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Retrospective analysis of criminal responsibility cases in Ordu, Türkiye

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Abstract

According to the Turkish Penal Code, individuals who commit an offense under the influence of mental illness, rendering them incapable of understanding the legal meaning and consequences of their actions, cannot be held criminally responsible. This study aims to develop a sociodemographic profile of individuals referred for criminal responsibility evaluations and to discuss the approach taken in expert decision-making. The cases referred to Ordu University Training and Research Hospital for criminal responsibility evaluations between 2017 and 2023 were retrospectively analyzed. Of the 93 cases included in the study, 73 (78%) were diagnosed with a psychiatric condition. Among these, 18 cases (25%) were diagnosed with alcohol and substance use disorders, 13 cases (14%) with major depressive disorder, 12 cases (13%) with borderline intellectual functioning, and 14 cases (15%) with mild-to-moderate intellectual disability. The distribution of alleged offense types revealed that 59 cases (63%) were related to crimes against persons, 27 cases (29%) to property crimes, and 7 cases (8%) to other offenses. The forensic evaluation results showed that 52 cases (56%) were deemed fully criminally responsible, 19 cases (20%) were referred for observation, 17 cases (18%) were assessed as not criminally responsible, and 5 cases (5%) were evaluated as having diminished criminal responsibility. The distribution of psychiatric diagnoses, the nature of alleged offenses, and the criminal responsibility decisions among individuals evaluated in our clinic, which lacks inpatient psychiatric facilities and observation units, were found to be consistent with the findings of other studies conducted in Türkiye.

Keywords: Forensic psychiatry, criminal responsibility, crime

Introduction

While references to defenses involving mental illness can be traced back to ancient documents, including the Code of Hammurabi, the earliest recorded precedent for such a defense appears in a 1581 English legal review [1,2]. The historical evolution of insanity defenses gained significant momentum with the pivotal 1843 case of Daniel M'Naughten, who attempted to assassinate British Prime Minister Sir Robert Peel while reportedly exhibiting symptoms of mental illness [1]. This case established the M'Naughten Rules, which provided a formal framework for determining criminal insanity. According to these rules, "to establish a defense on the grounds of insanity, it must be clearly proven that, at the time of the act, the accused was suffering from a defect of reason caused by a disease of

the mind, rendering them incapable of understanding the nature and quality of their actions, or, if they did, of comprehending that the actions were wrong" [1,2]. These principles remain a cornerstone of legal standards in over 20 states within the United States today.

The Durham Rule, a broader concept compared to previous standards, is defined as "a determination of innocence based on the premise that the criminal act was the product of mental illness." However, it is currently applied exclusively in the state of New Hampshire [2]. Another perspective focusing on volitional control is the Irresistible Impulse Test, which was first implemented in Alabama. This test emphasizes that "if, as a result of mental illness, the defendant was unable to control impulses leading to the criminal act," they are exempt from

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criminal responsibility [2].

In the modern criminal code formulated by the American Law Institute, widely adopted across several U.S. states, it is emphasized that criminal responsibility can be exempted under circumstances where "at the time of the offense, the defendant, as a result of mental illness or defect, lacked substantial capacity either to recognize the criminal nature of their conduct or to conform their behavior to the requirements of the law." Similar principles are embedded within the legal systems of several European countries, including Switzerland [3].

In countries adhering to the common law model, such as the United States, Canada, the United Kingdom, Australia, and New Zealand, there is a binary distinction between the presence or absence of criminal responsibility. By contrast, other nations, including the Netherlands, Belgium, and Germany, implement systems based on varying degrees of criminal responsibility [4].

A comparative study by Radovic and colleagues on criminal responsibility practices in Sweden and the Netherlands highlights that insanity is considered a legal construct requiring specific evaluation standards. They emphasize the importance of a multidisciplinary approach, involving expert teams of psychiatrists and neuropsychiatrists, in developing these standards [3]. In Canada, a ruling of not criminally responsible due to mental illness constitutes a final decision rendered by a judge or jury upon determining that the defendant was suffering from a mental disorder at the time of the offense, thereby exempting them from criminal responsibility. This decision results in one of three outcomes: absolute discharge, conditional discharge, or detention in a hospital [5].

Article 32 of the Turkish Penal Code (TPC) regulates criminal responsibility for adults, while Article 31 of the TPC regulates criminal responsibility for children. Under the criminal law of our country, for an individual to be held accountable for a crime, both the material and mental elements of the offense must be fulfilled. Additionally, the individual must possess "culpability capacity," defined as the ability to accurately comprehend the needs of social life and act accordingly [6,7]. In judicial practice, prosecution offices or criminal courts may request expert opinions from the forensic medicine, psychiatry, and neurology clinics of local hospitals or from forensic medicine branch directorates regarding an individual's criminal responsibility. These local healthcare institutions, when deemed necessary, may refer individuals to psychiatric hospitals equipped with observation clinics and/or forensic medicine institutions based on an observation order issued in accordance with Article 74 of the Code of Criminal Procedure (CMK). Additionally, prosecution offices and criminal courts may seek expert opinions from various institutions and organizations pursuant to Article 67 of the CMK. In current practice, these supplementary evaluations are predominantly conducted by the Fourth Specialization Board of the Forensic Medicine Institute and/or university hospitals. As a result of various legal procedures and requirements, a limited

number of cases are ultimately reviewed by the Supreme Board of the Forensic Medicine Institute, which functions as a superior board in this process.

The aim of this study is to evaluate the data collected in conjunction with the existing literature, to develop a profile of individuals whose criminal responsibility was questioned based on their sociodemographic characteristics, and to discuss the approach in expert decision-making.

Material and Methods

In our hospital, criminal responsibility evaluations are conducted by a board consisting of forensic medicine specialists, psychiatry specialists, and neurology specialists. Case files referred by the prosecution and courts are initially reviewed by the Department of Forensic Medicine. Files that lack a case dossier or contain insufficient/missing historical medical records are returned through an official correspondence for completion. Once the files are deemed complete and all requested aspects have been addressed, they are presented to the board for evaluation.

During the board examination, interviewing close family members, if present, is a standard practice. Psychiatric diagnoses are established in accordance with the DSM-5 criteria. Additionally, for conditions such as dementia and intellectual disability, all necessary tests and examinations are conducted. No report is issued until the final decision of the relevant specialist has been obtained.

The cases referred to Ordu University Training and Research Hospital for criminal responsibility evaluations between 2017 and 2023 were retrospectively analyzed. Data included the year of application, gender, age, education, military service, marital status, family and personal medical histories, the time interval between the incident and the examination, the nature of the offense, and the conclusions of the forensic reports.

Statistical analysis was performed using the SPSS 20.0 software. Descriptive statistics were expressed as mean $\pm$ standard deviation for continuous variables and as frequencies and percentages for categorical variables. Group comparisons were conducted using the student's t-test for quantitative data and the chi-square test for qualitative data. A p-value of less than 0.05 was considered statistically significant.

Ethical approval for the study was obtained from the Ethics Committee of Ordu University, under approval number 2025/07 and dated 03.01.2025.

Results

A total of 93 cases were included in the study, comprising 82 males (88.20%) and 11 females (11.80%). The mean age of the cases was 40.29 ± 17.09 years, with the youngest being 15 years old and the oldest 86 years old. Upon analyzing the yearly distribution of cases, it was observed that the highest number of referrals ($n=36$) occurred in 2023 (Figure 1).

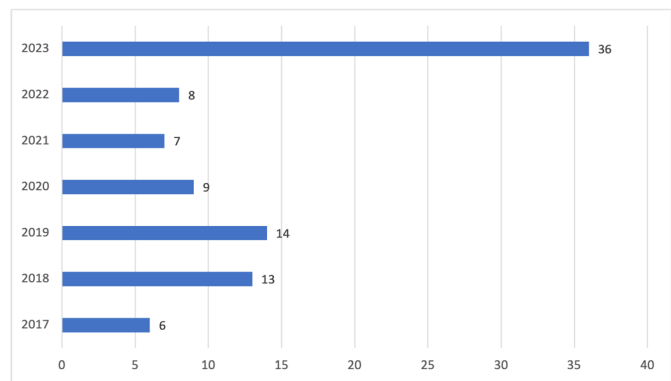


Figure 1. Distribution of criminal responsibility cases by year

Among the cases, 49 (52.78%) were single. In terms of educational status, 30 cases (32.35%) were identified as illiterate, and 60 cases (64.51%) were unemployed. An evaluation of military service status among male cases indicated that 41 cases (44.10%) were deemed unfit for military service, while

4 cases (4.29%) had been granted temporary leave during their service. The sociodemographic characteristics of the cases are summarized in Table 1.

No psychiatric diagnosis was made in 20 (21.50%) of the study cases. 73 of the cases (78.49%) had a psychiatric diagnosis. The distribution of diagnoses, ranked by frequency, revealed the following: 15 cases (16.12%) were referred to an inpatient psychiatric clinic for observation due to suspected psychiatric disorders, 13 cases (13.97%) were diagnosed with major depressive disorder, 12 cases (12.90%) with borderline intellectual functioning, 8 cases (8.60%) with mild intellectual disability, 6 cases (6.45%) with moderate intellectual disability, 3 cases (3.2%) with antisocial personality disorder, 3 cases (3.22%) with schizophrenia, 2 cases (2.15%) with psychosis, 2 cases (2.15%) with dementia, 2 cases (2.1%) with substance dependence, 1 case (1.07%) with severe intellectual disability, 1 case (1.07%) with mild cognitive impairment, 1 case (1.07%) with Parkinson’s disease, and 1 case (1.07%) with post-traumatic stress disorder.

Table 1. Distribution of sociodemographic characteristics of cases by gender

	Male		Female		p
Age (mean±SD)	40.28±16.56		40.36±21.59		0.98*
Marital status					
Married	27	29.03%	5	5.37%	0.35**
Single	43	46.23%	6	6.45%	
Widowed	12	12.90%	-	-	
Education					
Illiterate	25	26.88%	5	5.37%	0.26**
Primary school	15	16.12%	1	1.07%	
Middle school	16	17.20%	2	2.15%	
High school	16	17.20%	1	1.07%	
University	3	3.22%	2	2.15%	
Special education school	7	7.52%	-	-	
Occupation					
Unemployed	52	55.91%	8	8.60%	0.26**
Student	6	6.45%	1	1.07%	
Self-employed	5	5.37%	-	-	
Civil-servant	1	1.07%	-	-	
Retired	7	7.52%	-	-	
Worker	8	8.60%	2	2.15%	
Farmer	3	3.22%	-	-	

*p value by Independent t test, **p- value by Chi square

Upon evaluating all cases, including those with or without additional psychiatric comorbidities, it was observed that 18 cases (19.35%) were diagnosed with alcohol and substance use disorders. Of the participants, 63 (67.74%) reported not using any psychiatric medication, whereas 16 cases (17.20%) were

using antipsychotic medication, 12 cases (12.90%) were using antidepressants, and 2 cases (2.15%) were using antiepileptic medication. Additionally, 8 cases (8.60%) had a documented history of psychiatric illness, 4 cases (4.30%) had a history of suicide attempts, and 2 cases (2.15%) had a history of substance

dependence. Moreover, 20 cases (21.50%) had received inpatient treatment in a psychiatric ward, with the number of hospitalizations ranging from a minimum of one to a maximum of eight. A statistically significant association was identified, indicating that cases with a medical diagnosis had a higher frequency of hospital admissions (Table 2).

Table 2. Distribution of medical and family history characteristics among cases with and without a medical diagnosis

	Undiagnosed cases		Diagnosed cases		p
Age (mean±SD)	42.4±21.2		39.6±15.8		0.52*
Substance use					0.93**
None	16	17.20%	59	63.44%	
Present	4	4.30%	14	15.05%	
Medication status					0.76**
None	13	13.97%	50	53.76%	
Present	7	7.52%	23	24.73%	
Family history					0.48**
None	16	17.20%	63	67.74%	
Present	4	4.30%	10	10.75%	
Hospitalization					0.04**
None	19	20.43%	54	58.06%	
Present	1	1.07%	19	20.43%	

*p value by Independent t test, **p- value by Chi square

The distribution of the alleged types of offenses revealed that 59 cases (63.44%) involved crimes against persons, 27 cases (29.03%) were related to property crimes, and 7 cases (7.26%) were categorized as other offenses. Upon evaluation of the forensic reports, it was determined that 52 cases (55.91%) were deemed fully criminally responsible, 19 cases (20.43%) were referred for psychiatric observation, 17 cases (18.27%) were found to be not criminally responsible, and 5 cases (5.37%) were assessed as having diminished responsibility (Table 3).

Table 3. Distribution of forensic report results and categories of offenses

	Without psychiatric diagnosis		With psychiatric diagnosis		p
Type of offense					0.75*
Crimes against persons	12	12.90%	47	50.53%	
Property crimes	7	7.26%	20	21.58%	
Other	1	1.07%	6	6.45%	
Forensic report results					0.01*
Fully responsible	19	20.43%	33	35.48%	
Referred for observation	1	1.07%	18	19.35%	
Not criminally responsible (article 32/1)	-	-	17	18.27%	
Diminished responsibility (article 32/2)	-	-	5	5.37%	

* p- value by Chi square

Discussion

The reasons why some cases with psychiatric disorders are more prone to violent behavior, while others are not, remain one of the most debated topics in contemporary research. The literature highlights an increased risk of violence among cases with schizophrenia [8-10]. In a study by Ural et al., it was found that 80.7% of the schizophrenia patients in the offender group

belonged to the paranoid schizophrenia subtype. The authors attributed this to less cognitive impairment and more intense delusions in this subgroup [11]. Comparative studies between cases with and without psychiatric disorders indicate that schizophrenia and mood disorders increase the risk of violent behavior by fivefold, whereas alcohol and substance use raise this risk by 12 to 16 times [12]. Among forensic psychiatric cases, the prevalence of all personality disorders ranges from 60% to 70%,

with antisocial personality disorder being the most frequently observed, reported at rates between 40% and 70% [13]. In cases of personality disorders, criminal responsibility is thoroughly evaluated. However, when substance use coexists with a personality disorder, it is crucial to consider substance-induced psychotic disorders in the differential diagnosis, as this plays a significant role in the assessment of criminal responsibility. In our study, the recent increase in cases referred for criminal responsibility evaluations is particularly notable and aligns with findings reported in the existing literature [14]. Studies indicate that the majority of forensic cases consist of cases who are single, unemployed, and have a history of prior psychiatric hospitalizations [15]. In our study, 25% of the cases had a history of inpatient treatment in psychiatric clinics. The rate of hospitalization history was significantly higher among cases with a medical diagnosis, as expected. Numerous clinical studies have demonstrated that medications such as carbamazepine, valproate, lithium, propranolol, and antipsychotics, used appropriately for psychiatric treatment, can help reduce aggression and impulsive behaviors [16,17].

In alignment with our findings, numerous studies conducted in our country have highlighted that the majority of cases undergoing criminal responsibility evaluations are male [18-20]. Although there is no significant difference in the prevalence of psychotic disorders, such as schizophrenia and paranoid disorders, between genders, men's greater involvement in outward-directed social activities, influenced by their societal roles, may increase their likelihood of engaging in criminal behavior. This observation can be attributed to the interplay between men's social roles, their societal positions, and the cultural dynamics of the community in which they live.

Studies conducted in our country report average ages for these cases ranging from 35 to 44 years [14,19-21], consistent with the mean age identified in our study. While some studies indicate that cases undergoing criminal responsibility evaluations have higher educational levels [22], the majority of studies, including ours, report that these cases tend to have lower levels of education [14,23]. This divergence may be due to regional and cultural differences or reflect the demographic characteristics of the patient population admitted to the hospital where the study was conducted.

Studies indicate that the majority of forensic cases consist of cases who are single, unemployed, and have a history of prior psychiatric hospitalizations [15]. In our study, 25% of the cases had a history of inpatient treatment in psychiatric clinics. The rate of hospitalization history was significantly higher among cases with a medical diagnosis, as expected. Numerous clinical studies have demonstrated that medications such as carbamazepine, valproate, lithium, propranolol, and antipsychotics, used appropriately for psychiatric treatment, can help reduce aggression and impulsive behaviors [18,19]. In our study, 53.7% of cases with a medical diagnosis reported not

using medication. Patients often discontinue their medications for various reasons, including fatigue from prolonged use, loss of faith in their efficacy, or other excuses, which may make it difficult for them to control their impulsive behaviors.

Most studies report that cases diagnosed with substance use disorders exhibit the highest rates of criminal behavior, followed by those with schizophrenia [12,14]. In our study, 27 cases (24.3%) referred for criminal responsibility evaluations were diagnosed with varying degrees of intellectual disability. Compared to other psychiatric disorders, intellectual disability may be associated with an increased likelihood of impulsive behaviors and susceptibility to external suggestions, potentially making these cases more prone to being directed toward criminal acts. One of the reasons intellectual disability emerged as the most frequently diagnosed group in our findings could be related to the nature of the alleged crimes. In psychotic disorders such as schizophrenia, delusional disorder, and substance-induced psychotic disorder—where delusions and hallucinations are prominent—there is a higher likelihood of committing severe crimes motivated by persecutory, jealous, or referential delusions. In contrast, cases with intellectual disabilities may be more inclined to commit relatively simpler crimes driven by impulsive behaviors.

The second most frequently observed diagnosis, accounting for 13% of our cases, is major depression. Contrary to the analyses of Hannan [24] and Schopp [25], in traditional philosophical terms, an individual experiencing severe depression is deprived of free will. Furthermore, since depression may be considered a component of schizoaffective disorder, it is a condition that necessitates a comprehensive evaluation.

In legal case files, multiple factors play a crucial role in differential diagnosis and the assessment of criminal responsibility. These factors include eyewitness testimonies dated to the incident, surveillance footage from the time of the event, statements from family members, the individual's own narration of the incident, and their subjective perception of the event. Particularly, a broad evaluation incorporating hospital records from around the time of the incident is essential.

In our study, 15 cases (16%) evaluated for criminal responsibility were referred to inpatient psychiatric wards for observation. Since our hospital lacks an inpatient psychiatric unit, cases requiring observation are transferred to regional hospitals with such facilities. The final psychiatric diagnoses of these referred cases remain unknown, representing one of the limitations of our study. Among cases deemed not criminally responsible, bodily harm/homicide, threats/insults, and theft are highlighted in the literature as the most prevalent offense categories [15,23]. Consistent with our findings, studies conducted in our country over the past 19 years indicate that crimes against persons are the most commonly committed offenses, although the prevalence varies with sample size. A review of 14 articles

accessible through Google Scholar revealed the distribution of criminal responsibility outcomes, as summarized in Table 4 [10,17,20,21,26-36].

Due to the absence of an inpatient psychiatric unit and appropriate observation facilities in our hospital, this study is among the few in which final decisions could not be rendered for cases requiring observation. As illustrated in Table 4, studies that did not involve observation decisions were predominantly conducted in institutions such as the Council of Forensic Medicine or inpatient psychiatric facilities equipped with comprehensive observation capabilities.

An evaluation of both broad-based and small-sample studies conducted in our country reveals that the most frequently committed offenses among cases referred for criminal responsibility assessments are crimes against persons. The proportion of those deemed fully criminally responsible has been reported to range between 23% and 58%, whereas the proportion of those deemed not criminally responsible ranges from 12% to 58%. Additionally, recent studies demonstrate an increasing prevalence of diminished criminal responsibility compared to earlier research, with rates varying between 2.4% and 20.2% (Table 4).

Table 4. Evaluations of crime and criminal responsibility in studies conducted in Türkiye

Reference number and year	Sample size	Most frequently committed crime (%)	Fully responsible (%)	Not responsible (%)	Diminished responsibility (%)	Observation decision (%)
Our study	93	Crimes against persons 59	55.9	18.27	5.37	20.4
[10] (1995)	871	Crimes against persons 33.90	39.0	34.2	6.9	-
[17] (2015)	332	Crimes against persons 52.20	75.5	39.5	6.0	
[20] (2021)	85	Crimes against persons 33.0	40.5	34.5	6.0	
[21] (2023)	174	-	23.7	18.5	5.5	5.8
[26] (2014)	1482	-	88.7	19.9	2.4	-
[27] (2000)	1814	-	43.5	48.9	6.7	-
[28] (2023)	917	-	55.1	33.6	11.2	-
[29] (2023)	706	Crimes against persons 54.1	55.7	35.4	8.9	-
[30] (2020)	163	Crimes against persons 68.7	42.9	36.8	20.2	-
[31] (2014)	130		33.1	53.8	13.0	-
[32] (2004)	11	Crimes against persons 63.6	54.5	45.5	-	-
[33] (2002)		Crimes against persons 53.70	66.0	25.0	-	-
[34] (1999)	32	Crimes against persons 34.4	56.3	12.5	9.7	21.9
[35] (1997)		Crimes against persons 31.29	41.37	58.63 (Diminished responsibility included)	-	-
[36] (2024)	57	Crimes against persons 49.1	19.3	66.7	14.0	-

The findings of our study reveal a strong alignment with prior research regarding the nature of offenses and the distribution of cases classified as fully, partially, or not criminally responsible. Nevertheless, the significantly higher number of cases referred for observation in our study is plausibly attributed to the absence of an inpatient psychiatric unit within our institution.

In criminal responsibility evaluations, a multidisciplinary approach is essential for ensuring an impartial assessment of cases, facilitating the determination of summation, enabling the discussion of different disciplinary perspectives within the context of concrete cases, and fostering intellectual development. Another finding of our study is that cases of intellectual disability, which are more easily recognized by society, are more frequently referred for criminal responsibility evaluations.

Furthermore, in cases of depression, comprehensive and multidimensional evaluations of criminal responsibility require broader and more diverse research encompassing different case contexts. Studies conducted in this field since 1995 have highlighted that, in our country, criminal liability is more frequently questioned in crimes committed against individuals. Additionally, within the scope of the existing literature, the scarcity of studies addressing the observation process and its outcomes has been notable.

Apart from the inherent limitations of a retrospective study, another constraint of our study is the lack of available data regarding the final forensic reports of referred patients. It is evident that addressing such limitations through the dissemination of studies conducted in healthcare institutions with observation units would provide valuable feedback and contribute to professionals working in this field.

Conclusion

In conclusion , our results are parallel to previous research and draw attention to multidisciplinary studies. The main goal should be to conduct a forensic psythiatric evaluation that is impartial and accepts the possibility of error for ethical values. In addition to, there is a need for broad-based research on the observation part, which is an important part of forensic psychiatric evaluation.

Conflict of Interests

The authors declare that there is no conflict of interest in the study.

Financial Disclosure

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Ethical Approval

Ethical approval for the study was obtained from the Ethics Committee of Ordu University, under approval number 2025/07 and dated 03.01.2025.

References

- Kelly BD. Criminal insanity in 19th-century Ireland, Europe and the United States: Cases, contexts and controversies. *Int J Law Psychiatry*. 2009;32:362-8.
- Tsimploulis G, Niveau G, Eytan A, et al. Schizophrenia and criminal responsibility. A systematic review. *J Nerv Ment Dis*. 2018;206:370-7.
- Radovic S, Meynen G, Bennet T. Introducing a standard of legal insanity: The case of Sweden compared to The Netherlands. *Int J Law Psychiatry*. 2015;40:43-9.
- Grossi LM, Green D. An international perspective on criminal responsibility and mental illness. *Practice Innovations*. 2017;2:2-12.
- Miladinovic M, Lukassen J. Verdicts of not criminally responsible on account of mental disorder in adult criminal courts, 2005/2006–2011/2012. *Statistics Canada*. <https://www150.statcan.gc.ca/n1/pub/85-002-x/2014001/article/14085-eng.htm#a6> access date 12.11.2024.
- Cavlak N. An overview of criminal responsibility reports in the light of supreme court decisions: cross-sectional research. *Türkiye Klinikleri J Foren Sci Leg Med*. 2023;20:46-52.
- Duran G. Ceza kanunlarımızda akıl hastalığı. *Ceza Hukuku Dergisi*. 2020;15:355-419.
- Schanda H, Stompe T, Ortwein-Swoboda G. Increasing criminality in patients with schizophrenia: Fiction, logical consequence or avoidable side effect of the mental health reforms?. *Neuropsychiatr*. 2010;24:170-81.
- Richard-Devantoy S, Olie JP, Gourevitch R. Risk of homicide and major mental disorders: a critical review. *Encephale*. 2009;35:521-30.
- Çöpür M, Elmas İ, Can Y. Ceza ehliyeti, uyuşturucu madde bağımlılığı, Farık ve Mümmeyizlik tespiti istenen olgularla ilgili istatistiksel bir çalışma. *Kriz Dergisi*. 1995;3:197-200.
- Ural C, Öncü F, Belli H, et al. Violent behavior variables among patients with schizophrenia under forensic psychiatric process: a case-control study. *Türk Psikiyatri Derg*. 2013;24:17-24.
- Brennan PA, Medrick SA, Hodgins S. Major mental disorder and criminal violence in a Danish birth cohort. *Arch Gen Psychiatry*. 2000;57:494-500.
- Lymburner JA, Roesch R. The insanity defense: five years of research (1993-1997). *Int J Law Psychiatry*. 1999;22:213-40.
- Bailey JM, MacCulloh M. Characteristics of 112 cases dischnaged directly to the community from a new special hospital and some comparison of performance. *J Foren Psychiatry Psychol*. 1992;3:91-112.
- Eastman N, Adshead G, Fox S, et al. Forensic Psychiatry. In: *Oxford Specialist Handbooks in Psychiatry*. New York: Oxford University Press 2012;28-40.
- Kalenderoğlu A, Yumru M, Selek S, et al. Evaluation of cases, referred to forensic psychiatry unit in Gaziantep University. *Archives of Neuropsychiatry*. 2007;44:86-90.
- Görgülü Y, Küçük A, Uysal Çetinkaya S. Evaluating the people who were sent for determining of criminal responsibility. *Anatolian Journal of Psychiatry*. 2015;16:270-5.
- Brodsky H, Ames D, Snowdon J, et al. A randomized placebo-controlled trial of risperidone for the treatment of aggression, agitation, and psychosis of dementia. *J Clin Psychiatry*. 2003;64:134-43.
- Donovan SJ, Stewart JW, Nunes EV, et al. Divalproex treatment for youth with explosive temper and mood lability: a double-blind, placebo-controlled crossover design. *Am J Psychiatry*. 2000;157:818-20. Erratum in: 2000;157:1192. Erratum in: *Am J Psychiatry*. 2000;157:1038.
- Aydın S, Batmaz S, Akpınar Aslan E, et al. Multidisciplinary approach to evaluation of forensic psychiatry reports. *The Bulletin of Legal Medicine*. 2021;26:101-11.
- Kocakaya H, Deniz Özturan D. Retrospective analysis of cases admitted to an university hospital psychiatry outpatient clinic. *KÜ Tıp Fak Derg*. 2023;25:285-92.
- Polat S, Hocaoglu Ç. Clinical features, cases of psychiatric diagnosis and socio-demographic characteristics of patients with polyclinics of forensic psychiatry in education research hospital. *Ortadoğu Medical Journal*. 2020;12:290-4.
- Örüm MH. Evaluation of forensic cases admitted to Kahta State Hospital. *Phoenix Medical Journal*. 2021;3:26-30.
- Hannan B. Depresion, responsibility and criminal defenses. *Int J Law Psychiatry*. 2005;28:321-33.
- Schopp RF. Automotism, insanity and the psychology of criminal responsibility; a philosophical inquiry. Cambridge; Cambridge University Press.1991;45-8.
- Bolu A, Toygar M, Pan E, et al. Evaluation of forensic cases in the psychiatric clinic of a training hospital; five-year rewiev. *Gulhane Med J*. 2014;56:1-4.
- Türkcan S, İncesu C, Canbek Ö, et al. 1831 adli olgunun tanı dağılımı ve tanı-suç bağlantısının değerlendirilmesi. *Düşünen Adam*. 2000;13:132-7.
- Koç A, Parlak E. Diagnostic and sociodemographic characteristics of cases evaluated for criminal liability in the forensic psychiatry outpatient clinic: 6.5-year retrospective study. *Türkiye Klinikleri J Foren Sci Leg Med*. 2023;20:115-23.
- Ergün Karataş S. Retrospective analysis of the cases evaluated at bursa Uludağ University medical faculty forensic psychiatry comittee between 2018-2021. Ph.D. thesis. Uludağ University, Bursa, 2023.
- Ersolak C. Retrospective evaluation of cases referred to a university hospital forensic psychiatry outpatient clinic. Ph.D. thesis. Atatürk University, Erzurum, 2020.
- Çöpoğlu ÜS, Bülbül F, Kokaçya MH, et al. Evaluation of psychiatric diagnosis, substance use situations, sociodemographic and clinical features of cases in forensic psychiatry unit. *Neuropsychiatric Investigation*. 2014;52:1-6.

32. Yağmur F. 1992-2002 yılları arasında Ankara Üniversitesi Tıp Fakültesi Adli Tıp Anabilim Dalına başvuran adli psikiyatri olgularının değerlendirilmesi. Ph.D. thesis. Ankara University, Ankara, 2004.
33. Cantürk G, Biçer Ü, Cantürk N. 1997 yılında 4. İhtisas Kurulunda muayene edilen Ceza Ehliyeti olgularının Değerlendirilmesi. Yıllık Adli Tıp Toplantıları, 16-19 May 2002. Antalya, Türkiye, 6-13
34. Ersoy MA, Zeyfeoglu Y, Hancı İsmail H, et al. Examination of forensic reports given by a university hospital department of psychiatry. Bull Leg Med. 1999;4:60-4.
35. Kendi Ö, Bilge Y, Aksoy MA, et al. Ankara Üniversitesi Tıp Fakültesi Adli Tıp Anabilim Dalına gönderilen konvulsiv bozukluğu olan vakalarla cezai sorumluluğu etkileyen diğer vakalar üzerine istatistiksel olarak karşılaştırılmalı bir araştırma. Ankara Üniversitesi Hukuk Fakültesi Dergisi. 1997;46:1-4.
36. Sehlikoğlu K, Sehlikoğlu Ş, Eğilmez OB. Sociodemographic, clinical, and forensic characteristics of cases sent for criminal responsibility assessment: a sample from the Southeastern Region of Türkiye. Psychiatry and Behavioral Sciences. 2024;14-2:125-32.