ORIGINAL ARTICLE

International Journal of Risk and Recovery
EST. 2017

Beyond the Myths: Exploring the Complex Relationship Between Mental Disorders and Violence

Mini Mamak,[1,2] Gary Chaimowitz[1,2]

[1] McMaster University, Department of Psychiatry and Behavioural Neurosciences, Hamilton, Canada; [2] St. Joseph's Healthcare Hamilton, Forensic Psychiatry Program, Hamilton, Canada

This paper explores and challenges three enduring misconceptions related to mental illness: that individuals with psychiatric conditions are prone to violence, that their behaviour is unpredictable and cannot be managed, and that people involved with the legal system are beyond rehabilitation. These beliefs — though widespread — are unsupported by current evidence and contribute to stigma and fear. The paper examines the complex interplay between mental illness and violence, noting that specific risk factors, rather than diagnoses alone, are most predictive. It also outlines advancements in structured risk assessment tools that enhance reliability and reduce bias. Rehabilitation is addressed through evidence-based models, highlighting the capacity of legally involved individuals with mental illness to respond to treatment and reintegrate successfully. Rather than focusing solely on media influence, this paper emphasizes the need for professionals in forensic psychiatry and mental health to actively dispel myths through public education, policy input, and ethical practice. Promoting an accurate, compassionate understanding of mental illness is not only a clinical necessity but a societal responsibility — critical to reducing stigma and improving outcomes for impacted individuals.

Key Words: *violence, mental disorders, rehabilitation*

In its various forms, the media has long shaped public perception. With the introduction of the internet and the development of social media platforms and streaming services, the public has little reprieve from this influence. Unfortunately, these platforms have become the main pathway of information dissemination. In turn, the messaging on these platforms has shaped public perceptions about various topics, including mental disorders, violence, and criminal behaviour. With a focus on sensational and extreme cases, the public has come to view individuals diagnosed with a major mental disorder as inherently violent and dangerous, and as people to be feared and avoided (Carmichael et al., 2019; McGinty et al., 2016; McKenna et al., 2007; Stout et al., 2004; Wahl, 1992). These perceptions contribute to the stigmatization already faced by individuals diagnosed with a major mental disorder and have had significant impact on the development of mental health policies, justice reform, and mental health law. Unfortunately, there is little discussion on these platforms that corrects these myths or misperceptions. Rather, these platforms use algorithms to highlight negative or sensational news stories and events to boost readership and commercial output (Metzler & Garcia, 2024).

It is incumbent on people working in the forensic field to educate the media, public, and policy makers to change the discussion and understanding of the associations between mental disorders, criminal conduct, and dangerousness. Consequently, this paper strives to dispel three common myths.

- Individuals with mental disorders are violent and dangerous.
- Individuals with mental disorders are unpredictable, so it is impossible to predict violence.
- Legally involved individuals who suffer from a mental disorder cannot be rehabilitated and should not be released into the community.

Myth 1: Individuals with mental disorders are violent and dangerous.

Before we discuss this myth, remember that individuals diagnosed with a mental disorder are at a much greater risk of being victims of violence than perpetrators of it (de Waal et al., 2018; Elbogen & Johnson, 2009; Harris et al., 2020; Langeveld et al., 2018; Latalova et al., 2014).

Understanding the link between major mental disorders and violence has long been debated but has evolved over the past two to three decades. Early in the study of the association, researchers proposed that the factors that contributed to violence were shared between people with and without a mental disorder (Monahan, 1992). However, others have argued that there was indeed an association between mental disorder and the demonstration of violence (Krakowski & Czobor, 1994; Link & Stueve, 1994) and that people with a mental disorder were more likely to act out aggressively.

In recent years, a clearer understanding of the association between mental disorders and violence has emerged. It is now recognized that while an association exists, it is dependent on the specific mental disorder, its presentation, and the presence or absence of psychosocial factors, such as adverse childhood experiences, traumatic experiences, personal and professional supports, and problematic substance use (Douglas et al., 2009). It is also dependent on individual factors, such as personality variables, emotion regulation skills, and neurocognitive factors. Unpacking the factors associated with violence for individuals diagnosed with a mental disorder is a critical skill for people tasked to assess and ultimately provide treatment to this population.

Today, the leading consensus is that certain symptoms or constellation of symptoms can increase the risk of violence for individuals diagnosed with a mental disorder. Individuals demonstrating paranoid delusions, command hallucinations, and disorganized thinking are particularly vulnerable to acting out aggressively (Coid et al., 2013; Keers et al., 2014; McNeil et al., 2000; Nederlof et al., 2011; Patel et al., 2019). The experience of delusions, hallucinations, and thought disorder are the hallmark symptoms of psychosis. While such symptoms are most frequently observed in individuals diagnosed with schizophrenia, they are also symptoms experienced by individuals diagnosed with bipolar mood disorder. The experience of delusions is the key feature for individuals diagnosed with delusional disorder (American Psychiatric Association, 2022).

While an individual experiencing psychosis can hold delusional beliefs about various themes, it is the experience of paranoid beliefs that is most frequently associated with violence. Frequently referred to as persecutory delusions, paranoid delusions are false fixed beliefs about one's life or one's being in danger, typically by external forces, such as other individuals, government agencies, or unworldly forces (Jones et al., 2020; Lemonde et al., 2021). Acts of aggression perpetrated by individuals suffering from such symptoms typically intended to protect themselves or loved ones from harm. From the individual's perspective, the aggression is a defensive reaction, justified in the context of the perceived threat.

On the other hand, hallucinations are false sensory experiences. Hallucinations can be experienced in any of the five sensory modalities, but auditory hallucinations (hearing voices or things) are most commonly experienced (Hugdahl et al., 2008; Waters & Fernyhough, 2017). About 75% of individuals diagnosed with schizophrenia experience auditory hallucinations (Thakur & Gupta, 2023). Command hallucinations refer to the experience of voices that direct the actions of the person experiencing them. While the commands are benign for most individuals who experience command hallucinations, the commands can be more problematic and will direct some individuals to harm themselves or another person. The experience of such commands increases the risk of violence. In their study, Dugré & West (2019) found that in a sample of individuals who experienced command hallucinations, just over half experienced voices that were malevolent, about a third experienced voices described as benevolent, and a smaller percentage (3%) experienced both. Shawyer et al., (2003) found that about one in three individuals reported that they have complied with harmful command hallucinations. However, varying rates of compliance with harmful command hallucinations have been found in the extant literature (Dugré & West, 2019; Shawyer et al., 2008). As detailed in a review by Dugré & West (2019), reports range from 15% to 90%, with somewhat higher rates of compliance reported for command hallucinations about harming others (Barrowcliff & Haddock, 2010; Fox et al., 2004; Kasper et al., 1996) compared with those about self-harm (Barrowcliff & Haddock, 2010; Dugré et al., 2018; Fox et al., 2004; Harkavy-Friedman et al., 2003; Kasper et al., 1996).

Disorganized thinking is also a potential symptom that individuals diagnosed with schizophrenia

may experience. Disorganized thinking disrupts the individual's ability to process thoughts in a logical and coherent manner. Consequently, disorganized thinking can impact an individual's capacity for language and speech processing, reasoning, decision-making, and problem solving (Bora et al., 2019; Silva et al., 2021). Understandably, when one's thinking process is disrupted in such a manner, they become confused, misread the actions of others, or struggle to make sense of what is happening around them. This in turn can lead to an individual acting out aggressively.

Each of these symptoms increases the risk of violence for individuals suffering from a mental disorder. However, as stated at the outset, individuals diagnosed with a mental disorder are much more likely to be victims of violence than perpetrators. In Ontario, when someone with a mental disorder commits a criminal offence, they may be sent to a specialized hospital for an assessment of criminal responsibility. Section 16 of the Canadian *Criminal Code* specifies that:

> *no person is criminally responsible for an act committed or an omission made while suffering from a mental disorder that rendered the person incapable of appreciating the nature and quality of the act or omission or of knowing that it was wrong.*
>
> (*Criminal Code,* RSC 1985, c. C-46, s.672.81)

Thus, not every person with a mental disorder will be found not criminally responsible (NCR). Individuals who receive an NCR verdict will enter the forensic psychiatry system and be under the jurisdiction of a provincial or territorial review board (e.g., Ontario Review Board). In contrast to the correctional system, there is no predetermined length of sentence for individuals in the forensic psychiatry system. Rather, the review boards review the status of every person found NCR annually (Criminal Code, RSC 1985, c. C-46, s.672.81).

In addition to delusions, hallucinations, and disorganized thinking, factors that contribute to the expression of violence in the general population also increase risks for individuals diagnosed with a major mental disorder. Problematic substance use, antisocial personality disorder, poor emotion regulation skills, and poor impulse control also contribute to the risk of violence for this population (Andrews & Bonta, 2010; Cohn et al., 2010; Donahue et al., 2014; Douglas et al., 2013; Iozzino et al., 2015; Witt et al., 2013).

Myth 2: Individuals with mental disorders are unpredictable, so, it is impossible to predict violence.

Predicting violence is indeed a difficult task. However, as our understanding of the link between mental disorder and violence has evolved through research, so too has our ability to make reasonable risk predictions following formal study of risk assessment methods. In a similar trajectory as described previously in this article, there have been significant gains made in risk prediction over the past two to three decades.

Before the 1990s, clinicians employed what we now refer to as clinical judgment to form an opinion about someone's risk. These decisions were made based on clinical impressions of an individual. Early research into this method determined that the clinical judgment approach was not very accurate, and that such risk predictions were no better than chance (Ægisdóttir et al., 2006; Cocozza & Steadman, 1976).

In response, researchers began to formally examine the factors that contributed to violent behaviour by way of a prospective approach (following people on release from detention and watching what happens) and retrospective analyses (looking back at factors that may have impacted behaviour). Because of this research, a clearer picture emerged as to the primary factors that increased someone's risk to act out violently. From this, the risk assessment field emerged, and various risk assessment strategies were developed to assist clinicians in assessing someone's risk of violence.

It is well understood that there are several factors that increase or decrease a person's risk of acting out violently. These factors can either be static (i.e., do not change over time), stable (i.e., factors that endure but can change over months or years), or dynamic (i.e., can change rapidly depending on situation, emotional state, or treatment response).

Static factors are typically historical factors that cannot be changed. History of violence is a particularly important static risk factor because understanding how someone has behaved in the past helps us predict what they are likely to do in the future (Douglas et al., 2013; Witt et al., 2013). Examining static risk factors improves our ability to make long-term risk estimates.

Stable risk factors can change over months or years. Our personality (i.e., how we solve problems, behave, and interact with the world) is considered a stable factor because, although it is generally stable, certain aspects of personality

can be impacted by maturation and the aging process, learning from experience, and even treatment (Davies et al., 2023; Douglas & Skeem, 2005).

Dynamic risk factors can change more rapidly. Changes in these risk factors can serve to quickly increase someone's risk to act out violently. Examples of dynamic risk factors include the consumption of drugs or alcohol, anger response, or even the discontinuation of psychiatric medications. Monitoring and assessing dynamic factors help to inform opinions about someone's short-term risk (Greer et al., 2020; Johnson et al., 2016).

As stated, the development of risk measures has significantly improved our ability to make predictions about risk. That said, while our ability to make predictions about risk has improved, we are not yet able to make risk predictions with 100% certainty. Risk is complex and impacted by a host of factors, both internal and external to an individual. However, the field continues to evolve, so it is hoped that our ability to be more accurate in our risk determinations will also continue to advance.

Myth 3: Legally involved individuals who suffer from a mental disorder cannot be rehabilitated and should not be released into the community.

There is typically a great public outcry in response to the release of someone who has committed a violent offence. This outcry is louder and more pronounced when it involves the release of someone with a major mental disorder who has committed a violent offence and has been held in a forensic psychiatric environment (Markham, 2024). Misconceptions about the rehabilitation pathway for individuals in the forensic psychiatric system contribute to the perpetuation of stigma.

Rehabilitation is a key focus in all forensic and correctional settings. Addressing risk factors, building skills, improving daily functioning, and directing individuals toward leading meaningful and prosocial lives are all components of rehabilitation in such settings (Bredenoort et. al., 2022). In recent decades, the perception of recovery in these settings has also moved beyond focusing solely on the alleviation of symptoms. The risk-need-responsivity (RNR) model has contributed to this shift and has been an influential model in assessing and rehabilitating of legally involved individuals (Andrews & Bonta, 2010; Andrews, Bonta, & Hoge, 1990).

The core principles of the RNR model guide interventions and treatments for legally involved individuals toward ensuring that the level of service provided is matched to the individual's level of recidivism risk (i.e., Risk principle), and that criminogenic needs are assessed and targeted at the individual level (i.e., Need principle) (Andrews, Bonta, & Hoge, 1990). The last core principle of the RNR model proposes that to maximize a legally involved individual's rehabilitation and their ability to learn from interventions treatments need to be modified to correspond to the individual's learning style, motivation, abilities, and strengths (i.e., Responsivity principle) (Andrews, Bonta, & Hoge, 1990).

The shift toward a more holistic view of recovery, exemplified by approaches like the RNR model, underscores that rehabilitation must be tailored to each individual. Every person has unique goals, values, and strengths, and effective rehabilitation recognizes and addresses these personal differences to foster more meaningful and lasting progress.

Previous literature has highlighted that individuals in the forensic psychiatry system tend to have lower rates of recidivism compared with their correctional counterparts. In a study by Fazel and colleagues (2016) in which forensic psychiatry populations were matched with correctional populations to adjust for some confounding variables, such as differing legislation across countries, forensic psychiatry patients continued to have lower rates of recidivism. However, the existing evidence has also highlighted that in comparison with correctional populations, those in the forensic psychiatry system were often detained longer, were subject to more interventions, and were more likely to be involved in care after release (Bengtson et al., 2019).

While still a growing area of empirical inquiry, there is increasing evidence demonstrating the effectiveness of rehabilitative interventions for justice-involved populations. Indeed, following the core principles of the RNR model in the application of interventions has been found to reduce various types of reoffending (Andrews & Bonta, 2010; Dowden & Andrews, 2000). In a meta-analysis including 68 studies and 55,604 individuals, Gannon and colleagues (2019) found that involvement in specialized psychological treatments significantly lowered recidivism rates in legally involved populations. The extant literature has also demonstrated that interventions with violent justice-involved individuals were effective in reducing both general and violent recidivism. Jolliffe and Farrington (2007) also found that interventions addressing cognitive skills and with longer durations or longer session durations increased the overall effectiveness.

In addition to the shift in how we view recovery, there has also been a dispelling of the notion that providing psychiatric treatment and reducing symptoms alone will reduce justice involvement. Indeed, in conjunction with the RNR model, increased emphasis is being placed on including treatment services for individuals in the criminal justice system with mental disorders that focuses on reducing recidivism (Skeem et al., 2015).

There has long been a perception of a link between mental disorder and violence. Misperceptions about the strength of this link have the potential to be accentuated and distorted through social media. Conversely there are opportunities to use social media to educate the public and to dispel myths about mental illness and its association with violence.

Given the persistence of stigma about mental illness, it is imperative that education and dispelling of myths be both active and ongoing. There are treatments for mental illnesses. There are means to predict future violence. People with a history of mental illness and violence can be successfully reintegrated into the community.

Unfortunately, mental illness affects a large portion of the population, either directly or indirectly. As a society, we must prioritize increasing resources for those impacted by mental health conditions — not only in terms of treatment but, more importantly, also prevention. It is crucial to advocate for increased funding for research, education, and the enhancement of clinical psychiatric services. By doing so, we can build a more proactive and effective approach to mental health, ensuring that individuals receive the support they need before crises arise.

Summary

This paper emphasized the importance of challenging prevalent misconceptions about mental illness — especially those concerning associations with violence, the accuracy of risk assessments, and the potential for rehabilitation. These misconceptions, though persistent, lack empirical support and contribute to stigma that negatively affects both individuals and communities. Promoting accurate, evidence-based understanding is essential to building a more compassionate and informed approach to mental health and justice.

Advancements in risk prediction, treatment strategies, and rehabilitation models such as the RNR model provide evidence that individuals with mental disorders can successfully be treated, rehabilitated, and reintegrated into the community. It is essential that education and awareness campaigns continue to challenge these misconceptions and emphasize that mental illness does not equate to dangerousness.

Ultimately, addressing the stigma associated with mental illness requires active and ongoing efforts, including investment in mental health resources, prevention programs, and continued research. By improving access to quality care and ensuring informed public discussions, we can not only reduce stigma but also create a society better equipped to support individuals living with mental health challenges.

References

Ægisdóttir, S., White, M. J., Spengler, P. M., Maugherman, A. S., Anderson, L. A., Cook, R.S., … Rush, J. D. (2006). The meta-analysis of clinical judgment project: Fifty-six years of accumulated research on clinical versus statistical prediction. *The Counseling Psychologist, 34*(3), 341–382. https://doi.org/10.1177/0011000005285875

American Psychiatric Association. (2022). *Diagnostic and statistical manual of mental disorders* (5th ed., text rev.). https://doi.org/10.1176/appi.books.9780890425787

Andrews, D., & Bonta, J. (Eds.). (2010). The Psychology of Criminal Conduct (5th Edition ed.). New Providence, NJ: Matthew Bender & Company, Inc., LexisNexis Group.

Andrews, D. A., Bonta, J., & Hoge, R. D. (1990). Classification for effective rehabilitation: Rediscovering psychology. *Criminal Justice and Behavior, 17*(1), 19–52. https://doi.org/10.1177/0093854890017001004

Barrowcliff, A. L., & Haddock, G. (2010). Factors affecting compliance and resistance to auditory command hallucinations: Perceptions of a clinical population. *Journal of Mental Health, 19*(6), 542–552. https://doi.org/10.3109/09638237.2010.520365

Bora, E., Yalincetin, B., Akdede, B. B., & Alptekin, K. (2019). Neurocognitive and linguistic correlates of positive and negative formal thought disorder: A meta-analysis. *Schizophrenia Research, 209,* 2–11. https://doi.org/10.1016/j.schres.2019.05.025

Bredenoort, M., Roeg, D. P. K., & van Vugt, M. D. (2022). A shifting paradigm? A scoping review of the factors influencing recovery and rehabilitation in recent forensic research. I*nternational Journal of Law and Psychiatry, 83*, Article 101812. https://doi.org/10.1016/j.ijlp.2022.101812

Carmichael, V., Adamson, G., Sitter, K.C., & Whitley, R. (2019). Media coverage of mental illness: A comparison of citizen journalism vs. professional journalism portrayals. *Journal of Mental Health 28*(5), 520–526. https://doi.org/10.1080/09638237.2019.1608934

Cocozza, J. J., & Steadman, H. J. (1976). The failure of psychiatric predictions of dangerousness: clear and convincing evidence. *Rutgers Law Review, 29*(5), 1084–1101.

Cohn, A. M., Jakupcak, M., Seibert, L. A., Hildebrandy, T. B., & Zeichner, A. (2010). The role of emotion dysregulation in the association between men's restrictive emotionality and use of physical aggression. *Psychology of Men and Masculinity, 11*(1), 53–64. https://doi.org/10.1037/a0018090

Coid, J. W., Ullrich, S., Kallis, C., Keers, R., Barker, D., Cowden, F., & Stamps, R. (2013). The relationship between delusions and violence: Findings from the East London First Episode Psychosis Study. *JAMA Psychiatry, 70*(5), 465–471. https://doi.org/10.1001/jamapsychiatry.2013.12

Criminal Code, RSC 1985, c. C-46, s.16. https://laws-lois.justice.gc.ca/eng/acts/c-46/section-16.html

Criminal Code, RSC 1985, c. C-46, s.672.81. https://laws-lois.justice.gc.ca/eng/acts/c-46/section-672.81.html

Davies, S. T., Lloyd, C. D., & Polaschek, D. L. L. (2023). Do some dynamic risk factors signal imminent recidivism? Testing the conceptual distinction between stable and acute dynamic risk factors. Criminal Justice and Behavior, 50(8), 1120-1139. https://doi.org/10.1177/00938548231174903

de Waal, M. M., Christ, C., Dekker, J. J. M., Kikkert, M. J., Lommerse, N. M., van den Brink, W., & Goudriaan, A. E. (2018). Factors associated with victimization in dual diagnosis patients. *Journal of Substance Abuse Treatment, 84*, 68–77. https://doi.org/10.1016/j.jsat.2017.11.001 Donahue, J. J., Goranson, A. C., McClure, K. S., & Van Male, L. M. (2014). Emotional dysregulation, negative affect, and aggression: A moderated, multiple mediator analysis. *Personality and Individual Differences, 70*, 23–24. https://doi.org/10.1016/j.paid.2014.06.009

Douglas, K. S., Guy, L. S., & Hart, S. D. (2009). Psychosis as a risk factor for violence to others: A meta-analysis. *Psychological Bulletin, 135*(5), 679–706. https://doi.org/10.1037/a0016311

Douglas, K. S., Hart, S. D., Webster, C. D., & Belfrage, H. (2013). *Historical-Clinical-Risk Management-20, Version 3 (HCR-20 V3) Manual*. Burnaby, Canada: Mental Health, Law, and Policy Institute, Simon Fraser University. https://protect-international.com/product/historical-clinical-risk-management-20-version-3-hcr-20-v3-manual/

Douglas, K. S., & Skeem, J. L. (2005). Violence risk assessment: Getting specific about being dynamic. *Psychology, Public Policy, and Law, 11*(3), 347–383. https://doi.org/10.1037/1076-8971.11.3.347

Dowden, C., & Andrews, D. A. (2000). Effective correctional treatment and violent reoffending: A meta-analysis. *Canadian Journal of Criminology, 42*(4), 449–467. https://doi.org/10.3138/cjcrim.42.4.449

Dugré, J. R., Guay, J. P., & Dumais, A. (2018). Risk factors of compliance with self-harm command hallucinations in individuals with affective and non-affective psychosis. *Schizophrenia Research, 195*, 115–121. https://doi.org/10.1016/j.schres.2017.09.001

Dugré, J. R., & West, M. L. (2019). Disentangling compliance with command hallucinations: Heterogeneity of voice intents and their clinical correlates. *Schizophrenia Research, 212,* 33–39. https://doi.org/10.1016/j.schres.2019.08.016

Elbogen, E. B., & Johnson, S. C. (2009). The intricate link between violence and mental disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 66*(2), 152–161. https://doi.org/10.1001/archgenpsychiatry.2008.537

Fazel, S., Wolf, A., Fimińska, Z., & Larsson, H. (2016). Mortality, rehospitalisation and violent crime in forensic psychiatric patients discharged from hospital: Rates and risk factors. *PloS One, 11*(5), Article e0155906. https://doi.org/10.1371/journal.pone.0155906

Fox, J. R. E., Gray, N. S., & Lewis, H. (2004). Factors determining compliance with command hallucinations with violent content: The role of social rank, perceived power of the voice and voice malevolence. *The Journal of Forensic Psychiatry and Psychology, 15*(3), 511–531. https://doi.org/10.1080/1478994042000226741

Gannon, T. A., Olver, M. E., Mallion, J. S., & James, M. (2019). Does specialized psychological treatment for offending reduce recidivism? A meta-analysis examining staff and program variables as predictors of treatment effectiveness. *Clinical Psychology Review, 73*, Article 101752. https://doi.org/10.1016/j.cpr.2019.101752

Greer, B., Taylor, R. W., Cella, M., Stott, R., & Wykes, T. (2020). The contribution of dynamic risk factors in predicting aggression: A systematic review including inpatient forensic and non-forensic mental health services. *Aggression and Violent Behavior, 53*, 101433. https://doi.org/10.1016/j.avb.2020.101433

Harkavy-Friedman, J. M., Kimhy, D., Nelson, E. A., Venarde, D. F., Malaspina, D., & Mann, J. J. (2003). Suicide attempts in schizophrenia: the role of command auditory hallucinations for suicide. *The Journal of Clinical Psychiatry, 64*(8), 871–874. https://www.psychiatrist.com/jcp/suicide-attempts-schizophrenia-role-command-auditory/

Harris, M. N., Baumann, M. L., Teasdale, B., & Link, B. G. (2020). Estimating the relationship between perceived stigma and victimization of people with mental illness. *Journal of Interpersonal Violence, 37*(3-4), NP1226–NP1252 https://doi.org/10.1177/0886260520926326

Hugdahl, K., Løberg, E.-M., Specht, K., Steen, V. M., van Wageningen, H., & Jørgensen, H. A. (2008). Auditory hallucinations in schizophrenia: The role of cognitive, brain structural and genetic disturbances

in the left temporal lobe. *Frontiers in Human Neuroscience, 1,* Article 6. https://doi.orb/10.3389/neuro.09.006.2007

Iozzino, L., Ferrari, C., Large, M., Nielssen, O., & de Girolamo, G. (2015). Prevalence and risk factors of violence by psychiatric acute inpatients: A systematic review and meta-analysis. *PLoS One, 10*(6), Article e0128536. https://doi.orb/10.1371/journal.pone.0128536

Johnson, K. L., Desmarais, S. L., Grimm, K. J., Tueller, S. J., Swartz, M. S., & Van Dorn, R. A. (2016). Proximal risk factors for short-term community violence among adults with mental illnesses. *Psychiatric Services, 67*(7), 771–778. https://doi.org/10.1176/appi.ps.201500259

Jolliffe, D., & Farrington, D. P. (2007, December). *A systematic review of the national and international evidence on the effectiveness of interventions with violent offenders*. Series 16/07. London: Ministry of Justice Research.

Jones, A., Read, J., & Wood, L. (2020). A retrospective case study of the thematic content of psychotic experiences in a first episode psychosis population. *Journal of Mental Health, 30(4),* 509–517. https://doi.org/10.1080/09638237.2020.1755024

Kasper, M. E., Rogers, R., & Adams, P. A. (1996). Dangerousness and command hallucinations: An investigation of psychotic inpatient. *The Bulletin of the American Academy of Psychiatry and the Law, 24*(2), 219–224.

Keers, R., Ullrich, S., DeStavol, B. L., & Coid, J. W. (2014). Association of violence with emergence of persecutory delusions in untreated schizophrenia. *The American Journal of Psychiatry, 171*(3), 332–339. https://doi.org/10.1176/appi.ajp.2013.13010134

Krakowski, M. I., & Czobor, P. (1994). Clinical symptoms, neurological impairment, and prediction of violence in psychiatric inpatients. *Hospital and Community Psychiatry, 45*(7), 700–705. https://doi.org/10.1176/ps.45.7.700

Langeveld, J., Bjørkly, S., Evensen, J., Joa, I., Johannessen, J. O., Larsen, T. K., … Friis, S. (2018). A 10-year follow-up study of violent victimization in first episode psychosis: Risk and protective factors. *Psychiatry Research, 259*, 545–549. https://doi.org/10.1016/j.psychres.2017.11.013

Latalova, K., Kamaradova, D., & Prasko, J. (2014). Violent victimization of adult patients with severe mental illness: A systematic review. *Neuropsychiatric Disease and Treatment, 10,* 1925–1939. https://doi.org/10.2147/NDT.S68321

Lemonde, A. C., Joober, R., Malla, A., Iyer, S. N., Lepage, M., Boksa, P., & Shah, J. L. (2021). Delusional content at initial presentation to a catchment-based early intervention service for psychosis. *The British Journal of Psychiatry, 218*(4), 217–223. https://doi.org/10.1192/bjp.2020.157

Link, B. G., & Stueve, A. (1994). Psychotic symptoms and the violent/illegal behavior of mental patients compared to community controls. In J. Monahan & H. J. Steadman (Eds.), *Violence and mental disorder: Developments in risk assessment* (pp. 137–159). The University of Chicago Press. https://press.uchicago.edu/ucp/books/book/chicago/V/bo3684057.html

Markham, S. (2024). Stigmatization and marginalization of forensic psychiatric patients. *Illness, Crisis & Loss, 0*(0). https://doi.org/10.1177/10541373241268095

McGinty, E.E., Kennedy-Hendricks, A., Choksy, S., Barry, C. L. (2016). Trends in news media coverage of mental illness in the United States: 1995–2014. *Health Affairs, 35*(6), 1121–1129. https://doi.org/10.1377/hlthaff.2016.0011

McKenna, B., Thom, K., Simpson, A. (2007). Media coverage of homicide involving mentally disordered offenders: A matched comparison study. *International Journal of Forensic Mental Health 6(1)*, 57–63. https://doi.org/10.1080/14999013.2007.10471249

McNeil, D. E., Eisner, J. P., & Binder, R. L. (2000). The relationship between command hallucinations and violence. *Psychiatric Services, 51*(1), 1288–1292. http://dx.doi.org/10.1176/appi.ps.51.10.1288

Metzler, H., & Garcia, D. (2024). Social drivers and algorithmic mechanisms on digital media. *Perspectives on Psychological Science*, *19*(5), 735–748. https://doi.org/10.1177/17456916231185057

Monahan, J. (1992). Mental disorder and violent behavior: Perceptions and evidence. *American Psychologist, 47*(4), 511–521. https://doi.org/10.1037/0003-066X.47.4.511

Nederlof, A. F., Muris, P., & Hovens, J. E. (2011). Threat/control-override symptoms and emotional reactions to positive symptoms as correlates of aggressive behavior in psychotic patients. *The Journal of Nervous and Mental Disease, 199*(5), 342–347. https://doi.org/10.1097/NMD.0b013e3182175167

Patel, A. H., Barot, C, Vankar, G., & Pal, S. (2019). Acting on delusions in patients suffering from schizophrenia. *Archives of Psychiatry and Psychotherapy, 21*(4), 52–61. https://doi.org/10.12740/APP/109009

Shawyer, F., Mackinnon, A., Farhall, J., Sims, E., Blaney, S., Yardley, P., … Copolov, D. (2008). Acting on harmful command hallucinations in psychotic disorders: an integrative approach. *The Journal of Nervous and Mental Disease, 196*(5), 390–398. https://doi.org/10.1097/NMD.0b013e318171093b

Shawyer, F., Mackinnon, A., Farhall, J., Trauer, T., & Copolov, D. (2003). Command hallucinations and violence: Implications for detention and treatment. *Psychiatry, Psychology, and Law, 10*(1), 97–107. https://doi.org/10.1375/pplt.2003.10.1.97

Silva, A., Limongi, R., Mackinley, M., & Palaniyappan, L. (2021). Small words that matter: Linguistic style and conceptual disorganization in untreated first-episode schizophrenia. *Schizophrenia Bulletin*

Open, 2(1). Article sgab010. https://doi.orb/10.1093/schizbullopen/sgab010

Skeem, J. L., Steadman, H. J., Manchak, S. M. (2015). Applicability of the Risk-Needs-Responsivity Model to persons with mental illness involved in the criminal justice system. *Psychiatric Services, 66(9),* 916–922. https://doi.org/10.1176/appi.ps.201400448

Stout, P. A., Villegas, J., & Jennings, N. A. (2004). Images of mental illness in the media: Identifying gaps in the research. *Schizophrenia Bulletin, 30*(3), 543–561. https://doi.org/10.1093/oxfordjournals.schbul.a007099

Thakur T., & Gupta V. (2023). Auditory hallucinations. In StatPearls [Internet]. Treasure Island, United States: StatPearls Publishing. https://www.ncbi.nlm.nih.gov/books/NBK557633/

Wahl, O. F. (1992). Mass media images of mental illness: A review of the literature. *Journal of Community Psychology 20*(4), 343–352. https://doi.org/10.1002/1520-6629(199210)20:4<343::AID-JCOP2290200408>3.0.CO;2-2

Waters, F., & Fernyhough, C. (2017). Hallucinations: A systematic review of points of similarity and difference across diagnostic classes. *Schizophrenia Bulletin, 43*(1), 32–43. https://doi.org/10.1093/schbul/sbw132

Witt, K., van Dorn, R., & Fazel, S. (2013). Risk factors for violence in psychosis: Systematic review and meta-regression analysis of 110 studies. *PLoS One, 8*(2), Article e55942. https://doi.org/10.1371/journal.pone.0055942