Chapter 10
Violence Against People with Mental Disorders

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Introduction

Historical Overview. The Role of Violence and Punishment in the Origins of Psychiatry

Tie them keeper in a tether
Let them stare and stink together
Both are apt to be unruly
Lash them daily, lash them duly,
Though 'tis hopeless to reclaim them
Scorpion Rods perhaps tame them.

These verses by Jonathan Swift, presenting the instructions to a madhouse keeper, clearly depict, without mincing words, the prevailing attitudes towards madness and its treatment in eighteenth-century England (Swift 1736).

As reported in the thorough historical overview by Scull (1983), madness was then considered a condition that required taming, as the behavior of wild animals characterized by irrational violence, fury and incoherent bestiality. Corresponding to these views of mad people as beasts was an armamentarium of coercive practices aimed at taming their ferocity by harsh discipline, punishments and infliction of physical suffering.

Although such practices were widely used with inmates of lower social classes, in workhouses or privately owned madhouses run for profit, as a consequence of an unregulated 'trade in lunacy' (Parry-Jones 1972), they were employed even in situations where the patients were not lacking in wealth or power.

The most extreme case was represented by the treatment experienced by the king of England George III during his episodes of illness, first diagnosed as 'mania' by

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the clergyman Francis Willis in 1788. A contemporary eyewitness reports that the king *was no longer treated as a human being. His body was immediately incased in a machine which left no liberty of motion. He was sometimes chained to a stake. He was frequently beaten and starved, and at best he was kept in subjection by menacing and violent language*. (Harcourt 1880).

Throughout the eighteenth and early nineteenth century the widespread use of chains in the institutions for the people labeled as mad is well documented. The image of Pinel breaking the inmates' chains at Bicêtre Hospital in Paris is considered a landmark of the birth of psychiatry, although historians showed long ago that it was likely a manufactured myth (Weiner 1994). According to all textbooks, modern psychiatry was born from this action, which freed the insane from restraint. Madness was getting out from the domain of generic segregation and getting into the medicine domain, transforming the insane into a psychiatric patient (Agnetti 2008). The birth of psychiatry was paralleled by the elaboration of a specific form of therapy aimed at introducing a therapeutic goal in the approach to madness, the moral treatment (Scull 1979; Postel 1979). In 1813 Samuel Tuke carefully described the first institution entirely managed according to the principles of the new system: the York Retreat in England (Tuke 1964).

Moral treatment has been for long time described in most psychiatric texts as a by-product of the enlightenment philosophy, a triumph of humanism leading to a rational therapeutic approach in which kindness and patience, along with recreation, walks, conversations and manual labour within an orderly environment, replaced brutal coercion (Bynum 1974). The advocates of milieu therapy in the 1950s and 1960s considered moral treatment as an earlier version of the therapeutic community (Carlson and Dain 1960). Later, occupational therapy (Peloquin 1989) and even the recovery movement (Shepherd et al. 2009) claimed its legacy.

However, it is worth noting that the current meaning of the term "moral" in the sense of "ethical" does not reflect its use three centuries ago. The words "moral treatment" was not synonymous with "kind treatment". They were taken in a broader sense of "psychological treatment" as opposed to "physical treatment", as in the title of the book by the French doctor and philosopher Pierre Cabanis *Rapports du physique et du moral de l'homme,* published in 1802.

Therefore, the view of moral treatment as an exclusively humanitarian approach opposed to any form of violence and control is misleading. First, confinement in asylums and control over the inmates "living environment" was a core aspect of the new approach. Second, its main goal was to educate the patients to discipline and restrain themselves through environmental manipulations and psychological influence. Actually, induction of fear was considered as an important instrument to regulate patients' emotions. This concept was pushed to the extreme by some practitioners, such as the French alienist Leuret, who endorsed an aggressive confrontation of patients' views, thus leading to a repressive form of management (Wolpe and Theriault 1971). Moreover, moral treatment was seldom available for the majority of patients and remained limited to a low number of institutions. Descriptions of harsh treatments of person with mental illness are easily found in journal articles, reports or books throughout the nineteenth century. The list of the

extravagant tools employed for the management and the physical coercion of patients is impressive: straitjackets, spinning chairs, immersion in icy water, surprise baths, bloodletting, blistering, gags, wooden cribs, cramped boxes, to name just a few (De Fréminville 1975).

In England, campaigns to address abuses in asylums were prompted by first person accounts, such as the one by John Perceval, son of a prime minister, who spent 2 years in private asylums between 1832 and 1834. He reported that he was forced to use a clyster in his brother's presence, was kept in a strait-waistcoat, was repeatedly beaten, pulled by the nose and saw attendants half-strangling an inmate (Hervey 1986). However, although the introduction of "moral treatment" may have improved to some extent the conditions of some inmates, around the half of nineteenth century the optimism brought by moral treatment and its influence on practices institutional began quickly to wane.

In 1841, the nurse and social activist Dorothea Dix surveyed the institutions for the insane in Massachusetts (United States of America) and sent a memorial to the state legislature, depicting an appalling situation: *The condition of human beings, reduced to the extreme states of degradation and misery, cannot be exhibited in softened language, or adorn a polished page. I precede, gentlemen, briefly to call your attention to the present state of Insane Persons confined within this Commonwealth*, in cages, closets, cellars, stalls, pens! Chained, naked, beaten with rods, *and* lashed *into obedience!*" (Dix 2006).

Roughly around the same time, Robert Gardiner Hill and John Conolly in England advocated against the use of mechanical restraints in asylums and made a plea for the implementation of a non-restraint approach in institutional care of the person with mental illness (Jones 1984; Scull 1984). The uproar caused by such views showed that use of restraint was actually widespread and was considered by most doctors not as a necessary evil, but as an essential treatment tool. This opinion was best exemplified by a well-known alienist in a letter send to the Times: *Restraint forms the very basis and principle on which the sound treatment of lunatics is founded* (Scull 1984).

The non-restraint approach in United Kingdom was widely supported by the lay press and endorsed by public authorities, leading to a reduction in the use of violence in the management of patients, although it is unclear to what extent the abolition of mechanical restraints was fully applied in English asylums. Moreover, a perusal of Conolly's works shows that he did not consider as restraints a number of tools which would have been later classified as such: *As regards keeping dressings on the head or elsewhere, the secured covers and cases of ticken with small locks are generally efficacious; but if they do not prove to, the confinement of the hands comes within the surgical category and is of course allowable*. (Walk 1954). There is evidence that the reduction in restraint use was counterbalanced by the spread of seclusion, i.e. the solitary confinement of patient in a locked bare room, usually with padded walls.

Outside the United Kingdom this innovative system never gained wide acceptance. In Germany, Italy and France the mechanical restraints continued to be in use (Dörner 1969; Canosa 1975; De Fréminville 1975). The American alienists

remained skeptical, as witnessed by a retrospective analysis published in 1880 in the prestigious *Boston Medical and Surgical Journal* by William Channing, who wrote the following dismissive sentences: *Conolly was possessed of the enthusiasm and extravagance characteristic of reformers in other fields. Viewed in the sober light of today we see that many of his ideas were impracticable. He imagined a state of affairs impossible anywhere except in the lunatic asylum of paradise*. (Channing 1880).

At the end of the 19th century, in parallel to overcrowding of asylums and the decline of psychological approaches to mental disorders (Clark 1981), a rise in coercive practices was evident everywhere. England remained the only country where the mechanical restraints were seldom used and considered as inappropriate. The gradual inclusion of the care of the person with mental illness in the medical field had not been able to clear the issue of coercion, control and power away from the new science of psychiatry. Asylums in late nineteenth centuries became custodial institutions and when, almost one century later, the deinstitutionalization movement led to downsizing or closing the large mental hospitals, psychiatry still had to come to term with violent practices.

Violence Against Patients in Modern Psychiatric Settings

After the decline of non-restraint movement in late nineteenth century, the role of coercive measures in mental hospital care was taken for granted and their practice remained unchallenged all over the world for more than 70 years. However, despite their widespread use, papers addressing this issue are seldom found in the psychiatric literature until the 1970s. A reference to the index of the most influential American Psychiatric textbook, the mammoth *Comprehensive Textbook of Psychiatry* (Freedman et al. 1975), fails to find any entry under “Seclusion” or “Restraint”. Such topics are not mentioned at all in its 2,700 pages.

It is worth noting that the debate in the 1970s and 1980s saw the confrontations around 2 positions: were restraints and seclusion useful for the control of dangerous behaviors or were treatment modalities being part of the armamentarium of psychiatry. Gutheil (1978) presented in a widely quoted paper the theoretical bases of seclusion, claiming that, beyond its use to control violent behavior and to prevent patients to harm themselves or others, it was an effective treatment to reduce the sensory overload and to isolate patients from pathological relationships and paranoid interpretations. Grigson (1984) advocated the use of restraints to address patients’ maturational needs and to develop a treatment contract, by eliciting their participation in treatment. Critical views on coercive measures appeared more frequently in nursing journals than in psychiatric literature (Pilette 1978).

Modern studies on these contentious issues started in 1984, with the publication of a report by a task force of the American Psychiatric Association (Tardiff 1984). In 1985 the first review was published (Soloff et al. 1985), soon followed by many others (Angold 1989; Begin 1991; Brown and Tooke 1992; Fisher 1994). It was clear that freedom-restrictive interventions were common in any inpatient service,

including services for children (Cotton 1989) and new services conceived as alternatives to mental hospitals, such as the community mental health centers (Convertino et al. 1980).

The task force report and the paper by Soloff et al. (1985) were prompted by a 1982 US Supreme Court Decision, which gave to the clinicians the right to exercise professional judgment to use seclusion to control violent patients or even patients showing disruptive behaviors which could lead to violence. Therefore, the authors reviewed the empirical studies on restraint with the aim of providing data to support the decision-making by psychiatrists. They found only 13 studies conducted in various psychiatric inpatient settings and observed wide variation in incidence of seclusion or restraint, with high rates up to more than 50.0 % of patients secluded in acute care units. However, the most striking finding was that nonviolent disturbed behavior was the main reason leading to the decision to restrain patients.

Soon after the publication of the American Psychiatric Association report Elyn Saks, then staff attorney at Connecticut legal services, published a harsh critique of the use of mechanical restraints in the prestigious *Yale Law Journal* (Saks 1986). She had suffered from schizophrenia since few years before and had a direct experience of restraint. Despite her illness, that she later disclosed, she pursued a brilliant academic career, specializing in mental health law and reaching the position of professor of law, psychology and psychiatry at the University of Southern California Law School.

The authors of the first wave of modern reviews on restraints, almost exclusively based on British and American studies, shared the following conclusions:

- This was a still under researched area, plagued by lack of consensus on definitions and methods.
- Restraints and seclusion were widely used, but epidemiological data showed highly variable rates of patients exposed to such interventions.
- Local factors, such as cultural biases, staff role perceptions, and the attitude of the hospital administration, more than clinical characteristics of patients, had a greater influence on rates of restraint and seclusion.
- It was impossible to run a program for severely symptomatic individuals without some form of seclusion, physical or mechanical restraint.
- Restraint and seclusion had deleterious physical and psychological effects on patients and staff, and the psychiatric consumer movement, then a newcomer in the mental health scenario, emphasized these effects.

The last point was especially important, because, as observed by Fisher (1994), in the early 1990s the consumer movement started to give a new voice to criticisms of violent practices in psychiatric care. From 1990 to 1992 the US National Institute of Mental Health sponsored a series of meetings on alternatives to compulsory treatment, involving clinicians, consumers, family members and administrators. A report on the meetings noted with surprise that patients described the experience of restraint as similar to the experience of rape and physical abuse (Blanch and Parris 1992).

In the past 20 years refinements in epidemiological methods, more rigorous study designs and attention to the evidence-based approach produced relevant changes in psychiatric research. To what extent did such changes influence our knowledge of coercive and violent practices?

Through a careful review of the recent literature we identify the following trends:

- Multicenter studies confronting rates of coercive practices across countries (Raboch et al. 2010).
- Studies investigating restraints in large epidemiologically representative samples of people in contact with psychiatric services (Lay et al. 2011).
- Studies broadening the area of interest by investigating all traumatic and harmful experiences of patients in psychiatric settings (Frueh et al. 2005).
- Studies focused on the subjective experience of people who underwent coercive practices (Newton-Howes and Mullen 2011).
- Studies focused on strategies to reduce or eliminate coercive measures in psychiatric care (Scanlan 2010).
- Studies of professional attitudes toward restraint (van Doselaar et al. 2008).

The last update of quantitative data on seclusion and restraints in different countries has been provided by Steinert et al. (2010). The authors noted that, despite recent advances, epidemiologically sound data on this issue were scarcely available. Moreover, no information was available on low-income countries, with very few exceptions. Anecdotal reports from India showed that practice of restraint were widespread and approved by most clinicians (Khastgir et al. 2003).

The authors were able to present figures on rates of seclusion and restraint on all psychiatric admissions and on the annual number of coercive interventions per 100,000 inhabitants from 11 countries. Nationwide data were available from Norway, Finland and Iceland. Huge variations were evident: percentages of admissions exposed to coercive measures ranged from zero in Iceland to 36.0 % in Austria. Rates per 100,000 inhabitants were high in Austria and Germany and low in Japan, Finland and New Zealand. Iceland was the only country with a full non-restraint policy. No epidemiological data were available for the USA, due to the fragmentation of the US healthcare system.

Interesting data came also from the European EUNOMIA project, aimed at assessing the practice of coercive measures in 11 European countries (Raboch et al. 2010). The project assessed not only seclusion and restraint, but also forced medication. Overall, restraint was applied to 36.0 % of involuntary patients admitted during the first 4 weeks of admission in an index period of 18 months, seclusion to 8.0 % and forced medication to 56.0 %. Great variability across countries was observed, with a minimum of 21.0 % of patients experiencing coercion in Spain up to 59.0 % in Poland. Seclusion was used only in the United Kingdom and Italy, the use of restraint was very high in Greece. The authors concluded that coercion was used in a substantial group of involuntary admitted patients across countries and the differences in use across European countries mainly reflected differences in societal attitudes and clinical traditions. To some extent, high rates of coercion are

paralleled by high rates of involuntary hospital placement, such as in Austria, Finland and Germany (Salize and Dressing 2005).

Such differences are partly related to differences in professional attitudes: some studies showed that in countries with fairly high use of restraint professionals tend to believe in its usefulness. This is, for example, the case of psychiatrists in the Netherlands (van Doeselaar et al. 2008), by contrasts with their English peers (Gordon et al. 1999).

As previously said, a number of recent studies broadened the definition of violent practices by including all aspects of psychiatric care likely to induce harmful or traumatic experiences (Frueh et al. 2005), as suggested by early reports showing that even a number of routine clinical procedures in inpatients services were highly distressing for patients (Meyer et al. 1999). The term “sanctuary trauma” has been applied to events in psychiatric settings meeting the *DSM-IV* criteria for a traumatic event and the term “sanctuary harm” has been suggested for events that, although not meeting the full criteria for trauma, are nonetheless frightening or humiliating. Traumatic and harmful experiences can induce a post-traumatic stress disorder in people with mental disorders, especially because they have high lifetime rates of victimization and are therefore vulnerable to additional negative iatrogenic experiences (Grubaugh et al. 2011).

The largest and more rigorous study of harmful experiences in psychiatric care has been realized in the USA on a sample of randomly selected patients with severe mental disorders who attended a day hospital program (Frueh et al. 2005). Table 10.1 shows the percentage of people reporting a variety of harmful events experienced in any psychiatric service. Most events occurred many times, for example, handcuffed transport occurred almost 3.4 times, seclusion 4.0 times and so on. Stress related to such events often persisted for 1 week or more.

Such findings clearly show that psychiatric services are, at least for some group of patients, unsafe places where various types of violence are fairly common. The authors of this remarkable study noted that few empirical studies have examined in depth traumatic experiences and harmful practices in psychiatric care and concluded that their data support concerns raised to this respect by consumer and advocacy groups. Other studies show that the experience of coercion is commonly felt by patients as dehumanizing (Newton-Homes and Mullen 2011). This is an issue not only in inpatient or institutional care, but also in community-based services. Coercive aspects, such as the community outpatient commitment, have been recently introduced in community care (Salize and Dressing 2005) and some assertive outreach models may be perceived by users as intrusive forms of control (Watts and Priebe 2002).

In the previous years, clinicians and administrators focused on strategies for reduction of restraint and seclusion in psychiatric services. A recent review presents a hopeful picture, showing that it is possible to significantly reduce or eliminate such practices in a range of settings (Scanlan 2010). Although any development in this direction is welcome, the issue of coercion goes beyond this aspect. Violence looks still deeply intertwined with current psychiatric culture and practice. A reorientation of models underlying the social and scientific approaches to mental illness and its treatment is required to deal with this problem.

Table 10.1 Lifetime rates of violence experienced in a psychiatric setting by a random sample of psychiatric patients (N = 142) (Frueh et al. 2005)

Violence type	Rate (%)
Being handcuffed	65.0
Being placed in seclusion	59.0
Being put in restraint	34.0
Witnessing another patients being physically assaulted	25.0
Experiencing unwanted sexual advances	18.0
Experiencing physical assault	13.0
Witnessing another patient being sexually assaulted	7.0

Victimization of People with Mental Disorders

Historically, person with mental illness often have been perceived by the general public as violent and dangerous. This has been confirmed by recent surveys of general population attitudes towards mental disorders in many countries (Angermeyer and Dietrich 2006). Such negative views are often portrayed by the media and are shared, to some extent, by many healthcare professionals, at least as far as psychoses are concerned (Nordt et al. 2006). Moreover, there is evidence that beliefs did not change over the last decades and have not been influenced in a positive way, as expected by many psychiatrists, by neurobiological explanations of mental disorders (Pescosolido et al. 2010; Mehta et al. 2009). As a consequence much research has been produced on crimes by people with mental disorders, violent behavior in psychiatric services, treatment approaches to violent patients, risk to be assaulted for staff in psychiatric facilities and so on.

In recent years, however, the other side of the coin as well has become the focus of a growing attention, namely the risk for the person with mental illness to be victims of abuse and violence after the onset of their illness. The interest about this issue grew as a result of the downsizing of mental hospitals, with an increasing number of people with severe mental disorders spending most of their life outside psychiatric institutions. An early report from the USA on people discharged from mental hospitals to board and care homes in the 1980s showed that at least one third had been victim of crime in the preceding year (Lehman and Linn 1984).

Subsequent studies focused on domestic violence by partners or other family members, especially in women (Cascardi et al. 1996), and on criminal victimization in the community (Aldigé Hiday et al. 1999), and later adopted an epidemiological perspective by comparing the rates of victimization in person with mental illness with those of the general population.

Two recent reviews summarized the findings of the research study conducted in the last 20 years on criminal victimization outside home (Lovell et al. 2008; Maniglio 2009). Lovell et al. (2008) included in their review some studied showing lifetime rates of victimization, thus failing to differentiate between past history of violence as a risk factor for occurrence of mental disorders and violence against people with an already established illness. However, if we consider only the study

focused on recent victimization, despite some differences in assessment of study quality, definition of victimization and methodology to present the results, very similar conclusions can be drawn from both reviews.

Despite the heterogeneity of studies in term of sample characteristics, measures and analyses and considering that most studies come from the USA, rates of victimization for individuals with mental disorders are far greater than those of general population. Some variables raise the risk of becoming a victim: alcohol and substance abuse, severity of psychopathology, homelessness, and residence in a poor neighborhood, history of abuse in childhood or adolescence.

Table 10.2 presents the results of high quality studies using a rigorous epidemiological design, in which the comparison with a matched sample of general population in the same area allowed the authors to calculate both the absolute and relative risk of being subjected to violence in the recent past for people with severe mental disorders. All studies were included in the reviews, with the exception of the recent Swedish study (Sturup et al. 2011). The paper by Honkonen et al. (2004) is remarkable, because it reported data from a nationwide survey covering the whole population of Finland.

The North American studies reported the highest rates of victimization and the highest relative risks in comparison with the general population, showing that risks for the mentally are higher in a society, such as the USA, where exposure of population to crimes is fairly high, with 159.5 property crimes per 1,000 households and 24.6 violent crimes per 1,000 adults estimated in 2006 by the National Crime Victimization Survey (Rand and Catalano 2007). In Europe and Australia absolute risks are considerably lower, but relative risks between 2.3 and 5.7 point out that persons, with mental illness are a group in danger even in countries with low crime rates. Risk is high in relation to every type of crime, but especially for violent crimes. A recent national cohort study from Sweden examined the risk of people with mental disorder of being victim of the most extreme form of violence, i.e. homicide (Crump et al. 2013). Mortality rate due to homicide for adults in the period 2001–2008 was 2.8 per 100,000 person-years, representing a fivefold risk relative to people without mental disorders. The risk was increased not only for people with schizophrenia and other psychoses, but also for those with less severe disorders, such as anxiety and depression. The authors noted that in Sweden the homicide rate is relatively low (1.1 per 100,000 person-years), as in other European countries. In countries such as the USA, where rates are 6 times higher, findings on vulnerability of mentally to homicide could have a larger public health impact.

Two categories of violence deserve a special consideration: sexual violence in women and violence by a family member. Early surveys showed a very high risk of sexual assault for women with severe mental disorders. The results of one of the first studies addressing this issue led the authors to conclude that the risk for sexual violence in homeless women with mental illness was so high as to amount to a normative experiences for this population: 30.0 % had been recently assaulted, 15.0 % in the last month (Goodman et al. 1995). Further studies showed that such experiences were to some extent shared by women with less serious disorders living in normal households in various countries. In Brazil, 27.0 % of women with a variety of mental disorders reported sexual violence (Nunes de Oliveira et al. 2012), in India,

Table 10.2 Recent epidemiological studies on risk of victimization by people with mental disorders

Country	Author	Time frame	Absolute risk (%)	Relative risk
USA	White et al. (2006)	6 months	25.6	10.3
USA	Goodman et al. (2001)	1 year	36.7	10
USA	Teplin et al. (2005)	1 year	25.3	11.8
Finland	Honkonen et al. (2004)	3 year	5.6	3.3
Sweden	Sturup et al. (2011)	1 year	20.0	5.7
England	Walsh et al. (2003)	1 year	16.0	2.3
Australia	Chapple et al. (2004)	1 year	17.9	3.5

16.0 % of female psychiatric inpatients had experienced sexual abuse by a partner (Chandra et al. 2003), in the USA, 32.0 % of a sample of female psychiatric patients had experienced partner sexual abuse, 7.0 % in the past year (Chang et al. 2011). It is worth noting that the Brazilian study by Nunes de Oliveira et al. (2012) reported that even men with mental illness can be subjected to sexual abuse, albeit to a lesser extent with respect to women (13.0 % vs 27.0 %). The authors observed that men were more often abused in the streets and women at home.

Domestic violence has been the focus of a recent thorough systematic review (Oram et al 2013). The authors located 42 studies from 11 countries meeting their inclusion criteria (Australia, Austria, Canada, Finland, India, Portugal, South Africa, Turkey, United Kingdom, and United States of America). However, two-third of studies came from the USA. Thirty-five studies reported lifetime prevalence rates and found a median rate around 30.0 % among female patients. Prevalence among men was assessed only by 1 study, reporting a rate of 32.0 %. However, although most studies examined adult lifetime violence, thus excluding events in childhood and adolescence, the possibility that in some cases violence predated the onset of mental disorder cannot be ruled out. Therefore, past year prevalence, reported by 7 studies represents a more conservative estimate of victimization experienced by the person with mental illness. Rates found in good quality studies clustered around 20.0 % among women for intimate partner physical violence. Fewer data were available for men or for violence by other family members. Overall, this review highlighted the high prevalence rates of domestic violence among people using psychiatric services. However, this is still an area where research is lagging behind, despite recent efforts in last years, and the quality of most studies was considered as low by the authors. Although most studies provided higher estimates than have been reported for the general population, no study included controls representative of the general population, by contrast with studies on community violence, thus preventing to quantify the extent to which person with mental illness are at greater risk of being victims of violence by family members.

Conclusion

At the end of this review we can conclude that it is clear that violence and abuse experienced by people with mental disorders within psychiatric services and in the community should be a major public health concern. However, although we know the deleterious impact of violence on the course and outcome of mental disorders (Grubaugh et al. 2011), little attention has been paid so far to this issue by clinicians, researchers and policymakers. This lack of interest is reflected by the scarcity of high quality research addressing this topic, in sharp contrast with the investigations focused on violence perpetrated by the person with mental illness. Moreover, we know almost nothing on the extent of this problem outside the Western countries. Some data are available from India, Brazil and South Africa, but I am not aware of any study on this topic from China or other large countries.

Few years ago, Choe et al. (2008) reviewed empirical studies realized in the USA since 1990 with the aim of weighing the relative public health impact of both violence perpetration and victimization among people with severe mental disorders. They found more than 30 studies of perpetration and only 10 of victimization. Few studies examined both aspects in the same samples. However, studies of comparable populations showed rates between 12 and 22.0 % of perpetration, by contrast with rates of 30–35.0 % of victimization. As a consequence, the authors suggest that victimization should be a greater public health concern than perpetration.

Moreover, we know that routine psychiatric examination often fails to detect experiences of violence and abuse, unless probes focused on this issue are used (Chang et al. 2011). Therefore, it is likely that victimization of person with mental illness is underreported and underestimated. Hopefully, the growth of the consumers' movement might help to provide an impetus to address causes, features and consequences of this phenomenon.

It is our responsibility, as scientists and practitioners, to do our best to raise the awareness of the professionals and the lay public of this very simple fact: the person with mental illness are much more a vulnerable than a dangerous social group. A change in attitude in this direction could have a deep impact on practice of mental health care and on social consideration of the needs of people with mental disorders.

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