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Axis I Psychopathology and the Perpetration of Intimate Partner Violence

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Abstract

Objectives—Initial evidence suggests that individuals with specific psychiatric conditions may perpetrate intimate partner violence (IPV) at greater frequency than non-diagnosed comparison samples. The present investigation examined the relationship between IPV and specific clinical diagnoses.

Method—The current investigation utilized data provided by 190 (34% female) adult offenders during court-mandated substance use evaluations to investigate the incidence of past-year IPV among samples of dual diagnosed (bipolar, PTSD, and ADHD) clients relative to 3 comparison samples matched on substance use and sociodemographic variables.

Results—Bipolar and PTSD diagnosed participants were more likely to perpetrate IPV than matched comparison and ADHD participants. Bipolar and PTSD diagnosed participants were equally likely to perpetrate IPV, as were ADHD and matched comparison samples.

Conclusions—The frequency of IPV perpetration among bipolar and PTSD diagnosed clients may complicate interpersonal and relationship functioning. The development of integrated treatments for IPV and underlying psychopathology are recommended.

Keywords

Partner Violence; Bipolar Disorder; PTSD; ADHD; Substance Use

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A wide range of extant factors have been attributed to the occurrence of physical intimate partner violence (IPV), which describes a pattern of inflicting physical harm upon a significant other (Saltzman, Fanslow, McMahon, & Shelley, 2002). Heavy episodic alcohol use, previous violent behavior, and an angry disposition number among the most robust individual risk factors for IPV (see Stith, Smith, Penn, Ward, & Tritt, 2004). Researchers have advanced persuasive evidence suggesting that various axis I psychopathologies may be associated with IPV victimization (e.g. Stuart, Moore, Godon, Ramsey, & Lahler, 2006). With the exception of post-traumatic stress disorder (PTSD) and substance use disorders, however, the body of literature describing the association between psychiatric illnesses and IPV perpetration remains limited.

Bipolar disorders (Swann et al., 2003), PTSD (van der Kolk, 2002), attention-deficit/hyperactivity disorder (ADHD) (Barkley, 2002), and substance use disorders (e.g., Giancola, 2000) share common features that may elevate the risk of violent behavioral responding, such as acute deficits in impulse control and impairment of executive functioning. Bipolar disorders and PTSD are also associated with affect dysregulation, a significant predictor of IPV perpetration (Cloitre, Miranda, Stovall-McClough, & Han, 2005; McNulty & Hellmuth, 2008). The effects of substance use on IPV have been widely examined (e.g. Foran & O'Leary, 2008; Moore, Stuart, Meehan, Rhatigan, Hellmuth, & Keen, 2008). Initial evidence suggests, however, that select Axis I diagnoses beyond substance use may place individuals at increased risk for both victimization and perpetration of IPV. The incidence of IPV perpetration among women with severe mental illness was determined to be high in a recent review of four published studies (Hatters-Friedman & Loue, 2007). Among a female sample of 103 court mandated IPV offenders, high rates of PTSD and mood disorders were observed (Stuart et al., 2006). The current investigation utilized forensic data from a sample of male and female offenders to examine the relationship between IPV and psychopathology, including bipolar disorders, PTSD, and ADHD.

Bipolar Disorders

Empirical data, though limited, suggest an association between IPV and both uni and bipolar depression. In a birth cohort of 480 participants, Danielson and colleagues (1998) reported that male perpetrators of severe IPV were more likely to meet criteria for a mood disorder than non perpetrators (OR = 3.73, 95% CI = 1.53–9.07). Stuart and colleagues (2006) reached similar conclusions about heightened depression among female IPV perpetrators compared to the general U.S. population (OR = 7.2). Anderson (2002) reported that among a sample of 7,395 males and females surveyed during wave 1 of the National Survey of Families and Households, depressed participants were more likely to perpetrate minor acts of physical IPV than non-depressed participants. Collateral reports collected during a survey of caregivers suggest that the manic phase of a bipolar disorder is a period of increased vulnerability to and fear of IPV victimization among intimate partners of bipolar patients (Dore & Romas, 2001). Finally, using the MCMI III in a sample of 2,535 (11% female) IPV offenders, Henning and colleagues (2003) reported that 3.6% of male and 9.8% of female IPV offenders demonstrated elevations on the bipolar scale.[1] Thus, the few investigations into the relationship between mood disorders and IPV indicate the existence of a significant association.

Post Traumatic Stress Disorder (PTSD)

Consistent findings suggest that victims of childhood abuse and veterans who have experienced violence in combat both demonstrate increased rates of IPV (e.g., Dutton, 1995; Dutton, 1999). A recent meta analysis of 19 studies (N=4,630) concluded that PTSD and physical IPV perpetration shared an association of medium magnitude (ρ=.42) (Taft, Watkins, Stafford, Street, & Monson, 2011). Despite the strong correlation between PTSD and alcohol abuse as a theoretical coping strategy, investigations show that specific PTSD symptoms individually predict IPV even when accounting for substance use. Savarese and colleagues (2001), for example, demonstrated that hyperarousal symptoms directly affected IPV perpetration, though the relationship was moderated by alcohol consumption such that partner violence was greatest among individuals with high hyperarousal that also drank large quantities and lowest among individuals who drank frequently but in low quantities. The relationship between IPV and PTSD among forensic populations has received little research attention with discrepancies across samples. For instance, 44% of female IPV offenders were diagnosed with PTSD in one sample (Stuart et al., 2006) while only 3.2% of male and 5.4% of female IPV offenders mandated to treatment met criteria for PTSD in a separate sample (Henning, Jones, & Holdford, 2003).[2]

Attention Deficit Hyperactivity Disorder (ADHD)

To date, there have been few epidemiological studies designed to examine the direct association between ADHD and IPV. Fang and colleagues (2010) examined data from 11,238 participants involved in the National Longitudinal Study of Adolescent Health and reported that the inattentive component of ADHD was associated with mild to moderate IPV perpetration while the hyperactive component was implicated in severe IPV perpetration. Wymbs and colleagues (2010) also concluded, from a sample of 213 males who took part in the Pittsburgh ADHD Longitudinal Study, that participants diagnosed with childhood ADHD were more likely to display verbally and physically aggressive behavior toward a romantic partner than young adults with no diagnosis. In the only relevant forensic investigation, Mandell (1999) determined that 23% of a small male sample (N=65) of treatment mandated IPV offenders also displayed significant ADHD symptomatology.

These studies, however, failed to control for substance use and comorbid psychiatric conditions. ADHD is associated with greater substance use problems, including tobacco (Pomerleau at al., 2003), cannabis (Biederman et al., 1999), alcohol (Adler & Cohen, 2004) and cocaine (Levin et al., 1998) abuse. Heavy episodic drinking and cocaine use have been associated with the perpetration of intimate partner violence (Chermack & Blow, 2002). General violence among incarcerated samples diagnosed with adult ADHD demonstrate relatively low levels of violent criminal behavior, with nearly 75% sentenced for non-violent crimes (Torgersen, Gjervan, Polit, & Rasmussen, 2006). Despite deficits in inhibitory control, ADHD is not generally associated with violent behavior. ADHD is often comorbid

[1]The American Psychiatric Association (2000) estimates the lifetime prevalence of Bipolar I Disorder at between 0.4% and 1.6% and Bipolar II Disorder at 0.5%.
[2]Lifetime prevalence of PTSD is estimated at 8.0% (APA, 2000).

with diagnoses, such as substance abuse and conduct disorder or intermittent explosive disorder, that are associated with an increased risk of violence (Kessler et al., 2006).

The Current Study

The present investigation explored relationships between specific Axis I disorders and partner violent behavior using a sample of substance-involved offenders legally mandated to undergo a psychological and substance abuse evaluation. We hypothesized that past-year IPV perpetration would be more prevalent among 1) participants with Axis I psychopathology beyond substance use in comparison to participants with no Bipolar, PTSD, or ADHD diagnosis, 2) diagnosed bipolar participants contrasted with a matched comparison group, 3) PTSD participants contrasted with a matched comparison group, 4) bipolar participants compared to ADHD participants, and 5) PTSD compared to ADHD participants. We further hypothesized that IPV would be equally prevalent among 6) ADHD and matched comparison participants as well as 7) bipolar and PTSD diagnosed participants.

Method

Sample

Individual substance abuse evaluations were court-ordered for 1,926 criminal offenders with suspected substance use involvement in an urban Connecticut town during the presentencing trial phase to investigate potential mitigating factors. All participants with substance use comorbid diagnoses of a bipolar disorder (n=37), PTSD (n=26), or ADHD (n=32) were selected for inclusion in the current study. Participant diagnosed with comorbid target disorders (e.g., both a bipolar disorder and PTSD) were excluded from the current analyses. Substance use was not required for selection into a diagnosed group but all bipolar, PTSD, and ADHD participants were dual diagnosed with at least one substance abuse disorder during the evaluation. A sample of 95 participants closely matched on gender, ethnicity, and substance use diagnoses (alcohol, cocaine, cannabis and opiate) were also randomly retained as comparison groups resulting in a total sample of 190 participants. Offenders were, on average, 30.44 years (*SD* = 10.00 years) old and ranged from 18 to 59. Participants identified as Caucasian (78%), African American (12%) Hispanic (7%), and other (3%) ethnicities. There were twice as many males (66%) than females (34 %). Thirty-five percent of the sample reported current employment. Demographic data are presented for each subgroup in Table 1.

Procedure

Connecticut state legal statutes call for an evaluation of substance use involvement among criminally accused defendants for whom substance abuse or dependence was expected at the time of alleged criminal offending. The substance use treatment needs of each defendant were determined by trained, licensed clinical social workers (LCSW) who reviewed relevant legal and medical records, conducted the evaluation, and made appropriate referrals to the court for no, outpatient, or residential treatment.

The 190 participants in the current investigation all voluntarily completed the substance use evaluation after consulting with legal counsel. At the onset of each session, an interviewer

reminded the participant of the limits of confidentiality and his or her legal right to discontinue the interview at any point. The single, 2-hour evaluation session included a detailed clinical interview at the Office of Forensic Substance Dependence Evaluations in New Haven, Connecticut. Each interview focused on psychosocial history, substance use, and legal involvement. Participants were informed that questions pertaining to domestic violence were for research purposes only, would not influence the outcome of the evaluation or have any legal implications, and were entirely voluntary. LCSWs administered the measures discussed below and entered diagnoses into the dataset used in the current investigation at the conclusion of each evaluation. An IRB waiver was granted to permit use of the data, which were collected, de-identified, and retained for program evaluation purposes. The Human Investigation Committee (HIC) at the Yale University School of Medicine granted approval to conduct the current research.

Measures

Socio-Demographic Data—Participants provided socio-demographic data in response to structured questions during the clinical interview. Interviewers collected and used court documents to confirm dates of birth, arrest (total number of arrests, longest incarceration), ethnicity (Caucasian, African American, Hispanic, other), employment (employed or unemployed), and income data to enter into the dataset used for the current study.

Violence—IPV was assessed during the course of the intimate partnerships section of the clinical interview. Each participant was asked if they had, "…been physically aggressive toward a romantic partner during the previous year." Participants were informed that responding to the domestic violence question was optional and would not influence the results of the substance abuse evaluation. Participants who reported past-year partner violence were then verbally asked to respond "yes" or "no" to the 12-item physical assault subscale of the conflict tactics scale (CTS2; Straus et al., 1996) to confirm perpetration of physical violence. LCSWs recorded each participant who endorsed the perpetration of one or more acts of IPV over the previous year as "partner violent" and those who refused any perpetration as "non-partner violent."

Additional violence variables were assessed in a similar manner. Participants were questioned about general violence during the social functioning section of the clinical interview by asking if they had, "…been physically aggressive toward anyone other than a romantic partner over the previous year." CTS2 questions were adapted for more general perpetration and interviewers again dichotomously categorized participants as "generally violent" or "not generally violent" based upon responses to the initial and follow-up items. Participants were questioned about family violence during the developmental section of the clinical interview by asking if they had, "…been the victim of physical or sexual violence by a parent prior to the age of 16." Interviewers coded participants who reported childhood victimization by a parent as victims of "family violence" and participants who refused any parental physical or sexual abuse as individuals with "no family violence" history.

Axis-I Diagnoses—Interviewers determined psychiatric diagnoses from a review of medical and psychiatric records. Participant data in the current dataset was updated to reflect

documented psychiatric history at the conclusion of the interview. Clients with a history (past 5-years) of a bipolar disorder, PTSD, or ADHD were retained for the current investigation. Two clients were eliminated due to comorbid bipolar and PTSD diagnoses. Additional comorbid diagnoses included unipolar depression (2 PTSD; 2 ADHD), schizoaffective disorder (2 Bipolar), an anxiety disorder (1 bipolar, 1 ADHD), and Axis II personality disorders (5 Bipolar, 3 PTSD, 3 ADHD).

Substance Use Disorders—LCSWs recorded clinical substance use diagnoses as informed by the clinical interview consisting of adapted versions of the Addiction Severity Index (ASI; McLellan et al., 1992) and the substance abuse section of the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID; First, Spitzer, Gibbon, & Williams, 1995). The use of these adapted forms is described elsewhere (Scott, Edwards, Lussier, Devine, & Easton, 2011). Interviewers used toxicology, collateral interview, and legal reports to confirm substance use diagnoses as available. As the most frequently occurring substance use diagnoses in the current dataset, alcohol, cocaine, cannabis, and opioid (e.g. heroin) diagnoses were used to construct the matched comparison group for each Axis-I disorder group (Bipolar, PTSD, and ADHD).

Data Analysis

We constructed a series of binary logistic regression analyses with IPV as the primary dependent variable of interest and diagnostic status as the individual predictor variables. We first examined the relationship between general Axis-I psychopathology and partner violence perpetration by examining IPV frequency differences among aggregated diagnosed (bipolar, PTSD, and ADHD) participants and all matched comparison groups. We then examined the relationships between IPV and each diagnostic group with its matched comparison sample [Bipolar vs. Matched Bipolar Comparison (MBC); PTSD vs. Matched PTSD Comparison (MPC); and ADHD vs. Matched ADHD Comparison (MAC)]. Diagnostic groups were then compared to one another [PTSD vs. Bipolar, Bipolar vs. ADHD, and PTSD vs. ADHD) on IPV history. Finally, we adjusted each model for alcohol use history, gender, general violence, prior arrests, family history of violence, education history, and substance use diagnoses. As the adjusted models failed to eliminate observed IPV effects, only the odds ratios (OR) and associated 95% confidence intervals (CI) for the most parsimonious, unadjusted models are presented below. Statistical significance was set at $p<0.05$.

Results

Descriptive Statistics

Substance abuse was prevalent with 53% of the sample meeting diagnostic criteria for an alcohol abuse disorder, 58% for a cocaine use disorder, 54% for a cannabis use disorder, and 49% for an opiate use disorder. Further post hoc investigation using a Tukey correction for multiple comparisons revealed no differences between bipolar (M=2.14, SD=0.79), PTSD (M=2.15, SD=0.78), and ADHD (M=2.47, 0.62) diagnoses on the number of diagnosed substance use disorders ($F(2, 92)=2.09$, $p=.13$). Violent behavior was also common in the sample with 39% reporting IPV and 31% reporting general violence perpetration. Data

reflected an association between IPV and general violence (χ^2 (1)=28.9, p<.001) across the sample as a whole.

IPV and General Psychopathology

Findings offered support for hypothesis 1. Participants in the aggregated diagnosed groups were significantly more likely to engage in IPV than the participants in the comparison groups (OR = 3.045, C. I.− 1.651–5.62, p<.001). Thus, results demonstrate a significant association between IPV and psychopathology such that partner violence was more common among participants with significant Axis I diagnoses than among those with only matched substance use diagnoses. Examining gender differences in IPV, follow-up analyses revealed significantly more violence among females (78.1%) with diagnosed psychopathology than males (40.3%) with diagnosed psychopathology (χ^2(1, n=95)=12.11, p = .001). Gender differences were not observed within the comparison sample χ^2(1, n=95)=2.03, p = .16).

IPV and Individual Diagnoses

Results for effects between diagnostic categories and their matched comparison as well as other diagnostic categories are presented in Table 2. Overall, data reflected robust effects for individuals diagnosed with bipolar or PTSD to have more incidence of past-year IPV relative to their individual MBC and MPC groups, respectively. ADHD diagnosed participants were no more likely to perpetrate IPV than the MAC sample. Thus, hypotheses 2, 3, and 6 were supported by the current data. Insufficient power precluded the analysis of gender effects within specific diagnostic categories.

A comparison of IPV between diagnostic categories further supported hypotheses 4, 5, and 7. Participants in both bipolar and PTSD groups were significantly more likely to perpetrate IPV than individuals in the ADHD sample. The incidence of IPV did not significantly differ between bipolar and PTSD diagnosed participants. Thus, the association between IPV and Axis I psychopathology seems strong among bipolar and PTSD diagnosed participants and non-significant among ADHD diagnosed individuals.

Discussion

The current study used data collected from a subset of criminal defendants court referred for assessment to examine the association between IPV and psychopathology using participants previously diagnosed with a bipolar disorder, PTSD, ADHD, and three matched comparison groups with only substance abuse diagnoses. Results indicated that a significant history of Axis I psychopathology, controlling for Axis I substance use disorders, was significantly associated with the perpetration of IPV. An examination of individual disorders confirmed that offenders with bipolar and PTSD diagnoses were both significantly more likely to perpetrate IPV than respective substance abuse comparison and ADHD diagnosed participants. In the current sample, bipolar disorder and PTSD were statistically equivalent risk factors for IPV.

Current results offer support for the hypothesis that a history of bipolar and post-traumatic stress disorders are associated with the perpetration of IPV. The current method does not allow for an assertion of directionality or causality. Several potential explanations exist for

the relationship between psychopathology and IPV perpetration reported above. It is possible that the various symptoms of both disorders, including irritability and hyperarousal, may directly contribute to aggressive behavior. The accumulated PTSD literature supports this relationship (e.g., Taft, Watkins, Stafford, Street, & Monson, 2011). It is also possible that substance use, as a coping mechanism for psychological distress, may increase an offender's likelihood of becoming violent. We attempted to control for this possibility by selecting comparison groups matched on substance use diagnoses. Alternatively, it is possible that mental illness places individuals at risk for IPV victimization and that the observed association between psychopathology and perpetration may be moderated through a response to victimization. If the latter were true, we would expect the association between diagnoses and IPV perpetration to be eliminated after adjusting for victimization. Future studies should examine the presence of bi-directional IPV among clinical samples and implement longitudinal methods to address the issue of causality in the relationship between psychopathology and IPV perpetration.

Having eliminated all ADHD clients with comorbidity, results indicated no greater risk of IPV perpetration among the current ADHD sample than substance-diagnosed comparison groups. The ADHD group was also significantly less likely to perpetrate IPV than the individuals with bipolar or PTSD diagnoses, despite a disproportionately larger number of male ADHD offenders. The discrepancy in IPV perpetration among ADHD diagnosed adults observed in the current investigation with those previously reported may be the result of selection bias. Unlike the majority of adults with ADHD who have gone undiagnosed (Kessler et al., 2006), the current participants were diagnosed prior to the evaluation, likely during the course of their education, and were more likely to have been medicated for the disorder as a result. ADHD clients in the current sample were also gathered from an inmate population, where the rates of IPV are likely to be generally higher among comparison groups than among the larger population (e.g. Easton, Mandel, Hunkele, Nich, Roundsaville, & Carroll, 2007). Finally, substance use rates were relatively consistent across diagnosis groups with the exception of cannabis, which was highly comorbid with an ADHD diagnosis. This substance use difference should be considered when interpreting the results as cannabis is generally thought to share an inverse relationship with aggression (Boles & Miotto, 2003).

The dearth of knowledge about the role of psychopathology in the perpetration of IPV may partially result from existing theoretical models that have dominated IPV theory and practice since its inception in the 1970s and 1980s (Pence & Paymar, 1983). Under the canon of such controversial models (e.g., Dutton & Corvo, 2007), psychopathology is considered one of many mitigating factors that would be counterproductive to non-violent behavior change among male perpetrators. The influence of psychopathology on IPV perpetration represents a domestic violence domain for which females perpetrators have received disproportionately greater attention than males. Within female samples, for example, psychopathology is seen as both a precipitant to and consequence of aggression (e.g., Hatters-Freidman & Loue, 2007) as the primary motivations to aggress among females include the dysregulation of negative affective experiences and reciprocation for potentially traumatizing IPV victimization (Caldwell, Swan, Allen, Sullivan, & Snow, 2009). Indeed, current results indicate that IPV perpetration occurred more frequently among women with mental illness

than among males with mental illness. IPV rates were comparable across genders in the larger comparison sample.

Efforts must be devoted to surveying the presence and influence of psychopathology within the greater IPV population. Existing mental illness may represent an unintentional barrier to behavior change for both genders. Acknowledging and accommodating individuals with mental health disorders in the treatment of IPV may help reduce the risk of reoffending in repeat offenders and, thus, serve to protect victims from further abuse. Treatment providers are encouraged to perform a thorough psychological evaluation on IPV referred offenders to detect clinical elevations in mood and anxiety disorders. Individualized treatment plans involving specialized groups of diagnostically similar clients that integrate relevant modules to address psychological symptoms associated with violent behavior may concurrently reduce active psychopathology and the risk of recidivism, though additional research on integrated treatments is required to evaluate efficacy. Integrated treatments for co-occurring IPV and substance abuse disorders have demonstrated improved treatment results over non-integrated programs (Easton et al., 2007; O'Farrell et al., 2000).

The l*imitations* of the current study should be recognized. As a secondary analysis of existing data from a larger program evaluation effort, we were unable to obtain detailed information about substance use and IPV frequency and severity. Additionally, variability in the sample limited our ability to perfectly match comparison groups on all criteria, resulting in some substitutions in gender and ethnicity. Consistently significant but wide OR confidence intervals were observed and may indicate underpowered models. This likely resulted from the examination of small diagnostic subgroups and, thus, our significant relationships may be even more pronounced with larger samples. Similarly, data pertaining to recent participant relationship status were not available for the current investigation. Given that the severity of psychopathology has been associated with reduced involvement in marital and romantic relationships (e.g., Kessler et al., 2005), it stands to reason that individuals with diagnoses such as a bipolar or post-traumatic stress disorder would be less likely to have been involved in an intimate partnership over the previous year than participants in the comparison groups and that future analyses of only romantically-involved participants may yield greater effects than those presented here. Finally, self-report and chart review methods of gathering IPV, substance use, and diagnostic data present with potential limitations. The quality/accuracy of psychiatric diagnoses as well as treatment/compliance may vary significantly across both providers and clients. While the current results suggest that IPV perpetration may be more strongly associated with a history of bipolar and PTSD diagnoses than ADHD or comparable substance use diagnoses alone and there is no reason to assume a systematic error in diagnostic procedures that may have biased the results against any of the included samples, future investigations need to examine IPV base rates among samples diagnosed using a controlled, standardized assessment battery to remove the potential variability associated with diagnostic procedures.

In *conclusion*, the prevalence of psychopathology within the IPV perpetrator population is unknown. The current study is consistent with the growing literature that supports an association between IPV perpetration and psychopathology. Specifically, individuals with a bipolar disorder or PTSD, but not ADHD, diagnosis were more likely to perpetrate partner

violence than participants matched on substance abuse and demographic variables. Identifying and treating underlying psychopathology may be integral in providing effective IPV intervention and reducing the risk of future violence for both males and females.

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Table 1

Demographics for disorders and comparison groups

	Bipolar (n=37)	Bipolar Comparison (n=37)	PTSD (n=26)	PTSD Comparison (n=26)	ADHD (n=32)	ADHD Comparison (n=32)
Demographics						
Employed (%)	10 (27%)	15(40%)	7 (27%)	8 (31%)	9 (28%)	17 (50%)
Male n (%)	23 (62%)	23 (62%)	11 (42%)	12 (46%)	29 (91%)	28 (88%)
Caucasian n (%)	29 (78%)	33 (89%)	17 (65%)	19 (73%)	25 (78%)	25 (78%)
African American n (%)	3 (8%)	3 (8%)	6 (23%)	7 (27%)	1 (3%)	2 (6%)
Latino/a n (%)	1 (3%)	1 (3%)	2 (8%)	-	5 (16%)	5 (16%)
Substance Use						
Alcohol Use n (%)	21 (57%)	21 (57%)	19 (73%)	19 (73%)	20 (62%)	20 (63%)
Cocaine Use n (%)	23 (62%)	23 (62%)	14 (54%)	14 (54%)	18 (56%)	18 (56%)
Marijuana Use n (%)	17 (46%)	17 (46%)	12 (46%)	12 (46%)	23 (72%)	22 (69%)
Opiate Use n (%)	18 (49%)	18 (49%)	11 (42%)	11 (42%)	18 (56%)	18 (56%)
Violence						
Partner Violence n (%)	22 (60%)	10 (27%)	20 (77%)	10 (39%)	8 (25%)	5 (16%)
General Violence n (%)	15 (41%)	10 (27%)	12 (46%)	8 (31%)	11 (34%)	3 (9%)
Family Violence n (%)	16 (43%)	12 (32%)	20 (77%)	12 (46%)	15 (46%)	9 (28%)

Note. PTSD = post-traumatic Stress disorder, ADHD = attention deficit-hyperactivity disorder

Table 2

IPV Odds Ratios for disorders compared to matched comparisons and other disorders

	Bipolar	PTSD	ADHD
Bipolar Comparison	3.67** (1.37–9.81) n=72		
PTSD Comparison		5.00** (1.49–16.83) n=51	
ADHD Comparison			1.88 (.54–6.54) n=63
PTSD	0.440 (0.14–1.35) n=60		
ADHD	4.22** (1.49–11.91) n=67	9.58** (2.84–34.34) n=57	

Note. PTSD = post-traumatic Stress disorder, ADHD = attention deficit-hyperactivity disorder

* $p<.05$,

** $p<.01$