Recent Victimization Increases Risk for Violence in Justice-Involved Persons With Mental Illness

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A large body of research has examined relationships between distal experiences of victimization and the likelihood of engaging in violence later in life. Less is known about the influence of recent violent victimization on risk for violence perpetration. To our knowledge, this is the first study to examine prospectively whether recent victimization in adulthood increases the risk of future violence. Specifically, the present study assessed the incremental validity of recent violent victimization in the prediction of future violence in a sample of justice-involved adults with serious mental illness. The study examined (a) whether recent experiences of violent victimization (i.e., within 6 months of the baseline assessment) predicted a greater likelihood of perpetrating violence in the next year, and (b) whether inclusion of recent victimization enhanced the predictive validity of a model of violence risk in a sample of justice-involved adults with severe mental illness (N = 167). Hierarchical logistic regression analyses indicated that exposure to recent violent victimization at the baseline assessment predicted a greater likelihood of engaging in violent behavior during the year follow-up period. Additionally, recent exposure to violence at the baseline assessment continued to explain a significant amount of variance in a model of future violence perpetration above the variance accounted for by well-established violence risk factors. Taken together, the findings suggest that recent victimization is important to consider in understanding and evaluating risk of violence by persons with mental disorders who are involved in the criminal justice system.

Keywords: recent victimization, violence, mental illness, criminal justice system

Other-directed violence is a costly social problem that generates immense public health, economic, and social burden in the United States. The total lifetime cost of injuries from violent victimization in the United States was estimated at $37 billion in 2002 (Corso, Mercy, Simon, Finkelstein, & Miller, 2007). The vast burden produced by violent victimization speaks to the need for improved violence prevention efforts and research on how to enhance violence risk assessment.

One well-established risk factor for the perpetration of violence is a history of violent victimization. The association between violent victimization and violent behavior is supported by a large number of empirical studies that indicate exposure to violence early in development is associated with increased risk for aggression and violent crime in adolescence and adulthood. Seminal work by Widom and colleagues provided evidence for a cycle of violence whereby children who are exposed to physical abuse are at elevated risk (e.g., odds ratio 1:9) for perpetrating violent crime later in development (e.g., Maxfield & Widom, 1996; Widom, 1989; Widom & Maxfield, 1996). Several hypotheses have been proposed to explain the association between early victimization and later engagement in criminal and violent behavior (e.g., Widom, 2000). One theory is that individuals with early exposure to violent victimization learn to view aggressive behavior as a salient and potentially effective coping response through social modeling (e.g., social learning theory; Akers, 2009). Other explanatory psychological mechanisms for the victimization–violence link include an increased tendency to misinterpret social information as threatening (e.g., Dodge, Bates, & Pettit, 1990), desensitization to violence that results in a lack of empathy (e.g., Klimes-Dougan & Kistner, 1990; Porter, 1996), changes in physiological reactivity and other biological systems that regulate the stress response (e.g., Repetti, Taylor, & Seeman, 2002; Scarpa & Ollendick, 2003), violence as a maladaptive coping strategy for the psychological sequelae of victimization (e.g., substance use, depression; Green et al., 2010), and heritable traits that confer risk for both victimization and violent behavior (e.g., impulsivity; Jaffee, Caspi, Moffitt, & Taylor, 2004). Criminological theories posit that a high-risk/deviant lifestyle (e.g., routine activities theory; Jensen & Brownfield, 1986), self-selection to risky situations as a result of low self-control (e.g., self-control theory; Gottfredson & Hirschi, 1990), and weak social bonds (e.g., social control theory; Hirschi, 1969) may explain the link by increasing exposure to environments that confer risk for both victimization and violence perpetration.

Although the association between early experiences of victimization and subsequent violent behavior is well documented in the
literature (e.g., Jennings, Piquero, & Reingle, 2012), much less research has investigated how recent violent victimization is related to risk for violence in adulthood. Examining the risk associated with victimization in adulthood is potentially important for understanding risk for violence, given that the short-term effects of victimization on violence perpetration may be strongest when an individual is recovering from the stress of a recent victimization. Further, a history of violent victimization in childhood predicts revictimization throughout the life span (Widom, Czaja, & Dutton, 2008), suggesting that it is a risk factor that is likely to reoccur into adulthood and create periods of heightened risk, particularly in groups with high rates of victimization.

Understanding the risk conferred by victimization for future violence is particularly important in groups that are especially vulnerable to experiences of victimization. Research indicates that individuals with severe mental illness and those involved in the criminal justice system are at particularly high risk for violent victimization, as they report higher rates of victimization over the criminal justice system are at particularly high risk for violent individuals with severe mental illness and those involved in the vulnerable to experiences of victimization. Research indicates that violence is particularly important in groups that are especially groups with high rates of victimization.

Further, a history of violent victimization in childhood predicts victimization on violence perpetration may be strongest when an example, in a randomly selected sample of 936 individuals with severe mental illness, the incidence of violent victimization was more than 4 times greater than the rate in the general population (Teplin et al., 2005). Similarly, retrospective reports of childhood abuse in a sample of 301 offenders varied from 35% to 58% (Weeks & Widom, 1998), which is consistent with rates in other samples (e.g., Silver, Arseneault, Langley, Caspi, & Moffitt, 2005; Teplin, McClelland, Abram, & Werner, 2005; Weeks & Widom, 1998). For example, a history of mental illness, including demographic characteristics (i.e., age, gender), distal experiences of victimization (i.e., a history of childhood physical abuse), personality traits (i.e., anger, impulsivity), mental health symptoms (i.e., 30-day drug and alcohol use, psychiatric symptoms in the last month), and a recent history of violent behavior (e.g., Monahan et al., 2001; Silver, 2002). Based on the few cross-sectional studies that have examined relationships between victimization and violence risk in samples of individuals with mental illness or justice-involved persons, we hypothesized that recent experiences of violent victimization would increase risk for violence in a sample of criminal-justice-involved individuals with mental illness.

**Method**

**Participants**

Participants consisted of 254 adult men (74%) and women (26%) ages 19 to 63 years ($M = 38.8, SD = 10.5$) with mental disorders. Participants were recruited at the San Francisco site of a multisite study on the effectiveness of mental health courts (McNiel, Delucchi, & Binder, 2011; Steadman, Redlich, Callahan, Robbins, & Vesselinov, 2011). Individuals were eligible to participate in the study if they were age 18 or older, diagnosed with a mental illness (those with a primary diagnosis of mental retardation or a developmental disability were not eligible), able to speak English well enough to answer the interview questions, and incarcerated for less than 60 days prior to the baseline interview. The study employed a prospective research design whereby participants completed a baseline assessment interview and were subsequently reassessed at 6 months and 12 months.

To maximize the number of participants included in the follow-up period, data from the 6-month and 12-month assessments were combined in the present study. The final sample consisted of 167 adult men (75%) and women (25%) ages 19 to 63 ($M = 38.3, SD = 10.5$) who had both baseline and follow-up data. The most common mental disorders were mood disorders ($n = 90, 54\%$), schizophrenia ($n = 62, 37\%$), and anxiety disorders ($n = 13, 8\%$), allowing for comorbidity. A co-occurring diagnosis of a substance use disorder was present for 89.2% ($n = 149$) of the study group. Participants who did not complete a follow-up as-
assessment did not differ from those in the final sample on any of the hypothesized predictors.

Procedures and Measures

Procedures. All of the assessments were completed during an hour-long structured clinical interview that was conducted by trained interviewers. Participants received monetary compensation for their participation (baseline assessment = $20.00, follow-up assessment = $25.00). Relevant institutional review boards approved the study procedures prior to data collection. Research staff obtained written informed consent from each participant after providing a detailed description of the study.

Recent violent victimization. Recent violent victimization was assessed by asking participants about victimization experiences in the 6 months prior to the baseline assessment. Participants were asked if they were slapped, kicked, hit with a fist or object, sexually assaulted, or threatened or assaulted with a weapon in the 6 months prior to the baseline assessment using a three-item modified version of the Conflict Tactics Scale (Straus, Hamby, Boney-McCoy, & Sugarman, 1996) that has been used in previous research on violent victimization (e.g., Silver, 2002). Recent violent victimization was coded dichotomously as the presence (coded as 1) or absence (coded as 0) of recent victimization. Approximately half of the sample reported a recent history of violent victimization (present = 92, 55.1%; absent = 75, 44.9%).

Childhood physical abuse. At the baseline assessment, participants were asked about experiences of physical abuse during childhood using a four-item adapted version of the Physical Assault Scale of the Revised Conflict Tactics Scale (PC-CTS; Straus & Hamby, 1997). Specifically, participants were asked if their parents hit them with their bare hand or fist, hard object, whip, strap, or belt, or injured them with a knife, gun, or weapon, as a child or teenager. Participants who endorsed an experience of physical abuse were then asked how frequently the abuse occurred on a scale from 0 (never) to 5 (most of the time). The frequency of childhood physical abuse was summed to create a total score (M = 5.5, SD = 4.9; Min/Max = 0/20; Cronbach’s alpha = .77 in present sample).

Trait anger. A brief four-item version of the Behavior Subscale of the Novaco Anger Scale (NAS; Novaco, 1994) was used to index a disposition toward angry behavior, and it was administered at the baseline assessment. The subscale describes behavioral manifestations of anger, including impulsive reaction and physical confrontation. For each item, participants rated how true a statement was of their thoughts, feelings, and behavior on a scale from 1 (never true) to 3 (always true), and items were summed to create a trait anger total score (M = 6.7, SD = 2.5; Min/Max = 4/12; Cronbach’s alpha = .87 for the present sample).

Impulsivity. The 10-item Motor Impulsiveness subscale of the Barratt Impulsiveness Scale Version–10 (BIS-10; Barratt, 1994) was measured at the baseline assessment and used as an indicator of trait impulsivity. The Motor Impulsiveness subscale measures tendencies toward acting on the spur of the moment without thinking. Participants were asked to rate how often they act in the manner described from 1 (rarely/never) to 4 (almost always/always), and items were summed to create an impulsivity total score (M = 22.4, SD = 5.9; Min/Max = 10/40; Cronbach’s alpha = .80 for present sample).

Psychiatric symptoms. To assess current psychiatric symptoms, participants completed the modified Colorado Symptom Index during the baseline assessment (CSI; Conrad et al., 2001). The CSI is a 14-item measure that asks participants to describe how often symptoms have been experienced within the last month on a scale from 1 (not at all) to 5 (at least every day). A total score was calculated by summing each item (M = 27.13, SD = 14.25; Min/Max = 0/60).

30-day alcohol and substance use. Recent alcohol and substance use was measured by asking participants how many days in the month before the baseline assessment they (a) used illegal or nonprescribed drugs to get high, and/or (b) drank alcohol. Approximately 60% of the sample reported using alcohol (M = 8.2, SD = 11.3; Min/Max = 0/30) and 74% of the sample reported illicit substance use to get high (M = 14.7, SD = 12.9; Min/Max = 0/30) in the 30 days before the baseline assessment.

Recent history of violence. A recent history of violence was assessed by asking each participant if he or she had physically harmed, sexually assaulted, or threatened/used a weapon against another person in the 6 months prior to incarceration using a modified version of the Physical Assault Scale from the Revised Conflict Tactics Scale (Silver, Mulvey, & Monahan, 1999; Straus et al., 1996). Recent violence was coded dichotomously as the presence (coded as 1) or absence (coded as 0) of recent violence perpetration. Approximately 30% of the sample reported a recent history of violence (present = 54, 32.3%; absent = 113, 67.7%).

Violence perpetration during the year follow-up period. At the 6-month and 12-month follow-up assessments, participants were asked if they had perpetrated violence in the last 6 months. Violence was operationalized as physically harming, sexually assaulting, or threatening assault with/using a weapon against another individual, and it was derived from a modified version of the Physical Assault Scale from the Revised Conflict Tactics Scale (Straus et al., 1996). We selected this definition of violence, because it has been thoroughly studied in previous research on violence risk (e.g., Monahan et al., 2001; Silver et al., 1999) and describes serious forms of violence that are most likely to cause harm to others. Future violence was coded dichotomously as the presence (coded as 1) or absence (coded as 0) of violence perpetrated at any time during the year follow-up period. Approximately 20% of the sample reported perpetrating violence during the year follow-up period (present = 34, 20.4%; absent = 133, 79.6%).

Data Analysis

The incremental validity of recent violent victimization in the prediction of violence risk was assessed with multiple logistic regression analyses. Covariates initially were included in the model that were not hypothesized to predict future violence but may have altered a participant’s opportunity to perpetrate violence during the year follow-up period—specifically, the duration of the follow-up period, the number of nights spent in jail, as well as the recruitment sample (mental health court vs. treatment as usual). The covariates were not included as moderator variables in the final model because supplemental analyses showed they did not interact with the hypothesized predictors. Intercorrelations between the study variables were all below .50 and tolerance levels were all above .63, indicating acceptable collinearity in the regression models (Gaur & Gaur, 2006; Leahy, 2000). Odds ratios were
calculated to provide a measure of effect size. Predictors and covariates were z-scored before they were entered into the regression models to standardize the interpretation of odds ratios.

**Results**

Bivariate correlations between the hypothesized predictors and violence in the year follow-up period are provided in Table 1 as a reference for subsequent multivariate analyses. At the bivariate level, violence during the year follow-up period was positively associated with a history of childhood physical abuse, trait anger, 30-day alcohol use, psychiatric symptoms, recent perpetration of violence, and recent violent victimization. A recent history of violent victimization was positively associated with these same variables and also evidenced positive correlations with trait impulsivity and 30-day substance use.

Our first study aim was to assess whether victimization experiences in the 6 months prior to the baseline assessment predicted engagement in violence during the year follow-up period. To address this aim, we conducted a logistic regression analysis with recent victimization entered as a predictor of future violence. As expected, recent violent victimization predicted future violence, Wald’s $\chi^2 = 13.14, p < .001, OR = 2.64$. A cross-tabulation of the relationship between recent violent victimization assessed at baseline and the perpetration of violence in the following year is provided in Table 2. These data illustrate that, of individuals who reported engaging in violence during the year follow-up period, a higher proportion endorsed a recent history of violent victimization (85%) than did not (15%).

Our second study aim was to examine whether including recent victimization in a model with other predictors that research suggests increase risk for violent behavior enhances the predictive power of the model. We constructed a hierarchical logistic regression model to test this research question by creating separate blocks of predictors that represent key categories of well-established risk variables.

### Table 1

**Bivariate Relationships Among Predictors and Future Violence (N = 167)**

<table>
<thead>
<tr>
<th>Predictor</th>
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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<tbody>
<tr>
<td>1. Age</td>
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<td>2. Gender</td>
<td>-.10</td>
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<td>3. Childhood physical abuse</td>
<td>.07</td>
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<td>4. NAS Behavior Scale</td>
<td>-.20*</td>
<td>.20*</td>
<td>.21*</td>
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<tr>
<td>5. BIS motor impulsiveness</td>
<td>-.24*</td>
<td>.22*</td>
<td>.24*</td>
<td>.51*</td>
<td></td>
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<td>6. 30-day alcohol use</td>
<td>-.04</td>
<td>.14</td>
<td>.22*</td>
<td>.23*</td>
<td>.23*</td>
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<tr>
<td>7. 30-day substance use</td>
<td>-.20*</td>
<td>.10</td>
<td>.14</td>
<td>.14</td>
<td>.14</td>
<td>.23*</td>
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<tr>
<td>8. Colorado Symptom Index</td>
<td>-.07</td>
<td>.07</td>
<td>.29*</td>
<td>.42*</td>
<td>.40*</td>
<td>.15</td>
<td>.30*</td>
<td>.12</td>
<td></td>
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<tr>
<td>9. Recent history of violence</td>
<td>-.23*</td>
<td>.13</td>
<td>.21*</td>
<td>.26*</td>
<td>.15</td>
<td>.13</td>
<td>.30*</td>
<td>.12</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Recent violent victimization</td>
<td>-.22*</td>
<td>.00</td>
<td>.23*</td>
<td>.33*</td>
<td>.21*</td>
<td>.20*</td>
<td>.20*</td>
<td>.28*</td>
<td>.39*</td>
<td></td>
</tr>
<tr>
<td>11. Future violence</td>
<td>-.13</td>
<td>.08</td>
<td>.20*</td>
<td>.27*</td>
<td>.15</td>
<td>.18*</td>
<td>.14</td>
<td>.18*</td>
<td>.29*</td>
<td>.31*</td>
</tr>
</tbody>
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*Note.* Gender: male = 1, female = 0. Recent history of violence: present = 1, absent = 0. Recent violent victimization: present = 1, absent = 0. Future violence: present = 1, absent = 0. BIS = Barratt Impulsiveness Scale Version 10 (Barratt, 1994); NAS = Novaco Anger Scale (Novaco, 1994). *p < .05.

When the personality predictors were entered into the model in Block 3, trait anger positively predicted future violence, Wald’s $\chi^2 = 4.92, p = .027, OR = 1.66$, whereas impulsivity did not ($p > .69$). Childhood abuse history continued to be a significant predictor in Block 3 with the personality predictors entered in the model, Wald’s $\chi^2 = 5.37, p = .02, OR = 1.66$. The addition of recent psychopathology symptoms in Block 4 did not account for significant variance in predicting future violence ($p > .32$). However, a history of childhood abuse, Wald’s $\chi^2 = 4.63, p = .031, OR = 1.62$, and trait anger, Wald’s $\chi^2 = 4.17, p = .041, OR = 1.64$, continued to predict violence during the follow-up period in Block 4. When a recent history of violence was entered in Block 5, it became the only significant predictor of future violence in the model, Wald’s $\chi^2 = 4.87, p = .027, OR = 1.63$. Recent victimization in the 6 months prior to the baseline assessment was added in the final step of the model. As illustrated in the final multiblock model in Table 3, recent victimization continued to explain a significant amount of variance in the prediction of future violence above that accounted for by the other predictors in the model, Wald’s $\chi^2 = 4.61, p = .032$, for the final block, and was a

### Table 2

**Cross-Tabulation of Recent Victimization and Future Violence (N = 167)**

<table>
<thead>
<tr>
<th>Recent victimization</th>
<th>Present</th>
<th>Absent</th>
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<tbody>
<tr>
<td>Present</td>
<td>29 (85)</td>
<td>63 (47)</td>
</tr>
<tr>
<td>Absent</td>
<td>5 (15)</td>
<td>70 (53)</td>
</tr>
</tbody>
</table>
significant predictor of violence, Wald’s $\chi^2 = 4.25$, $p = .039$, OR = 1.92. Thus, results indicated that recent violent victimization increased the likelihood of perpetrating violence during the year follow-up period when assessed in a model with other well-established predictors of violence.

### Discussion

Concerns about associations between mental illness and violent behavior have become increasingly visible in the media and a focus of policy reform by lawmakers. The elevated rates of victimization endorsed by persons with mental illness, and the association between victimization and violence, underscore the importance of better understanding how recent experiences of victimization in adulthood may increase the risk for future violence. To our knowledge, the present study is the first to investigate the predictive relationship between recent violent victimization and risk for later violence in a sample of individuals with severe mental illness who are involved in the criminal justice system. The main finding of the study is that recent violent victimization is an important risk factor to consider when assessing risk for violence among justice-involved persons with serious mental illness. Specifically, violent victimization in the 6 months prior to the baseline assessment predicted a greater likelihood of perpetrating violence during the year follow-up period above the variance accounted for by other well-established risk factors for violence. This finding suggests that recent violent victimization adds incremental validity to models of future violence in samples of criminal-justice-involved persons with mental illness, a group that is especially vulnerable to exposure to victimization and is at elevated risk of perpetrating violence.

Underscoring its relevance as a risk factor, recent victimization was an all-too-common experience in the study sample. Slightly over half of individuals endorsed a recent history of violent victimization, which replicates other research that finds higher rates of victimization among individuals with serious mental illness than those in the general population (e.g., Teplin et al., 2005). Although a high percentage of the individuals who perpetrated violence during the follow-up period also reported a history of recent victimization, it is important to note that only 30% of individuals victimized in the 6 months prior to the baseline assessment perpetrated violence during the follow-up period. Thus, the majority of individuals with mental illness who experienced recent victimization did not later report perpetrating violence toward others. The present findings do suggest, however, that exposure to victimization increases the risk that persons with serious mental illness will engage in future violent behavior.

Multiple theories have been proposed to explain relationships between distal experiences of victimization in childhood and risk for aggressive and violent behavior in adulthood (e.g., Widom, 2000). However, less research has examined the link between recent victimization and violence perpetration. Silver et al. (2011) identified several risk factors that are associated with both violent victimization and violence perpetration in civil psychiatric patients, including substance abuse, psychopathic personality traits, stress, and unstable living situations. Those findings are consistent with the bivariate relationships observed in the present study. In particular, violent victimization at the baseline assessment and violence during the year-long follow-up period evidenced similar associations with several risk factors, including a history of childhood physical abuse, trait anger, recent alcohol use, and recent psychiatric symptoms. When entered into a multivariate model, the relative utility of these risk factors for predicting violence changed, and the experience of violent victimization in the 6 months prior to the initial assessment remained the only robust predictor of violence perpetration.

The present study cannot speak to potential causal relationships between victimization and violence, and more research is needed to further understanding of the processes by which victimization may increase violence risk. One possibility is that experiences of violent victimization create periods of increased stress and vulnerability that worsen mental health symptoms (e.g., substance abuse, posttraumatic stress symptoms) and activate preexisting tendencies toward violent behavior (e.g., personality traits). However, additional prospective research is needed to further unpack these relationships. It may be fruitful to examine potential moderators and mediators of the victimization–violence relationship to identify dynamic intervening variables (e.g., impulsiveness, anger, substance use, posttraumatic stress symptoms, antisocial attitudes; Douglas & Skeem, 2005) that may be amenable to treatment interventions. Additionally, research has found meaningful differences in the risk factors associated with relatively minor aggressive acts and the more serious acts of violence that were assessed in the present study (e.g., Monahan et al., 2001). Assessment of victimization in this study combined exposure to minor aggressive acts and serious violence, which did not allow for separate analysis of these experiences, and these relationships might be informative to examine in future research.

There may also be environmental factors that increase risk for both exposure to violent victimization and violence perpetration that were not assessed in the present study. For instance, economic disadvantage, impoverished neighborhoods, and weak social bonds may contribute to the likelihood that at individual is exposed to risky situations that promote both victimization and violence (e.g., Hirschi, 1969; Jensen & Brownfield, 1986). The high rates of substance abuse in the present sample (i.e., approximately 90%...
with diagnosed co-occurring substance use disorder) may have strengthened the observed relationship between victimization and violence by virtue of the risky lifestyle that is often associated with illicit substance use. Given the elevated rates of both victimization and violence among individuals with severe mental illness and justice-system involvement, future research is needed to evaluate what mechanisms account for the associations between these variables.

As with any study, the present investigation has potential limitations. One limitation of the present study is that not all of the participants had data for both the 6-month and 12-month follow-up period, which introduces variability in the follow-up time period assessed. Although we adjusted for this by including time period assessed as a covariate in analysis, this design limits our ability to speak to different time periods at which violence risk may be particularly elevated following exposure to violent victimization. The modest size of the study group is another potential limitation that may have reduced our ability to detect small relationships, and null findings should be interpreted with caution. Additionally, the number of individuals who perpetrated violence during the follow-up period was low in relation to the number of predictors included in the hierarchical logistic regression analysis (e.g., Peduzzi, Concato, Kemper, Holford, & Feinstein, 1996), which may reduce the stability of the parameter estimates. Thus, examination of the relationship of recent victimization and violence perpetration in larger samples is needed to verify the reliability of the current results.

Further, the model we tested only included a subset of risk factors that prior research indicates increase violence risk, and a more comprehensive test of the recent victimization–violence relationship should be investigated in future work that incorporates additional risk factors not assessed in the present study. This study did not evaluate the incremental validity of recent victimization in relation to validated risk assessment instruments. Examining whether recent victimization improves the predictive validity of established risk assessment tools is a potentially interesting avenue for future research. Another potential limitation is the restricted range of substance use disorders, which may have limited our ability to assess relationships between alcohol use and substance use with future violence. For example, although alcohol use and substance use both showed positive relationships with victimization at baseline, their relationships with a recent history of violence and future violence were variable. We also did not have collateral information to verify self-reports of victimization experiences and violence perpetration, which is a limitation of the findings. Finally, this study cannot address the relationship between the victim and aggressor (e.g., stranger vs. family member), and examining these relationships may help identify motivational (e.g., revenge, intimate partner conflict) and contextual (e.g., high crime neighborhoods) factors that contribute to the victimization–violence relationship.

The present study also has several strengths, including the use of a prospective design to evaluate risk factors for future violence. It also benefits from recruitment of a clinical–forensic sample of individuals with both mental illness and involvement in the criminal justice system. Further, the present findings extend current models of violence risk by demonstrating that incorporating assessments of recent victimization into models of risk for violence toward others adds incremental validity above other well-established risk factors.

**References**


