JOURNAL OF PSYCHOPATHOLOGY
2017;23:49-51

Interpersonal violence and mental illness

Definition

The World Health Organization (WHO) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychophysiological harm, maldevelopment or deprivation". This concept can be distinguished into three wide categories: self-inflicted, interpersonal, and collective violence.

"Interpersonal violence" stands for acts of violence inflicted by an individual or a small group of individuals to another; it can occur between family members or intimate partners, especially at home, or between close friends, acquaintances and strangers, often, but not always, outdoor. Parts of it are child maltreatment, sexual violence, elder abuse; it is considered to be a predictable and preventable risk factor for lifelong health and social problems.

In the first report on interpersonal violence, released by the WHO in 2014 (*The Global status report on violence prevention)*, data from 133 countries was collected, representing 6.1 billion people, which represents 88% of world population. Cruent deaths are the most evident outcome of violent behaviour recorded in official statistics: half a million people have been victims of homicide in 2012, for an overall rate of 6.7 per 100,000 people; 60% of these were males aged 15-44 years and, globally, 82% of all homicide victims are males, having a fourfold higher violent death rate than females; in 38% of cases, when a woman is killed the assassin is the partner. Deaths are only the tip of the iceberg of health and social burden arising from violence. It was estimated that in 2012 in the USA about 2 million people were treated in emergency departments for injuries sustained in an assault; 37% were aged 10-24. Women, children and elderly people are the principle victims of non-fatal physical, sexual and psychological abuse: 25% of all adults report having been physically abused as children, 36.3% experiencing emotional abuse and 16.3% experiencing physical neglect; one out of five women has reported having been sexually abused as a child and one out of three has been a victim of physical or sexual violence by an intimate partner at some point in her lifetime; about 6% of older adults reported significant abuse in national surveys conducted in the preceding 12 months in predominantly high-income countries.

Considering these data, we can state that violence represents a staggering problem of global Public Health; moreover, violence creates an economic load on society, although the accurate cost is unknown, especially in developing countries where there could be the risk of underestimating the impact of the problem. Violence consequences have both direct and indirect costs: provision of treatment in mental health or emergency care services and criminal justice administration are examples of direct ones; unemployment, absenteeism, permanent or temporary disability, provision of shelter for victims, disincentives to investment and tourism are some examples of indirect ones. The majority of nations spend a notable quantity of resources in responding to violence. In the United States the yearly economic cost of violence against women estimated in 2003 was approximately US$ 5.8 billion; the total lifetime cost resulting from incidence of deaths and non-fatal

child maltreatment is about US$ 124 billion annually. Public Health is promptly concerned with violence also for the significant contribution that health care professionals, in particular mental health professionals, can offer to reduce its consequences.

State of knowledge

Over the years, there has been a progressive convergence of mental illness and violence in the daily psychiatric practice, causing a broad number of violent individuals to be hospitalized. But what is the link between mental disorders and violence? Despite a certain connection between the two factors exists, both related to biological and psychological factors, it is now established that a severe psychiatric pathology itself it is not enough to determine violent behaviours and that there are other factors that play a role. Several studies affirm that family and social factors during childhood and adolescence have a huge impact in causing a tendency to violence in adulthood: within these factors there can be found family functioning, abuse and family neglect, parental conflict, support and social network, socioeconomic status and the social-working functioning. In general, individuals affected by mental disorders, particularly those within the schizophrenic spectrum, have a higher possibility to be violent compared to non-clinical population, even if the most of them are not violent. The incidence of violent behaviours gets higher in patients when a combination of these factors is found: active psychotic symptoms, male gender, lifetime history of violence and alcohol or drugs abuse, although substance consumption increases the risk of violent behaviours in the general population also.

The correlation between violence and suicidality is well known: an individual who has been repeatedly violent has a twofold higher suicide risk even after receiving treatment in a psychiatric inpatient care and, in the same way, a history of suicidal attempts is related to a future risk of violence. Moreover, self-injury and episodes of aggression represent one of the main causes for compulsory admissions, bringing plural management problems to psychiatrists.

There are specific categories of people with a higher risk of becoming victims of violence from individuals affected by psychiatric disorders. Recent studies suggest that severely ill patients engage more often in violent behaviours against family members and friends, and that violence usually takes place at home; they hit strangers 50% less compared to their community controls. Health professionals are another category at high risk: 20% of psychiatric acute inpatients may commit an act of violence against health workers, and 75% of nursing staff on acute psychiatric units reports experiencing at least one episode of aggression during their career.

Future perspectives

Considering these data, it is extremely important to determine the best prevention and intervention strategies. Currently, in Europe there is no unanimous approval upon which procedures are more effective in managing violent episodes in mental health services.

A descriptive survey study across 17 European countries reveals that almost 20% of health professionals employed in psychiatric wards had no received training on risk assessment and violence management; furthermore, this study shows that the most used intervention procedures were coercive ones, like physical restraint, rapid tranquillisation and seclusion, despite their higher efficiency has not been demonstrated and they cause negative effects on the prognosis.

Public Health should therefore focus on primary prevention of violence, through early identifications and treatment of dynamic risk factors, like substances abuse, active psychotic symptoms, impulsiveness, and the identification and treatment of static risk factors like previous history of violence and diagnosis.

One of the most used instrument is the Historical-Clinical-Risk Management-20, a structured clinical judgement tool useful to classify risk. There also are some specific instruments to evaluate interpersonal violence, like the Karolinska Interpersonal Violence Scale, currently being in the validation phase in Italy, composed by four sub-scales to evaluate the expression and exposure to violence during childhood and adulthood.

It is also necessary to work for reducing the environmental risks e.g. by acting on the lack of structured activities, temporary staff, low levels of staff-patient interaction. At the same time, mental health professionals should be provided with adequate training for risks evaluation and violence management in order to foster non-coercive methods such as de-escalation techniques, time out and increased observation and support.

Supporting actions on violence would bring benefits for the Government that reduces criminality levels and related costs, and the Public Health that reduces compulsory admissions and simplify the management in mental health services. Last but not least, there would be prognosis improvements for patients admitted to psychiatric units.

Hence, it is extremely important and a matter of interest for Public Health to identify the “violent phenotype”. This is also useful to approach an educational treatment towards patients, their families and health workers: within the next years, scientific research will have to address its interest to obtain this objective.

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