

Clinical and Forensic Characteristics of Homicide Offenders With Bipolar Disorder: A Retrospective Study From a National Forensic Psychiatry Center

Hızır Aslıyüksək^{ID}, Muhammed Emre Yılmaz^{ID}, Sümeyye Demirdöven Özbakır^{ID}, Zehra Topaloğlu Türkmen^{ID}, Ömer Asan^{ID}, Hüseyin Çağrı Şahin^{ID}, Hasan Gökçay^{ID}

Council of Forensic Medicine, Ministry of Justice, İstanbul, Türkiye

WHAT IS ALREADY KNOWN ON THIS TOPIC?

- Bipolar disorder can be accompanied by severe behavioral dysregulation during acute mood episodes.
- In rare cases, this dysregulation may result in serious violent acts, including homicide.

WHAT DOES THIS STUDY ADD TO THIS TOPIC?

- This study shows that homicide in bipolar disorder is largely impulsive and closely linked to clinical instability rather than planned criminal intent.
- Prior criminal history was associated with markers of illness severity, including a history of manic episodes and a higher number of psychiatric hospitalizations.

Corresponding author:
Hasan Gökçay

E-mail:
hasangkcy@yahoo.com

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ABSTRACT

Objective: To characterize the clinical and forensic features of individuals with bipolar disorder who committed homicide and to examine factors associated with prior criminal history.

Methods: This retrospective, single-center study included 62 individuals with bipolar disorder who underwent criminal responsibility evaluation for homicide at the First Board of the Council of Forensic Medicine in Türkiye (2021–2025). Sociodemographic, clinical, and criminological variables were extracted from forensic psychiatric records. Participants with and without prior criminal history were compared using appropriate statistical tests.

Results: The sample was predominantly male (88.7%) and showed a high prevalence of lifetime psychotic symptoms (91.9%), most commonly paranoid or persecutory delusions. At the time of the offense, residual or subthreshold psychopathological features were frequently documented; however, a causal link with the homicidal act was not established in most cases in terms of criminal responsibility. Most homicides were impulsive in nature (72.6%) and involved victims known to the offender. Alcohol or substance use at the time of the offense was documented in 17.7% of cases (alcohol: 12.9%; substance: 4.8%) and was not a predominant feature of the sample. A history of prior criminal offenses was observed in more than half of the cases (58.1%). Compared with participants without prior criminal history, those with prior criminal history more frequently exhibited a history of manic episodes, self-harm behavior, comorbid personality disorder, and a higher number of psychiatric hospitalizations, whereas sociodemographic characteristics and treatment adherence were broadly similar between groups.

Conclusion: Homicidal behavior in bipolar disorder appears to be more closely associated with impulsivity and interpersonal or situational stressors than with severe, responsibility-abolishing psychopathology. Recurrent offending was linked to markers of illness severity, underscoring the need for sustained psychiatric follow-up and continuity of care in forensic populations.

Keywords Bipolar disorder, forensic psychiatry, impulsivity, psychiatric hospitalization, psychosis

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INTRODUCTION

Bipolar disorder is a chronic and recurrent psychiatric disorder characterized by fluctuations between manic or hypomanic and depressive states, which may result in periods of impaired functioning and reduced quality of life. Classified by the World Health Organization as one of the most disabling mental illnesses, bipolar disorder affects an estimated 29.5 million individuals worldwide. Prevalence rates vary depending on diagnostic thresholds, ranging from approximately 0.5% under narrow definitions to nearly 6% when broader bipolar spectrum classifications are applied.^{1,2} Large-scale epidemiological studies report comparable figures across regions; for example, Merikangas et al³ documented prevalence rates of 0.6% for bipolar I and 0.4% for bipolar II disorder. Onset typically occurs in late adolescence or early adulthood, although variations by clinical subtype and developmental trajectory have been described.^{1,5} Its relevance has also been increasingly examined in forensic psychiatry, particularly in relation to serious violent crime, including homicide.

Beyond its significant clinical burden, bipolar disorder has been consistently associated with heightened impulsivity, affective instability, psychotic symptoms during mood episodes, and impaired judgment.^{1,6,7} These characteristics may, in certain contexts, contribute to an increased risk of violent behavior. While the majority of individuals with bipolar disorder do not engage in criminal acts, research indicates that manic episodes, particularly those marked by irritability, grandiosity, disinhibition, and psychotic features, can elevate the likelihood of impulsive aggression.⁸ Comorbidities such as substance use disorders, personality traits involving emotional dysregulation, and a history of childhood trauma may further exacerbate this vulnerability.⁹ However, the relationship between bipolar disorder and homicidal behavior is complex and multifaceted; it cannot be reduced to a simple causal pathway but instead emerges from dynamic interactions between psychopathology, environmental stressors, and individual predispositions.^{6,10} Despite the clinical and forensic relevance of this issue, empirical data on homicide committed specifically by individuals with bipolar disorder remain limited, heterogeneous, and underreported.^{1,6}

Existing literature often aggregates bipolar disorder with other severe mental illnesses when examining violent crime, making it difficult to delineate disorder-specific risk profiles.¹

However, studies focusing specifically on bipolar populations have highlighted distinct patterns of homicidal behavior. For example, Yoon et al⁶ reported that in bipolar I disorder, homicide victims were most often family members, with depressive-phase offenders, particularly women, exhibiting higher rates of planned filicide-suicide. Furthermore, Minero et al's systematic review emphasized that homicides by individuals with mood disorders frequently involve mothers killing their own children, often using less violent methods such as strangulation, asphyxiation, suffocation, or drowning.¹¹ The consistency across studies concerning the association between close-contact homicide methods and mood disorders suggests that specific methods are particularly prevalent among offenders with mood disorders and schizophrenia. Nevertheless, these studies often suffer from small sample sizes, retrospective designs, or insufficiently detailed psychiatric evaluations.^{7,12,13} Moreover, variations in legal standards, forensic assessment protocols, and cultural contexts contribute to the inconsistency of findings across jurisdictions. Consequently, a significant gap persists in understanding the clinical characteristics, criminological patterns, and forensic

psychiatric determinants of homicidal behavior uniquely associated with bipolar disorder. Clarifying these factors is essential both for risk assessment and for ensuring appropriate medico-legal decision-making.

To address this gap, the present study examines individuals diagnosed with bipolar disorder who have committed homicide and subsequently underwent comprehensive forensic psychiatric evaluation. Conducted at the Council of Forensic Medicine, the largest and most authoritative forensic psychiatry institution in Türkiye, this research provides a detailed analysis of clinical features, psychopathological states at the time of the offense, criminological variables, and legal responsibility assessments. We hypothesize that psychotic features, affective instability, and comorbid clinical conditions will be associated with prior criminal history. Furthermore, we anticipate that the use of firearms will be more prevalent in these offenses. By presenting systematically evaluated data from the nation's principal expert body, this study aims to make a substantive contribution to the international literature on bipolar disorder and homicidal behavior, offering insights from a large and rigorously assessed forensic population.

MATERIAL AND METHODS

Study Design and Setting

This study was conducted as a single-center, retrospective, cross-sectional analysis focusing on individuals diagnosed with bipolar disorder who committed homicide and were evaluated for criminal responsibility at the First Board of Council of Forensic Medicine in Türkiye. The Council of Forensic Medicine functions as the primary medico-legal authority in the country and provides expert opinions to criminal courts in the absence of an independent forensic psychiatry subspecialty system. All evaluations were carried out within the legal framework of the Turkish Penal Code, particularly Article 32, which defines the parameters of criminal responsibility. Article 32 specifies that individuals who, due to mental illness, cannot comprehend the legal meaning or consequences of their actions, or whose ability to control their behavior is significantly impaired, are not held criminally responsible. It also allows for reduced sentencing when impairment exists but does not reach the threshold for legal insanity. In cases where individuals are found not responsible, courts order compulsory treatment in secure psychiatric facilities until their potential danger to society is sufficiently mitigated.

Forensic psychiatric evaluations were conducted by multidisciplinary expert boards composed of forensic medicine specialists and psychiatrists. Determinations of criminal responsibility were based on a comprehensive review of medical records, witness statements, judicial files, and clinical examinations performed at the time of assessment. The presence, severity, and functional impact of psychiatric symptoms at the time of the offense were specifically evaluated to determine whether a causal nexus existed between mental illness and the criminal act, in accordance with Article 32 criteria.

Ethical Approval

Ethical committee approval was received from the Ethics Committee of the Council of Forensic Medicine (Approval no: 21589509/2025/1429; Date: 17/12/2025). All procedures were conducted in accordance with the ethical principles of the Declaration of Helsinki. As this research involved a retrospective analysis of anonymized forensic records, obtaining informed consent was deemed unnecessary.

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Participants

The electronic archives of the First Board of the Council of Forensic Medicine were reviewed for all homicide offenders referred for criminal responsibility evaluation between January 1, 2021, and September 30, 2025. Individuals were included if they had a documented diagnosis of bipolar disorder based on expert psychiatric assessment and if the forensic files contained sufficient information to determine clinical and criminological characteristics. Exclusion criteria consisted of being younger than 18 years at the time of the offense, not meeting diagnostic criteria for bipolar and related disorders, the presence of cognitive disorders that prevented diagnostic clarity, and incomplete or inconsistent documentation. After applying these criteria, the final analytic sample consisted of 62 individuals.

Data Collection

Data extraction was performed by 2 independent researchers between November 1, 2025, and November 30, 2025. Forensic psychiatric files were reviewed in their entirety and included mental status examinations, longitudinal symptom histories, collateral information, prior medical and psychiatric records, official police and crime-scene reports, statements from victims or witnesses, and legal documents submitted to the Council of Forensic Medicine in Türkiye. Any discrepancies between reviewers were resolved through consensus.

A structured data form was used to collect the following variables. Sociodemographic information included age, sex, marital status, educational attainment, employment status, and socioeconomic indicators. Clinical variables included bipolar subtype, mood state at the time of the offense, presence of psychotic symptoms, comorbid psychiatric disorders, substance use, trauma history when available, treatment history, medication adherence, and previous psychiatric hospitalization. Lifetime history of manic episodes was recorded; participants without a lifetime manic episode met Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition criteria for Bipolar II Disorder, which requires at least one lifetime hypomanic episode and one major depressive episode, or were classified as Bipolar Disorder Not Otherwise Specified. The diagnosis of bipolar disorder in this forensic sample was established through DSM-5–based clinical consensus and thorough review of longitudinal psychiatric records, including prior psychiatric evaluations, hospitalization reports, and treatment history. Although no structured diagnostic interviews were conducted due to the retrospective design, all diagnoses were confirmed independently by at least two forensic psychiatrists to ensure diagnostic reliability.

Criminological characteristics included the type of homicide, relationship with the victim, situational context, presence of planning or impulsivity, intoxication status, previous criminal behavior, suicidal intent associated with the offense, and prior criminal history, defined as any prior criminal offense irrespective of type. Offense-related psychopathology, such as delusions, hallucinations, disorganized behavior, affective instability, and motive classification, was recorded in detail. All identifiable personal information was excluded to preserve confidentiality.

Statistical Analysis

All statistical analyses were performed using SPSS, version 27 (IBM Corp., Armonk, NY, USA). Descriptive statistics were calculated for sociodemographic, clinical, and forensic variables, including means,

standard deviations, medians, and interquartile ranges. Group comparisons between participants with and without prior criminal history were conducted using chi-square tests, Fisher's exact tests, and likelihood ratio tests for categorical variables, and Mann–Whitney *U*-tests for continuous variables. A *P* value <.05 was considered statistically significant.

RESULTS

The study included 62 patients with bipolar disorder who committed homicide (Table 1). Most participants were male (88.7%), with a mean age of 42.44 ± 12.14 years at the time of evaluation and 37.15 ± 11.62 years at the time of the offense. Nearly half of the sample was single (49.2%), while 26.2% were married and 24.6% widowed or divorced. Regarding educational attainment, 58.1% had primary education or less, 19.4% were high school graduates, and 22.6% had a university degree or higher. The majority were unemployed (62.9%), with 24.2% engaged in regular employment and 11.3% in irregular employment.

In terms of living arrangements, 50.0% lived with parents, 30.0% with a spouse and children, 6.7% alone, and 13.3% in prison or care facilities. Most participants resided in urban areas (73.3%). Clinically, based on post-offense forensic psychiatric evaluation, 51.6% of participants had a history of manic episodes, and 91.9% reported past psychotic symptoms. Among those assessed for delusions ($n=50$), all had experienced delusional symptoms, predominantly paranoid/persecutory (68.0%). A history of suicide attempt and self-harm was reported in 24.2% and 19.4% of participants, respectively. Past substance use and alcohol use were present in 33.9% and 53.2%, respectively, while comorbid personality disorder was documented in 16.1% of cases. Nearly all participants (96.8%) had a history of psychiatric hospitalization, with an average of 1.89 ± 0.41 hospitalizations (Table 1).

At the time of the offense, 25.8% of patients were using psychiatric medication, and 21.0% were adherent to regular treatment (Table 2). Antipsychotics were the most commonly used medications (98.4%), followed by mood stabilizers (77.0%) and antidepressants (52.5%). Alcohol or substance use at the time of the offense was present in 17.7% of participants, with alcohol alone in 12.9% and illicit substances in 4.8% of cases, indicating that the majority of offenses occurred in the absence of acute intoxication.

The majority of offenses occurred at the offender's residence (59.7%), followed by the street (24.2%) and indoor public areas (16.1%). Daytime offenses were slightly more common (58.3%) than nighttime offenses (41.7%). Sharp force trauma was the most frequent method of homicide (56.4%), followed by firearms (22.6%), blunt force trauma (11.3%), strangulation (6.5%), and other methods (3.2%). Most offenses were classified as impulsive (72.6%). Motivational factors were coded based on forensic file documentation, with primary motives identified as anger (41.9%), loss of control or reference thinking (30.6%), and paranoid ideation (21.0%). Paranoid ideation refers specifically to delusional beliefs documented during psychiatric evaluation; cases could present overlapping motives, but coding reflected the predominant motive as judged from the forensic assessment. The victims were predominantly male (75.0%), and the offender–victim relationship was most often with friends (46.8%) or family/partners (41.9%) (Figure 1). A history of prior criminal offenses was observed in 58.1% of participants, defined as any criminal offense committed before the index homicide, regardless of type or severity.

Table 1. Sociodemographic and Clinical Characteristics of Patients with Bipolar Disorder Who Committed Homicide (Clinical Variables Reflect Lifetime History Before the Offense)

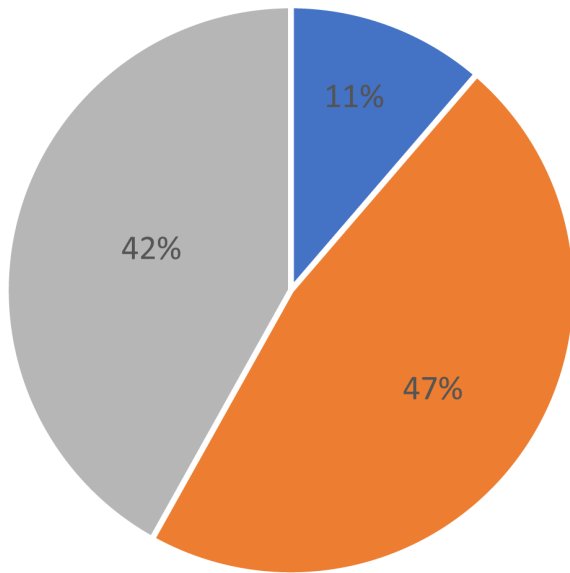
Variable	n (%) / Mean ± SD
Sex	
Male	55 (88.7)
Female	7 (11.3)
Age (years)	42.44 ± 12.14
Age at the time of offense (years)	37.15 ± 11.62
Marital status	
Married	16 (26.2)
Single	30 (49.2)
Widowed/divorced	15 (24.6)
Educational level	
Primary school or less	36 (58.1)
High school graduate	12 (19.4)
University or higher	14 (22.6)
Employment status	
Unemployed	39 (62.9)
Regular employment	15 (24.2)
Irregular employment	7 (11.3)
Living arrangement	
With parents	30 (50.0)
With spouse and children	18 (30.0)
Living alone	4 (6.7)
Prison/care facility	8 (13.3)
Place of residence	
Urban	44 (73.3)
Rural	10 (16.7)
History of manic episode	32 (51.6)
History of psychotic symptoms	57 (91.9)
Presence of delusions (n = 50)	50 (100)
Paranoid/persecutory	34 (68.0)
Other types	16 (32.0)
History of suicide attempt	15 (24.2)
History of self-harm	12 (19.4)
History of substance use	21 (33.9)
History of alcohol use	33 (53.2)
Comorbid personality disorder	10 (16.1)
History of psychiatric hospitalization	60 (96.8)
Total number of hospitalizations	1.89 ± 0.41

Criminal responsibility was retained in 96.8% of cases. Although lifetime psychotic symptoms were highly prevalent (91.9%), active psychotic features at the time of the offense were documented in 21% of cases; in forensic evaluations, these symptoms were generally assessed as insufficient in severity or functional impact to establish a direct causal nexus with the homicidal act. Evidence of malingering was detected in 11.3%. Hypomanic episodes at the time of the offense were rare (4.8%), while the majority of participants were neither in a manic nor depressive episode, representing euthymic or subthreshold/unclear mood states (Table 2).

Table 2. Forensic Characteristics of the Offense (n = 62)

Variable	n (%) / Mean ± SD
Use of psychiatric medication at the time of offense	16 (25.8)
Adherence to regular treatment	13 (21.0)
Medications used	
Antipsychotics	61 (98.4)
Mood stabilizers	47 (77.0)
Antidepressants	32 (52.5)
Alcohol/substance use at the time of offense	
None	51 (82.3)
Alcohol	8 (12.9)
Substance	3 (4.8)
Crime scene	
Residence	37 (59.7)
Street	15 (24.2)
Indoor public place	10 (16.1)
Time of offense	
Daytime	35 (58.3)
Nighttime	25 (41.7)
Method of homicide	
Sharp force trauma	35 (56.4)
Firearm	14 (22.6)
Blunt force trauma	7 (11.3)
Strangulation	4 (6.5)
Other methods	2 (3.2)
Nature of the offense	
Impulsive	45 (72.6)
Premeditated	17 (27.4)
Motivation for the offense	
Anger	26 (41.9)
Jealousy	4 (6.5)
Paranoid thoughts	13 (21.0)
Loss of control, Reference thinking	19 (30.6)
Victim sex (n = 56)	
Male	42 (75.0)
Female	14 (25.0)
Victim-offender relationship	
Family member/partner	26 (41.9)
Friend	29 (46.8)
Other	7 (11.3)
Prior criminal history	36 (58.1)
Full criminal responsibility	60 (96.8)
Evidence of malingering	7 (11.3)
Hypomanic episode at the time of offense	3 (4.8)

When comparing participants with prior criminal history (n = 36) to those without prior criminal history (n = 26), no significant differences were observed in age at the time of the offense (median 32.5 vs. 37.5 years, $Z = -1.243$, $P = .214$), sex distribution, marital status, education level, employment status, or residence (Table 3). However,



■ Other ■ Friend ■ Family member/partner

Figure 1. Distribution of offense motivation and victim-offender relationship among homicide offenders with bipolar disorder (n=62).

participants with prior criminal history had a significantly higher total number of hospitalizations (median 2 vs. 2, $Z = -2.720$, $P = .007$) and a greater history of manic episodes (63.9% vs. 34.6%, $\chi^2 = 5.180$, $P = .023$). A history of self-harm was also more frequent in this group (27.8% vs. 7.7%, $\chi^2 = 3.902$, $P = .048$), as was comorbid personality disorder (27.8% vs. 0.0%, Fisher's exact $P = .003$) (Figure 2).

DISCUSSION

This study represents one of the largest and most systematically assessed forensic cohorts of individuals with bipolar disorder who have committed homicide in Türkiye. Previous research on the relationship between bipolar disorder and homicidal behavior has often aggregated bipolar disorder with other severe mental illnesses or relied on small, heterogeneous samples, limiting disorder-specific insights.^{1,13} By focusing exclusively on individuals with a confirmed diagnosis of bipolar disorder, this study provides a comprehensive examination of sociodemographic, clinical, and criminological characteristics, as well as factors associated with prior criminal history. In doing so, it offers novel empirical evidence to delineate the unique risk profiles for homicidal behavior within the bipolar population, addressing a critical gap in both clinical and forensic psychiatry literature.

Recurrent offending has been identified as a significant risk factor, particularly among individuals with severe psychiatric disorders.¹⁴ In our study, approximately half of homicide offenders diagnosed with bipolar disorder exhibited recurrent offending; this rate supports the high recidivism risk reported in the literature. For example, in the Texas prison system, inmates with severe psychiatric disorders were significantly more likely to experience multiple incarcerations, and a diagnosis of bipolar disorder specifically increased the risk of four or more re-incarcerations.^{14,15} Our findings align

Table 3. Comparison of Participants With and Without Prior Criminal History

	Prior Criminal History n (%) / Median (IQR)		χ^2/Z	P
	Yes (n=36)	No (n=26)		
Age at time of offense (years)	32.5 (16)	37.5 (13)	-1.243	.214
Sex (male)*	33 (91.7)	22 (84.6)		.439
Marital status (married)	7 (20.0)	9 (34.6)	1.829	.401
Education level			0.512	.774
Primary school or less	22 (61.1)	14 (53.8)		
High school graduate	7 (19.4)	5 (19.2)		
University or higher	7 (19.4)	7 (26.9)		
Employment status**			0.664	.724
Unemployed	23 (63.9)	16 (64.0)		
Regular employment	8 (22.2)	7 (28.0)		
Irregular employment	5 (13.9)	2 (8.0)		
Living arrangement**			1.889	.596
With parents	18 (52.9)	12 (46.2)		
With spouse and children	8 (23.5)	10 (38.5)		
Alone	3 (8.8)	1 (3.8)		
Prison / care facility	5 (14.7)	3 (11.5)		
Residence (urban)	24 (77.4)	20 (87.0)	0.796	.372
Total number of hospitalizations	2 (0)	2 (0)	-2.720	.007
History of manic episode	23 (63.9)	9 (34.6)	5.180	.023
History of psychotic symptoms**	33 (91.7)	24 (92.3)	0.008	.927
Suicide attempt history	11 (30.6)	4 (15.4)	1.895	.169
Self-harm history	10 (27.8)	2 (7.7)	3.902	.048
Substance use	14 (38.9)	7 (26.9)	0.965	.326
Alcohol use	22 (61.1)	11 (42.3)	2.144	.143
Comorbid personality disorder*	10 (27.8)	0 (0.0)		.003
Regular treatment	8 (22.2)	5 (19.2)	0.082	.775
Medications used				
Antipsychotics	36 (100.0)	25 (100.0)	—	—
Mood stabilizers	30 (83.3)	17 (68.0)	1.962	.161
Antidepressants	18 (50.0)	14 (56.0)	0.213	.644
Alcohol use at offense	6 (100.0)	2 (40.0)		.061
Crime scene			0.320	.852
Residence	22 (61.1)	15 (57.7)		
Street	9 (25.0)	6 (23.1)		
Indoor public area	5 (13.9)	5 (19.2)		
Time of offense (daytime)	17 (50.0)	18 (69.2)	2.242	.134
Method of homicide**			3.981	.409
Sharp object	18 (50.0)	17 (65.4)		
Firearm	10 (27.8)	4 (15.4)		
Blunt force	4 (11.1)	3 (11.5)		
Strangulation	2 (5.6)	2 (7.7)		
Other	2 (5.6)	0 (0.0)		
Impulsive offense	25 (69.4)	20 (76.9)	0.424	.515

(Continued)

Table 3. Comparison of Participants With and Without Prior Criminal History (Continued)

	Prior Criminal History n (%) / Median (IQR)		χ^2/Z	P
	Yes (n = 36)	No (n = 26)		
Motivation for the offense**			2.510	.643
Anger	16 (44.4)	10 (38.5)		
Jealousy	3 (8.3)	1 (3.8)		
Paranoid ideation	7 (19.4)	6 (23.1)		
Loss of control	10 (27.8)	8 (30.8)		
Victim sex (male)	25 (73.5)	17 (77.3)	0.100	.752
Victim-offender relationship**			0.729	.695
Family member/partner	14 (38.9)	12 (46.2)		
Friend	17 (47.2)	12 (46.2)		
Other	5 (13.9)	2 (7.7)		
Full criminal responsibility	34 (94.4)	26 (100)		.505

χ^2 test was used; *Fisher's exact test, **likelihood ratio test, or Mann-Whitney U-test was applied when appropriate. A P value < .05 was considered statistically significant.

The values shown in bold indicate statistical significance. A p-value < 0.05 was considered statistically significant (bold).

with the "revolving-door" phenomenon observed in previous studies, in which individuals with severe mental illness cycle between hospitalizations, homelessness, and the criminal justice system.¹⁶ Additionally, the absence of differences in pharmacological treatment between recurrent and non-recurrent offenders should be interpreted cautiously, given the overall low rates of medication use and adherence (medication use at the time of offense 25.8%, adherence 21.0%). Taken together, these findings highlight the importance of addressing systemic gaps, enhancing continuity of care, and improving medication management alongside structured community-based interventions.

In previous studies, the relationship between psychiatric disorders and recurrent offending was often examined using broad diagnostic

categories, without adequately assessing clinical severity. Studies by Feder, Lovell et al, Teplin et al, and Porporino & Motiuk (Canada) reported that inmates with severe psychiatric disorders exhibited re-incarceration rates that were comparable to or lower than those of other inmates.^{14,17-19} However, differences in sample sizes, psychiatric assessment criteria, and definitions of recidivism limit direct comparisons with our findings. In our study, one of the clinical factors most strongly associated with recurrent offending was a history of manic episodes. The literature indicates that manic episodes are closely linked with impulsivity, risk-taking, and aggressive behaviors; these clinical features play a decisive role in establishing a repetitive pattern of criminal behavior, particularly among individuals with bipolar disorder.²⁰ Accordingly, our findings underscore that recurrent offending in individuals with psychiatric disorders is shaped not solely by diagnosis, but by illness severity, particularly a history of manic episodes, which substantially elevates recidivism risk.

Comorbid personality pathology and self-injurious behavior represent important clinical dimensions in understanding recurrent offending among individuals with bipolar disorder. Previous research has consistently demonstrated that personality disorders, particularly cluster B traits, are associated with an increased risk of violent and criminal behavior across clinical and forensic populations, largely through mechanisms related to impulsivity, impaired response inhibition, and interpersonal dysfunction.²¹ Within bipolar disorder, personality disorder comorbidity has been conceptualized not merely as an additional diagnosis, but as an indicator of a more severe and unstable illness course, potentially amplifying behavioral dysregulation and impulsive tendencies.²¹ In parallel, self-mutilation and suicidal behaviors have been linked to heightened impulsivity, affective instability, and recurrent illness trajectories and have been shown to cluster with other adverse behavioral outcomes, including criminal behavior.^{22,23} In our sample, both comorbid personality disorder and a history of self-harm were significantly more prevalent among individuals with recurrent offending, supporting the notion that these clinical features reflect a broader vulnerability to behavioral dyscontrol rather than isolated risk factors.

Frequent psychiatric hospitalizations have been widely regarded as an indicator of illness severity, clinical instability, and difficulties

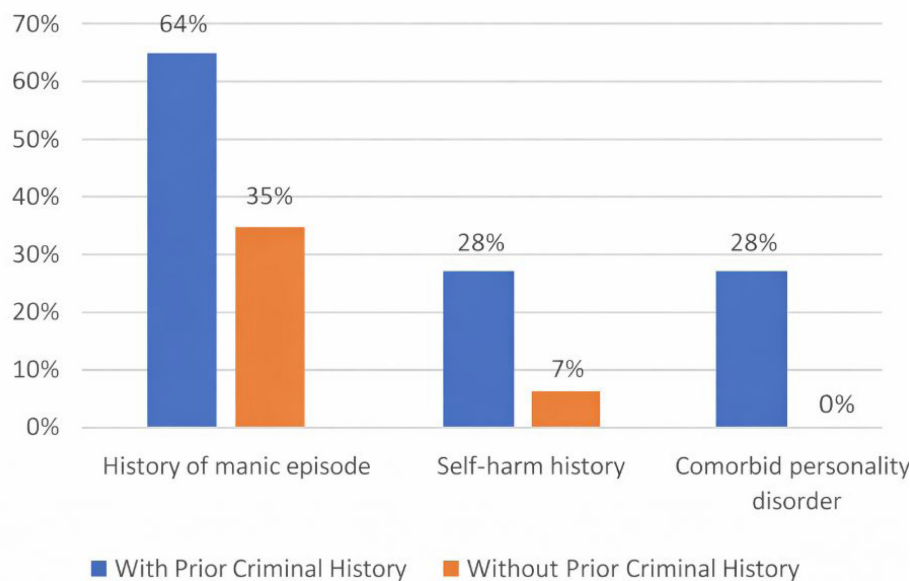


Figure 2. Comparison of clinical characteristics between participants with and without prior criminal history (n = 36 vs. n = 26).

in achieving sustained remission in bipolar disorder.^{22,24,25} Repeated admissions are often linked to affective dysregulation, impaired impulse control, and fragmented continuity of care, factors that have also been implicated in increased contact with emergency and forensic services.²⁵⁻²⁷ Within this framework, our findings suggest that patterns of psychiatric hospitalization are meaningfully associated with recurrent offending, supporting the notion that repeated hospital contact reflects a broader trajectory of clinical severity and system-level treatment disruption rather than isolated episodes of care. Such trajectories may increase vulnerability to repeated involvement with the criminal justice system, particularly in individuals with severe mood disorders.

Homicidal behavior among individuals with severe psychopathology has been linked more strongly to acute psychotic symptomatology than to stable, goal-directed criminal intent, as psychosis significantly increases the risk of violence.^{13,28,29} In this context, violence is better conceptualized as a reactive phenomenon arising from psychotic ideation, impaired reality testing, and deficient impulse control, rather than as a premeditated act.³⁰ Paranoid and persecutory beliefs are particularly salient, as they may transform neutral interpersonal encounters into perceived threats, thereby precipitating defensive or retaliatory aggression.³¹ The frequent coexistence of impulsive offense patterns with recurrent contact with psychiatric services further supports a model in which repeated episodes of clinical decompensation, rather than entrenched criminal motivation, underlie the trajectory toward severe violence.^{20,32} Such a pattern is consistent with a course marked by affective instability and psychosis-driven behavioral disinhibition, in which homicide represents an extreme but situationally determined outcome of illness severity.²⁰ In line with this conceptual framework, our sample was characterized by a high prevalence of psychotic features, predominantly paranoid delusions, an impulsive nature of the index offense, prior criminal history, and extensive psychiatric hospitalization histories, collectively supporting the view that homicidal behavior in this population is more closely related to clinical vulnerability and impulsivity than to premeditated intent. In terms of victim characteristics, the predominance of male victims and the high proportion of offenses committed against individuals known to the offender, particularly family members or close acquaintances, indicate that homicide in bipolar disorder predominantly occurs within close interpersonal contexts rather than involving strangers. Previous studies have consistently demonstrated that homicides associated with severe mental illness are more likely to occur in domestic or familiar settings, where sustained interpersonal conflict, emotional intensity, and relational proximity increase the risk of lethal violence.³³ This pattern suggests that violent behavior in this population is less reflective of generalized criminality and more closely linked to situational and relational factors embedded within the immediate social environment.^{33,34} The concentration of homicides among relatives or acquaintances further underscores the importance of evaluating family dynamics, conflictual relationships, and caregiving burden in forensic risk assessments of individuals with bipolar disorder.

In the present sample, sharp force trauma was the most common method of homicide (56.4%), followed by firearms (22.6%), blunt force trauma (11.3%), strangulation (6.5%), and other methods (3.2%). The majority of offenses occurred in residential settings (59.7%), with fewer incidents on the street (24.2%) or in indoor public places (16.1%). These findings are consistent with Minero et al,¹¹ who reported that stabbing was the predominant method among bipolar

offenders, reflecting the accessibility of sharp instruments in domestic contexts and the impulsive nature of many offenses. Similarly, Yoon et al⁶ observed that in depressive phases of bipolar disorder, less overtly violent methods such as suffocation or asphyxiation were more common, whereas stabbing predominated in manic phases, emphasizing the influence of affective state on method selection. The predominance of residential crime scenes in our sample aligns with these observations, suggesting that homicidal acts often occur in familiar, private settings where interpersonal conflict is immediate and emotional arousal is heightened. Taken together, the convergence of impulsive methods, familiar interpersonal settings, and prevalent psychopathological features suggests that homicidal acts among individuals with bipolar disorder are more closely associated with impulsivity and situational dynamics than with premeditated criminal intent. While psychiatric symptoms were common, the predominance of full criminal responsibility decisions indicates that these acts cannot be understood solely as acute illness-driven phenomena, but rather as the result of complex interactions between individual vulnerability and contextual factors.

The retrospective, single-center design, lack of a control group, and absence of multivariate regression analyses limit the generalizability of the findings and preclude conclusions about independent risk factors. In addition, the diagnosis of bipolar disorder was established based on DSM-5-guided clinical consensus and thorough review of longitudinal psychiatric records; no structured diagnostic interviews were conducted due to the retrospective nature of the study, which may have affected diagnostic verification. Although lifetime psychotic symptoms were reported at high rates, the presence and type of psychotic symptoms at the time of the offense (e.g., delusions, hallucinations) were not consistently documented in all cases. This distinction is particularly relevant for forensic interpretation and understanding the causal relationship between acute psychopathology and homicidal behavior. Finally, the retrospective design precludes prospective assessment of treatment adherence, acute symptom severity, and other potentially relevant clinical variables, limiting causal inferences regarding the relationship between psychiatric features, treatment, and offense characteristics.

CONCLUSION

This study delineates a distinct clinical and criminological profile among individuals with bipolar disorder who committed homicide, characterized by high rates of psychotic symptoms, predominantly impulsive offense characteristics, frequent prior criminal history, and extensive psychiatric hospitalization. The findings indicate that homicidal behavior in this population arises from a complex interaction of clinical instability, impaired impulse control, and contextual or interpersonal factors, rather than reflecting stable, goal-directed criminal intent. Although acute psychopathological states and markers of illness severity were prominent, the high prevalence of prior criminal history suggests that vulnerability to violent behavior may not be limited to acute mood episodes alone. Recurrent offending was associated with indicators of clinical instability, including a history of manic episodes, comorbid personality pathology, self-injurious behavior, and repeated hospitalizations, while also underscoring the importance of prior criminal behavior as an independent consideration in homicide risk assessment. These findings emphasize the need for comprehensive forensic psychiatric approaches that integrate longitudinal clinical monitoring with careful evaluation of past criminal behavior, prioritizing continuity of care, community-based interventions, and structured risk

management strategies to reduce repeated involvement with the criminal justice system.

Data Availability Statement: The data that support the findings of this study are available on request from the corresponding author.

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Informed Consent: As this research involved a retrospective analysis of anonymized forensic records, obtaining informed consent was deemed unnecessary.

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