Prevalence of violence among psychiatric patients

Thesis

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Introduction

Despite its clinical importance, aggression is a scarcely studied topic. This is mostly due to the innate nature of the conditions encircling the aggressive psychiatric patient. Today aggression and violence pose a major problem for public health and criminal justice systems. Aggression usually causes harm and injuries to either self, others or environment. Despite its noteworthy prevalence and serious consequences, methodological problems and difficulties derived from the innate nature of the pathology hampers research on violence and aggression. However, much has been learned about the complex and controversial relationship between violence and mental disorders and the assessing violence risk over the last 30 years (**Turgut et al, 2006**).

Aggression can be observed in numerous different clinical conditions and has a fluctuating course. Definition of violence widely vary in the literature including: 1) physical aggression; 2) both physical and verbal aggression; and 3) physical aggression that results in significant injury. Similar to the challenge on defining these terms, the assessment and measurement of aggression and violence are challenges for mental health professionals, with no single instrument being the "gold standard" to assess violence across various conditions **(Hughes and Kleespies, 2003)**.

Historically, psychiatry practice emerged to protect public by confining people with mental illness who can pose a danger to the

community. Privileged with considerable developments in the last century, most of the mentally ill are unconfined today and psychiatry has seized its respectable place amongst other medical disciplines. Psychiatrists are no longer regarded as guardians of society against individuals that are "dangerous, bizarre and immoral". In contrast to general public opinion, violence arises in individuals with no psychiatric condition, as well as those with psychiatric conditions. In fact violent crimes are predominantly committed by "mentally well people" and most mentally ill people never commit a violent act throughout their illness. Regardless of the statistics, mentally ill people are usually associated with violence and aggression in public mind. This stigmatization is mostly due to the tragic, albeit uncommon, and well-publicized events highlighting individuals with psychiatric conditions committing violent acts **(Pescosolido et al, 1999)**.

Undeniably, a relationship exists between mental disorders and offending behaviors, but nature and extent of this association is controversial. Mental health disorders associated with violence include psychoses, substance use disorders, personality disorders, as well as neuropsychiatric conditions like delirium and dementia. While earlier reports claimed that the relationship was unclear and statistically insignificant, recent reports suggest that people with mental illnesses such as schizophrenia, bipolar disorder, substance use disorders and antisocial personality disorder are more likely to be violent than general population. However, because of the

inherent difficulties of conducting epidemiological research, the findings should be appraised cautiously **(Walsh et al, 2002)**.

Broadly speaking, risk factors for violence among persons with mental disorders fall into one of two categories. Static risk factors are those that either cannot be changed (e.g., age, sex) or are not particularly amenable to change (e.g., psychopathic personality structure). Identification of these factors is important in terms of identifying the client's absolute or relative level of risk; however, these factors typically have few implications for treatment or management of risk since the factors, static risk factors by definition, cannot be changed. In contrast, dynamic risk factors are those that are amenable to change (e.g., substance abuse, psychotic symptomatology). Identification of these factors is important both in terms of estimating the client's absolute or relative level of risk, as well as for purposes of treatment planning **(Randy, 2000)**.

Violence is not necessarily a characteristic of mental disorders but occurs with a low degree of frequency among mentally ill. However, people with certain mental disorders and who have some symptoms are at a higher risk in engaging violence. Past violent acts and substance use disorders are apparently foremost risk factors associated with future violence. Mental health professionals have some, albeit limited, ability to predict future violence. Nevertheless, the risk assessment is crucial and could be life-saving for the patient and people related to him/her. It should be part of everyday psychiatric examination similar to enquiring suicide and self-mutilation. Good clinical practice compels

clinicians to familiarize themselves with risk factors and structure their interviews, which enable guided judgment in management of violent patients (**Turgut et al, 2006**).

Aim of the work

The aim of this work is to answer the following questions:

- What is the lifetime prevalence of violence among psychiatric patients?
- What are the differences between violent and non-violent patients regarding some related factors including socio-demographic variables, service setting (inpatient & outpatient), type of diagnoses, major psychiatric symptoms (e.g. Delusions of hallucinations) and substance abuse.

Introduction to Violence

Acts of violence account for an estimated 1.43 million deaths worldwide annually. Today, aggression and violence pose a major problem for public health and criminal justice systems **(Siever, 2008)**. The question of why human beings engage in harmful acts of aggression has long been the subject of serious debate.

The terms ‘‘aggression’’ and ‘‘violence’’ while essentially interchangeable, do differ in as much as the former is predominantly an empirical term and the latter predominantly a forensic term **(Hoaken et al, 2003).** Aggression is any form of behavior directed toward the goal of harming or injuring another living being who is motivated to avoid such treatment **(Hoaken et al, 2003).** Whereas violence is an actual, attempted, or threatening harm to a person or objects, a behavior which would be fear-inducing to the average person may be counted as violence. Violence is a description of the act itself, not the damage to a victim **(Webster et al, 1997).** Violence has also been defined as the physical force exerted for the purpose of violating, damaging, or abusing (**Scarpa et al, 1997).**

Nonetheless, World report on violence and health (WRVH) defined 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, psychological harm, maldevelopment, or deprivation." **(Krug et al, 2002).**

Factors influencing violent behavior:

Ø **Gender :**

One of the risk factors of violence is gender. Men have been found to commit more serious violent acts than that committed by females. **(Robbins et al, 2003)**. While **Pearson (1998)** argues that violence in women in the wider community is underestimated, and that women are actually more violent than official statistics suggest.

For both violence and other aggressive acts, the targets of women were significantly more likely than the targets of men to be spouse, children and other family members, and the targets of men were significantly more likely than the targets of women to be friends and acquaintances, or to be strangers. Again for both violence and other aggressive acts, the locations of women were significantly more likely than the locations of men to be the subject's home, and the locations of men were significantly more likely than the locations of women to be outdoors on the street **(Robbins et al, 2003).**

Recent research on gender differences in violence risk among adolescents has observed no difference between males and females. However, **Fehon et al (2001)** have noted differences in the nature of the violence and among adults, although the overall prevalence rates are similar for women and men, there are some substantial gender differences in the quality or context of the violence committed **(Gelles & Straus, 1998).** Men are more likely to have been drinking or using street drugs, and less likely to have been adhering to prescribed psychotropic medication, prior to committing violence.

Ø **Age:**

Age is another well-known risk factor for violence (as well as criminal behavior more generally) in the general population. Persons in their late teens and early twenties are at highest risk for violent or threatening behavior **(Bonta et al, 1998).**

Age appears to be a risk factor for persons with mental illnesses as well as persons without mental illnesses. **Steadman et al (1994)** in their pilot study, found that patients with age 40 and above with mental illnesses reported rates of violence approximately one third that of persons between the ages of 25 and 40. Moreover **McNiel (1997**) concluded that, among persons with mental disorder, the predictive utility of age as a risk factor for violence may vary, depending on their mental state. He proposed that age may be a less powerful predictor of violence potential among persons who are acutely ill as symptom risk factors will mask or overshadow age effects, whereas age may be a more powerful predictor of violence among persons with mental disorder who are not acutely ill, as is the case among nondisordered persons in the community **(Wiley et al, 2000).**

Ø **Race:**

Rates of violent behavior are differentially distributed by race, as measured by self report, arrest rate and incarceration rate, with African Americans having higher rates than Caucasians **(McNiel, 1997).**

Ø **Socioeconomic level:**

Low Socioeconomic class and inequality in economic income is a serious risk factor for violence **(Tardiff, 1992).** Poor socioeconomic classes are associated with an increase in the crowding index which may enhance the likelihood of aggressive outbursts **(Soliman et al, 2007).** Also poor socioeconomic level is associated with low levels of education which is also associated to increase in violent behavior **(Soliman et al, 2007).**

The connection between the socioeconomic class and violence, however, is complicated; with some violence presumably instrumental; some violence results from higher levels of stress endured by the poor, and some violence being contextually determined and occurring as a function of living in criminogenic environments **(John Wiley, 2000).** As homelessness is an important pathway to incarceration among the mentally ill, studies estimate that approximately one-third of homeless persons meet diagnostic criteria for a major mental illness **(Jencks, 1994).** The presence of homeless persons and associated public order offenses may be a source of neighborhood disorder, generating fear and reducing social cohesion among neighborhood residents, thus facilitating more serious crime, such as robbery **(Markowitz et al, 2011).**