 3**  
**A Comparison of the MMPI Scores of Eight Inmates Who Committed Violent Crimes with Eight who Committed Nonviolent Crimes**

MMP1 Item	NV Group			V Group			NV-V Diff.	95% CI		t Test p Value	Wilcoxon p Value
	N	Mean	SD	N	Mean	SD		(Lower	Upper)		
L	8	49.4	11.0	8	47.1	6.3	2.3	(-7.4	11.9)	0.624	0.749
F	8	65.0	16.0	8	66.9	13.9	-1.9	(-17.9	14.2)	0.806	0.712
K	8	39.5	11.0	8	39.9	7.4	-0.4	(-10.5	9.7)	0.938	0.672
HS	8	47.6	11.6	8	51.8	6.6	-4.2	(-14.3	6.0)	0.398	0.668
D	8	54.4	13.7	8	57.0	11.6	-2.6	(-16.2	11.0)	0.685	0.674
HY	8	43.0	8.9	8	48.3	8.5	-5.3	(-14.6	4.1)	0.248	0.247
PD	8	68.5	12.8	8	64.1	15.1	4.4	(-10.6	19.4)	0.542	0.492
MF	8	43.8	7.1	8	39.5	8.7	4.3	(-4.3	12.8)	0.302	0.245
PA	8	66.5	16.3	8	58.8	11.9	7.7	(-7.5	23.0)	0.295	0.397
PT	8	57.0	16.5	8	63.9	7.6	-6.9	(-20.6	6.9)	0.302	0.492
SC	8	60.6	15.8	8	64.4	14.5	-3.8	(-20.0	12.5)	0.629	0.563
MA	8	59.1	7.6	8	56.4	9.9	2.7	(-6.7	12.2)	0.542	0.490
SI	8	57.0	15.9	8	57.4	13.3	-0.4	(-16.1	15.3)	0.960	0.916

verbal intelligence was found to be in the average range for both groups but significantly lower for S-IIIs ( $p < .001$ ) (see Table 4). No difference in IQ scores was found between S-IIIs inmates who had committed violent versus nonviolent crimes. More of the S-IIIs inmates were reported as having been placed in special classes while attending school. Approximately 51 percent of the S-IIIs had a learning disability (LD) or emotionally handicapped (EH) school history compared with 33 percent of the S-Is ( $p <$

.01) (see Table 5). Very few of these young people in either the S-I or S-III category reached the twelfth grade (9.2%) or beyond to college (2.8%). The mean highest grade levels achieved by S-I and S-III subjects (9.70 and 9.55 respectively) are not significantly different. Of 77 S-III inmates reporting a school background of special classes, 62 of them also had a mental health treatment background prior to incarceration; of S-I inmates, 50 reported a special class background, and of those only 17 had a prior mental health

**Table 4**  
**Comparison of S-I with S-III Inmates**

	S-I	S-III	p Value
IQ (Beta) score	97.43	92.12	<.001
No. with family history of psychiatric problems	15	54	<.001
Prior hospitalizations	14	70	<.001
Prior outpatient treatment	30	92	<.001
Prior psychotropic medications	3	85	<.001

**Table 5**  
**Comparison of Highest Grade Level Achieved and the Incidence of Inmates Admitting to Placement in Special Classes for the Learning Disabled (SLD) or Emotionally Handicapped (EH)**

	S-I	S-III	p Value
Mean grade level	9.70	9.55	NS
SLD/EH classes	50 (33%)	77 (51%)	<0.01

problem before their current incarceration. Thus, 80 percent of the S-IIIs with such a background also had mental health problems, while only 34 percent of S-Is reported the same combination.

There is a difference between the S-III and S-I populations in the extent to which each group admits to substance abuse, with the S-III population admitting to more drug use as well as more varied forms of drugs ( $p < .01$ ). More S-III inmates report treatment in drug/alcohol programs and mental health programs than do S-Is (53 of 150 S-III in drug treatment compared with 22 of 148 S-I; and 114 of 150 S-III in mental health treatment compared with 36 of 150 S-I) before present incarceration. Also, S-III inmates report more types of treatment than do their S-I counterparts. In our population, 44 of 53 (83%) of the S-IIIs with a history of drug treatment also had a history of mental health treatment as compared with 8 of 22 (36%) of the S-Is.

Many of the inmates interviewed reported that their families were highly dysfunctional during their developmental years. The possibilities for early attachment and development of trust were probably limited.

To obtain information regarding the motivation for these inmates to commit violent or nonviolent crimes at the risk of imprisonment, they were asked what prompted them to take such risks. Although each person was somewhat different from the others with regard to his particular reasons, there was considerable similarity in their answers. These inmates committed either nonviolent or violent crimes to obtain money, or sex, or a sense

of importance, which they were unable to obtain through conventional means because they lacked the skills to achieve their goals through work or study. Thus, their motivation for committing crimes may be similar whether they be crimes against people or property. Often the inmate would state that he was unable to obtain or hold a job, even at minimum wage; others had opportunities to work for relatives at a somewhat higher income, but wanted even more money. They learned "on the street" that they could make thousands of dollars stealing or dealing in stolen goods or drugs. One such inmate related that he was proud of his ability to steal. He would walk along any city street and find a house with a door unlocked. He would take what he wanted and leave. Although this inmate did not carry weapons, many others did, just in case they encountered resistance. Unlike armed robbery, which is a violent crime, stealing is not a violent crime. To a lesser extent, inmates who were imprisoned for repetitious charges of assault and battery admitted to a loss of control of anger when they had attacked others. One such inmate became furious at a psychiatrist in prison when denied the medicine he wanted and stated that he would see the psychiatrist in hell. Later, he threw a chair at a psychologist who attempted to interview him. He had previously been convicted of battery several times, including an attack on a police officer. He remained hostile toward various inmates and personnel. Eventually, he accepted medicine to assist him in controlling his anger, which led to some improvement in impulse and anger control.

## Discussion

In this study, all of the paranoid schizophrenic patients had committed a violent crime, while all of the dysthymic individuals had committed a nonviolent crime. Although the number in each of these groups is small, it is an impressive finding. It is well accepted that persons who tend to become depressed also tend to internalize emotion, including aggressiveness, but highly suspicious and grandiose persons tend to externalize hostility.

Emotionally disturbed people are often considered dangerous and potentially violent. This study of two groups of prison inmates demonstrates that the people with emotional disturbances were somewhat less likely to have committed violent crimes than those who were not considered emotionally disturbed. Studies performed in Sweden indicated that severely mentally ill and mentally retarded individuals commit crimes, both violent and nonviolent, more frequently than control subjects. In the United States, however, where substance abuse-related crime is very frequent, mentally ill persons probably commit a lower number of crimes than the non-mentally ill, according to Hodgin.<sup>3</sup>

In comparing those inmates who committed violent crimes with those who committed nonviolent crimes, the differences were less striking than one might expect. For example, the Beck Hopelessness Scale, prior psychiatric care, IQ, and family history of mental illness were not significant when sorted for violence. N. Wiener<sup>8</sup> has reported that violent acts are usually committed after histories of non-

violent crimes. Apparently, the similarities may outweigh the differences between persons who commit violent crimes and those who commit nonviolent crimes, including personality characteristics as measured by MMPI, when the factor of current mental disorder is minimized. One of the reasons for minimal differences between these V and NV groups may be related to the study having been conducted on a medium security prison that contains few murderers. Also, some individual differences may be observed by studying the group means.

In 1995, Yashikawa<sup>9</sup> reviewed the literature on the long-term effects of early childhood programs on social outcomes and delinquency from journals in criminology, psychology, and education. His review identified key early childhood factors in children at risk for antisocial behavior. These risk factors included perinatal problems, neurological factors, low cognitive ability, insecure attachment to parent, parental criminality, parental substance abuse, poor or harsh parenting, low socioeconomic status, violent or disorganized neighborhoods, single-parent families, and media violence. Risk factors are not necessarily the cause of delinquency; however, multiples of these probably have a strong influence in the development of delinquency.

In future studies on this prison population, a psychiatric evaluation of the control subjects might lead to a better understanding of the reasons some prisoners with psychiatric problems seek help while others do not. Also, a follow-up study after release from prison would provide information regarding the impact of the

use of medicine and/or counseling on recidivism. Did the inmates use these aids after release to avoid impulsive behavior? Many of the inmates interviewed described dysfunctional families and traumatic early development. Early attachment and emotional developmental psychopathology may be related to the development of aggressiveness in children, according to Constantino.<sup>10</sup> In subsequent research, a developmental history obtained from the family may clarify this correlation.

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