Indian Journal of Clinical Psychiatry
An Official Journal of **Association of Clinical Psychiatry**
(Indian Psychiatric Society- Uttar Pradesh State Branch (IPS-UPSB))

REVIEW ARTICLE

Violence in Psychiatry: An Over-emphasised Subject

Chitrakshee Singh*, Dharamveer Choudhary, Vipul Singh, Priyanka Kumari

Department of Psychiatry, Government Medical College, Kannauj, Uttar Pradesh, India

Abstract

Psychiatry as popularly said is a subject in its infancy and various aspects of it remain unexplored of which one is violence. Violence in psychiatry has intrigued researchers for decades and yet remains understudied. Various neurotransmitters and brain pathways have been found to be associated with aggression and vivid mechanisms have been hypothesised in violent patients. Schizophrenia, mania, depression, some particular personality disorders etc. are predominant mental illnesses associated with some incidences of violence but not exceeding that done in general. News and media notoriously present the scenarios of violence and add to the already existing stigma in general public about violence done by patients with mental illnesses. This leads to an opinion in public of chronic mentally ill patients being better in institutions. Though in recent years with development of forensic psychiatry and newer mental health care acts emphasis has been given to rights of mentally ill patients.

ARTICLE INFO

***Correspondence:**
Chitrakshee Singh
chitrakshee2000@gmail.com
Department of Psychiatry, Government Medical College, Kannauj, Uttar Pradesh, India

Dates:
Received: 25-01-2022
Accepted: 20-03-2022
Published: 26-04-2022

Keywords:
Mental illness, Psychiatry, Violence.

How to Cite:
Singh C, Choudhary D, Singh V, et al. Violence in Psychiatry: An Over-emphasised Subject. Indian Journal of Clinical Psychiatry. 2022;2(1): 16-18.

Introduction

World Health Organization (WHO) has defined the "violence" as "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, mal development or deprivation" (WHO, 1996).[1]

It has always been an association widely studied and discussed yet remains partially explored and controversial till this decade. Violence in society may have huge impacts on public health that requires an open-minded approach to understand and diminish. In the sector of mental health care, several hurdles must be crossed with regards to notions about preventing violence and to reduce the number of people with mental health and substance use disorders stuck into the justice system. In practice, other areas of mental health are given precedence over such issues as clinicians' focus on patients rather than the caregivers who actually suffer more than the patient in cases of violence, so this write-up is an effort to highlight this underlying lacuna.

In general, the prominent determinants of violence are young age, male gender and lower socioeconomic status.[2] Meanwhile research suggests higher occurrence of aggression in persons with mental illnesses on top of which

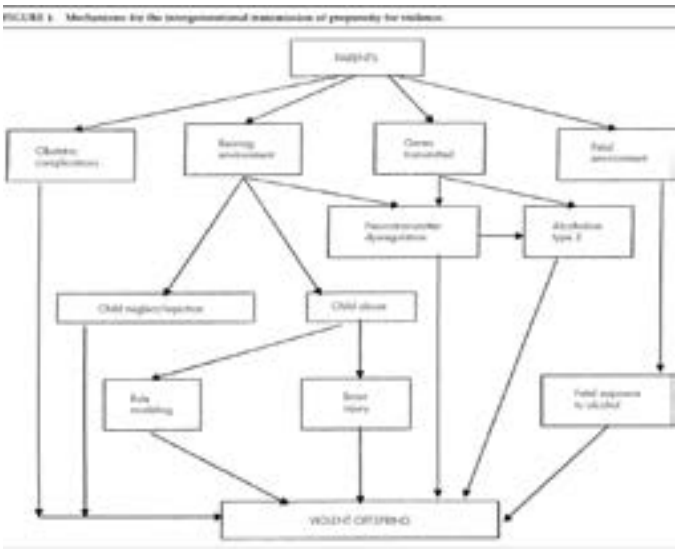

Figure 1: Intergenerational transmission of violence-mechanism.[4]

concurrent use of substance by a person with mental illness increases the chances of violence by two-fold.[3]

As for the neurotransmitters under studies for violence hyper-dopamine in striatum has been found to weaken inhibitory pathways which regulate impulsivity. Lower serotonin levels especially in pre-frontal cortex are found to be associated with aggressive behaviour. Association has also been found between arginine-vasopressin, cortisol and testosterone as they also promote aggression in a person.

Previous literature on neurobiology of violence various mechanisms for violent behaviour have been suggested as summarised in Figure 1.

Studies have classified violence into mainly three categories:

- *Impulsive:* As assault committed without forethought in response to a provocation,
- *Planned/Predatory:* An intentional assault committed for specific goal/purpose,
- *Psychotic:* As assault committed because of delusions, hallucinations, and/or disordered thinking.

The evidences have emerged that a diagnosis of schizophrenia has an association with rise in criminal offending. This has implications for caregivers, mental health professionals, administrators, law enforcement personnel, court system and policy makers, although majority of these individuals with schizophrenia do not show violent behavior.[5] It has been recorded that the criminal behaviors by these patients, could not be entirely owed to active symptoms or comorbid substance use or characteristics of systems of care, but also attributable to brain abnormalities, demographic factors and other psychiatric co-morbidities.

As also suggested by studies, depression is the primary diagnosis in murder-suicides i.e., individuals with depression may act out violently against others in anguish and after such act may attempt suicide.[5] Violence risk assessment study, with a diagnosis of depression, recorded two key findings related to depression with future violence risk:

- First was that future risk of violence in depressed individuals may be better predicted by past (last 10 weeks) history of violence compared to individuals with psychosis.
- Second was that the risk of future aggression is increased with alcohol use by individual with depression,

It has been advised that assessment of the risk of violence (both towards self and outside) should be considered routinely for individuals with clinical depression.

Patients with a diagnosis of mania mostly act out violently only when they are being restrained or limits are set on their actions; they exhibit aggressive or threatening behavior but serious violence is usually rare.[6]

It has been observed that individuals who are usually short tempered and lack empathy for others, also those with personality disorders especially borderline and antisocial are at increased risk for violent behavior.

It is advisable to assess for suicide risk in individuals threatening for homicide. The incidences of future violence may be predicted if patient attempts violent suicide act, so such individuals should be carefully evaluated.

There is a high possibility that the persons with mental illness might be the victims of violence while it has been observed frequently that general public usually magnify the relationship between major mental illnesses and violence. Violence by individuals with mental illness especially as

exaggerated in entertainment and news media leads to an increase in stigma against individuals with mental illness. This contributes to avoiding treatment, as well as less access to good jobs and housing, causing frustration and ultimately leading to greater risk of violence by such deprived people.

Deinstitutionalization which began in 1955 was a sound idea but it failed to ensure that the individuals leaving the hospital engage in society and continue to receive the necessary treatment to safeguard from again developing illness or relapsing has been a disaster. This has led to a misconception in public that patients with mental illnesses can not be treated and they pose a threat to society and are better in institutions or asylums.[7]

Some of the most effective forms of treatment compliance for individuals who have serious mental illness are-

- Assisted outpatient treatment (AOT),
- Conditional release and
- Mental health courts etc.

In fact, the new mission of forensic mental health systems is- managing violence as medical disorder in an environment that maintains balance between treatment and safety. It emphasises on patients staying in the society while regularly maintaining treatment and periodic assessment for risk factors and managing risks if any.

Behavioural, psychological, pharmacological, and environmental interventions may help in reducing the occurrence of patient violence in acute inpatient units. When a therapist ascertains, or should ascertain, that his patient may present a serious risk of violence to another person, he has an obligation to use reasonable amount of care to protect the person/persons that the patient intends to harm (Tarasoff II).

The psychiatrist, to prevent any unfortunate future catastrophe, can consider various options like hospitalization, warning the intended victim, warning the police or if possible letting the patient himself warn the intended victim and at the same time considering to increase the OPD follow-ups and appointments along with advising the caregivers to stay cautious and report timely if danger persists or if the patient becomes unmanageable.

A structured program in which along with managing the active symptoms of the patient's illness, his criminogenic personality (if assessment suggests), and other behavioural factors and comorbidities like substance misuse (if found) and social dislocation are managed then it could help in preventing the progress to violence.

References

1. Daher M. World report on violence and health. J Med Liban. 2003 Apr-Jun;51(2):59-63. PMID: 15298158.
2. Heshmat R, Qorbani M, Ghoreshi B, et al. Association of socioeconomic status with psychiatric problems and iolent behaviours in a nationally representative sample of Iranian children and adolescents: the CASPIAN-IV tudy. BMJ Open 2016;6: e011615. doi:10.1136/bmjopen2016-011615.
3. Pickard, Hanna, and Seena Fazel. "Substance abuse as a risk factor for violence in mental illness: some implications for forensic psychiatric practice and clinical ethics." Current opinion in psychiatry vol. 26,4 (2013): 349-54. doi:10.1097/YCO.0b013e328361e798.
4. Volavka J. The neurobiology of violence: An update. J Neuropsychiatry Clin Neurosci. 1999;11(3):307-314. Ýoi:10.1176/jnp.11.3.307.
5. Nolan KA, Czobor P, Roy BB, Platt MM, Shope CB, Citrome LL, Volavka J. Characteristics of assaultive behavior among psychiatric inpatients. Psychiatr Serv. 2003 Jul;54(7):1012-6. doi: 10.1176/appi.ps.54.7.1012. PMID: 12851439.
6. Asnis GM, Kaplan ML, Hundorfean G, Saeed W. Violence and homicidal behaviors in psychiatric disorders. Psychiatr Clin North Am. 1997 Jun;20(2):405-25. doi: 10.1016/s0193-953x(05)70320-8. PMID: 9196922.
7. Steadman HJ, Mulvey EP, Monahan J, Robbins PC, Appelbaum PS, Grisso T, Roth LH, Silver E. Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Arch Gen Psychiatry. 1998 May;55(5):393-401. doi: 10.1001/archpsyc.55.5.393. PMID: 9596041.