# Clinical and Sociodemographic Characteristics That Affect The Recommendation For Assignment of A Legal Representative in Patients with Bipolar Disorder

Erhan AKINCI[1], Fatih ÖNCÜ[2], Can GER[3], Mustafa SABUNCUOĞLU[4], Anıl KIRMIZI[5], Nezih ERADAMLAR[6]

**SUMMARY**

**Objective:** In this study, we aimed to evaluate the clinical and sociodemographic characteristics of patients with bipolar disorder who had been sent to the Forensic Psychiatry Unit by the court in order to determine factors that affected the decision to appoint a legal representative.

**Methods:** The reports of health council, follow-up outpatient, and hospitalization files of a total of 78 patients with bipolar disorder who had been sent to the Department of Forensic Psychiatry Outpatient Clinic of Bakirköy Mental Health and Neurological Diseases Education and Research Hospital between 1st June 2009 - 31st December 2011 were examined. Patients had been sent by the court in order to determine whether a legal representative was required. Seventy patients meeting enough to sociodemographic and clinical form were separated as appointment group of legal representative or not and decision variables were compared statistically.

**Results:** Forty-six patients (66%) were recommended assignment of a legal representative. In the patients with bipolar disorder for whom a legal representative was recommended, the presence of other first axis comorbidity, the presence of psychotic episodes, delusions of persecution and reference, hallucinations, the total number of manic and mixed episodes, incidence of alcohol and substance abuse, lifetime total number of attacks, and the total number and duration of hospitalizations were found to be significantly higher. The probability of assignment of a legal representative was increased 11-fold by the presence of first axis comorbidity, 1.3-fold by the number of manic episodes, and 2.2-fold by the number of mixed episodes were specified.

**Conclusion:** In the practice of forensic psychiatry, clinicians should focus on the course of the disease, especially the number and frequency of manic or mixed episodes, total number of episodes and hospitalizations, duration of hospitalizations, alcohol and substance use, the presence of episodes accompanied by psychosis with paranoid delusions and hallucinations, and the presence of the other first axis comorbidity in the patient with bipolar disorder for assessment of the decision to appoint a legal representative.

**Keywords:** Forensic psychiatry, legal representative, guardianship, bipolar disorder

## INTRODUCTION

If requested by judicial authorities, patients with psychiatric diseases may be subject to examination and investigation within legal processes (Sercan 2007). Forensic psychiatric investigation and examination may be requested throughout the trial process of a criminal or civil lawsuit or to protect a person or society against the adverse effects of the disease. A person's criminal responsibility or legal capacity is assessed and determined by judicial authorities depending on forensic psychiatric expert evaluation (Biçer et al. 2009, Akgün 1987).

The Civil Law defines the conditions of a person's entitlement to and exercise of rights and also guarantees those rights in cases where such rights are subject to any obstacle or restriction. As per the Turkish Civil Code, every adult has the

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[1]MD, Balıklıgöl State Hospital, Department of Psychiatry, Şanlıurfa, [2]Assoc. Prof., [3, 6]MD, Bakırköy Mazhar Osman Mental Health and Neurological Diseases Education and Research Hospital, Department of Psychiatry, İstanbul, [4]MD, Ümraniye Education and Research Hospital, Department of Psychiatry, İstanbul, [5]MD, Yalvaç State Hospital, Department of Psychiatry, Isparta, Turkey.

**e-mail:** *drerhanakinci@yahoo.com*

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right to entertain civil rights. Civil rights are applicable to all citizens, and all adults with distinguishing power are equal in their capacity of entitlement to rights and obligations within the framework of the legal order (TCC 8). Distinguishing power refers to the ability to comprehend the causes and effects of one's actions and act rationally. Persons with mental defects or weaknesses that affect one's distinguishing power, minors, and those beyond self-control are deprived of exercising their civil rights. In such a case, courts restrict the civil rights of said persons and transfer their obligation to exercise their rights to their legal representative, thereby putting such a person under guardianship. Legal acts on behalf of those persons may only be conducted by their legal representative or guardian. The legal capacity of an adult may be partially restricted if there is no sufficient reason fully to deprive such a person of legal capacity, i.e. to put them under guardianship, provided that their opinion is consulted as well. A legal consultant, i.e., advisor, is appointed to a person whose legal capacity is partially restricted (Kaçak 2007).

TCC 405 governs the full deprivation of a person of their civil rights if they suffer from a mental illness or weakness. The article states the following: "Any adult who is not able to manage his/her affairs due to mental illness or mental weakness or who is in permanent need of care and protection or any adult who puts other people's safety at risk must be appointed a guardian." To put a person under guardianship both guarantees the rights of a person and restricts their power to perform legal acts. As per law, mental illness is not sufficient per se to put a person under guardianship. The person must also meet other conditions stated above. A legal consultant is assigned to an adult if it is necessary to restrict their legal capacity in order to protect them and insofar as there is no sufficient reason to restrict their capacity as per TCC 429. In psychiatric diseases presenting an episodic course, such as the bipolar disorder categorized under mood disorders, complete or partial and irreversible loss of the distinguishing power may be the case, depending on the course and severity of the disease. Under such circumstances, in the case of bipolar disorder, a court may decide to restrict the patient's legal capacity or assign a legal representative in order to protect the individual (Kaçak 2007, Özden 2007, Duman and Göka 2002).

The present study aims to evaluate the sociodemographic and clinical factors influencing the decision to assign legal representatives to patients with bipolar disorder who had been referred to the Forensic Psychiatry Outpatient Clinic by a court for a report on the necessity of guardianship or the assignment of a legal representative.

## METHOD

We scanned the health committee archive for all guardianship petitions submitted to the Department of Forensic Psychiatry Outpatient Clinic of Bakırköy Prof. Dr. Mazhar Osman Hospital for Mental and Neurological Diseases (BRSHH) between June 1, 2009 and December 31, 2011, and picked as sampling candidates the patients with bipolar disorder for whom a health committee report was produced. The candidates were then categorized into two groups—those who required assignment of a legal representative (guardian or legal consultant) and those who did not. We included in the sample those cases that completely met the criteria of the sociodemographic and clinical data form produced based on the outpatient clinic patient follow-up files and hospitalization epicrisis reports. Moreover, after examining the patient hospitalization files or in the case of missing data, we contacted patients or their relatives by phone to complete missing information. Then, we formed a group of sampling candidates with 78 patients who met all the criteria. The hospital's ethics committee granted the necessary permissions for the study with decision no. 39473 on October 16, 2012.

The study consisted of a retrospective file scanning. We employed a sociodemographic and clinical data form created in line with the information obtained from the patients' outpatient clinic files, epicrisis reports, or hospitalization files. Statistically, the data included in the form were classified and analyzed based on a dependent variable of guardian assignment decision and an independent variable of sociodemographic and clinical characteristics. Eight cases in the candidate group were excluded because of incomplete data. The study proceeded with 70 cases that completely met the DSM-IV TR criteria and had complete sociodemographic and clinical data forms.

The patients were diagnosed by at least one psychiatrist according to DSM-IV TR diagnosis criteria, and a health committee consisting of four psychiatrists confirmed the diagnoses.

With the assumption that it could be decisive in assigning a legal representative to the patients, a 42-question sociodemographic and clinical evaluation form was employed. The form was structured by the authors.

## STATISTICAL ASSESSMENT

We used SPSS 20.0 package software for statistical data input and assessment. A descriptive statistical calculation was performed for variables related to sociodemographic characteristics, first and second axis diagnoses, medication, and medical history. The qualitative variables were compared using the Chi-Square test to compare selected series of sociodemographic and clinical differences between the groups. In comparing the quantitative variables, we first evaluated whether the groups presented a normal distribution with the Kolmogorov–Smirnov test, and independent groups were subject to t-test

or one-way analysis of variance test depending on availability. Then, when a significant difference was detected as a result of the one-way analysis of variance, we performed a Tukey test to determine which group caused that difference. A logistic regression analysis was applied to the variables deemed to be related to the recommendation for the assignment of a legal representative. $P<0.05$ was taken to indicate statistical significance following a relevant statistical analysis.

## RESULTS

The patients' mean age was 44.8±13.7 years (min=22, max=77). The patients' mean age was calculated as 45.8±15.81 years and 42.7±8.61 years for the groups that required and did not require a legal representative, respectively, and no statistically significant difference was found between mean ages for both decision variables.

Of the participants, 44.3% were female (n=31), and 55.7% were male (n=39). Regarding marital status, 34.3% of the patients were married (n=24), 11.4% were unmarried (n=8), and 54.3% were either widowed or divorced (n=38). The patients' mean period of education was 7±3.68 years (min=0, max=15). An analysis of the patients' educational background showed that 2.9% of them were illiterate (n=2), 5.7% were literate without primary education (n=4), 51.4% completed primary school (n=36), 15.7% completed secondary school (n=11), 12.9% completed high school (n=9), and 11.4% graduated from higher education institutions. The whole patient group had a mean period of education of 7±0.8 years; this period was 6.7±3.7 years in patients with a legal representative and 7.5±4.1 years patients without a legal representative. In both decision variables, mean values over the period of education were close and there was no significant difference ($p>0.05$).

The occupational distribution of the whole group was as follows: 22.9% (n=16) of the patients were housewives, 17.1% (n=12) were workers, 17.1% (n=12) were retired on disability or retired, 4.3% (n=3) were farmers, and the rest was categorized as 'other or no occupation'. Currently employed patients comprised 34.3% (n=24) of the whole group, and the remaining 65.7% (n=46) were unemployed. The ratio of employed individuals was 30.4% (n=14) within the group of patients with a legal representative, and 41.7% (n=10) within the other group. No significant correlation was found between the decision of guardianship and employment ($p>0.05$).

The patients with a history of suicide attempt comprised 28.6% (n=20) of all patients, and the remaining 71.4% (n=50) did not present such a history. Among the cases with a history of suicide, 44.4% (n=12) of them attempted with drug intoxication, 22.2% (n=6) by leaping off a high place, 18.5% (n=5) with sharp objects, 7.4% (n=2) by hanging, and the remaining cases by self-burning or with firearms.

Regarding the drugs used by the patients, 23.9% used lithium, 19.1% used quetiapine, 13.5% used valproic acid, 13% used olanzapine, 3.9% used aripiprazole, and another 3.9% received carbamazepine. The remaining 8.3% were administered other psychotropic drugs. Moreover, 80% of the patients presented a history of psychotic episodes accompanying manic, depressive, or mixed periods during the follow-up with bipolar disorder. The remaining 20% presented no psychotic episodes during the follow-up period. Of those with a history of psychotic episodes, 68.6% had delusions of persecution and reference (n=48), 11.4% had a superiority delusion (n=8), 12.9% had a mystical delusion (n=9), and 27.1 presented no hallucination history (n=19).

Of the cases included in the study, 65.7% (n=46) were recommended for a legal representative (45.7% for a guardian and 20% for a legal consultant), and the remaining 34.3% (n=24) were found not to require a legal representative by a health committee report. The distribution of the parties that filed a lawsuit of guardianship was as follows: public agencies comprised 48.6% (n=34) and family members comprised 51.4%. The distribution of family members included spouses (22.9%, n=16), parents (15.7%, n=11), children (10%, n=7), and siblings (2.9%, n=2).

As to whether the plaintiff was a family member (parent, spouse, or sibling) or public agency, there was a significant difference between the groups, although the number of individuals with a legal representative was higher in both groups ($p<0.05$, $\chi^2=4.787$). An evaluation of the grounds for filing a lawsuit showed that the number of individuals without a legal representative was higher in lawsuits on divorce, while those with a legal representative was higher in lawsuits filed on other grounds (salary, overspending, sale of property, to get a loan, etc.) ($p<0.05$, $\chi^2=6.407$).

Also, there was no significant correlation between those with and without a family history of psychiatric diseases, married and unmarried-divorced individuals, those with and without personal income, employed and unemployed individuals, those with an educational background of secondary school or lower and high school or higher, or females-males with decision variables.

75.7% of the patients (n=53) did not present another first axis diagnosis, whereas 24.2% of them (n=17) had a first axis diagnosis accompanying BPD. In addition, 71.4% of the patients (n=50) did not have a second axis diagnosis, while 28.6% of them (n=20) presented a second axis diagnosis accompanying BPD. Alcohol and substance abuse was the primary first axis psychiatric comorbidity among the patients included in the study [18.6%, (n=13)]. Of them, top comorbidities were mixed alcohol and substance abuse [8.6%, (n=6)] and alcohol abuse [7.1%, (n=5)]. The second axis comorbidities were personality disorder [14%, (n=10)], and borderline or

**Table 1**. Comparison of the sociodemographic characteristics of the groups recommended and not recommended for a legal representative

| | | Legal Representative (+) Group N(%) | Legal Representative (-) Group N(%) | p | $\chi^2$ |
|---|---|---|---|---|---|
| Guardianship case filed by | Family member | 28 (77.8) | 8 (22.2) | 0.026* | 4.787 |
| | Public agency | 18 (52.9) | 16 (47.1) | | |
| Grounds for filing a case | Divorce | 11 (45.8) | 13 (54.2) | 0.012* | 6.407 |
| | Other | 35 (76.1) | 11 (23.9) | | |
| Gender | Female | 19 (61.3) | 12 (50) | 0.329 | 0.483 |
| | Male | 27 (69.2) | 12 (50) | | |
| Family History | Yes | 20 (62.5) | 12 (50) | 0.394 | 0.270 |
| | No | 26 (68.4) | 12 (50) | | |
| Marital Status | Married | 16 (66.7) | 8 (33.3) | 0.561 | 0.015 |
| | Unmarried/Widow | 30 (65.2) | 16 (34.8) | | |
| Educational Background | Secondary education or lower | 36 (67.9) | 17 (32.1) | 0.342 | 0.473 |
| | High school and higher | 10 (58.8) | 7 (41.2) | | |
| Employment Status | Yes | 14 (58.3) | 10 (41.7) | 0.249 | 0.883 |
| | No | 32 (69.6) | 14 (30.4) | | |
| Income | Yes | 26 (65) | 14 (35) | 0.545 | 0.021 |
| | No | 20 (66.7) | 10 (33.3) | | |

*p<0.05

**Table 2**. Comparison of first axis and second axis comorbidities in the decision for the assignment of a legal representative

| | | Legal Representative (+) Group | | Legal Representative (-) Group | p | $\chi^2$ |
|---|---|---|---|---|---|---|
| | | Recommended for guardianship | Recommended for legal consultant | | | |
| | | N(%) | N(%) | N(%) | | |
| 1st Axis Comorbidity | Yes | 12 (70.6) | 4 (23.5) | 1 (5.9) | 0.015* | 8.462 |
| | No | 20 (37.7) | 10 (18.9) | 23 (43.4) | | |
| 2nd Axis Comorbidity | Yes | 12 (60) | 3 (15) | 5 (25) | 2.304 | 0.316 |
| | No | 20 (40) | 11 (22) | 19 (38) | | |

*p<0.05

**Table 3**. Comparison of psychotic characteristics of episodes in the decision for the assignment of a legal representative

| | | Legal Representative (+) Group N(%) | Legal Representative (-) Group N(%) | p | $\chi^2$ |
|---|---|---|---|---|---|
| Psychotic episode history | Yes | 40 (87) | 16 (66.7) | 0.044* | 4.058 |
| | No | 6 (13) | 8 (33.3) | | |
| Hallucination | Yes | 17 (37) | 2 (8.3) | 0.011* | 6.534 |
| | No | 29 (63) | 22 (91.7) | | |
| Delusion | Yes | 38 (82.6) | 15 (62.5) | 0.063 | 3.468 |
| | No | 8 (17.4) | 9 (37.5) | | |
| Delusion of Persecution and Reference | Yes | 36 (78.3) | 12 (50) | 0.016* | 5.845 |
| | No | 10 (21.7) | 12 (50) | | |
| Mystical Delusion | Yes | 5 (10.9) | 4 (16.7) | 0.492 | 0.473 |
| | No | 41 (89.1) | 20 (83.3) | | |

*p<0.05

mild mental retardation [13%, (n=9)]. Antisocial and paranoid personality disorders were the most prominent personality disorders. While comparing the assignment decision with psychiatric comorbidities, a significant difference was detected between having another first axis diagnosis other than BPD and the decision variables ($p<0.05$, $\chi^2=6.461$). Restriction decision ratios increased statistically with the presence of another first axis psychiatric comorbidity other than BPD. However, no significant correlation was found between the second axis comorbidities and decision variables ($p>0.05$) (Table 2).

An analysis of the decision variables and psychotic findings revealed a significant difference between decision variables and history of psychotic episode ($p<0.05$, $\chi^2=4.058$), delusions of persecution and reference ($p<0.05$, $\chi^2=5.845$), delusions of superiority ($p<0.05$, $\chi^2=4.712$) and especially hallucinations

**Table 4**. Comparison of the number of hospitalization and episodes in the decision for the assignment of a legal representative

| | Legal Representative (+) Group | | Legal Representative (-) Group | p | F |
|---|---|---|---|---|---|
| | Recommended for Guardianship | Recommended for legal consultant | | | |
| | Mean±SS | Mean±SS | Mean±SS | | |
| Total Number of Hospitalizations | 5.47±3.80 | 5.64±3.18 | 2.83±2.76 | 0.009* | 5.079 |
| Total Duration of Hospitalization (days) | 79.75±51.15 | 90.8±63.15 | 43.13±39.67 | 0.008* | 5.231 |
| Total Number of Episodes | 9.50±8.57 | 7.35±4.68 | 4.91±3.43 | 0.039* | 3.406 |
| Total Manic Episodes | 6.41±5.36 | 4.78±3.26 | 2.50±2.39 | 0.004* | 6.034 |
| Total Mixed Episodes | 1.91±2.88 | 0.93±1.73 | 0.38±0.82 | 0.033* | 3.585 |
| Total Depressive Episodes | 2.31±3.35 | 2.00±2.83 | 2.46±2.83 | 0.907 | 0.098 |

*p<0.05, Mean±SD: Mean ± standard deviation

**Table 5**. By logistic regression, the effects of family issues as grounds for filing a case (yes/no), whether the case was filed by family (yes/no), presence of another first axis comorbidity (yes/no), the number of psychotic episodes, manic episodes, depressive episodes, and mixed episodes on the assignment of a legal representative (yes/no) when the former are taken as explanatory variables

| | β | S.E. | p | OR | Cl 95% |
|---|---|---|---|---|---|
| Grounds for filing a case (yes/no) | -0.783 | 0.849 | 0.356 | 0.457 | 0.087-2.411 |
| Plaintiff (yes/no) | -0.460 | 0.862 | 0.594 | 0.632 | 0.117-3.418 |
| 1. Axis Comorbidity (yes/no) | 2.397 | 1.161 | 0.039* | 10.990 | 1.130-106.866 |
| Number of Psychotic Episodes | 0.022 | 0.783 | 0.978 | 1.022 | 0.220-4.739 |
| Number of Manic Episodes | 0.298 | 0.129 | 0.021* | 1.347 | 1.046-1.734 |
| Number of Depressive Episodes | -0.128 | 0.145 | 0.378 | 0.880 | 0.662-4.496 |
| Number of Mixed Episodes | 0.809 | 0.354 | 0.022* | 2.245 | 1.121-4.496 |

*p<0.05

($p<0.05$, $\chi^2=6.534$) Although delusions of persecution and reference were significantly different between the two groups, the presence of hallucination was not significant per se ($p>0.05$, $\chi^2=3.468$). The restriction decision rates were found to be increased statistically in the presence of a psychotic episode history, hallucinations, and delusions of persecution and reference through the course of the disease (Table 3).

One-way analysis of variance comparing the patients recommended for guardianship, those recommended for a legal consultant, and those who did not require a legal representative suggested that they significantly differed in terms of the following variables: total number of hospitalizations ($p<0.01$), total days of hospitalization ($p<0.01$), total number of episodes ($p<0.05$), total number of manic episodes ($p<0.01$), and total number of mixed attacks ($p<0.05$) (Table 4). According to the Tukey test results, conducted to determine which group was responsible for the difference, the group of individuals who did not require a guardian had significantly different and lower mean values for the total number of hospitalizations and total duration of hospitalization than the other two groups. There was no significant difference between the mean values of the patients recommended for guardianship and those recommended for legal representation. For the total number of episodes, manic episodes, and mixed episodes, there was a significant difference between the mean values of those individuals who required and did not require a guardian, and no significant difference was found between other groups concerning the same.

We created a logistic regression model based on variables such as whether the lawsuit was filed on family grounds, whether the lawsuit was filed by family members, presence of a first axis comorbidity, and number of psychotic, manic, depressive and mixed episodes, and this model was highly significant ($\chi^2=32.233$, $p<0.001$). We concluded that the presence of a first axis comorbidity accompanying the bipolar disorder (11-fold), increased number of manic episodes (1.3-fold), and increased number of mixed episodes (2.2-fold), as three separate and independent variables, significantly increased the likelihood of the assignment of a legal representative (Table 5).

## DISCUSSION

To our knowledge, the present study is the first in Turkey to evaluate the factors influencing the decision to assign legal

representatives to patients with bipolar disorder. In sum, we found no difference among sociodemographic variables such as gender, educational background, marital status, employment and social insurance concerning the recommendations for the assignment of legal representatives; clinically, psychotic episode history, delusions of persecution and reference, and hallucinations were higher in the cases recommended for a legal representative; and the same cases presented a notably higher total number of manic episodes, mixed episodes, and total number of episodes in lifetime, and they also had a marked chronic course and a remarkably higher number and longer duration of hospitalization.

Of the patients referred to the Bakirköy Mental Health and Neurological Diseases Education and Research Hospital forensic psychiatry unit for an assessment of restriction, 44% were female and 56% were male. Available studies in the literature report that BPD prevalence is equal in men and women (Yazıcı 2007, Sadock and Sadock 2007). The present study found no difference among the included forensic psychiatry cases in terms of gender.

We found that 34% of our cases were married, 11% were unmarried, and 54% were divorced, about to divorce, or widowed. The family disintegration (breakup or divorce) rate is higher in patients with BPD than the rest of the population (Sadock and Sadock 2007, Sanchez et al. 2009, Szádóczky et al. 1998). It is reported that bipolar disorder prevalence is higher in individuals with a history of divorce than married individuals without this history, regardless of their current marital status (Williams et al. 2006). The findings of our study comply with results reported in the literature regarding the high divorce rate in patients with bipolar disorder. The fact that a certain portion of the cases included in the study was referred to us in divorce suits may both be considered a factor of our findings and an indicator of family disintegration. The plaintiffs of guardianship cases part of our study were as follows: 49% of them were public agencies, 23% were spouses, 10% were fathers, 6% were mothers, 10% were children, and 3% were siblings. As can be seen, public agencies comprise the highest number of plaintiffs and grounds for filing a case. The TCC states that "administrative authorities, public notaries, and courts shall report any situation that requires guardianship to the authorized guardianship agency as they carry out their duties" (TCC 405). Also, in cases of legal capacity restriction to protect the individual and mandatory treatment (TCC 432), the guardianship authority may file a guardianship case upon a guardianship report. Within the scope of the civil code, the guardianship authority or civil courts of peace may act as plaintiff (Sercan 2007, Aral et al. 2012). In our study, the high rate presented by public authorities may be due to the provisions of the TCC. However, further studies are required to clarify the relationship between this situation and guardianship.

High number and frequency of episodes, the presence of mixed episodes and a chronic course are markers of poor prognosis in BPD (Angst and Sellaro 2000, MacQueen et al. 2000, Cusin et al. 2000). Periods of relapse lead to progressive dysfunctions (APA 2000). Goldberg et al. (1995) report a powerful association between the number of episodes and poor prognosis in patients with bipolar disorder. Further, the number of episodes increases the number of hospitalizations. In our study, we detected that patients recommended for a guardian presented a significantly greater number of manic and mixed episodes. The total number of episodes, manic episodes, and mixed episodes patients had throughout their lives were notably higher in the group of patients recommended for a guardian than the others. Regarding the duration and number of hospitalizations, the patients who did not require a guardian presented significantly different and lower mean values than the other two groups. One could thus conclude that the group of patients who did not require a guardian were rather subject to outpatient follow-up. Studies in the literature also report that a high number of episodes and their high recurrence rate are important for the restriction decision (Sercan 2007, Özden 2007, Balcıoğlu and Başer 2008, Hua et al. 2011)

The presence of a psychotic picture during the episodes indicates poor prognosis in bipolar disorder. It is stated that mood disorders with psychotic symptoms present a higher compliance with treatment, episode frequency, and hospitalization rates (Hua et al. 2011, Yen et al. 2003); they exhibit a worse prognosis and higher psychosocial dysfunction (Tuncer 2001, Soysal 2012, Dunayevich and Keck 2000). If the content of psychotic symptoms demonstrates manic characteristics, one speaks of a 'mood-congruent' psychotic mania (Yazıcı 2007). The presence of mood-incongruent or non-megalomaniac psychotic symptoms is one of the factors associated with poor prognosis (Tsuang and Stone 2002). The present study found that clinical psychotic episode history, delusions of persecution and reference, and especially hallucinations were statistically higher in cases recommended for a legal representative. Although the presence of hallucinations was not significant per se, the findings of our study suggest that the delusions of persecution constitute a decisive factor in the assignment of a legal representative. In this sense, an overall evaluation of our findings implies that the frequency and form of episodes and the accompaniment of some psychotic characteristics adversely affect the prognosis, increase the number of hospitalizations, and that such variables may influence the restriction decision. Our data comply with the literature in this respect as well.

Some studies in the literature report that coexisting psychiatric disorders in patients with BPD negatively affect the prognosis and response to treatment, and increase the number and severity of episodes, as well as the number of hospitalizations

(Krishnan 2005, Cassidy et al. 2001, Merikangas et al. 1996). It is important that coexisting psychiatric disorders should also be evaluated concerning the decision to assign a legal representative in cases of BPD. Characteristics such as psychiatric comorbidities or substance abuse should be assessed separately for each case (Türkcan 2007, Soysal 2012). Alcohol and substance abuse is a quite frequent comorbidity accompanying BPD (Levin and Hennessy 2004, Strakowski et al. 2000). There are available data suggesting that BPD occurs earlier and follows a more severe course in individuals with alcohol and substance abuse (Strakowski et al. 2000, Brady and Sonne 1995). In our study, alcohol and substance abuse was a prominent psychiatric comorbidity among the cases. Our findings comply with those reported in the literature in both showing its frequency in BPD and suggesting that alcohol and substance abuse may be a determining factor for the restriction decision.

In patients followed up for BPD, the comorbidity of personality disorder has been defined as a factor forcing poor prognosis of the disease and associated with increased frequency of residual symptoms and worse response to treatment (George et al. 2003, Bieling et al. 2003). In general, numerous psychiatric diseases may coexist with mental retardation (MR). It is quite challenging to diagnose and distinguish psychiatric comorbidities in moderate and severe cases of MR (Eaton and Menolascino 1982, Campbell and Malone 1991). Psychiatric disorders may develop depending on the brain damage that leads to MR. A low intellectual capacity adversely affects one's skills of coping with stress and solving psychosocial problems as well (Bouras 1994). Thus, the presence of borderline intellectual functioning or mild MR can be considered to worsen the course of the disease. However, the present study did not reveal a significant difference between decision variables and the presence of a comorbidity, particularly personality disorder and borderline-mild MR. In this respect, these data did not comply with the reports in the literature. Nevertheless, this discrepancy might be explained by the fact that the patients' prior diagnoses and psychometric examination reports in outpatient and hospitalization files largely concerned the first axis diagnoses or that MR is evaluated per se as a ground for guardianship in forensic psychiatry processes.

Our study presents certain methodological limitations. The primary limitation consists in the fact that patient assessments were limited to the data available in the files, as the study employed a retrospective file scanning method. In this respect, face-to-face interviews with patients may positively contribute to the retrospectively obtained data. Moreover, the statistical assessment showed that the sample size remained inadequate for the distribution of some variables between groups. Those variables could have been included in the study with a larger sample size.

The findings of this study show that, in their evaluation of the assignment of a legal representative to cases with bipolar disorder, it is important for clinicians to focus on first axis comorbidities, course of disease, total number of episodes and duration and number of hospitalizations, including the frequency and number of manic or mixed episodes, alcohol and substance abuse (abuse or addiction), and psychotic episodes including hallucinations and delusions of persecution. Also, we concluded that the utilization of assessment questionnaires in evaluating the social functionalities and course of forensic cases and use of questionnaires in the assessment of legal capacity will help researchers obtain more detailed data in future studies.

## REFERENCES


Akgün N (1987) Adli Psikiyatri, Ankara.

American Psychiatric Association (2000) Diagnostic and statistical manual of mental disorders (4th ed., text rev.). Washington, DC: Author.

Angst J, Sellaro R (2000) Historical perspectives and natural history of bipolar disorder. Biol Psychiatry 48:445-57.

Balcıoğlu İ, Başer SZ (2008) Türkiye'de sık karşılaşılan psikiyatrik hastalıklar hekimlerin karşılaştığı adli ve psikiyatrik problemler. Sempozyum Dizisi 62:41-8.

Biçer Ü, Tırtıl L, Kurtaş Ö, Aker T (2009) Adli Psikiyatri. Klinik Gelişim Dergisi (Adli Tıp Özel Sayı) 22:126-32.

Bieling PJ, MacQueen GM, Marriot MJ et al (2003) Longitudinal outcome in patients with bipolar disorder assessed by life-charting is influenced by DSM-IV personality disorder symptoms. Bipolar Disord 5:14-21.

Bouras N (1994) Mental Health in Mental Retardation: Recent Advances and Practices. Cambridge, Cambridge University Press.

Brady KT, Sonne SC (1995) The relationship between substance abuse and bipolar disorder. J Clin Psychiatry 56:19-24.

Campbell M, Malone RP (1991) Mental retardation and psychiatric disorders. Psychiatr Serv 42:374-9.

Cassidy F, Ahearn EP, Carroll BJ (2001) Substance abuse in bipolar disorder. Bipolar Disord 3:181-8.

Cusin C, Serretti A, Lattuada E et al (2000) Impact of clinical variables on illness time course in mood disorders. Psychiatry Res 97:217-27.

Duman ÖY, Göka E (2002) Yeni Türk Medeni Yasası ve psikiyatri. Psikiyatri Psikoloji Psikofarmakoloji (3P) Dergisi 10:25-32.

Dunayevich E, Keck PE Jr (2000) Prevalence and description of psychotic features in bipolar mania. Curr Psychiatry Rep 2:286-90.

Eaton LF, Menolascino FJ (1982) Psychiatric disorders in the mentally retarded: types, problems, and challenges. Am J Psychiatry 139:1297-303.

George EL, Miklowitz DJ, Richards JA (2003) The comorbidity of bipolar disorder and axis II personality disorders: prevalence and clinical correlates. Bipolar Disord 5:115-22.

Goldberg JF, Harrow M, Grossman LS (1995) Course and outcome in bipolar affective disorder: a longitudinal follow-up study. Am J Psychiatry 152:379-84.

Hua LL, Wilens TE, Martelon M (2011) Psychosocial functioning, familiality, and psychiatric comorbidity in bipolar youth with and without psychotic features. J Clin Psychiatry 72:397-405.

Kaçak N (2007) Yeni İçtihatlarla Türk Medeni Kanunu (2. Baskı). Ankara, Seçkin Yayıncılık.

Krishnan KR (2005) Psychiatric and medical comorbidities of bipolar disorder. Psychosom Med 67:1-8.

Levin FR, Hennessy G (2004) Bipolar disorder and substance abuse. Biol Psychiatry 56:738-48.

MacQueen GM, Young LT, Robb JC (2000) Effect of number of episodes on wellbeing and functioning of patients with bipolar disorder. Acta Psychiatr Scand 101:374-81.

Merikangas KR, Angst J, Eaton W (1996) Comorbidity and boundaries of affective disorders with anxiety disorders and substance misuse: Result of an international task force. Br J Psychiatry (Suppl.30):58-67.

Özden SY (2007) Adli Psikiyatri. 3P PharmaPublication Planning, İstanbul.

Sadock BJ, Sadock VA (2007) Kaplan & Sadock's Comprehensive Textbook of Psychiatry, 8. Baskı, Cilt 2, Bölüm 13: Duygudurum Bozuklukları (Çev. Ed. H Aydın, A Bozkurt). Güneş Kitabevi, İstanbul 2007.

Sanchez J, Martinez A, Tabarés R (2009) Functioning and disability in bipolar disorder: An extensive review. Psychother Psychosom 78:285-97.

Sercan M (2007) Yurttaşlık Hukukunda (Medeni Hukuk) Adli Psikiyatri. Sercan M (Ed.). Adli Psikiyatri Uygulama Kılavuzu. Türkiye Psikiyatri Derneği, Tuna Matbaacılık, Ankara.

Soysal H (2012) Adli Psikiyatri. Özgür Yayınları, İstanbul.

Strakowski SM, DelBello MP, Fleck DE (2000) The impact of substance abuse on the course of bipolar disorder. Biol Psychiatry 48:477-85.

Szádóczky E, Papp Zs, Vitrai J (1998) The prevalence of majör depressive and bipolar disorders in Hungary: Results from a national epidemiologic survey. J Affect Disord 50:153–62.

Tsuang MT, Stone WS (2002) Understanding outcome differences in bipolar disorder. Maj M, Akiskal HS, López-Ibor JJ, Sartorius N (Ed). Bipolar Disorder, New York, John Wiley&Sons Ltd, s.152-4.

Tuncer ET (2001) Duygudurum Bozukluklarının Adli Yönü. Duygudurum Dizisi 4:198-203.

Türkcan S, Yeşilbursa D (2007) Adli Psikiyatri. Köroğlu E, Güleç C (Ed), Psikiyatri Temel Kitabı (2.Baskı), Ankara, Hekim Yayın Birliği, s.937-44.

Ünal M, Aral F, Başpınar V (2012) Medeni Hukuk Pratik Çalışmaları, 8. Baskı. Ankara, Yetkin Yayınları.

Williams DR, Neighbors HW (2006) Social Perspectives on mood disorders. Stein DJ, Kupfer DJ, Schatzberg AF (Ed) The American Psychiatric Publishing Textbook of Mood Disorders, Washington DC, American Psychiatric Publishing Inc s.145-58.

Yazıcı O (2007) Bipolar-1 ve bipolar-2 bozuklukları. Köroğlu E, Güleç C (Ed.), Psikiyatri Temel Kitabı (2.Baskı), Ankara, Hekim Yayın Birliği, s.265-78.

Yen CF, Chen CS, Yeh ML (2003) Changes of insight in manic episodes and influencing factors. Compr Psych 44:404-8.