Violence and Official Diagnostic Nomenclature

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There have been increasing concerns about the relationship between mental disorders and violence during the past 15 years. Monahan[1] notes that there is a persistent belief in a positive association between the two, despite empirical evidence suggesting that such an association is anecdotal at best. He further suggests that inadequate definitions are a major problem in studying this relationship.

One measure of the degree to which we have officially accepted the belief in a positive association between mental disorders and violence would be to compare the proportions of disorders with descriptive phrases or diagnostic criteria, including words about violent acts among our past and present diagnostic nomenclatures. Although these diagnostic schemata are different, this would provide a rough index of our changing conceptualization of this relationship. In this article, I report the change in these proportions and discuss some medicolegal and basic research implications of this observation.

Method

The descriptive paragraphs of each disorder listed in DSM-I[2] and DSM-II[3] were inspected for words pertaining to violent acts. The descriptive paragraphs and diagnostic criteria for each disorder listed in DSM-III[4] were also examined for words describing violent behavior. Such items as "temper tantrum," "aggression," "combative," "assault," "rape," "violence," "dangerous," "suicide," "self-mutilation," "fights," and "murder," were considered among the violent words. Words such as "agitation," "hostility," "irritability," "stealing," and "theft," were considered as nonviolent words for the purposes of this study.

DSM-I and DSM-II disorders were considered as violent disorders if they had any violent words among their respective descriptive paragraphs. DSM-III disorders were considered to be violent disorders if they had any violent words among their respective descriptive paragraphs or diagnostic criteria.

Each disorder in the different diagnostic methods has a unique diagnostic code. I calculated the proportion of violent disorders in each diagnostic

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Table 1. Numbers of Disorders Described by Violent Words According to DSM-III Diagnostic Group

Diagnostic Group	Number of Disorders	
	Violent Words in Diagnostic Criteria, Associated, or Complicating Features	Violent Words in Diagnostic Criteria Only
1. Substance use disorders	44	44
2. Organic mental disorders	36	8
3. Affective disorders	23	22
4. Disorders first manifest before adulthood	23	11
5. Schizophrenic disorders	8	0
6. Psychosexual disorders	7	2
7. Paranoid disorders	5	0
8. Impulse control disorders	4	3
9. Personality disorders	3	3
10. Anxiety disorders	3	0
11. Adjustment disorders	2	2
12. Other psychotic disorders	1	0
13. Factitious disorders	1	0
14. Dissociative disorders	1	0
15. Psychosomatic disorders	1	0

scheme by dividing the number of violent disorders in that nomenclature by the number of unique diagnostic codes for each respective nomenclature.

Results

There were 276 possible DSM-I disorders, of which 6 (2.17 percent) were violent disorders. These disorders were: acute brain syndrome associated with convulsive disorder; schizophrenic disorder, paranoid type; passive-aggressive personality; sexual deviation; gross stress reaction; and adjustment reaction of childhood.

In DSM-II, 9 (2.67 percent) of the possible 337 disorders were described by violent words. These disorders were: schizophrenia, catatonic type; schizophrenia, catatonic type, excited; schizophrenia, catatonic type, withdrawn; schizophrenia, paranoid type; explosive personality; adjustment reaction of adult life; adjustment reaction of adolescence; unsocialized aggressive reaction of childhood or adolescence; and group delinquent reaction of childhood or adolescence.

DSM-III has 348 disorders, of which 162 (46.6 percent) have violent words as part of any respective descriptive paragraphs or diagnostic criteria. Ninety-one (26.15 percent) have violent words as part of their diagnostic criteria only. While space precludes listing all of these disorders, Table 1 shows the number of disorders in each diagnostic group that have violent words as part of any descriptive or diagnostic paragraph and as part of the diagnostic criteria only. The groups with the largest numbers of violent disorders are substance use disorders, organic mental disorders, affective disorders, and those disorders first manifest before adulthood. A substantial

portion of those organic mental disorders associated with violence are alcohol or drug related. Suicide is the most common violent act among affective disorders, while assaults and fights are most common among other disorders.

Discussion

This study has found that the percentages of mental disorders officially described or defined by violent acts has increased from less than 3 percent in both DSM-I and DSM-II to 46.6 percent in DSM-III. This finding may have several explanations that are not necessarily mutually exclusive. These include the "psychiatrization"[5] or "medicalization"[6] of behaviors previously considered as possibly criminal, the "criminalization"[7] of mental disorders, or perhaps the substantial acceptance of the belief in a positive relationship between violence and mental disorders. Regardless of the reasons, it is apparent that any boundary that may have existed between the two has become blurred. This finding may have several clinical ramifications but its medicolegal and basic research implications may be more significant.

One implication of having a violent act listed among a disorder's associated or complicating features is that it appears we expect this act might be likely to occur in the disorder's future clinical course. This might make it easier to render, justify, or expect predictions of future dangerousness about patients with that disorder. It might be easier to civilly commit or deny release of patients with such disorders. Mental health professionals also might be more vulnerable to tort liability for the acts of their patients with such disorders.

When a violent act is among a disorder's diagnostic criteria, it suggests that we are somewhat more likely to make the diagnosis of that disorder after such violence has occured. This may increase the chances that some offenders would receive an insanity acquittal of their criminal charges because their alleged disorder was partly defined by such violence. McGarry[8] has alerted us to similar problems regarding the use of interdependent definitions in the context of pathologic gambling. He criticized the wording of pathologic gambling's diagnostic criteria where it is stated that being "unable to resist impulses to gamble" may lead to other illegal activities. He also cited examples in which "psychiatric testimony has offered the diagnosis as exculpatory *per se* for a criminal offense committed in order to acquire money to pursue gambling." While pathologic gambling is not a violent act, the thrust of McGarry's argument[8] may apply to those DSM-III disorders with violent words among their diagnostic criteria.

The inclusion of violent words among our diagnostic nomenclature also may confound basic research into the relationship between mental disorders and violence. As noted previously, Monahan[1] believes that empirical evi-

dence directly linking mental illness and violence is lacking. Rather, he suggests that any apparent association is actually a function of underlying sociologic and economic factors that are common to both. A recent review by Monahan and Steadman[9] strongly supports the epidemiologic independence of a crime and mental illness. While they acknowledged that there are anecdotal cases in which mental disorders and crimes are related, they attribute any apparent positive relationship to common factors such as age, social class, and prior contact with either the mental health or criminal justice systems. Taylor[10] reviewed the literature on the relationship between schizophrenia and violence. She noted that "it is unlikely that mental illness puts people at any greater or lesser risk of committing violent offenses" than people without mental illnesses, but that "schizophrenics are probably the most violence prone" among those with mental illnesses. She seemed to suggest that any relationship between schizophrenia and violence is a complex interaction between phenomenology, social and demographic factors, and common psychologic, biologic, and etiologic factors. Among several things, these reviews suggest that one should carefully reconsider any presumptions about a simple, positive association between mental disorders and violence as reflected in our present diagnostic nomenclature.

The increasing occurrence of words characterizing violent behavior among the descriptive and diagnostic criteria of mental disorders may reflect several interactive processes. It may also increase the confusion at the interface between psychiatry and law. It is somewhat more disturbing that this ocurrence may contaminate basic research aimed at understanding the relationship between mental disorders and violence. We should critically examine the use of such words in our diagnostic nomenclature.

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