CRIMINAL NARRATIVE EXPERIENCE AND EMOTIONAL STATE OF SCHIZOPHRENIC OFFENDERS

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Abstract

It is deeply rooted in the social consciousness that dangerousness in inherent in the mental disorder. Over recent years, few extremely violent crimes committed by individuals suffering from schizophrenia have had an adverse impact on public opinion enhancing the widespread social misconception. Considering there is limited research on crimes committed by offenders suffering from schizophrenia, the present study carried out in the interest of obtaining a better knowledge of schizophrenic offenders' criminal actions and the etiological factors associated to the expression and maintenance of the violent behaviour in such populations.

The general purpose of the present study was to investigate the Criminal Narrative Experience of the Schizophrenic Offenders by the application of the Criminal Narrative Experience framework proposed for non mentally ill offenders (Ioannou, 2006); and further explore the emotional state of that population in terms of moral emotions, depression and suicidal ideation regarding the CNE of these offenders. This is the first study to examine the CNE framework solely in schizophrenic offenders and the first one to explore the emotional state in terms of the above mentioned aspects in combination to schizophrenic offenders during incarceration.

A total of 64 schizophrenic offenders who have been found Not Guilty by Reason of Insanity and recruited from three Psychiatric Hospitals in Greece, were voluntary participated in the present study. All the participants completed the demographic questionnaires regarding their personal, psychiatric and criminal background and seven questionnaires regarding their Criminal Narrative Experience and their emotional state.

The present research successfully implemented the Criminal Narrative Experiences model and revealed the internal motives and the emotional gratifications that lead to crime. The findings mirrored partially the findings of previous studies in non mentally and mentally ill populations. Specifically, the study identified three Criminal Narrative Experience themes the Displeased Victim, the Contradicted Revenger and the Pleased Hero. Furthermore, it was found that the most dominant criminal narrative experience was the Displeased Victim as the majority of the participants experienced negative emotions and felt as victims during the crimes they had committed. Last but not least, there were found differences between the three Criminal Narrative Experience themes in terms of their emotional state and there was found that the background characteristic of schizophrenic offenders do not play any significant role in the formation of their criminal experience.

Keywords: Schizophrenia, Crime, Schizophrenic Offenders, Criminal Narrative Experience, Narrative Roles, Emotions Felt During a Criminal Offence, Depression, Suicidal Ideation, Moral Emotions, Guilt, Shame

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Mental Illness and Crime

1.1 Initial Thoughts on Mentally Disordered Offenders

The qualities of an individual suffering form a mental illness on the one hand and those of an individual who has offended on the other, despite the fact they relate to two totally different and independent aspects of human life, someone can easily see that these two individuals share a common element. Both of them are marginalised and stigmatised in modern societies because of their divergence from social norm; in the form of mental normality in the case of mental illness and obeying the law in the second one. Human societies for a very long time, have been trying to get rid of their members suffering from mental illness by banishing them to institutions or psychiatric clinics. The phenomenon is very reminiscent of imprisonment, both in terms of restriction of liberty and with being cut off from the rest of the "healthy" lawful society (Striggaris, 1980).

The coincidence of these two marginalised and stigmatised identities in the same person is of particular interest. The criminality exhibited by mentally ill individuals tends to generate a metaphysical and mystical sense almost certainly because this action is usually incomprehensible in collective consciousness. Concurrently, public usually views the crimes commited by mentally ill individuals with fear and panic mostly because of the distortion of reality systematically cultivated by the mass media, in combination with the long-standing perception of a mentally ill as someone "evil" and dangerous to the common human mind (Van Dorn, Volavka, & Johnson, 2012; Striggaris, 1980).

The introduction of the concept of “dangerousness” by the Italian Positive School, played a key role in the construction and maintenance of the myth of the dangerous mental patient, since it occurred at a time when the scientific and public interest was placed on the criminal and not on the crime (Giotopoulou-Maragkopoulou, 1975). This notion had been reinforced by a number of studies conducted since the late 20th century and on, which suggested that mentally ill people are more likely to act violently compared to the general population; and they are at an increased risk of committing a crime of increased severity. The scientific dialogue followed these research data, suggested that mental illness and criminal behavior are casually related (Alexiadis, 1986; Appleby & Wessely, 1988; Striggaris, 1980, 1983).

1.2 Society’s Opinion for Mentally Disordered Individuals

The stereotype of the dangerous mental patient seems to be embedded in modern society’s collective consciousness (Douzenis, 1995; Levey, Howells & Levey, 1995; MacLean, 1969; Skaragkas, 1997; Tsalikoglou, 1987). According to relevant research, the general public views the mentally ill as violent, unpredictable and uncontrollable (Markowitz, 2011; Stuart, 2003). While the potential crime of a mentally ill individual is always regarded as an unreasonable and incomprehensible action, which lacks motivation and it is interpreted as the result of his madness (Douzenis, 1995; Tsalikoglou, 1987). The public beliefs lead to the conclusions that when a mentally ill person commits a crime, it is considered to be the result of his mental illness; and that every mentally ill person is regarded as a potential criminal (Livaditis, 1994; Skaragkas, 2002; Tsalikoglou, 1987). Consequently, society is at the mercy of "paranoid" and "crazy" individuals who, like time bombs, can at any time "explode" at the expense of anyone who happens to be in the wrong place at the wrong time.

At the same time, when a particularly violent crime is reported, public opinion, motivated by the mass media, hastens to attribute it to psychpathological agents before any psychiatric assessment (Szasz, 1971; Tsalikoglou, 1987; Van Dorn, Volavka, & Johnson, 2012). It is clear that mental illness causes negative emotions (Striggaris, 1980) in the general public because of the mass media and the performing arts which play a neuralgic role in shaping these negative emotions (Stuart, 2006; Wahl, 1992). Some writers refer to the "emotional remnants of primitivism" that are encountered in society, as *"a large number of people are held inwardly by a primitive awe mixed with hostility to the madness"* (Skaragkas, 2002, p. 4).

1.3 Mass Media and Mental Illness

The mass media are an integral part of Western culture, with their 'omnipresence' governing modern day life and largely defining social life and interaction. Media, in their ideal form, are called upon to provide fair and reliable information on public affairs, to enable access to the various “voices” of society they wish to be expressed through them and thus to facilitate citizens' participation in public sphere (McQuail, 2003). Mass media have been very aptly described as a mirror of society; but a mirror very often distorted reality. The need for commercialization of news requires that topics be selected and presented in such a way as to promote extremity and exaggeration (Luhman, 2000). The media construct an appearance of reality in the receptions of the receiver, often dramatized or fragmented and thus distorted (Bennett, 1999). They influence the public's consciousness by directing it to the adoption of certain beliefs that influence its future behavior and actions.

Mental illness is a component that only a small proportion of population comes into direct and frequent contact, particularly when it regards its severe forms. Consequently, the impact that mass media have is crusial on shaping mental illness' social image and formulating public's attitudes towards mentally ill patients (Chatzoglou, 2010; Coverdale, Nairn &Claasen, 2002; Economou, Richardson, Gramandani, Stalikas, Stefanis, 2009; Wahl, 1996, 2003). The extremes, the exaggeration and the tension are prerequisites that make a journal topic trigger the immediate interest and emotional engagement of the public (Wahl, 1996). Therefore, news about extreme or violent incidents that link mental illness to either dangerousness or crime or to incidents of victimization of an individual suffering from a mental disorder; always aim at the emotional stimulation of the public.

The perception that the mentally ill individuals are dangerous and violent is largely due to the spectacular news coverage of mentally disordered offenders as well as the influence of fiction products; in particular classic characters such as Norman Bates on Psycho or Hannibal Lecter on Silence of the Lambs who confirm the stereotype above (Birch, 2016; Skopeteas, 2015). The portrayal of a schizophrenia patient as unpredictable, dangerous, violent and potentially criminal seems to be remarkably "popular", largely because of the psychotic symptoms of the disorder and their severity and the "dark" nature attributed to it (Corrigan et al., 2005; Coverdale et al., 2002; Cutcliffe & Hannigan, 2001; Levin, 2005; Magli et al., 2004; Wahl, 1992, 1996, 2003).

A study revealed that the media presented a stereotype of dangerous mentally ill individual and that newspaper articles tended to link mental illness to crime, as such stories become headlines more often (Torrey, 1994). In television programs, dangerous and unpredictable characters are usually attributed to television characters

suffering from mental illness. Sevently two percent of television characters with mental illness are described as violent.

According to a recent study by the Johns Hopkins Bloomberg School of Public Health, Emma McGinty's research team (2014) analyzed a random sample of 400 mental health articles in 11 popular media and found that a high proportion, about 40% linked mental illness to episodes of interpersonal violence. The team also found that 30% of articles linked mental illness to suicide, and that only 14% of the articles analyzed revealed evidence of successful treatment. One important finding from McGinty's team (2014) was the lack of discussion about successful treatment; and the team concluded that there was very little change in the way media described mental illness over the past 20 years, despite significant advances in the science in this field. She emphasized on the possibility of treatment which she suggested should be viewed by the media and could help "demolish" thestigma.

The picture presented by the Greek reality regarding the presentation of mental illness in the mass media follows the international trends. According to research findings on representations reproduced in the Greek press (Economou et al., 2009), mental illness is associated with violence and dangerousness. In fact, schizophrenia appears to be on the first place among mental disorders in the reproduction of stigmatic stereotypes. Another research by Chatzoglou (2010) revealed that the main source of information regarding mental illness for the public was television at a percent of 66%. Also revealed that tv programmes present negative descriptions of mental illness, and especially link schizophrenia to violent or dangerous behaviour at a percent of 74.6% of the tv programmes.

Very few publications pay particular attention to more positive parameters of the disorder, which could reveal promising dimensions and positive aspects of mental illness by presenting for example the advances in the field of psychotherapy and pharmacotherapy or the achievements of individuals who have overcome the problems derived by the mental illness and have distinguish themselves in various fields (Coverdale et al., 2002; Wahl, 2003). Another aspect that is systematically neglected by the mass media when presenting mental illness is the perspective, the thoughts and experiences of both the patients themselves and their families. People who are dealing with mental illness are almost never given the opportunity to publicise their personal experience of the disorder, their day-to-day life, the effort they put to have a normal life, the struggles, successes, or frustrations (Chatzoglou, 2010; Nairn & Coverdale, 2005; Wahl, Wood, & Richards, 2002).

Even when the journalistic approach to the issue it is not in the context of violence and danger, mental illness and especially schizophrenia is almost always presented in the media by emphasising on the negative and stereotypical aspects. Images that are often reproduced of the mentally ill focus on the individual's dysfunction, lack of ability to meet life's demands, self-destructive behavior, the misery that can lead to illness, his vulnerability, which makes him prone to victimization, and frequently to the harsh conditions of incarceration (Levin, 2005; Wahl, 2003).

The use of terms such as "paranoid", "crazy", "schizophrenic", "maniac" in the headlines of news or articles or even in daily conversations about mentally ill and crimes indicates that the perpetrator apparently committed the crime because he was just presenting the above characteristics and that any further explanation of his act is

superfluous (Coverdale et al., 2002; Cutcliffe et al., 2001). Such an interpretation, however, exaggerates a rather complex issue.

According to the school of social construction (Best, 2008; Jenkins, 2001), the headlines of many news and articles regarding the alleged threat from the “crazy” members of society reveal less about the threat itself and more about how the media and society in general understand and treat those suffering from a mental illness. The image of the "crazy" presented through the mass media most of the time cause fear and disklike to the public. When it does not do that, it could alternatively cause sadness and compassion of the public for the mentally ill individual. Furthermore, many times mentally ill individuals are depicted as mock objects (Barnes & Earnshaw, 1993).

The scientific community has repeatedly criticise the way mental illnesses are portrayed in the press and television, as media portrayals reinforce negative mental disorder perceptions and contribute to stigmatization of mental patients and seriously threatens the rights of people with mental illnesses (Cuttcliffe et al., 2001; McGinty et al., 2014; Sartorius & Schulze, 2005; Torrey, 1994). Besides, the myths of the "dangerous mentally ill individual" and the "Schizophrenic murderer" have been rejected for decades. Over the past few years, advocacy groups’ activation for the rights of people with mental disorders, “Stigma-busters”, have imposed pressure on media professionals. Thereby mass media have gradually reduced the frequency of reports of the violence and the risk of mentally ill individuals and, to some extent, shifted the focus of journalistic interest of the media from the crime itself ti the aspects that cause the mental illness and its possible treatment (Arboleda Florez & Sartorius, 2008).

1.4 Mental Illness and Criminal Behaviour

The relationship between mental disorder and violent behaviour is not necessarily causal; though the close relationship between violent behaviour and mental illness is one of the most widespread perceptions in society (Douzenis, 1995; Sullivan, Bezmen, Barron, Rivera, Curley-casey & Marino, 2005). Classical psychiatric textbooks from early years (Cramer 1908; Hubner 1914; Krafft-Ebing 1892) reiterated the common belief that mentally ill people are violent to a large extent. Addressing the issue only in terms of case studies had as a result created a "shift" in psychiatric and psychological typology, the phenomenology of crime, which is the attempt to correlate the type of crime with a specific clinical entity. Examples of such attempts are Nacke's (1908) analysis of crimes against family by mentally ill and Wetzel's (1920) regarding multiple homicides. Remarkable is also the work of Bonhoeffer and Aschaffenburg (1912), who visited many European states in an attempt to increase the scope of the review. He concluded that out of 50,000 people on average, one mentally ill person should be considered dangerous; a conclusion that is striking because it is quite close to today's views (Douzenis, 1995).

Despite the consolidation of the relationship between mental illness and violence, many research findings through the years, support that the increased levels crime committed by mentally ill are not consistent. In particular, it has been observed that many studies showed lower levels of crime among mentally ill and especially psychotic patients compared to the general population. These studies underlined the extremely low crime rate of the mentally ill (Ashley, 1922; Cohen & Freeman, 1945; Harris & Koepsell, 1996; Monahan, Brodsky, & Shan, 1981; Monahan & Steadman, 1983a,b; Pollock, 1938; Steadman & Cocozza, 1977; Stuart, 2003).

Contrary to these findings, a large body of more recent scientific research has established the link between the two concepts; suggesting that there is an increased risk of violent offence commission by a mentally ill individual. Associations between mental disorder and criminal violence, homicide and sexual offences have been extensively reported [1](a summary of each study's findings is presented in Appendix A).

Contradicted findings and inconsistences in research occur commonly in academia and that may happen for a number of reasons. One of the most impotant reasons is the period when the study was done. Depending on the period of the study the researcher may have available different measures and questionnaires to use in order to collect the data and additionally other information from the available literature review to any given time on which s/he bases the whole research and the interpretation of the results. As it can also been seen from the abovementioned studies those who suggest there is no association between mental illness and violent behaviour are chronologically older compared to those which support the opposite which are more recent studies.

Another reason that explain the differences in research findings are the validity and reliability of the research methodologies being used in each study. That

[1] (Arnold-Williams, Vail, & MacLean, 2008; Arseneault, Moffitt, Caspi, Taylor & Silva, 2000; Brennan, Mednick & Hodgins, 2000; Choe, Teplin, & Abram, 2008; Dunsieth et al., 2004; Giovannoni & Gurel, 1967; Erb, Hodgins, Freese, Müller-Isberner, Jöckel, 2001; Hodgins, 1992; Hodgins, Mednick, Brennan, Schulsinger & Engberg, 1996; Large, Smith, & Nielssen, 2009; Link, Andrews, & Cullen, 1992; Monahan, 1992; Mullen, 1997; Nielssen, Westmore, Large, & Haye 2007; Rappeport & Lassen, 1965, 1966; Silver, Felson, & Vaneseltine, 2008; Sosowsky, 1978; Steadman & Cocozza, 1977; Swanson, Holzer, Ganju, & Jono, 1990; Tehrani & Brennan, 1998; Tiihonen, Eronen, & Hakola, 1993; Tiihonen & Hakola, 1995; Tiihonen, Isohanni, Rasanen, Koiranen & Moring, 1997; Torrey, 2011; Van Dorn, Volavka, & Johnson, 2012; Volavka, Laska, & Baker, 1997; Wallace, Mullen, & Burgess, 2004; Zitrin, Hardesty, Burdock, & Drossman, 1976).

has to do with the sampling techniques and the sample size; as well as with the validity and reliability of the measures or questionnaires being used for the data collection. Another important factor that could possibly explain such differences regarding the knowledge and objectivity of the researcher. The knowledge has to do with the depth of the literature review the researcher has done, as well as with the diciplince s/he conducts the research. Additionally , in many studies it has been obsereved that researchers are biased leading the results/conclusions to a specific direction that allow him/her to confirm his/hers hypotheses of point of view.

Furthermore, other reasons that could explain the contradicted findings of the studies are the disorders the sample suffers from, as mental illness is a quite broad term including heterogenous disorders which appear a great variety of symptoms; and the individual differences the sample of each study appear. It is well known than in every reaserch individuals characteristics could be major factos influencing the findings; for that reason there are being set strict inclusion and exclusion criteria to elimitate as much as possivle external influences. The contradiction of the findings in various studies which examine the same population may be due to differences in these criteria. A more in-depth elaboration of these two reasons is following in text.

Any scientist conducting a research on mentally ill individuals should keep in mind that mentally disordered people are not a homogeneous population, as it is shown by the different diagnostic categories. Some of them are listed for psychosis like schizophrenia and mania, mental retardation or mood disorders like depression, and others for organic disorders including alcoholism disorders or drug abuse disorders etc. (Greene, Ablon & Martin, 2006; Sukhodolsky, Cardona & Martin, 2005). Therefore, aggression and violence can be manifested in different ways depending on the general psychopathological context in which it occurs. For

example, in the case of antisocial personality disorder, there is a lack of empathy and frequent criminal activity (Richard-Devantoy, Olie, & Gourevitch, 2009; Woodward, Nursten, Williams, & Badger, 2000).

In psychosis the tendency for aggression is associated with co-occurring cognitive disruption or lack of reality control; where aggression can manifest itself as strongly divergent behaviours like murder, rape and serial killings (Giotakos, 2013). Similarly, episodic aggression often appears in dementia patients. When aggression is related to emotional instability, impulsive aggression often refers to personality disorder. The tendency for aggression can also be increased by a change in mood, such as in the bipolar disorder or in a panic disorder. But the most common comorbidity in aggression and violence is substance abuse disorder, which strongly contributes to cognitive disruption and lack of inhibition (Giotakos, 2008; 2013; Richard-Devantoy, Olie, & Gourevitch, 2009; Woodward, Nursten, Williams, & Badger, 2000).

In any case, mental illness and its symptoms are manifested in a wide environment influenced by demographic factors such as gender (men are more aggressive than women), and age (younger patients more aggressive than older) (Dean, Duke, George & Scott, 2007; Krakowski, Volanka & Brizer, 1986) and numerous social factors like inadequate resources (Swanson et al., 2002), dysfunctional families (Matejkowski & Solomon, 2008), lack of social welfare (Silver, Mulvey, & Monahan, 1999; Silver & Teasdale, 2005), substance abuse (Elbogen & Johnson, 2009), among others, which increase the probability of violent behaviour of individuals suffering from a mental disorder. Nevertheless, these factors can lead to violent and criminal behaviour irrespective of mental illness (Hiday, 1995,

2006; Link & Stueve, 1995; Mullen, 1997; Noffsinger & Resnick, 1999; Zeleznik, 2001).

Therefore, the perception that any criminal act perpetrated by a mentally ill individual is an outcome of his mental disorder is inadequate; though not completely wrong considering the abovementioned information (Fazel & Grann, 2006). In fact, the proportion of violent crimes that have been committed by individuals suffering from a mental illness is not significantly different from that attributed to the general population (Eronen, Hakola, & Tiihonen, 1996; Monahan, 1997; Stuart & Arboleda-Florez, 2001). Moreover, the majority of violent acts committed by mentally ill individuals are identified in cases where there is lack of treatment or incomplete or inappropriate treatment (Swanson, 1997; Walsh, Buchanan, & Fahy, 2002); whereas effective treatment has been found to reduce the aggressive and sexual behavior (Economou, Gramandani, Richardson, & Stefanis, 2005).

Taking into consideration the above, the association of mental disorder and crime is evident; but a question that troubles many researchers is if there is a specific mental illness that is associated with violent behaviour more. According to Wallace and his colleagues' (1998) research, some groups of mentally ill are at increased risk of committing crime. One of those is schizophrenia, which has been repeatedly found to be correlated with increased risk of committing violent crimes and especially homicide (Nordstrom & Kullgren, 2003; Zarafonitou, 1995). Additionally, a study conducted by Salize et al. (2005) across the European Union revealed that the majority of mentally disordered offenders and in particular more that 50%, in EU suffer from schizophrenia or other psychotic disorders.

1.5 Schizophrenia

Schizophrenia is a chronic and serious psychiatric disorder which often results in devastating effects on the personal, social, and occupational sectors of people suffering from it and it exhibits educational, social, cognitive and neuropsychological impairments (Andreasen & Olsen, 1982; APA, 2000; Buchanan & Carpenter 2005; Cannon et al., 2000; Carpenter, 2003; Corcoran & Frith, 2003; Goldman-Rakic, 1994; Jackson, 1983; Landgraf et al., 2010, 2011, 2012; Langdon, Coltheart, Ward, & Catts 2002; Langdon & Ward, 2008; Lysaker et al., 2007; Swanson et al., 1998; Talreja, Shah, & Kataria, 2013).

Schizophrenia has been described as complex and heterogeneous entity with different clinical manifestations (Dutta et al., 2007; Roy, Lehoux, Brassard, Rene, Trepanier, & Merette, 2001; Tsuang, Lyons, & Faraone, 1990; Tsuang, Stone, & Faraone, 2000; Walker, Kestler, Bollini & Hochman, 2004). The clinical symptoms of schizophrenia are generally classified into symptom dimensions.

Positive symptoms concern reality control and include thought disorders, delusional ideas, hallucinations and other distortions of reality (Chatzoglou, 2010; Madianos, 2006). Delusional ideas could be defined as long lasting thoughts and beliefs that concerns patient's aspect of inner and/or outer reality and which he/she fails to justify rational, theoretical and/or empirical (Garrett, 2009; Oulis, 2006). Delusions can vary in intensity, systematization and the degree to which they affect a person's functionality. Types of delusional ideas are delusional ideas of persecution, sin, reference, control, grandiocity, impoverishmentetc. Hallucinations consist of abnormal perceptions derived by any of the senses. Schizophrenia has hallucinations of all senses, but acoustics are the most common and are reported by 50-70% of patients (Hoffman et al. 2003; Lindenmayer & Khan 2006). Voices discussing with

each other or commenting on a patient's thinking or behavior are considered to be typical; however voices with critical or threatening content are more common. Negative symptoms consist of mitigating and reducing the range of thinking, emotion and motivation. These include the emotional blunting and affective flattening, lack of insight, decreased volition, altered perception, reduced attention and memory, alogia, unemployment, anxiety, anhedonia, apathy and lack of empathy, and social withdrawal (APA, 2013; Garrett, 2009; Lindenmayer & Khan 2006; Pu et al., 2014; Tandon et al., 2009) (for diagnostic criteria of schizophrenia according the DSM-V (APA,2013) see Appendix B).

The disorder can vary in clinical course. It may have an acute onset with complete recovery, presenting with repeated acute episodes or as a chronic disease with repeated acute episodes (relapses). Relapses are considered the reappearance and worsening of active psychotic symptoms. Relapse rates within two years after the onset are in 40% in cases with drug-treatment and 80% in untreated cases. Sixteen percent of patients are fully recovered, 32% have multiple episodes, 43% have a progressive decrease, and 9% are on a chronic basis. Regarding the progress of the disease and reintegration into the community, international studies have found that the improvement of the patients is 10-46% and the recovery is 7-45% (Sadock & Sadock, 2011). Thus, the myth that schizophrenia is an incurable disease is teared down. It is also shown that if the patient avoids long hospitalization in the psychiatric clinic and participates in special rehabilitation programs, the likelihood of relapse is reduced and his/her community functioning is increased (Buonocore et al., 2018; Chou et al., 2012; Kurtz, Rose, & Wexler, 2011; Lee, 2013; Morin, & Franck, 2017; Mura, Petretto, Bhat, & Carta, 2012; Sadock & Sadock, 2011; Tomás, Fuentes, Roder, & Ruiz, 2010).

The disorder has been the subject of many studies to determine its cause or causes. What makes a person susceptible to schizophrenia is unclear and many researchers support that the development of the disorders is affected by various factors such as biological, genetic, psychological and social. Although the aspects that cause schizophrenia are unknown, the disorder has clearly biological basis (Madianos, 2006).

Neurotransmitters play an important role in the development of psychotic symptoms (Mayo Clinic, 2020) as neuroimaging studies have proved there are abnormalities in the brains and the central nervous system of individuals diagnosed with schizophrenia compared to healthy controls (Parvaz, Konova, Tomasi, Volkow, & Goldstein, 2012). Furthermore, the brains of schizophrenia patients appear changes in the volume of amygdala (Gur et al. 2004; Takayanagi et al. 2011); hypothalamus (Goldstein et al. 2007), hippocampus (Irle et al. 2011), insular cortex (Duggal et al. 2005) and they have reported to have less grey matter, which cause a number of dysfunctions in cognitive skills (Frederikse et al. 2000; The University of Iowa, 2020).

Many experts accept the "stress-susceptibility" model, in which schizophrenia is thought to occur in people who are biologically prone. What makes a person susceptible to schizophrenia is unclear. According to that model, stress from the environment, such as distressed life events or drug use problems, triggers the onset and relapse of schizophrenia in susceptible individuals (Madianos, 2006). Other factors include perinatal complications, viral infections during pregnancy, increased dopaminergic activity in central nervous system and genetic factors (Madianos, 2006).

Besides biological factors, there is also a genetic component to schizophrenia. Although researchers support that genes can’t cause schizophrenia disorder directly,

as they can't find a single gene or a combination of genes to be responsible, they can make an individual venerable to developing the disorder (Gottesman, 1991; Torrey, 2006). Evidence from family, twin and adoption studies support that heritability of the disorder is up to 70-80% (Goldstein et al. 2013). An individual who has a first degree relative diagnosed with schizophrenia has an increased risk of developing the disorder too. More specifically, an individual like that has 10% chances of developing the disordered compared to those who have no first or second degree relatives who have 1% chance of developing schizophrenia (Torrey, 2006).

Studies of twins have also supported that schizophrenia is partly inherited (Cannon, Kaprio, Lönnqvist, Huttunen, & Koskenvuo, 1998; Cardno et al., 1999; Cardno, Sham, Murray & McGuffin, 2000). In identical twins, who share the same genes, if the one develop schizophrenia, the other one has 50% chances of developing the disorder as well. This case stands also in occasions where the identical twins have been raised separately. Contrary, in non-identical twins, who have different genes, when the one twin has schizophrenia, the second one has only 12.5% chances of developing the disorder too (Cannon et al., 1998; Cardno et al., 1999; Cardno et al., 2000; Gottesman,1991).

Despite the neurobiological model which with robust evidence supports that schizophrenia is a brain disorder, more recent studies support that there are also social factors like ethnicity, social adversity and urbanization that play a vital role in the development of the disorder (Bramon, Kelly, Van Os, & Murray, 2001; Cantor-Graae, 2007; Cantor-Graae & Selten, 2005; Krabbendam, & Van Os, 2005). Studies of immigrants provide evidence that social factors play a causal role in the development of schizophrenia. Ødegaard (1932) and Malzberg (1935, 1955, 1964a) found a twofold increase in admission rates for schizophrenia among immigrants,

compared to nonimmigrant individuals. They supported that these findings are due to negative selection to schizoid features of individuals which work as a predisposition to migration or to social stressors associated with migration (Ødegaard, 1932; Malzberg, 1935, 1955, 1964a).

Malzberg (1964b) also observed that schizophrenia rates varied in a given neighborhood, according to the relative size of each ethnic group. More specifically, the admission rates for schizophrenia were higher among those who constituted a minority ethnic group compared to those who were the majority population in particular area. His findings have been supported by further studies in different setting and they referred to that situation as the "ethnic density" effect (Boydell et al., 2001; Cantor-Graae, 2007; Cantor-Graae & Selten, 2005; Fearon et al., 2006; Rabkin, 1979).

Furthermore, urban birth and urban upbringing has also been recognized as a social factor associated with the development of schizophrenia (Pedersen & Mortensen, 2001a, b). Research supports that there is a twofold rate of schizophrenia in urban areas compared to the rural areas (Krabbendam & van Os, 2005). Till now, none of the known risk factors for schizophrenia can sufficiently explain the "urban effect"; although some research studies support that various aspects of the social environment like community levels of psychotic symptoms may be relevant to the increased prevalence of schizophrenia disorder (Bo Mortensen, 2000; van Os, Hanssen, Bijl, & Vollebergh, 2001).

Nevertheless, none of these casual models supported by findings is enough to eliminate all the others; and be presented as the sole explanation of the cause of schizophrenia disorder. In order to be in a position to explain more in depth a heterogenous disorder like schizophrenia and be able to understand its causes it would

be wiser to adopt the most recent biopsychosocial model which examines schizophrenia from an holistic perspective (Cairns, Reid, Murray, & Weatherhead, 2015; Gaebel, & Zielasek, 2015; Kotsiubinskii, 2002; Kotsubinsky, Erichev, Klaiman, & Shmonina, 2017).

Schizophrenia is a serious mental illness afflicting approximately 1% of the population. According to the World Health Organization, schizophrenia is ranked 4th in the causes of disability and early mortality of all medical causes worldwide and it is perceived to be the most common psychiatric disorder with 24 million people suffering from it worldwide (World Health Organization, 2014). In earlier years schizophrenia appeared a prevalence rate approximately at 0.5 ranging from 0.11 to 0.83 (Eaton 1985; 1991). In more recent years the prevalence seems to be massively increasing with a median lifetime prevalence at 4.0 per 1000 and lifetime morbid risk at 7.2 per 1000 (McGrath et al., 2008); which is explained by different studies as an outcome of the industrial development and modernization of societies as in developing countries there was noted increased prevalence of the disorder (Eaton & Chen 2006; McGrath & Susser 2009; Rajkumar, Padmavathi, Thara, & Menon, 1993; Torrey & Miller 2001). In Greece, prevalence rates of schizophrenia range from 0.05 to 1.9 (Chatzoglou, 2010).

Although it is traditionally thought that the incidence of the disease does not differ between the sexes, epidemiological research in recent years has concluded that schizophrenia occurs more frequently in men than in women, with a relative risk for male sex by 1.4 (Aleman, Kahn, & Selten, 2003; McGrath, Saha, Chant, & Welham; 2008; Tandon, Keshavan, & Nasrallah, 2008). The age of onset of the disease also varies between the sexes. It has been found that by the age of 30 it has affected 90% of men but only 67% of women (Gureje, 1991; Loranger, 1984). The incidence peak

for both sexes is found at ages 15-24, however, women present a second peak at ages 55-64 (Kirkbride et al. 2012; Madianos, 2006; Munk-Jørgensen, 1987). From a psychopathological point of view, men appear to have a higher negative symptomatology than women (Goldstein, Santangelo, Simpson, & Tsuang, 1990; Rund et al., 2004) while women are more likely to be depressed (Goldstein & Link, 1988; Häfner et al., 1994; Lindamer, Lohr, Harris, McAdams, & Jeste, 1999).

In more detail, men and women with schizophrenia appear different clinical features, with women exhibiting greater affective component and more positive psychotic symptoms (Foti, Kotov, Guey & Bromet, 2010; Zhang et al., 2012) by scoring higher than men in general psychopathology scales (Zhang et al., 2012). That means that female schizophrenia patients experience more delusions, hallucinations, affective symptoms (e.g. depression and social anxiety), irrational thinking (e.g. paranoia) and odd behavior. [2] Contrary, male patients experience more negative symptomatology like social withdrawal, poorer cognitive and social functioning, disorganised communication, anhedonia, lack of motivation and blunted affect. [3] Also, men are reported to have more drug and alcohol abuse (Cotton et al. 2009; Køster et al. 2008; Thorup et al., 2007).

Gender differences in schizophrenia have also been spotted in cognitive functioning with studies supporting that male patients are worse at this domain (Krysta, Murawiec, Klasik, Wiglusz, & Krupka-Matuszczyk, 2013; Zhang et al.,

[2] (Abel, Drake, & Goldstein, 2010; Canuso & Pandina 2007; Heitz et al. 2019; Ochoa et al., 2012; Pruessner et al. 2017; Riecher-Rössler & Häfner 2000; Riecher-Rössler et al. 2010; Rietdijk et al. 2013; Waford et al. 2015; Zhang et al., 2012).
[3] (Abel et al. 2010; Bertani et al. 2012; Canuso & Pandina 2007; Galderisi et al. 2012; Heitz et al. 2019; Holtzman et al. 2010; Hui et al. 2016; Køster et al. 2008; Ochoa et al., 2012; Riecher-Rössler & Häfner 2000; Riecher-Rössler et al. 2010; Rietschel et al. 2017; Salokangas & Stengard 1990; Shibre et al. 2015; Theodoridou et al. 2017; Thorup et al. 2007; Thorup et al., 2014; Zhang et al., 2012).

2012). These differences are being more evident and significant in chronic schizophrenia and not during the first acute psychotic episodes (Zhang et al., 2012); and are irrelevant to demographical or clinical variables (Abu-Akel & Bo, 2013). More specifically, female patients have better performance in executive functions, memory, attention, social cognition, emotion recognition and verbal abilities (Abu-Akel & Bo, 2013; Carter et al. 2009; Ochoa et al., 2012; Zhang et al., 2012); contrary to male patients who appear to be better only in visuospatial functioning and reaction time on tests (Ayesa-Arriola et al., 2014; Halari, Mehrotra, Sharma, Ng, &, Kumari, 2006; Hui et al. 2016; Ittig et al. 2015).

Female schizophrenia patients have been also found to outperform male counterparts in social functioning in both first episode and later course of the disorder (Canuso & Pandina 2007; Ochoa et al., 2012; Thorup et al., 2014; Zhang et al., 2012). Studies support that men diagnosed with schizophrenia have more relapses and spent more time in psychiatric facilities until recovery (Uggerby, Nielsen, Correll, & Nielsen, 2011); also they exhibit greater risk of institutionalization (Zhang et al., 2012). Men also appear to have lower education compared to women; have more behavioural disorder with more incidents of aggression, use drugs more often, tend to live alone after psychiatric release, have weaker social network, and have fewer employment opportunities (Aleman, Kahn & Selten, 2003; Ochoa et al., 2012; Thorup et al., 2014; Zhang et al., 2012). They also face difficulties in talking about the symptoms they experience and asking help (Ferrari et al. 2016) which relates to the fact that male schizophrenia patients show longer duration of untreated psychosis (Barajas et al. 2015; Cascio et al. 2012; Fridgen et al. 2013) and commit suicide seven times more frequently than women (Gonzalez-Pintoet al., 2012). The women's overall better social functioning and generally better life quality might be a consequence of

the later age of onset of the disorder and their greater ability in social adjustment (Riecher-Rössler, Butler, & Kulkarni, 2018).

Regarding treatment, female schizophrenia patients exhibit greater treatment adherence and response better to psychosocial treatment[4]; which is related to schizophrenia female patients' better-preserved social skills (Brabban, Tai & Turkington, 2009). Women also have greater adherence to medical appointments and treatment (Law et al., 2008; Nose, Barbui, & Tansella, 2003); which can be explained by the fact that female patients have a more positive attitude towards medication and help receiving (Galdas, Cheater, & Marshall, 2005). Regarding medication, it has also been seen that women respond better to antipsychotic medication compared to men who also need greater dosages of medications to work (Begemann et al., 2012; Galdas et al., 2005; Ghafari et al., 2013; Kulkarni et al., 2015; Law et al., 2008; Nose et al., 2003). The female patients overall better course of schizophrenia, despite the abovementioned, is also positively correlated with the fact that women have less co-morbid substance abuse disorders (Cotton et al. 2009; Thorup et al. 2014). Last, women diagnosed with schizophrenia shorter psychiatric hospital stays and readmitted less frequently compared to men (Abel et al. 2010; Angermeyer et al., 1990; Canuso & Pandina 2007; Grossman, Harrow, Rosen, Faull, & Strauss, 2008; Ochoa et al. 2012; Seeman, 2019).The term schizophrenia is itself a source of labelling for the person suffering from this disease no matter their gender. Patients with schizophrenia are stigmatized; perceptions of dangerous and unpredictable behaviour, social dysfunction, inability to meet work and family life requirements are

[4] (Abel et al., 2010; Angermeyer, Kóhn, & Goldstein, 1990; Cano-Baena, Garcia-Ayala, Zubia-Martin, Zorrilla-Martinez & Arrillaga, 2019; Cotton et al., 2009; da Silva & Ravindrana, 2015; Grigoriadis & Seeman, 2002; Leung & Chue, 2000; Morken, Widen &, Grawe, 2008; Ochoa et al., 2012; Riecher-Rössler et al. 2010; Thorup et al. 2014)

automatically shaken to the public mind on hearing the word "schizophrenia" (Angermeyer, Beck, Deitriech, & Holzinger 2004; Crisp, Gelder, Rix, Meltzer, & Rowlands, 2000; Jackowska, 2009). In a research study in Sao Paulo they believe that schizophrenia patients are dangerous at a percent of 74,2% (Peluso & Blay, 2011). In another research study they believe that at least half of the schizophrenia patients have split personality (Leiderman et al., 2010). Although the majority of people with schizophrenia are not violent (Joyal, Putkonen, Paavola, & Tiihonen, 2004; Swanson et al., 2006), clinicians recognize that some people with this diagnosis may be a high risk for the community, particularly those with co-occurring substance use, poor adherence to psychiatric treatment, and a history of repeated hospitalizations or arrest history (Bonta, Law & Hanson, 1998; Giotakos, 2013).

1.6 Schizophrenia and Criminal Behaviour

As mentioned above, dangerousness and violence are a common stigma attached to schizophrenia. In a review of articles on violence and schizophrenia, the researchers concluded that the proportion of violence in the community attributed to schizophrenia was small and fewer than 10% (Walsh, Buchanan, & Fahy, 2002).

In accordance with that, a plethora of clinical researches concluded to results that there is no association of schizophrenia with violence[5], and some other reporting there is a slightly negative association (Appelbaum et al., 2000; Monahan et al., 2001; Steadman et al., 1998).

[5] (Appelbaum, Robbins, & Monahan, 2000; Arboleda-Flórez, Crisanti, & Holley, 1995; Bjørkly, 2002a; Bonta et al., 1998; Bradford, 2008; De Pauw & Szulecka, 1988; Douglas, Guy, & Hart, 2009; Elbogen & Johnson, 2009; Junginger, 1996; Monahan, 1992; Mulvey, 1994; Swartz & Lurigio, 2004; Taylor, 2008; Quinsey, Harris, Rice, & Cormier, 2006)

Contrary to these researches, there is also a large body of research suggesting that schizophrenia indeed increases the risk of aggression and violence (Alevizopoulos, 1998; Arseneault et al., 2000; Brennan et al., 2000; Bjørkly, 2002a, 2002b; Bloom, 1989; Bradford, 1983; Brennan et al., 2000; De Pauw & Szulecka, 1988; Erb et al., 2001; Etherington, 1993; Fazel & Danesh, 2002; Fazel & Yu,2011; Fazel, Langstrom, Hjern, Grann & Lichtenstein, 2009; Hodgins, 2008; Junginger, 1996; Krakowski, Jaeger, & Volavka, 1988; Lindqvist & Allebeck, 1990; Modestin & Ammann, 1996; Monahan, 1992; Mullen, Burgess, Wallace, Palmer, & Ruschena, 2000; Naudts & Hodgins, 2006; Nitschke, Osterheider, & Mokros, 2011; Singh et al., 2012; Tardiff, 1984; Tiihonen et al., 1997; Walsh et al., 2002; Wessely, Castle, Douglas, & Taylor, 1994).

The increased risk of violence in schizophrenia was also revealed in the study of Lindqvist and Allebeck (1990) who found that patients with schizophrenia are four times more prone to criminal behavior compared to general population. Another study showed that both males and females diagnosed with schizophrenia exhibited increased violent behavior in comparison to control subjects (Wessely et al., 1994). Likewise, Eronen, Hakola and Tiihonen (1996) reported that schizophrenia has eight times higher risk than general population in male homicidal behaviour. Similarly, Tiihonen and his colleagues (1997) in a 26years cohort study revealed that the risk factor for violence was seven times higher in schizophrenia compared to individuals with no mental illness. Furthermore, Hodkins et al., (1996) and Brennan et al. (2000) reported that there is an increased engagement in violence in schizophrenic patients who have been hospitalized compared to mental ill patients who have never been hospitalized.

Contrary to that, researchers have reported that almost 20% of schizophrenic patients had exhibited violent behavior before their implication with the mental health

system (Humphreys, Johnstone, MacMillan, & Taylor, 1992; Large & Nielssen, 2011; Volavka et al., 1997). Arseneault, Moffitt and Taylor (2000) also found that individuals with schizophrenia are 2.5 times more likely to be violent compared to control subjects. In accordance with the above, a Swedish study reported that individuals with schizophrenia compared to the general population are four times more likely to have a criminal record (Tuninger, Levander, Bernce, & Johansson, 2001). Last, the recent meta-analysis of 20 studies by Fazel et al. (2009) concluded to the result that both men and women who are diagnosed with schizophrenia are at an increased risk of violence compared to the general population.

There have been identified many factors that are associated with violence in schizophrenia (Douglas et al., 2009). Some of these predictors appear to be common in individuals with or without schizophrenia such as gender, males tend to be more violent than females; age, those of younger age appear to be more violent and commit more criminal behaviour compared to older individuals (Andrews & Bonta, 1998; Farrington, 1995; Fazel & Grann, 2006; Modestin & Ammann, 1996; Monahan, 1997; Swanson et al., 1990); developmental and environmental factors like neurological impairments or low IQ (Fazel, Wolf, Palm, & Lichtenstein, 2014; Moffitt & Caspi 2001; Stratton, Brook & Hanlon, 2017; Stratton, Cobia, Reilly, Brook, & Hanlon, 2018; Ttofi et al., 2016), lower socio-economic class, substance abuse and criminal history (Bonta, Law & Hanson, 1998; Fazel et al., 2014; Witt et al., 2013), economic deprivation (Modestin & Ammann, 1996; Monahan, 1993; Swanson et al., 1990; Swanson, Van Dorn, et al., 2008), family dysfunction or parental criminality and substance abuse (Addad et al., 1981; Tengström, Hodgins & Kullgren, 2001), childhood conduct disorder and antisocial personality (Bonta et al., 1998) and last but

not least harsh or inconsistent childhood discipline (Loeber, Farrington, Stouthamer-Loeber, Moffitt & Caspi, 1998) and severe childhood abuse (Caspi et al., 2002).

Researchers have also identified disorder-related factors and specific psychotic symptoms that appear to be linked with increased risk of violence and criminal behaviour in schizophrenia and particularly with homicide (Amore et al., 2008; Angermeyer, 2000; Arango, Calcedo Barba, González-Salvador, & Calcedo Ordóñez, 1999; Beck-Sander et al., 1997; Bentall &Taylor, 2006; Cheung, Schweitzer, Crowley, & Tuckwell, 1997a, b; Douglas et al., 2009; Fazel, Gulati, Linsell, Geddes, & Grann, 2009; Fresán et al., 2005; Hodgins, 2007, 2008; Krakowski, Czobor, & Chou, 1999; Landgraf, Blumenauer, Osterheider, & Eisenbarth, 2013; McNiel, 1994; McNiel, Eisner, & Binder, 2003; Mougia, 1999; Peterson, Skeem, Kennealy, Bray, & Zvonkovic, 2014; Steinert, Wölfle, & Gebhardt, 2000; Stuart, & Arboleda-Flórez, 2001; Swanson et al., 2006; Taylor, 2006, 2008; Taylor et al., 1998; Valença & Moraes, 2006; Volavka & Citrome, 2008).

It has been widely reported that the active positive symptoms of schizophrenia like delusions and particularly of persecution (Bjørkly, 2002a; Coid et al., 2003; Freeman et al., 2001; Joyal et al., 2004; Nestor et al., 1995; Swanson et al., 2006; Whelan et al., 2012), "threat/control override" symptoms (delusion that causes an overestimation of a personal threat by an outside agent and a perceived lack of self-control) (Arboleda-Flórez, 1998; Bjørkly, 2002a; Hodgins, Hiscoke, & Freese, 2003; Link, Stueve, & Phelan, 1998; Link et al., 1999; Link & Stueve, 1994) and threatening or command auditory hallucinations[6] have a significant correlation with the expression of aggression and violent behaviour. Beyond that, grandiocity and

[6] (Häfner & Böker, 1982; Hersh & Borum, 1998; Janofsky, Spears, & Neubauer, 1988; Lowenstein, Binder, & McNiel, 1990; McNiel, Eisner, & Binder, 2000; Noble & Rodger, 1989; Nolan et al., 2003; Rudnick, 1999; Stompe, Ortwein-Swoboda, & Schanda, 2004;Striggaris, 1980; Swanson et al., 2008; Yesavage, 1983, 1984)

hostility are also factors associated with increased violence in schizophrenia (Swanson et al., 2006). Last but not least, poor or lack of insight into psychotic symptoms has been found as a predictor of violent behaviour especially in first-episode schizophrenia patients (Arango et al., 1999; Lincoln & Hodgins, 2008; Verma, Poon, Subramaniam, & Chong, 2005; Witt et al., 2013).

In contradiction, it has also been identified that negative symptoms of schizophrenia, like avolition and social withdrawal mitigate the risk of aggression and violence; and work as predictors of reduced violence. Also when these negative symptoms are high it is suggested that decrease the association of positive ones with violence (Swanson et al., 2006).

Social cognitive deficits (inability to process social information) (Green, Horan, & Lee, 2015) have also been identified as predictors of violence in schizophrenia.[7] Social cognitive deficits are obvious in schizophrenia and are associated with poor function outcome and lead to difficulties in social interactions, social communication and interpersonal conflicts management (Ahmed et al., 2016; Barkataki et al., 2005; Bellack Morrison, & Mueser, 1989; Bergman & Ericsson, 1996; Fett et al., 2011; Fullam & Dolan, 2008; Green, 2016; Green & Harvey, 2014; Hanlon, Coda, Cobia, & Rubin, 2012; Juola et al., 2015; Stratton et al., 2017).

Emotional processing (emotional perception and regulation) and theory of mind (ability to make inference of oneself and others' mental states) (Arborelius, Fors, Svensson, Sygel, & Kristiansson, 2013; Murphy, 1998, 2006) consist the social cognition (Pinkham, 2014). Difficulties in these two domains may lead to faulty social

[7] (Barkataki et al., 2005; Brewer et al., 2006; Dickinson, Ragland, Gold, & Gur, 2008; Enticott, Ogloff, Bradshaw & Fitzgerald, 2008; Kern et al., 2011; Meijers, Harte, Meynen & Cuijpers, 2017; Mesholam-Gately, Giuliano, Goff, Faraone, & Seidman 2009; O'Reilly et al., 2015; Penn, Spaulding, Reed, & Sullivan, 1996; Reilly & Sweeney, 2014; Schulze-Rauschenbach et al., 2015).

inferences, incorrect interpretation of others' emotions and intentions and failure in understanding negative emotions like anger or fear which could make a schizophrenia patient incorrectly perceive threat or express violence. According to that, a hypothesis has been formed that patients with schizophrenia with large social cognitive deficits are at an increased risk of committing a violent crime such as homicide, because his/hers reduced ability to understand and relate to others.

Furthermore, Abu-Akel and Bo (2018) suggested that "[p]athological aggression can be conceptualized as a disorder of the social brain" (p. 545). Additionally, recent researches have indicated that cognitive and neurobiological factors play an important role in violence in schizophrenia (Abu-Akel & Bo, 2018; Naudts & Hodgins, 2005; O'Reilly et al., 2015; Schug & Raine, 2009; Sedgwick et al., 2017; Soyka, 2011; Stratton et al., 2018; Waldheter, Jones, Johnson, & Penn, 2005).

According to biological data, alteration to the cortical structure (Ahmed et al., 2014; Hoptman, 2015; Hoptman & Ahmed, 2016; Soyka, 2011), increased activity of the amygdale (Adolphs, 2009; Lawrie, Whalley, Job, & Johnstone, 2003; Okruszek et al., 2017), in combination with inadequate pre-frontal regulation (Lesh, Niendam, Minzenberg, & Carter, 2011), contributes to the increased likelihood of aggressive behavior. Deficits in the parahippocampal gyrus (Yang, Raine, Han, Schug, Toga, & Narr, 2010) and volume reductions in the hippocampus (Barkataki et al., 2006; Kumari et al., 2009; Yang et al., 2010) have also been found to contribute aggression expression in schizophrenia (Antonova, Sharma, Morris, & Kumari, 2004; Barkataki et al., 2006; Naudts & Hodgins, 2006; Yang et al., 2010). Developmental lesions in the pre-frontal cortex as well as abnormal neurotransmitter function cause negative emotionality and poor decision-making (Serper, Beech, Harvey, & Dill, 2008); which

contribute to the development of aggression. So far, PET or SPECT studies focusing on schizophrenia have shown reduced activity in the frontal-temporal circuit; which lead to increased aggressive behaviour in schizophrenia (Cheung, Schweitzer, Crowley & Tuckwell, 1997a; Giotakos, 2013).

Individuals suffering from schizophrenia may exhibit aggression and violence during all phases of the disorder; although the early stages of the disorder are perceived to be more dangerous as the acute psychotic symptomatology, which is intent at that stage, has been considered the most important risk factor for aggressive behavior. Similar incidents of violent behavior are more likely to occur immediately after the person is introduced to the psychotic episode than later. In one study, the number of assaults occurring in the first 10 days following admission to psychiatric clinic was significantly higher than in other periods of hospitalization (Mougia, 1999).

During the first-episode psychosis schizophrenia patients tend to be more violent compared to later stages of the disorder because of the severity of delusions and hallucinations observed in acute phases (Foley et al., 2007; Krakowski et al., 1986; Milton et al., 2001; Nielssen, 2009; Steinert, Wiebe, & Gebhardt, 1999). Nolan et al. (2003) found that there is a casual relationship between positive psychotic symptoms and violent behaviour in schizophrenia patients. Further, Felthous (2008) revealed that 20% of schizophrenic offenders' criminal actions are driven be delusion and hallucination of command or threatening content. Auditory hallucinations are more likely to be associated with violent acts if the prosody and content of the voices being herd are negative (Cheung et al., 1997b).

These auditory hallucinations often give rise to delusional beliefs (Nielssen et al., 2007). In a recent study by Laajasalo & Häkkänen (2006) their suggestions were in line with previous work (Bjorkly, 2002a; Marleau, Millaud, & Auclair, 2003;

Taylor et al., 1998) that delusion especially of persecution and control are more common than hallucinations in cases of homicidal schizophrenic patients. Moreover, Yee, Large, Kemp and Nielssen (2011) reported that schizophrenic offenders were experiencing delusions at a percent of 92% while crime commission. Similarly, Coid et al. (2013,2016) and Ullrich, Keers and Coid , (2014) found that there is a significant correlation between a serious violent act by schizophrenia patients and delusions of threatening content like persecutory delusions, delusions of being spied on and delusions of conspiracy. The literature also indicates that there is an increased risk of violence when patients experience negative feelings of anxiety, anger, sadness, and terror arising from delusions and hallucinations (Braham, Trower & Birchwood, 2004; Buchanan et al., 1993; Cheung et al., 1997b; Coid et al., 2013; Vandamme & Nandrino, 2004). In the residual phase of the disorder the positive symptoms are not that intent and in that phase it is more possible that the individual will have violent behavior because of cognitive deficits and distortions (Abrahamson 1983; De Jong, Giel, Slooff, & Wiersma, 1985; Owens & Johnstone, 1980).

Studies also indicate that schizophrenia is correlated with both serious and violent crimes and non violent crimes (Brennan et al., 2000; Cheung et al., 1997a; Fazel et al., 2009; Hodgins, 2008; Nestor, 2002; Soyka, Graz, Bottlender, Dirschedl, & Schoech, 2007; Swanson et al., 1990; Valença, & Moraes, 2006). During the first-episode psychosis there have been found increased levels of self-directed and not violence and have been reported self-mutilation and suicide attempts (Jovanovic, Kudumija Slijepcevic, & Podlesek, 2019; Larger, Babidge, Andrews, Storey, & Nielssen, 2009; Nielssen, 2009), violence against family members (Nielssen et al., 2007, 2009), and homicide (Nielssen et al., 2007). In another study, Joyal et al. (2004) reported that over half of the homicidal schizophrenic offenders are motivated by

psychotic symptoms. Other studies also revealed a correlation of schizophrenia and homicidal acts in untreated psychosis (Large & Nielssen, 2011; Nielssen & Large, 2010), something that come in accordance with Greek studies revealed that high rates of schizophrenia have been reported in homicide (Livaditis, 1994; Striggaris, 1980, 1983; Tsalikoglou, 1986; Zarafonitou, 1995).

Schizophrenia is the most common disorder in mentally ill individuals who have committed homicide compared to other disorders (Zartaloudi, 2009). Additionally, schizophrenia has been reported to have 6.5 to 8 times higher risk of homicidal behaviour compared to the general population (Eronen et al., 1996; Large et al., 2009; Tiihonen & Hakola, 1995; Tiihonen et al., 1997). Several studies indicate that people with schizophrenia often target family members and friends (Joyalet al., 2004; Krakowski et al., 1986; Pontius, 2004) and it appears that when a patient is financially dependent on a family member, the risk of targeting that member is increased (Nordstrom & Kullgren, 2003). Homicide of strangers is particularly seldom in patients with schizophrenia (Joyal et al., 2004; Nielssen, 2009; Nordström, Dahlgren, & Kullgren, 2006). Additionally, most of the acts of violence by schizophrenic patients take place at home rather than in a public place (Swanson, 1994).

In any case, even when the homicidal act is not directly attributable to positive symptoms of the disorder, the vast majority of schizophrenic offenders had active psychotic symptoms at the time of the crime (Flynn et al., 2014; Joyal et al., 2004). This has lead the legal system to form special codes and laws, as someone suffering from mental illness and active psychotic symptoms cannot be treated like a common offender.

1.7 Legal Framework about Mentally Disordered Offenders (MDO)

Of particular interest to the scientific community are people with mental health problems who, for some reason, have committed a crime. The responsibility and judgment of the offender should be clarified by the subjective responsibility and judgment of the accused for the crime he has committed.

In the criminal justice system, examining a defendant's ability to stand trial is known as "criminal responsibility" and no defendant can be tried if he or she is incapable of understanding the charges brought against him or her. This fundamental point of view concerns the mental state of the accused, from which two basic, overlapping but essentially different issues arise. The first concerns the case of a person committing a serious crime while in such a state of mind, which ultimately renders him or her irresponsible to the law in relation to what he or she is accused of having committed. The second is the case when a person accused of committing a serious crime, no matter what his mental state is at the time of crime commission, is or may be at the time of his trial in such a mental state which makes him incompetent to stand trial (Hart & Gardner, 2008; Martinaki, Asimopoulos, Papaioannou, Antonakaki, & Magiropoulou, 2018; Morse, 1999; Smith, 2012; Torry & Billick 2010). Because of that the mental state of the offender is taken under consideration (Hart & Gardner, 2008).

Challenges have arose between maintaining a balance between fair, humane treatment, and protecting public safety from those who are not capable of being judged by the standard practice, determining what their guilt is, and amidst the perception that mentally disordered people have a right to access treatment and not punishment (Denno, 2002).

Even though some forms of criminal responsibility and insanity defence referred in such ancient documents as the code of Hammurabi (Kelly, 2009; Smith, 2012), the first reference of insanity defense was recorded in the English legal treatise of 1581, stating that "*a madman, a natural fool or a lunatic in the time of his lunacy cannot be held accountable for his crime"* (Tsimploulis, Niveau, Eytan, Giannakopoulos, & Sentissi, 2018, p.370). Later on in the UK, during the 18th century, the individual who was unable to understand the nature of his crime was not being convicted.

The modern history of insanity defence derives from the case of Daniel M'Naughten, a mentally disordered man who at 1843 attempted to murder the British Prime Minister, Sir Robert Peel (Kelly, 2009). After the close examination of the case, the British House of Lords formed the M'Naughten Rules which is a set of precise criteria for criminal insanity stating that *"to establish a defense on the ground of insanity, it must be clearly proved that at the time of committing the act the party accused was laboring under such a defect of reason, from disease of the mind, as not to know the nature and quality of the act he was doing, or as not to know that what he was doing was wrong"* (United Kingdom House of Lords Decisions, 1943 as referred in Tsimploulis et al., 2018,p. 370-371). This set of rules in still applicable in over 20 US states (Borum & Fulero, 1999; Malo, Barach & Levin, 1994).

There is also another rule known as the Durham Rule that introduces the concept of the not guilty by reason of insanity (NGRI) verdict for the cases when the offence was resulted from mental illness. According to this rule only the presence of a mental disorder without taking into consideration the cognitive/emotional deficits it causes, could be enough to excuse a violent act. Nowadays the Modern Penal Code elaborated by the American Law Institute perceives insanity and considers NGRI

verdict when *"at the time of the crime as a result of mental illness or defect the defendant lacks substantial capacity either to appreciate the criminality of his conduct or to conform his conduct to the requirements of the law."* (Tsimploulis et al., 2018, p. 371). This interpretation of insanity has also been accepten by most European countries.

Therefore, in the United Kingdom mentally disordered offenders (MDO) cannot be found guilt and imprisoned, but they are subjected to compulsory admission and treatment at secure hospitals according the Mental Health Act (MHA) 2007. MHA is the law in UK that provides a legal framework for the requirements someone must have to be perceived as MDO such as having a mental disorder and being risk for himself and others; and for the treatment he must be subjected to in order to improve the MDO's mental health and prevent recidivism (Bal & Koenraadt, 2000; Spruin, Canter, Youngs, & Coulston, 2014).

1.7.1 Legal System for MDO around the World

Legislation for mentally disordered offenders is included in the law of all Western countries (Europe, USA, Canada, Australia) (Dressing & Salize, 2006), but also in other countries, such as China (Wang, Livingston, Brink, & Murphy, 2006), Brazil (Taborda, Cardoso, & Morana, 2000) and Muslim states such as Turkey and Iran (Pridmore & Pasha, 2004). Contrary, in many African countries, there is not a specific legislation regarding mentally disordered offenders and in some cases is it still believed that this individual is possessed by god or devil (Tzeferakos & Douzenis, 2017).

Although, there are corresponding laws for mentally disordered offenders across the world, it is worth noting that there are also major differences between

counties in terms of criminal responsibility. All European legislations appreciate the concept of criminal responsibility as a prerequisite for punishment. In cases of reduced responsibility the court orders entry in a forensic psychiatric unit, whereas offenders with complete criminal responsibility are subjected to trial and prison sentence. Though, in the United Kingdom, only on the basis of the presence of a mental disorder during of the assessment can be required entry in forensic psychiatric unit (Völlm et al., 2018). It is also important to note that in some US states (Idaho, Kansas, Montana, and Utah), they use the verdict guilty but insane" instead of the NGRI verdict (Radovic, Meynen, & Bennet, 2015). Also in Sweden, all individuals who have committed a criminal act are considered guilty, and the existence of mental illness is considered after that verdict and leads that individual to compulsory treatment (Grossi & Green, 2017). Contrary in Canada, when an offender is diagnosed with mental disorder may not necessarily be detained in a psychiatric hospital, but he also is eligible for taking two other dispositions the one of absolute discharge and the other of conditional discharge (Miladinovic & Lukassen, 2014).

When interpreting the legal notion of insanity is vital to consider the cultural differences that underlie. The Anglo-American model is based on powerful past rules, as mentioned before; whereas the Roman-Germanic model is based on legal principles and Islamic model and set of laws are formed on the idea of what are the duties of the citizens (Abdalla-Filho & Bertolote, 2006). Furthermore, in some countries like United States, Canada, United Kingdom, Australia, and New Zealand there is a dichotomy between the presence or the absence of criminal responsibility while in other countries like Netherlands, Belgium, and Germany there are degrees on criminal responsibility (Grossi & Green, 2017; Shah, 2012).

The tool established by the law to investigate the existence of psychopathology that justifies the diminished criminal responsibility is known as "psychiatric expertise" (Dressing & Salize, 2006). Psychiatrists as experts but most times they do not attend court proceedings but they simply send their reports which are included in the case file. Of course, there is the possibility of attending if a party makes a specific request for their report. The court-appointed psychiatrist-expert, is not the only psychiatrists who may be involved in the process of hearing in such a case. The victim's side has the right to designate a psychiatrist as a technical advisor and to present his report in turn, which is also taken into account by the court (Traverso, Ciappi, & Ferracuti, 2000).

In the United States, and probably worldwide the majority of those found not guilty by reason of insanity suffer from schizophrenia (Degl'Innocenti et al., 2014; Glancy & Regehr, 1992; Greenberg & Felthous, 2007; Schanda, Stompe, & Ortwein-Swoboda, 2009). In a case were an individual commits a crime due to psychotic symptoms he is eligible to get the insanity defense and be found not guilty by reason of insanity or receive a relative verdict depending the country (Dietz, 1992). It can be reasonably argued that an individual who acted violently because of cognitive deficits or in response to a persecution delusion that he/she believes is at risk of being killed or to a command auditory hallucination did not know or realize that the violent act was wrong (Felthous, 2008; Smith, 2012). Taking that under consideration, psychotic disorders have been found to be a major factor for diminished criminal responsibility (Swinson et al., 2011; Vinkers et al., 2011).

1.7.2 Legal System for MDO in Greece

In Greek penal law, the terms related to subjective liability are criminal responsibility and guilt. Criminal responsibility refers to the judgment that the individual has the subjective responsibility of the offense committed and expresses the action of the person in question and its effect, the accusation. The concept of guilt is the object of imputation, that is, the perpetrator's mental attitude towards the particular act (Skaragkas, 2002). Conditions of criminal responsibility are: (a) The perpetrator's guilt in the form of fraud (Article 26 of the Penal Code [PC]), or in the form of light or heavy negligence (Article 28 PC), (b) the absence of apology, and (c) the ability to impute (mental disorder) (Articles 34, 69, 70 PC).

In Greece, article 34 specify the criteria for a patient to be listed as incompetent, while articles 69 and 70 include provisions concerning the detention and duration of it. These articles have been in force from 1951 until today. According to Article 34 of the PC, the perpetrator after the commission of the crime is charged with the crime commission, but the act is not imputed to the perpetrator if during the offence the perpetrator, because of "morbid disturbance of mental functions" or a "disturbance of consciousness", did not have the capacity to perceive the wrongdoing of his act or to act according to his perception of this crime.

In the process to judge one's ability to impute an illegal act, the assistance of a psychiatric expert is requested, who, according to the principles of Psychiatric Forensics, conducts an investigation to determine if this person is indeed mentally disturbed and to elaborate on how this disorder influence his way of thinking and his actions; if s/he is considered dangerous and to what extent s/he is likely to recover (Kakkalis, 1990). Regardless of the expert's report usefulness, the report of a

psychiatric expert does not bind the court to its decision, as the court may rule contrary to its findings. The court is free to assess this expert's opinion freely and accept it or reject it. Judges consider this to be perfectly normal, since expert opinion is a means of evidence, and by law all evidence is open to trial, and is freely assessed by the court (Derks, Blankstein, & Hendrickx 1993; Douzenis & Lykouras, 2013; Kotsalis, 1990; Skatagkas, 2002). However, a parameter that the court takes into account is the offender's mental health past. According to some judges, the existence of a mental disorder before the crime committed suggests the possibility of diminished criminal responsibility. The rationale behind this view is that a serious mental illness may not manifest itself all of a sudden.

After the defendant is found not guilty by reason of insanity for the crime, the perpetrator is not prosecuted for the crime but acquitted. However, according to Article 69 of the Penal Code, if a person has been exonerated for a felony or misdemeanour due to morbid disturbance of mental functions, for which he or she would have been sentenced to more than 6 months of imprisonment, the court may order him/her to be kept in a public psychiatric hospital if he or she is perceived to be dangerous to public safety (Kosmatos, 1998; Fytrakis, 2014).

The "criminal incarceration" of MDO in Greece is provided in three psychiatric hospitals in the country: the Psychiatric Hospital of Attica "Dafni", "Dromokaitio" Psychiatric Hospital of Attica and the Northern and Central Greece Psychiatric Hospital of Thessaloniki Papanikolaou. Particularly in the Psychiatric Hospital of Thessaloniki, by the decision of the Central Health Council in 1988, the Department of Mentally Disordered Offenders has been established, which is the only specialized department in Greece. The selection of these hospitals was mainly based

on specially designed clinics with balustrades in the windows and doors that lock, and also on the presence of specialized care staff (Asimopoulos, 2009; Malainos, 2016).

The length of time a person is kept in the psychiatric clinic is not fixed, but according to Article 70 of the PC "as long as public security requires", noting that every three years the court, based on the opinion of psychiatrist-expert, decides whether detention will continue and adds that the court may, at any time, at the request of the public prosecutor or store manager, order the dismissal of the guarded person (Kosmatos, 1998; Kotsalis, 2002; Panousis, 2007; Papadopoulou, 2007; Skaragkas, 2002; Tsalikoglou, 1987).

1.7.3 Critique on Legislation for Mentally Disordered Offenders

As shown by the literature review, both in Greece (Kosmatos, 2002; Paraskevopoulos & Kosmatos, 1997) and internationally (Ciszewski & Sutula, 2000; Laberge & Morin, 1995; Slobogin, 2000), the mode of admission, the health care conditions, length of stay in a psychiatric institution and, subsequently, the future prospect of social reintegration for MDO are not carried out in positive terms and are not surrounded by favourable prospects.

The position of mentally disordered offenders is difficult. As Skaragkas (2002) and Tsalikoglou (1987) noted, mentally disordered offenders are a population group with a peculiar legal status quo. Typically, they do not serve a sentence for the offense they committed, but they are ordered to be confined to a psychiatric clinic as a security measure. Their incarceration and lifting of their incarceration are judged by the court, taking into account the psychiatric expertise report that is usually ordered. The therapeutic nature of their incarceration has been questioned by many legal authorities and psychiatrists. In practice, mentally disordered offenders are deprived of the rights of both prisoners (serving a specific sentence, having a right to appeal,

hoping for a sentence reduction) and psychiatric patients (leave days, lifting of the confinement based on medical advice); while on the contrary endures all the deprivations of both of the above categories (Derks at al., 1993; Menzies; 2002; Solivetti, 1999).

As to the duration of the MDO's stay in the psychiatric clinic, in correlation with the length of time spent in prison for the crime in case of no mental disorder, the judges declare that the time cannot be equal. The person stays in the psychiatric clinic for as long as the treatment process requires, potentially less or longer than the actual sentence would have been attributable. In contrast, the literature states that it is more common to stay in a psychiatric clinic for longer time (Derks at al., 1993; Edworthy, Sampson, & Völlm, 2016; Laberge & Morin, 1995), and the incarceration can last from a minimum to a lifetime depending on improvement of MDO's mental health (Ciszewski & Sutula, 2000). According to literature, only in Croatia, Italy and Portugal, the time of psychiatric detention is equal to the prison sentence an individual would have received in case of no mental disorder. Contrary in Germany, the duration of detention in the forensic psychiatric hospital equals to the perceived dangerousness this MDO pose to the community (Edworthy et al., 2016).

Whether the MDO can leave the psychiatric clinic or not, is not a decision the psychiatrist can make as it happens in other cases, but it is also requires the court decision. The court uses psychiatrists' reports from the psychiatric clinic to get a picture of the state of the mental health and its improvement in order to conclude to a decision (Dahlin et al., 2009; Derks at al., 1993; Shah, 1989). The MDO will receive treatment for the mental illness s/he is suffering from, and will remain there until his or her health is restored and deemed not to be dangerous to himself or those around him (Kosmatos, 1998; Perlin, Gould, & Dorfman, 1995; Skaragkas, 2002).

Considering all of that it is perceived that safeguarding public safety and not the defendant's therapeutic needs seems to be the ultimate goal; as the concept of dangerousness seems to weigh more on legal and psychiatric decisions than on the course of the defendant's mental health (Kosmatos, 1998).

This phenomenon is not only visible in Greece. Also in a research conducted in Australia regarding the reasoning of judicial decisions in lifting the confinements of mentally disordered offenders, it was found that the safety of the community as a whole, and not the treatment of patients, was a key consideration for the judges. It is also noted that the stereotypes of the association between mental illness and dangerousness are still quite strong (Freckelton, 2005).

Additionaly, fear of relapse and recurrence of aggressive behavior leads the psychiatrists and therefore court to be extremely cautious in “releasing” an MDO (Tsalikoglou, 1987). During the present research’s data collection, in a conversation with a psychiatrist in the Psychiatric Hospital of Thessaloniki regarding the MDOs and the duration of their stay in the psychiatric clinic he said *“I have seen many cases that they [mentally disordered offenders] leave the clinic in great condition and they go well for a while, but after a short time they interrupt their pharmacotherapy and keep it secret from their family or caregivers. The result is the worsening of their mental health and their aggression expression which is an outcome of the disorder”*.

To conclude, the fact that there appear to be disproportionate numbers of mentally ill criminals (Morris, 2006) may be due to the so-called "criminalization of mental illness" (Teplin, 1984). This "criminalization" refers to the possibility that law enforcement agencies and the judiciary consider the actions of mentally ill persons more suspecious (and therefore, criminal) than the actions of mentally healthy people.

Moreover, psychiatrists tend to regard mentally ill as more dangerous than the general population. This is a trend that exists in other groups of experts (e.g. judges, psychologists, criminologists, prison managers) and is attributed to their increased moral and legal responsibility in the case of false assessment (Livaditis, 1994). As a result of the above there is an overestimation or an overstatement of dangerousness of the mentally disordered by specialists (Resnick, 1998; Skaragkas, 2002; Tsalikoglou, 1987).

Chapter 2

The Experience of Crime

Notwithstanding the overall low base rated of the offenders suffering from schizophrenia, there is some evidence of a relationship that is worth studying between schizophrenia and violent offending. During the past few years, there is an increased consideration of the narrative theory as an effective technique to understand how individuals perceive their lives as whole by telling story about it; offering their insights and experiences. Studying schizophrenic offenders using the narrative approach may reveal unreported evidence regarding the nature of their offence which would possibly result in a greater understanding of violent offending in that particular population.

2.1 Narrative Theory

Narrative theory indicates that individuals create a narrative consisting of particular sequence of events and state of mind so they are able to make sense of their lives. In their narratives they involve others as characters or actors and assign to themselves the lead character (Baumeister & Newman, 1994; Booker, 2005; Bruner, 1990; Habermas & Bluck, 2000). These narratives are stories individuals tell about specific events of their lives or their lives as a whole and they are formed under the narrator's notion of the significance of what has happened to him and what he has done; providing a cognitive and emotional significance to the experience (Roberts, 2000).

McAdams (1985, 1993, 2001) argued that through these narratives individuals comprehend their lives by giving identity to their character and coherence and

meaning to their life story. As such, these narratives are essentially about their effort to conciliate who they are, who they think they are and who they might be within various social settings. According to his theory, all narratives are built upon the agency-communion dimension of motivation; where agency refers to the effort of being successful, powerful, competent and independent and communion refers to the effort of building close relationships and connecting to other by developing the values of love and intimacy (Ioannou, Canter & Youngs, 2017).

Additionally, Baumeister and colleagues (Baumeister, Stillwell & Heatherton, 1995; Baumeister, Stillwell, & Wotman, 1990; Leith & Baumeister, 1998) argued that personal narratives are functional as tools for understanding the motives of an individual, as what happens in his life and what s/he perceives as significant events are all described in the narration (Booker, 2005).

Taking under consideration the above, narrative psychologists (McAdams, 1988; Polkinghorne, 1988) have indicated that for every story being told there is a limited range of possible frameworks (Canter & Youngs, 2009), and that there are few enthralling ways to tell a story (Polkinghorne, 1988). In particular, McAdams (1988, 2001, 2006) suggested that narratives can be analyzed in terms of characters and their roles, plot, settings, scenes and themes. He furthers suggested that the four archetypal story forms proposed by Frye (1957) in his book entitled "*The Anatomy of Criticism*" can work as concepts for interpreting life narratives.

Frye (1957), based on the Aristotle's Poetics, developed the "Theory of Mythoi" and proposed a classification system for several classic stories. According to that theory all life narratives can take one of the four dominant themes, which Frye calls 'mythic archetypes' that he related to the four seasons of the year: Comedy (spring), Romance (summer), Tragedy (autumn) and Irony (winter). He further

suggested that each narrative can be considered as either a pure manifestation of a single archetype, or a hybrid of two or more archetypes. This categorization system is a reflection of "ethos" which refers to how the protagonist of the story is represented in relation to the rest of humanity and to his/hers social and natural environment. While these four indentified forms are developed independently, Frye (1957) stated that each form was also related to the others and suggested that "cyclical movement" was the primary structure of the narrative process.

From the past times till the present day, people use stories to explain whatever happens around them and to them. Under that notion, narratives provided by individuals allow researchers to distract rich and valuable information on how their subjects perceive their own lives (Ioannou, 2006; Polkinghorne, 1996). As McAdams (1996) argued, narratives are the psychosocial constructions that constitute identity. These narratives provide an efficient knowledge on an individual's actions, experiences and motivations and especially on how individuals give meaning to thing they have done and to things that have happened to them.

Narrative theory has a number of advantages as a theoretical tool. It provides a flexible theoretical framework as the individual's identity is open to interpretation and it is not tied down to some unchangeable attributes. Narrative theory uses a combination of strategies as framework (O'Sullivan, 2005) which allows the exploration and interpretation of inconsistencies within the narrations by using them as evidence of the various facets of individuals' complex narrative identities. Another advantage of narrative theory is that it regards the interpretation of the dehaviour as dynamic, and not as static, because it accepts the narrator's/ actor's relationships are a subject of change over time and space (Somers & Gibson, 1994). One of the major advantages of narrative theory is its focus on researchers and interpreters as *"real-life*

individuals rather than theoretical abstractions" (Baker, 2007, p.154). This theory focuses on real-life events and allows interpreting the event under various social and political contexts without the attention being distracted from the original narration. Under his notion, the narrative theory demands from researcher and interpreters to recognize their subjectivity. Last but not least, despite the fact narrative theory accepts there are some dominant narratives in any given situation or society; it also acknowledges that these narratives can be either accepted or rejected. In cases they are rejected they are been replaces by alternative narratives that best explain and interpret a given event (Currie, 2010).

Despite all the advantages, narrative theory and narrative methodologies appear some disadvantages too. One of the most interesting disadvantages of this approach has to do with the narrator's reliability (Almén, 2003). This is not referred to the truthfulness of the story but on causality; where in some stories casual relationships seem to be contrived and arbitrary. In such cases, the sequence of events narrated often appeared to be motivated by the beliefs of the individual narrating the story; but these beliefs are after event constructions, namely ways of the narrator to justify his/hers behavior after the event (Almén, 2003). That is not something reprehensible as in many cases people are unaware of the reasons of their own acts, and their explanations over the event may be incomplete or inaccurate. Something like that happened for a variety of reasons such as because individuals are unaware of the truth, or because they are not in an emotional and mental state to see the truth, or even because there is no coherent explanation that link events together in the narrators mind. Under that notion is vital to note that casual relationships derived from a narration are in many instances provisional and subject to question or alternative reading (Almén, 2003).

That leads to the second disadvantage that has to do with the researcher/listener/ reader. That person who reads or listens the story is the one who ultimately makes connections between events. That individual may be affected to the interpretation of the events by his perception on the narrator's reliability or his personal beliefs and experiences. An individual's personal experiences influence him/her on the interpretation of other events and situations that s/he listens. Thus different researchers/listeners/ readers with different experiences and general background may interpret the same narrative differently. The subjectivity of the researcher is a disadvantage in all qualitative research approaches and of the narrative research approach; and the researcher should avoid imputing meaning on the narration that wasn't placed there in the original narration (McAlpine, 2016).

Another issue that draws attention to the narrative research approach is the relationship that develops between the researcher and the research subjects (Altork, 1998; Connelly & Clandinin, 1990; Heikkinen, 2002; Kyratzis & Green, 1997). It is of vital importance in a research of such nature that the researcher builds a collaborative, non-judgment and caring relationship with the research subject, based on equality, so both parties feel comfortable and be able to develop a intersubjective understanding of the stories being told during the research process (Connelly & Clandinin, 1990; Fetterman, 1998; Moen, 2006). A dilemma on if that can occur if the researcher can't build such a relationship the research subject, if these parties interpret specific events on the narration in different ways or if the research subject questions the interpretive ability of the researcher (Gudmundsdottir, 2001; Moen, 2006). In cases like that the narration of the events and emotions may be shaped by the narrator and the researcher does not extract all these rich and meaningful information that he indented to get.

Despite the abovementioned limitation of Narrative Theory, many disciplines took advantage of the knowledge provided by this research approach and scientist from various disciplines like anthropology, sociology and psychology collected and interpreted narratives by their research subjects, clients, patients and so forth (Ioannou, 2006; Ruth & Kenyon, 1996). Especially in psychology it has been given a great emphasis on narrative methods and these have been used in various areas like industrial/organisational psychology (Pondy, Morgan, Frost, & Dandridge, 1983); counselling (Polkinghorne, 1988); psychotherapy through the development of narrative therapy (Spence, 1982; White & Epston, 1990) and later in clinical psychology (Howard, 1991); in developmental psychology (McCabe & Peterson, 1991); social psychology (Murray & Holmes, 1994); and last but not least in cognitive psychology (Schank & Abelson, 1995).Furthermore, no matter that Frey's Theory of Mythoi first developed more than sixty years ago, it has led and still is leading many researchers to explore an individual's subjective accounts of an event in order to better understand that individual's thoughts, beliefs, motivations and roles (Zechmeister & Romero, 2002). That consideration also led the research in the discipline of Investigative Psychology toward this direction. Investigative psychologists focused their research within the area of narratives in an effort to better understand the motives and coherence of offending behaviour.

2.2 Narratives in Criminal Context

Professor David Canter and Professor Maria Ioannou (2004a) were the first to expand McAdams' idea, proposing that offenders' narratives could possibly reveal the covert nature of lives and criminal behaviour of that specific population. Canter applied the narrative approach to demonstrate how the narratives of offenders gives form and meaning to their criminal activities in order to acquire a deeper knowledge

of the nature and the motives of their offences (Canter, 1994; Canter & Youngs, 2009; Ioannou, 2006; Spruin, Canter, Youngs, & Coulston, 2014; Youngs & Canter, 2012a, b). This process of integrating the perception of the self in an unfolding personal story, called by Canter (1994) "inner narrative". He also argued that criminal actions can be comprehended exclusively through a thorough analysis and interpretation of these inner narratives and by linking them to specific roles and actions.

Other theorists supported Canter's idea, and specifically Maruna (2001) stated that criminal narratives are very effective in describing the changing dynamics features of an offender's life and generally in revealing particular components of his/hers life. Likewise, Presser (2009, 2012) suggested that an offender's narrative is a direct outcome of offending and therefore has a direct influence as a key instigator of the criminal activity. Also in accordance with Toch's (1993) study of violent men's narratives, Presser stated that offending is perceived as the enactment of a narrative and not as an explanation of the circumstances out of which the offence arose. Last but not least, Yang and Mulvey (2012) supported that exploring criminal behaviour from a first-person perspective can call attention to the fundamental psychological processes that propel offending behaviour and consequently develop insight into this specific population.

Researchers analysed the structure of offenders' narratives in accordance with the narrative approach. The results of these analyses revealed that there are a specific number of patterns in offenders' behaviours, actions, beliefs, thoughts and experiences. These specific patterns fall into distinct themes reflecting the role the offender took within the overall criminal context. These themes of criminal actions are interpretable taking under consideration the Frey's (1957) "Theory of Mythoi" and McAdams (1985, 1993) ideas on narratives.

Canter, Kaouri & Ioannou (2003) were the first to explore Canter's (1994) initial hypothesis that offenders may perceive their criminal acts in terms of one of Frye's mythoi. They argued that in order to describe the distinctive natute of something as complex as a personal narrative, they had to investigate the roles criminals assign to themselves during crime commission. The study's results revealed four distinct patterns of offending, which are associated to four different roles that offenders assign to themselves: the Victim (irony); the Professional (adventure); the Hero (quest), and the Revenger (tragedy) (Canter et al., 2003). Based on this research, Ioannou (2006) created a questionnaire based on the different role statements formed by the information gathered from interviews with offenders (Canter, Ioannou & Youngs, 2009). The study's results supported that there are four separate roles and they established the previously revealed the roles offenders assign to themselves. Further empirical exploration of narratives has also supported the existence of four discrete roles (Canter & Youngs, 2009, 2012; Ioannou, 2006; Ioannou et al., 2015, 2017; Ioannou, Synnott, Reynolds, & Pearson, 2018; Spruin et al., 2014; Youngs & Canter, 2012a, b, 2013).

2.2.1 Victim

The Victim role has its roots in Frye's Irony myth and it is related to disconnectedness and despair. The offenders under that role perceive themselves as powerless and helpless victims of the event. The sense of confusion makes them believe that they live in a world where there are no social and moral codes and where nothing makes sense and nothing matters. In this world the victim role offenders perceive themselves as secluded from others; living in a world of repulsiveness and idiocy, a world without pity and hope. This kind of offenders is commonly associated with emptiness and depression and generally negative emotions.

2.2.2 Professional

The Professional role is part of an Adventure narrative, which Frye refers to as "romance". These offenders believe they have competency and mastery of the environment, and they are adventures who attempt to emerge victorious by overcoming the adversities throughout life journey which is full of various obstacles, constantly changing circumstances and continually arising challenges. These offenders perceive themselves as adventures and risk takers who have the ultimate control and they enjoy their powers. Also for them others are irrelevant. This kind of offenders is associated with positive emotions and especially with calm and satisfaction.

2.2.3 Hero

The Hero role is consistent with Frye's Comedy archetypal myth. The offenders under the Hero role perceive themselves as powerful. For them other individuals and their reactions are significant for the formation of their narrative, and they are usually in the pursuit of true love, happiness and stability in life with others. Under that purpose the hero role offenders attempt to minimise or eliminate environmental and individual obstractions and restrictions which cause interferences. In the criminal context these offenders interpret their actions as a part of righteous mission in an attempt to accomplice to defend their manly honour and to obtain respect. These offenders have a sense of bravado and casualness and they are discharged from anxiety and guilt. These offenders are generally optimistic individuals who seek pure pleasures and a successful conclusion in their criminal activities and they are associated with positive emotions like happiness, joy and contentment.

2.2.4 Revenger

The Revenger role has been associated with the Frye's Tragedy myth. These offenders have little concern for others and believe they have little control over their actions as they are being pushed by the fates. The offenders under this role are extremely proud and passionate individuals who inevitably take revenge from those who have been treated them unfairly, deprived or wrong them. They support that their criminal actions are right and justified and they bear no blame for them as they had no choice but to avenge this wrong to protect their own back. These offenders perceive themselves as victims of their nemesis and "extraordinary victims" who face inevitable dangers and believe they are overpowered by the fates. The Revenge role offenders are generally pessimistic and distressed and from their criminal action they gain ambivalent feeling like pain and pleasure and happiness and sadness. This kind of offenders is commonly associated with negative emotions like sadness and fear.

2.3 Relative Research on Criminal Narrative Roles

The analysis and understanding of the inner narratives provide and deeper understanding of why individuals exhibit violent behaviours and specifically why the commit crimes (Canter, 1994; Canter & Youngs, 2009, 2012; Ioannou, 2006; Youngs & Canter, 2011, 2012). This notion has led a great number of studies to explore the roles offenders assign to themselves during the crime commission and support the findings of the initial research which identified four dominant narrative themes (Canter & Fritzon, 1998; Canter & Ioannou, 2004b; Canter et al., 2009; Canter & Youngs, 2009; Canter & Youngs, 2012; Ioannou, 2006; Salfati & Canter, 1999; Youngs, 2004; Youngs & Canter, 2012a, b).

Many recent studies have used the narrative approach to gain an in depth understanding of the motivation and sustainability of harmful and criminal actions. Such criminal narrative themes have been proposed by research conducted on crack cocaine use (Copes, Hochstetler, & Williams, 2008); cannabis use (Sandberg, 2012); drug dealing (Sandberg, 2009, 2016; Sandberg, Tutenges & Copes, 2015); cocaine trafficking amongst women (Fleetwood, 2015); violence among incarcerated drug dealers (Sandberg et al., 2015); drinking (Tutenges & Sandberg, 2013); carjackers' decision-making strategies who use violence to steal cars (Copes, Hochstetler & Sandberg, 2015); violence (Brookman, 2015); young offenders (Ioannou, Synnott, Lowe, & Tzani-Pepelasi, 2018); women offenders (Ciesla, Ioannou & Hummond, 2019); rewriting of criminal narratives amongst violent women offenders (Africa, 2015); contract killers (Yaneva, Ioannou, Hammond, & Synnott, 2018) and for offences such as burglary, robbery, arson, stalking, rape and serial homicide (Canter & Youngs, 2009; Youngs & Canter, 2012a); street violence (Brookman, Bennett, Hochstetler, & Copes, 2011); white-collar crime (Klenowski, Copes, & Mullins, 2011); mass murder (Presser, 2012) and terrorism (Joosse, Bucerius & Thompson, 2015; Sandberg, 2013). This Criminal Narrative Framework has also been implemented in Anders Breivik's acts (Sandberg, Oksanen, Berntzen, & Kiilakoski, 2014). Finally yet importantly, the narratives approach lately implemented in a study with mentally disordered offenders (Spruin et al., 2014) and with offenders with personality disorders and psychopathy (Goodlad et al.,2018)

Chapter 3

Emotions

3.1 Theory of Emotions

Criminal Narratives have received intense criticism because they disregard emotions and emotional experience of the offender (Ioannou, 2006; Ioannou et al., 2017).

The concept of emotion has been in the spotlight of many scientists and has caused an intense debate and discussion since the earliest philosophers to present day researchers. The complexity of this term is quite broad and there is not a universally accepted definition. Though, Smith and Kosslyn (2007, p. 535) attempted to define emotion as "*a relatively brief episode of synchronized responses (which can include bodily responses, facial expression, and subjective evaluation) that indicates the evaluation of an internal or external event as significant*".

Human relationships are laden with emotion whether they are articulated through actions or behaviours, expressions, voice or body movements; that is why many theorists support that emotions are an important and of high significance component of human behaviour (Adolphs, 2002; Lazarus, 1991). Emotions are directly associated with how individuals interpret things and how they communicate and interact with other individuals and the environment (Barrett, Gross, Christensen & Benvenuto, 2001; Campos, Mumme, Kermoian & Campos, 1994; Ekman, 1992; Hess & Thibault, 2009); and their regulation advance personal and social well-being (Balzarotti, Biassoni, Villani, Prunas, & Velotti, 2016; Barrett, Lewis, & Haviland-Jones, 2016; Baumeister, 2016).

Emotional expressions, either verbal or non-verbal, serve information regarding one's own or others' emotions, thoughts, intentions and behaviours (Buck, 1976; Ekman, 1973; Erickson & Schulkin, 2003; Gazzaniga, Ivry & Mangun, 2009; Keltner & Haidt, 2001). As Caruso (2008) observes, "*emotions direct our attention and motivate us to engage in certain behaviors*". Emotions according to him "*do not interfere with good decision making, they are, in fact, necessary and critical for all effective decisions*" (Caruso, 2008, p.5).

Substantially, emotions are at the centre of individuals' mental life (Oatley & Jenkins, 1996) and define them into the people they are (Katz, 1988). In spite of the amount of studies that support the relationship between emotions and human behaviour (Albelson & Sermat, 1962; Izard, 1972, 1977; Larsen & Diener, 1992; Plutchik, 1980; Oatley & Jenkins, 1996; Posner, Russell & Peterson, 2005; Russell, 1978; 1980; Schlosberg, 1952); it is of vital importance to note that emotions are dynamic and complex entities which are ruled by biological mechanisms beyond the individuals' control. This makes the understanding the structure of human emotions quite vague and uncertain (Cropanzan, Rupp & Byrne, 2003; Seo, Barrett & Bartunek, 2008).

Withal, many studies conducted on emotions structures such as facial and vocal emotional expressions (Albelson & Sermat, 1962; Schlosberg, 1952), mood words (Russell, 1980) and semantic differentiation of moods (Averill, 1975) agreed on the existence of a double dimensionality (Albelson & Sermat, 1962; Averill, 1975; Aviezer, Trope, & Todorov, 2012; Daly, Lancee, & Polivy, 1983; Larsen & Diener, 1992; Leary, 1957; Mehrabian & Russell, 1974; Posner, Russell, & Peterson, 2005; Russell, 1979, 1980; Schlosberg, 1954). These two dimensions have been named and conceptualized in various ways, for example valence and arousal (Russell, 1979,

1978, 1997, 1980), positive and negative affect (Holbrook & O'Shaughnessy, 1984; Watson, Clark & Tellegen, 1988; Watson & Tellegen, 1985), tension and energy (Thayer, 1989) and approach and withdrawal (Lang, Bradley, & Cuthbert, 1998). Regardless the label placed on these two dimensions, many researchers have supported that this double dimensionality is consistent (Posner et al., 2005).

3.2 Russell's Circumplex Model of Affect

One of the most recognised dimensional model of emotions that has been extensively researched and supported to provide a practical framework for affective experiences exploration (Posner et al., 2005), is the Russell's Circumplex Model of Affect (Russell, 1980). The Russell's model embodies the notion that all affective states are derived from two distinct dimensions of mood; valence pleasantness or unpleasantness (happy, enthusiastic vs. afraid, sad), and degree of arousal or activation (excited, tense vs. relaxed).

In more detail, the valence system determines the degree to which the individual experiences positive or negative emotions. These emotions are divided in pleasurable experiences, like happiness or joy and in unpleasant experiences like sadness and despair (Posner et al., 2005; Russell, 2003). The second dimension, named arousal system, determines the degree to which certain behaviours are activated by the emotions the individual experience. The degree of arousal can be divided in intense arousal, like excitement or panic and in minor arousal like sleep or coma (Posner et al., 2005).

Russell (1979, 1980, 1997, 2003) expanded this further the particular emotions framework suggesting that there is a "circumplex" (circular order) of emotions formed around these two dimensions; pleasure-displeasure and arousal-non-arousal.

He also stated that these emotional states also tend to merge one into each other. Thus, emotional states are first felt and communicated within this framework, on which cognitive interpretation describes the emotional shifts in valence and arousal systems. When these affective shifts are established, they are structured on the basis of stimuli, previous experiences, behavioural reactions and semantic awareness (Posner et al., 2005; Russell, 2003). This as a consequence, activates the two dimensions to varying degrees considering the extent of stimulation as an affective state occurs.

Four wide themes of mood generated by the proposed two dimensions: Elation (High Arousal, High Pleasure), Calm (Low Arousal, High Pleasure), Depression (Low Arousal, High Displeasure) and Distress (High Arousal, High Displeasure) (e.g., Russell, 1997, 2003). A visual representation of Circumples of Affect representing in the vertical axis the arousal dimension (arousal-sleepiness) and in the horizontal axis the valence dimension (pleasantness-unpleasantness) is illustrated in Figure 1. Studies followed in that field supported Russell's circumplex model of affect (Feldman, 1995; Fisher, Heise, Borhnstedt & Lucke, 1985; Remington, Fabrigar & Vissar, 2000; Watson & Tellegen, 1985).

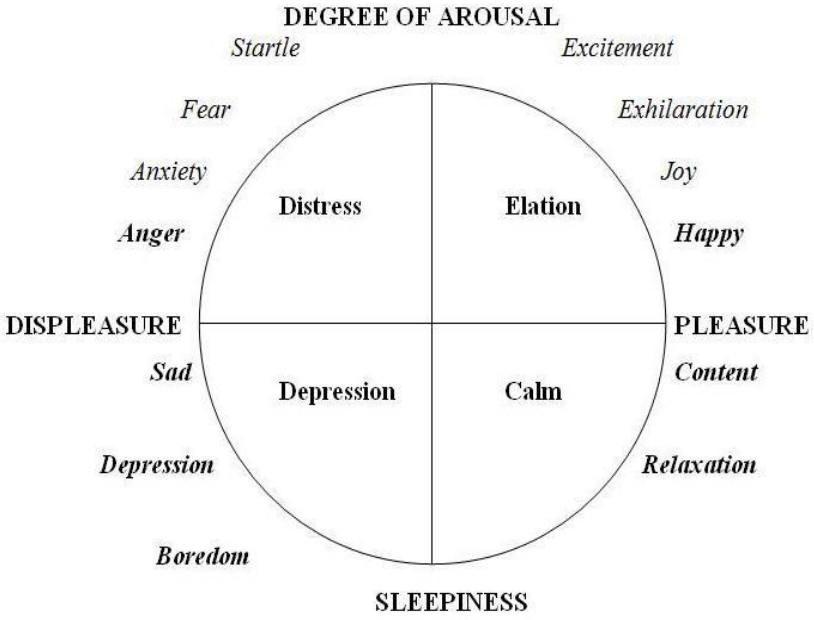

Figure 1: Russell's (1997) Circumplex of Emotions

3.3 Emotions in Schizophrenia

Individuals suffering from schizophrenia, as already stated before (see section Schizophrenia in page) exhibit impairments in cognitive functioning (Harvey, 2014; McCleery et al., 2014; Rajji,Miranda, & Mulsant, 2014; Reichenberg & Harvey, 2007) and particularly in emotion processing (Aleman & Kahn, 2005; Hoertnagl et al., 2014; Irani, Kalkstein, Moberg & Moberg, 2011; Kring & Moran, 2008; Potvin, Lungu, Tikàsz, & Mendrek, 2017; Rahm et al., 2015) which are important components of vocal function, social relationships (Ochsner, 2008) and life as a whole (Brekke, Hoe & Green, 2009; Green, 2006; Kee, Green, Mintz & Brekke, 2003).

Brain regions and specifically amygdala and hippocampal dysfunction may be responsible for the deficits in cognitive and emotional processing presented in schizophrenia (Adolphs & Spezio, 2006; Benes & Beretta, 2000; Gur, McGrath,

Chan, Schroeder, Turner et al., 2014; Heckers & Konradi, 2002; LeDoux, 2009; Phillips et al., 1999; Rahm et al., 2015). These two brain regions, as supported by a bulk of research, are useful components in the formation of emotional states and behaviors[8], in the recognition of visual stimuli[9] and identification of auditory stimuli (Phillips, Young, Scott, Calder, Andrew et al., 1998), in the regulation of attention and awareness to emotionally significant information (Davis & Whalen, 2001) and in the memory and particularly in the evaluation and the encoding of emotional content information (Cahill, Haier, Fallon, Alkire, Tang et al., 1996; Canli, Zhao, Brewer, Gabrieli & Cahill, 2000; Li, Weerda, Milde, Wolf, & Thiel, 2015; Yonelinas, & Ritchey, 2015).

Several studies on schizophrenia have supported that patients suffering from it exhibit impairment in semantic processing (Condray, Steinhauer, van Kammen & Kasparek, 2002; Pesciarelli et al., 2014; Nestor et al., 2001; Tan, Neill, & Rossell, 2015; Walder, Seidman, Cullen, Su, Tsuang et al., 2006; Zeev-Wolf, Goldstein, Levkovitz, & Faust, 2014), in the recognition of prosody (emotional tone in speech)[10] and last in nonverbal emotional cues (Edwards, Jackson & Pattison, 2002; Kohler et al., 2003; Mandal et al., 1998).

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[8] (Fastenrath et al., 2014; Hanson et al., 2015; Madan, Fujiwara, Caplan, & Sommer, 2017; Mier etal., 2014; Morris et al., 1998; Pessoa, 2017; Reiman et al., 1997; Whalen, 1998)

[9] (Adolphs, Tranel, Damasio & Damasio, 1994; Belge, Maurage, Mangelinckx, Leleux, Delatte, & Constant, 2017; Phelps & Anderson, 1997)

[10] (Edwards, Pattison, Jackson, & Wales 2001; Kantrowitz et al., 2016; Leentjens et al., 1998; Murphy & Cutting, 1990; Petkova et al., 2014; Pinheiro et al., 2014, 2016; Ross et al., 2001; Shea et al., 2007), in the recognition of emotions in facial expressions (Bordon, O'Rourke, & Hutton, 2017; Cao et al., 2016; Daros, Ruocco, Reilly, Harris, & Sweeney, 2014; Edwards et al., 2001; Jang, Kim, Kim, Lee, & Choi, 2016; Johnston, Devir & Karayanidis, 2006; Kring, Siegel, & Barrett, 2014; Mandal, Pandey & Prasad, 1998; Okada, Kubota, Sato, Murai, Pellion, & Gorog, 2015; Sachs et al., 2012; Sachse et al. 2014; Tsotsi, Kosmidis, & Bozikas, 2017; Yalcin-Siedentopf et al., 2014; Wölwer, Streit, Gaebel & Polzer, 1996)

Recent studies indicate that schizophrenia patients have low levels of emotional intelligence and face difficulties not only on recognizing emotions in others, but also in the capability of understanding and managing emotions in oneself and others, in accurately perceiving emotions and in using emotions to facilitate thinking and decision making (Couture, Penn, & Roberts, 2006).

Despite the large body of research on emotion in general and clinical populations, empirical studies into the experience of emotions in criminal populations are quite infrequent. Emotions as they play an important role in one's life, it is also believes to play a vital role in the violent behavior and formation of criminal action. Therefore, the exploration of emotions and emotional state in offending populations is of high importance.

3.4 Emotions and Criminal Behaviour

For many decades, crime theorists neglected the idea that emotions and emotional arousal may form a significant role in offending (Ioannou, 2006; Ioannou, Canter, & Youngs, 2017). Consequently, the vast majority of studies attempting to explain criminal behaviour, focus on various personal and social aspects. Only in the last few decades the attention posed in internal factors and specifically on emotions and how they affect an individual to engage in criminal activities (Åkerström, 1999; Adler, 1999; DeLisi, 2011; DeLisi & Vaughn, 2016; Feeney, 1999; Indermaur, 1996; Ioannou, 2006; Mesquita, 2016; Youngs & Canter, 2012b; Wright, Decker, Redfern, & Smith, 1999).

Katz (1988) was one of the first to argue that there is a relationship between an individual's emotions and the crime s/he commits. Katz (1988) in his book *"Seductions of Crime"* explored the emotions felt be offenders during the crime

commission; and offered in-depth description of main components of offending some of which are “sneaky thrills”, humiliation, feelings of righteousness, and cynicism. His position supports the idea that the emotional experience of the offence is relevant to the formation and understanding of different criminal narratives.

Likewise, years later, Elias (1994) suggested that investigations into crimes apart from the reasons and ideas behind the offence which was examined till then; the investigations also need to consider the emotion that propels these ideas into action and direct or urge individuals in offending. Taking this idea into account, a large body of researches conducted to explore the emotional copmonent in the causation of violence and crime (Åkerström, 1999; Adler, 1999; Bumby & Hansen, 1997; De Haan & Loader, 2002; Feeney, 1999; Garlick, Marshall & Thornton, 1996; Indermaur, 1996; Marshall, Champagne, Brown & Miller, 1997; Marshall & Hambley, 1996; Seidman, Marshall, Hudson, & Robertson, 1994; Wright et al., 1999).

General strain theory (Agnew, 1992, 2001; Ganem, 2010) argues that stressful factors increase the experience of negative emotions and these emotions consequently trigger violent and offending behaviour (Agnew, 2001, 2013; Ousey, Wilcox, & Schreck, 2015). Several studies have reported the relationship between negative emotions and aggressive/violent behaviour and offending (Connolly & Beaver, 2015; Day, 2009; DeLisi & Vaughn, 2015; Donahue, Goranson, McClure, & Van Male, 2014; Ganem, 2010; Garofalo, Velotti, Crocamo, & Carrà, 2017; Hollist, Hughes, & Schaible, 2009; Jones, Miller, & Lynam, 2011; Mazerolle, Burton, Cullen, Evans, & Payne, 2000; Miller & Lynam, 2006; Miller, Zeichner, & Wilson, 2012; Moon, Morash, McCluskey, & Hwang, 2009; Nestor, 2002).

Studies examining negative emotions supported that specifically anger and grief are related to offending (Batchelor, 2005; Berkowitz, 2012; Mitscherlisch &

Mitscherlisch, 1975; Novaco, 2011); and most of all shame and humiliation are involved in the genesis of violence and crime (Elison, Garofalo, & Velotti, 2014; Hagan & McCarthy, 1997; Luckenbill, 1977; Ribeiro da Silva, Rijo, & Salekin, 2015; Scheff & Retzinger, 1991; Sherman, 1993; Tangney, Stuewig, & Hafez, 2011; Tangney, Stuewig, & Martinez, 2014; Velotti, Elison, & Garofalo, 2014; Winlow & Hall, 2009).

According to Baumeister's theory of self-regulation (Baumeister, 1990; Baumeister, Heatherton, & Tice, 1994) is not only the individual's experience of negative affect that leads to violent behaviour but also individual's inability to regulate that emotions (Day, 2009). In this theory he argued that in events of negative emotional arousal certain people may experience reduced cognitive control and they exhibit disconnection from self-awareness, and particularly emotional awareness. In such cases, they tend to focus on temporary hedonic considerations that will make them feel better or offer the pleasure; or on instrumental considerations that will lead them to actions such as getting revenge.

Based on Baumeister's theory, many studies strongly correlated deficits in cognitive control to violent behaviour (Agnew, 2001; Caspi, Moffitt, Newman, & Silva, 1996; de Ridder, Lensvelt-Mulders, Finkenauer, Stok, & Baumeister, 2012; Denissen, Thomaes, & Bushman 2017; Denson, DeWall, & Finkel, 2012; DeWall, Finkel, & Denson, 2011; Elison et al., 2014; Farrington, 2005; Gratz & Roemer, 2004; Moffitt et al., 2011; Velotti et al., 2014); and in specific deficits in emotional awareness to aggression (Garofalo, Holden, Zeigler-Hill, & Velotti, 2016; Roberton, Daffern, & Bucks, 2015).

Motivated by the above, Canter and Ioannou (2004a) investigated the emotions offenders were experiencing during the crime commission. They suggested

that emotions are also significant components in understanding the experience of crimes and maybe they are relevant to different narratives of offending population (Ioannou, 2006; Ioannou, Canter, & Youngs, 2017).The Circumplex Model of Affect initially proposed by Russell (1997) for non-criminal experiences (for a description see above chapter: Russell's Circumplex Model of Affect in page 67) was used and assimilated to explore the offenders' emotion during crime commission. The findings of Canter and Ioannou's study (2004a) reflected Russell's circumplex structure of affect by identifying four themes of emotion (e.g. elation, calm, distress and depression) that displeyed greater contrasts between bipolar emotional dimensions (e.g., pleasure and displeasure and arousal-sleepiness); and they proposed that this particular model is also applicable to accounts of violent and criminal behaviours.

Correspondingly, Ioannou (2006) in her thesis investigating male offenders' emotional experiences represented the Russell's circumplex; revealing the four distinct themes already proposed before. Likewise, Ciesla et al. (2019) revealed similar emotional themes exploring women offenders. Regarding mentally disordered offender populations, Spruin (2012) was the first to explore the emotions during crime commission in such population. The results of her study partially mirrored Russell's circumplex. She accomplished to find the two distinct regions of Pleasure-Displeasure but failed to indentify a degree of the activation dimension (Arousal-Sleepiness) as there were previously identified in prison populations studies.

The results of these studies demonstrate that emotions felt by offender during crime commission are displayed in different contexts compared to the general population, but still reveal a form of normal emotional functioning. Thereafter, these two studies have placed emotions in the centre of offending behaviour, and there is definitely a need for more research in this particular area.

Chapter 4

Criminal Narrative Experience (CNE)

4.1 Criminal Narrative Experience Framework

Canter and Ioannou (2004a) not only revealed that emotions play a particular role in offending behaviour, but also that the methodology used to explore narrative roles in offending population can be used in exploring emotion during crime commission too. Therefore, this provides a method to explore the relationship between narrative roles and emotions. Later, Ioannou (2006) in her thesis explored the narratives roles in relation to emotions through the multidimensional analysis of Smallest Space Analysis and revealed four CNE themes: Depressed Victim, Distressed Revenger, Calm Professional and Elated Hero.

Ioannou (2006) linked criminal narratives and emotional experiences during crime commission and proposed the criminal narrative experience framework which reflects the stories presented by Frye (1957) and the Russells circumplex of emotions (1997). Through her study she revealed four dominant CNE themes and she supported further her thesis findings. The Depressed Victim takes no responsibility for his actions and feels that there is no choice and his offending acts are unavoidable as they are driven by fates. He experiences low arousal negative emotions and especially loneliness, depression and misery. The Distressed Revenger feels wronged and justifies his offending as he must take revenge to protect his own back and avoid humiliation. He feels high arousal negative emotions like anger, scare and irritation. The Calm Professional perceives the offence as a job and claims that there is nothing special about what happened. He experience low arousal positive emotions like calm, confidence, safety and relaxation. Last, the Elated Hero describes the offence as a

brave and exciting adventure that offers him positive emotions of high arousal like pleasure, excitement and enthusiasm (Ioannou, 2006; Ioannou et al. 2017).

The Criminal Narrative Experience Framework has also been replicated in other studies with different populations like psychopathic and personality disorder offenders (Goodlad et al., 2018), young offenders (Ioannou et al., 2018) and women offenders (Ciesla et al., 2019).

4.2 Criminal Narrative Experience and Background Characteristics

Katz (1988) supported that no other factors play a significant role to crime than the sensual dynamics. This argument was also supported by by Link et al. (1999) who conducted research specifically on mentally disorders individuals and he revealed that no demographic and socioeconomic variables were responsible for the aggressive behavior of this population. Contrary to these views, McCarthy (1995) supported the notion that crime can be affected by various other background characteristics.

Social theories of crime support that external factors like social, cultural and economic pose a great influence to people as if they will develop or not deviant or even criminal behaviour. More specifically, sociologists have put their attention to economic factors like economic status and/or unemployment; to cultural, social and community factors that influence the individuals like media, school, neighborhood and peer; and last but not least to family factors like parenting and poor parenting skills and offending history of parents and/or siblings (Ioannou, 2006). Criminologists further added to the abovementioned factors, the list of factors that influence people on offending individual background characteristics like gender, age, race and the presence of a mental disorder (2006).

Despite the theories that support social and background characteristics play a vital role in crime commission there is limited research on if these factors play any role in the formation of Criminal Narrative Experience. The only available data on that issue comes from Ioannou's (2006) doctoral thesis. In her thesis she explored whether there is any relationship between the offenders' CNE and their personal background characteristics and criminal history.

Regarding criminal history, her findings revealed that those assigned themselves the Elated Adventurer CNE exhibited offending behaviours of Planning (e.g. prepare an escape route, leave no evidence, get others to lookout, taking tools with him at the offence), Dishonest (e.g. burglary, arson, shoplifting, stealing car/bike, stealing purse) and Antisocial (e.g. fight, illegal driving, taking drugs, being drunk, break into properties, truancy). Those that assign themselves the Calm Professional CNE correlated significantly with Planing offending behaviours and last those who assigned themselves the Distresses Revenger and the Depressed Victim CNEs exhibited no correlation with any type of offending behaviour. At this point it is of great importance to note that the D42 Self-Report Offending Questionnaire used for offending behaviours, includes offending behaviours which are typicaly more prevalent among young offenders. Further analysis revealed that those who score higher on these questionnaire were younger in age; that could be translated that offenders assigned themselves the Elated Adventurer and Calm Professional CNEs are younger in age in comparison to the other CNE themes (Distresses Revenger and the Depressed Victim) (Ioannou, 2006).

Further analysis conducted regarding the relationship between CNEs and type of crime. The findings suggest that offenders who had committed offences against property (e.g. burglary, robbery, theft, shoplifting and fraud) assigned themselves the

CNE of Elated Adventurer and Calm Professional; while those committed offences against person (e.g. violence, sexual offences and murder) assigned themselves the CNEs of Distressed Revenger and Depressed Victim themes. A more detailed analysis on the type of crimes revealed that the offenders who had committed property offences, drug offences and robbery in a vast majority assigned themselves the CNEs of Elated Adventurer and Calm Professional; contrary those who had committed violence, sexual offences and murder assigned themselves the CNEs of Distressed Revenger and Depressed Victim. Additionally, the offenders who committed property offences, drug offences and robbery had experienced positive emotions during crime commission; while those committed offences against person like sexual offences, violence and murder had experienced negative emotions at the time of the offence (Ioannou, 2006).

Last but not least, Ioannou (2006) explored whether background characteristics play any role in the CNE. Regarding age there was found a significant negative correlation with Elated Adventurer and Calm Professional which means that offenders who assign themselves these themes are the younger offenders. Contrary, there was no significant differences that was found between age and the Distressed Revenger and Depressed Victim CNEs. As it concerns education no significant differences were found with any of the CNE themes, which means that education does not play any role in the formation of the CNE. In the same line, socio-economic status appeared no significant differences with any of the CNE themes, which means that offenders assign themselves any of these themes are from all socio-economic backgrounds. Concerning with who the offenders grow up as children there were no differences found for Calm Professiona, Distressed Revenger and Depressed Victim CNEs indicating that these offenders could have any type of family background;

while those who assigned themselves the Elated Adventurer CNE were those growing up without their both birth parents.

Regarding the age of the first conviction a significant correlation was found with Elated Adventurer and Calm Professional, indicating that these offenders had an early age at first conviction; contrary there was no correlation found with either Distressed Revenger or Depressed Victim CNEs. Last, as it concerns prison sentence or probation in the past the analysis revealed there were no differences for the Distressed Revenger and Depressed Victim; while Elated Adventurer had higher levels of prison probation and Calm Professionals had lower levels of prison sentence or probation which suggests that these offenders due to their professionalism and their ability to plan carefully their action managed to avoid detection and subsequently crime conviction.

Chapter 5

Depression

5.1 Definition, Causes and Prevalence of Depression

Sadness is a normal and expected feeling following some traumatic situations (Christodoulou, 2005). In other words, sadness can be defined as the normal reaction to unpleasant events. These events are usually characterized by a tendency for crying and a decreased willing for various activities or entertainment, symptoms that are transient and recede, thereby reducing sadness. But if these symptoms persist and cause the feeling of sadness to be extremely intense and last a long time affecting one's functionality and daily life, then we are talking about depression.

Depression is a very common mental disorder. The individual suffering from depression experiences depressed mood, reduced energy, loss of interest or pleasure, pessimism, feelings of low self-esteem or guilt, sleep or eating disorders, lack of concentration, unrealistic negative thoughts about oneself and the future, and social withdrawal. Additionally, depression is frequently comorbid with symptoms of anxiety. These issues can become persistent or recurring and can give rise to considerble impairments in a individual's ability to take care of their daily needs and responsibilities (American Psychiatric Association, 2013; Cambridge Dictionary of Psychology 2015; Kessing, et al., 2010; Kokkosi & Synodinou, 2010; Koulouvari & Efthimiou, 2006; Oxford English Dictionary, 2008; Polykandrioti & Stefanidou, 2013; World Federation of Mental Health, 2013; WHO, 2008, 2012, 2017).

Depression is the disease of the 21st century for the modern western world as it is estimated to affect over 350 million people worldwide. A survey conducted in seventeen countries around the word revealed that approximately one in every twenty

people has depression (WHO, 2012). Furthermore, it has been found that depression affects more often females than males (Giotopoulou-Maragopoulou, 1991; Joyce, 2009; Kessler et al., 2005; Kessler & Bromet, 2013; Murray & Lopez, 1996; Murray et al., 2012; Stylianidis, Pantelidou, Chondros, Roelandt & Barbato, 2014; WHO, 2008). Depression is expected by 2020 to be the leading cause of sick leave and disability and the most common cause of suicide. Depression has severe negative impacts in various aspects of people's lives such as in personal, social and economic fields that may lead to poor quality of life, risk of suicide, alcohol and substance abuse, difficulty coping with other co-morbid physical disorders like cardiac problems and cancer (Aggelopoulos, 2009; Alevizos , 2008; American Psychiatric Association, 2013; Bylsma, Taylor-Clift, & Rottenberg, 2011; Kessler et al., 2009; Knol et al., 2006; Lykouras, Soldatos & Zervas, 2009; Luppino et al., 2010; Myin-Germeys et al., 2003; Pedrelli et al., 2011; Peeters, Nicolson, Berkhof, Delespaul, & deVries, 2003; Polykandrioti & Stefanidou, 2013; Silk et al., 2011; Soldatos , 2005; Christodoulou, 2005; Wittchen & Jacobi, 2005; World Federation of Mental Health, 2013; WHO, 2008, 2012, 2017).

Recently, researches have also revealed that depression cause deficits in cognitive functioning and especially difficulties in executive functioning (planning, problem solving and inhibiting and processing of information) working memory, attention and processing speed have been identified (Ahern & Semkovska, 2017; Chakrabarty, Hadjipavlou, & Lam, 2016; Gotlib et al., 2011; Gualtieri & Morgan, 2008; Joormann, Siemer, & Gotlib, 2007; Levin, Heller, Mohanty, Herrington, & Miller, 2007; McIntyre et al., 2013; Mogg et al., 2006; Nitschke, Heller, Imig, McDonald, & Miller, 2001; Porter, Gallagher, Thompson, & Young, 2003; Snyder, 2013; Whitmer & Gotlib, 2013).

Depression has many “faces” and can take many forms with quantitative and qualitative variations of its symptoms. In addition, this disease does not occur with the same symptoms in all individuals. Most people tend to feel depressed at some point in their lives. The least severe form of depression, "melancholy", is usually short in duration and has little or no effect on daily activities. The symptoms of "mild" depression are more severe and last longer. For people with mild depression, daily activities are more difficult, but the person is still able to perform them. In "severe" depression there can be intense variations in mood or even the complete withdrawal of an individual from his everyday routine and/or the rest of the world. Feelings of hopelessness can become so intense that suicide thinking may seem like the only "viable" option (Garyfalos, 2008; Kessing et al., 2010).

Depression is a psychiatric disease that needs to be diagnosed (for diagnostic criteria of Depression according the DSM-V (APA, 2013) see Appendix C) and treated by specially trained professionals (American Psychiatric Association, 2013). Individuals who suffer from depression are unable to recognize the symptoms and therefore few of them seek help from professionals. Without proper treatment, depression can last for months or even years (Garyfalos, 2008). Approximately, 80% of patients having an episode of major depressive disorder, during their lifetime will have at least one more episode (APA, 1994; Fava, Ruini & Sonino, 2003; Solomon et al., 2000). Furthermore, one or two out of ten may also experience a subsequent manic episode, which will cause the alteration of the diagnosis from depression to bipolar disorder. Also, a small proportion of depressed patients may experience psychotic symptoms (APA, 1994; Fava et al., 2003).

Nowadays, the etiology of depression is not completely clear. At first, due to the strong link with grief and feeling of sadness, depression was perceived as a

response to the traumatic events of life. But over the past few dacades, the quick development of psychopharmacology, neurogenetics and other neurosciences has brought to light diverse biological/ brain mechanisms responsible for the development and maintenance of depression. Nowadays, it is assumed that depression is a multifactorial disorder, due to the interaction of biological, genetic psychological and social social factors that contribute to its varying degrees (Chatzaki, 2008; Christodoulou, 2005; Soldatos, 2005; Tsigos & Chrousos, 2002).

Depression is characterised as a "brain disease" (because of the brain dysfunction) irrespective of the potential engagement of other diverse factors in its causative pathogenesis. In more detail, brain function is related with disturbances of the neurotransmitter system (in particular a decrease in serotonergic and noradrenergic activity) and hyperactivity of particular neural groups (the almond nucleus and other areas of the thalamic and adrenal system). The precise nature of the neurotransmitter disorder is unknown, but depression is thought to increase in the number and functional readiness of the serotonin and noradrenaline receptors, leading to a decreased availability of such neurotransmitters. Furthermore, central to the causal pathogenesis of depression is the disorder of self- and hetero-regulatory homeostatic mechanisms of neurotransmitter function (Chatzaki, 2008; Christodoulou, 2005; Soldatos, 2005; Tsigos & Chrousos, 2002).

The participation of heredity in the manifestation of depression is very important. More specifically, depression is observed in 15% of first degree relatives of depressed patients, 8% of second degree relatives and 4% of relatives of healthy controls; while twin and adopted studies have shown that the common genes are mainly responsible for the familial occurrence of the disease. Despite the certain contribution of genetic factors to the causative pathogenesis of depression, it is not

possible to identify gene damage attributed to the heterogeneity of depression (Chatzaki, 2008; Christodoulou, 2005; Langlieb & DePaulo, 2008; Soldatos, 2005; Tsigos & Chrousos, 2002).

Of the psychosocial factors, mourning, migration, unemployment and the occurrence of serious physical illness such as thyroid disorders, hormonal imbalances, chronic viral infections, cancer and heart disease (NHS CRD, 2002; Rost, 2009) often precede the first manifestation of depression. The disease later becomes 'autonomous' and no longer requires psychosocial events to relapse. In other words, it seems that over time the brain becomes more and more aware of the consequences of incidents without the presence of stimuli. The early loss of a parent or the existence of a history of bad parenting during childhood, social isolation, low education, social and economic levels, poor marital relations, and widowhood are associated with depression. The existence of certain 'dysfunctional' personality traits also predisposes to depression (Andrews, Poulton, & Skoog, 2005; Chatzaki, 2008; Christodoulou, 2005; Joyce, 2009; Kessler et al., 2005; Kessler & Bromet, 2013; Langlieb & DePaulo, 2008; Paykel, 2001; Rost, 2009; Soldatos, 2005; Tsigos & Chrousos, 2002).

5.2 Depression and Schizophrenia

The observation that depressive symptoms are present during schizophrenia has a long history. Kraepelin in "dementia praecox", and Bleuler in "schizophrenia" considered the fundamental characteristics of this clinical entity to be emotionally distressed and melancholic, recognized melancholy syndrome as having the same syndrome clinical severity with the main disease, due to its significant burden (Becker, 1988). In the 1970s, McGlashan and Carpenter (1976) revisited the study of

depressive symptomatology in the course of schizophrenia with its reports on post-psychotic depression, while in the years that followed, other researchers studied depression in schizophrenia (Johnson, 1981; Kay, Fiszbein & Opler, 1987; Siris, Adan, Cohen, Mandeli, Aronson & Casey, 1988).

Nowadays, depressive symptomatology is commonly found in patients with schizophrenia, with prevalence of over 50% (An der Heiden et al., 2005; Conley, Ascher-Svanum, Zhu, Faries, & Kinon, 2007; Häfner, Maurer, Trendler, an der Heiden, Schmidt, & Könnecke, 2005). It can develop at any stage of the disorder and greatly increases the discomfort. Depressive symptoms and depression may occur before the onset of psychotic symptoms (schizophrenia precursor), during the acute phase of the disease, during the period after the onset of acute symptoms (post-psychotic depression), or during the chronic phase of the disease (Stamouli, 2010). With some researchers supporting that patients during the prodromal stage preceding psychosis onset and during the first schizophrenic episode develop a more severe form of depression (Addington, Addington, & Patten, 1998; an der Heiden et al., 2005; Emsley et al., 1999; Hafner et al., 2002; Koreen et al., 1993; Krabbendam et al., 2005; Lancon et al., 1999; Sim, Mahendran, Siris, Heckers, & Chong, 2004; Smeets, Lataster, Dominguez & Hommes, 2012; Stamouli, 2010).

Several researchers have estimate that during schizophrenia, a prevalence of depression of 6-75% is reported (Addington , Addington & Schissel, 1990; Addington, Addington , Maticka-Tyndale &, Joyce, 1992; Addington, Addington & Maticka-Tyndale, 1994; Bartels & Drake, 1988; Kontaxakis et al., 2000; Siris & Bench, 2003), with the lowest rates reported in a population of hospitalized patients (Hirsch et al., 1989; Kilzieh, Wood, Erdman, Raskind & Tapp, 2003; Roy, Lehoux,

Brassard, Rene, Trepanier & Merette, 2001; Tapp, Tandon, & Douglass, 1994), and the largest in outpatients (Johnson, 1988; Koreen et al., 1993).

A review of studies (Conley et al., 2007; Sands & Harrow, 1999; Siris, 2000; Siris & Bench, 2003) found an average incidence of depression in the long-term course of the disease 25%, whereas for the first psychotic episodes and recurrences 65-80% (Häfner et al., 1999, 2005; Koreen et al., 1993; Lancon et al., 1999; Stamouli, 2000; Subotnik et al., 1997), and 4-20% in the post-psychotic phase (Siris & Bench, 2003). Sands et al. (1999) found that depression is a consistent longitudinal feature of the disorder of schizophrenia, whereas only 35% of patients had no depressive episode at any stage, results confirmed by other studies (Marengo, Harrow, Herbener, & Sands, 2000). Bottlender and his colleagues (2000) found that the symptom of "depressive mood" was present in 38.9% of the first admissions with schizophrenia, while clinically significant depression was present in 15, 5%. Generally, patients with schizophrenia are 14 times more likely to experience depression during their lifetime than the general population (Robins & Regier, 1991).

Several mechanisms may be involved in the development of depressive symptoms; they may be part of the primary manifestations of the disorder, may occur following insight, may be due to another disorder, such as major depression, which may co-exist with schizophrenia, or may be a side effect of antipsychotic treatment (Birchwood, Mason, Macmillan & Healy, 1993; Liddle, Barnes, Curson & Patel, 1993; Möller, 2005; Tandon et al. 2009). A vast amount of factor analysis researches though support the notion that depression is a distinct area in the psychopathology of schizophrenia (Marengo et al., 2000; McGorry, Bell, Dudgeon & Jackson, 1998; Peralta & Cuesta, 2001; Salokangas, Honkonen, Stengard & Koivisto, 2002; Van Os, Gilvarry, Bale, Van Horn, Tattan, White & Murray, 1999; Yazaji El et al., 2002).

The presence of depression in schizophrenia has been associated with more frequent psychotic episodes (Buckley, Miller, Lehrer, & Castle,2008; Siris, 1991, 2000), increased duration of illness (Lancon et al.,1999; Whitehead, Moss, Cardno, Lewis, & Furtado, 2002), worse prognosis (An der Haiden et al., 2005; Birchwood et al., 1993; Fichtner, Grossman, Harrow, Goldberg & Klein, 1989; Häfner et al., 1999; Harrow, Yonan, Sands, Marengo, 1994; Jin, Zisook, Palmer, Patterson, Heaton & Jeste, 2001; Conley et al., 2007), substance misuse (Addington, & Duchak, 1997; Bühler, Hambrecht, Löffler, an der Heiden, & Häfner, 2002) and poor quality of life and suicide (Reine, Lancon, Di Tucci, Sapin, & Auquier, 2003; Saha, Chant, & McGrath, 2007). Depression in schizophrenia also affects systems beyond the burden of individuals and health care with increased use of mental health services and the criminal justice system (Conley et al., 2007); as some recent studies have found a particularly high risk of violent crime and increased aggression in patients with severe emotional disorders (Valença, & Moraes, 2006; Volavka, 2013).

5.3 Depression and Suicide

Over the last few decades, the recognition, evaluation and treatment of depression has drawn the attention and interest of Health Sciences, as many researches have shown an increased incidence of the disorder in psychiatric and non-psychiatric patients. The most important casue that makes the diagnosis and treatment of depression a necessity is the prevention of suicides. As depressed individuals experience feelings of sadness and guilt, helplessness, hopelessness, worthlessness, and despair, they regard their problems as insuperable, and in general they feel that they are deadlocked, which make an individual resort to suicidal acts in an attempt to stop suffering (Alevizos , 2008; Beck, Kovacs, & Weissman, 1975; Beck, Rush, Shaw, & Emery, 1979; Beck, Weissman, Lester, & Trexler, 2008; Beck et al., 1974;

Christidoulou, 2005; Drake & Cotton, 1986; Khan, 2011; Lykouras, Soldatos & Zervas, 2009; Nordentoft et al., 2002; Soldatos , 2005; Young et al., 1996).

Depression has been identified as one of the leading risk predictors for suicide (King, O'Mara, Hayward, & Cunningham 2009). Clinical and general population studies have revealed that depression is the strongest clinical indicator of suicide (Bramness, Walby, Hjellvik, Selmer, & Tverdal, 2010; Harris & Barraclough, 1997; Qin & Nordentoft, 2005), and that the risk of suicide is related with the severity of the depressive symptoms (Kessing, 2004). Major depression is responsible for suicide attempts, and depressive mood and despair are associated with suicidal ideation (Harkavy-Friedman et al., 1999; 2004). Individuals who do not receive treatment for the depression have approximately 20% increased risk of suicide compared to the ones who receive treatment (Gotlib & Hammen, 2008). Furthermore, according to the American Association of Suicidology (2012) six out of ten people how complete a suicide attempt perceived to have high levels of depression the period before their deaths.

Depression is an important risk factor for suicide not only in the general population but also in those suffering from schizophrenia (Barraclough, 1987; Cotton, Drake, & Gates, 1985; Harkavy-Friedman et al., 2004; Strosahl, Chiles & Linehan, 1992). However, depression is often overlooked, ignored, untreated or even misdiagnosed as negative symptoms or as a side effect of antipsychotic medication (Jones et al., 1994) in patients with schizophrenia, resulting in an increased risk of suicide.

Studies report that suicidal schizophrenics have more depressive symptoms in their history than those in the general population (Kreyenbuhl, Kelly, & Conley,

2002); and that depression and not the psychotic symptoms is the major predictor of suicidal behavior (Siris, 2001). However, research has also found that predictive factors for suicidal behavior in schizophrenia include multiple psychotic episodes and psychiatric hospital admissions, the severity of positive symptoms (e.g., delusions, suspicion), recognition of progressive deterioration, and fear of further deterioration, low self-esteem and negative attitude toward treatment (Caldwell & Gottesman, 1990; De Hert, McKenzie, & Peuskens, 2001).

The majority of those who suffer from schizophrenia that commit suicide or attempt suicide had a history of depressive episodes or recent signs of depression.[11] This is also supported by a research that took place in a neuropsychiatric hospital in Greece, that found that one out of four schizophrenia patients who experience depression, also experience suicidal ideation and have attempted a suicide (Stamouli, 2000).

[11] (Cohen, Lavelle, Rich & Bromet, 1994; Drake, Gates & Cotton, 1986; Heila, Isometsa, Henriksson, Heikkinen, Marttunen & Lonnqvist, 1997; King, 1994; Prasad, 1986; Radomsky, Haas, Mann & Sweeney, 1999; Roy, 1982, 1984, 1986; Siris, 2001; Taiminen & Kujari, 1994).

Chapter 6

Suicidality

6.1 Suicidal Ideation and Suicidal Behaviour

The term suicide derived from the Latin "suicaedere", which means "kill myself" and was first used in England in 1651 (World Health Organization, 1974). The term suicide is defined *"the act or instance of taking one's own life voluntarily and intentionally"* (Merriam-Webster Collegiate Dictionary, 2004, p. 1249). Various scholars attempted to interpret and define this concept. Noteworthy is Durkheim's (1978) definition of suicide, who defines suicide as any case of death, which is the direct or indirect result of an act, positive or negative, committed by the individual himself knowing the outcome. Shneidman (1977) defines suicide as a conscious act of self-destruction, a consequence of a multidimensional inability of a person with complete urgency, in which interruption of life seems the best solution. And last but not least, Freud (1957) stated that individuals are driven to suicide, due to the collapse of their "Ego". Suicide has been described as a process with different stages of increasing severity, beginning with thoughts of death and suicide, continuing with suicide attempts and possibly ending with successful suicide (Chavaki-Kontaxaki, Margariti, Stamouli, Kolias, & Kontaxakis, 2004; Plutchik & Van Praag, 1994; Plutchik, Van Praag, Picard, Conte, & Korn, 1989).

Before elaborating extensively in the concept of suicide, it is of vital importance to clarify the terms surround this phenomenon. Suicidal ideation refers to the significant occupation and intense thinking, related to verbal expression or the planning of actions that would endanger the physical integrity or even the life of an individual. Suicidal ideation can be chronic and persistent, or it can be transient and

triggered by adverse life events; and it is suggested to be the strongest predictor of suicidal behavior. Suicidal behaviour refers to the attempted suicide (deliberate act of low lethality and intention) or completed suicide. Suicidality, on the other hand, is a broader term that includes both the abovementioned terms (Belegrinos, Zacharis & Fradelos, 2014; Celder, Lopez-Ibor, & Andreasen, 2009; Jenkins & Singh, 2000; Johnson, 2006; Khan, 2011; Kessler, Borges & Walters, 1999; Klonsky & May, 2014; Kokkosi & Synodinou, 2010; Manos, 1997; Merriam-Webster Collegiate Dictionary, 2004; Nock et al., 2008a; Shneidman, 1985; ten Have et al., 2009; Videbeck, 2010).

The American Psychiatric Association (APA) in the fifth edition of the Diagnostic and Statistical Manual for Mental Disorders (DSM-5; APA, 2013) propose the Suicidal Behaviour Disorder as a condition for further study in an attempt to differentiate it from the nonsuicidal self-injury (NSSI) diagnosis that already exists in the manual. Although nonsuicidal self-injury is high related with suicide attempts (Klonsky, May, & Glenn, 2013; Wilkinson & Goodyer, 2011), many researchers have supported the differentiation of the two entities as the suicidal behavior has significant differences from nonsuicidal self-injury in terms of prevalence, frequency, methods used, severity and functions (Klonsky, 2007; Klonsky & Muehlenkamp, 2007; Muehlenkamp, 2005; Muehlenkamp & Gutierrez, 2004).

Suicidal behavior is a serious health problem and a worldwide cause of death and disability. Globally, suicide is the fifteenth leading cause of death, accounting for 1.4% of all deaths (WHO, 2014); and it is the sixth and ninth leading cause of burden of disease among young (15 to 44 years old) men and women respectively (WHO, 2008). Almost 800.000 lives are getting lost every year because of suicide, which equals to approximately 2000 suicide deaths every day (Giotakos, Tsouvelas, Kontaxakis, 2012; WHO, 2012, 2017). It has also been estimated that for every single

person who completes a suicide, there are twenty more that attempt suicide (WHO, 2012, 2014). Suicidal thoughts and nonfatal suicide attempts also have drawn the attention of the scientific community. Kessler and his colleagues (1999) in a research revealed that 34% of the individuals with suicidal ideation have also a suicide plan; and that 72% of those having a suicide plan move on to a suicide attempt. For suicidal ideation there is a prevalence of 9.2% and for suicide attempt is at 2.7% (Nock et al. 2008a). Both suicidal ideation and suicide attempts are strong predictors of deaths caused by suicide and also result in negative consequences for the individual such as injury and prolonged hospitalization (Nock et al., 2008a,b; WHO, 2014).

Several theorists through the years have attempted to give an explanation on why people attempt suicide; with many of them highlight the role of interpersonal communication (Farberow, Shneidman, & Leonard, 1961; Kobler & Stotland, 1964; Kreitman, 1977), problem-solving (Baechler, 1979), importance assigned to reasons for living (Linehan, Goodstein, Nielson, & Chiles, 1983), social isolation (Durkheim, 2005), hopelessness (Abramson, Metalsky, & Alloy, 1989), impulsivity (Simon et al., 2001), physical suffering (Ratcliffe et al., 2008) and defeat and entrapment (O'Connor, 2011) in motivating a suicide attempt. Baumeister (1990) on the basis of cognitive, personality and social psychology constructed the "escape theory" suggesting that the majority of suicide attempts are driven by the need to minimize negative self-perception and aversive emotions, experiences, sensations and thoughts. Later, Shneidman (1987, 1993, 1998) in the "cubic model" proposed that psychache is the leading motivator of an attempted suicide. By psychache he meant the emotional and psychological pain an individual can experience which includes emotions like anxiety, fear, guilt, shame, lonelinees and humiliation. He believed that people with low tolerance in psychache are those who commit suicide. Following that, Thomas

Joiner (2007) with the interpersonal theory of suicide suggests that perceived burdensomeness (the feeling caused by the perceived idea that someone is a burden to those around him) and thwarted belongingness (the idea of not belonging to any particular group or generally in society) are the two factors that increase the desire for suicide.

More recently, Klonsky and May (2015) developed the three-step theory (3ST) of suicide. According to their theory, pain is the leading cause of suicidal ideation; and in most times this pain has the form of psychache. They explained that because people are shaped by behavioural conditioning (Skinner, 1965); when someone experience pain perceives he/she is being punished for living and that leads to the reduced desire to live. They also included the concept of hopelessness as requirement in the development of suicidal ideation; and they explained that when an individual believes that the pain he/she is feeling will not be reduced or disappeared tents to considering committing suicide. Klonsky and May (2015) suggested that pain and hopelessness are factors of moderate suicidal ideations; and there is the lack of connectedness that strengthens that thoughts. The term connectedness refers to the connection someone can have to other people, project or interest that keeps him/her interested in life.

Joiner (2005) and later Klonsky and May (2015) advocated that not all individuals who develop suicidal ideation attempt suicide. They supported that the key determinant to commit a suicide attempt is the individual's capacity to do so. Joiner (2005) suggested that fear of death is a strong instinct that makes attempting a suicide extremely difficult no matter how strong the suicidal ideation is. Both studies suggested that only the individuals who develop the capacity to overcome this instinctive obstacle are attempting suicide (Joiner, 2005; Klonsky & May, 2015).

Research highlights the differences between suicidal individuals and those who attempt suicide (Thio, 2003). For example, individuals who attempt to commit suicide are, women rather than men, younger (24 to 44 years) than older (55 to 66 years), and belong to the lower than the upper socio-economic class. On the contrary, suicidal people are usually older men, mostly single, separated or widowed, who live alone and are unemployed or retired. There are also differences in the means of suicide with women using poisons or overdoses compared to men who use more effective means like knives and guns (Thio, 2003). Studying these cases, it is surprising, that only 5% to 19% of people who attempt to commit suicide eventually do so, indicating the variety of motivations behind this practice (Giotakos, Tsouvelas & Kontaxakis, 2012; Thio, 2003).. An attempt may testify either to one's desire to end his life or to feel nothing for a moment, or to his cry for help or even his attempt to manipulate others (Giotakos, Tsouvelas & Kontaxakis, 2012; Kovacs, Beck, & Weissman, 1975; Thio, 2003).

Suicide is the outcome of a complex interaction of various variables and many factors are implicated in suicide including male gender and young age (Nock et al. 2008a; Patton et al. 2009; WHO 1999, 2014), unemployment and being divorced (Gunnell, Middleton, Whitley, Dorling, & Frankel, 2003), poverty, social isolation and poor family and peer relationships (Dogra, Basu, & Das, 2011; Gutierrez, Osman, Kopper, Barrios, & Bagge, 2000), medical problem or chronic illness (Kovacs et al., 1975), childhood adversity (e.g. physical and/or sexual abuse) (Afifi et al., 2008), along with biomedical pathologies such as reduced levels of serotonin (Szanto et al., 2002).

There are also some clinical factors suggesting a high risk of suicide including certain personality traits (Blüml et al. 2013; Gvion et al., 2014) like increased distress

(Bryan, Morrow, Etienne, & Ray- Sannerud, 2013; Rudd, Schmitz, McClenen, Joiner, Elkins & Claasen, 2010), deep emotional or mental pain (psychache)[12], hopelessness (Chapman, Specht, & Cellucci, 2005; Gutierrez et al., 2000; Trakhtenbrot, 2016), low self-esteem, rage, reckless/ impulsive behavior, severe anxiety/agitation (Busch, Fawcett, & Jacobs, 2003; Rudd, 2008; Rudd, Joiner, & Rajab 2001; Sani et al., 2011; Wenzel, Brown, & Beck, 2009); borderline personality disorder (Paris & Zweig-Frank, 2001; Pompili, Girardi, Ruberto & Tatarelli, 2005; Zanarini, Frankenburg, Hennen & Silk, 2003), substance misuse disorders (Arria et al. 2009; Dhossche, Meloukheia, & Chakravorty, 2000; Gunnell et al., 2003; Nock, Prinstein, & Sterba, 2009), mental disorder like bipolar disorder and posttraumatic stress disorder (Bertolote & Fleischmann 2002; Nock et al. 2009; Peterson & Collings, 2015), non-suicidal self-injury (Whitlock et al. 2013) and recent suicide attempts (APA, 2003; Jobes, Rudd, Overholser, & Joiner, 2008; Rudd et al., 2006).

Despite the fact that diverse social, psychological and biological determinants can result in suicide, depression mostly in its severe forms, as already mentioned in the previous chapter, is the highest risk factor of attempting suicide (Gonzalez, 2008; Nock et al. 2009; Sokero et al. 2005; Trakhtenbrot et al., 2016). Psychotic symptoms of psychosis or schizophrenia have also been identified as a risk factor of suicidality (De Hert et al. 2001; DeVylder, Lukens, Link, & Lieberman, 2015; Hawton, Sutton, Haw, Sinclair, & Deeks, 2005; Hor & Taylor, 2010; Radomsky, Haas, Mann, & Sweeney, 1999; Sani et al., 2011).

[12] (Barak & Miron, 2005; Buchwald, 2006; Levi et al., 2008, 2014; Mee, Bunney, Bunney, Hetrick, Potkin & Reist, 2011; Nahaliel, Sommerfeld, Orbach, Weller, Apter & Zalsman, 2014; Orbach et al., 2003; Pompili et al., 2008; Shneidman, 1993; Soumani et al., 2011)

6.2 Suicidality and Schizophrenia

Schizophrenia is a psychiatric disorder with a high rate of suicide (Brown, 1997; Jovanovic et al., 2019; Meltzer, 2002; Osmond & Hoffer, 1973; Saha et al., 2007); and suicide ideation is the main predictor of suicide (Chang et al., 2014; Funahashi et al., 2000; Suominen, Isometsä, Ostamo, & Lönnqvist, 2004). It has been estimated that suicide is eight (Harris & Barraclough, 1997) to thirteen (Saha et al., 2007) times more common in individuals diagnosed with schizophrenia compared to the general population.

The risk of self-harm behaviours and suicidality is greater in the early stages of the disorder and particularly during the first episode of psychosis than in the later course, because the sense of personal identity is highly confused; the patient is distressed due to the unfamiliar emerging psychotic symptoms and may feel external forces threatening him or an impending catastrophe coming. At this stage, the schizophrenia patient may also hear inner voices commanding him to commit suicide or be conquered by persecution delusion in which he is called upon to act in order to avoid his persecutors, in various ways (e.g. by jumping out of the window) (Ayesa-Arriola et al., 2015; Brown, 1997; Chavaki-Kontaxaki et al., 2004; De Hert et al., 2001; Dutta et al., 2010; Dutta et al., 2012; Fleischhacker et al., 2014; Melle et al., 2006; Munk-Jorgensen & Mortensen, 1992; Nordentoft, Madsen & Fedyszyn, 2015; Ösby, Correia, Brandt, Ekbom & Sparén, 2000; Palmer, Pankratz &, Bostwick, 2005; Randall et al., 2014; Taylor, Hutton & Wood, 2015).

The risk of suicide during the later stages of the disorder and specifically during the post-psychotic recovery/residual phase are associated with the loss of identity and function particularly due to neurocognitive sequelae (Holder & Wayhs, 2014; Power & McGowan, 2011). It is also important to note that these patients

attempt to commit suicide impulsively (Allebeck, Varla, Kristjansson, & Wistedt, 1987), and use particularly violent and lethal methods (jumping, hanging, stabbing, firearm) compared to general population who use relatively less violent methods (overdose, single cuts) (Arora & Meltzer, 1989; Pompili, et al., 2007).

Palmer and his colleagues (2005) have reported that the lifetime risk of suicide in schizophrenia is 5.6%. This prevalence rate is also supported by more recent studies (Hor & Taylor, 2010; Nordentoft et al., 2015) which revealed that 579 individuals with schizophrenia commit suicide in every 100.000 patients. Suicide is reported to cause 10% -13% of schizophrenic patient deaths (Caldwell & Gottesman, 1990; Drake et al., 1985; Roy, 1986; Siris, 2001; Siris & Bench, 2003), and it is considered the most common cause of premature death in schizophrenia patients (Allebeck, 1989; Black, Winokur, & Warrack, 1985; Fenton, 2000; Kasckow et al., 2014; Tsuang, Woolson, & Fleming, 1980).

It is estimated that 10-50% of schizophrenia patients attempt to commit suicide and life prevalence is 18-55% for suicide attempts[13] whereas suicidal ideation occurs at least one time during the course of the disorder in 40-80% of patients with schizophrenia (Asnis et al., 1993; DeVylder, Oh, Ben-David, Azimov, Harkavy-Friedman & Corcoran, 2012; Drake et al., 1985; Fenton, 2000; Fenton, Mc Glashan, Victor & Blyler, 1997; Gill et al., 2015; Nieto et al., 1992; Skodlar, Tomori & Parnas, 2008).

[13] (Aleman & Denys, 2014; Asnis et al., 1993; Castelein et al., 2015; Chavaki-Kontaxaki et al., 2004; Drake et al., 1985; Gupta, Black, Arndt, Hubbard, & Andreasen, 1998; Harkavy-Friedman, Restifo & Malaspina, 1999; Heilä & Lönnqvist, 2003; Nieto, Vieta, Gasto, Vallejo, & Cirera, 1992)

Many risk factors for suicide are found to be common between general population and schizophrenia patients including male sex[14] substance misuse (Haw et al.,2005; Hawton et al., 2005; Witt et al., 2013), hopelessness (Chang et al., 2014; Schreiber, Culpepper, & Fife, 2010; Siris, 2001), agitation or motor restlessness (Cem Atbaşoglu, Schultz, & Andreasen, 2001; Hawton et al.,2005), history of depression or depressive disorders[15] and history of previous suicide attempts (Albayrak, Ekinci & Çayköylü, 2012; Chavaki-Kontaxaki et al., 2004; Chang et al., 2014; Fleischhacker et al., 2014; Haas, 1997; Hawton et al., 2005; Kelly et al., 2004; Limosin et al., 2007; Lopez-Morinigo et al., 2019; Radomsky et al., 1999; Sanchez-Gistau et al., 2013; Schreiber, Culpepper, & Fife, 2010).

Further, there have been identified some additional social risk factors of increased suicide for schizophrenia patients like higher education (Agerbo, 2007; Björkenstam et al., 2011; Kao, Liu, Cheng & Chou, 2012), lack of social support (Heilä & Lönnqvist 2003; Pokorny & Kaplan, 1976; Yarden, 1974), loneliness (Castelein et al., 2015) , social isolation (Caldwell & Gottesman, 1990; 1992; Rogers & Fahy, 2008) and fear of losing a partner or social position (Agerbo, 2007),

Some clinical risk factors have also been identified to increase the risk of suicide in schizophrenia including the initial contact with the mental health services (Björkenstam et al.,2014), prolonged untreated psychosis (Barrett et al., 2011; Clarke et al., 2006; Melle et al., 2006; Mitter, Subramaniam, Abdin, Poon, & Verma, 2013),

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[14] (Caldwell & Gottesman 1990, 1992; Chavaki-Kontaxaki et al., 2004; Dutta, Murray, Allardyce, Jones & Boydell, 2011; Healy et al., 2012; Lester, 2006; Rogers & Fahy, 2008) and young age (Alaräisänen et al., 2009; Barrett et al., 2010a,b; Caldwell & Gottesman 1990; Dutta et al., 2010; Lopez-Morinigo et al., 2019; Limosin, Loze, Philippe, Casadebaig, & Rouillon 2007; Osborn, Levy, Nazareth, & King, 2008; Palmer, Pankratz, & Bostwick, 2005),

[15] (Austad, Joa, Johannessen, & Larsen, 2015; Barret et al., 2015; Chavaki-Kontaxaki et al., 2004; Haw et al.,2005; Hawton et al., 2005; Heilä et al., 1997; Kohler & Lallart, 2005; Sanchez-Gistau et al., 2015; Schneider, 2003)

hostility and delusions (Fenton, 2000; Krupinski et al., 2000; Siris, 2001), command auditory hallucinations (DeVylder & Hilimire, 2015; Kjelby et al., 2015; Koyanagi, Stickley & Haro, 2015; Mitter et al., 2013; Nordentoft et al., 2002), higher cognitive functioning (attention, memory and executive functioning) (Castelein et al., 2015; Chang et al., 2014; Drake et al., 1985; Delaney et al., 2012; Kim, Jayathilake & Meltzer, 2003; Nangle et al., 2006; Reutfors et al., 2009), multiple relapses (Chavaki-Kontaxaki et al., 2004; Drake et al., 1985; Roy, 1982; Yarden, 1974), repeated hospital admissions (Haw et al.,2005; Heilä & Lönnqvist 2003), fear of mental disintegration (Cotton et al., 1985; Drake et al., 1984; Hawton et al., 2005), internalized stigma (Sharaf, Ossman, & Lachine, 2012) and poor adherence to treatment (Belvederi Murri et al., 2015; Hawton et al., 2005; Qin et al., 2006; Witt et al., 2013).

Age of onset has also been identified as a predictor of suicide with some researches support that early age of psychotic onset increase the risk of suicide (Austad et al., 2015; Bertelsen et al., 2007; Gupta et al., 1998; Krausz, Müller-Thomsen, & Haasen, 1995; Nangle et al., 2006; Vinokur, Levine, Roe, Krivoy, & Fischel, 2014); while other have supported a relationship of later onset of psychosis with suicide risk (Kuo, Tsai, Lo, Wang & Chen, 2005; Mitter et al., 2013; Pompili et al., 2009; Reutfors et al., 2009). In addition, contrary to the above there are some other studies which failed to reveal any relationship of age of psychotic onset with increased risk of suicide (Fedyszyn, Robinson, Harris, Paxton & Francey, 2012; Pratt, Gooding, Johnson, Taylor & Tarrier, 2010).

Insight in psychosis has also been identified as a risk factor for suicide as it leads to depression which increases the suicide risk (Amador, Friedman, Kasapis, Yale, Flaum & Gorman , 1996; Barrett et al., 2010a; Crumlish et al., 2005; Drake et

al., 1985; Drake & Cotton, 1986; Foley et al., 2008; Robinson, Cotton, Conus, Schimmelmann, McGorry & Lambert , 2009; Siris, 2001). Contrary, another study (McEvoy, 2004) supported that insight may decrease the suicide risk as it improves the treatment compliance; this view also supported by more recent studies (Barrett et al., 2015; Bourgeois et al., 2004;).

Assaultive behaviour and history or convictions of violent crime have also been found to be positive correlated with increased risk of suicide (Björkenstam et al., 2014; Fazel et al., 2014; Hunt, Sweeting, Keoghan, & Platt. 2006; Suokas et al., 2010; SanSegundo et al., 2018; Tardiff & Sweillam 1980; Witt et al., 2013), in schizophrenia patients as well as in mentally disordered offenders suffering from schizophrenia (Baillargeon et al., 2009; Haglund et al., 2014; Webb et al., 2011; Witt, Hawton, & Fazel, 2014).

High prevalence of suicidal behaviour has been reported among mentally disordered offenders in forensic psychiatric units (Webb et al., 2011; Abidin et al., 2013) as well as in correctional settings (Palmer & Connelly, 2005; Lekka, Argyriou, & Beratis, 2006; Fazel et al., 2008). Offenders who suffer from a serious mental illness exhibit decreased ability to cope with stress derived from the long-term detention (DuRand et al., 1995; Lamb & Bachrach, 2001; Metzner & Fellner, 2010; Palmer & Connelly, 2005). This in combination with the fact that mentally disordered offenders are placed in single room/cells at most of the time (Fazel et al., 2008; Lekka et al., 2006) and are separated by their loved ones (Bennefeld-Kersten, 2009) increases the risk of suicidal behaviour in this population.

A more recent study also revealed that exposure to the criminal justice system in general plays a part in increasing the risk of suicide specifically among mentally disordered offenders who are sentenced to mandatory psychiatric treatment (Webb et

al., 2011). In the study of Kullgren, Tengström and Grann (1998) schizophrenia offenders exhibited a significant correlation with suicide. The prevalence of risk of suicide in that population is relatively stable (Bhatia et al., 2006); but it has been noted to be elevated thoughtout the course of hospitalization and immediately after discharge (Qin & Nordentoft, 2005; Meehan et al., 2006). Suicide has been positively correlated with the presence of positive psychotic symptoms (delusions and hallucination) among schizophrenic and other psychotic violent offenders (Hor & Taylor, 2010; Rogers, Watt, Gray, MacCulloch, & Gournay, 2002). In this population, the risk of suicide is also elevated due to the experiencing of intense feelings of regret, guilt and shame, especially in those who have committed the offence against a family member (Dooley, 1990; Palmer & Connelly, 2005; Webb et al., 2011).

6.3 Suicidality and Moral Emotions

Taking into consideration the above information, it is obvious there are associations between suicidal ideation and the presence of depressive, guilt and shame emotions. Both shame and guild have been linked to the suicidal ideation and suicidal behaviour; even thought these moral emotions are implicated in the engagement of reconciliatory behaviours and in improvement of one's self (Kemeny, Gruenewald, & Dickerson, 2004; Tangney, Stuewig, & Martinez, 2014; Zahn-Waxler, & Kochanska, 1990). These emotions are also common in accounts of individuals who have attempted suicide and in suicide notes of individuals who have completed a suicide (Coster & Lester, 2013; Foster, 2003; Shneidman, 1998).

Irreparable compromission of one's social image and/or the feelings that someone's conscience has been irreversibly impaired due to their misdeeds (Lester, 1997; Pridmore & McArthur, 2008) are considered self-ridicule events (Mokros,

1995) that elicit high levels of shame and guilt emotions leading an individual considering suicide as a viable option.

Shame is an intense and aversive emotion that has been associated with self-injurous behaviours with or without suicide intent (Brown, Linehan, Comtois, Murray & Chapman, 2009; Milligan & Andrews, 2005). Shame is also considered as a source of psychological pain; intolerance to psychological pain, as already mentioned before, is a risk factor of suicide (Baumeister, 1990; Mokros, 1995; Shneidman, 1993). At the same time, guilt is not only associated with suicidal behaviour but also with depression which also considered a risk factor of suicide (Alexander, Brewin, Vearnals, Wolff, & Leff, 1999; Boye, Bentsen, & Malt, 2002; Quiles & Bybee, 1997). Guilt is a moral emotion that leads individuals to help others and make reparations; maladaptive guilt though is an excessive and self-critical emotion increasing the negative self-image and making an individual considering himself responsible and blaming him for everything that goes wrong that eventually conclude to self-punishment (Zahn-Waxler & Kochanska, 1990

Concluding, moral emotions are considered strong predictors of suicidal ideation and suicidal behaviour (Baumeister, 1990; Bryan, Morrow, Etienne, & Ray-Sannerud, 2012; Hastings, Northman & Tangney, 2000; Kolves, Ide, & De Leo, 2011; Lester, 1997, 1998; Lewis, 1992; Tangney & Dearing, 2002).

Chapter 7

Moral Emotions

7.1 Moral Emotions of Guilt and Shame

Guilt and shame are included in the moral emotions (other emotion in this category are embarrassment and pride) as they provide information on what human behavior is socially and morally accepted and promote the ethical actions (Tangney & Dearing, 2002; Tangney, Miller, Flicker, & Barlow, 1996; Tangney, Stuewig, & Mashek, 2006, 2007). They are also known as self-conscious emotions and in social situations have been proved to be the most significant emotions (Lindsay-Hartz, 1984; Tangney, 1991). Self-conscious emotions focus on self and self-evaluation assuming that the individual is aware of the self-image (sense of self) (Lewis et al. 1989; Tangney, 1999; Tangney & Dearing 2002; Tracy & Robins 2004).

Additionally they put the individual's self-image and behaviour in comparison with the social standards. These emotions inspire group behaviors such as cooperation/teamwork and competitiveness (De Hooge, Breugelmans, & Zeelenberg, 2008; Fessler & Haley, 2003), they contribute to relational behaviours such as gift-giving, advice giving and taking and prosocial behaviour (Caplovitz Barrett, 1995; De Hooge, 2012; De Hooge, Verlegh, & Tzioti, 2012; De Rivera, 1984; Keltner & Buswell, 1996; Smith, 1759), and inspire intrapersonal characteristics such as feelings of empathy and anxiety (Hoffman, 1982).

Guilt and shame are the two most common moral emotions that play a key role in the humans ability to live with others as they prompt individuals to adhere social norms in order to avoid unpleasant emotions and social rejection (Clark, 2012;

Keltner & Buswell 1997; Kroll & Egan 2004; Sedikides & Skowronski 2000; Tangney et al., 2007), and to decrease or eliminate such emotions when individuals do experience them (Baumeister, Stillwell, & Heatherton, 1994; De Hooge, Zeelenberg, & Breugelmans, 2010). Guilt and shame have many similarities, as they both perceived to be negative emotions and are triggered when people interpret an action or behaviour as important but incompatible with their ideal self and/or social or moral standards (Batson, Fultz, & Schoenrade, 1987; Kim, Thibodeau, & Jorgensen, 2011; Orth, Berking, & Burkhardt, 2006; Tracy & Robins 2004).

Guilt and shame are used interchangeably and often experienced at the same time in real life as someone can feel guilty about something he has done and ashamed about how this reflects on who he is at the same time (Carnì et al., 2013; Clark, 2012). Although, they are two distinct emotions and have different impact on the individual (Agrawal & Duhachek 2010; Day, 2014; Davitz, 1969/2016; Dearing, Stuewig, & Tangney, 2005; Duhachek, Agrawal, & Han, 2012; Emde & Oppenheim, 1995; Harder, 1995; Keltner, 1996; Kim et al., 2011; Leith & Baumeister 1998; Lindsay-Hartz, de-Rivera, & Mascolo, 1995; Lewis, 1971; Tangney, 1995; Tangney & Fischer, 1995; Tangney et al. 1996; Tangney et al., 2007; Welleck, 1993).

While both deal with evaluation judgments, their main difference is that guilt is experienced as an interpersonal cognitive-affective state and evaluate negatively the action or behaviour in a case of a transgression (e.g. “Look at the horrible thing I have done”); while shame is experienced as a intrapersonal cognitive-affective state and evaluates negatively the entire self (e.g. “I am a horrible person”) (Barrett, 1995; Baumeister et al., 1994; Blum, 2008; Bryan, Morrow, Etienne, & Ray- Sannerud, 2013; Carnì et al., 2013; Day, 2014; Ferguson & Stegge, 1995; Kim et al., 2011; Lewis, 1971, 1974; Lindsay-Hartz et al., 1995; O’Connor et al, 2002, 2007, 2012;

Tangney, 1995; Tangney & Dearing, 2002; Tangney et al., 1996; Tangney et al., 2007; Tracy & Robins, 2004; Wallbott & Scherer, 1995; Weiss, 1993; Weiss et al.,1986).

In more detail, guilt and shame differs in the context of perception. Guilt focuses on the person's own behavior, which he considers a "sin" that has been or will be done because of failure to care about those around him. Contrary, shame emphasizes on the values and beliefs of others, which determines what actions should be taken on the part of the individual. Specifically, shame focuses on the negative evaluations of "third parties", while guilt is an internal function based on one's own thoughts (Huhmann & Brotherton, 1997; Niedenthal, Tangney, & Gavanski, 1994; Wicker, Payne, & Morgan, 1983). Lewis (1971, p.30) proposed a distinction based on the self-action view stated that *"(t)he experience of shame is directly about the self, which is the focus of evaluation. In guilt, the self is not the central object of negative evaluation, but rather the thing done is the focus. In guilt, the self is negatively evaluated in connection with something but it is not itself the focus of the experience".*

Similarly, Tangney (1996, p.742) stated that in guilt the individual puts emphasis on a "bad behaviour", whereas in shame the emphasis is on "bad self". In other words, guilt is a negative emotion related with beliefs that there is "something wrong with what I did.", whereas shame is perceived as a negative emotion related with beliefs that there is "something wrong with me". Later on, Jennifer Manion (2002, p.76) gave her opinion on the distinction of these emotions stating that "*one's feeling of guilt concerns a rule or rule-like constraint that one has broken, the harm that has ensued and the people affected by the harmful act . . . the feeling of shame indicates a profound disappointment in the kind of person one thought one was*".

Last, in a more recent approach on the explanation of distinction of these two moral emotions, Miller (2010) stated that guilt is a "private" emotion including unpleasant feelings of conscience, while contrary shame is a "public" emotion implicating public disapproval.

7.1.1 The Emotion of Guilt

The emotion of guilt has formed a significant role in the development of human societies, as it has been claimed that guilt encourages personal and social responsibility and motivates individuals to act according to ethical and moral manners, enhancing the prevention of transgressions (Damasio, 1994; Deem & Ramsey, 2016; Eisenberg, 2000; Hoffman, 2000; Izard, 1991; Pennington & Staples, 2011; Sabini & Silver 1997; Smith, Webster, Parrott, & Eyre, 2002; Tangney & Dearing, 2002). Cross-cultural studies have also found that guilt is a universal moral emotion, as they revealed that its characteristics are quite similar in various cultures (Breugelmans & Poortinga, 2006; Chang, 2012; Fontaine et al., 2006; Izard, 1977; Zahn- Waxier, Kochanska, Krupnick, & McKnew, 1990).

Guilt is described as an outcome of a particular unpleasant action or behaviour in the context of community relations that violates moral standards, like being untruthful or deceptive to others. The people who feel guilty are the ones who realize that they have broken the rules and violated their standards and beliefs and those who acknowledge their failure to accept and take responsibility (Basil, Ridgway, & Basil 2006; Baumeister et al.,1994; Blum, 2008; de Hooge, Zeelenberg & Breugelmans 2011; Deem & Ramsey, 2016; Fessler & Haley, 2003; Haidt, 2003; Izard,1977; Mosher, 1965; Sinnott-Armstrong, 2005; Kubany et aI., 1995; Tangney & Dearing, 2002; Tracy & Robins 2004). This kind of guilt is also known as interpersonal guilt

(Baumeister et al., 1994; Hoffman, 1982, 1998; Niedenthal et al., 1994; Tangney, 1991, 1995, 1999; Tangney & Dearing, 2002).

Guilt though, does not only refer to actions associated with wrongdoing, but it has also been described as a psychological construct that can be experienced without a specific behaviour or event being referred to (Berrios et al., 1992). Interesting is the fact that someone can feel guilty even in the absence of wrongdoing and violation of social or moral standards. This kind of guilt is also known as intrapsychic guilt or as altruistic guilt (Izard, 1977; Lewis, 1971, 1992; Mancini, 2008; Monteith, 1993; Mosher, 1965, 1966; Piers & Singers, 1953/1971; Wertheim & Schwartz, 1983). Individuals may feel guilty if they are in a better or more privileged position than other people, even if they are not responsible for this inequity (Baumeister et al., 1994; Hoffman, 1981, 1987; Izard 1977; Lascu, 1991; O'Connor & Bush, 1989; Ruth & Faber, 1988). In such cases the emotion of guilt is liked to altruistic tendencies (Basile et al., 2011; Mancini, 2008) and a distinct example is the survivor guilt.

Feelings of guilt can also be categorized in two different concepts, the state guilt and the trait guilt (Kugler & Jones, 1992; Tangney, 1996; Tangney et al. 2007). Trait guilt, which is more researched, is a personality trait which refers to the ongoing sense of guilt or guilt proneness. It is more reliable over time and less occasionally engaged; and its level of experience differs among individuals (Day, 2014; Kugler & Jones, 1992; Tangney, 1996). Contrary, state guilt refers to current experience of guilt which is directly associated with a specific behaviour or event (Kugler & Jones, 1992).

People who feel guilty, whether that is due a personality trait or a particular event, do not exhibit any distinct facial of bodily expressions; in contrast with the experience of other negative emotions (Izard, 1977, 1992). It is more common a

person feeling guilty to experience an internal sense of change as the heart rate elevates, irregular respiration respiration (Barrett, 1995; Ekman, Levenson, & Friesen, 1983) and neurophysiological and hormonal processes that change. These changes lead to cognitive ruminations and emotional reactions. The cognitive ruminations refer to intense thinking of the wrongdoing, the individual been wronged, the corrective actions can take place and the evolution of the relationship that has been unsettled (Izard, 1992; Tangney & Dearing, 2002).

Regarding emotional reactions, according to Izard (1992) and Tangney and her colleagues (1992) and more recent studies (Cohen, Wolf, Panter, & Insko, 2011; Gilbert, 2003) guilt encompasses feelings like sadness, fear tension, shyness, regret and remorse about a specific action. These emotions act as motivation to change one's actions that contradict moral standards (Ferguson, Stegge, and Damhuis, 1991; Ferguson, Stegge, Miller, & Olsen, 1999). Some theorist have stated that guilt also acts as a self-directed punishment as it conserves the memories of previous wrongdoings alive that helps an individual to reduce or eliminate the triggering event occurrence over time (Mosher, 1979; Wertheim & Schwarz, 1983). Guilt over thoughts of transgression could obstruct the planning of an act making it less tempting, less feasible and less likely to occur (Bybee & Williams, 1994, 1996).

People feel that they can take a reparative action and correct a behaviour, and that is the reason why they are able to isolate the negative evaluation to the behavior and the self-esteem remains intact (Burnett & Lunsford, 1994; Huhmann & Brotherton, 1997; Tracy & Robins, 2004). Guilt is perceived as an adaptive moral emotion and motivates people to develop a good social adjustment and empathy and promote prosocial behaviour in social dilemmas by engaging in positive behaviours and forgiveness seeking in order to repair the past wrongdoings and maintain positive

interpersonal relationships.[16]. Furthermore, guilt leads the individual to reparative actions like confessions or apologies from the victim of the wrongdoing (Caplovitz Barrett, 1995; Lindsay-Hartz, 1984; Thrane, 1979)

Some theorists suggested that the experience of guilt and especially chronic guilt have been associated with negative psychopathological states like hostility, aggression, melancholia, obsessional neuroses, and masochism (Freud, 1917/1957, 1923/1961; Harder, 1995; Harder, Cutler, & Rockart, 1992; Jones & Kugler, 1993; Jones, Kugler, & Adams, 1995; Kugler & Jones, 1992). The vast majority of research though, suggests that the experience of guilt has numerous positive consequences for the individual. Empirical studies have found that guilt elevates the sense of personal responsibility, moral behaviour, compliance, empathy, compassion, fairness, forgiveness, honesty, trust worth and develops more constructive strategies to anger management (Baumeister et al., 1994; Bybee & Williams, 1994, 1996; Cohen et al. 2011; Covert, Tangney, Maddux, & Heleno, 2003; Day, 2014; Deem & Ramsey, 2016; Fontaine. Luyten, De Boeck, & Corveleyn, 2001; Freedman, Wallington, & Bless, 1967; Leith & Baumeister, 1998; McCullough, Worthington, & Rachal, 1997; Merisca & Bybee, 1994; Strelan, 2007; Tangney, 1991, 1994, 1995; Tangney & Dearing, 2002; Tangney et al., 1992; Quiles & Bybee, 1997).

De Hooge (2013) also found that the experience of guilt may improve well-being in case the individual can take a reparative action. Guilt has also been negatively correlated with problematic and unhealthy behaviours like moralistic

[16] (Amodio, Devine, & Harmon-Jones, 2007; Baumeister et al., 1994, 1995; Day, 2014; De Hooge et al., 2007; Haidt, 2003; Katchadourian, 2010; Ketelaar & Au, 2003; Kim et al., 2011; Kugler & Jones, 1992; Leach & Cidam, 2015; Malti & Krettenauer, 2013; Nelissen, Dijker, & De Vries, 2007; Roos, Hodges & Salmivalli, 2014; Sabini & Silver 1997; Schmader & Lickel, 2006; Silfver, 2007; Smith et al. 2002; Stuewig et al., 2015; Stuewig, Tangney, Heigel, Harty, & McCloskey, 2010; Tangney & Dearing, 2002; Tangney, Wagner, Fletcher, & Gramzow, 1992)

attitudes towards individuals with unethical inclinations, aggressive/antisocial behaviour, sexual behaviour and substance abuse (Cohen et al. 2011; Dearing et al., 2005; Eisenberg, 2000; Lutwak, Panish, Ferrari, & Razzino, 2001; Mosher, 1979, 1998; Olthof, 2012; ; Paulhus, Robins, Trzesniewski, & Tracy, 2004; Roos et al. 2014; Stuewig & McCloskey 2005; Stuewig et al., 2010; Svensson, Weerman, Pauwels, Bruinsma, &Bernasco, 2013; Tangney, 1994).

7.1.2 The Emotion of Shame

Shame according to Erikson's theory (1968) is perceived developmentally as a more primitive emotion than guilt and generally is considered as a more helpless and harmful emotion compared to guilt. There is a debate in the experience of shame with some developmental psychologist supporting that shame is experiences from birth (Music, 2011; Nathanson, 1987, 1992; Schore, 2012; Thompson & Newton, 2010); while others supporting that shame is experienced in later years when the child is capable to understand another's perspective (Lewis, 1992; 1993; Stipek, 1995). According to the latest, a prerequisite for the manifestation of shame is the development of certain cognitive mechanisms, such as self-representations, self-awareness and self-evaluation, that affect human thinking, emotions and behavior (Grout, 2013; Lewis, 1995; Strömsten, Henningsson, Holm, & Sundbom, 2009; Tangney & Dearing, 2002; Thompson, Altmann, & Davidson, 2004; Tracy, Robins, & Tangney, 2007). In Psychoanalysis, shame is viewed as a collapse of self-esteem or "narcissistic wound" (Kohut, 1971); and later Tangney (2002) suggested that shame arise from abandonment anxiety.

Shame as an aspect can be distinct in two dimensions known as internal and external shame (Gilbert, 2006). Shame is associated with beliefs that one's personal attributes (e.g. body shape, weight or skin color); personality traits (e.g. dull, ignorant

or dishonest) or actions (e.g. cheating, stealing) are considered unattractive by others which result to lower desirability and social rejection (Gilbert, 1998; Kaufman, 1989; Tangney & Fischer, 1995; Oliveira, Trindade, & Ferreira, 2018). In such cases shame can be internalized, and internal shame is associated with negative evaluations of one's own attributes, personality characteristics or behaviours (Cook, 1996; Kaufman, 1989). According to Lindsay-Hartz (1984) internal shame is activated when one thinks like s/he is less than the person s/he want to be or when one fails to meet the standards of the ideal self. It is accompanied by feelings of inferiority, inexperience, inadequacy, and can lead to eating disorders, such as anorexia nervosa (Cheung, Gilbert, & Irons, 2004; Gouva et al., 2016a; Gilbert, 1998; Gilbert & Procter, 2006; Matos et al., 2015; McKendry, 2014; Saggino et al., 2017; Thibodeau et al., 2011; Tracy et al., 2007; Ward, 2014).

Contrary, external shame refers to how one thinks others perceive him as a person (Allan, Gilbert, & Goss, 1994; Goss, Gilbert, & Allan, 1994; Pinel, 1999); and evaluations focus on aspects individuals believe that other would possibly reject or attack if they became known. It is a more painful feeling as it relates to internalized stigma, social exclusion, unattractive self-image and subsequent manifestations of psychopathology (Cheung et al., 2004; Corrigan, Larson, & Rusch, 2009; Gilbert, 1998; Gilbert & Procter, 2006; Gouva et al., 2016b; Matos et al., 2015; McKendry, 2014; Saggino et al., 2017; Thibodeau et al., 2012; Tracy et al., 2007; Yanos, Roe, Markus, & Lysaker, 2008; Ward, 2014; Wilson, Drozdek, & Turkovic 2006).

Shame's aim is to protect the ideal image someone would like to show to others; and is not caused by a particular situation, but by the way a situation is interpreted, which can be both public and private (Gilbert, 1998; Lewis, 1995; McKendry, 2014; Rousseau, 2005). Shame makes an individual perceives that the self

could be considered defective in some way because of a violation of moral standards or a failure to meet important social standards of the ideal self (Fessler, 2004, 2007; Gilbert & Andrews 1998; Heller, 2003; Piers & Singer, 1971; Shapiro, 2003; Tangney, 1995; Tangney & Fisher 1995; Tracy & Matsumoto, 2008).

Gilbert (1989) posits that shame can be derived by serious and harmful change in ones social status such as loss of social sanding or being demeaned or diminished like in cases of being stigmatized by a mental illness. Shame takes into account the entire self and is experienced with a sense of exposure, vulnerability, shrinking, inferiority, powerlessness and worthlessness (Bryan et al., 2013; Day, 2014; Lewis 1992, 2000; Shapiro, 2003; Tangney 1995, 1999; Tangney et al., 1992; Tangney & Dearing 2002; Tracy & Robins 2004).

Additionally, shame perceives one's self inherently wrong or fundamentally flawed and gives rise to feelings of wanting to hide or conceal an aspect of himself or escape from negative feelings and situations (Barrett, 1995; Clark, 2012; Ketelaar & Au, 2003; Kim et al., 2011; Leach & Cidam, 2015; Lindsay-Hartz, 1984; Sabini & Silver, 1997; Tangney, 1996; Tangney & Dearing, 2002; Van Vliet, 2009; Wellek, 1993). Recent studies of De Hooge et al. (2010, 2011) found that shame not only exhibits avoidance behaviours but also approach behaviours. More specifically, they supported that shame motivates first and foremost actions to recover the damaged self and that avoidance behaviours become predominant in cases where restoration is too difficult or risky due to situational factors that reduces the restoration motive.

According empirical studies shame exhibits cross cultural facial and bodily expressions (Ekman, 1992, 1994; Ekman & Friesen, 1971; Izard, 1971; Sznycer et al., 2016. Gaze aversion and blushing when others are present are the two characteristic

facial indicators (Barrett, 1995; Buss, 2009; Darwin, 1872; Darwin & Pinker, 1998; Lewis, 1971, 2003). Smaller posture, slumping of the shoulders, head turning, lower vocalic patters and various inhibitions on speech are the most common bodily indicators of shame (Barrett, 1995; Scherer, 1986). Based on these expressions shame can be easily identified by others (Keltner, 1995; Keltner & Buswell, 1996).

Shame devaluates self and affects emotions, self-criticism, attention, information processing, social comparison and generally well-being (Oliveira et al., 2018; Tangney et al., 1996; Tangney, Wagner, Hill-Barlow, Marschall, & Gramzow, 1996). It also contributes to problematic health resulting in low self-esteem, fear of negative evaluation, humiliation, anger, disgust, lack of empathy, self blame, eating disorders, social avoidance, social and generalized anxiety, affective disorders and particularly depression, post-traumatic stress disorder, alcohol and drug misuse and even suicide, deviant/antisocial behaviour, criminal offending and psychosis [17]

Besides the negative outcomes the experience of shame has, it has been characterized as a moral emotion as it is a response to violating ethical rules and values, contributing to the cultivation of ethical behavior (Davidson, Vanegas, & Hilvert, 2017; Elias, 1997; Lewis, 1995; Lutwak et al. 1997; Strömsten et al., 2009;

[17] (Andrews, Brewin, Rose, & Kirk, 2000; Averill et al. 2002; Bennett, Sullivan, & Lewis, 2005; Crossley & Rockett, 2005; De Hooge, 2013; Dearing, Stuewig, & Tangney, 2005; Feiring, Taska, & Lewis, 2002; Fergus, Valentiner, McGrath, & Jencius, 2010; Ferguson, 2005; Ferreira, Pinto-Gouveia, & Duarte, 2013; Ferreira, Matos, Duarte, & Pinto- Gouveia, 2014; Gilbert & Maguire, 1998; Gilbert & Miles, 2000; Gilbert & Procter, 2006; Gilbert, Pehl, & Allan, 1994; Goss & Allan, 2009; Harder et al., 1992; Harper & Arias, 2004; Harper, Austin, Cercone, & Arias, 2005; Heitmeyer & Hagan, 2003; Hoblitzelle, 1987; Leskela, Dieperink, & Thuras, 2002; Lewis, 1971,1987; Lutwak et al., 2001; Luyten, Fontaine, & Corveleyn, 2002; Mills, 2003; Paulhus et al., 2004; Stuewig & McCloskey, 2005; Stuewig et al., 2015; Tangney, 1990, 1992, 1996; Tangney & Dearing, 2002; Tangney & Fisher 1995; Tangney et al., 1992; Tangney et al. 1995; Tangney et al., 1996; Walker & Knauer, 2011; Ward, 2014; Woien, Ernst, Patock-Peckham, & Nagoshi. 2003; Wolf, Cohen, Panter, & Insko, 2010; Wright, Gudjonsson, & Young, 2008).

Tangney & Dearing, 2002; Thompson et al., 2004; Tracy et al., 2007). According to Scheff (1990, 1994, 1997), the concept of shame signifies the value system of human civilization, which contributes to the shaping of this concept-feeling in the consciousness of people, with the aim of exercising social control for the benefit of the wider social community (Elias 1997). Shame determines the quality of the social bond that develops between people but also between wider social groups (e.g. between nation-states, etc.). In addition, as emotion shame can also have a social character, as it is derived through social interaction and it contributes to the formation of personal and social identity and a sense of social acceptance (Grout, 2013; Lutwak et al. 1997; Ward, 2014).

7.2 Moral Emotions and Mental Illness

In clinical psychology, guilt and shame are dominant emotions in narratives of many individuals with mental health issues. For some patients negative feelings derived by guilt and shame contribute to mood disturbances; while for others the difficulties in coping with such negative emotions lead to the development of avoidant behaviours that assimilate to the existed disorder in case of anxiety disorders, obsessive–compulsive disorders or addictive behaviours (Clark, 2012). It is also important to note that for many patients guilt and shame are consequence of the stigma surrounds mental illness (Clark, 2012).

Regarding the relation of guilt and mental illness the results of many empirical studies seem to be contradicting. Guilt has been related with various disorders such as anxiety, eating disorders, somatization and psychosis/paranoia (Averill et al., 2002; Blatt & Schichman, 1983; Bybee & Quiles, 1998; Fairburn & Cooper, 1984; Harder, 1995; Harder et al., 1992; Jones & Kugler, 1993; Lewis, 1979a; Lindsay-Hartz et al.,

1995; Luyten et al., 2002; Quiles & Bybee, 1997); while the study of Tangney et al., (1992) revealed there is no relation between guilt and psychopathology.

In more detail, many researches support that there is a positive correlation between obsessive-compulsive disorder (OCD) and guilt (Niler & Beck, 1989; Shafran, Watkins & Charman, 1996). Individuals with OCD may use compulsive rituals in order to prevent an imagined event from happening; which will possibly cause the patient feeling guilty (Clark, 2012). Contrary, Reynolds & Salkovskis (1991) and Steketee et al. (1991) supported that only depression and anxiety and not guilt are risk factors for OCD. Research regarding the relationship of depression and guilt is also controversial. Depression is recognized as the most frequently associated disorder with guilt (Blatt & Schichman, 1983; Harder, 1995; Harder et al., 1992; Kugler & Jones, 1992; Leckman et al., 1984; Lewis, 1979b; Quiles & Bybee, 1997; Zahn-Waxler et al., 1991). Whereas, there are other studies supporting that there is no association between guilt and depression (Bybee et al., 1991; Bybee & Williams, 1994, 1996; Tangney, Burggraf, & Wagner, 1995; Tangney et al., 1992)

The emotion of guilt is also associated with psychosis and a recent research Clark, 2012) revealed that the most extreme form of experience of guilt occurs in patients with delusional guilt that may be tortured by the irrational belief that they are responsible for a global catastrophe like tsunami or earthquake. Also in schizophrenia, there has been found that the experience of guilt emotion is positively correlated with the chronicity of the disorder (Suslow, Roestel, Ohrmann & Arolt, 2003).

At the same line, the emotion of shame is also evident in many psychiatric disorders. Individuals with disorders characterized by low self–esteem like depression, have high levels of shame (Clark, 2012). A deep sense of shame is also relates with fear of exposure which is evident in individuals with anxiety disorders

and particularly social phobia. Shame is also a common emotion if those with addictive behaviours, as they develop such behaviours in order to manage shameful feelings (Clark, 2012).

Regarding psychosis, Morrison (1987) stated that some symptoms of schizophrenia such as flat affect, echolalia, echopraxia, withdrawal, catatonia and paranoia are exhibited in the disorder as protective agents against shame. Also in schizophrenia guilt and shame seems to be elevated after the first episode of psychosis when the body image changes due to weight gain and/or when the sexual proficiency is diminished due to medication (Miller & Mason, 2002, 2005). Even more, the expression of critical remarks and negative feelings by the family members of patients with schizophrenia add to the shame; and may they feel humiliated, worthless embarrassed and rejected (Miller & Mason, 2002, 2005).

Feelings of shame and guilt are also associated with societal stigma that is evident in schizophrenia; where patients are stigmatized by being defined only by the illness they suffer from (Miller, & Mason, 2005). Shame is also associated with self-stigma, depression and to a lower degree with positive symptoms and recovery (Birchwood, 2003; Wood & Irons, 2016). Individuals suffering from schizophrenia experience moral emotions at later stages of recovery when they are capable to perceive themselves as defective and humiliated. According to Lansky (1983) this situation is a predictive factor of suicide in such mentally ill populations.

A clinical population that has diminished ability to experience moral emotions and guilt in specific is the individuals who have clinically diagnosed with psychopathic traits. According to that, infrequent feelings of guilt have been related with higher levels of antisocial personality and psychopathy, which are also psychiatric conditions frequently diagnosed in forensic populations (Day, 2014). This

population experience no unpleasant feeling or empathy towards their victim (APA, 1994; Kubany, & Watson, 2003; Pithers, 1999). Many sexual offenders like rapists, child molesters, and wife batterers exhibit inhibited guilt as they present empathy deficits and develop strategies of violence justification and victim blaming (Chaplin, Rice & Harris, 1995; Kubany, & Watson, 2003; Marshall & Serran, 2000; Scully, 1988).

7.3 Moral Emotions and Criminality

Contrary to what is may be believed most criminal offenders do not lack the capacity of moral emotions. Mental health professionals working with offenders realize that many of them suffer from guilt which is proportionate to their offence. For some, the burden of guilt is that much that they develop avoidance strategies such as social withdrawn and/or alcohol and drug abuse; while others seek opportunities to atone and perform redemptive acts (Clark, 2012). Among those in prisons, the experience of guilt emotion has been associated with fewer delinquent activities, commission of less severe crimes and having fewer criminal convictions (Cohen, Panter, & Turan, 2012; Cohen et al., 2011; Day, 2014; Stuewig & McCloskey 2005).

Regarding the emotion of shame, theory supports that individuals that experience shame are more prone to violent perpetration as an outcome of the maladaptive strategies they use to cope with unpleasant emotions (Kivisto, Kivisto, Moore, & Rhatigan, 2011; Scheff, 2008, 2011; Shanahan, Jones, & Thomas-Peter, 2011; Tangney et al., 1996; Walker & Knauer, 2011). Shame can elicit externalizing reaction and aggressive misbehavior (Elison et al., 2014; da Silva, Rijo, & Salekin, 2015; Tangney et al., 2011; Tangney et al., 2014; Velotti et al., 2014); and some theorist support that experience of shame is fundamental prerequisite for aggressive

behaviour (Scheff, 2008; Thomas, 1995). Gilligan (1997) stated *"The emotion of shame is the primary or ultimate cause of all violence…The different forms of violence, whether towards individuals or entire populations, are motivated (caused) by secret shame"* (pp. 110-111).

Shame plays a crucial role in various types of violence perpetration including sexual violence, hate crimes (Ray, Smith, & Wastell, 2004) and mass killings like school shootings (Scheff, 2008; Spiegal & Alpert, 2000). The vast majority of research examining the relationship between shame and violence has focused on intimate partner violence (IPV) (Balcom, 1991; Brown, 2004; Dutton, van Ginkel, & Starzomski, 1995; Hundt & Holohan, 2012; Lansky, 1987; Lawrence & Taft, 2013; Loeffler, Prelog, Prabha Unnitham, & Pogrebin, 2010; Moore et al., 2004; Nathanson, 1987; O'Neil & Harway, 1997; Scheff & Retzinger, 1991; Wallace & Nosko, 2003). Male offenders of IPV who experience elevated shame are at greater risk to practice psychological (Harper et al., 2005; Kivisto et al., 2011), physical (Dutton et al, 1995; Moore et al., 2004) and sexual abuse (Kivisto et al., 2011) to their partners.

In mentally disordered offenders shame is a predictor of violent acts (Gilligan, 2000). In a research to inpatients in forensic psychiatric unit Tangney, Stuewig, Mashek, & Hastings (2011) found that this population experience guilt and shame at the shame degree; thought they found that those who are prone to shame are more likely to act impulsively and misuse substances.

Moral emotions are also predictors of re-offending. A research in young offenders revealed that shame is related with higher recidivism rates whereas guilt work as a protective factors and is related with lower recidivism (Hosser, Windzio, & Greve, 2008). This was also supported by Walker & Knauer (2011), who found that

offenders who experience shame are more prone to re-offend compared to those who do not feel shame. A more recent research (Tangney, Stuewig, & Martinez, 2014) also supports the results that guilt is negatively associated with re-offending, whereas shame is positively associated with re-offending in the first year after release.

Chapter 8

The Present Study

8.1 Rationale

Dangerousness is an inherent characteristic of mentally disordered individuals it is a widespread social belief that leads to the stigmatization of such populations (Levey, Howells & Levey, 1995; MacLean, 1969). Due to poor awareness regarding mental health, the majority of society considers mentally disordered individuals as potential criminals. Additionally, each time a serious or violent crime is committed society tends to assign the responsibility to an individual that his/hers offending behavior is an outcome of the mental disorder s/he suffers from (Appleby & Wessely, 1988; Miles, 1981). As already stated in the literature review, schizophrenia is the most common associated mental disorder with criminal behaviours.

The research on offending behaviours and crimes in general is wide; and the research about offenders who have diagnosed with a mental disorder is also ample (Gosden et al., 2006; Montanes-Rada, Ramirez, & Taracena, 2006; Soyka et al., 2007; Wallace et al., 1998). Though, there is limited exploration into the impact mental disorder, and in particular schizophrenia has on offenders Criminal Narrative Experience. In order to gain this knowledge, it is of great importance to not only investigate the schizophrenic offenders (SO) in terms of criminal, psychological and social behaviour, but also in terms of offending experience by exploring their emotions during the illegal act and their narratives for this specific act.

Because data on such population are infrequent, it is of great importance to conduct research to explore the offending behaviours of schizophrenic individuals in

order to gain a greater and deeper understanding on the etiological and emotional factors that trigger the expression of violent behaviour through an illegal act. Additionally, as Ioannou (2006; Ioannou et al., 2017) mentioned the CNE framework is newly developed and needs to be tested in different populations in order to explore its reliability and validity.

Additionally, as negative emotions have been identified as predictors or triggers of offending behaviour it is essential to investigate the depressive emotions and negative thoughts they have during their incarceration; and the existence of moral emotions that are associated with the crime commission. Studying this, not only there will be revealed the association of negative emotion with the CNE but also will be revealed how the stigmatization this population experience produce negative emotions during incarceration. In more detail, the exploration of moral emotions and particularly of guilt and shame will provide additional information on how schizophrenic offenders perceive themselves and how they think others perceive them after they have committed an illegal act. Furthermore, there was an investigation if these moral emotions and the overall situation of the SOs can lead to depressive emotions and even to suicidal thoughts. Such results could lead to an in depth understanding of the emotional state of the SOs and could potentially shed some light on where the treatment of such populations could be focused to be more effective.To the author's knowledge there are only three studies exploring criminal narratives and emotional experiences in mentally disordered offenders. Spruin (2012) investigated the emotions during the crime commission by mentally disordered offenders. The results found the two distinct regions of Pleasure-Displeasure of Russell's circumplex model, but failed to find a degree of the activation dimension (Arousal-Sleepiness) as they were identified in previous research in prison populations. The same author

(Spruin et al., 2014) also conducted a second research on mentally disordered offenders to explore the criminal narratives. In her research she identifies four narrative roles Victim, Professional, Hero, and Revenger that are conceptually similar to previous studies for non-mentally ill offenders. Both of Spruin's studies offer a more in-depth understanding in MDOs crimes and it is considered to be the first study examining emotions felt during crime and narrative roles of mentally disordered offenders. Additionally, these studies have the advandage of a randomized sampling which add to the reliability and validity of the findings.

Despite all of the advantages and implications of these studies, they also have some limitations. Both studies had as participants seventy adult male mentally disordered offenders incarcerated in facilities in south London. A limitation of the study is that the sample consisted only by male participants and there are no females; moreover these participants where from various ethnicities which is also a limitation considering that mentall illness symptoms are experience in a variety of extent across different ethnic populations and because even the calture plays a role in the expression of criminal violence. Another limitation is that Spruin examined the mentally disorders offenders as one group even thought they were diagnosed with different disordered either from Axis I ot from Axis II accornding to DSM-IV. As it is already know from the literature review that different mental disorders have different symptoms and express violence in a different extent. It could be vital to conduct further research investigating whether any specific mental disorder is associated with any particular emotion or role theme. Last but not least, Spruin in her studies does not combine the emotions and the narrative roles to explore the CNE of mentally disordered offenders that could add important information to the literature.

Goodlad et al. (2018) also conducted a research exploring the CNE in offenders diagnosed with personality disorders and psychopathy. Her finding supported the CNE framework proposed by Ioannou et al. (2017) and validated once again that the CNE framework is also applicable to mentally disordered offenders. Despite all the implications Goodlad's study had, it also appears some limitations. A major limitation is the sample size; the study had only 22 male offenders diagnosed with psychopathy and personality disorders, recruited from just one high security prison. Besides the small sample also that is derived from one prison is a drawback that support that the results can't be generalized. Furthermore, despite the fact that Goodlad explored whether any particular disorder is associated with any specific CNE; the results are not that valid as some diagnostic categories had only one participant.

At this point it is vital to note that no matter that these studies have some limitations, every study has, they are quite important for a discipline that is under-researched and their results provide the bases for future studies. The present research continues a previous pilot research executed by the same author (see Appendix D for the similarities and differences between the MSc and the PhD studies). The previous study was pilot study and it was part of the dissertation for the MSc Investigative Psychology. The findings of that study reflected, with some differences, the results of previous studies and achieved to identify four distinct Narrative Roles: Hero, Professional, Revenger and Victim; four distinct emotional states Elation, Calm, Distress and Depression; and last three dinstict Criminal Narrative Experience: Depressed Victim; Aroused Revenger and Pleased Professional. That study managed to successfully implement the Criminal Narrative Experiences model, and revealed the inner motives and the emotions experience by the SOs during the crime

commission. These motioves and emotions are perceived to be the aspects that maintain their criminal lifestyle. This study also has some limitations and that is the reason it works as the bases for the present study. This research study was a pilot study to investigate if the tanslated version of the emotion and roles questionnaires could be applied to mentally disorderd offenders in Greece. Also the study had a small sample size; they were recruited only 33 schizophrenic offenders from two psychiatric hospitals only from the capital city of Athens. The small sample size and the geographical constraint does not allow these results to be generalized. Last, another limitation of this research study was that there were not conducted any further analyses to explore if there is any relationship of the demographic characteristics with the CNE; that could add the the importance of the study. The purpose of the present thesis is to contribute to and increase the body of knowledge regarding schizophrenia and criminal behaviour and challenge some of the domintant concepts existing conserning this association. At the present study the author tries to support the validity of the CNE framework in schizophrenic offenders by examining a larger sample of such population. Additionally, she explores the emotional state of that population in terms of moral emotions, depression and suicidal ideation regarding the CNE of these offenders. This is the first study to examine the CNE framework solely in schizophrenic offenders and the first one to explore the emotional state in terms of the above mentioned aspects in combination to schizophrenic offenders during incarceration.

The present research is of great importance as its implementation will benefit at multiple levels and its finding will have various theoretical and practical implications. Despite the implementation of the CNE in clinical population which will add to its reliability and th deeper understanding of ctime committed by schizophrenic

offenders as noted above; the present study will also shed light into the emotional state of these offerender during the crime and after that. Furthermore, the exploration of their narratives will provide information regarding their inner motives which is a fundamental element in understanding the criminal behavior.

All these information regading emotions during crime and inner motives for offending, and additionally the exploration of the background characteristics of schizophrenic offenders could potentially inform risk management by identifying various risk factors sourounding an offence commeted by an individual suffering from schizophrenia. Additionally, these information could also assist law endforcement agencies to gain a deeper understanding on how these individuals offent and they would enable them to draw inferences which is a vital element in an investigation's decision making process. Also in a lated stage of the investigation these information could be valuable assets in the formation of interviews and interrogation techniques.

Furthermore, the information that will be derived by the exploration of the schizophrenic offenders' emotions during incarceration will help clinicians to specify the symptoms and emotions they have to work with and to develop more targeted and effective treatment programmes, rehabilitation processes and reintegration techniques. The implementation of these could potentially help to crime and relapses prevention of SOs and could also improve their well-being during and afren incarceration. Last but not least, the present study producing information regarding the criminal behavior of individuals suffering from schizophrenia aims to exculpate schizophrenia and to reduce the social stigma burdens the SOs. For a more detailed report on the implications of the present study please see chapter 10.8 Theoretical and Prectical Implications.

8.2 Aims and Objectives

8.2.1 The Relationship between Criminal Narratives and Schizophrenia

Previous research on role narratives and criminal actions (Canter et al., 2003; Canter et al, 2009) and on criminal narratives and mental disorder (Speuin, 2012) pose the bases on the exploration of the association between criminal narratives and schizophrenia. This part of the study helps to further understand how SOs view their crimes and the roles they assign to themselves regarding their crime commission. Also it additionally aids to the formation of a criminal narrative framework particularly for SO populations.

Therefore, the aim of of the present study is to explore the roles schizophrenic offenders assign to themselves during crime commission. In specific, to investigate whether the particular structure of roles proposed by previous studies exists for schizophrenic offenders too; to investigate the relationship between these roles as it is already known that individuals may appear elements from different roles; and to explore whether schizophrenia is related with any specific role.

Therefore, the objectives of the study are:

1. To determine whether the overall structure of roles SOs' assign to themselves during crime commission can be differentiated in terms of different roles themes (e.g. adventurer, professional, revenger, victim).
2. To explore if there is relationship between the narrative roles that will emerge from the analysis.
3. To determine whether schizophrenia is associated with any particular narrative role.

4. To examine all the SO cases to verify if they could be assigned to a specific theme on the bases of the roles that SO acted out during the crime commission.

8.2.2 The Relationship between Emotions Felt During a Crime and Schizophrenia

The focus on emotions that can enhance or trigger criminal behaviour is an integral component of a general approach to understand criminal activity. The emotions exploration is based on the Russell's circumplex model of affect as previous studies (Canter & Ioannou, 2004a; Ioannou, 2006) argued that this model is also applicable in accounts of crimes in general and in crimes committed by mentally disorder offenders particularly (Spruin, 2012).

Therefore, the aim of the present study is to explore the emotions felt by schizophrenic offenders during crime commission. In specific, to investigate whether the particular structure of emotions proposed by previous studies exists for schizophrenic offenders too; to investingate the relationship between these emotion themes as it is already known a difficulty schizophrenic individuals haves with regulation, identification and expression of emotions; and to explore whether schizophrenia is related with any specific emotion theme

5. To determine whether the overall structure of emotions that experienced by SOs when committing their crimes can be differentiated in terms of different emotion themes e.g. elation, calm, distress, depression.
6. To explore if there is relationship between the emotional experiences that will emerge from the analysis.

7. To find out whether schizophrenia is associated with particular emotional experiences during crimes.
8. To examine all the SO cases to verify if they could be assigned to a specific theme on the bases of emotions that SO experienced during the crime commission.

8.2.3 The Relationship between Criminal Narrative Experience and Schizophrenia

As already mentioned, all criminal narratives carry emotional components; and they suggest particular ways in which emotions are implicated in criminal behaviours. Therefore, exploring the narrative roles and the emotional experiences of offenders could shape particular CNEs (Ioannou, 2006) that would aid in the better understanding of the offenses. Additionally, the exploration of emotional state during incarceration of each specific CNE could give more information on how the SOs emotionally experience their offence and how these emotions could possibly aid or prevent the therapeutic and reintegration process. Last but not least, the background characteristics exploration of each CNE could also provide information on whether demographic characteristics play a vital role in crime or not.

Thus, aim of the study is to explore the experience of committing a crime by schizophrenic offenders and to validate the proposed CNE framework which brings together narrative roles and emotional experiences of offender while crime commission (Ioannou,2006; Ioannou et al., 2017); to investingate the relationship between these CNEs; and to explore whether schizophrenia is related with any specific CNE. Additionally, aim of the particular study is to examine the moral emotions of guilt and shame, the levels of depression and suicidal ideation in

schizophrenic offenders and discover if there is a correlation between them and the CNE themes. Last aim of the present study is to examine if the demographic, clinical and criminal characteristics of the SOs play any role in the crime commission and the CNE.

9. To determine whether the overall structure of roles and emotions that experienced by SOs when committing their crimes can be differentiated in terms of different Criminal Narrative Experience themes.
10. To explore if there is relationship between the CNEs that will emerge from the analysis.
11. To determine whether schizophrenia is associated with any particular CNE.
12. To examine all the SO cases to verify if they could be assigned to a specific theme on the bases of CNE that SO develop during the crime commission.
13. To explore if the demographic characteristics play any particular role in the development of CNE.
14. To explore if the psychiatric background play any particular role in the development of CNE.
15. To explore if the criminal history and crime aspects play any particular role in the development of CNE.
16. To explore if the emotional state plays any particular role in the development of CNE.
    - 16.1 To investigate the relationship of the CNE themes to the levels of depression.
    - 16.2 To investigate the relationship of the CNE themes to the levels of suicidal ideation.

16.3 To investigate the relationship of the CNE themes to the levels of guilt

16.4 To investigate the relationship of the CNE themes to the levels of shame.

16.5 To explore if these is any correlation between these emotional components.

8.3 Method

8.3.1 Research Design

The present study has a within subjects research design without repeated measures. The independent variable of the study is the diagnosis of schizophrenia. The dependent variables of the study are depression; suicidal ideation; emotions felt during crime; narrative roles; guilt which has three subscales trait guilt, state guilt and moral standards; external shame which has three subscales inferiority, exptiness and mistakes; and last the internal shame which also has three subscales characterological shame, behavioral shame and bodily shame.

8.3.2Participants

The sample of the present study consisted by 64 offenders who have received the diagnosis of schizophrenia (Schizophrenic Offenders-SO) and have been found by the legal system as Not Guilty by reason of Insanity (NGI) or Incompetent to Stand Trial (IST). As these legal decisions have been made for them, these offenders do not serve sentence in prison but they incarcerated in psychiatric hospitals as the laws command (see section Legal Framework about Mentally Disordered Offenders in page 53).

All the 64 participants of the study were inpatients in the three psychiatric hospitals in Greece that treat clinical forensic population. In more detail, 31 (48%) participants were recruited from the Papanikolaou Psychiatric Hospital of Thessaloniki, 21 (33%) participants were recruited from the Dafni Psychiatric Hospital of Athens and last 12 (19%) participants were recruited from the Dromocaition Psychiatric Hospital of Athens.

For the needs of the study, strict inclusion and exclusion criteria for the participants were set in order to minimise the risk for both the participants and the researcher of the study; and additionally to exclude any factors that would potentially affect the study's variables and influence the results.

Various inclusion criteria were set including all the participant being adults (over the age of 18), have been diagnosed with schizophrenia, have committed a crime (any offence that could be considered a crime according to the penal law), have been found Not Guilty by Reason of Insanity (NGI) or been judged Incompetent to Stand Trial (IST), to be inpatients in one of the three psychiatric hospitals in Greece that treat clinical forensic populations, to receive fixed antipsychotic medication for at least one month, to be considered not dangerous and clinically stable for at least half a year before the examination by their treating psychiatrist and last to speak and read Greek fluently.

As exclusion criteria there were set factors that have been proved to be positively correlated with depression and negative emotions in an attempt to eliminate or avoid the misinterpretation of the results. These factors are intellectual disability/ mental retardation, pregnancy, childbirth, breast-feeding or (peri)menopause (Beydoun, Beydoun, Kaufman, Lo & Zonderman, 2012), head injury , stroke and

other psychotic disorders (Nuijen, 2009), severe or chronic physical disease (Beydoun et al., 2012; Clarke & Currie , 2009; Hansen et al., 2001; Moussavi et al., 2007), unstable and/or severe organic disorder (e.g. cardiovascular, endocrine, metabolic), diabetes, cancer and Parkinson disease (Anderson, Freedland, Clouse & Lustman, 2001; Hotopf, Chidgey, Addington-Hall & Ly, 2002; Nuijen, 2009; Reijnders, Ehrt, Weber, Aarsland & Leentjens, 2008; Taylor, 2008).

For the recruitment of the participants a randomized sampling approach was implemented. The researcher presented all the inclusion and exclusion criteria set for the participants to the psychiatrists of the psychiatric hospital units and then they identified potential participants for the study. At first, the psychiatrists contacted the potential participants informing them roughly regarding the research and its purposes. Then the researcher contacted all the schizophrenic offenders in the hospitals indicated in lists provided by the psychiatrists in order to inform them in detail about the research's purpose and importance, what would be asked them to do if they participate and what would happen with the information they will share during the study's process. Despite the overall number of potential participants conducted, the number of total participants formed depending on their will to voluntarily participate in the research (for the descriptive characteristics of the participants of the study see section Descriptive Characteristics of the Sample in page 160).

8.3.3 Measures

For the purposes of the study there were used seven questionnaires.

8.3.3.1 Beck Depression Inventory (BDI)

To measure the levels of depression there was used the most commonly used questionnaire for such purpose which is the Beck's Depression Inventory. The scale

was initially created by symptom descriptions derived by patients. In the first part of the questionnaire there are evaluated the psychological symptoms, while in the second part there are evaluated the physical symptoms (Beck, Ward, & Mendelson, 1961; Beck, Sterr, Varbin, 1988; Beck, Steer & Brown, 1996). The BDI is a self-reporting questionnaire with 21 items, which measures the characteristic attitudes and symptoms of depression by using a 4-point Likert scale ranging from 0 (the symptom is not present) till 3 (the symptom is very intense) (Beck, et al., 1961). Total scores ranged from 0 to 63; total score of 0-13 is considered minimal range, 14-19 is mild, 20-28 is moderate, and 29-63 is severe.

The BDI exhibits high internal consistency with Cronbach's alpha .86 and .81 for psychiatric populations and none respectively (Beck et al., 1988). The questionnaire's adaptation in Greek also exhibit high internal consistency (Tzemos, 1987). This questionnaire as been used previously in studies with schizophrenic patients sample (Barnes, Curson, Liddle & Patel, 1989; Baynes et al.,2000; Birchwood, Iqbal, Chadwick & Trower, 2000; Hirsch et al., 1989; Norman & Malla, 1991,1994) (see Appendix E, Part a and b for English and Greek versions of the questionnaire).

8.3.3.2 Suicidal Ideation Scale (SIS)

The Suicidal Ideation Scale is a questionnaire that evaluated the frequency and the severity of suicide ideas and desires of a person. The scale was created in USA and its built was based on the Los Angeles Suicide Prevention Center Assessment of Suicide Potentiality (Froyd & Perry, 1985). The translation and standardization of the scale in Greek conducted by Kleftaras (2012). It is consisted of 4 sentences-questions which measure the frequency and the tension of one's suicidal ideation (Doyle, 1980).The first three questions are refered to the frequency of the suicidal thoughts

and the answer to them is given by a 5 point Likert scale (1= never 5= all the time). The forth question is referred to the severity of these suicidal thoughts and the answer to it is given by a 4 point Likert scale (1=not severe at all, 4=existence of a specific suicidal plan). For each person it is estimated a SIS score that result from the sum of the four questions which can vary from 4 to 19 points. The highest score indicates more serious form of suicidal ideation (Froyd & Perry, 1985). The SIS has a Cronbah a=.86 which indicate a high internal consistency (Froyd & Perry, 1985; Kleftaras, 2012).(see Appendix F, Part a and b for English and Greek versions of the questionnaire).

8.3.3.3 Emotions Felt During Crime Questionnaire

The Emotions Felt During Crime Questionnaire was developed from pilot research (Oldale, 1997; Cross, 1998; Murray, 1998; Canter & Ioannou, 2004a; Ioannou, 2006) that had proved that the experience of emotions made sense to offenders as reasonable descriptions of their feelings during a crime they have commited and they could remember the best. The questionnaire was translated in Greek by two psychology researches/academics and then translated back t English by a third one. The questionnaire consisted of 26 emotion statements like “I felt scared”, “I felt depressed”, “I felt safe” and so on, representing emotions selected from Russell’s (1997) circumplex in order to cover its full gamut. A five-point Likert scale is used to measure the extent to which offenders felt the emotions applied to their experience of the crime they had committed, ranging from “Not at all” (1) to “Very much indeed” (5) with (3) being the mid-point “Some ”. The items of the questionnaire form four distinct themes that exhibit high internal consistency with Elation a=.93, Calm a=.87, Distress=.90 and Depression a=.93 (Ioannou, 2006) (see Appendix G, Part a and b for English and Greek versions of the questionnaire).

8.3.3.4 Narrative Roles Questionnaire

The Narrative Roles Questionnaire was developed following consideration of the Frye's archetypal mythoi (1957), the Narrative theory (McAdams, 1985, 1988) and the roles narratives that were identified from pilot work (Oldale, 1997; Cross, 1998; Murray, 1998; Canter et al., 2003; Canter et al., 2009; Ioannou, 2006). The questionnaire was translated in Greek by two psychology researches/academics and then translated back in English by a third one. The questionnaire consisted of 33 statements representing the type of role which is hypothesised each offender see himself playing during the crime commission. The questionnaire is formed bases on four themes, correlated to four distinct narrative roles offenders believe themselves to play during crime commission. These themes are Victim, Proffessional, Hero and Revenger. A five-point Likert scale was used in which offenders indicated the extent to which each of the statements described what it was like while they were committing their crime ranging from "Not at all" (1) to "Very much indeed" (5) with (3) being the mid-point "Some". The items of the questionnaire form four distinct themes that exhibit high internal consistency with Adventurer a=.81, Revenger a=.78, Victim=.85 and Professional a=.76 (Ioannou, 2006) (see Appendix H, Part a and b for English and Greek versions of the questionnaire).

8.3.3.5 Guilt Inventory

The Guilt Inventory is a 45- item self-referencing questionnaire, attributing ratings for trait of guilt, defined as a persistent propensity to feel guilty, repentant and grateful; state of guilt, defined as the direct experience of guilt apparently on the basis of a recent violation of one's moral code and moral standards, defined as the level of assistance to a set of ethical principles (Jones, Schratter, & Kugler, 2000). The Trait

Guilt subscale is consisted of 20 items (α = .89), the State Guilt subscale is consisted of 10 items (α = .84), and the Moral Standards Scale is consisted of 15 items (α = .88). The was questionnaire translated in Greek by two psychology researcher/academics and the translated back in English by a third one. All subscales are measured in 5 point Likert scale ranging from "Strongly agree" (1) to "Strongly disagree" (5) (see Appendix I, Part a and b for English and Greek versions of the questionnaire).

8.3.3.6 Other As Shamer Scale (OAS)

For the measurement of the externalized shame there were used the self-report "Other As Shamer scale" (OAS) created by Allan, Gilbert and Goss (1994). The OAS scale comes from the modification (Goss, Gilbert & Allan, 1994) of a pre-existing shame evaluation tool the Internalized Shame Scale (ISS) (Cook, 1993). This questionnaire was created to explore people's perceptions of how others see him and judge him; and it is divided into three sub-scales, the feeling of inferiority, the feeling of emptiness and the person's perception regarding the others reaction when he makes mistakes (Allan et al., 1994; Gouva et al., 2016a; Matos et al., 2015).

The questionnaire overall has an excellent reliability with Cronbach's alpha = 0.96. The Greek version of the questionnaire has a Cronbach's alpha = 0.87. The OAS includes 18 such sentences which are measured on a 5 point frequency Likert scale (where 0 = never, 1 = rare, 2 = sometimes, 3 = frequent and 4 = always). The overall score of the scale as well as each sub-scale is calculated by summing the subjects' individual responses to the relevant items. A higher sum indicates a higher degree of external shame (Goss et al., 1994; Gouva et al., 2016a; Gouva et al., 2012) (see Appendix J, Part a and b for English and Greek versions of the questionnaire).

8.3.3.7 Experience of Shame Scale (ESS)

The Experience of Shame Scale was created by Andrews, Qian and Valentine in 2002. The ESS measures three different types of shame, the characterological shame (regarding individual's habits), the behavioural shame (regarding individual's wrong actions), and the bodily shame (regarding bodily image). Altogether, 8 issues are covered, including the feeling of shame, each of which has an experiential, a cognitive and a behavioral element. It is a 25-item questionnaire and the answers are given on a 4-point Likert scale that indicates the frequency in which the individual has experienced what each sentence describes, within the last year (where 1 = no, 2 = little, 3 = moderate, and 4 = too much). The Cronbach's alpha is 0.92 for the English version (Andrews et al., 2002), and a=0.93 for the Greek version (Gouva et al., 2016b) (see Appendix K, Part a and b for English and Greek versions of the questionnaire).

8.3.4 Procedure

The research conducted in three different Psychiatric Hospitals in Greece after the researcher obtained all the necessary approvals from the three Psychiatric Hospitals' Ethics Committees and from the Hellenic Data Protection Authority. These approvals permitted the researcher to enter the psychiatric hospitals in order to examine the SOs and gave her access to the psychiatric and legal files of the SO participants.

Each participant examined individually in the psychiatric hospital where s/he lived in during morning and afternoon hours when the treating psychologist and psychiatrist of the SOs were present. An office close to the psychologists' and nursing team offices was chosen for the interviews in all three psychiatric hospitals. The blinds of the offices' windows were intentionally open for protection reasons; of both

the participant and the researcher. As the researcher did not knew the patients in person, their treating psychologist or a nurse of the particular unit of the hospital introduced the researcher to the potential participant.

The researcher followed the ethics protocol during the whole procedure. The participants were initially informed about what the research is about and what will be asked by them with a well-informative "Briefing Information Form" (Appendix L, Part a and b for English and Greek versions). They were also informed regarding the rights they have as participants and in particular for anonymity, confidentiality and their right to withdraw from the study at any time and for any reason without any consequences. Those who after receiving the information agreed to participate to the research had to sign the "Consideration Form" (Appendix M, Part a and b for English and Greek versions).

First there were collected the demographic data (Appendix N, Part a and b for English and Greek versions), then the information regarding the psychiatric history (Appendix O, Part a and b for English and Greek versions) and last the information regarding criminal history (Appendix P, Part a and b for English and Greek versions). Then the questionnaires were provided to the participant with the specific order as they were presented above in the Measures section. The researcher was in the office while the participant answered the questionnaires in case s/he had any questions; couldn't understand a sentence or even in the case where s/he didn't know or for any reason couldn't read. In such case, the researcher read all the questions slowly and clearly to the participant and noted his/her answer.

Upon the completion of the questionnaires, at each participant was reminded the purpose and the scope of the study and explained to him/her again the rights of

confidentiality, anonymity and withdraw with the provision of the "Debriefing Information Form" (Appendix Q, Part a and b for English and Greek versions). Each participant was also informed regarding the access s/he have to his/her results. It was made clear that no one could have access to his/her personal scores and each could get informed only about the overall results of the study.

The whole procedure lasted approximately one and a half hours.

8.4 Ethics and Deontology

Ethics and deontology are integral parts of research, from the point of conceiving an idea, though the research conduction, until the publishing of the results. There are some basic rules that all researchers must follow in the field of psychological research; and each researcher is responsible for adhering to ethical rules throughout the research process.

The present study conducted following closely the British Psychological Code of Conduct and American Psychological Societies' Code of Ethics and every possible measure was taken to ensure the maintenance of the highest ethical standards throughout the course of the research.

8.4.1 Respect for the Rights and Dignity of the Individual

Psychologists respect and promote the development and maintenance of the basic human rights, dignity and value of every individual. Additioanlly, they respect the fundmental human rights, as for example privacy, self-determination and autonomy, taking into consideration both all the professional obligations of their occupation and the laws.

8.4.2 Anonymity

According to the anonymity principle, the researcher has to respect the research participants' fundamental right of not disclosing personal or identifiable information. It therefore the researcher took all necessary measures, for instance the use of aliases or the removal of personal information that could lead to the participants' recognition with the purpose of safeguarding the participants' anonymity and protecting their identity (Anagnostopoulou, 2008). A file of the participants' names and the code that was used for each one has been securely stored in a locked drawer in the researcher's office. Researcher also took all appropriate technical and organizational measures to safeguard and protect data against accidental or unauthorized destruction, accidental loss, tampering, prohibited dissemination or access and any other form of improper processing in accordance with applicable law on protection of the individual from the processing of personal data (Gans - Combe, 2009). In addition, the participants' personal information would remain anonymous not only during the data collection of the research, but also after the analysis and interpretation of the findings, their publication and generally their use (Traianou, 2014).

8.4.3 Confidentiality

During the research, the researcher must maintain a genuine attitude and behavior towards the individuals participating in the study; with the intention of creating a trustworthy relationship that will enabel the participants to express themselves freely and genuinely (Anagnostopoulou, 2008). In the context of confidentiality all the participants were informed that no one else except the researcher and the supervisor of the research has access to the information collected.

Each participant was also informed that all the information collected during the research will remain confidential unless there is an indication of potential risk of serious harm to themselves or to another person, when the researcher had to reveal information to the principle of the psychiatric hospital and to his/hers personal treating psychiatrist and psychologist.

8.4.4 Protection from Potential Harm

All necessary measures were taken during the research process in order to protect the participants from any possible danger or potential harm. These possible risks might be physical like an accident during the research conduction or psychological, such as causing severe emotional distress or a potential adverse impact on the participant's self-esteem or even affect his interpersonal and social relationships, create problems within his work enviromrnt and their colleagues, etc. (Anagnostopoulou, 2008; Traianou, 2014). All the potential risk were taken into account and addressed already in the planning of the research, but the researcher was also alert to manage any contingencies throughout the research process. The magnitude of the risks that a person can be exposed to in a research is argued that *"it should not be greater than the one it faces ... in like-minded aspects of his or her daily life and if something unexpectedly appears to be harmful, researchers must interrupt the process and to help the participant receive appropriate support from a specialists"* (Tsiolis, 2014, p.258).

The researchers themselves, however, may be faced with situations that are potentially dangerous to their physical and psychological integrity - often travel, contacts with many and different individuals, illnesses, the delicate nature of the research topic, exposure to painful emotions et al. (Kallinikaki, 2010; Neuman &

Robson, 2007). The attention was therefore also directed towards the researcher's safety as well.

8.4.5 Right to Withdraw

The researcher respects the participant's right to refuse to participate in the study at the first place after receiving all the information regarding it or withdraw from research at any time s/he wishes (Anagnostopoulou, 2008). All participants were informed that they had the right to withdraw at any stage of the research process and for any reason with the simultaneous withdraw of their responses; without having any consequences to their stay or their treatment in the psychiatric hospital in any way. They were also informed that they had the right to withdraw their data from the research until three months after they have participated in it; when the researcher would not have yet do any statistical analysis. For that reason a code was given to each one of them that they could use in they wished to withdrawn their answers from the study. Furthermore, they were informed they had the right to decline to answer to any question that may discomfort them either from the demographic data, the psychiatric history, the criminal history or from any of the questionnaires they had to answer.

8.4.6 Informed Consent from Schizophrenia Patients

Informed consent is among the most significant deontological principles in research and it refers to the obligation of the researcher to make available to the participants all the information relevant to the research project (Iosifides, 2008). In more detail, all the research participants should know the aims of the research, its potential benefits and potential negative impacts, the right they have to refuse participating or withdrawing at any time of the research process without any

consequence etc. (Kallinikaki, 2010; Late & Brig, 2007; Pozón, 2015). Fundamentally, this principle is based on the acknowledgment of the basic right of the individual to decide freely and independently on his or her own life (Traianou, 2014). Therefore, participation in every research should not be deceprive and coercive but rather free and voluntary.

Consent must be given by people who can freely understand the question and agree. "Vulnerable" persons like prisoners, people with intellectual disabilities, patients with serious illnesses, very young children, etc. are influence by developmental, psychological or illness related factors (Geppert & Abbot 2007; Gupta & Kharawala 2012; Roberts 2002; Welie & Berghmans 2006), may have diminished decision-making capacity (understanding and appreciating information, reasoning and expressing stable choice) which is a prerequisite to give informed consent (Bilanakis, Vratsista, Athanasiou, Niakas & Peritogiannis, 2014). Psychiatric patients, including schizophrenia patients, have been found to have incapacity in decision making (Maxmin, Cooper, Potter, & Livingston, 2009; Owen, Richardson, David, Szmukler, Hayward, & Hotopf, 2008; Palmer, Dunn, Appelbaum & Jeste, 2004); and only a few researches have supported that despite the fact that incapacity is common among psychiatric patients, the majority of them are capable of making treatment decisions (Cairns et al., 2005; Okai, Owen, McGuire, Singh, Churchill, & Hotopf, 2007).

In schizophrenia decision-making abilities may be affected by psychopathological factors such as psychotic symptoms and by cognitive factors and neuropsychological impairments like diminished attention, learning, working memory and abstract reasoning (Capdevielle et al., 2009; Carpenter et al., 2000; Heaton et al., 1994; Kovnick, Appelbaum, Hoge, & Leadbetter 2003; Palmer, Dunn, Appelbaum, & Jeste, 2004; Palmer, Dunn Appelbaum & Jeste, 2007). On patients diagnosed with

schizophrenia the published studies demonstrate heterogeneous results regarding decision-making capacity (Cohen, McGarvey, Pinkerton, & Kryzhanivska, 2004; Davies, 2001; Hostiuc et al., 2018; Miller, & Rosenstein, 1997; Palmer et al., 2007; Royal College of Psychiatrists, 1990); and it has been indicated that the presence of schizophrenia does not necessarily means that the patient suffering from that disorder is unable to make decisions (Jeste, Depp & Palmer, 2006; Wong, Clare, Holland, Watson, & Gunn, 2000).

In schizophrenia also the patients' insight has been examined in terms of their capacity of consenting (Cairns et al. 2005; Capdevielle et al. 2009). Researchers have found that the majority of schizophrenia patients have poor insight that leads to impaired decision making; and that consequently to low risk appreciation and reduced ability to compare alternatives (Capdevielle et al., 2009). Patients with longer hospitalizations, active psychotic symptoms and lower education exhibited more impaired decision making capability (Appelbaum, 2006a; Combs, Adams, Wood, Basso, & Gouvier, 2005; Jeste et al., 2005).

Psychiatric patients have massively concerned many scientist and psychiatric and legal professionals regarding the ability to give informed consent as they are perceived to be more vulnerable and at a high risk of being exploited because of their diminish capability of decision making (Bonnie, 1997; Kong, Whitaker, & Globe, 1998; National Bioethics Advisory Commission, 2002). These king of individuals can participate only if there is an appropriate protective legal framework, ethics committee and legal or therapeutic representatives determine "whether the particular participants can reasonably, consciously and freely give informed consent" to the research (Robson, 2007, p.82). These representatives are also known as surrogate decision makers and make their decisions on the bases of the "substituted judgment"

standard (thinking under the notion what the individual would have choose if s/he was able to) and the "best interest" standard (Bagarić, Živković, Ćurković, Radić, & Brečić, 2014; Torke, Alexander, & Lantos 2008).

In more detail, a mentally ill individual is not excluded from a research and according the Helsinki Declaration *"For a potential research subject who is incapable of giving informed consent, the physician must seek informed consent from the legally authorized representative. These individuals must not be included in a research study that has no likelihood of benefit for them unless it is intended to promote the health of the group represented by the potential subject, the research cannot instead be performed with persons capable of providing informed consent, and the research entails only minimal risk and minimal burden."* (World Medical Association, 2013).

In Greece, researches are allowed to be conducted on persons who lack the capacity to consent, only if all of the following conditions are fulfilled: a) the results of the research have the potential to produce a real and immediate benefit to the participants or other persons of this age group or suffering from the same disease or disorder or those been in the same situation, b) it is not possible to conduct comparative efficacy research on people with consensus c) the research involves only minimal risk and minimal burden for the participant (discomfort for the participant will be very light and temporary), d) the requisite authorization has been given in writing and explicitly by the legal representative of the participant, authority, service or person designated by law, taking into account the participant's prior wishes or objections and e) the participant does not object (National Bioethics Committee, 2014).

In the present study, the legally authorized representatives of the participants, namely the psychiatric hospitals' ethics committees and the treating psychiatrist of each participant gave the permission to examine the specific offenders diagnosed with schizophrenia. Also it vital to remember that there was an inclusion criterion for all participants, to be considered stable by their treating psychiatrist and psychologist for at least half a year in order to minimize in advance any chances of problems to arise and to have higher possibilities of the participant to be able to understand the research process. Each participant was informed both in writing and orally about the research in simple language in order to be able to understand and comprehend the purposed of the study and the research process and totally voluntarily decide if s/he wants to participate or not.

8.5 Analysis Methods

For the purposes of the study, the analysis conducted using two statistical packages. The Statistical Package of Social Sciences (SPSS) (version 25) was used to produce the descriptive and inferential statistic; while the Hudap (version 8) was used to produce the Smallest Space Analysis (SSA) from the data gathered from the Emotions Felt During Crime Questionnaire and Narrative Roles Questionnaire.

8.5.1 Smallest Space Analysis (SSA)

Smallest Space Analysis (SSA) is a non-metric multidimensional scaling (MDS) procedure developed by Guttman and Lingoes (Guttman, 1968; Lingoes, 1973, 1979). SSA, like any other MDS procedure, is based on the assumption that the underlying structure will be better understood if the relationship between each variable and every other variable be examined.

In more detail, the SSA-I computed association coefficients between all variables. These coefficients are used to form spatial configuration with variables presenting in points. The interpretation of such a configuration is based on the notion that the closer the two points are, the higher the association between them. Thereby, the multivariate structure of relationships between variables can be easily examined in a statistically derived geometric space by considering the configuration of points as distances.

The "goodness-of-fit" of the SSA's configuration of data is measured be a "coefficient of alienation" (Borg & Lingoes, 1987). The fit between the SSA-I solution and the original correlation matrix is better when the coefficient of alienation is smaller. An SSA solution exhibits a good representation of the original matrix correlations if the coefficient of alienation values range between 0.05 and 0.25.

The fact that the SSA-I is typically used within the framework of Guttman's facet theory (FT), can be considered as one of its benefits (Canter, 1985). Depending on the contiguity of the items on the plot, regions/facets are drawn on the SSA-I according the facet approach. The variables that are presented within a classified facet are empirically supported by this facet rather than just being elements belonging to a particular region. Lines are marked on the plot to differentiate between regions of substantively equivalent contiguous items.

The SSA also exhibits some limitations. One of the basic advantages of SSA is that it can find a smaller space compared to factor analysis. Lingoes and Guttman (1967) (as quoted in Spaeth and Guthery, 1969: 508) argued that, *"In general a smaller space is required to reflect order than to reflect metric."*. However, Spaeth and Guthery (1969) couldn't support this argument, as they stated that the SSA is

highly dependent upon the number of variables and the metric space involved. Another limitation is that SSA is used as a two-facet method where both points and coordinated can be interpreted. However, there is a chance of the emerged SSA configurations not be easy to interpret. In case those configurations are not interpretable, the analysis lacks its robustness and there are no extra information derived by the SSA plots, as there is only one facet. In such cases the SSA is not the appropriate analysis as there is already the factor analysis which is a good one-facet method (Bailey, 1974). Last, but not least, it is essential to note that there are different forms of SSA configurations' interpretation (Bailey, 1974; Coxon,1971; Sokal & Sneath, 1963) and that can pose as limitations, as the interpretability of the plots may differe in terms of literature review the reseatcher has already done and his subjective point of view. Despite its limitations, SSA-I procedure is a quite well-established technique which has been used for more than 50 year to identify structure in diverse phenomena like intelligence (Guttman, 1954; Guttman & Levy, 1991) and self-esteem (Dancer, 1985). In Investigative Psychology the SSA is used when the researchers want a robust multivariate analysis without having formed any particular hypothesis. SSA is used in this domain in order to produce spatial configurations of variables that can be axially separated to form themes of action, behaviour or characteristics that will provide information in the description of the offenders (e.g., Canter, Bennell, Alison, & Reddy, 2003; Canter & Fritzon, 1998; Canter & Heritage, 1989; Canter & Ioannou, 2004a; Canter et al., 2003; Canter et al., 2009; Ioannou, 2006; Ioannou, Hammond, & Simpson, 2015; Ioannou et al., 2015; Ioannou et al., 2017; Ioannou et al., 2018; Salfati, 2000; Spruin, 2012; Spruin et al., 2014; Synnott, Ioannou, Coyne, & Hemingway, 2017; Yaneva, Ioannou, Hammond, & Synnott, 2018; Youngs & Canter, 2012a,b; Youngs, Ioannou, & Eagles, 2016).

In the present study, the SSA-I was used to explore the co-occurrence of emotions and narrative roles in order to reveal the existence of facets/themes refer to the classification of distinct emotional states (elation, calm, distress, depression) and distinct narrative roles (e.g., Hero, Professional, Victim, Revenger). The facets/themes emerged in the present study were based partially on literature and previous studies examined emotions felt during crime and narrative roles (Canter & Ioannou, 2004; Ciesla et al., 2019; Goodlad et al., 2018; Ioannou, 2006; Ioannou et al. 2017; Ioannou et al., 2018; Spruin, 2012). Though because there were no previous studies exploring these variables on schizophrenia patients it was expected that the SSA plots would differ from previous studies in terms of how the items would be spread in the space. So, the researcher also based to the interpretability of the variables in order to make the final decision upon the formation of the facets/themes emereged from the analyses, which is a matter of judgment. The researched chose the number of facets/themes which gave an acceptable visual representation and also had a satisfying low coefficient of alienation.

Chapter 9

Results

For the analysis of the data collected and the production of the descriptive statistics presented below the Statistical Package for the Social Sciences (SPSS) has been used.

9.1 Descriptive Characteristics of the Sample

9.1.1 Personal and family background.

The sample of the present study consisted of sixty-four participants. Out of them, the biggest majority 84.4% (n=54) were men and the rest 15.6% (n=10) were female. Regarding the age of the participants, it ranges from a minimum age of 25 to a maximum age of 77. The mean age of participants is M= 50.28, with a median age of 51.50 (SD= 11.43).

Regarding ethnicity, there are some variations. The vast majority of 58 participants were Greek (90.6 %), but there were also three participants from Albania (4.7%), one who was Armenian (1.6%), one who was Greek-German (1.6%) and one who was Greek-Australian (1.6%). In term of place of birth approximately one third of the participants, 23 (35.9%) specifically were born and raised in urban areas, while the rest 41 (64.1%) of them were born and raised in rural areas. In more detail the following figure (Figure 2) illustrates the exact place of birth of the participants.

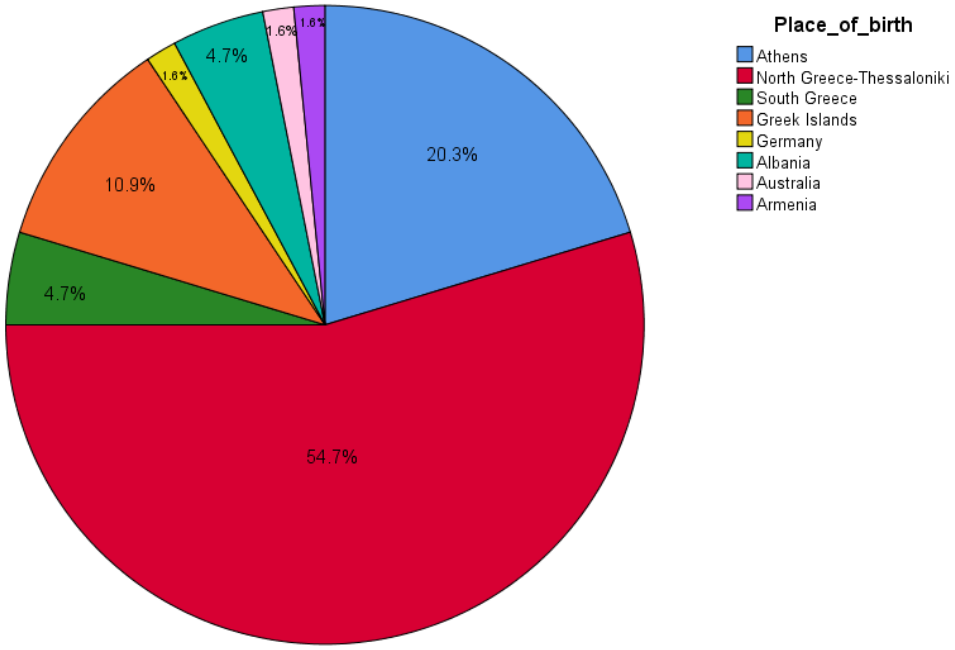

Figure 2: Place of Birth with percentages. This figure shows the places of birth the participants. Only Athens, Thessaloniki (excluding North Greece) and Melbourne (Australia) were considered as urban areas.

The following table (Table 1) illustrates with whom the SO participants lived with when they were children. Additionally, for the family background, the most of participants have siblings. In more detail, 58 (90.6%) of the participants have siblings, while only 6 (9.4%) had no siblings.

Table 1: With whom schizophrenic offenders lived as children.

Living with…	Number of participants	Percentage of sample
Mum and Dad	49	76.6
One parent	8	12. 2
Other relative	4	6.3
Dad and Step-mum	1	1.6
Adopted parents	1	1.6
Children's or Community Home	1	1.6

In terms of marital status, the vast majority of 46 (71.9 %) participants declared being single, nine (14.1%) were divorced, only five (7.8%) were married, two (3.1%) were separated and two (3.1%) were widows.

Regarding the level of education, Table 2 illustrates the education participants have received.

Table 2: Level of education of schizophrenic offenders

Education level	Number of participants	Percentage of sample
Uneducated	4	6.3
Primary school	18	28.1
Secondary school	14	21.9
High school	16	25.0
TEI[18]/ University	8	12.5
Other	4	6.3

Last, regarding occupation prior to their hospitalisations, the vast majority of 37 (57.5%) participants were workers (manual work), 13 (20.3%) of them were unemployed, nine (14.1%) were private employees, four (6.3%) worked as freelancers and last one (1.6%) was a state employee.

9.1.2 Psychiatric background.

All participants have been diagnosed with schizophrenia, were considered clinically stable for at least half a year from their treating psychiatrist and receive antipsychotic medication fixed for at least one month.

[18]TEI: Technological Educational Institute

Regarding the onset of the disorder it is very difficult to be estimated. Many people in Greece have psychiatric problems but never receive diagnosis and even treatment; not until something of great importance happen that can lead them to a psychiatric hospital either voluntary or involuntary. Taking under consideration this, it could only be recorded the time when the participants visited a psychiatric hospital and diagnosed with schizophrenia by a psychiatrist for the first time. The minimum age of first diagnosis is min=11 years of age and the max=63; with mean age M= 29.08 and median age of 25.00 (SD=12.43).

Because the interruption of antipsychotic medication for various reasons, many schizophrenic patients get in and out of the psychiatric hospitals many times and have multiple hospitalizations. The minimum number of hospitalizations was one and the maximum was 52; with a mean M= 3.95 and median 3 (SD= 6.73). All these hospitalizations have occurred before each one of the participants offend and be hospitalized for the last time.

Lastly, the duration of the last hospitalization was measured. That means the time each participant has spent in the psychiatric hospital after the commission of the crime, when he/she received forces hospitalization till the date data entered in the SPSS for analysis. The minimum time of hospitalization is twelve months and the maximum 23 years and 3 months, which equals to 315 months; with a mean of M= 112.52, with median 80.50 (SD= 84.73) in months.

9.1.3 Criminal background.

As offending population was under examination, it was deemed necessary to measure the previous criminal actions and convictions the participants had. Only 15

(23.4%) of the participants had previously offended with the vast majority of 49 (76.6%) participants never in the past been involved in any illegal act.

The age of the participants while committing the crime that led them to mandatory hospitalization also varies. The minimum age is min=20 years of age and the max=70 years of age; with a mean at middle adulthood M= 38.94, and median age of 36.00 (SD= 11.75). Additionally, at this point it is essential to note that only ten (15.6%) participants were directly hospitalized after the crime commission without spending any time in prison; with the rest 54 (84.4%) participants spending time in jail until the court order was made.

In terms of crime, it is also important to know against who the SOs offends. The majority of the participants, 81.3% (n=52) have committed crime against another person while the rest 18.8% (n=12) had committed an offence against property. The offences against person include homicide, attempted homicide, aggravated battery, homicide with mutilation, rape and attempted rape; while the offences against property include arson, burglary and public damage. The following table (Table 3) illustrates the exact type of crime the participants have committed; how many of them have committed it and what their gender is.

Table 3: Type of crime

Type of crime	Number of participants and Gender	Percentage of sample
Homicide	28 (25 males & 3 female)	43.8 (39.10 & 4.7)
Attempt homicide	16 (12 males & 4 female)	25.0 (18.8 & 6.2)
Arson	8 (7 males & 1 female)	12.5 (10.9 & 1.6)
Aggravated battery	4 (all males)	6.3
Burglary	3 (all males)	4.7
Homicide with mutilation	2 (1 male & 1 female)	3.1 (1.6 & 1.6)
Rape	1 (male)	1.6
Attempt rape	1 (male)	1.6
Public damage	1 (female)	1.6

Regarding people schizophrenic offenders choose as victims; the range is also wide in regards of the relationship they had with them. Thirty one (48.4%) of the offenders acted against family members which include all the victims of the categories below father/mother, brother/sister, son/daughter, husband/wife and 5 cases from the category multiple victims. Twelve (20.3%) offenders acted against acquaintances, which include all the victims of the categories below other family members, employer/coworker, neighbor and thee cases from the category multiple victims. Seven (10.9%) acted against strangers which include all the cases from the category strangers below and three cases from the category multiple victims. Only one (1.6%) acted against a friend. Additionally, 12 (18.8%) participants acted against property, which include all the cases from the category own home and other's property.

The table below (Table 4) shows the exact type of relationship the SOs had with their victims; the number of participants committing each specific crime and the offenders' gender and its percentage.

Table 4: Relationship of the offender with the victim

Relationship with the victim	Number of participants	Percentage of sample
Father/ Mother	15 (all males)	23.4
Multiple victims	10 (all males)	15.6
Other family members	8 (6 males & 2 females)	12.5 (9.3 & 3.2)
Brother/ Sister	5 (2 male & 3 females)	7.8 (3.1 & 4.7)
Stranger	4 (all males)	6.3
Son/ Daughter	3 (1 male & 2 females)	4.7 (1.6 & 3.1)
Husband/ Wife	3 (2 males & 1 female)	4.7 (3.1 & 1.6)
Neighbor	2 (males)	3.1
Employer/ Coworker	1 (male)	1.6
Friend	1 (male)	1.6

Additionally, regarding the gender of the victims, 22 (34.4%) SO had male victims, 24 (37.5%) had female victims and 6 (9.4%) of them had victims of both genders; as they are some of the SOs who had multiple victims.

For the rest twelve participants 9 (18.8%) who had offences against property; the following table (Table 5) shows to whom belonged the property damaged, how many SOs committed that offence and what their gender is.

Table 5: Belonging of property damaged by offenders who had crimes against property

Belonging of property	Number of participants	Percentage of sample
Other's property	8 (6 males & 2 females)	12.5 (9.4 & 3.1)
Own Home	4 (all males)	6.3

Concerning the presense of eye-witnesses during crime and concealment of the crime the numbers are quite interesting. Almost half of the offences 46.9% (n=30) had at least one eye-witness, while the rest 53.1% (n=34) of them having no eye-witnesses. In terms of crime concealment, it is proved that schizophrenic offenders do not try to conceal their crimes, as the vast majority of fifty five participants (85.9%) of whom 46 were males (71.8%) & 9 were females (14.1%), did not try to conceal their crime and only nine (14.1%) tried to do so; 8 of whom were males (12.5%) and 1 was female (1,6%).

Last but not least, the sudy examined the strength of the memories SOs have at the present time considering the day the crime committed using a self-reported estimation. The table below (Table 6) illustrates the strength of the memories; how many participants have that memory, what their gender is and percentages.

Table 6: Strength of memories

Memories	Number of participants	Percentage of sample
Very strong	22 (20 males & 2 females)	34.4 (31.3 & 3.1)
Strong	16 (15 males & 1 female)	25.0 (23.4 & 1.6)
Quite strong	11 (8 males & 3 female)	17.2 (12.5 & 4.7)
Weak	10 (8 males & 2 female)	15.6 (12.5 & 3.1)
Very weak	5 (3 male & 2 females)	7.8 (4.7 & 3.1)

9.2 Smallest Space Analyses Results

9.2.1 The Results of the SSA Analysis on Roles

The first objective of the study was to determine whether the overall structure of the roles schizophrenic offenders see themselves as acting out during crime commission could possibly be differentiated in different role themes as previous studies in the field of Criminal Narrative Experience have indicate (Canter & Youngs, 2009, 2012; Canter et al., 2003; Ioannou, 2006; Ioannou et al., 2015, 2017, 2018; Spruin et al., 2014; Youngs & Canter, 2012a, b, 2013). Therefore, an SSA was carried out on the responses of the 64 SOs answered to the 33-item Criminal Narrative Role Questionnaire.

The 2-dimensional SSA solution resulted from the analysis has a Guttman – Lingoes coefficient of alienation 0.26122 in 8 iterations, showing an adequate fit between the Pearson's coefficients of the role variables and their corresponding geometric distances in the configuration. Each point in the SSA plot (see Figure 3) is a role statement which participants indicate as acting out during the crime commission. The labels are brief summaries of the full questions; full descriptions of these labels are presented in Table **7**.

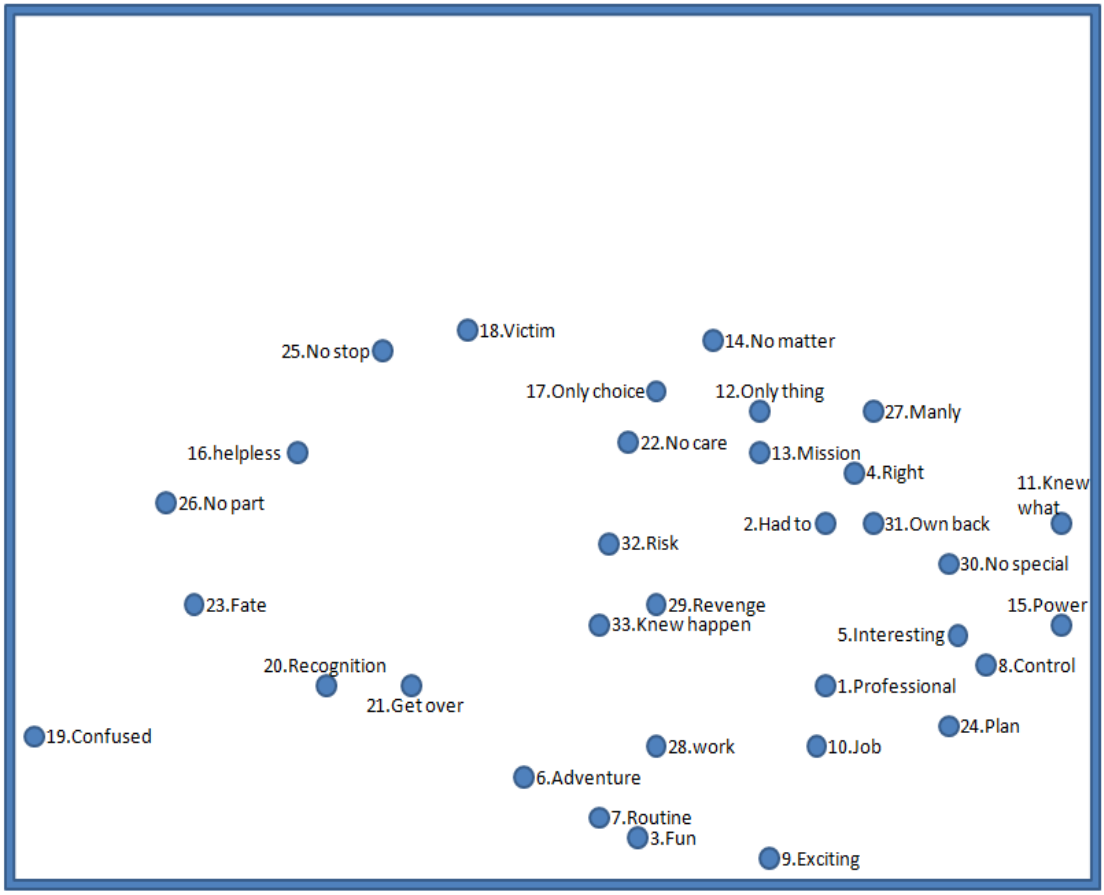

Figure 3: 1 by 2 Projection of the Two-Dimensional Smallest Space Analysis (SSA) of Roles.

Coefficient of alienation: 0.26122

Table 7: The Roles and Analysis Labels

Question Number	Full Question	Analysis Label
1	I was like a professional	professional
2	I had to do it	had to
3	It was fun	fun
4	It was right	right
5	It was interesting	interesting
6	It was like an adventure	adventure
7	It was routine	routine
8	I was in control	control
9	It was exciting	exciting
10	I was doing a job	job
11	I knew what I was doing	knew what
12	It was the only thing to do	only thing
13	It was a mission	mission
14	Nothing else mattered	no matter
15	I had power	power
16	I was helpless	helpless
17	It was my only choice	only choice
18	I was a victim	victim
19	I was confused about what was happening	confused
20	I was looking for recognition	recognition
21	I just wanted to get it over with	get over
22	I didn't care what would happen	no care
23	What was happening was just fate	fate
24	It all went to plan	plan
25	I couldn't stop myself	no stop
26	It was like I wasn't part of it	no part
27	It was a manly thing to do	manly
28	For me it was just like a usual days work	work
29	I was trying to get revenge	revenge
30	There was nothing special about what happened	no special
31	I was getting my own back	own back
32	I knew I was taking a risk	risk
33	I guess I always knew it was going to happen	knew happen

9.2.1.1 Themes of roles.

To interpret the SSA, a careful examination of the resulting figure executing in order to identify whether or not the roles could form distinct themes. Careful examination of the configuration of points suggested that it would be possible to differentiate distinct themes of roles. Specifically, three dominant themes of narrative offences roles were evident. These themes were labeled: Victim, Revenger and Hero; as illustrated in Figure 4.

A scale reliability analysis, using Cronbach's alpha, was conducted for the items within each of the proposed three themes, in order to give an indication of the adequacy of the split. The analyses confirmed that all scales had moderate to high internal consistency: Victim, α =0.71, Revenger, α = 0.70 and Hero, α = 0.85.

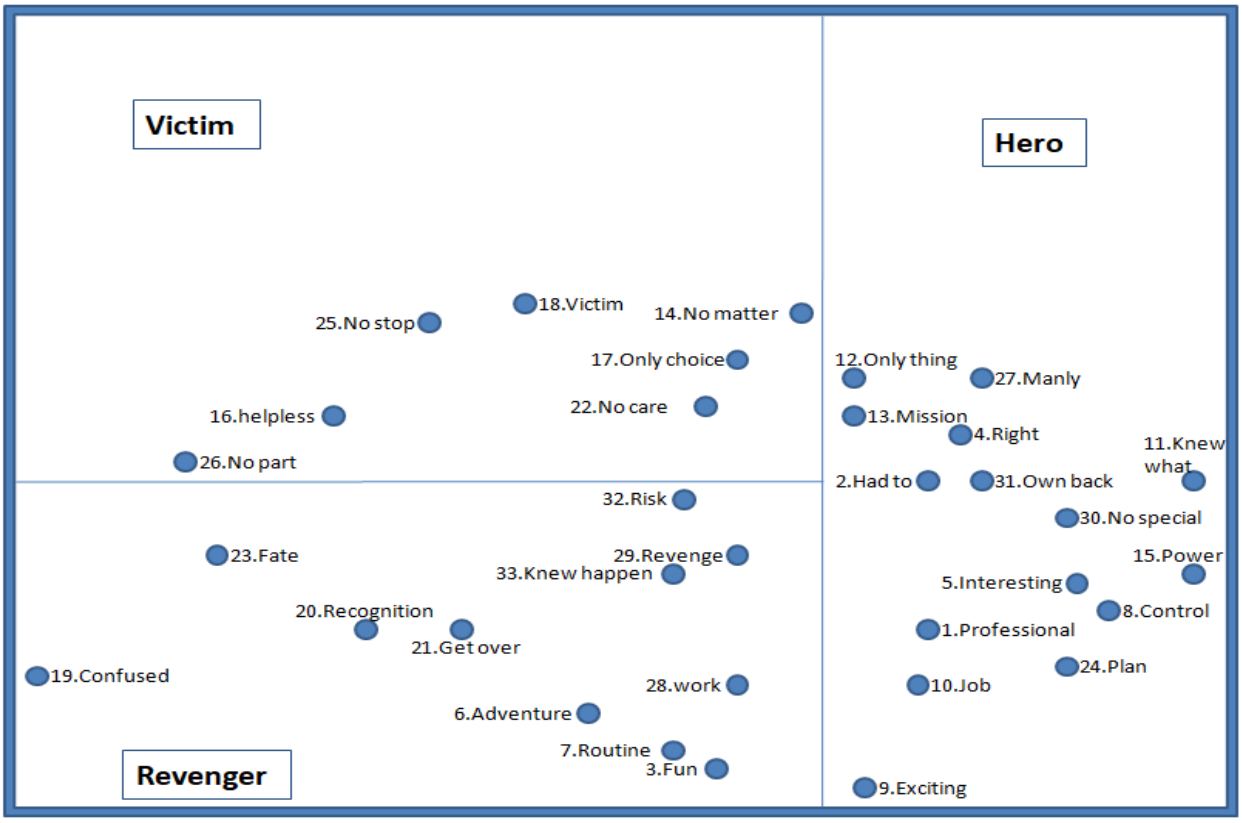

Figure 4: 1 by 2 Projection of the Two -Dimensional Smallest Space Analysis (SSA) of Roles with Regional Interpretation.

Victim.

There are seven elements that can be conceptually linked with the Victim role:

- 14. No matter
- 16. Helpless
- 17. Only choice
- 18. Victim
- 22. No care
- 25. No stop
- 26. No part

The Victim type of offender can be described as someone who regards himself as the victim of the situations. He believes that the offence was the only choice he had and during the crime commission that offender couldn't stop himself. Furthermore, he has a strong feeling of powerlessness (Helpless) and does not regard himself responsible for or part of the crime and he does not care about anything.

Case № 50.

He is a 59 years old man from north Greece. As a child he was living with both of his parents and his 5 brothers and sisters. He never got married and he used to work as a sailor as he had no specific knowledge because he has only graduate primary school. The years he worked as sailor he also admits high levels of alcohol consumption. Though the last few years before the crime he was unemployed, a reason that caused many argues with his mother who constantly telling him to change the way of his living. Furthermore he was telling his mother to not have relationships with his uncle and aunt, not going to church and generally not going out of home often because there are many people that can harm her. At the age of 36 he killed with a 30cm long knife his mother at their home. Then he stayed couple of hours at home to relax and changed his clothes and went to his uncles' home where he cut the telephone cables, broke in the home and killed them. He accused for intentional serial homicide and

illegal carry and use of weapons. Few days before the crime he had seen a dream that his uncles were destroying his home and his dead father was telling his mother to be cautious of them. Additionally, he had heard his mother having a conversation with his sister, telling her that she is "living in hell". This event in combination with his dream led him to the conclusion that his mother's live was a torture and that he had to help her by killing her. After his arrest he was diagnosed with schizophrenia with symptoms of diminished emotional understanding and expression, disorganized thinking, judgment and memory and delusion of persecution. He described that during the crime he was a helpless victim that he had no other choice but killing his mother because she was suffering and his uncles because they did bad to him. He said that he couldn't stop himself during the offence, that nothing else mattered and that he didn't care about what will happen and what the consequences will be. Also he described himself as not being a part of the crime.

Revenger.

There are ten elements that can be conceptually linked with the Revenger role:

- 3. Fun
- 6. Adventure
- 7. Routine
- 19. Confused
- 20. Recognition
- 21. Get over
- 23. Fate
- 28. Work
- 29. Revenge
- 32. Risk
- 33. Knew happen

The Revenger type of offender is someone who perceives the experience of crime as a routine which offers him the feeling of fun. He perceives the offence as an adventure in an attempt to seek revenge in order to get over with the situation he is into. He develops a risky behavior in the recognition seeking procedure. Additionally,

he believes that all the things happened are beyond his understanding (Confused) even though he believes that he always knew that the crime was going to happen, due to his belief that the events in his life are a function of fate or other external factors beyond his control or manipulation.

Case № 29.

He is a 58 years old man from a rural area close to the capital city of Athens. As a child he was living with both of his parents and his two younger brothers. He never got married and he used to work as a worker as he had no particular education because he has only graduate primary school. At the age of 53 he was diagnosed with schizophrenia with main symptom delusion of persecution. A year later he was accused for arson by intention. He had a strong confrontation with some municipal employees who put his property at auction due to depts. He got really mad with that situation and set fire to his home. Then he sat at home and because he was afraid that he will be a "cripple" because of the fire he drunk a poisonous substance. Firefighters dragged him out and led him to the police department. During interrogation he admitted that he put fire in an attempt to commit suicide. He described that during the crime he was confused and he only wanted to get revenge from those who tried to put his property in auction. He knew he is talking a risk but perceived the arson like an adventure from which he will gain recognition. He admitted he always knew what will happen because he believed that was a matter of fate.

Hero.

There are fifteen elements that can be conceptually linked with the Hero role:

- 1. Professional
- 2. Had to
- 4. Right
- 5. Interesting
- 8. Control
- 9. Exciting

- 10. Job
- 11. Knew what
- 12. Only thing
- 13. Mission
- 15. Power
- 24. Plan
- 27. Manly
- 30. No special
- 31. Own back

The Hero type of offender is someone who acts like a professional and experiences the crime as simply carrying out a task at a usual day at work (Job; Nothing special). He fully justifies his criminal behaviour as the right and only thing he could do in order to protect his own back. He perceived the offence as a mission and he is engaged in criminal activity in a methodical manner (Plan). Additionally, he implies a sense of competence and a mastery of an offender's environment (Control; Knew what; Power) and believes the offence was an interesting and manly thing to do who offers him excitement.

Case № 4.

He is a 64 years old man who grew up and lived his whole life in a Greek island. As a child he lived with both his parents and his 5 older brothers and sisters. He never got married and he was unemployed as from the young age of 25 he was diagnosed with schizophrenia. The main symptoms of the disorder were visual and auditory hallucinations and delusional ideas with intense religious and grandiose content. In past he was admitted multiple times at psychiatric hospitals due to relapses caused by interruption of medication. At the age of 45 he stabbed to death his mother at her head while she was sleeping. After the incident his nephew saw him covered in blood. The offender threw an iron at him and told him "go away Satan". After that he left home and he was wandering until he got arrested. He accused of intentional homicide and illegal use of weapon. During the interrogation and the psychiatric evaluation he said

that he had a delusion that his mother had hit him with a wood the same morning while he was sleeping because “she was jealous of him who had problem with his mind”. He also admitted that twelve days before the incident he had interrupted his medication; which is probably the reason of his delusions. He described that during the crime he had the control and power and believed that killing his mother was a mission and the right thing he had to do to protect his own back. He said that he knew what will happen, but that as the only thing a man like him could do.

9.2.1.2 Means of Roles Variables

The variables that form each one of the four distinct themes are given in the following figure (Figure 5) accompanied by the means and in the table (Table 8) accompanied by the means and the standard deviations for each role. The mean scores indicate that the roles statements by the sample reflect the criminal experience. The highest averages are for the roles confused (3.38), no stop (3.34), helpless (2.98), victim (2.94) and only choice (2.53) contributing to the victim and revenger regions.

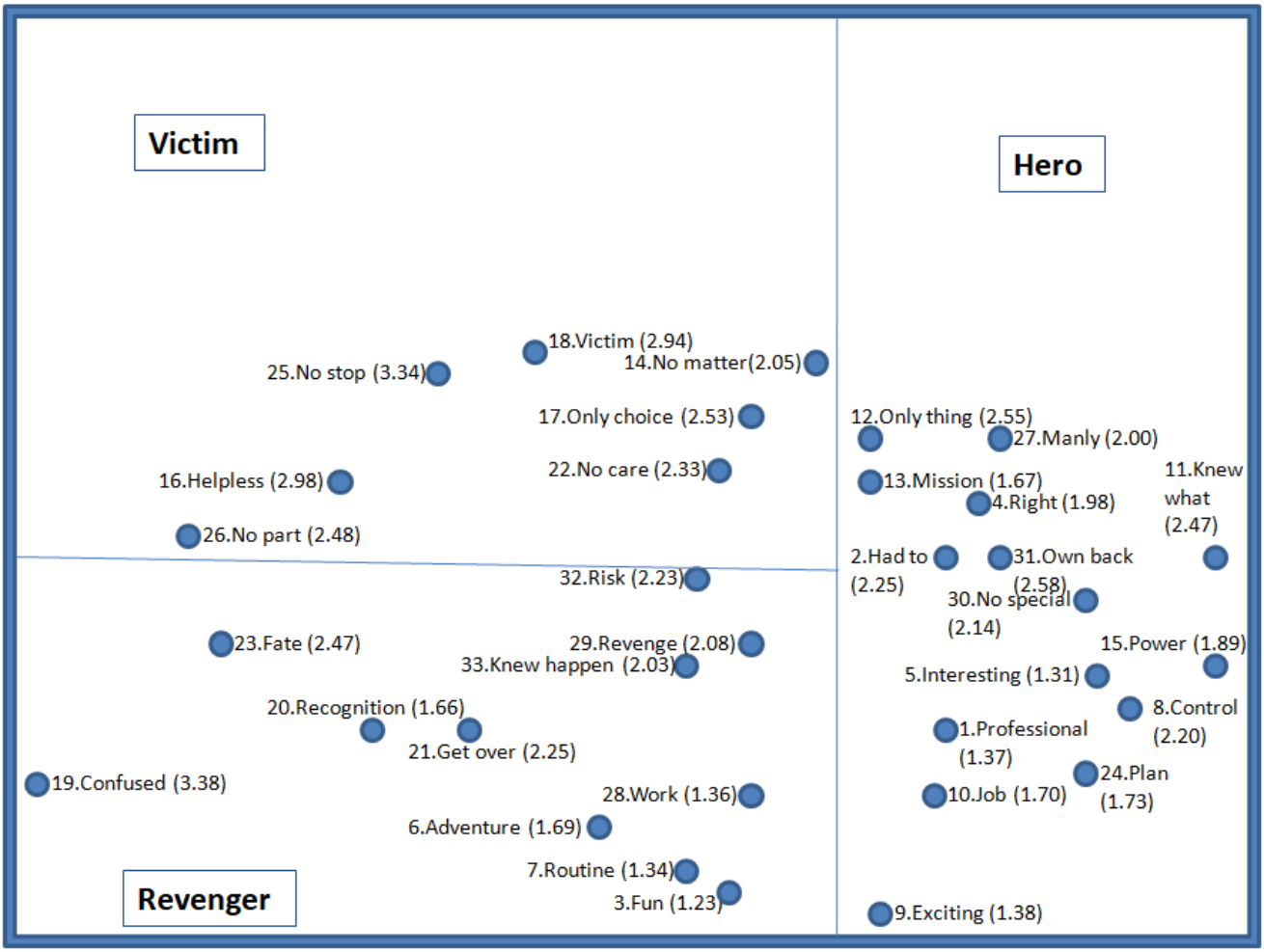

Figure 5: 1 by 2 Projection of the Two -Dimensional Smallest Space Analysis (SSA) of Roles with Regional Interpretation and Means.

Table 8: Means and Standard Deviations for the four distinct Role Themes

Role Themes/variables	Mean (SD)	Role Themes/variables	Mean (SD)
Victim		**Hero**	
14. No matter	2.05 (1.40)	1. Professional	1.37 (1.00)
16. Helpless	2.98 (1.63)	2. Had to	2.25 (1.54)
17. Only choice	2.53 (1.62)	4. Right	1.98 (1.36)
18. Victim	2.94 (1.62)	5.Interesting	1.31 (0.90)
22. No care	2.33 (1.65)	8. Control	2.20 (1.60)
25. No stop	3.34 (1.43)	9. Exciting	1.38 (0.96)
26. No part	2.48 (1.59)	10. Job	1.70 (1.25)
Revenger		11. Knew what	2.47 (1.65)
3.Fun	1.23 (0.79)	12. Only thing	2.55 (1.63)
6. Adventure	1.69 (1.18)	13. Mission	1.67 (1.28)
7. Routine	1.34 (0.96)	15. Power	1.89 (1.42)
19. Confused	3.38 (1.50)	24. Plan	1.73 (1.53)
20. Recognition	1.66 (1.18)	27. Manly	2.00 (1.54)
21.Get over	2.25 (1.50)	30. No special	2.14 (1.52)
23. Fate	2.47 (1.53)	31. Own back	2.58 (1.58)
28. Work	1.36 (0.91)		
29. Revenge	2.08 (1.44)		
32. Risk	2.23 (1.57)		
33. Knew happen	2.03 (1.49)		

9.2.1.3 Relationship between role themes.

Table 9 below presents the correlations between the three narrative role themes. As it can be seen the role of Victim correlates significantly positive with the role of Revenger with $r=.476$, $p< .01$. The role of Hero correlates significantly positive with the role of Victim with $r=.324$, $p< .01$ and finally the role of Revenger correlates significantly positive with the role of Hero with $r=.373$, $p< .01$. These findings are not that surprising as it already known that each participant does not simply score high only on the elements of one specific narrative role but also in elements of the other role themes; which make them blend into one another.

Table 9: Correlations between Narrative Role Themes

	Victim	Revenger	Hero
Victim	-	-	-
Revenger	.476**	-	-
Hero	.324**	.373**	-

*Correlation is significant at the 0.05 level
**Correlation is significant at the 0.01 level

9.2.1.4 Dominant narrative role in schizophrenia.

The second objective of the study was to find out if schizophrenia is associated with a particular narrative role. For this purpose the means and standard deviation of the narrative roles were estimated. The Victim role has a higher overall average in schizophrenia (M=2.66, SD=.94) compared to the other narrative roles. Second comes the Revenger narrative role (M=2.17, SD=.72) and last in association with schizophrenia comes the Hero narrative role (M=1.94, SD=.80). These results indicated that the Victim role is the most dominant narrative among schizophrenic offenders.

9.2.1.5 Assign cases to themes.

Each one of the 64 cases was individually examined to verify if it could be assigned to a specific theme on the bases of the roles that SO acted out during the crime commission; in order to examine the thematic split of the SSA of the schizophrenic offenders' narrative roles. It is of vital importance to note that even though the SSA indicates the roles SO were "playing" during crime commission can be classified in three distinct themes, it does not classify the offenders. An SO may score high on an item/role from more than just one SSA theme, although because these themes have been differentiated, it would be expected that the majority of items/roles which SO will score high would fall under one specific theme. For that

reason, it was necessary to examine whether it is possible the classification of an individual case as belonging to one of the three themes, emerged from the abovementioned analysis.

Every case was given a percentage score for each of the three themes, reflecting the proportion of Victim, Revenger and Hero narrative roles. Percentages were used rather than actual numbers of the sum score of each theme because the total number of item/roles in each theme was different (Victim=7, Revenger=11 and Hero=15). The percent of cases having a higher percent of occurrence in one theme was the criterion used for assigning a case to a specific theme. For example in case 6, 89% of the variables occurred in the Victim role theme, 31% in the Revenger and 28% in the Hero theme, thus this SO could be classified into the Victim theme.

At this point it is essential to note that there is a case that a SO may has the same proportion of variables between two or more themes. In this case it would be said that there is a hybrid of different themes, and the SO cannot be classified to one particular role theme (Ioannou, 2006).

Using that criterion, almost all of the cases, 98,6% (n=63), could be classified under a particular theme. In more detail, the most frequent type was Victim where 44 cases (68.8%) classified into this type. This is followed by Hero where 11 cases (17.2%) classified into and last is the Revenger where only 8 cases (12.5%) fall into this type of narrative role. The rest 1,6% (n=1) of the overall sample of the 64 SO could not be classified in either type of narrative role as this SO exhibits equal numbers of variables from more than two themes or does not appear any predominant type (Ioannou, 2006). This SO is case 60 which presented 80% of the variables occurring in the Victim role, 80% occurring in the Revenger role and last 80% occurring in the Hero role.

Case № 60.

He is a 60 years old man who grew up and lived in northern Greece. As a child he was living with both his parents and his two older siblings. He has only primary school education, he never got married and he was working as a breeder. At the age of 39 he was diagnosed with schizophrenia of paranoid type with delusions of persecution, auditory hallucinations, insomnia, distress, anorexia and irritability. Furthermore, he had a delusion that people can steal his thinking *"they steal my thinking from the mind, they can hear it"*. Ten years later, he was accused of attempted homicide and illegal use of weapon. He threatened with a carbine his aunt at her own home. He shot in the air 29 times to intimidate her. After his arrest he stated that he does not remember his actions as he was in confusion and ascribe the gun shots to his wish to talk with those who are guilty for the magic put on him. He stated he hadn't regret his actions and he believed that his aunt had put spells of black magic on him *"She (the aunt) has put spells of black magic on me and other people… because of her spells some animals die and some others never get pregnant. She has destroyed me"*. During the psychiatric evaluation that followed he also admitted that he had interrupted his medication the past six months. That is the reason he had auditory hallucinations as he was hearing the aunt's voice telling him *"I will destroy you", "I will burn you"*.

He described that during the crime he was victim and professional at the same time. From on hand he describe himself as a helpless victim of fate; who is confused and took a high risk as an only thing he could possibly do to protect his own back. During the crime he couldn't stop himself and he didn't care about the consequences. On the other hand he described himself as a man who has power and control over the situation. He had planned his actions and perceived them as an exciting, interesting

and adventurous mission. He thinks he is just doing a job, he had to do as the right thing who offers him fun and the wanted recognition. The crime for him is a manly action in order to take revenge from those who treat him wrong.

9.2.2 The Results of the SSA Analysis on Emotions

The third objective of the study was to determine whether the overall structure of the emotions schizophrenic offenders experience during crime commission could be possibly be differentiated in different emotion themes as previous studies in the field of Criminal Narrative Experience have indicate. Therefore, an SSA was carried out on the responses of the 64 SOs to the 26-item Emotions Felt During a Criminal Offence Questionnaire.

The 2-dimensional SSA solution resulted from the analysis has a Guttman – Lingoes coefficient of alienation 0.16238 in 10 iterations, showing an adequate fit between the Pearson's coefficients of the emotion variables and their corresponding geometric distances in the configuration. Each point in the SSA plot (see Figure 6) is an emotion statement which participants experience during the crime commission. The labels are brief summaries of the full questions; full descriptions of these labels are presented in Table 10.

Figure 6: 1 by 2 Projection of the Three-Dimensional Smallest Space Analysis (SSA) of Emotions.

Coefficient of alienation: 0.16238

Table 10: The Emotions and Analysis labels

Question Number	Full Question	Analysis label
1	I felt lonely	lonely
2	I felt scared	scared
3	I felt exhilarated	exhilarated
4	I felt confident	confident
5	I felt upset	upset
6	I felt pleased	pleased
7	I felt calm	calm
8	I felt safe	safe
9	I felt worried	worried
10	I felt depressed	depressed
11	I felt enthusiastic	enthusiastic
12	I felt thoughtful	thoughtful
13	I felt annoyed	annoyed
14	I felt angry	angry
15	I felt sad	sad
16	I felt excited	excited
17	I felt confused	confused
18	I felt miserable	miserable
19	I felt irritated	irritated
20	I felt relaxed	relaxed
21	I felt delighted	delighted
22	I felt unhappy	unhappy
23	I felt courageous	courageous
24	I felt content	content
25	I felt manly	manly
26	I felt pointless	pointless

9.2.2.1 Themes of emotions.

A careful study of the resulting figure and the identification of whether or not the emotions could form distinct themes were used as an approach to interpret the SSA. Careful examination of the configuration of points suggested that it would be possible to differentiate some themes of emotions. Specifically, four dominant themes of emotional states were evident; which reflect the circumplex of emotions proposed by Russell (1997). These regions were labeled: Distress, Elation, Depression and Calm; as illustrated in Figure 7.

Additionally, in the plot can be observed that all pleasurable emotions are clearly to the right side of the plot, except the emotion "excited" which on the left side close to the negative (high arousal) emotions. This division of positive and negative emotions accords directly with the dominant axis of pleasure-displeasure in the Russell's model of affect. In addition, it can be also seen that at the top of the plot there are more intense emotional states and at the bottom of the plot there are less energized emotions. This division is in accordance with the arousal axis (arousal-sleepiness) suggested by Russell's model of affect.

A scale reliability analysis, using Cronbach's alpha, was conducted for the items within each of the identified four themes, with the intention of giving an indication of the adequacy of the split. The analyses confirmed that all scales had moderate to high internal consistency: Distress, $\alpha = 0.75$, Elation, $\alpha = 0.83$, Depression, $\alpha = 0.75$ and Calm, $\alpha = 0.79$.

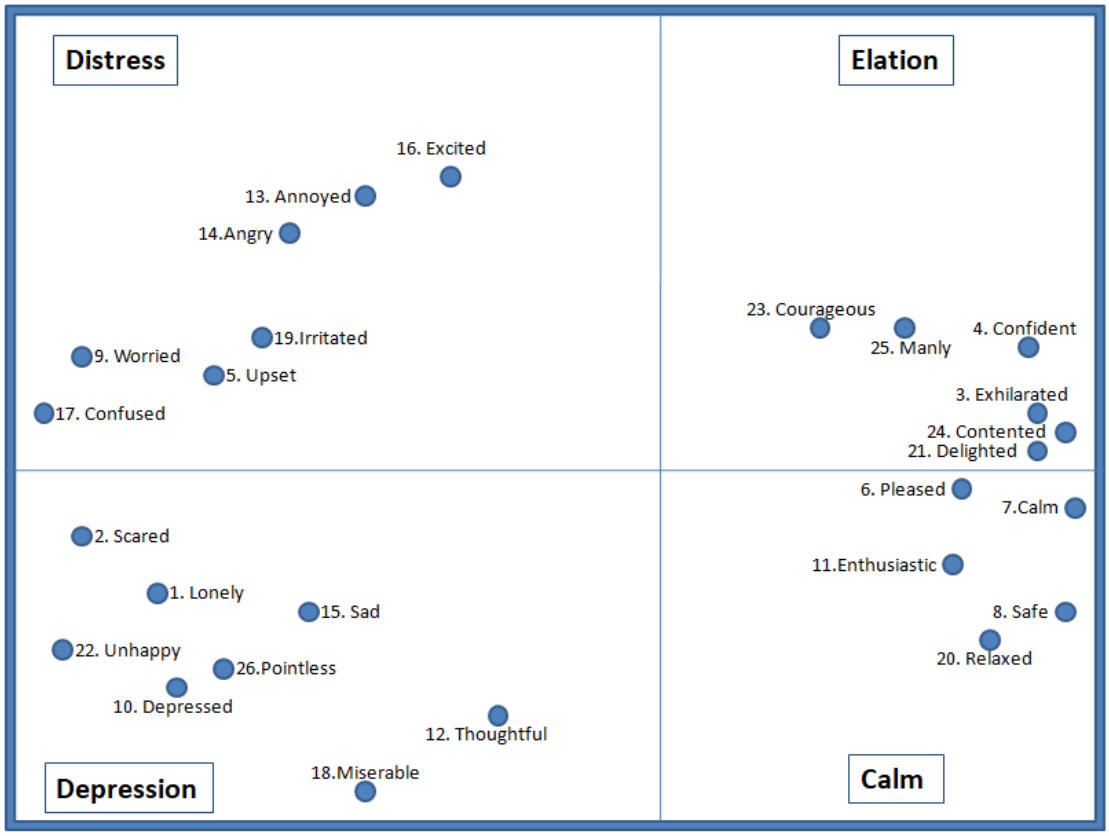

Figure 7: 1 by 2 Projection of the 2-dimensional SSA of Emotions with Regional Interpretation.

Distress.

The top left quadrant of the SSA plot includes the emotions that are distressful (displeasure – arousal) for the offender. These seven emotions in this region are:

- 5. Upset
- 9. Worried
- 13. Annoyed
- 14. Angry
- 16. Excited
- 17. Confused
- 19. Irritated

Case № 16.

He is a 46 years old man who was born from Greek parents in Melbourne Australia and moved to Greece at the age of ten. As a child he was living with both

parents and his two younger siblings. He never got married and he had graduate a technical school and used to work as a car mechanic. At the age of 23 he was diagnosed with schizophrenia with main symptoms ideas of thinking control and extreme aggressiveness. The following years he had never caused any problem and he had never had any implication with any illegal act; till the age of 42 when he accused with attempted rape. He tried to rape his 70 year old aunt at their home. A neighbor who witnessed the crime called the police and he immediately got arrested. During the interrogations he told that high levels of pressure lead him to the offending behaviour. The high levels of pressure caused him feeling very upset, annoyed, angry and irritated during the offence. He also stated that he was quite worried and confused about what happened though he had a feeling of excitement.

Elation.

The top right quadrant of the SSA configuration includes emotions of elation (pleasure – arousal). These six emotions in this region are:

- 3. Exhilarated
- 4. Confident
- 21. Delighted
- 23. Courageous
- 24.Contented
- 25. Manly

Case № 58.

He is a 43 years old man from north Greece. As a child he was living with both his parents and his younger sister. He never got married; he has a secondary education and he worked as a breeder. At the age of 25 he was diagnosed with schizophrenia of paranoid type and he has a main symptom delusion of persecution. At that time he referred he did alcohol abuse and he refused to take his medication which caused him to have multiple relapses. For that reason his mother secretly administered his medication through his food. At the age of 41 he had a fight with his cousin. He went to his cousin's store and poured oil into the shop and on his cousin in an attempt to burn him. After that he drove at his home, where police arrested him. He accused with attempted homicide by intention in calm mental state. What led him to offend is the delusional idea that his cousin wanted to harm him. During the incident he felt a little exhilarated but very confident, courageous, manly, delighted and contented.

Depression.

The bottom left quadrant on the SSA plot includes emotions relevant to depression (displeasure – sleepiness). These eight emotions in this region are:

- 1. Lonely
- 2. Scared
- 10. Depressed
- 12. Thoughtful
- 15. Sad
- 18. Miserable
- 22. Unhappy
- 26. Pointless

Case № 56.

He is a 49 years old man from north Greece. As a child he was living with both parents and his two younger siblings. He never got married and he had a higher education by studying in the Faculty of Agriculture, Forestry and Natural

Environment of Thessaloniki's University. He never worked as from the young age of 20 he was diagnosed with schizophrenia of paranoid type. At the age of 29 he killed his grandmother at her home and then he left the village and wandered to the nearby villages where he got arrested. He got accused for indented homicide and illegal use of weapon. During his interrogation he stated that *"there were many psychological problems from past that vented at a moment when his mind wasn't in its logic"*. He spent a year in prison and then he got transferred to a psychiatric hospital. During the crime he felt at a maximum level all the emotions described above which formulate the Depression theme.

Calm.

The bottom right quadrant of the SSA configuration contains variables indicative of the feelings of calmness (pleasure – sleepiness). These five emotions in this region are:

- 6. Pleased
- 7. Calm
- 8. Safe
- 11. Enthusiastic
- 20. Relaxed

Case № 14.

He is a 61 years old man from Athens. He lived with both parents and his 6 older siblings as child. He graduate secondary school and years later a public school for mechanics; and he worked as a joiner. He never got married and at the age of 30 he was diagnosed with schizophrenia with main symptom delusional ideas. In the past he had a couple of relapses which lead him to hospitalizations. At the age of 24 he was arrested for robbery and spent eight years in prison. Many years later, at the age of 47 he has an argument with his older brother at their mother's home and tried to hit

him with a screw driver. Eventually, he injured his mother who tried to separate them. After the incident he left on foot, and walked to the police station to surrender himself. He was drunk during the offence and he told the policemen that he had a relationship with a singer that his brother and mother didn't approve. His brother managed to break his relationship and that was the reason of their argument. During the offence he was feeling at a high level all the emotions that constitute the Calm theme. Probably the alcohol consumption he had done before the offence help him maintain low arousal positive emotions.

9.2.2.2 **Means of Emotion Variables**

The variables that form each one of the four distinct themes are given in the following figure (Figure 8) ccompanied by the means and in the table (Table 11) accompanied by the means and the standard deviations for each emotion. The mean scores indicate that the degree of emotions experience by the sample covers a wide range of intensity. The highest averages are for the emotions upset (3.39), annoyed (3.30), angry (3.20), irritated (3.19) and sad (3.09) contributing to the Distress and the Depression regions.

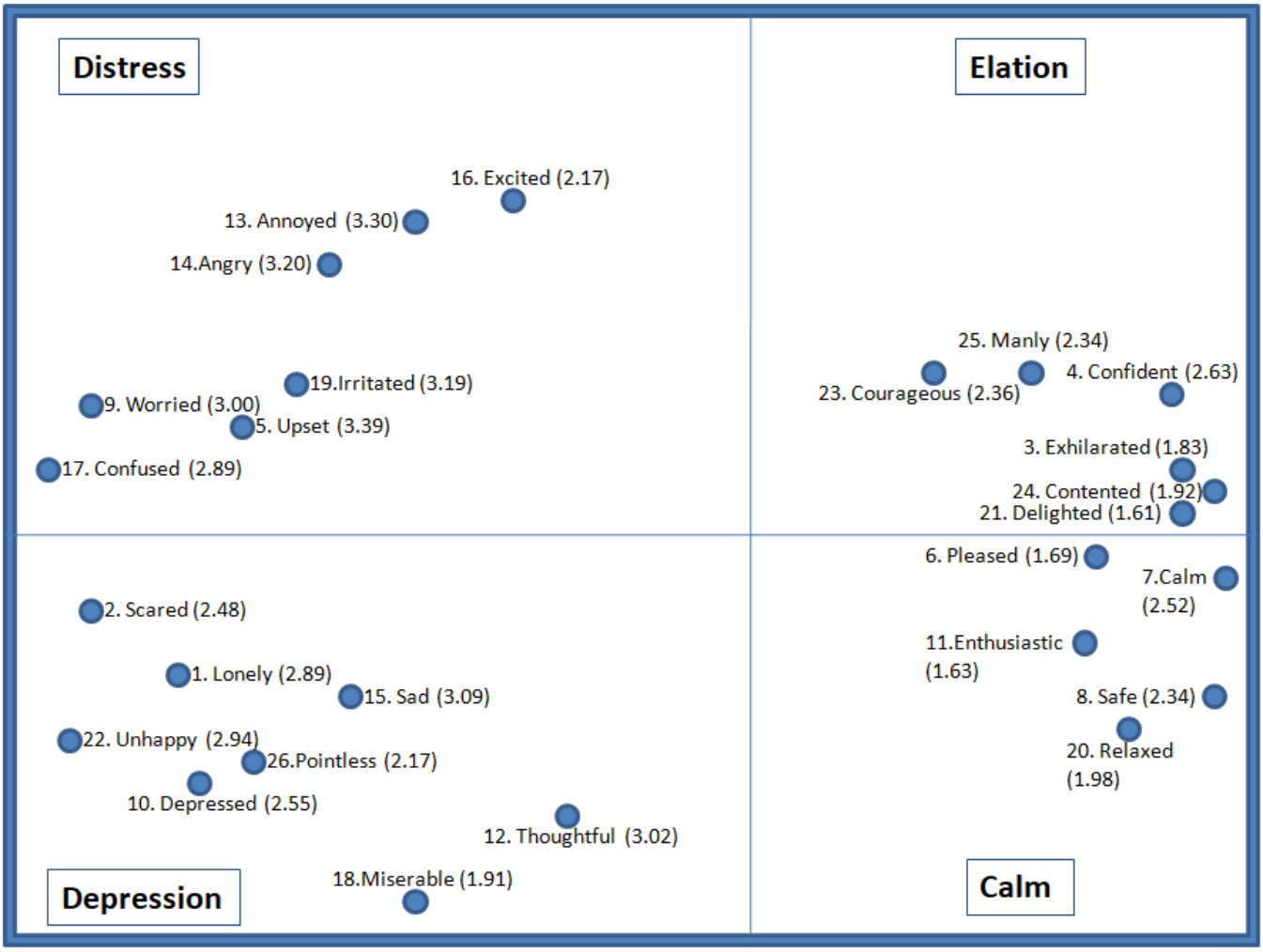

Figure 8: 1 by 2 Projection of the 2-dimensional SSA of Emotions with Regional Interpretation and Means

Table 11: Means and Standard Deviations for the four distinct Emotion Themes

Emotion themes/variables	Mean (SD)	Emotion themes/variables	Mean (SD)
Distress		**Elation**	
5. Upset	3.39 (1.39)	3. Exhilarated	1.83 (1.30)
9. Worried	3.00 (1.51)	4. Confident	2.63 (1.57)
13. Annoyed	3.30 (1.55)	21. Delighted	1.61 (1.28)
14. Angry	3.20 (1.64)	23. Courageous	2.36 (1.49)
16. Excited	2.17 (1.43)	24. Contented	1.92 (1.41)
17. Confused	2.89 (1.53)	25. Manly	2.34 (1.52)
19. Irritated	3.19 (1.55)		
Depression		**Calm**	
1. Lonely	2.89 (1.58)	6. Pleased	1.69 (1.29)
2. Scared	2.48 (1.58)	7. Calm	2.52 (1.59)
10. Depressed	2.55 (1.47)	8. Safe	2.34 (1.47)
12. Thoughtful	3.02 (1.52)	11. Enthousiastic	1.63 (1.25)
15. Sad	3.09 (1.54)	20. Relaxed	1.98 (1.33)
18. Miserable	1.91 (1.44)		
22. Unhappy	2.94 (1.46)		
26. Pointless	2.17 (1.45)		

9.2.2.3 Relationship between emotion themes.

Table 12 below shows the significant correlations between the four emotion themes as estimated by a Pearson correlation test. As it can be seen from the table, Elation has not a significant negative correlation with Distress with r=-.149, p=.240. Even thought Elation appears a significant negative correlation r=-.274, p=.028 with Depression. Contrary Depression has a significant positive correlation r=.344, p<.01 with Distress. Calm has a significant negative correlation r=-430, p<.01 with Distress, a significant positive correlation r=696, p<.01 with Elation and a non significant negative correlation with Depression r=-184, p=.146. What is obvious from the table below is that positive emotions (Elation-Calm) appear a significant positive correlation. The same stands for negative emotions (Distress-Depression) which also

appears a significant positive correlation. Contrary there is always a negative correlation (either significant or not) between the negative and positive emotions.

Table 12: Correlations between Emotion Themes

	Distress	Elation	Depression	Calm
Distress		-	-	-
Elation	-.149	-	-	-
Depression	.344**	-.274*	-	-
Calm	-.430**	.696**	-.184	-

*Correlation is significant at the 0.05 level

**Correlation is significant at the 0.01 level

9.2.2.4 Dominant emotional experience in schizophrenia.

The forth objective of the study was to determine whether any particular emotional experience during the crime commission could be associated with schizophrenia. For this purpose the means and standard deviations were estimated. From the four distinct emotion themes formed in the SSA plot, the Distress emotional experience has a higher overall mean in schizophrenia (M= 3.00, SD=.96) compared to the other emotional states. Second with minor difference comes the Depression (M= 2.62, SD= .91), following by Elation (M= 2.19, SD= 1.15) and last is the Calm (M= 2.03, SD= 1.03). That analysis further reveals that the displeasure emotions, either of arousal or sleepiness according to the Russell's Circumplex of Emotions, are more commonly felt by the SOs during the crime commission compared to the emotions of pleasure.

9.2.2.5 Assign cases to themes.

Each one of the 64 cases was individually examined to verify if it could be assigned to a specific theme on the bases of the emotions that SO experiences during the crime commission; in order to examine the thematic split of the SSA of the

schizophrenic offenders' emotional experience. It is of vital improtance to remember that even thought the SSA indicates the emotions SOs were experiencing during crime commission can be classified in four distinct themes, it does not classify the offenders. An SO may score high on an item/emotion from more than just one SSA theme, although because these themes have been differentiated, it would be expected that the majority of items/emotions which SO will score high would fall under one specific theme. For that reason, it was necessary to examine whether the classification of an individual case as belonging to one of the four themes is possible.

Every case was given a percentage score for each of the four themes, reflecting the proportion of Distress, Depression, Elation and Calm emotional experiences. Percentages were used rather than actual numbers of the sum score of each theme because the total number of item/emotions in each theme was different (Distress=7, Depression=8, Elation=6 and Calm=5). The percent of cases having a higher percent of occurrence in one theme was the criterion used for assigning a case to a specific theme. For example in case 16, 100% of the variables occurred in the Distress emotion theme, 60% in the Elation, 37,5% in the Depression and 28% in the Calm emotion theme, thus this SO could be classified into the Distress theme.

At this point it is essential to note that there is a case that a SO may has the same proportion of variables between two or more themes. In this case it would be said that there is a hybrid of different themes, and the SO cannot be classified to one particular emotion theme (Ioannou, 2006).

Using that criterion, almost all of the cases, 96,8% (n=62), could be classified under a particular type. In more detail, the most frequent type was Distress where 26 cases (40.6%) classified into this type. This is followed by Depression where 19 cases (29.7%) classified into, the Elation where 9 cases (14.1%) fall into and last is the

Calm where only 8 cases (12.5%) fall into this type of emotional experience. The rest 3.1% (n=2) of the overall sample of the 64 SO could be classified as a hybrid of emotional experience as these SOs exhibit equal numbers of variables to two themes. The one (case 3) is a Hybrid of Elation-Calm (1,6%) and appears 100% of the variables occurring in both positive emotions. The other one (case 44) is a Hybrid of Distress-Depression (1.6%) who appears 60% of the variables occurring in both negative emotions.

Case № 3 Hybrid Elation –Calm.

He is a 64 years old man who was born and raised in Germany by Greek parents. As child he was living with both parents and he had graduate a music academy and he was working as a piano teacher. He had been married in the past but at the present time he referred his marital status as divorced. At his 61he did an unnecessary use of an alarm at the Athens International Airport with intent to not lose his flight. He immediately got arrested and the police officers found out that he also had in his possession some artworks. During the interrogation he admitted that he had took the artworks from the home he was renting to someone else. He accused with burglary though he didn't perceive that as an offence because he told that the home was his and everything in it is his belonging. At the psychiatric evaluation that followed he diagnosed with schizophrenia with main symptoms delusions, logorrhea, lack of empathy and psychomotor tense. During the offence he felt positive emotions of high and low arousal. In more detail he felt high intensity positive emotions like exhilaration, confidence, delight, courage and content. At the same time he felt low arousal positive emotions like please, calm, safety, enthusiasm and relaxation. Maybe the feeling of positive emotions can be explained by the fact he does not regard himself guilty for no offence.

Case № 44 Hybrid Distress-Depression.

She is a 51 year old woman from Thessaloniki. As child she was living with both parents and her five siblings. He has a secondary education and she didn't work as she stayed home to look after her three children. She diagnosed with schizophrenia at the very young age of 12 years. She had paranoid delusions and suicidal and homicidal ideation. Also two of her siblings had also schizophrenia. Never mind her disorder she had never caused any problem till the age of 28 when she tried to kill her 10 month old son by giving him to drink hydrochloric acid. She got accused with attempted homicide and during the interrogation she said that she wanted to save her child from schizophrenia and later on she added that she wanted to kill him because he looked like his father. At the psychiatric evaluation she admitted she had auditory hallucinations "God and Jesus talk to me and guide me", and she also had delusion of persecution "They had put spells on me". Additionally she thought that her children suffer from schizophrenia because they cough. During the offence she felt negative emotions of high and low arousal. In more detail she felt high intensity negative emotions upset, annoy, anger, confusion and irritation. At the same time she felt low arousal negative emotions like loneliness, scare, sadness and she was also felt thoughtful and unhappy.

9.2.3 The Results of the SSA Analysis on Emotions and Roles

The fifth objective of the study was to determine whether the overall structure of the roles and emotions schizophrenic offenders experience during crime commission could be possibly be differentiated in different Criminal Narrative Experience themes as previous studies in the field of Criminal Narrative Experience have indicate. Therefore, an SSA was carried out on the responses of the 64 SOs

responded to the 33-item Criminal Narrative Role Questionnaire and the 26-item Emotions Felt During a Criminal Offence Questionnaire.

The 3-dimensional (axis 1 versus axis 3) SSA solution resulted from the analysis has a Guttman – Lingoes coefficient of alienation 0.19235 in 18 iterations, showing an adequate fit between the Pearson's coefficients of the role variables and their corresponding geometric distances in the configuration. Each point in the SSA plot (see Figure 9) is either a role or an emotion statement which participants saw themselves experience during the crime commission. The labels are brief summaries of the full questions; full descriptions of these labels are presented in Table 13.

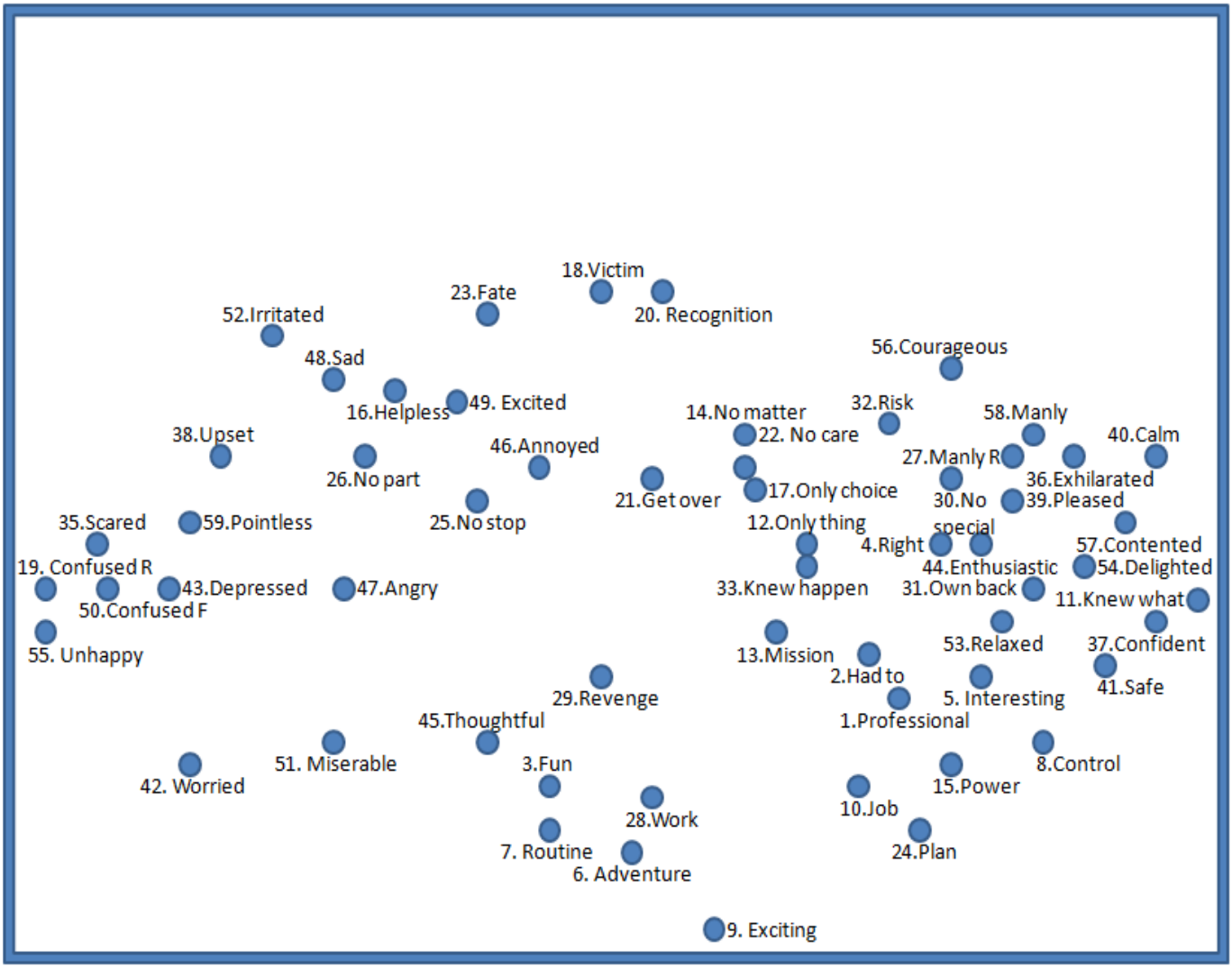

Figure 9: 1 by 3 Projection of the Three -Dimensional Smallest Space Analysis (SSA) of Emotions and Roles.

Coefficient of alienation: 0.19235

Table 13: The Emotions and Roles and Analysis Labels

Question Number	Full Question	Analysis label
1	I was like a professional	professional
2	I had to do it	had to
3	It was fun	fun
4	It was right	right
5	It was interesting	interesting
6	It was like an adventure	adventure
7	It was routine	routine
8	I was in control	control
9	It was exciting	exciting
10	I was doing a job	job
11	I knew what I was doing	knew what
12	It was the only thing to do	only thing
13	It was a mission	mission
14	Nothing else mattered	no matter
15	I had power	power
16	I was helpless	helpless
17	It was my only choice	only choice
18	I was a victim	victim
19	I was confused about what was happening	confused R
20	I was looking for recognition	recognition
21	I just wanted to get it over with	get over
22	I didn't care what would happen	no care
23	What was happening was just fate	fate
24	It all went to plan	plan
25	I couldn't stop myself	no stop
26	It was like I wasn't part of it	no part
27	It was a manly thing to do	manly R
28	For me it was just like a usual days work	work
29	I was trying to get revenge	revenge
30	There was nothing special about what happened	no special
31	I was getting my own back	own back
32	I knew I was taking a risk	risk
33	I guess I always knew it was going to happen	knew happen
34	I felt lonely	lonely
35	I felt scared	scared
36	I felt exhilarated	exhilarated
37	I felt confident	confident

38	I felt upset	upset
39	I felt pleased	pleased
40	I felt calm	calm
41	I felt safe	safe
42	I felt worried	worried
43	I felt depressed	depressed
44	I felt enthusiastic	enthusiastic
45	I felt thoughtful	thoughtful
46	I felt annoyed	annoyed
47	I felt angry	angry
48	I felt sad	sad
49	I felt excited	excited
50	I felt confused	confused E
51	I felt miserable	miserable
52	I felt irritated	irritated
53	I felt relaxed	relaxed
54	I felt delighted	delighted
55	I felt unhappy	unhappy
56	I felt courageous	courageous
57	I felt content	content
58	I felt manly	manly E
59	I felt pointless	pointless

9.2.3.1 Themes of Criminal Narrative Experience.

A careful study of the resulting configuration and the identification of whether or not the roles and emotions could form distinct themes were used as an approach to interpret the SSA. Before looking for identifiable regions within the SSA configuration, it is interesting to note that as it can be seen by a careful examination of the plot, the regional structure of both the roles and emotions have changed compared to the two previous SSA configurations (see page155 for the roles SSA and page 168 for the emotions SSA). Thorough examination of the graphic representation of points indicated that it would be possible to differentiate some themes of roles and emotions. Specifically, three dominant themes of Criminal Narrative Experience were evident.

These regions were labeled: Displeased Victim, Contradicted Revenger and Pleased Hero; as illustrated in Figure 10.

A scale reliability analysis, using Cronbach's alpha, was conducted for the items within each one of the identified three themes, with an intention of giving an indication of the adequacy of the split. The analyses confirmed that all scales had moderate to high internal consistency: Displeased Victim, α =0.79, Contradicted Revenger, α = 0.66 and Pleased Hero, α = 0.91.

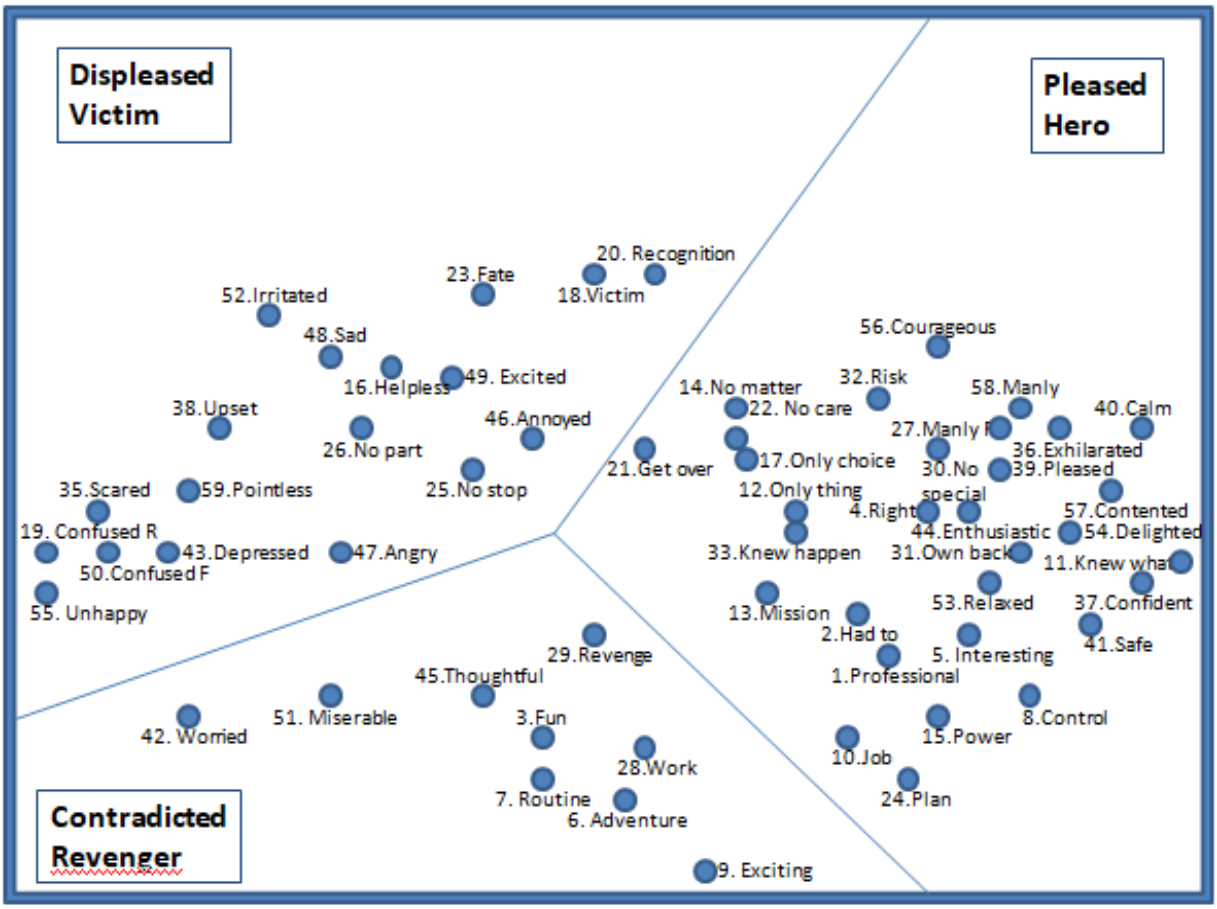

Figure 10: 1 by 3 Projection of the Three -Dimensional Smallest Space Analysis (SSA) of Emotions and Roles with Regional Interpretation.

Displeased Victim.

There are eighteen elements that can be conceptually linked with the Depressed Victim CNE are:

- 16. Helpless
- 18.Victim
- 19. Confused R
- 20. Recognition
- 23. Fate
- 25. No Stop
- 26. No part
- 35. Scared
- 38. Upset
- 43. Depressed
- 46.Annoyed
- 47. Angry
- 48. Sad
- 49. Excited
- 50. Confused F
- 52. Irritated
- 55. Unhappy
- 59. Pointless

The general framework of the Displeased Victim criminal experience indicates an offender who feels a sense of helplessness and confusion, believing that he is the victim of the situation. He believes that everything happens because of fate and other external factors that are beyond his control; for that reason he does not regard himself responsible for and part of his crime. Even though, during crime commission he can not stop his act because his ultimate goal is to gain recognition for his achievement. Regarding his feelings he has negative feelings, both in low (depressed, sad, unhappy, pointless) and high arousal (upset, annoyed, irritated, confused) while he is committing his crimes. These negative emotions can be regarded as triggers for the implication of this person with the criminal behavior.

Case № 6.

She is a 44 years old woman who was born in Albania and since the age of 24 she lives in Greece. She grew up with both parents and her 6 siblings. She has

graduate high school and she got divorced after the offence. At the age of 35 she drowned in the bathtub of their home her two children aged seven and eleven. After the incident she left on foot and felt in from of a car with intention to commit suicide. She got arrested and during the interrogation she couldn't remember anything about the crime she had committed. A psychiatric evaluation was ordered and she was diagnosed with schizophrenia of paranoid type. She had flat affect, anxiety, disturbed thinking, unreasonable laugh and visual hallucinations *"I see children's letters on the walls"*. She described that during the crime she was a helpless victim, conquered by confusion that she couldn't stop herself. She felt negative emotion of low arousal like depression, scare, sadness, unhappiness and pointless; and negative emotions of high arousal like upset, anger and irritation.

Contradicted Revenger.

There are nine elements that can be conceptually linked with the Contradicted Revenger CNE are:

- 3. Fun
- 6. Adventure
- 7. Routine
- 9. Exciting
- 28. Work
- 29. Revenge
- 42. Worried
- 45. Thoughtful
- 51. Miserable

This type of offender perceives the criminal experience as a funny and exciting adventure. He regards crime commission as routine and a work that must be done in order to get revenge from those who he believed has wronged him. This feeling of vengeance is probably the motive of crime. Regarding his emotions he has negative feelings of high arousal (worried) and low arousal (thoughtful and miserable). The contrast this offender experience in regards the roles (fun & exciting) with the emotions (worried & miserable) indicates a very complicated and contradicting situation.

Case № 59.

He is a 55 years old single man from north Greece. As a child he lived with both parents and his two siblings. He has graduate secondary school and he worked as a painter. At the age of 34 he stole a car and he got arrested. During the interrogation, regarding the incident he said that he saw the keys in the engine and he surrendered in his temptation. Though, he believed that he had been arrested because his neighbors initiated legal proceedings because he feeds the neighbor's stray dogs. After the psychiatric evaluation he was diagnosed with schizophrenia with an inclination to aggression. He also admitted that at the age of 23 and for a couple of years he abused alcohol due to his mother's death. He described the offence as something exciting and fun and perceived it as an adventure and as a routine day at work. He also described the offence as a revenge he had to take. During the offence he felt very worried and thoughtful and a little miserable.

Pleased Hero.

There are thirty one elements that can be conceptually linked with the Pleased Hero CNE are:

- 1. Professional
- 2. Had to

- 4. Right
- 5. Interesting
- 8. Control
- 10. Job
- 11.Knew what
- 12. Only thing
- 13. Mission
- 14. No matter
- 15. Power
- 17. Only choice
- 21. Get over
- 22. No care
- 24. Plan
- 27. Manly R
- 30. No special
- 31. Own back
- 32. Risk
- 33. Knew happen
- 36. Exhilarated
- 37. Confident
- 39. Pleased
- 40. Calm
- 41. Safe
- 44. Enthusiastic
- 53. Relaxed
- 54. Delighted
- 56. Courageous
- 57. Contented
- 58. Manly

Pleased Hero is the kind of offender who regards himself as an expert (professional) when committing his offence referring to his cruel behaviour as a job. He believes he is simple carrying out a task (no special); which is the only choice he has and the only thing he could possibly do. According to him nothing else mattered, as he always knew what will happen, and he develops a risky behavior and acts in a manly way in order to protect his own back. He believes the offence is the right thing to do and has planned it all along, which make him feel like having the ultimate power over the situation. Regarding his emotions he experience positive emotion to the full extend from high arousal (exhilarated, manly, confident, delighted, courageous, contented) to low arousal (safe, calm, relaxed, pleased, enthusiastic);

which implies that he is aware of the criminal behaviour and he get pleasure from it. This pleasure is the driving force which leads this offender to the criminal act.

Case № 55.

He is a 64 years old single man from Thessaloniki. As a child he was living with both parents and his younger brother. He has graduate high school and he was working in a supermarket which was a family business. At the age of 27 he diagnosed with schizophrenia of paranoid type with main symptoms anhedonia, irritability and delusional ideas of persecution and reference. Years later, at the age of 45 he had an argument with a neighbor and he killed him with a knife at the victim's store of electronics. A police officer saw the incident and arrested him immediately. He was accused with homicide and illegal use of weapon. During the psychiatric evaluation he told that the victim stared him threateningly and he believed he was the devil. Also he had auditory hallucinations *"There are voices in my head that talk to me"*.

Surprisingly, this was not the first offence he had committed but the third. The first offence occurred at the age of 27 when he attacked a woman with a knife in an attempt to steal her purse because he had no money and he owed some to others. He stabbed her 9 times in the head and the shoulder; he got arrested and he spent seven years in a psychiatric hospital. The second offence occurred few months after his release from the psychiatric hospital. Close to his brother's store, at the street he attacked a woman with a knife and injured her in the shoulder. He got arrested for the second time; he was accused for attempted homicide and gets hospitalized for eight years. He got released again and three years later he committed the abovementioned crime that led him to the psychiatric hospital for the third and final time.

He described that during the offence he knew that he was talking a risk but he had to do it because that was the only and right thing he could do. He knew what will happen and he didn't consider it as something special. He didn't care about what will happen next and he believed he did a manly thing. During the crime commission he felt exhilarated, confident and courageous. He also stated that he felt safe and he was quite calm and relaxed.

9.2.3.2 **Means of Roles and Emotions Variables per CNE**

The variables that form each one of the three distinct CNE themes are given in the following figure (Figure 11) accompanied by the means and in the table (Table 14) accompanied by the means and the standard deviations for each role and emotion. The mean scores indicate that the degree of CNE experience by the sample covers a wide range of criminal experience and emotional intensity. The highest averages are for the roles of Confused R (3.38), No stop (3.34), Helpless (2.98) and Victim (2.94) and for the emotions upset (3.39), annoyed (3.30), angry (3.20), irritated (3.19) and sad (3.09) all contributing to the Displeased Victim CNE theme.

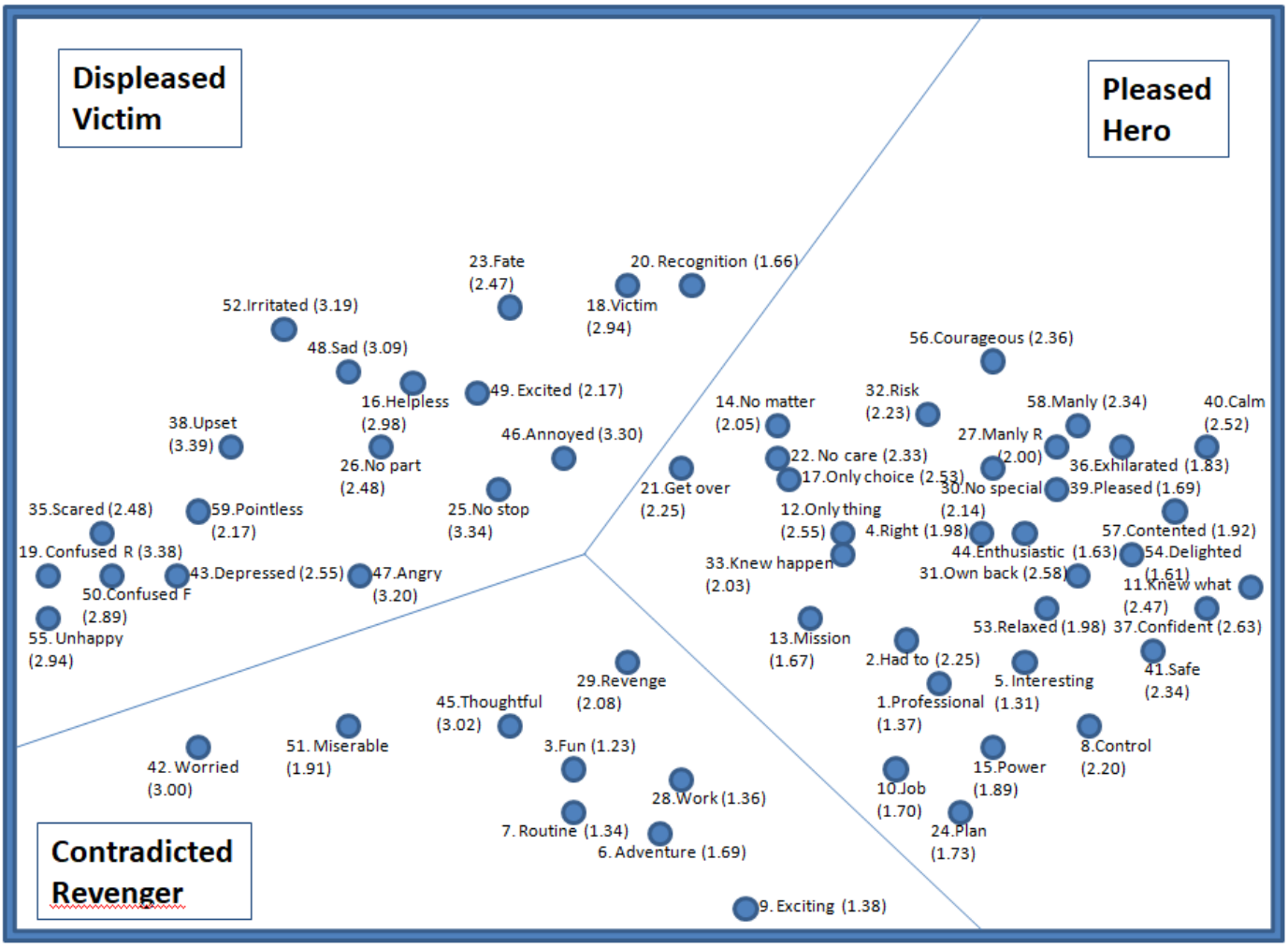

Figure 11: 1 by 3 Projection of the Three -Dimensional Smallest Space Analysis (SSA) of Emotions and Roles with Regional Interpretation and Means

Table 14: Means and Standard Deviations for the three distinct CNE Themes

CNE Themes/variables	Mean (SD)	CNE Themes/variables	Mean (SD)
Displeased Victim		**Pleased Hero**	
16. Helpless	2.98 (1.63)	1. Professional	1.37 (1.00)
18. Victim	2.94 (1.62)	2. Had to	2.25 (1.54)
19. Confused R	3.38 (1.50)	4. Right	1.98 (1.36)
20. Recognition	1.66 (1.18)	5.Interesting	1.31 (0.90)
23. Fate	2.47 (1.53)	8. Control	2.20 (1.60)
25. No stop	3.34 (1.43)	10. Job	1.70 (1.25)
26. No part	2.48 (1.59)	11. Knew what	2.47 (1.65)
35. Scared	2.48 (1.58)	12. Only thing	2.55 (1.63)
38. Upset	3.39 (1.39)	13. Mission	1.67 (1.28)
43. Depressed	2.55 (1.47)	14. No matter	2.05 (1.40)
46. Annoyed	3.30 (1.55)	15. Power	1.89 (1.42)
47. Angry	3.20 (1.64)	17. Only choice	2.53 (1.62)
48. Sad	3.09 (1.54)	21.Get over	2.25 (1.50)
49. Excited	2.17 (1.43)	22. No care	2.33 (1.65)
50. Confused	2.89 (1.53)	27. Manly R	2.00 (1.54)
52. Irritated	3.19 (1.55)	30. No special	2.14 (1.52)
55. Unhappy	2.94 (1.46)	31. Own back	2.58 (1.58)
59. Pointless	2.17 (1.45)	32. Risk	2.23 (1.57)
Contradicted Revenger		33. Knew happen	2.03 (1.49)
3.Fun	1.23 (0.79)	36. Exhilarated	1.83 (1.30)
6. Adventure	1.69 (1.18)	37. Confident	2.63 (1.57)
7. Routine	1.34 (0.96)	39. Pleased	1.69 (1.29)
9. Exciting	1.38 (0.96)	40. Calm	2.52 (1.59)
28. Work	1.36 (0.91)	41. Safe	2.34 (1.47)
29. Revenge	2.08 (1.44)	44. Enthousiastic	1.63 (1.25)
42. Worried	3.00 (1.51)	53. Relaxed	1.98 (1.33)
45. Thoughtful	3.02 (1.52)	54. Delighted	1.61 (1.28)
51. Miserable	1.91 (1.44)	56. Courageous	2.36 (1.49)
		57. Contented	1.92 (1.41)
		58. Manly	2.34 (1.52)

9. 2.3.3 Relationship between CNE themes.

15 below presents the correlations between the three Criminal Narrative Experience themes. As it can be seen the Displeased Victim correlates significantly positive with the Contradicted Revenger with $r=.350$, $p< .01$. This finding is not surprising, because the Contradicted Revenger experience negative emotions of high

and low arousal as the Displeased Victim does. Also, the Pleased Hero appears a non significantly negative correlation with the Displeased Victim with r=-.136, p=.282. This finding is quite surprising as anyone could expect a significant negative correlation between the two CNE themes, as they contain opposite roles and emotions. Finally, the Contradicted Revenger appears a non significant positive correlation with Pleased Hero with r=.206, p=.102. This findings is not that surprising as it can been seen that the role items contained in the Contradicted Revenger are being blended with those of the Pleased Hero in the SSA of Roles, though that is not enough to create a significant correlation.

Table 15: Correlations between Criminal Narrative Experience Themes

	Displeased Victim	Contradicted Revenger	Pleased Hero
Displeased Victim	-	-	-
Contradicted Revenger	.350**	-	-
Pleased Hero	-.136	.206	-

*Correlation is significant at the 0.05 level

**Correlation is significant at the 0.01 level

9.2.3.4 Dominant Criminal Narrative Experience in schizophrenia.

The fifth objective of the study was to find out if schizophrenia is associated with a particular Criminal Narrative Experience. For this purpose the means and standard deviation of the Criminal Narrative Experiences were calculated. The Displeased Victim has a higher overall average in schizophrenia (M=2.81, SD=.71) compared to the other narrative roles. Second comes the Pleased Hero (M=2.06, SD=.75) and last in association with schizophrenia comes the Contradicted Revenger (M=1.88, SD=.63).

9.2.3.5 Assign cases to themes.

Each one of the 64 cases was individually examined to verify if it could be assigned to a specific theme on the bases of the CNE that SO experience during the crime commission; in order to examine the thematic split of the SSA of the schizophrenic offenders' criminal narrative experiences. It is of vital importance to note that even thought the SSA indicates the CNE SO were experiencing during crime commission can be classified in three distinct themes, it does not classify the offenders. An SO may score high on an item/role or emotion from more than just one SSA theme, although because these themes have been differentiated, it would be expected that the majority of items/roles or emotions which SO will score high would fall under one specific theme. For that reason, it was necessary to examine whether the classification of an individual case as belonging to one of the three themes, emerged from the abovementioned analysis, is possible.

Every case was given a percentage score for each of the three themes, reflecting the proportion of Displeased Victim, Contradicted Revenger and Pleased Hero Criminal Narrative Experience. Percentages were used rather than actual numbers of the sum score of each theme because the total number of item/roles in each theme was different (Displeased Victim=18, Contradicted Revenger=9 and Pleased Hero=31). The percent of cases having a higher percent of occurrence in one theme was the criterion used for assigning a case to a specific theme. For example in case 34, 71.1% of the variables occurred in the Displeased Victim CNE theme, 35.6% in the Contradicted Revenger and 25.2% in the Pleased Hero theme, thus this SO could be classified into the Displeased Victim theme.

Using that criterion, all of the cases, 100% (n=64), could be classified under a particular type. In more detail, the most frequent type was Displeased Victim where

46 cases (71.9%) classified into this type. This is followed by Pleased Hero where 13 cases (20.3%) classified into and last is the Contradicted Revenger where only 5 cases (7.8%) fall into this type of narrative role. These findings are not surprising, as the ranking order of the CNEs follows the same order as the roles assignation to cases where Victim came first followed by hero and Revenger.

9.3 The Background to the Criminal Narrative Experience

Katz (1988) supported the idea that no other factors play a significant role to crime than the sensual dynamics; though some years later McCarthy (1995) supported the notion that crime can be affected by various other background characteristics. Therefore, this chapter examines whether different background characteristics play any role in the formation of the criminal narrative experience of the schizophrenic offender as they portrayed in previous analyses. The general background variables examined include gender, age, place of birth, ethnicity, family background, marital status, education and occupation. The psychiatric background variables consider age of 1st diagnosis, relapses and time of last hospitalization. The criminal background include variables like type of crime, age when crime, previous crimes and spending time in prison, type of victim and relationship to it, the presence of eyewitnesses during crime, the effort to conceal crime and the quality of their memories of crime at the present moment. Furthermore, this chapter explores the relationship of the Criminal Narrative Experiences with the variables of depression, suicidal ideation, guilt, external and internal shame.

9.3.1 The Criminal Narrative Experience and General Background

9.3.1.1 Gender and Criminal Narrative Experience.

Table 16 shows the differences between gender and the CNE types as they formed from the SSA analysis above. The independent samples t-test analysis revealed no significant differences between gender and any type of CNE. For Displeased Victim $t_{(62)}$= -.357, p=.722, for Contradicted Revenger $t_{(62)}$=.601, p=.550 and for Pleased Hero $t_{(62)}$=1.171, p=.246. For males the highest average is in the

Displeased Victim and follows the Pleased Hero themes and for females stand exactly the same results.

Table 16: Differences in gender and CNE types

	Males (n=54)		Females (n=10)			
	Mean	SD	Mean	SD	$t_{(62)}$	p value
Displeased Victim	2.79	.69	2.88	.86	-.357	.722
Contradicted Revenger	1.90	.67	1.76	.42	.601	.550
Pleased Hero	2.11	.78	1.81	.51	1.171	.246

9.3.1.2 Age and Criminal Narrative Experience.

Table 17 shows the relationship between age and CNE types. The analysis revealed that there is no significant negative correlation of age with the Displeased Victim with r= -.200, p= .114. The age also has a non significant positive correlation with the Contradicted Revenger with r=.042, p=.741. Last, the analysis indicated that there is a significant positive correlation of age with the Pleased Hero type with r=.395, p<.01; that means that schizophrenic offenders that described themselves as Pleased Hero are the oldest offenders.

Table 17: Relationship between age and CNE types.

	Age
Displeased Victim	-.200
Contradicted Revenger	.042
Pleased Hero	.395**

** Correlation is significant at the .01 level

9.3.1.3 Place of birth and Criminal Narrative Experience.

Table 18 shows the differences between urban and rural place of birth and the CNE types. The independent samples t-test analysis revealed no significant

differences between place of birth and any type of CNE. For Displeased Victim $t_{(62)}$= -1.244, p=.218, for Contradicted Revenger $t_{(62)}$=-1.147, p=.256 and for Pleased Hero $t_{(62)}$=-1.556, p=.125. For those born in urban areas the highest average is in the Displeased Victim and follows the Pleased Hero theme. For those born in rural areas stand exactly the same results. These results indicate that the place of birth plays no significant role in the criminal narrative experience the SO develops for the crime.

Table 18: Differences in place of birth and CNE types

	Urban (n=23)		Rural (n=41)			
	Mean	SD	Mean	SD	$t_{(62)}$	p value
Displeased Victim	2.66	.64	2.89	.74	-1.244	.218
Contradicted Revenger	1.75	.43	1.94	.72	-1.147	.256
Pleased Hero	1.87	.54	2.17	.83	-1.556	.125

A further and more detailed analysis regarding the differences of place of birth and the CNE conducted (Table 19). The analysis of variance revealed that there is a significant difference in Displeased Victim type of SO among the places of birth with $F_{(7,56)}$ =3.204, p<.01. The analysis also revealed that there is no significant difference in Contradicted Revenger among the places of birth with $F_{(7,56)}$ =1.018, p=.429 and last there is a significant difference in Pleased Hero among the places of birth with $F_{(7,56)}$ =3.571, p<.01. For those born in Athens, North Greece-Thessaloniki, South Greece, Greek Islands Albania Australia and Armenia the highest average is in the Displeased Victim. For the one participant who was born in Germany the highest average is in the Pleased Hero.

Table 19: ANOVA for places of birth and CNE types

		Displeased Victim		Contradicted Revenger		Pleased Hero	
	N	Mean	SD	Mean	SD	Mean	SD
Athens	13	2.58	.54	1.73	.35	2.01	.46
Norh Greece -Thessaloniki	35	2.96	.67	2.00	.72	2.02	.74
South Greece	3	2.71	.69	2.33	1.09	2.58	.51
Greek Islands	7	2.10	.63	1.60	.28	2.05	.65
Germany	1	2.11	-	1.00	-	5.00	-
Albania	3	3.66	.53	1.70	.42	1.55	.13
Australia	1	3.61	-	1.66	-	1.87	-
Armenia	1	3.55	-	1.77	-	1.25	-
Total	64	2.81	.71	1.88	.63	2.06	.75
F (p)		3.204 (.006)		1.018 (.429)		3.571 (.003)	

9.3.1.4 Ethnicity and Criminal Narrative Experience.

Table 20 below shows the differences in the Criminal Narrative Experiences across different ethnicities. The analysis of variance revealed there are no significant differences in Displeased Vitim among the ethnicities with $F_{(4,59)}$= 2.122, p=.089. Also there are no significant differences in Contradicted Revenger among the ethnicities with $F_{(4,59)}$= .589, p=.672. Thought, the analysis of variance revealed significant differences in Pleased Hero among the ethnicities with $F_{(4,59)}$=5.846, p<.01. Those with ethnicity Greek, Albanian, Greek-Australian and Armenian ethnicity have the highest average in Displeased Victim. Contrary the one person who has ethnicity Greek-German appears the highest average in Pleased Hero.

Table 20: Differences in ethnicity and CNE types

		Displeased Victim		Contradicted Revenger		Pleased Hero	
	N	Mean	SD	Mean	SD	Mean	SD
Greek	58	2.75	.69	1.91	.65	2.05	.66
Albanian	3	3.66	.53	1.70	.42	1.55	.13
Greek-German	1	2.11	-	1.00	-	5.00	-
Greek-Australian	1	3.61	-	1.66	-	1.87	-
Armenian	1	3.55	-	1.77	-	1.25	-
Total	64	2.81	.71	1.88	.63	2.06	.75
F (p)		2.122 (.089)		.589 (.672)		5.846 (.001)	

9.3.1.5 Family background and Criminal Narrative Experience.

Table 21 below shows the differences in the Criminal Narrative Experiences among different family backgrounds. The family background is based on the reporting of the SO as with whom they lived with as children. The analysis of variance showed that there are no significant differences in Displeased Victim among the family backgrounds with $F_{(5,58)} = .430$, p=.826. Also there are no significant differences in Contradicted Revenger among the family backgrounds with $F_{(5,58)} =.293$, p=.915 and last there are no significant differences in Pleased Hero among the family backgrounds with $F_{(5,58)} =.505$, p=.771. All the participants no matter the differences in with whom they lived as children have a highest average in Displeased Victim.

Table 21: Differences in family background and CNE types

		Displeased Victim		Contradicted Revenger		Pleased Hero	
	N	Mean	SD	Mean	SD	Mean	SD
Mum and Dad	49	2.79	.74	1.92	.70	2.09	.80
One parent	8	2.75	.77	1.71	.30	2.09	.46
Dad and step-mum	1	2.50	-	1.55	-	2.06	-
Adopted parents	1	3.72	-	2.22	-	1.00	-
Children's or Community home	1	2.83	-	1.66	-	1.51	-
Other relatives	4	3.02		1.77		2.09	
Total	64	2.81	.71	1.88	.639	2.06	.75
F (p)		.430 (.826)		.293 (.915)		.505 (.771)	

9.3.1.6 Marital status and Criminal Narrative Experience.

Table 22 below shows the differences in CNE among different marital status'. The analysis of variance revealed no significant differences in Displeased Victim among the marital statuses with $F_{(4,59)} = .904$, p=.468. Also there are no significant differences in Contradicted Revenger among the marital statuses with $F_{(4,59)} =.179$, p=.948 and last there are no significant differences in Pleased Hero among the marital statuses with $F_{(4,59)} =.157$, p=.959. All the participants no matter the differences in their marital status have the highest average in Displeased Victim. This analysis revealed that the marital status of the SO does not play any particular role in the Criminal Narrative Experience he/she develops for the crime.

Table 22: Differences in marital status and CNE types

		Displeased Victim		Contradicted Revenger		Pleased Hero	
	N	Mean	SD	Mean	SD	Mean	SD
Single	46	2.79	.72	1.92	.70	2.06	.67
Married	5	2.76	.35	1.79	.49	1.89	.73
Divorced	9	2.67	.85	1.77	.52	2.20	1.18
Separated	2	3.69	.35	1.88	.00	1.91	.34
Widow	2	3.05	.15	1.66	.00	1.99	1.13
Total	64	2.81	.71	1.88	.63	2.06	.75
F (p)		.904 (.468)		.179 (.948)		.157 (.959)	

9.3.1.7 Education and Criminal Narrative Experience.

Table 23 below illustrates the differences in CNE among different education levels. The analysis of variance revealed no significant differences in Displeased Victim and education with $F_{(5,58)} = .600$, p=.700. Also there are no significant differences in Contradicted Revenger among the education levels with $F_{(5,58)} =1.378$, p=.246 and last there are no significant differences in Pleased Hero among the education levels with $F_{(5,58)} =1.004$, p=.424. All of the education levels reveal the highest average is in the Displeased Victim. This analysis though revealed that the educational of the SO does not affect the Criminal Narrative Experience the SO develops for the crime.

Table 23: Differences in educational level and CNE types

		Displeased Victim		Contradicted Revenger		Pleased Hero	
	N	Mean	SD	Mean	SD	Mean	SD
Uneducated	4	2.53	.28	2.13	.77	2.38	.52
Primary school	18	2.83	.64	2.15	.89	2.22	.79
Secondary school	14	3.07	.41	1.74	.42	1.85	.64
High school	16	2.70	.87	1.65	.36	1.88	.62
TEI/University	8	2.73	.92	1.84	.60	2.35	1.13
Other	4	2.65	1.12	1.85	.63	1.87	.55
Total	64	2.81	.71	1.88	.63	2.06	.75
F (p)		.600 (.700)		1.378 (.246)		1.004 (.424)	

9.3.1.8 Occupation and Criminal Narrative Experience.

Table 24 below illustrates the differences in CNE among different occupations. The analysis of variance revealed no significant differences in Displeased Victim among the different occupations with $F_{(4,59)} = .942$, p=.446. Also there are no significant differences in Contradicted Revenger among the different occupation with $F_{(4,59)} = .643$, p=.634 and last there are no significant differences in Pleased Hero and occupation with $F_{(4,59)} = 2.432$, p=.057. All the different occupation, except freelance, have the highest average is in the Displeased Victim; the freelance has the highest average in Pleased Hero. This analysis revealed that the occupation of the SO previous hospitalization does not play any role in the Criminal Narrative Experience he/she develops for the crime.

Table 24: Differences in marital status and CNE types

		Displeased Victim		Contradicted Revenger		Pleased Hero	
	N	Mean	SD	Mean	SD	Mean	SD
Private employee	9	2.87	.69	1.81	.39	1.79	.61
State employee	1	3.77	-	1.77	-	1.54	-
Unemployed	13	2.94	.86	1.94	.57	2.00	.50
Freelance	4	2.39	.27	1.41	.31	3.07	1.33
Worker-Manual work	37	2.76	.69	1.93	.73	2.05	.72
Total	64	2.81	.71	1.88	.63	2.06	.75
F (p)		.942 (.446)		.643 (.634)		2.432 (.057)	

9.3.2 The Criminal Narrative Experience and Psychiatric Background

9.3.2.1 Age of 1st diagnosis with schizophrenia and Criminal Narrative Experience.

Table 25 shows the relationship between age of 1st diagnosis with schizophrenia and Criminal Narrative Experience. The analysis revealed that there is no significant negative correlation of age of 1st diagnosis with the Displeased Victim with r= -.019, p= .881. The age of 1st diagnosis also has a non significant positive correlation with the Contradicted Revenger with r=.160, p=.207. Last, the analysis indicated that there is a significant positive correlation of age of 1st diagnosis with the Pleased Hero type with r=.419, p<.01; that means that schizophrenic offenders that described themselves as Pleased Hero are the offenders who diagnosed with schizophrenia in an old age, which means that they were untreated and experiencing the symptoms of the disorder for longer time.

Table 25: Relationship between age of 1st diagnosis with schizophrenia and CNE types.

	Age of 1st diagnosis with schizophrenia
Displeased Victim	-.019
Contradicted Revenger	.160
Pleased Hero	.419**

** Correlation is significant at the .01 level

9.3.2.2 Number of hospitalizations and Criminal Narrative Experience.

Table 26 illustrates the relationship between number of hospitalization before crime commission and CNE types. The analysis revealed that there is no significant negative correlation of numbers of hospitalizations with the Displeased Victim with r= -.067, p= .598. The number of hospitalizations also has a non significant negative correlation with the Contradicted Revenger with r=-.093, p=.466. Last, the analysis indicated that there is no significant positive correlation of number of hospitalizations with the Pleased Hero type with r=.019, p=.881. These findings reveal that there is no correlation between number of hospitalization before crime and CNE types and that the number of hospitalizations cannot be a predictor of what CNE the SO will develop.

Table 26: Relationship between number of hospitalization before crime and CNE types.

	Number of Hospitalizations
Displeased Victim	-.067
Contradicted Revenger	-.093
Pleased Hero	.019

** Correlation is significant at the .01 level

9.3.3 The Criminal Narrative Experience and Criminal History

9.3.3.1 Crime against person or property and Criminal Narrative Experience.

Table 27 shows the differences between the crimes against person or property and the CNE types. Offences against person (n=52) include the offences of homicide, attempted homicide, attempted rape, homicide with mutilation, rape and aggravated battery. On the other hand, offences against property (n=12) included arson, public damage and burglary.

The independent samples t-test analysis revealed no significant differences between crime against person or property for Displeased Victim $t_{(62)}$= .872, p=.387, and for Pleased Hero $t_{(62)}$=-.976, p=.333. Though the analysis revealed significant differences between crime against person or property for Contradicted Revenger $t_{(62)}$=-2.012, p=.049. For those who committed crimes against person the highest average is in Displeased Victim and for those who committed crimes against property stand exactly the same result.

Table 27: Differences in crime against person or property and CNE types

	Person (n=52)		Property (n=12)			
	Mean	SD	Mean	SD	$t_{(62)}$	p value
Displeased Victim	2.84	.69	2.64	.80	.872	.387
Contradicted Revenger	1.80	.49	2.20	1.03	-2.012	.049
Pleased Hero	2.02	.68	2.25	1.00	-.976	.333

9.3.3.1.1 *Assigning cases to themes according the categories of crimes.*

After the SSA analyses the 64 cases were assigned to themes by estimating the percentage for each of the three themes, reflecting the proportion of Displeased

Victim, Contradicted Revenger and Pleased Hero Criminal Narrative Experience (for more info see p. 180), an additional analysis is being conducted to further assign these cases according the crimes against person or property.

Table 28 shows how many of the cases under examination who committed a crime against person and against property can be classified to each one of the three emerged themes of Criminal Narrative Experience. By examining the table below it can been seen that the 60.9% (n=39) of the offences against Person are Displeased Victim, 17.2% (n=11) are. Pleased Hero and 3.1% (n=2) are Contradicted Revenger. For Offences against Property 10.9% (n=7) are Displeased Victim, 4.7% (n=3) are Contradicted Revenger and 3.1% (n=2) are Pleased Hero theme.

Table 28: Offences against person or property and their frequency for each CNE type

	Person (N=52)		Property (N=12)		Total	
	Freq.	%	Freq.	%	Freq.	%
Displeased Victim	39	60.9	7	10.9	46	71.9
Contradicted Revenger	2	3.1	3	4.7	5	7.8
Pleased Hero	11	17.2	2	3.1	13	20.3
Total	52	81.2	12	18.7	64	100

9.3.3.2 Types of crimes and Criminal Narrative Experience.

A further and more detailed analysis regarding the different type of crimes and the CNE conducted (Table 29). At this analysis the crimes did not categorized in terms of crime against person or property, but they are referred as the per se crime has been committed.

The analysis of variance revealed no significant differences in Displeased Victim among the different types of crime with $F_{(4.59)} = .942$, p=.446. Also there are no significant differences in Contradicted Revenger among the different type crimes

with $F_{(4,59)}$ =.643, p=.634 and last there are no significant differences in Pleased Hero and type of crimes with $F_{(4,59)}$ =2.432, p=.057. Some of the crime types like homicide, attempted homicide, arson, aggravated battery, homicide with mutilation, rape, attempted rape and public damage have the highest average in Displeased Victim. Contrary burglary has the highest average in the Pleased Hero type of CNE. This analysis revealed that the type of crime the SO has committed does not play any significant role in the Criminal Narrative Experience he/she will develop for the crime.

Table 29: Differences in type of crime and CNE types

		Displeased Victim		Contradicted Revenger		Pleased Hero	
	N	Mean	SD	Mean	SD	Mean	SD
Homicide	28	2.92	.79	1.72	.40	1.81	.61
Attempted homicide	16	2.59	.55	1.91	.62	2.27	.80
Arson	8	2.61	.89	1.99	.73	1.97	.63
Aggravated battery	4	2.96	.52	1.94	.53	2.52	.30
Burglary	3	2.53	.73	2.85	1.77	3.14	1.60
Homicide with mutilation	2	3.27	.00	1.58	.11	1.96	.33
Attempted rape	1	3.61	-	1.66	-	1.87	-
Rape	1	2.72	-	2.55	-	2.54	-
Public damage	1	3.27	-	2.00	-	1.87	-
Total	64	2.81	.71	1.88	.63	2.06	.75
F (p)		.942 (.446)		.643 (.634)		2.432 (.057)	

9.3.3.2.1 *Assigning cases to themes according to type of crimes.*

After the SSA analyses the 64 cases were assigned to themes by estimating the percentage for each of the three themes, reflecting the proportion of Displeased Victim, Contradicted Revenger and Pleased Hero Criminal Narrative Experience, a

further analysis has been conducted to assign these cases to themes according the type of crimes.

Table 30 shows how many of the cases under examination that committed different type of crimes can be classified to each one of the three emerged themes of Criminal Narrative Experience. By examining the table below it can be seen that:

- 43.75% (n=28) of the overall sample have committed homicide. Of those 34.37% (n=22) are Displeased Victim, 7.8% (n=5) are Pleased Hero and 1.56% (n=1) is Contradicted Revenger.
- 25% (n=16) of the overall sample have committed attempted homicide. Of those 15.62% (n=10) are Displeased Victim, 7,8% (n=5) are Pleased Hero and 1.56% (n=1) is Contradicted Revenger.
- 12.5% (n=8) of the overall sample have committed arson. Of those 9.37% (n=6) are Displeased Victim, 1.56% (n=1) is Pleased Hero and 1.56% (n=1) is Contradicted Revenger.
- 6.25% (n=4) of the overall sample have aggravated battery. Of those 4.68% (n=3) are Displeased Victim and 1.56% (n=1) is Pleased Hero.
- 4.68% (n=3) of the overall sample have committed burglary. Of those 3.12% (n=3) are Contradicted Revenger and 1.56% (n=1) is Pleased Hero.
- 3.12% (n=2) of the overall sample have committed homicide with mutilation. All of those are Displeased Victim.
- 1.56% (n=1) of the overall sample has committed attempted rape. This offender sees himself as Displeased Victim.
- 1.56% (n=1) of the overall sample has committed rape. This offender sees himself as Displeased Victim.

- 1.56% (n=1) of the overall sample has committed public damage. This offender sees himself as Displeased Victim.

Table 30: Type of crimes and their frequency for each CNE type

	Displeased Victim		Contradicted Revenger		Pleased Hero		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Homicide	22	34.37	1	1.56	5	7.81	28	43.75
Attempted homicide	10	15.62	1	1.56	5	7.81	16	25
Arson	6	9.37	1	1.56	1	1.56	8	12.5
Aggravated battery	3	4.68	0	0	1	1.56	4	6.25
Burglary	0	0	2	3.12	1	1.56	3	4.68
Homicide with mutilation	2	3.12	0	0	0	0	2	3.12
Attempted rape	1	1.56	0	0	0	0	1	1.56
Rape	1	1.56	0	0	0	0	1	1.56
Public damage	1	1.56	0	0	0	0	1	1.56
Total	46	71.9	5	7.8	13	20.3	64	100

9.3.3.3 Age of the offender when crime commission and Criminal Narrative Experience.

Table 31 shows the relationship between the age of the offender when he committed the crime and CNE types. The analysis revealed that there is no significant negative correlation of age with the Displeased Victim with r= -.200, p= .113. The age also has a non significant negative correlation with the Contradicted Revenger with r=-.031, p=.808. Last, the analysis indicated that there is a significant positive correlation of age of the offender when he committed the crime with the Pleased Hero type with r=.465, p<.01 ; that means that schizophrenic offenders that described themselves as Pleased Hero are the offenders who committed their crimes in an older age.

Table 31: Relationship between age when crime commission and CNE types.

	Age when crime
Displeased Victim	-.200
Contradicted Revenger	-.031
Pleased Hero	.465**

** Correlation is significant at the .01 level

9.3.3.4 Previous Crimes and Criminal Narrative Experience.

Table 32 shows the differences between the existence of previous crimes and the CNE types. The independent samples t-test analysis revealed no significant differences between the existence of previous crimes any type of CNE. For Displeased Victim $t_{(62)}$= -1.534, p=.130, for Contradicted Revenger $t_{(62)}$=-.707, p=.482 and for Pleased Hero $t_{(62)}$=-.383, p=.703. For those who have also committed other crimes previous the one put them into the psychiatric hospital the highest average is in the Displeased Victim. For those who had no previous crimes stand exactly the same results. These results indicate that the existence of previous crimes plays no significant role in the CNE the SO assign to himself while crime commission.

Table 32: Differences in the existence of previous crimes and CNE types

	Yes (n=15)		No (n=49)			
	Mean	SD	Mean	SD	$t_{(62)}$	p value
Displeased Victim	2.56	.61	2.88	.73	-1.534	.130
Contradicted Revenger	1.77	.45	1.91	.68	-.707	.482
Pleased Hero	1.99	.43	2.08	.82	-.383	.703

9.3.3.5 Spending time in prison for the crime committed and Criminal Narrative Experience.

Table 33 illustrates the differences between those who spent time in prison for the crime they committed before court order was made, that orders their transfer to a psychiatric hospital and the CNE types. The independent samples t-test analysis revealed no significant differences between prison and any type of CNE. For Displeased Victim $t_{(62)}$= .957, p=.342, for Contradicted Revenger $t_{(62)}$=-.196, p=.845 and for Pleased Hero $t_{(62)}$=.794, p=.430. For those who have spent time in prison before being transferred in a psychiatric hospital for the crime thy committed the highest average is in the Displeased Victim theme. For those who have never been in prison stand exactly the same results. These results indicate that the possibility of spending time in prison for the crime plays no significant role on how SO develop their CNE.

Table 33: Differences in spending time in prison and CNE types

	Yes (n=54)		No (n=10)			
	Mean	SD	Mean	SD	t (62)	p value
Displeased Victim	2.84	.72	2.61	.66	.957	.342
Contradicted Revenger	1.87	.56	1.91	.97	-.196	.845
Pleased Hero	2.09	.77	1.89	.63	.794	.430

9.3.3.6 Type of Victim and Criminal Narrative Experience.

Table 34 below shows the differences in the Criminal Narrative Experiences across different type of victims they had in the crime they committed. The analysis of variance revealed there are no significant differences in Displeased Vitim among the type of victim with $F_{(11,52)}$= .928, p=.521. Also there are no significant differences in

Contradicted Revenger among the type of victim with $F_{(11,52)}$= .815, p=.625. Last, the analysis of variance revealed no significant differences in Pleased Hero among the type of victims with $F_{(11,52)}$=.695, p=.737. Those who have victims their brother/sister, father/mother, son/daughter, husband/wife, stranger, multiple victims, other family members, neighbor and employ/coworker has the highest in Displeased Victim. Only the one participant who had as victim a friend has the highest average in Pleased Hero. Those who have committed property crimes and have as "victims" their own home or other's property have the highest in Displeased Victim.

Table 34: Differences in type of victim and CNE types

		Displeased Victim		Contradicted Revenger		Pleased Hero	
	N	Mean	SD	Mean	SD	Mean	SD
Brother/sister	5	2.96	.73	1.71	.21	1.75	.44
Father/mother	15	2.82	.75	1.62	.37	1.90	.63
Son/daughter	3	3.27	.65	2.29	.27	1.90	.55
Husband/wife	3	2.55	.54	1.77	.50	1.52	.66
Stranger	4	2.85	.58	1.90	.54	2.01	.35
Multiple Victims	10	2.43	.69	1.81	.33	2.24	.52
Other family members	8	3.22	.64	2.03	.88	2.34	1.02
Employ/coworker	1	3.05	-	1.22	-	1.41	-
Neighbor	2	3.22	.70	1.94	.39	1.95	1.34
Friend	1	2.27	-	1.66	-	2.93	-
Own home	4	2.95	.74	2.32	.86	2.11	.82
Other's property	8	2.49	.83	2.15	1.16	2.32	1.13
Total	64	2.81	.71	1.88	.63	2.06	.75
F (p)		.928 (.521)		.815 (.625)		.695 (.737)	

9.3.3.6.1 *Assigning cases to themes according to type of victim.*

After the SSA analyses the 64 cases were assigned to themes by estimating the percentage for each of the three themes, reflecting the proportion of Displeased

Victim, Contradicted Revenger and Pleased Hero Criminal Narrative Experience, a further analysis has been conducted to assign these cases according to type of victim.

Table 35 shows how many of the cases under examination who have different type of victims can be classified to each one of the three emerged themes of Criminal Narrative Experience. By examining the table below it can be seen that:

- 7.81% (n=5) of the overall sample had as victims their brother/sister. Of those 6.25% (n=4) are Displeased Victims and 1.56% (n=1) is Please Hero.
- 23.43 (n=15) of the overall sample had as victims their father/mother. Of those 17.18% (n=11) are Displeased Victims and 6.25% (n=4) are Please Hero.
- 4.68% (n=3) of the overall sample had as victim son/daughter. All of them 4.68% (n=3) see themselves as Displeased Victims.
- 4.68% (n=3) of the overall sample had as victim husband/wife. Of those who 3.12% (n=2) are Displeased Victims and 1.56% (n=1) are Contradicted Revenger.
- 6.25% (n=4) of the overall sample had as victim stranger, all of them 6.25% (n=4) see themselves as Displeased Victims.
- 15.62% (n=10) of the overall sample had multiple victims. Of those 10.93% (n=7) are Displeased Victims, 3.12 (n=2) are Pleased Hero and 1.56 (n=1) is Contradicted Revenger.
- 12.5% (n=8) of the overall sample had as victims other family members. Of those 9.37% (n=6) are Displeased Victims and 3.12 (n=2) are Pleased Hero.
- The only one who has as victim his employee/coworker 1.56 (n=1) of the overall sample, see himself as Displeased Victims.

- 3.12% (n=2) of the overall sample had as victims neighbors, one of them 1.56% (n=1) see himself as Displeased Victims and the other 1.56% (n=1) see himself as Pleased Hero.
- The only one who has as victim a friend 1.56 (n=1) of the overall sample, see himself as Pleased Hero.
- 6.25% (n=4) of the overall sample has as "victims" their own home. Of those 4.68% (n=3) are Displeased Victims and 1.56% (n=1) is Contradicted Revenger.
- 12.5% (n=8) of the overall sample has as "victims" other's property. Of those half of them 6.25% (n=4) see themselves as Displeased Victims, 3.12% (n=2) are Contradicted Revenger and 3.12% (n=2) are Pleased Hero.

Table 35: Type of victims and their frequency for each CNE type

	Displeased Victim		Contradicted Revenger		Pleased Hero		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Brother/sister	4	6.25	0	0	1	1.56	5	7.81
Father/mother	11	17.18	0	0	4	6.25	15	23.43
Son/daughter	3	4.68	0	0	0	0	3	4.68
Husband/wife	2	3.12	1	1.56	0	0	3	4.68
Stranger	4	6.25	0	0	0	0	4	6.25
Multiple Victims	7	10.93	1	1.56	2	3.12	10	15.62
Other family members	6	9.37	0	0	2	3.12	8	12.5
Employ/coworker	1	1.56	0	0	0	0	1	1.56
Neighbor	1	1.56	0	0	1	1.56	2	3.12
Friend	0	0	0	0	0	0	1	1.56
Own home	3	4.68	1	1.56	0	0	4	6.25
Other's property	4	6.25	2	3.12	2	3.12	8	12.5
Total	46	71.9	5	7.8	13	20.3	64	100

9.3.3.7 Relationship with the victim and Criminal Narrative Experience.

A further and more concise analysis regarding the different type of victims and the CNE conducted. Table 36 below shows the differences in the Criminal Narrative Experiences across different relationships styles the offenders had with the victim of their crime. At this analysis the type of victims categorized in terms of offences against family members (n=32) include victims like brother/sister, Father/mother, son/daughter, husband/wife and five cases of multiple victims; stranger (n=7) include victims like stranger and three cases of multiple victims; acquaintances (n=13) include victims like other family members, employ/coworkers, neighbors and two cases of multiple victims; friend (n=1) and property (n=12) which include "victims" like offender's property or other's property.

The analysis of variance revealed there are no significant differences in Displeased Vitim among the different relationships with the victim with $F_{(4,59)}$= .599, p=.665. Also there are no significant differences in Contradicted Revenger among the different relationships with the victim with $F_{(4,59)}$= 1.171, p=.333. Last, the analysis of variance revealed no significant differences in Pleased Hero among the different relationships with the victim with $F_{(4,59)}$=.865, p=.490. All of the offenders with different relationships with the victim appear the highest average in Displeased Victim, except the one who had a friendly relationship with the victim who has a highest average in Pleased Hero.

Table 36: Differences in relationship with the victim and CNE types

		Displeased Victim		Contradicted Revenger		Pleased Hero	
	N	Mean	SD	Mean	SD	Mean	SD
Family member	31	2.85	.65	1.74	.38	1.92	.62
Stranger	7	2.65	.79	1.89	.46	1.02	.29
Acquaintances	13	2.99	.78	1.90	.72	2.17	.98
Friend	1	2.27	-	1.66	-	2.93	-
Property	12	2.64	.80	2.20	1.03	2.25	1.00
Total	64	2.81	.71	1.88	.63	2.06	.75
F (p)		.599 (.665)		1.171 (.333)		.865 (.490)	

9.3.3.7.1 ***Assigning cases to themes according to relationship with the victim.***

After the SSA analyses the 64 cases were assigned to themes by estimating the percentage for each of the three themes, reflecting the proportion of Displeased Victim, Contradicted Revenger and Pleased Hero Criminal Narrative Experience, a further analysis has been conducted to assign these cases to themes according the relationship the offender has with the victim.

Table 37 shows how many of the cases under examination who have different relationship with the victims can be classified to each one of the three emerged themes of Criminal Narrative Experience. By examining the table below it can be seen that:

- 48.43% (n=31) of the overall sample had as victims family members. Of those 37.5% (n=24) are Displeased Victims 9.37% (n=6) are Please Hero and 1.56% (n=1) is Contradicted Revenger.
- 20.31 (n=13) of the overall sample had as victims acquaintances. Of those 14.06% (n=9) are Displeased Victims and 6.25% (n=4) are Please Hero.

- 10.93% (n=7) of the overall sample had as victims strangers. All of them 9.37% (n=6) are Displeased Victims and 1.56% (n=1) is Contradicted Revenger.
- 1.56% (n=1) of the overall sample had as victim a friend and he sees himself a Pleased Hero.
- 18.75% (n=12) of the overall sample had as "victim" some property. Of those 10.93% (n=7) are Displeased Victims 4.68% (n=3) are Contradicted Revenger and 3.12% (n=2) are Please Hero.

Table 37: Relationship with the victims and the frequency for each CNE type

	Displeased Victim		Contradicted Revenger		Pleased Hero		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Family member	24	37.5	1	1.56	6	9.37	31	48.43
Acquaintances	9	14.06	0	0	4	6.25	13	20.31
Stranger	6	9.37	1	1.56	0	0	7	10.93
Friend	0	0	0	0	1	1.56	1	1.56
Property	7	10.93	3	4.68	2	3.12	12	18.75
Total	46	71.9	5	7.8	13	20.3	64	100

9.3.3.8 Eyewitnesses during crime commission and Criminal Narrative Experience.

Table 38 shows the differences between the presence of an eyewitness and the CNE types. The independent samples t-test analysis revealed no significant differences between the presence of an eyewitness and any type of CNE. For Displeased Victim $t_{(62)}$= .440, p=.662, for Contradicted Revenger $t_{(62)}$=.648, p=.519 and for Pleased Hero $t_{(62)}$=-.349, p=.728. For both of those who had or not an eyewitness present during the crime commission the highest average is in the

Displeased Victim. These results indicate that the presence of an eyewitness at the crime plays no role in the role the SO assign to himself while crime commission.

Table 38: Differences in the presence of eyewitnesses and CNE types

	Yes (n=30)		No (n=34)			
	Mean	SD	Mean	SD	$t_{(62)}$	p value
Displeased Victim	2.85	.69	2.77	.74	.440	.662
Contradicted Revenger	1.93	.73	1.83	.54	.648	.519
Pleased Hero	2.02	.69	2.09	.81	-.349	.728

9.3.3.8.1 *Assigning cases to themes according to the presence on eyewitnesses during crime.*

After the SSA analyses the 64 cases were assigned to themes by estimating the percentage for each of the three themes, reflecting the proportion of Displeased Victim, Contradicted Revenger and Pleased Hero Criminal Narrative Experience, a further analysis has been conducted to assign these cases to themes according the presence of eyewitnesses during the crime.

Table 39 shows how many of the cases under examination who had eyewitnesses or not present during the crime commission can be classified to each one of the three emerged themes of Criminal Narrative Experience. By examining the table below it can be seen that:

- 46.87% (n=30) of the overall sample had had eyewitnesses during the crime commission. Of those 35.93% (n=23) are Displeased Victims, 7.81% (n=5) are Please Hero and 3.12% (n=2) is Contradicted Revenger.
- 53.12% (n=34) of the overall sample had no eyewitnesses during crime commission. Of those 35.93% (n=23) are Displeased Victims, 12.5% (n=8) are Please Hero and 4.68% (n=3) is Contradicted Revenger.

Table 39: Eyewitness and their frequency for each CNE type

	Displeased Victim		Contradicted Revenger		Pleased Hero		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Presence of Eyewitnesses	23	35.93	2	3.12	5	7.81	30	46.87
No eyewitnesses	23	35.93	3	4.68	8	12.5	34	53.12
Total	46	71.9	5	7.8	13	20.3	64	100

9.3.3.9 Crime concealment and Criminal Narrative Experience.

Table 40 shows the differences between those who tried to conceal their crime and not and the CNE types. The independent samples t-test analysis revealed no significant differences between crime concealment and any type of CNE. For Displeased Victim $t_{(62)}$= .841, p=.403, for Contradicted Revenger $t_{(62)}$=.508, p=.613 and for Pleased Hero $t_{(62)}$=.718, p=.476. For both of those who tried to conceal their crime and not the highest average is in the Displeased Victim. These results indicate that the crime concealment plays no part in the role the SO assign to himself while crime commission.

Table 40: Differences between crime concealment and CNE types

	Yes (n=9)		No (n=55)			
	Mean	SD	Mean	SD	$t_{(62)}$	p value
Displeased Victim	2.99	.81	2.77	.70	.841	.403
Contradicted Revenger	1.98	.47	1.86	.66	.508	.613
Pleased Hero	2.23	.74	2.03	.75	.718	.476

9.3.3.9.1 *Assigning cases to themes according to crime concealment.*

After the SSA analyses the 64 cases were assigned to themes by estimating the percentage for each of the three themes, reflecting the proportion of Displeased Victim, Contradicted Revenger and Pleased Hero Criminal Narrative Experience, an additional analysis conducted to assign these cases to themes according the crime concealment.

Table 41 shows how many of the cases under examination who had tried to conceal their crimes or not after the crime commission can be classified to each one of the three emerged themes of Criminal Narrative Experience. By examining the table below it can be seen that:

- 14% (n=9) of the overall sample tried to conceal the crime. Of those 9.4% (n=6) are Displeased Victims and 4.7% (n=3) are Please.
- 86% (n=55) of the overall sample did not tried to conceal the crime. Of those 62.5% (n=40) are Displeased Victims, 15.6% (n=10) are Please Hero and 7.8% (n=5) are Contradicted Revenger.

Table 41: Crime concealment and the frequency for each CNE type

	Displeased Victim		Contradicted Revenger		Pleased Hero		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Crime concealment	6	9.4	0	0	3	4.7	9	14
No crime concealment	40	62.5	5	7.8	10	15.6	55	86
Total	46	71.9	5	7.8	13	20.3	64	100

9.3.3.10 Strength of memories and Criminal Narrative Experience.

Table 42 below shows the differences in the Criminal Narrative Experiences across different strength of memories. The analysis of variance revealed there are no significant differences in Displeased Vitim among strength of memories with $F_{(4,59)}$= 1.103, p=.364. Contrary, there are significant differences in Contradicted Revenger among strength of memories with $F_{(4,59)}$= 3.578, p=.011. Last, the analysis of variance revealed no significant differences in Pleased Hero among strength of memories with $F_{(4,59)}$=1.046, p=.391. All the offenders who appear different strength of memories appear the highest average in Displeased Victim.

Table 42: Differences in strength of memories and CNE types

		Displeased Victim		Contradicted Revenger		Pleased Hero	
	N	Mean	SD	Mean	SD	Mean	SD
Very strong	22	2.27	.67	1.72	.55	2.18	.90
Strong	16	2.76	.68	1.76	.45	1.93	.67
Quite strong	11	2.89	.58	1.76	.40	1.75	.56
Weak	10	2.58	.90	2.11	.73	2.33	.78
Very weak	5	3.37	.82	2.72	1.08	2.11	.31
Total	64	2.81	.71	1.88	.63	2.06	.75
F (p)		1.103 (.364)		3.578 (.011)		1.046 (.391)	

9.3.3.10.1 *Assigning cases to themes according to strength of memories.*

After the SSA analyses the 64 cases were assigned to themes by estimating the percentage for each of the three themes, reflecting the proportion of Displeased Victim, Contradicted Revenger and Pleased Hero Criminal Narrative Experience, a further analysis conducted to assign these cases to themes according the strength of offenders' memories.

Table 43 shows how many of the cases under examination who have different memories' strength can be classified to each one of the three emerged themes of Criminal Narrative Experience. By examining the table below it can be seen that:

- 34.4% (n=22) of the overall sample have very strong memories. Of those 25% (n=16) are Displeased Victims, 7.8% (n=5) are Please Hero and 1.56% (n=1) is Contradicted Revenger.
- 25% (n=16) of the overall sample have strong memories. Of those 18.8% (n=12) are Displeased Victims, 4.7% (n=3) are Please Hero and 1.56% (n=1) is Contradicted Revenger.
- 17.2% (n=11) of the overall sample have quite strong memories. Of those 15.6% (n=10) are Displeased Victims and 1.56% (n=1) is Please Hero.
- 15.6% (n=10) of the overall sample have weak memories. Of those 7.8% (n=5) are Displeased Victims and 6.25% (n=4) are Please Hero and 1.56% (n=1) is Contradicted Revenger.
- 7.8% (n=5) of the overall sample have very weak memories. Of those 4.7% (n=3) are Displeased Victims and 3.12% (n=2) are Contradicted Revenger.

Table 43: Strength of memories and the frequency for each CNE type

	Displeased Victim		Contradicted Revenger		Pleased Hero		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Very strong	16	25	1	1.56	5	7.8	22	34.4
Strong	12	18.8	1	1.56	3	4.7	16	25
Quite strong	10	15.6	0	0	1	1.56	11	17.2
Weak	5	7.8	1	1.56	4	6.25	10	15.6
Very weak	3	4.7	2	3.12	0	0	5	7.8
Total	46	71.9	5	7.8	13	20.3	64	100

9.4 The Criminal Narrative Experience and the Emotional State

9.4.1 Depression and Criminal Narrative Experience.

Table 44 shows the relationship between depression levels and CNE types. The analysis revealed that there is no significant correlation of depression with the Displeased Victim with r= .213, p= .091. The depression though has a significant positive correlation with the Contradicted Revenger with r=.321, p=.01. Last, the analysis indicated that there is no significant positive correlation of age with the Pleased Hero type with r=.151, p=.235; that means that schizophrenic offenders that described themselves as Contradicted Revengers are those who score higher in the depression questionnaire

Table 44: Relationship between depression and CNE types.

	Depression
Displeased Victim	.213
Contradicted Revenger	.321**
Pleased Hero	.151

** Correlation is significant at the .01 level

A further and more detailed analysis conducted regarding depression and CNE types. The scores of depression can also be categorized in terms of levels of severity. For that reason an ANOVA conducted to explore the differences in the Criminal Narrative Experiences across different depression severities (Table 45).

The analysis of variance revealed there are no significant differences in Displeased Victim among depression severities with $F_{(5,58)}$= 2.354, p=.052. The analysis also revealed that there are significant differences in Contradicted Revenger among depression severities with $F_{(5,58)}$= 2.374, p=.050. Last, the analysis of variance revealed no significant differences in Pleased Hero among depression severities with

$F_{(5,58)}$=.427, p=.828. All the offenders who appear different depression severity appear the highest average in Displeased Victim.

Table 45: Differences in depression and CNE types

		Displeased Victim		Contradicted Revenger		Pleased Hero	
	N	Mean	SD	Mean	SD	Mean	SD
Ups and downs that considered normal	19	2.75	.88	1.69	.46	2.19	.87
Mild mood disturbances	8	2.36	.32	1.59	.16	1.98	.60
Borderline clinical depression	9	3.00	.58	1.71	.26	1.89	.85
Moderate depression	15	2.63	.74	2.02	.72	2.19	.73
Severe depression	7	3.43	.38	2.42	1.02	1.91	.49
Extreme depression	6	3.02	.35	2.13	.78	1.87	.78
Total	64	2.81	.71	1.88	.63	2.06	.75
F (p)		2.354 (.052)		2.374 (.050)		.427 (.828)	

9.4.1.1 Assigning cases to themes according to depression severity.

After the SSA analyses the 64 cases were assigned to themes by estimating the percentage for each of the three themes, reflecting the proportion of Displeased Victim, Contradicted Revenger and Pleased Hero Criminal Narrative Experience, a further analysis conducted to assign these cases to themes according to depression severity.

Table 46 shows how many of the cases under examination who have different depression severity can be classified to each one of the three emerged themes of Criminal Narrative Experience. By examining the table below it can be seen that:

- 29.7% (n=19) of the overall sample have ups and downs that considered normal. Of those 20.3% (n=13) are Displeased Victims and 9.4% (n=6) are Please Hero.

- 12.5% (n=8) of the overall sample have mild mood disturbances. Of those 9.4% (n=6) are Displeased Victims and 3.1% (n=2) are Please Hero.
- 14% (n=9) of the overall sample have borderline clinical depression. Of those 9.4% (n=6) are Displeased Victims and 4.7% (n=3) are Please Hero.
- 23.4% (n=15) of the overall sample have moderate depression. Of those 15.6% (n=10) are Displeased Victims and 4.7% (n=3) are Contradicted Revenger, and 3.1 % (n=2) are Please Hero.
- 11 % (n=7) of the overall sample have severe depression. Of those 7.8% (n=6) are Displeased Victims and 1.6% (n=1) is Contradicted Revenger.
- 9.4% (n=6) of the overall sample have extreme depression. Of those 7.8% (n=5) are Depressed Victim and 1.6% (n=1) is Contradicted Revenger.

Table 46: Depression severity and its frequency for each CNE type

	Displeased Victim		Contradicted Revenger		Pleased Hero		Total	
	Freq.	%	Freq.	%	Freq.	%	Freq.	%
Ups and downs that considered normal	13	20.3	0	0	6	9.4	19	29.7
Mild mood disturbances	6	9.4	0	0	2	3.1	8	12.5
Borderline clinical depression	6	9.4	0	0	3	4.7	9	14
Moderate depression	10	15.6	3	4.7	2	3.1	15	23.4
Severe depression	6	9.4	1	1.6	0	0	7	11
Extreme Depression	5	7.8	1	1.6	0	0	6	9.4
Total	46	71.9	5	7.8	13	20.3	64	100

9.4.2 Suicidal ideation and Criminal Narrative Experience.

Table 47 shows the relationship between suicidal ideation (SI) and CNE types. The analysis revealed that there is no significant negative correlation of suicidal ideation with the Displeased Victim with r= .064, p= .615. The suicidal ideation also has a non significant positive correlation with the Contradicted Revenger with r=.192, p=.128. Last, the analysis indicated that there is no significant correlation of suicidal ideation with the Pleased Hero type with r=.070, p=.585.

Table47: Relationship between suicidal ideation and CNE types.

	Suicidal Ideation
Displeased Victim	.064
Contradicted Revenger	.192
Pleased Hero	.070

** Correlation is significant at the .01 level

A further correlation analysis conducted in order to explore the relationship between the suicidal ideation and the depression. Table 48 below illustrates the relationship depression has with the suicidal ideation in schizophrenic offenders. The analysis showed that there is a significant positive correlation of suicidal ideation with the depression with r= .371, p= <.01. That means that the schizophrenic offenders who have higher levels of depression also appear higher levels of suicidal ideation.

Table 48: Relationship between suicidal ideation and depression in schizophrenic offenders

	Suicidal Ideation
Depression	.371**

** Correlation is significant at the .01 level

In more detail Table 49 illustrates the relationship of depression with the suicidal ideation in each CNE type. The analysis revealed that for Displeased Victim

there is a significant positive correlation of depression with suicidal ideation with r=.366, p<.01. Also, for the Contradicted Revenger there is a significant positive correlation of depression with suicidal ideation with r=.332, p<.01. Last, for Pleased hero there is also a significant positive correlation of depression with suicidal ideation with r=.386, p<.01. The results indicate that the higher the levels of depression the higher the levels of suicidal ideation in schizophrenic offenders assigning themselves any type of CNE.

Table 49: Relationship between suicidal ideation and depression in CNE types.

	Depression/Suicidal Ideation
Displeased Victim	.336**
Contradicted Revenger	.332**
Pleased Hero	.386**

** Correlation is significant at the .01 level

9.4.3 Guilt and Criminal Narrative Experience.

Table 50 shows the relationship between guilt and CNE types. In more detail, there where explored the relationship of CNE types with trait guilt, state guilt and moral standards.

9.4.3.1 Trait guilt and CNE types.

The analysis revealed that there is a significant negative correlation of trait guilt with the Displeased Victim with r= -.440, p<.01. The trait guild also has a non significant negative correlation with the Contradicted Revenger with r=-.106, p=.407. Last, the analysis indicated that there is significant positive correlation of trait guilt with the Pleased Hero type with r=.419, p<.01. The results revealed that those who perceive themselves as Displeased Victim have the lowest scores on trait guilt. Contrary, those who assign themselves the Pleased Hero type have the highest scores in trait guild.

9.4.3.2 State guilt and CNE types.

Regarding state guilt the analysis revealed that there is a significant negative correlation with the Displeased Victim with r= -.373, p<.01. The state guild also has a non significant negative correlation with the Contradicted Revenger with r=-.166, p=.189. Last, the analysis revealed that there is significant positive correlation of state guilt with the Pleased Hero type with r=.419, p<.01. These results indicate that those who assign themselves the Displeased Victim type have the lowest scores on state guilt. Contrary, those who perceive themselves as Pleased Hero have the highest scores in state guild.

9.4.3.3 Moral standards and CNE types.

Last, concerning moral standards the analysis revealed that there is no significant correlation with the Displeased Victim with r= .043, p=.736. Moral standards also have a non significant correlation with the Contradicted Revenger with r=.136, p=.284. Last, the analysis revealed that there is no significant correlation between moral standards and the Pleased Hero type with r=.202, p=.110. These results show that moral standards are uncorrelated with the Criminal Narrative Experience.

Table 50: Relationship between trait guilt, state guilt and moral standards with CNE types.

	Trait Guilt	**State Guilt**	**Moral Standards**
Displeased Victim	-440**	-.373**	.043
Contradicted Revenger	-.106	-.166	.136
Pleased Hero	.419**	.497**	.202

** Correlation is significant at the .01 level

9.4.3.4 Relationship of guilt with depression and suicidal ideation

Further analysis conducted to explore relationship of guilt with depression and suicidal ideation. Table 51 shows the relationship of depression and suicidal ideation with the scales of guilt which are trait guilt, state guilt and moral standards. The analysis revealed that trait guilt has a significant negative correlation with depression with r=-.419, p<.01 ; State guilt has a significant negative correlation with depression with r=-.470, p<.01 and last moral standards have a non significant negative correlation with depression with r=-.010, p=.941.

The analysis also revealed that there is a non significant correlation of suicidal ideation with any scale of guilt. In more detail, there is no significant correlation of trait guilt and suicidal ideation with r=-.134, p=209; state guilt has a no significant correlation with suicidal ideation with r=-.151, p=233 and last moral standards do not have a significant correlation with suicidal ideation with r=.037, p=772.

Table 51: Relationship between Guilt with Depression and Suicidal ideation in schizophrenic offenders.

	Trait Guilt	**State Guilt**	**Moral Standards**
Depression	-.419**	-.470**	-.010
Suicidal Ideation	-.134	-.151	.037

** Correlation is significant at the .01 level

9.4.3.5 Relationship of guilt with depression and suicidal ideation for each CNE

Additional analysis conducted to explore these correlations for each CNE type. Table 52 illustrates the relationship of depression with guilt for each CNE type. The analysis revealed that for Displeased Victim there is a significant negative correlation of depression with Trait Guilt with r=-.371, p<.01; a significant negative

correlation of depression with sate guilt with r=-.413, p<.01 and a no significant correlation of depression with Moral Standards with r= -.019, p=.882. For the Contradicted Revenger there is a significant negative correlation of depression with Trait Guilt with r=-.409, p<.01; a significant negative correlation of depression with sate guilt with r=-.447, p<.01 and a no significant correlation of depression with Moral Standards with r= -.057, p=.660. Last, for Pleased Hero there is a significant negative correlation of depression with Trait Guilt with r=-.397, p<.01; a significant negative correlation of depression wit sate guilt with r=-.461, p<.01 and a no significant correlation of depression with Moral Standards with r= .022, p=.867. The results indicate that in all CNE types the higher the depression the lower the trait and state guilt and reverse the lower the depression the higher the trait and state guilt.

Table 52: Relationship between guilt and depression in CNE types.

	Depression/ Trait Guilt	**Depression/ State Guilt**	**Depression/ Moral Standards**
Displeased Victim	-.371**	-.431**	-.019
Contradicted Revenger	-.409**	-.447**	-.057
Pleased Hero	-.397**	-.461**	.022

** Correlation is significant at the .01 level

Table 53 illustrates the relationship of Suicidal Ideation (SI) with guilt for each CNE type. The analysis revealed that for Displeased Victim there is a no significant negative correlation of suicidal ideation with Trait Guilt with r=-.118, p=.356; a no significant negative correlation of suicidal ideation with sate guilt with r=-.137, p=.283 and a no significant correlation of suicidal ideation with Moral Standards with r= .034, p=.790. For Contradicted Revenger there is a no significant negative correlation of suicidal ideation with Trait Guilt with r=-.117, p=.362; a no significant negative correlation of suicidal ideation with sate guilt with r=-.123,

p=.337 and a no significant correlation of suicidal ideation with Moral Standards with r= .011, p=.931. For Pleased Hero, there is a no significant negative correlation of suicidal ideation with Trait Guilt with r=-.180, p=.157; a no significant negative correlation of suicidal ideation with sate guilt with r=-.215, p=.091 and a no significant correlation of suicidal ideation with Moral Standards with r= .023, p=.855. The results indicated that there is no correlation between SI and guilt for any CNE type.

Table 53: Relationship between guilt and suicidal ideation in CNE types.

	SI/ Trait Guilt	**SI/ State Guilt**	**SI/ Moral Standards**
Displeased Victim	-.118	-.137	.034
Contradicted Revenger	-.117	-.123	.011
Pleased Hero	-.180	-.215	.023

** Correlation is significant at the .01 level

9.4.4 External Shame and Criminal Narrative Experience.

Table 54 illustrates the relationship between external shame and CNE types. In more detail, there where explored the relationship of CNE types with inferiority, emptiness, mistakes and the total score of external shame

9.4.4.1 Inferiority and CNE types.

The analysis revealed that there is no significant correlation of inferiority with the Displeased Victim with r= .194, p=.124. The inferiority also has a non significant correlation with the Contradicted Revenger with r=.209, p=.098. Last, the analysis indicated that there is no significant negative correlation of inferiority with the Pleased Hero type with r=.062, p=627.

9.4.4.2 Emptiness and CNE types.

Regarding emptiness the analysis revealed that there is a significant positive correlation with the Displeased Victim with r= .269, p=.032. The emptiness also has a

significant positive correlation with the Contradicted Revenger with r=.295, p=.018. Last, the analysis revealed that there is no significant correlation of emptiness with the Pleased Hero type with r=.158, p=.211. These results indicate that those who assign themselves the Displeased Victim and the Contradicted Revenger have high scores on emptiness.

9.4.4.3 Mistakes and CNE types.

The analysis revealed that there is a significant positive correlation of mistakes with the Displeased Victim with r= .313, p=.012. The mistakes also has a significant positive correlation with the Contradicted Revenger with r=.295, p=.018. Last, the analysis indicated that there is no significant negative correlation of mistakes with the Pleased Hero type with r=-.031, p=.805. The results revealed that those who perceive themselves as Displeased Victim and Contradicted Revenger have high scores on mistakes.

9.4.4.4 Total External Shame and CNE types.

Last, concerning the total score of external shame the analysis revealed that there is significant positive correlation with the Displeased Victim with r= .299, p=.016. External shame also has a significant positive correlation with the Contradicted Revenger with r=.355, p<.01. Last, the analysis revealed that there is no significant correlation between external shame and the Pleased Hero type with r=.015, p=.905. These results indicate that those who perceive themselves as Displeased Victim and Contradicted Revenger have high scores on the scale of external shame.

These overall results of this correlation analysis indicate that those who assign themselves the roles of Displeased Victim and Contradicted Revenger have high levels of emptiness, mistakes and in general external shame. Contrary those who

perceive themselves as Pleased Heroes do not exhibit any sign of external shame in total or in any of its components.

Table 54: Relationship between External Shame and CNE types.

	Inferiority	**Emptiness**	**Mistakes**	**Total External Shame**
Displeased Victim	.194	.269*	.313*	.299*
Contradicted Revenger	.209	.295*	.359**	.355**
Pleased Hero	-.062	.158	-.031	.015

* Correlation is significant at the .05 level

** Correlation is significant at the .01 level

9.4.4.5Relationship of external shame with depression, SI and guilt

Further analysis conducted to explore the relationship of depression, suicidal ideation and guilt with external shame and its scales. Table 55 shows that Inferiority has a significant positive correlation with depression with r=.377, p<.01; a no significant correlation with Suicidal ideation with r=.245, p=.051; a no significant negative correlation with trait guilt with r=-.104, p=.414; a no significant negative correlation with State guilt with r=-.129, p=.311 and last a no significant correlation with moral Standards with r=.145, p=.254.

Emptiness appears a significant positive correlation with depression with r=.377, p<.01; a significant positive correlation with Suicidal ideation with r=.245, p=.034; a no significant negative correlation with trait guilt with r=-.221, p=.079; a no significant negative correlation with State guilt with r=-.139, p=.273 and last a no significant correlation with moral Standards with r=.126, p=.321.

Mistakes have a significant positive correlation with Depression with r=.445, p<.01; a no significant correlation with Suicidal ideation with r=.177, p=.162; a no significant negative correlation with trait guilt with r=-.238, p=.058; a significant

negative correlation with State guilt with r=-.378, p <.01 and last a no significant correlation with moral Standards with r=.058, p=.648.

Last, Total External Shame has a significant positive correlation with depression with r=.463, p<.01; a significant correlation with Suicidal ideation with r=.254, p=.043; a no significant negative correlation with trait guilt with r=-.210, p=.096; a significant negative correlation with State guilt with r=-.248, p=.048 and last a no significant correlation with moral Standards with r=.134, p=.290.

Summarily, depression appears a positive correlation with all the aspects of external shame which means the higher the depression the higher the external shame and its scales. Suicidal ideation appears positive correlation only with Emptiness and Total External Shame, which means the higher the SI the Higher the emptiness and the Total external shame. And state guilt appears negative correlation with Mistakes and Total External Shame, which means the higher the state guilt the lower the Mistakes and the Total External Shame and vice versa.

Table 55: Relationship between external shame and, depression, suicidal ideation and guilt in schizophrenic offenders.

	Inferiority	**Emptiness**	**Mistakes**	**Total External Shame**
Depression	.377**	.377**	.445**	.463**
Suicidal Ideation	.245	.265*	.177	.254*
Trait Guilt	-.104	-.221	-.238	-.210
State Guilt	-.129	-.139	-.378**	-.248*
Moral Standards	.145	.126	.058	.134

* Correlation is significant at the .05 level

** Correlation is significant at the .01 level

As there have been conducted multiple comparisons there is an increased chance of committing a Type I error; which means there are higher chances of

rejecting the null hupothesis when it should not been rejected. In order to avoid such a statistical error a Bonferroni Correction, which is a more conservative test, is being conducted. To get a Bonferroni adjusted *p* value, the original α-value is devided by the number of correlation analysis that have been conducted. More specifically, for the abovementioned correlation the a-value 0.05 is being devided by 20 which is the number of correlation analyses: ($\alpha_{adjasted}$=.05/20) = .002. The Table 56 below is a copy of the table 53 above, but it shows the significant correlation with the adjusted alpha.

Table 56: Relationship between external shame and, depression, suicidal ideation and guilt in schizophrenic offenders with adjusted alpha

	Inferiority	**Emptiness**	**Mistakes**	**Total External Shame**
Depression	.377*	.377*	.445*	.463*
Suicidal Ideation	.245	.265	.177	.254
Trait Guilt	-.104	-.221	-.238	-.210
State Guilt	-.129	-.139	-.378*	-.248
Moral Standards	.145	.126	.058	.134

* Correlation is significant at the .002 level

As it can been seen fewer correlations appeared to be significant after the application of the adjusted alpha. More specifically, inferiority has a significant positive correlation with depression with r=.377, p=.002. Emptiness has a significant positive correlation with depression with r=.377, p=.002. Mistakes has a significant positive correlation with depression with r=.445, p=.000 and a significant negative correlation with state guilt r=-.378, p=.002. And last, total external shame has a significant positive correlation with depression with r=.463, p=.000.

9.4.4.6 Relationship of external shame with depression, SI and guilt for each CNE

Additional analysis (see Table 57) conducted to explore the relationship for each CNE type only in the significant positive and negative correlation revealed

above (Table 55) and not from the significant correlations revelaed in the table 56 with the adjusted alpha because it was extremely strict and some important correlations would be missed out. For Displeased Victim there is a significant positive correlation between depression and inferiority with r=.350, p<.01; there is a significant positive correlation between depression and Emptiness with r=.340, p<.01; there is a significant positive correlation between depression and Mistakes with r=.407, p<.01; there is a significant positive correlation between depression and Total External Shame with r=.429, p<.01; there is a significant positive correlation between suicidal ideation and Emptiness with r=.258, p=.041; there is no significant correlation between suicidal ideation and Total External Shame with r=.247, p=.051; there is a significant negative correlation between State guilt and mistakes with r=-.296, p=.018 and last there is no significant negative correlation between state guilt and total external shame with r=-.154, p=.228.

For Contradicted Revenger there is a significant positive correlation between depression and inferiority with r=.335, p<.01; there is a significant positive correlation between depression and Emptiness with r=.312, p=.013; there is a significant positive correlation between depression and Mistakes with r=.373, p<.01; there is a significant positive correlation between depression and Total External Shame with r=.395, p<.01; there is no significant correlation between suicidal ideation and Emptiness with r=.222, p=.080; there is no significant correlation between suicidal ideation and Total External Shame with r=.203, p=.111; there is a significant negative correlation between State guilt and mistakes with r=-.345, p<.01 and last there is no significant negative correlation between state guilt and total external shame with r=-.205, p=.108.

For Pleased Hero there is a significant positive correlation between depression and inferiority with r=.373, p<.01; there is a significant positive correlation between depression and Emptiness with r=.411, p<.01; there is a significant positive correlation between depression and Mistakes with r=.445, p<.01; there is a significant positive correlation between depression and Total External Shame with r=.471, p<.01; there is a significant positive correlation between suicidal ideation and Emptiness with r=.258, p=.041; there is significant positive correlation between suicidal ideation and Total External Shame with r=.254, p=.045; there is a significant negative correlation between State guilt and mistakes with r=-.417, p<.01 and last there is significant negative correlation between state guilt and total external shame with r=-.294, p=.019.

Table 57: Relationship between significant correlations of depression, suicidal ideation quilt and external shame in CNE types.

	Displeased Victim	Contradicted Revenger	Pleased Hero
Depression/Inferiority	.350**	.335**	.373**
Depression/ Emptiness	.340**	.312*	.411**
Depression/ Mistakes	.407**	.373**	.445**
Depression/ TES	.429**	.395**	.471**
SI/Emptiness	.258*	.222	.258*
SI/TES	.247	.203	.254*
State Guilt/Mistakes	-.296*	-.345**	-.417**
State Guilt/ TES	-.154	-.205	-.294*

* Correlation is significant at the .05 level

** Correlation is significant at the .01 level

9.4.5 Internal shame and Criminal Narrative Experience.

Table 58 illustrates the relationship between external shame and CNE types. In more detail, there where explored the relationship of CNE types with characterological shame, behavioral shame, bodily shame and the total score of internal shame

9.4.5.1 Characterological Shame and CNE types.

The analysis revealed that there is no significant correlation of Characterological Shame (CS) with the Displeased Victim with r=.229, p=.069. The CS also has a no significant correlation with the Contradicted Revenger with r=.174, p=.169. Last, the analysis indicated that there is no significant correlation of CS with the Pleased Hero type with r=.057, p=656.

9.4.5.2 Behavioral Shame and CNE types.

Regarding Behavioral Shame (BeS) the analysis revealed that there is no significant correlation with the Displeased Victim with r=.232, p=.065. The BeS also has no significant correlation with the Contradicted Revenger with r=.022, p=.861. Last, the analysis revealed that there is no significant correlation of BeS with the Pleased Hero type with r=.077, p=.544.

9.4.5.3 Bodily Shame and CNE types.

The analysis revealed that there is no significant correlation of Bodily Shame (BoS) with the Displeased Victim with r= .232, p=.065. The BoS has a significant positive correlation with the Contradicted Revenger with r=.281, p=.025. Last, the analysis indicated that there is no significant negative correlation of mistakes with the Pleased Hero type with r=-.003, p=.978. The results revealed that those who perceive themselves as Contradicted Revenger have high scores on Bodily Shame.

9.4.5.4 Total Internal Shame and CNE types.

Last, concerning the total score of internal shame (TIS) the analysis revealed that there is significant positive correlation with the Displeased Victim with r= .260, p=.038. Internal shame has no significant correlation with the Contradicted Revenger with r=.152, p=231. Last, the analysis revealed that there is no significant correlation between internal shame and the Pleased Hero type with r=.062, p=.624. These results indicate that those who perceive themselves as Displeased Victim have high scores on the scale of internal shame in total.

These overall results of the correlation analysis indicate that those who assign themselves the roles of Displeased Victim have high levels of internal shame and those to perceive themselves as Contradicted Revenger have high levels of bodily shame. Contrary those who perceive themselves as Pleased Heroes do not exhibit any sign of internal shame in total or in any of its components.

Table 58: Relationship between internal shame and CNE types.

	Characterological Shame	**Behavioral Shame**	**Bodily Shame**	**Total Internal Shame**
Displeased Victim	.229	.232	.232	.260*
Contradicted		.022	.281*	.152
Revenger	.174			
Pleased Hero	.057	.077	-.003	.062

* Correlation is significant at the .05 level
** Correlation is significant at the .01 level

9.4.5.5Relationship of internal shame with depression, SI, guilt and external shame

Further analysis conducted to explore the relationship of depression, suicidal ideation, guilt, external shame with internal shame and its scales. Table 59 shows that Characterological Shame has a significant positive correlation with depression with

r=.385, p<.01; has a significant positive correlation with Suicidal Ideation with r=.275, p=.028; has a no significant negative correlation with Trait guilt with r=-.155, p=.222; has a no significant negative correlation with State guilt with r=-.158, p=.212; has a no significant correlation with Moral Standards with r=.148, p=.242; has a significant positive correlation with Inferiority with r=.587, p<.01; has a significant positive correlation with Emptiness with r=.430, p<.01; has a significant positive correlation with Mistakes with r=.553, p<.01 and last has a significant positive correlation with Total External Shame with r=.613, p<.01.

Behavioral shame has a significant positive correlation with depression with r=.294, p=.019; has a no significant correlation with Suicidal Ideation with r=.115, p=.366; has a no significant negative correlation with Trait guilt with r=-.246, p=.050; has a no significant negative correlation with State guilt with r=-.150, p=.217; has a no significant correlation with Moral Standards with r=.035, p=.785; has a significant positive correlation with Inferiority with r=.471, p<.01; has a significant positive correlation with Emptiness with r=.400, p<.01; has a significant positive correlation with Mistakes with r=.544, p<.01 and last has a significant positive correlation with Total External Shame with r=.542, p<.01.

Bodily Shame has a no significant correlation with depression with r=.100, p=.432; has a no significant correlation with Suicidal Ideation with r=.204, p=.105; has a significant negative correlation with Trait guilt with r=-.260, p=.038; has a no significant negative correlation with State guilt with r=-.122, p=.336; has a no significant correlation with Moral Standards with r=.099, p=.438; has a significant positive correlation with Inferiority with r=.385, p<.01; has a significant positive correlation with Emptiness with r=.286, p=.022; has a significant positive correlation

with Mistakes with r=.342, p<.01 and last has a significant positive correlation with Total External Shame with r=.410, p<.01.

Total Internal Shame has a significant positive correlation with depression with r=.342, p<.01; has a no significant correlation with Suicidal Ideation with r=.229, p=.068; has a no significant negative correlation with Trait guilt with r=-.232, p=.065; has a no significant negative correlation with State guilt with r=-.171, p=.177; has a no significant correlation with Moral Standards with r=.110, p=.389; has a significant positive correlation with Inferiority with r=.575, p<.01; has a significant positive correlation with Emptiness with r=.445, p<.01; has a significant positive correlation with Mistakes with r=.580, p<.01 and last has a significant positive correlation with Total External Shame with r=.623, p<.01.

Table 59: Relationship between internal shame and depression, suicidal ideation, guilt and external shame in schizophrenic offenders

	Characterological Shame	**Behavioral Shame**	**Bodily Shame**	**Total Internal Shame**
Depression	.385**	.294*	.100	.342**
Suicidal Ideation	.275*	.115	.204	.229
Trait Guilt	-.155	-.246	-.260*	-.232
State Guilt	-.158	-.156	-.122	-.171
Moral Standards	.148	.035	.099	.110
Inferiority	.587**	.471**	.385**	.575**
Emptiness	.430**	.400**	.286*	.445**
Mistakes	.553**	.544**	.342**	.580**
Total External Shame	.613**	.542**	.410**	.623**

* Correlation is significant at the .05 level

** Correlation is significant at the .01 level

As there have been conducted multiple comparisons there is an increased chance of committing a Type I error; which means there are higher chances of rejecting the null hupothesis when it should not been rejected. In order to avoid such a

statistical error a Bonferroni Correction, which is a more conservative test, is being conducted. To get a Bonferroni adjusted *p* value, the original α-value is devided by the number of correlation analysis that have been conducted. More specifically, for the abovementioned correlation the a-value 0.05 is being devided by 36 which is the number of correlation analyses: ($\alpha_{adjasted}$=.05/36) = .001. The Table 60 below is a copy of the table 59 above, but it shows the significant correlation with the adjusted alpha.

Table 60: Relationship between internal shame and depression, suicidal ideation, guilt and external shame in schizophrenic offenders with adjusted alpha

	Characterological Shame	**Behavioral Shame**	**Bodily Shame**	**Total Internal Shame**
Depression	.385	.294	.100	.342
Suicidal Ideation	.275	.115	.204	.229
Trait Guilt	-.155	-.246	-.260	-.232
State Guilt	-.158	-.156	-.122	-.171
Moral Standards	.148	.035	.099	.110
Inferiority	.587*	.471*	.385	.575*
Emptiness	.430*	.400*	.286	.445*
Mistakes	.553*	.544*	.342	.580*
Total External Shame	.613*	.542*	.410*	.623*

* Correlation is significant at the .001 levelAs it can been seen fewer correlations appeared to be significant after the application of the adjusted alpha. More specifically, characterological shame has a significant positive correlation with Inferiority with r=.587, p=.000; has a significant positive correlation with Emptiness with r=.430, p=.000; has a significant positive correlation with Mistakes with r=.553, p=.000 and last has a significant positive correlation with Total External Shame with r=.613, p=.000.

Behavioural shame has a significant positive correlation with Inferiority with r=.471, p=.000; has a significant positive correlation with Emptiness with r=.400,

p=.001; has a significant positive correlation with Mistakes with r=.544, p=.000 and last has a significant positive correlation with Total External Shame with r=.542, p=.000.

Bodily shame has a significant positive correlation only with Total External Shame with r=.410, p=.001.

And last, total internal shame has a significant positive correlation with Inferiority with r=.575, p=.000; has a significant positive correlation with Emptiness with r=.445, p=.000; has a significant positive correlation with Mistakes with r=.580, p=.000and last has a significant positive correlation with Total External Shame with r=.623, p=.000.

9.4.5.6Relationship of internal shame with depression, SI, guilt and external shame for each CNE

Additional analysis (see Table 61) conducted to explore the relationship for each CNE type only in the significant positive and negative correlations revealed above (Table 59)and not from the significant correlations revelaed in the table 60 with the adjusted alpha because it was extremely strict and some important correlations would be missed out. For Displeased Victim there is a significant positive correlation between Depression and Characterological Shame with r=.354, p<.01; there is a significant positive correlation between Depression and Behavioral Shame with r=.257, p=.042; there is a significant positive correlation between Depression and Total Internal Shame with r=.304, p=.016; there is a significant positive correlation between Suicidal Ideation and Characterological Shame with r=.268, p=.033; there is no significant correlation between Trait Guilt and Bodily Shame with r=-.180, p=.157; there is a significant positive correlation between Inferiority and

Characterological Shame with r=.568, p<.01; there is a significant positive correlation between Inferiority and Behavioral Shame with r=.446, p<.01; there is a significant positive correlation between Inferiority and Bodily Shame with r=.356, p<.01; there is a significant positive correlation between Inferiority and Total Internal Shame with r=.553, p<.01; there is a significant positive correlation between Emptiness and Characterological Shame with r=.393, p<.01; there is a significant positive correlation between Emptiness and Behavioral Shame with r=.360, p<.01; there is no significant correlation between Emptiness and Bodily Shame with r=.239, p=.059; there is a significant positive correlation between Emptiness and Total Internal Shame with r=.403, p<.01; there is a significant positive correlation between Mistakes and Characterological Shame with r=.521, p<.01; there is a significant positive correlation between Mistakes and Behavioral Shame with r=.511, p<.01; there is a significant positive correlation between Mistakes and Bodily Shame with r=.292, p=.020; there is a significant positive correlation between Mistakes and Total Internal Shame with r=.543, p<.01; there is a significant positive correlation between Total External Shame and Characterological Shame with r=.587, p<.01; there is a significant positive correlation between Total External Shame and Behavioral Shame with r=.507, p<.01; there is a significant positive correlation between Total External Shame and Bodily Shame with r=.367, p<.01 and last there is a significant positive correlation between Total External Shame and Total Internal Shame with r=.592, p<.01.

For Contradicted Revenger there is a significant positive correlation between Depression and Characterological Shame with r=.353, p<.01; there is a significant positive correlation between Depression and Behavioral Shame with r=.302, p=.016; there is a significant positive correlation between Depression and Total Internal Shame with r=.313, p=.012; there is a significant positive correlation between

Suicidal Ideation and Characterological Shame with r=.250, p=.048; there is no significant correlation between Trait Guilt and Bodily Shame with r=-.241, p=.057; there is a significant positive correlation between Inferiority and Characterological Shame with r=.572, p<.01; there is a significant positive correlation between Inferiority and Behavioral Shame with r=.477, p<.01; there is a significant positive correlation between Inferiority and Bodily Shame with r=.347, p<.01; there is a significant positive correlation between Inferiority and Total Internal Shame with r=.562, p<.01; there is a significant positive correlation between Emptiness and Characterological Shame with r=.402, p<.01; there is a significant positive correlation between Emptiness and Behavioral Shame with r=.412, p<.01; there is no significant correlation between Emptiness and Bodily Shame with r=.222, p=.080; there is a significant positive correlation between Emptiness and Total Internal Shame with r=.424, p<.01; there is a significant positive correlation between Mistakes and Characterological Shame with r=.534, p<.01; there is a significant positive correlation between Mistakes and Behavioral Shame with r=.575, p<.01; there is a significant positive correlation between Mistakes and Bodily Shame with r=.270, p=.033; there is a significant positive correlation between Mistakes and Total Internal Shame with r=.569, p<.01; there is a significant positive correlation between Total External Shame and Characterological Shame with r=.599, p<.01; there is a significant positive correlation between Total External Shame and Behavioral Shame with r=.572, p<.01; there is a significant positive correlation between Total External Shame and Bodily Shame with r=.346, p<.01 and last there is a significant positive correlation between Total External Shame and Total Internal Shame with r=.616, p<.01.

For Pleased Hero there is a significant positive correlation between Depression and Characterological Shame with r=.399, p<.01; there is a significant positive

correlation between Depression and Behavioral Shame with r=.310, p=.014; there is a significant positive correlation between Depression and Total Internal Shame with r=.356, p<.01; there is a significant positive correlation between Suicidal Ideation and Characterological Shame with r=.273, p=.031; there is a significant negative correlation between Trait Guilt and Bodily Shame with r=-.284, p=.024; there is a significant positive correlation between Inferiority and Characterological Shame with r=.593, p<.01; there is a significant positive correlation between Inferiority and Behavioral Shame with r=.478, p<.01; there is a significant positive correlation between Inferiority and Bodily Shame with r=.385, p<.01; there is a significant positive correlation between Inferiority and Total Internal Shame with r=.581, p<.01; there is a significant positive correlation between Emptiness and Characterological Shame with r=.427 p<.01; there is a significant positive correlation between Emptiness and Behavioral Shame with r=.394, p<.01; there is a significant positive correlation between Emptiness and Bodily Shame with r=.291, p=.021; there is a significant positive correlation between Emptiness and Total Internal Shame with r=.441, p<.01; there is a significant positive correlation between Mistakes and Characterological Shame with r=.556, p<.01; there is a significant positive correlation between Mistakes and Behavioral Shame with r=.549, p<.01; there is a significant positive correlation between Mistakes and Bodily Shame with r=.342, p<.01; there is a significant positive correlation between Mistakes and Total Internal Shame with r=.583, p<.01; there is a significant positive correlation between Total External Shame and Characterological Shame with r=.614, p<.01; there is a significant positive correlation between Total External Shame and Behavioral Shame with r=.543, p<.01; there is a significant positive correlation between Total External Shame and Bodily

Shame with r=.410, p<.01 and last there is a significant positive correlation between Total External Shame and Total Internal Shame with r=.623, p<.01.

Table 61: Relationship between significant correlations of depression, suicidal ideation, guilt, external and internal shame in CNE types.

	Displeased Victim	Contradicted Revenger	Pleased Hero
Depression/ CS	.354**	.353**	.399**
Depression/ BeS	.257*	.302*	.310*
Depression/TIS	.304*	.313*	.356**
SI/CS	.268*	.250*	.273*
Trait Guilt/ BoS	-.180	-.241	-.284*
Inferiority/ CS	.568**	.572**	.593**
Inferiority/ BeS	.446**	.477**	.478**
Inferiority/ BoS	.356**	.347**	.385**
Inferiority/TIS	.553**	.652**	.581**
Emptiness/ CS	.393**	.402**	.427**
Emptiness/BeS	.360**	.412**	.394**
Emptiness/BoS	.239	.222	.291**
Emptiness/TIS	.403**	.424**	.441**
Mistakes/ CS	.521**	.534**	.556**
Mistakes/ BeS	.511**	.575**	.549**
Mistakes/BoS	.292*	.270*	.342**
Mistakes/TIS	.543**	.569**	.583**
TES/ CS	.587**	.599**	.614**
TES/BeS	.509**	.572**	.543**
TES/BoS	.367**	.346**	.410**
TES/TIS	.592**	.616**	.623**

* Correlation is significant at the .05 level

** Correlation is significant at the .01 level

Chapter 10

Discussion

The overall purpose of the study was to gain insight and understanding into the criminal narrative experience of schizophrenic offenders who experienced psychotic symptoms while crime commission and have been found by the court as Non Guilty by Reason of Insanity, through implementation of the Criminal Experience Framework proposed for non mentally disordered offenders; which brings together the narrative roles acted out by offenders and the emotions experienced during the crime commission. Additional to the main purpose is the exploration of whether the demographic characteristics, the psychiatric history, criminal history or emotional state in terms of depression, suicidal ideation and moral emotions of the schizophrenic offender play any particular role of have any particular association with the Criminal Narrative Experience.

10.1 Criminal Narrative Roles of Schizophrenic Offenders

The first objective of the present study was to determine whether the overall structure of roles schizophrenic offenders assign to themselves during crime commission can be differentiated in terms of different role themes as have been reported by previous research. The analysis of the SSA configuration revealed that SOs have assigned to themselves different narrative roles; in particular Victim, Revenger and Hero. These findings are partially similar to previous studies (Canter et al., 2009; Ioannou, 2006; Ioannou et al., 2015; Spruin, 2012; Spruin et al., 2014; Youngs & Canter, 2011; 2012a,b).

The present study though, failed to identify the Professional role in schizophrenic offenders; as previous studies had done in mentally disordered

offenders (Spruin, 2012; Spruin et al., 2014) and in criminal populations (Canter et al., 2009; Ioannou, 2006; Ioannou et al., 2015; Youngs & Canter, 2011; 2012a, b).The core characteristics of the Professional role as described in previous studies on mentally disordered offenders, such as being professional, perceiving the offence as routine, having a sense of bravado (manly) and believing his actions are defined by fates (Spruin, 2012; Spruin et al., 2014); and those described in studies with criminal populations, such as perceiving the offence as adventure and the offender having competency and mastery of the environment (e.g. Canter et al., 2009; Youngs & Canter, 2011), regard the offence as routine and he is engaged in risky behaviours (Canter et al., 2009; Ioannou, 2006; Ioannou et al., 2015; Youngs & Canter, 2011, 2012a, b) are scattered in the three other themes identified in the present study. Furthermore, the role themes differentiate pragmatically with those of previous finding due to the specific nature of schizophrenia mental disorder of the offending population under examination.

Specifically, the Victim role schizophrenic offender regards himself as a victim of the situation. He perceives himself as helpless and as having no responsibility for his crime because he took no part at it. He did not care about what will happen next and the offence was his only choice; which explains why he couldn't stop himself from doing it. The description of this role is extremely similar to the one Spruin (2012) and Spruin et al. (2014) presented for the Victim role in mentally disordered offenders. She suggested that the core characteristic of this role is the feeling of victimization and helplessness. She also propose that these offenders exhibit despair of their crimes as they state that they had "*no other choice"*, "*nothing mattered", "not part",* and "*I couldn't stop myself"*. The Victim role profile also mirrors the one presented by studies for non mentally disordered offenders (Canter et

al., 2009; Ioannou, 2006; Ioannou et al., 2015, 2018; Youngs & Canter, 2011, 2012a, b); which also present victimization and powerless (helplessness) as core characteristics.

Despite the similarities, some differences also exist with other studies. More precisely, the present study failed to find the elements of *nothing special* and *confusion* in the Victim role as previous studies had done (Canter et al., 2009; Ioannou, 2006; Ioannou et al., 2015; Spruin, 2012; Spruin et al. 2014; Youngs & Canter, 2011, 2012a, b); and as Spruin et al. (2014) had identified that lack of understanding (confusions) is a main characteristic of mentally disordered offenders who assign themselves the Victim narrative role.

The Revenger role SO perceives the offence as an adventure which offers him pleasure (fun). He is engaging in risky behaviours in order to get over what has happened to him, gain recognition and take revenge from those who have wrongfully treated him. He believes the offence is an outcome of external factors which are beyond his control (fate) and what happed is beyond his understanding (confusion). The Revenger profile resembles the one previous studies had described for that role (Canter et al., 2009; Ioannou, 2006; Ioannou et al., 2015, 2018; Spruin, 2012; Spruin et al. 2014; Youngs & Canter, 2011, 2012a, b) but there are some distinct differences. For example, the present study did not find that the Revenger role perceives the offence as a usual day at work, does not care or gets engaged in criminal behaviour to get his own back, as the studies in mentally disordered offenders had revealed (Spruin, 2012; Spruin et al., 2014). In the present study the element of *no care* is found in the Victim narrative role; while the other elements are presented in the Hero narrative role.

Additionally, considering the results of studies with criminal population without mental disorder,it could be said that the differences lies within how the offender perceives his role. Contrary to the present study, these studies support the notion that the offender assign to himself the Revenger role believes that the offence is his only option (no choice) and justifies his actions (right thing to do) (Canter et al., 2009; Youngs & Canter, 2012b). Furthermore, he perceives the offence as a mission (Ioannou, 2006; Ioannou et al., 2015, 2018; Youngs & Canter, 2011, 2012a). In the present study, the explanation of offence as only choice is a characteristic of the Victim narrative role, while the rest of the characteristic fall within the Hero narrative role.

The Hero role SO perceives himself as a professional and regards the offence as a usual day at work (job) and nothing special. He believes the offence is an interesting mission to protect his own back as any man could do. He has everything planned and under control and during the act he has the ultimate power. Last, he fully justifies his actions stating that the offence was the only thing he could do. These findings are extremely similar to those provided by other studies in mentally disordered offenders (Spruin, 2012; Spruin et al., 2014) and in non mentally disordered criminal populations (Ioannou, 2006; Ioannou et al., 2015, 2018; Youngs & Canter, 2012b).

Therefore, there are some conceptual differences within the Hero role as revealed in the present study compared to the corresponding one in previous studies. The Hero SO in the present study does not regard the offence as an adventure neither is seeking for recognition as mentally disordered offenders in the studies of Spruin (2012; Spruin et al., 2014) and offenders without mental disorder (Canter et al., 2009; Ioannou, 2006; Ioannou et al., 2015; Youngs & Canter, 2011; 2012b). Last, the Hero

SO has everything planned and under control and does not exhibit risky behaviours as found in Hero role in criminal population studies (Ioannou, 2006; Ioannou et al., 2015).

The second objective of the study was to explore if there is correlation between the narrative roles emerged from the SSA. The results indicate there is a significant positive correlation between all three themes. These findings are not that surprising as it already known that each participant does not simply score high only on the elements of one specific narrative role but also score either high, moderate or low in elements of the other role themes; which make them blend into one another.

The third objective of the study was to determine whether schizophrenia offenders are associated with any particular role. The analysis revealed that the Victim narrative role is the most dominant, followed by Revenger and Hero. The finding of the Victim as dominant role is in accordance with the findings of Spruin (2012, Spruin et al., 2014) in her study in mentally disordered offenders. She supported that individuals suffering from schizophrenia because of the psychotic symptoms often have deluded perception of reality and they are lacking the capacity to completely understand their current environment. The psychotic symptoms patients with schizophrenia experience may lead them to incapacity on social and problem-solving skills, which are a possible explanation of their criminal behaviour (Melamed, 2012). Additionally, these deficits may also cause a schizophrenic offender to not understand many aspects of the offending behaviour; resulting in a lack of control or responsibility for their action (Spruin et al., 2014).

The forth objective of the study was to examine all the SO cases to verify if they could be assigned to a specific theme on the bases of the roles that SO acted out

during the crime commission. In accordance with the analysis which found the Victim role as the most dominant the assignation of cases to roles revealed that the majority of the schizophrenic offenders 68.8% (n=44) assigned to themselves the Victim role; 17.2% (n=11) assigned to themselves the Hero role; 12.5% (n=8) assigned themselves the Revenger role and last 1.6% (n=1) schizophrenic offender was identified as a hybrid as he assigned himself all the three roles revealed from the SSA in equal proportion. That one participant is also a distinct example of the findings revealed in objective two of the study.

10.2 Emotions Felt During Crime by Schizophrenic Offenders

The fifth objective of the study was to determine whether the overall structure of emotions experienced by schizophrenic offenders during crime commission can be differentiated in terms of different emotion themes as they have been emerged in previous studies (Canter & Ioannou, 2004a; Ioannou, 2006; Spruin, 2012; Spruin et al., 2014). The present study's SSA plot for emotions revealed four distinct themes reflecting the Russell's Circumplex of Emotions (1997) model for non-criminal experiences. Additionally, the SSA and particularly the presence of Pleasure-Displeasure axis and Arousal-Sleepiness axis mirror the findings of previous studies within criminal populations (Canter & Ioannou, 2004a; Ioannou, 2006).

The findings of the present study are also partially in accordance with those Spruin (2012, Spruin et al., 2014) reported for mentally disordered offenders. She managed to identify the Pleasure-Displeasure axis that distinguish positive from negative emotions; but she failed to identify the Arousal-Sleepiness axis that distinguish these emotions in terms of intensity. A finding of the present study worth mentioning is that high and low arousal of negative emotions is quite distinct as the

items within each theme (Distress and Depression) of the plot are at distance between each other. Whereas, this distinction is not that clear for the low and high arousal of positive emotions where the items within each theme (Elation and Calm) seem to be quite close to one another.

An interesting, quite notable finding is that the excitement ("*I felt excited*"), fell under the Distress theme and not under the Elation theme as in previous studies. This finding can be interpreted under the notion that both positive and negative emotions make people excited; and particularly for schizophrenic offenders excitement is experiences more frequently when they are feeling annoyed, angry or irritated. Moreover, thoughtfulness ("*I felt thoughtful*") felt under the Depression theme and not under the Calm theme as in previous studies. Thoughtfulness according the SO is perceived as a negative low arousal emotion. Last, another interesting finding is that scare ("*I felt scared*") felt under the Depression theme and not under the Distress theme as in previous studies. The emotion of scare is sill negative for the SOs but it is of low intensity instead of high. These findings could be possible interpreted as outcomes of the negative symptoms of schizophrenia such as emotional blunting and affective flattening, decreased volition, altered perception, anhedonia, apathy that affect the thinking and emotionality of the patient (Garrett, 2009; Lindenmayer & Khan 2006; Pu et al., 2014; Tandon et al., 2009).

The sixth objective of the study was to explore if there is any relationship between the emotions themes emerged from the SSA. The analysis revealed that depression and distress have a significant positive correlation. That can easily be understood considering that these emotional states form the Arousal-Sleepiness axis of negative emotionality. Similarly, the calm and elation emotional themes were significantly positively correlated; and can be interpreted in terms of forming the

Arousal-Sleepiness axis of positive emotionality. Further, there was found negative correlation between the calm and distress emotional themes and between the depression and elation emotional themes. These finding could be easily be interpreting considering that these emotions are not correlated neither in term of arousal nor in terms of pleasure. Last, there was found no correlation between the elation and distress emotional themes and between the calm and depression themes. Form that analysis is evident that despite the fact that these emotions are under the Arousal theme and Sleepiness theme respectively, are not associated as they are differentiated in terms of Pleasure-Displeasure axis.

The seventh objective of the study was to find out whether schizophrenia is associated with particular emotional experiences during crimes. The analysis discovered that Distress is the dominant emotion among schizophrenia offenders. It follows the depression, next elation and last calm emotions. Schizophrenia offenders possibly because of the psychotic symptoms of their disorder and their incapacity to regulate their emotion may experience emotions such worry, annoy, anger, irritation and confusion in a greater extent than all the other negative and positive emotions.

These finding are contradicted to Spruin's (2012) in mentally disordered offenders who had identified depression as dominant emotion. She elaborated on that stating that the paranoid features of schizophrenia are related with the clinical symptoms of depression such as hopelessness, worthlessness and helplessness. Both studies though, found as dominant emotions that fall under the displeasure theme. The experience of negative emotions could possibly be explained by Seligman and Csikszentmihalyi (2014) who suggested that negative emotions and negative experiences caused to the individual may be more urgent and may therefore outweigh positive emotions. That happens because these feelings frequently mirror immediate

problems or objective risks. They are therefore considered strong enough to cause individuals to stop, enhance their alertness, reflect on their behavior, and alter their actions, where appropriate.

The eight objective of the study was to examine all the SO cases to verify if they could be assigned to a specific theme on the bases of emotions that SO experienced during the crime commission. The findings agree with those of the seventh objective. More than 1/3 of the schizophrenia offenders 40.6% (n=26) experience mainly distress during the crime commission; 29.7% (n=19) experienced depression; 14.1% (n=9) experienced elation; 12.5% experiences calm; and two were identified as hybrids. The one (1.6%) experienced at the same intensity elation and calm; these emotions are forming the Arousal-Sleepiness axis of positive emotionality and verify the positive correlation revealed for them in the sixth objective of the study. Likewise, the other hybrid case (1.6%) experiences at the same extend distress and depression. These emotions are forming the Arousal-Sleepiness axis of negative emotionality and support the correlation analysis reported above.

10.3 Criminal Narrative Experience of Schizophrenic Offenders

The ninth objective of the present study was to determine whether the overall structure of narrative roles and emotions experienced during crime commission by schizophrenic offenders can be differentiated in terms of distinct Criminal Narrative Experience themes. The present findings revealed three different themes labeled Displeased Victim, Contradicted Revenger and Pleased Hero. These themes identified are unique to the research of Criminal Narrative Experience and vary from previous findings which revealed four distinct themes of CNE labeled Depressed Victim, Distressed Reveneger, Elated Hero and Calm professional.

Thought, it could be said that the emerged themes are partially correspond conceptually to the findings of previous studies (Goodlad et al., 2018; Ioannou, 2006; Ioannou et al., 2017; Spruin, 2012). Additionally, the present study failed to identify any particular theme for Pleased Professional as previous studies had done (Goodlad et al., 2018; Ioannou, 2006; Ioannou et al., 2017; Spruin, 2012). But that comes in accordance with the failure to identify the Professional role in the Narrative roles described above. The items used in previous studies to describe this theme, fall in their majority under the Pleased Hero experience of the present study.

The Displeased Victim SO described himself as a victim of the situation who has a sense of helplessness and confusion. He perceives himself not responsible for the crime as he has nothing under control and there are external factors (fates) which are responsible for what happened. No matter what, during crime commission he is the one that couldn't stop himself as he was seeking for recognition. He also experience negative emotions of high and low arousal such as depression, sadness, irritation, confusion etc.

This CNE theme is partially similar to the Depressed Victim previous studies in criminal population (Ioannou, 2006; Ioannou et al., 2017), in mentally disordered offenders population (Spruin, 2012) and in offenders with personality disorders and psychopathy (Goodlad et al., 2018) had identified. Despite the differences between the previous studies and the present one; the general structure of this CNE is in essence similar, as all studies described the offender under this CNE theme as an individual who is the victim of fates and feels helpless and confused. The major noteworthy difference though, is that the offender under this CNE theme experience only low arousal negative emotions and for that reason it was labeled Depressed Victim. Contrary, in the present study the offender under this CNE theme experience

both low and high arousal negative emotions, as Goodlad et al., (2018) found in her study with offenders with personality disorders and psychopathy. Particularly, this offender experience negative emotions that fall under the themes of Depression and Distress as identified above. For that reason the CNE theme in the present study labeled Displeased Victim.

The Contradicted Revenger SO has a strong feeling of vengeance which probably motives the offence. He believes that others have treated him wrongly and he is seeking revenge. He perceives the offence as a usual day at work and describes it as a routine but funny and exciting adventure. He experience emotions of worry, thoughtfulness and misery. This CNE theme resembles the Distress Revenger previous studies in criminal population (Ioannou, 2006; Ioannou et al., 2017), in mentally disordered offenders population (Spruin, 2012) and in offenders with personality disorders and psychopathy (Goodlad et al., 2018) had identified. The differences between the Contradicted Revenger of the present study and the Distress Revenger of previous studies is that in the present study the offender under this CNE does not justifies his criminal act ("right thing to do"), and neither has the control of the situations and feels powerful as previous studies had indicated (Ioannou, 2006; Ioannou et al., 2017; Spruin, 2012). Also, the Contradicted Revenger exhibits couple of items such as "it was fun" and "it was like and adventure" that correspond to the Elated Hero in a previous study (Ioannou et al., 2017).

Another difference, is that in previous studies this offender experience only high arousal negative emotions such as anger, annoy and irritation (Goodlad et al., 2018; Ioannou, 2006; Ioannou et al., 2017; Spruin, 2012); while in the present study he experience both high arousal and low arousal negative emotions and particularly worry, thoughtfulness and misery. The label of this particular CNE theme does not

only stems from the contradiction of high and low intensity of negative emotions; but also from the contradiction between the narrative role items and the emotions experienced described by this type of offender. From one hand he describes the offence as a funny and exciting adventure but the emotions he is really feeling are worry and misery.

Last but not least, the Pleased Hero is the offender who regards himself as a professional who carry out a simple task in a day at work. He develops risky behaviour and he knows in advance what the consequence may be but nothing matters to him in his effort to protect his own back. He fully justifies his actions and he has everything planed which enables him to have the ultimate power over the situation. He also experiences positive emotions of high and low arousal such as safe, exhilarated, confident, relaxed, pleased etc.

This theme seems to be a combination of the Elated Hero and Calm Professional as described in previous studies of criminal populations (Ioannou, 2006; Ioannou et al., 2017); as the Pleased Hero exhibits most of the items used to describe these two CNE themes. Particularly, the Pleased Hero exhibits the characteristics of Calm Professional in terms of acting professionally, perceiving the crime as a day at work and experiencing positive emotions of low arousal; while at the same time exhibits characteristics of Elated Hero in terms of taking a risk, having a plan, having a sense of bravado (manly) and experiencing positive emotions of high arousal (Ioannou et al., 2017).

Considering the previous study of Spruin (2012) on mentally disordered offenders, the finding of the Pleased Hero in the present study also seems to be a combination of the Elated Hero and the Neutral Professional Spruin had identified in

mentally disordered offenders. Particularly, the Pleased Hero exhibits the characteristics of Elated Hero in terms of perceiving the offence as doing a job and as a mission where the offender has the power over the situation. Also they are similar regarding the experience of the full gamut of positive emotions of both high and low intensity. Similarly, the Pleased Hero exhibits characteristic of the Neutral Professional in terms of perceiving the offender as a professional who plan his actions and despite knowing what will the consequences will be develops a risky behaviour.

Last, taking under consideration the study of Goodlad et al. (2018) on offenders with personality disorders and psychopathy, the Pleased Hero CNE again seems to be a combination of the Elated Hero and the Calm Professional. Particularly the Pleased Hero exhibits characteristics of the Elated Hero in terms of acting like a professional who has a plan and the power and justifies himself about the offence; being on a mission that is like doing a job and being at a usual day at work; knowing what happens but not being worried about it and experiencing positive emotions of high arousal such as enthusiasm, excitement, pleasure, confident ect. Similarly, the Pleased Hero exhibits all the characteristic identified by Goodlad et al. (2018) in the Clam Professional CNE which are perceiving the offence as routine, having the control of the situation, believing that the offence is nothing special and experiencing positive emotions of low arousal such as calm, safety and relaxation.

Considering the tenth objective of the study, correlation analysis conducted to explore if there is relationship between the CNEs that emerged from the SSA. The findings revealed that there is a positive correlation between the Displeased victim and the Contradicted Revenger. This can be understood under the notion that schizophrenia offenders under both of these CNEs experience negative emotions of high and low arousal. Contrary, the findings also revealed that there is a negative

correlation between the Displeased Victim and Pleased Hero, as the SOs under these CNEs experience opposite emotions. The Displeased Victim experience emotions form the full gamut of negative emotionality; whereas Pleased Hero experience positive emotions of both high and low arousal. Last, the analysis found no correlation between the Contradicted Revenger and the Pleased Hero as they experience opposite emotions but their narrative roles are not that opposite after all.

The eleventh objective of the study was to determine whether schizophrenia is associated with any particular CNE. The analysis revealed that the Displeased Victim is the dominant theme among schizophrenia offenders, followed by Pleased Hero and last is the Contradicted Revenger. That finding is not surprising considering that the dominant role is Victim and the dominant emotion is Distress followed by Depression. It could be said that the experience of negative emotions and the patient's inability to regulate his emotions are mainly the triggers of the implication of Displeased Victim SO in criminal behaviour. As it has already mentioned in the literature review, the deficits in self-control are highly correlated to aggression (Caspi et al., 1996; de Ridder et al., 2012; Denissen et al., 2017; Denson et al., 2012; DeWall et al., 2011; Farrington, 2005; Moffitt et al., 2011).

Self-control has been linked with the ability to regulate emotions (García-Sancho, Salguero, & Fernández-Berrocal, 2014; Garofalo et al., 2016; Roberton, Daffern, & Bucks, 2012). Miller et al., (2012) revealed that emotion dysregulation is a factor affecting positively the negative emotions with the violent behaviour. Likewise, Donahue et al., (2014) supported that individuals' inability to regulate emotions leads to excessive negative emotions that are associated with physical aggression. More recent studies (Garofalo et al., 2016; Roberton et al., 2015) provided evidence on the association of emotion dysregualtion and negative emotionality to aggressive

behaviour. Overall these findings, support the theories of aggression and criminal behaviour (Agnew, 1992; Baumeister et al., 1994; DeLisi & Vaughn, 2014, 2015; DeWall et al., 2011; Gottfredson & Hirschi, 1990), suggestin)g that emotion dysregulation plays an vital role in experience of negative emotionality that contributes to violent offenders' aggressive tendencies.

Last, the twelfth objective of the study was to examine all the SO cases to verify if they could be assigned to a specific theme on the bases of CNE that SO develop during the crime commission. The findings support the Displeased Victim identification as dominant theme, as the majority 71.9% (n=46) of the schizophrenic offenders describes themselves as Displeased Victims considering the offence that led them to the psychiatric hospital. A smaller proportion of 20.3% (n=12) SO described themselves as Pleased Heroes and last 7.8% (n=8) assigned themselves the Contradicted Revenger CNE.

10.4 Criminal Narrative Experience and Demographic Characteristics of SOs

The thirteenth objective of the study was to explore if the demographic characteristics play any particular role in the development of Criminal Narrative Experience. The present study found that the demographic characteristics of the sample in general do not play any particular role in the Criminal Narrative Experience as there were not differences found between them in term of CNE in the biggest majority. Only few demographic characteristics presented differences among CNEs that are reported below. The finding comes in accordance with a research conducted by Link et al. (1999) in which he supported that no demographic and socioeconomic variables were responsible for the aggressive behavior of mentally disorders individuals. The only variable that made the difference was the different level of

psychiatric symptoms that is, the more active the symptoms are, the more likely patients is to exhibit aggressive behavior (Torrey, 1994; Zartaloudi, 2009).

10.4.1 CNE and Offenders' Gender

The present study revealed no significant differences between the genders as both genders had higher means on the Displeased Victim, then on the Pleased Hero and last on the Contradicted Revenger. These findings, specifically for women are in accordance with a research conducted by Ciesla et al. (2019) on female offenders found that the dominant role is the "Choiceless Victim", explaining that form many women the implication in crime is a negative experience.

Though, the present study recognises that gender does not play any particular role by itself in terms of criminality but identifies that schizophrenia and how this affects the genders differently is the aspect that needs to be examined. The research supporting that schizophrenia is related with increased criminal behaviour is wide (Fazel & Yu, 2009; Haller et al., 2001; Hodgins & Muller-Isberner, 2004; Lincoln et al., 2006; Nitschke, Osterheider, & Mokros 2011; Singh et al., 2012; Walsh et al., 2002); though most of these investigate male contrary to female schizophrenia patients (Landgraf et al., 2013; Robertson et al., 2014). Therefore, gender-specific trajectories to schizophrenia in association with criminal behavior are underestimated (Klein, 2007).

The available literature argue that men are more prone to express hetero-directed violent behavior or even more violent behavior than women who are more prone to self-directed violence; though among psychiatric patients, men and women are likely to have similar rates of violence (Giotakos, 2013; Miller, 1994; Minutolo et al., 2010). Contrary, other studies concerning gender argued that men with mental

illnesses have higher rates of risk of violent behavior than women (Lykouras & Douzenis, 2011). However, this does not mean that women are not violate or exhibit violent behaviour, but this behavior is reported or officially recorded less frequently than that of men (Martinaki et al., 2013). Many researchers support this view by arguing that women's violence is predominantly reactive, non-sexual, and without the use of weapons, more commonly occurring at home (Monahan et al., 2001; Moretti, Catchpole & Odgers, 2005).

It should be noted that the sample of the present study in the biggest majority 84.4% (n=54) were men and only a 15.6% (n=10) were female; which is an indication that female schizophrenia patients offend less frequently than men. That is also supported by Martinaki et al. (2018) who conducted a census of mentally disordered patients in Greece. She found that from the 155 MDOs that are treated in psychiatric hospitals in Greece only the 21 were women while the 134 were men. The lower rated of female MDOs are also supported by a UK survey which reported that of a total of 295 mentally disordered offenders, 88% were found to be male (Grubin, 1991).

In Greece, female criminality is generally low and women are not often implicated in violent crimes and in crimes against life (Giotopoulou-Maragkopoulou, 1991). That is mainly because of social stereotypic roles that define that when women get attacked or oppressed should react passively with submission and non-aggression. Furthermore, Giotopoulou-Maragkopoulou (1991) supported that other factors that contribute to low female crime rates are the increased "informal" social control, and the fewer opportunities for crime. Nowadays, there is an increase in female criminality due to the increased women independence and involvement in socio-economic activities and the decreased social stereotypic roles existed for them.

10.4.2 CNE and Offenders' Age

The analysis between the CNEs and the age of the offenders revealed that there is no correlation between Displeased Victim and Contradicted Revenger and offenders' age. Contrary it revealed a significant positive correlation between Pleased Hero and offenders' age, which means that schizophrenic offenders that described themselves as Pleased Hero are the oldest offenders within the sample. The only available data that these findings can be compared are derived form Ioannou's (2006) study in non-mentally offenders. The finding that Displeased Victim and Contradicted Revenger hve no correlation with the age, agrees with Ioannou's findings where she found that the similar CNE themes named Distressed Revenger and Depressed Victim has also no correlation with age. Though the results are contradictory as it concerns the Pleased Hero offenders of the present study who were the older offender of the sample; while the similar Elated Adventurer and Calm Professional offenders in Ioannou's study found to be those with the younger age.

Unfortunately, no other research has been conducted on Criminal Narrative experience in accordance with offenders' demographic characteristics; it is not possible to compare or contrast the results of the present study. Contrary a comment could be made on the age of SOs in general. The mean age of the SOs is at 50.28 years of age; which is quite similar to the findings of Martinaki et al. (2018) who found a mean age of mentally disordered offenders to be 49.7 years of age. The findings of these Greek studies are contradicted with a study conducted in UK which found that mentally disordered offenders have a mean age of 35.7 years (Grubin, 1991). This contradiction may indicate that mentally disorders offenders and particularly schizophrenia offenders in Greece stay longer in the psychiatric hospital or commit their crimes in an older age; and for that reason there are differences in the mean ages.

10.4.3 CNE and Offenders' Place of birth and Ethnicity

Regarding CNE and offenders' place of birth the present study found no significant differences between the SOs that have been born in urban places to the SOs that have been born to rural places. Individuals from both groups assigned to themselves in the biggest majority the Displead Victim CNE, then the Pleased Hero and last the Contradicted Revenger.

Once again the diagnosis and course of schizophrenia is the factor that plays a more significant role in terms of offending and not the place of birth. However taking the occasion of place of birth and the occurrence of schizophrenia is vital to comment that on the present study the 64.1% (n=41) of the participants were born in rural areas and only a 35.9% (n=23) of the participant were born and raised in urban areas. That is quite striking considering that those who born and raised in urban areas have 2 to 4 time higher risk of schizophrenia. Indeed, there seems to be a proportional relationship between exposure to urban environments and the likelihood of schizophrenia, with the highest risk occurring in the most urbanized areas (Eaton, Mortensen, & Frydenberg, 2000; March et al., 2008; Van Os, Pedersen, & Mortensen, 2004). Other studies have also argued that urban living is a predictive factor for schizophrenia patients to implicate in serious violence and even homicide (Gjelsvik, Zierler, & Blume, 2004; Pedersen & Mortensen, 2001).

A more detailed analysis concerning the place of birth and CNE was conducted to reveal if any particular area is correlated with any particular CNE. The analysis revealed no significant difference in Contradicted Revenger among the places of birth. Then analysis though revealed a significant difference in Pleased Hero among the places of birth. A deeper investigation in that finding discovered that the

correlation probably formed because of a particular participant which had the highest possible score in that role. This participant was from Germany but the author's perception is that the correlation is an outcome of the offender's crime and not place of birth.

Contrary to the above the analysis revealed a significant difference in Displeased Victim type of SO among the places of birth. An in depth exploration of that finding revealed that those who were born in foreign countries such as Albania, Australia and Armenia had higher means in this CNE type. It could be argued that because these people were immigrants may perceive themselves victims of their fates or even of the foreign societies that treats them in a negative way in general. Also because of immigration of because of the maltreatment they experience negative emotions such as fear, anger, depression and helplessness that not only lead them to the crime but also formed their CNE that way. That view is partially supported by research that has reported the migration has been found to be a predictive factor of serious violence and homicide among schizophrenia patients (Cantor-Graae & Selten, 2005; Frye et al., 2008).

10.4.4 CNE and Offenders' Family Background

The analysis revealed that there are no significant differences in CNE among the different offenders' family backgrounds. All the participants no matter the differences in with whom they lived as children have a highest average in Displeased Victim. In Ioannou's (2006) study there were found no differences among family backgrounds and CNE themes, except those who grew up without their both birth parents who had a higher average score in Elated Adventurer theme. Again, because of lack of other research on Criminal Narrative experience in accordance with

offenders' demographic characteristics, it is not possible to compare or to contrast the findings.

It is worth to note though, that the majority of the participants 76.6% (n=49) grew up living with both of their parents; 20.1% (n=13) of the participants grew up with one parent or other relatives and only 3.2% (n=2) of the participants grew up with adopted parents or in Children's or Community Home. Two comments need to be made on these percentages.

The first is the majority of the sample grew up with both parents, and childhood adversities in terms of adoption, parental loss or family dysfunction do not pose a factor in the development of schizophrenia for this particular sample, as previous studies have reported (Heads, Taylor & Leese, 1997; Schiffman et al., 2001).

The second comment is that because the role of family and parental factor play an important role in the development of criminal behaviour among individuals with major mental disorders (Gibbon, Ferriter, & Duggan, 2009), maybe in Greece, as the biggest majority grew up with both parents, the structure or function of the Greek family is a factor that leads the mentally disordered individual to crime. That view will be elaborated more and explained to some extent below in the section CNE and Type of Victim and Offenders' Relationship with the Victim.

10.4.5 CNE and Offenders' Marital Status

The analysis revealed that there are no significant differences in CNE among the different offenders' marital statuses. All the participants no matter the differences

in their marital status have the highest average in Displeased Victim. This analysis revealed that the marital status of the SO does not play any particular role in the Criminal Narrative Experience s/he develops for the offence.

Considering the SOs' marital status, the vast majority of 71.9 % (n=46) participants declare being single, 14.1% (n=9) are divorced, only 7.8% (n=5) are married, 3.1% (n= 2) are separated and 3.1% (n=2) are widows. As expected, most patients were single. This is consistent with the finding that people with mental illness marry less often compared to people without mental illness (Douzenis, 1995; Mental Welfare Commission for Scotland, 1994; The Law Commission, 1993).

10.4.6 CNE and Offenders' Educational Level and Occupation

The analysis revealed that there are no significant differences in CNE among the different offenders' education. All of the education levels reveal the highest average is in the Displeased Victim. This analysis though revealed that the educational of the SO does not affect the Criminal Narrative Experience the SO develops for the crime. This finding agrees with Ioannou's (2006) findings, where she also found that the educational status of the offenders does not play any role in what CNE the offender assign to himself.

The majority of the sample is have receive no education 6.3% (n=4) or only the compulsory education 40% (n=32). Only 25% (n=16) had graduate high school and the minority of 12.5% (n=8) has studied in a University or in a Technological Educational Institute. Additionally, 6.3% (n=4) reported having another education. These findings agree with those of Jones, Rodgers et al. (1994) and Cannon et al. (1997) who found that people with schizophrenia are poorly educated as from a young age they exhibit difficulties in social adjustment.

In regards to occupation, the analysis did not found any significant differences in CNE among different occupations. All the different occupation, except freelance, have the highest average is in the Displeased Victim; the freelance has the highest average in Pleased Hero. This analysis revealed that the occupation of the SO previous hospitalization does not play any role in the Criminal Narrative Experience he/she develops for the crime.

Regarding the offenders' occupation prior their hospitalizations, the vast majority of 57.5% (n=37) participants were workers (manual work), 20.3% (n=13) of them were unemployed, 14.1% (n=9) were private employees, 6.3% (n=4) worked as freelancers and 1.6% (n=1) was a state employee. These results are in accordance with other research which state that violence seems to be three times more likely in the lower socioeconomic classes than in the higher classes; violence appears to be more likely for the unemployed and those with lower education (Giotakos, 2013). Furthermore, studies have supported that school failure and economic deprivation have been linked with increased adult offending (Kolvin, Miller, Fleeting, & Kolvin, 1988; Farrington, 1995) and that low level of education is an additional risk factor for homicide risk (Jovanovic et al., 2019).

10.5 The Criminal Narrative Experience and Psychiatric Background

10.5.1 CNE and Offenders' Age of 1st Diagnosis

Many theorists have supported that the age of onset of schizophrenia is very difficult to be determined and it would be long precede formal diagnosis by mental

health services (Lindqvist & Allebeck, 1990; Humphreys et al., 1992). For the reason the present study reported the age of 1st diagnosis instead of the age of onset.

The analysis revealed that there is no significant correlation of offenders' age of 1st diagnosis with the Displeased Victim and with Contradicted Revenger. Though, the analysis revealed that there is a significant positive correlation of offenders' age of 1st diagnosis with the Pleased Hero; which means that schizophrenic offenders that described themselves as Pleased Hero are the offenders who diagnosed with schizophrenia in an old age. That may indicate that they were untreated and experiencing the psychotic symptoms of the disorder for longer time till they offended and hospitalized.

Studies also support that untreated psychosis is associated with serious violence (Harris et al., 2010; Humphreys et al., 1992; Imai et al., 2014; Nielssen et al., 2007; Verma et al., 2005) and probably the untreated psychotic symptoms such as delusions especially of persecution and/or auditory hallucinations, specifically of command (Coid et al., 2013, 2016; Cheung et al., 1997a, b; Felthous, 2008; Fotiadou, Priftis & Kyprianos, 2005; Laajasalo & Häkkänen, 2006; Nielssen et al., 2007,2009; Ullrich et al., 2013; Yee et al., 2011) lead these individuals to offend (Christodoulou et al., 2006).

At this point it is important to note that some participants of the present study did not know they were suffering with schizophrenia before the crime (at least according to their histories). For some of these patients it is possible that the crime took place during the first acute episode or may had the psychotic symptoms for some time but had not received any treatment. Similarly, Nielssen & Large (2010) reported that almost half of the male schizophrenic offenders were experiencing first-episode

psychosis at the time of their offence; while this statement stands only for the 12.5% of the female schizophrenic offenders. The study's findings are consistent with another study in Greece concluded at the same finding; reporting that 102 out of 267 mentally disordered offenders didn't know they have a mental disorder before the crime (Douzenis, 1995). That comes in accordance with the study of Large et al. (2009) who argued that a significant proportion of homicide offenders where first diagnosed with schizophrenia after the homicidal act.

Taking under consideration the above it could be said that a schizophrenic offender that assigns himself the Pleased Hero is an individual is experiencing persecution delusions or auditory hallucination of command and may regard the offence as his only choice and the only think he could possibly do in order to be discharged by the commands in his head. He is an individual that knows what will happen if he offends but he doesn't matter of the consequences as he believes that offence is the right thing to do, to act manly and protect his own back. Under that notion he develops a risky behavior and gets engaged in criminal activities. During the crime and shortly after it he probably experience positive emotions such as manly and courageous for having committing the offence; exhilarated, delighted and pleased for obeying to the command or getting rid of the person that persecuted him as he was hallucinating throughout the course of the crime; and safe, calm and relaxed because the persecution or command would possibly stop after the offence.

Contrary for those committing a crime after receiving the diagnosis of schizophrenia, the offence and generally their criminal behaviour is attributed not to the psychotic symptoms as described above but to cognitive and perceptual symptoms of the disorder (Hodgins, 1995, 2008; Pedersen, Rasmussen, Elsass, & Hougaard, 2010). According to Hodgins (2008) these offenders are mostly males at their late

thirties who suffer from schizophrenia and unexpectedly commit an extremely serious offence which is often fatal; without exhibiting any signs of antisocial personality or violent behaviour.

10.5.2 CNE and Offenders' Number of Hospitalizations

The analysis revealed that there is no significant correlation between the offenders' numbers of hospitalizations before the crime and any particular CNE. So it could be possibly said that the number of hospitalizations cannot be a predictor of what CNE the schizophrenic offender will develop for his crime.

It is important to note that the sample had a minimum number of hospitalization prior crime at one and a maximum at 52. As expected, most of the patients with a psychiatric history had one or three admissions. More specifically 48 patients (75%) had one to three hospitalizations before crime whereas 16 patients (25%) had more than three and one participant has as many as 52 hospitalizations.

This participant is case No17. He is a 56 years old single man from Northern Greece. As child he lived only with his mother and his 5 siblings. He has graduate primary school and he was working as a painter. At the age of 21 he diagnosed with schizophrenia and he reported as main symptoms "headaches". Since the age of 21 till the age of 50 when he committed the crime that lead him to the psychiatric hospital for the last time, he had done 52 hospitalizations. He was admitted to the psychiatric hospital for a shot time where he was taking his medication and after his discharge he was interrupting the antipsychotic medication. That caused him to experience the psychotic symptoms again and got hospitalized again. He had developed such a behaviour till the age of 50 when again because of non adherence to medication attempted to kill his mother because he thought she was spending his money and the home economies. A neighbor heard the incident and called the police. He stayed at the

prisons psychiatric hospital for approximately 4 months and then he leaded to the psychiatric hospital.

Multiple hospitalizations is not an unusual incident in Greece as Douzenis (1995) also found in his study that the 11.2% of the mentally disordered offenders he examined had more than three hospitalizations before crime with one participant had 30 hospitalizations. He also noted that having one hospitalization doesn't mean that these patients were discharges in shorter time, but in most cases, one admission meant a long (lasting many years) hospitalization.

Unfortunately, there is no information on treatment at these admissions nor on post-discharge follow-up. Most likely, these patients when they were discharged were receiving an antipsychotic treatment that was discontinued after sometime. Non adherence to medication is definitely related to psychiatric relapse and possibly criminal behaviour (Douzenis, 1995; Ritchie, Dick & Lingham, 1994). Three retrospective database studies revealed that patients who adhere to medical treatment have lower hospitalization rates (Acosta et al., 2009; Hudson et al., 2004; Rettenbacher et al., 2004). Additionally, non adherence to antipsychotic medication has been associated with severe violence in schizophrenia (Ascher-Svanum, 2006; Fazel et al., 2009; Higashi et al., 2013; Svestka & Bitter, 2007; Witt et al., 2013). Nielssen and Large (2010) revealed that schizophrenia patients commit homicide in a rate 1 in 600 per year prior receiving antipsychotic medication; and that rate falls to 1 in 10.000 homicides after the adherence to medication.

10.6 The Criminal Narrative Experience and Criminal History

10.6.1 CNE and Crime against Property or Person and Specific Type of Crime

The analysis revealed that there are no significant differences in CNE among crimes against property and person. For both of those who committed crimes against a person 81.3% (n=52) and those who committed crimes against a property 18.8% (n=12) the highest average is in Displeased Victim.

Further analysis conducted on the specific type of crime. The analysis revealed there are no significant differences in CNE among the different types of crime. Some of the crimes against person such as homicide, attempted homicide, aggravated battery, homicide with mutilation, rape and attempted rape and some crimes against property such as arson and public damage have the highest average in Displeased Victim. Contrary the property offence of burglary has the highest average in the Pleased Hero type of CNE. This analysis revealed that the type of crime the SO has committed does not play any significant role in the Criminal Narrative Experience he/she will develop for the crime.

The present findings come partially in accordance with Ioannou's (2006) findings on non-mentally offenders. She found that offenders who had committed offences against property assigned themselves the CNE of Elated Adventurer and Calm Professional; while those committed offences against person assigned themselves the CNEs of Distressed Revenger and Depressed Victim themes. In a more detailed analysis she conducted she further revealed that the offenders who had committed property offences, drug offences and robbery in a vast majority assigned themselves the CNEs of Elated Adventurer and Calm Professional; contrary those who had committed violence, sexual offences and murder assigned themselves the CNEs of Distressed Revenger and Depressed Victim.

Concerning the type of cases that the courts are dealing with, when the offender is a mentally disordered offender are in a vast majority crimes against person such as aggravated battery, attempted homicide and homicide; and they are not in crimes that require some form of organization and planning such as forgery and financial crimes. It is evident from the results of the present study that schizophrenic offenders commit mostly violent crimes against person. From those charged with a crime against person the 43.8% (n=28) had committed homicide, 25% (n=16) had attempted homicide 6.3 (n=4) has committed aggravated battery, 3.1% has committed homicide with mutilation; 1.6% (n=1) had committed rape and last 1.6% (n=1) has attempted rape.

These findings are in accordance with the other Greek study in mentally disordered offenders of Douzenis (1995) who found that the crimes that resulted in the patient being admitted to the psychiatric hospital were for the most part crimes against life and are considered to be more violent. That contrasts with old forensic evidence (Gardikas, 1957) that property crime is the majority of crimes of MDOs and that only 3% of crimes are violent (McClintock & Avinson 1968). Douzenis (1995) stated that in the Greek psychiatric population, specifically schizophrenics, who are the 54% of his studies' sample, committed 64% of violent crimes and in more detail the 74.3% of the homicides and 64% of bodily harms. No evidence other than a diagnosis of schizophrenia increased the likelihood of a patient committing a violent crime.

These findings are in line with the findings of Hafner and Boker (1982) and Hodgins (1992) and the older ones of McKnight et al., (1966a) and Wong and Singer (1973). More recent studies have established the association between schizophrenia and crimes against person, especially homicide (Brennan, Mednick, & Hodgins, 2000;

Eronen et al., 1996; Fazel et al., 2009; Golenkov et al., 2011). Also, other Greek studies have reported that psychiatric patients who committed homicide have mostly been diagnosed with schizophrenia with paranoid/delusional symptoms (Giotakos, 2013; Diaourta-Tsitouridi, 2008). Once again, the presence of delusions and acoustic hallucinations make the schizophrenia patient particularly dangerous for committing a very serious crime.

A meta-analysis conducted by Large et al. (2009) estimated that schizophrenia patients commit the 6.5% of all homicides, which is in accordance with previous findings that estimate the schizophrenia prevalence rates in homicide in 6 to 11% (Eronen et al., 1996; Fazel & Grann, 2004). Fazel et al. (2009) also stated that schizophrenia patients are about twenty times more likely to commit homicide compared to the general population. Additionally, a Greek study conducted recently found that with regard to the offenses of mentally disordered offenders, homicide was recorded at 52.9%, attempted homicide at 20.6%, arson at 9.7%, and a percentage of 16.8% of patients committed various types of offenses, such as robbery, seduction/sexual abuse of a minor, public damage, causing grievous bodily harm etc. (Martinaki et al., 2018).

Though, it is vital to be mentioned that committing homicide is usually not the first manifestation of a patient's violent behavior, as at least 70% are preceded by other violent behaviors, as well as manifestations of suicidal behavior (Mc Grath & Oyebode, 2005; Meeham et al., 2006; Shaw et al., 1999). It is also important to note, that the homicide rates by mentally disordered offenders are unrelated to the total homicide rates (Schipkowensky, 1973). This view has gained wide acceptance in modern days (Shaw, 1999; Coid et al., 2006; Simpson, McKenna, Moskowitz, Skipworth, & Barry-Walsh, 2004; Taylor & Gunn, 1999) and has been extended to

the nonlethal violence rates by the mentally disorders offenders (Appelbaum, 2006b; Buchanan, 2008).

A notable observation regarding the offences against person is that schizophrenic offenders do not commit rapes, as in the study's sample on one person has committed rape and only another ha attempted rape. This finding is in accordance with Douzenis (1995) findings where there were statistically significant differences showing that schizophrenics commit far more homicides and bodily harms and much less rape than other mentally ill patients. This finding is in line with clinical experience and the often described sexual indifference and apathy of people with this disorder. Another possible explanation of not having sex offenders (except two participants) in the study is that this population often has high rates of nonpsychotic disorders such as anxiety and mood disorders (Dunsieth et al., 2004; Firestone, Bradford, Greenberg & Larose, 1998; Kafka & Hennen, 2002; Kafka & Prentky, 1994; Raymond et al., 1999; McElroy et al., 1999).

As regards the crimes against property, there were only 12 participants who corresponded to the 18.8% of the overall sample. From those 12.5% (n=8) had committed arson, 4.7% (n=3) had been charged with burglary and only 1.6% (n=1) has done public damage.

These findings are supported by the other researches which have found that arson has been associated with psychotic disorders and especially with schizophrenia (Anwar, Langstrom, Grann, & Fazel 2011; Ducat, Ogloff, & McEwan, 2013a; Geller 1987; Lindberg, Holi, Tani, & Virkkunen, 2005; O´Sullivan & Kelleher, 1987; Ritchie & Huff 1999). Psychotic fire-setters light fires more often in response to psychotic delusions or hallucinations (Lewis & Yarnell 1951; Lindberg et al. 2005) in addition a motive such as revenge (Geller 1987; Koson & Dvoskin 1982); though this

motive is not common among schizophrenia fire-setters (O´Sullivan & Kelleher 1987).

The arsons committed by psychotic individuals are usually set to their own home or to other people's property while there are people in the building. For that reason they are considered to be more dangerous (Dalhuisen, Koenraadt, & Liem, 2015; Rix, 1994). The study of Anwar et al. (2011) reported a prevalence rate of 8.1% of psychotic disordered individuals who set fires; while a more recent study reported a prevalence rate at 6.9 (Ducat et al., 2013a). Further researches have indicated that schizophrenia rate for arsonist is more elevated for women (40 times more likely be fire-setters) than for men (20 times more likely to be fire –setters) (Anwar et al. 2011; Hollin et al., 2013). This does not come in accordance with the findings of the present study, which there is only one woman who has been charged with arson.

Furthermore, fire-setters have been described as individuals with low self-esteem, poor communication skills increased levels of social isolation and have exhibited a self-harm proneness (O´Sullivan & Kelleher 1987). All these are considered risk factors of suicidal ideation and suicidal behavior (Ducat, McEwan, & Ogloff, 2013b; Räsänen, Hakko, & Vaisanen, 1995); and it has been found that sometimes this population use fire as a mean to commit suicide (Green, Lowry, Pathé, & McVie. 2014) as described in the Case №29 above (for the Case No29 see p. 158).

10.6.2 CNE and Offender's Age when Crime

The analysis between the CNEs and the offenders' age when the offenders occurred revealed that there is no correlation between Displeased Victim and Contradicted Revenger and offenders' age when crime. Contrary the analysis revealed a significant positive correlation between Pleased Hero and offenders' age when

crime occurred, which means that schizophrenic offenders that described themselves as Pleased Hero are the offenders who committed their crimes in an older age. These results are in accordance with the results revealed for the age of the offender and the CNE above.

Unfortunately, no other research has been conducted on Criminal Narrative experience in accordance with offenders' age when crime occurred so it is impossible to compare or contrast the results of the present study with others. Though the age of offender when crime can be discussed in general. The age of the participants when they committed the crime that led them to mandatory hospitalization varies with a minimum age of 20 years, a maximum age of 70 years and a mean age at 38.94 years of age.

The large variation in the ages of hospitalized criminals causes impression. The youngest schizophrenic offender (case № 23) who committed the offence at the age of 20 is a now a 45years old man from a Greek island. As child he was living with his grandparents and his siblings as his parents were immigrants in the USA. He never got married and he used to work as a worker as he had no particular education because he had only completed secondary school. At the age of 18 he was diagnosed with schizophrenia with the main symptom being delusional ideas of grandiose and persecution and auditory and visual hallucination. He believed that someone is inside of him and speaks to him; and when sometimes he "hides" he reported to be afraid. He also exhibited hetero- and self-destructive ideas. At the age of 20 he was accused for attempted homicide as he stabbed three strangers in a football stadium. Firstly, he said that they attacked him but them he stated that he was drunk and he didn't know what he was doing. After the offence he tried to hide himself and he went to a forest and then he tried to take a boat to go to Athens. He got arrested in his attempt to travel

and he stayed for some days at the psychiatric unit of the prison before being sent to the psychiatric hospital. An interesting fact about that person is that while he was detained at the psychiatric unit of prison he attempted to kill another patient who tried, as he states, to sexually assault him.

The oldest schizophrenic offender (case № 37) who committed the offence at the age of 70 is a now a 76 years old woman from Northern Greece. As a child she was living with her grandmother, her aunt and her younger brother. Her mother died in labor of her brother and his father died three years later in the civil war. She graduated primary school and she got married but her husband died when she was 33 years old. She used to work at a tobacco store but the last six years she was unemployed. She was first diagnosed with schizophrenia at the age of 61, which means she had untreated psychosis for many years as the disorder does not start at that age, and has as main symptoms delusions of persecution, auditory hallucinations and suicidal ideation. She has done multiple hospitalizations and one time she stopped antipsychotic medication and attempted suicide. At the age of 70 she killed her aunt at her aunt's home. She visited her to tell her to shut down the machines through which were watching her (delusional idea of persecution). They argued and the patient took a meat cutter and hit her and then stubbed her. She then went to a friend of hers and told her what she had done. The friend called the police and she got arrested and transferred to the psychiatric hospital.

The interest of these individual cases should not detract from the main finding that the vast majority of patients were between 25 and 45 years old, and the overall sample has a mean age of 38.94. This finding is no different from that of international literature (Dell, 1984; Dawson & Langan, 1994; Hafner & Boker, 1982) and another Greek study (Douzenis, 1995). In the same line, more recent studies found that mid-

30s are the average age of mentally disordered offenders when they commit their crime (Golenkov et al., 2011; Laajasalo & Häkkänen, 2006; Meehan et al., 2006). Also, another recent Greek study reported that the mean age when the mentally disordered offenders commit a crime is at the age of 37.7 years (Martinaki et al., 2018).

10.6.3 CNE and Offenders' Previous Crime

The analysis revealed that there are no significant differences in terms of CNE between of those having committed previous crimes and those who had never in the past exhibited criminal behaviours. For both groups, those who have committed other crimes previous the one put them into the psychiatric hospital and who had no previous crimes the highest average is in the Displeased Victim. These results indicate that the existence of previous crimes plays no significant role in the CNE the schizophrenic offenders assign to themselves while crime commission.

It is worth to mention that only 15 (23.4%) of the participants had previously offended; with the vast majority of 49 (76.6%) participants never in the past been involved in any illegal act. The result resembles those of another Greek study which found that 38.7% of mentally disordered offenders had previous criminal history. Specifically, people with schizophrenia had a significantly lower rates criminal history and schizophrenia patients were breaking the law much less frequently than patients with other diagnosis (Douzenis, 1995).

These findings are also in accordance with previous study which reported that people with schizophrenia were found to have been involved in crime before the first hospitalization only at a rate of 20% (Mourikis & Dozenis, 2008). Additionally they supported that these individuals committed abusive acts, at acute phases of the

disorder when they were experiencing positive symptoms such as delusional ideas of persecution, disturbed self-esteem, and delusional ideas of erotic content.

Contrary to these findings, an old study of Guze, Woodruff and Clayton (1974) did not found any schizophrenic patients in his study with a criminal record. These findings are also opposite with the findings of Zitrin and his colleagues' study (1976) who found a higher rate of arrests in schizophrenia patients 2 years before their first hospital admission and Dell and Robertson (1987) who had found a 70% of previous offending in their study. Diaourta-Tsitouridi (2008) also supported that almost 70% of schizophrenia patients who commit a crime have had other violent events before.

These variations can be attributed to different sample selection criteria. We could assume, however, that the disordered behavior due to psychiatric disorder instead of leading the patient to psychiatric services many times led him to the police stations and courts.

10.6.4 CNE and Spending Time in Prison

The analysis revealed that there are no differences between those spending time in prison and those who had never been in prison in term of CNE. For both groups, those who have spent time in prison before being transferred in a psychiatric hospital for the crime they committed and those who have never been in prison the highest average is in the Displeased Victim theme. These results indicate that the possibility of spending time in prison for the crime plays no significant role on how SO develop their CNE. The findings disagree with the findings of Ioannou (2006) where she found that those who had higher levels of prison probation assigned

themselves the Elated Adventurer CNE; while those who had the lower levels of prison sentence or probation were assigned themselves the Calm Professional CNE.

Sadly, there are no other previous studies exploring the possibility of different CNEs in cased when the offender spent time in prison or not. So the present finding cannot be compared or contrasted with other studies.

10.6.5 CNE and Type of Victim and Relationship with the Victim

Canter (1989) stated that crime can be perceived as an interpersonal transaction and that all crimes have an implicitly or explicitly interpersonal quality. He argued that all crimes involve a relationship to some extent between the offender and his victim. In more detail, he argued that in crimes against person like homicide, rape and aggravated battery there is an explicit relationship; whereas in crimes against property such as arson or burglary there is an implicit relationship. He further hypothesised that as the CNE is an outcome of the transaction's nature, those offenders with closer interpersonal relationships will have more negative CNE.

The analysis of the present study revealed there are no significant differences in CNE among the type of victim. Those who have victims their brother/sister, father/mother, son/daughter, husband/wife, stranger, multiple victims, other family members, neighbor and employ/coworker had the highest average in Displeased Victim. Only the one participant who had as victim a friend had the highest average in Pleased Hero. Those who have committed property crimes and have as "victims" their own home or other's property have also the highest average in Displeased Victim.

A further analysis conducted to estimate the differences in CNE among different relationships of the offender with the victim. The analysis revealed there are

again no significant differences in CNE among the different relationships with the victim. All of the offenders with different relationships with the victim appeared the highest average in Displeased Victim, except the one who had a friendly relationship with the victim who has a highest average in Pleased Hero, as stated in the previous analysis.

In the present study, excepting those who had property offences 18.8% (n=12), the rest had crimes against person and almost half of the participants 48.4% (n=31) expressed their violence against a family member, 20.3% (n=13) against acquaintances, 10.9% (n=7) against strangers and 1.6% (n=1) against a friend. The findings are in accordance with another Greek study which examined the relationship between the offender and the victim. Mertinaki et al. (2018) reported from data that were available for mentally disordered offenders (91.6% of the total 155 patients), that 42.2% of patients attacked a first and second degree relative, 28.3% of a third person, and 10.5% to someone unknown. The present study's results are also compatible with previous studies suggesting that family members, including spoused are more likely to be victims of schizophrenic offenders, followed by acquaintances and lastly strangers (Angermeyer, 2000; Belli et al., 2010; Gholoum, AbuZaid, Rami, & El Dardiri, 2007; Golenkov et al., 2011; Joyal et al., 2004; Nordström et al., 2006; Richard-Devantoy et al., 2009).

Despite the social view that schizophrenic patients pose a risk to the public, they are rarely turning their violence against strangers (El-Hadidy, 2012; Johnston & Taylor, 2003; Nielssen et al., 2009; Shaw et al., 2004). Consequently, the violent behavior of the mentally ill is not directed blindly and uncontrollably, but instead is primarily directed at people who are involved in their lives in various ways. Estroff, Swanson, Lachicotte, Swartz, and Bolduc (1998) suggested that the family members

and individuals from the immediate social network of a mentally disordered individual experience greater risk of receiving this violence.

Some old studies suggested that mentally disordered individuals, and in particular schizophrenia patients, may pose risk to individuals from their family environment and not to those out of it (Guttmacher, 1965; East, 1936; Daly & Wilson, 1988; Gottlieb, Gabrielsen, & Kramp, 1987; Gillies, 1976; Wong & Singer, 1973). Also a bulk of more recent research supports the present findings that the victims of the schizophrenia offender's aggressive behavior come from the person's familiar environment (El-Hadidy, 2012; Häkkänen & Laajasalo, 2006; McKnight, Mohr, Quinsey & Erochko, 1966a, b; Nijman, Cima, & Merckelbach, 2003; Nordström & Kullgren, 2003; Steadman et al., 1998; Steury & Choinski, 1995).

Solomon, Cavanaugh and Gelles (2005) in a review article estimated that the prevalence rate of someone diagnosed with a psychiatric disorder that turns his violence towards family members is in the range of 10 to 40%. Furthermore, Gibson and Klein (1969) in an old study have found that 49% of homicidal mentally disordered offenders had killed their relatives. A result that comes in accordance with Douzeni's (1995) research that highlights hat homicide is a crime that is almost always committed by people with schizophrenia; which is something that has been reported many times in the past (Gilles, 1965; McKnight et al., 1966b).

In the present study, out of the 46 participants who committed homicide, homicide with mutilation or attempted homicide, the 27 had family members as victims, 12 had acquaintances, six had as victims strangers and only one had as his victim a friend of his. From those having a family member as victim, the majority of them 14 participants had as victim one of their parents, five had as victims their

siblings, three had multiple victims from the family environment, three had as victims their husbands and two had as victims her children.

The findings of the present study are in accordance with the findings of Douzenis (1995) who found that the majority of schizophrenia offenders' victims are family members and specifically the patient's mother or father. Eleven participants out of 28 who had committed homicide performed parricide (the crime of murdering a parent). Other studies have also found that parricidal offenders suffer from schizophrenia in a rate of 47 to 60% (Baxter, Duggan, Larkin, Cordess, & Page, 2001; Devaux, Petit, Perol, & Porot, 1974; Marleau, Millaud, & Auclair, 2003; Young et al., 1998). Several studies have attempted to identify the risk factor of parricide by schizophrenia patients. The majority of parricides is committed by sons, and typically occurs when the victim is alone with the offender at home (Green, 1981).

A quite striking fact in this research is that out of the ten women of the overall sample, eight of them had performed homicide or attempted homicide within the family environment. The present findings also support the findings of previous studies reporting that females mostly kill inside their families (Gottlieb et al., 1987; Monahan et al., 2001; Moretti et al., 2005). Other studies have also supported that female psychotic offenders kill more children compared to men who rarely attack children (Gottlieb et al., 1987; Putkonen, Collander, Honkasalo, & Lönnqvist, 2001).

The role of the victim in the crime of schizophrenia is also important, a factor that is often overlooked in view of schizophrenic crime as incomprehensible and unreasonable (Skaragkas, 2002). The patient's relatives, who are also his most frequent victims as revealed by the results above, are likely to fuel the patient's jealous or persecuting delusions, in which cases the delusion is being based on objective events that will gradually lead to crime. In fact, the majority of the mentally

disordered offenders studied in Greece (Skaragkas, 2002), prior to the crime there is the victim's negative attitude towards the perpetrator, which is usually long-term and contributes to the perpetrator's hostile attitude towards the victim, culminating in the crime itself (Baxter et al., 2001; Young et al., 1998). Young et al. (1998) supported this by stating that verbal or psychological abuse of the mentally ill by the victim occurred in 40% of the cases with parents as victims. Specifically, people with psychiatric disorders are more likely to exhibit aggressive behavior in a family environment that exerts stress, anxiety, and does not provide them with the desired emotional support (Monahan et al., 2001).

10.6.6 CNE and Presence of Eyewitnesses and Crime Concealment

The analysis revealed that there are no significant differences between the presence and the absence of an eyewitness during the crime commission and any type of CNE. For both of those who had or not an eyewitness present during the crime commission the highest average is in the Displeased Victim. These results indicate that the presence of an eyewitness at the crime plays no role in the role the SO assign to himself while crime commission. In the present study 53.1% (n=34) had no eyewitnesses while the rest 46.9% (n=30) had eyewitnesses.

Regarding concealment, the analysis revealed that there are no significant differences between crime concealment or not and any type of CNE. For both of those who tried to conceal their crime and not the highest average is in the Displeased Victim. These results indicate that the crime concealment plays no part in the role the SO assign to himself while crime commission. In particular in the present study the biggest majority of the participants 85.9% (n=55) did not tried to conceal their crime; whereas only 14.1% (n=9) tried to conceal their crime. Of those who tried to conceal

their crime six assigned to themselves the Displeased Victim CNE while the rest three perceived themselves as Pleased Heroes.

It could be stated that schizophrenic offenders who usually act under psychotic symptoms do not care if someone sees them or do not try to conceal their crimes, as they don't comprehend their action and they do not understand the injustice of the act due to their symptoms, the cognitive deficits and the lack of self-regulation that as already mentioned in the literature affect their behaviour. The above adds to the findings that when mentally disordered people commit crimes, they usually do so without the cooperation of others, without skills, less carefully, while at the same time they are not interested in being arrested, leaving trace of their act and they are not taking caring for an alibi (Robertson, 1988; Tsalikoglou, 1987).

10.6.7 CNE and Offenders' Strength of Memories

The analysis revealed there are no significant differences in CNE themes among strength of memories. All the offenders who appear different strength of memories appear the highest average in Displeased Victim. A total of 34.4% (n=22) report having very strong memories of the incident, 25% (n=16) report having strong memories, 17.2% (n=11) report having quite strong memories and only 15.6% (n=10) has weak memories and 7.8% (n=5) had very weak memories. The striking majority of the participants reported having very strong or simple strong memories of the incident. That in quite surprising considering the fact that reduced memory is one of the negative symptoms schizophrenia exhibits (APA, 2013; Garrett, 2009; Lindenmayer & Khan 2006; Pu et al., 2014; Tandon et al., 2009).

10.7 The Criminal Narrative Experience and the Emotional State

10.7.1 CNE and Depression

The analysis revealed that there is no significant correlation of depression with the Displeased Victim and the Pleased Hero CNE themes. Though it revealed a significant positive correlation with the Contradicted Revenger; which means that schizophrenic offenders that described themselves as Contradicted Revengers are those who score higher in the depression questionnaire.

There are multiple variations in the experience of depression contingent on the number and severity of the symptoms the individual experience. According to that the depression can be classified as mild, moderate or severe. An individual who experiences mild depression (including ups and downs that considered normal and mild mood disturbances) exhibits some difficulties in work and in social activities, but not to an extent to affect the daily file activities. Contrary, during severe depression (including severe and extreme depression) the person is not able to perform any social or domestic activities except to a very limited extent (World Federation of Mental Health, 2013).

The majority of the sample 29,7% (n=19) found to experience some ups and downs that considered normal, 12.5% (n=8) are experiencing mild mood disturbances; 14.1% (n=9) found to experience borderline clinical depression, 23.4% (n=15) are experiencing moderate depression whereas 10.9% (n=7) are experiencing severe depression and 9.4% (n=6) are experiencing extreme depression.

Participants assigned to themselves the Displeased Victim CNE seem to be allocated in all different depression severities; whereas those assigned to themselves the Pleased Hero seem to have ups and down till moderate depression. Contrary from the five participants that assigned to themselves the Contradicted Revenger CNE that found to have correlation with depression, three of them found to experience

moderate depression, one is eperiencing severe depression and one is experiencing extreme depression. A possible explanation for that may be that the contradictory experience they had caused them depression. Also maybe the fun and excitement they felt during the crime commission would now be perceived as negative, due to social stereotypes and in combination with the negative emotions they had experience such as worry and misery may led to the experience of severe depression.

An interesting finding is that the Displeased Victim, while experienced the crime in a negative emotionality does not exhibit correlation with depression. That would be possibly be explaine considering the general strain theory which indicates that a maladaptive way to cope or regulate the persistent or intense experience of negative emotions is the anger expression (Agnew, 2013; Joon Jang, 2007; Joon Jang & Song, 2015). This theory further suggests that a potential function of aggression and consequently criminal act is to alleviate these negative emotions (Agnew, 2001; Berkowitz, 1993). Possibly the Displeased Victim offender alleviated his negative emotions through the criminal act and now experience no or in low intensity negative emotions and particularly depression.

It is also important to note that generally schizophrenic offenders do not experience high levels of depression contrary to the finding that support depressive symptomatology to be common in patients with schizophrenia and is one of the most common and early signs of schizophrenia (An der Heiden et al., 2005; Conley et al., 2007; Häfner et al., 2005).

The present study's findings could be supported by reporting that it is evident that depressive symptoms coexist with an increased incidence of psychotic episodes, decline in the majority with antipsychotic treatment, and are less frequent after psychotic symptoms recede (An der Haiden et al., 2005; Birchwood et al., 2000;

Goldman, Tandon, Liberzon & Greden, 1992; Hirsch et al., 1989; Koreen et al., 1993; Krakowski, Czobor & Volavka, 1997; Mauri et al., 1999; Nakaya, Ohmori, Komahashi & Suwa, 1997; Tapp et al., 2001; Zisook et al., 1999). Aslo, Häfner et al. (1999; 2005) observed depression over 2 weeks, up to 52 months before the first episode, in 81% of patients with schizophrenia.

Furthermore, An der Heiden et al., (2005) in a longitudinal follow-up study showed that depressive symptoms are elevated in the acute phase (in the first episode and in each recurrence) and remain elevated until the first month after the end of the episode. The same study found that after the first psychotic episode, for a follow-up period of approximately 12 years, in any one month, at least one depressive symptom appeared (depressive feeling with loss of pleasure and interest, loss of confidence, feelings of guilt, suicidal ideation/ suicide) to 40% of patients in the first months, then in the following years it stabilizes in 30-35% of patients (without decreasing over time).These findings are supported by previous research which state that post-psychotic depression is more common in the first psychotic episodes (Addington et al., 1998; Birchwood et al., 2000; Birchwood, Iqbal, & Upthegrove, 2005).

According to the above studies and considering that the sample of the study were inpatients, with chronic psychosis in most cases, receiving fixed antipsychotic medication for at least one month, and considered clinically stable for at least half a year before the examination by their treating psychiatrist; it totally make sense that the study's participants score relatively low or moderately in depression.

10.7.2 CNE and Suicidal Ideation

The analysis revealed that there is no significant correlation between suicidal ideation and the CNE themes schizophrenic offenders assign to themselves contrary to the finding that suicide is one of the leading causes of premature death in patients

suffering from schizophrenia (Palmer et al., 2005). This finding can be explained considering various factors. The most important to note is that SO did not have any suicidal thought because they are inpatients and they adhere to antipsychotic medication; as the non adherence in medication has been identified as a risk factor of suicidal thought and behaviour in schizophrenia patients (Higashi et al., 2013; Llorca, 2008; McCann, Clark & Lu, 2009; Rossau & Mortensen, 1997; Weinmann, 2004).

Furthermore, the low educational level of the sample may be a protective factor against suicidal ideation and suicide as it has been reported that higher level of education is an additional risk factor for increased suicide risk (Jovanovic et al., 2019). A higher level of education may indicate increased accessibility to information that may help a schizophrenia patient to develop a better insight. The insight in such cases may result to an increased risk of depressive symptomatology and suicidal thoughts (Fazel et al., 2009; Murri et al., 2015).

Another factor that may contribute to the absence of suicidality in the sample is that no one of them is in acute psychotic phase and the majority of them suffer from chronic psychosis without ever expressing thought of harming thmeselves. This view is supported by findings of studies which reported that suicidal ideation during the pre-schizophrenia period is a risk factor for suicidal behavior after active psychosis begins. Nearly 70% of patients with suicidal ideation during the preceding period also had suicidal ideation in this assessment episode. It is also noteworthy finding that almost 90% of patients who were not suicidal during the preceding period remained without suicidal behavior and in the subsequent course of the disorder, both in periods of depression and in relapses (Andriopoulos, 2011; Spyropoulou & Sideri, 2015).

Another possible explanation of low suicidal ideation that is in accordance with the low levels of depression is that the act of suicide is usually seen as an act

where aggression is directed at the individual himself. A detailed observation of each attempt, however, indicates that the aggression is in fact directed at another person. The person in the psychoanalytic terminology is often referred to as the "significant other" and is usually the one closest to the suicidal individual (spouse, child, parent, etc.). Prior to the attempt, the suicidal individual had usually felt significant frustration with this person because he did not spend the necessary time, he did not repay the love and recognition he expected ect. The aggression directed at this person is ultimately directed at himself (Belegrinos, Zacharis, & Fradelos, 2014).

In cases of SO the aggression has been putted to that significant other “the victim” or the victims property and did not internalized to him; so these individuals do not exhibit high rates of suicidal ideation. According to psychiatrist Karl A. Menninger, murder and suicide are interchangeable acts. Suicide sometimes prevents murder and vice versa (Menninger, 1933/1996, 1936; Pokorny, 1965; Porterfield, 1960).

Another possible explanation that the sample does not exhibit high levels of depression and suicidal ideation is the low levels of insight they have. There has been found that schizophrenia patients with poor insight into illness underestimate problems in their social functioning (Lysaker, Bell, Bryson & Kaplan, 1998) and generally in their life and their psychological needs (Carroll & Mortimer, 1998; Doyle et al., 1999). Consequently, poor insight works as a protective factor against self-esteem (McGlashan & Carpenter, 1976); risk of depressive mood associated with hopelessness (Carroll et al., 1999; Gutierrez et al., 2000; Smith, Hull & Santos, 1998) and even suicidal ideation and suicide (Meltzer & Mann, 2001; Wolfersdorf, Keller, & Kaschka, 1997).

10.7.3 Correlation between Suicidal Ideation and Depression

The analysis revealed that there is a significant positive correlation between suicidal ideation and depression; which means that schizophrenic offenders who have higher levels of depression also appear higher levels of suicidal ideation. Though, it should be mentioned that no particular CNE exhibited suicidal ideation, according to the above analysis, not even the Contradicted Revenger who found to be correlated with depression and it has been suggested by research that the risk of suicide is correlated with the severity of the depressive symptoms (Kessing, 2004) and that severe depression is responsible for suicide attempts and despair associated with suicidal ideation (Harkavy-Friedman et al., 1999; 2004).

The correlation of depression with suicidal ideations is supported by various studies that have identified depression as one of the leading risk predictors for suicide in both clinical and general population studies (Bramness et al., 2010; Harris & Barraclough, 1997; King et al. 2009; Qin & Nordentoft, 2005); and specifically in those suffering from schizophrenia (Barraclough, 1987; Cotton et al., 1985; Harkavy-Friedman et al., 2004; Strosahl et al., 1992).

Worth mentioning is the fact that, traditionally, depression is negatively associated with delinquency, given its known relationship with suicidal rather than homicidal behavior (Douzenis, Ferentinou & Lykouras, 2005). In particular, the homicide associated with depression is often followed by the perpetrator's suicide attempt and is called altruistic suicide or extended suicide. The altruistic character (Douzenis, Ferentinou & Lykouras, 2005) attributed to suicide stems from the patient's intention to rescue his victim (usually the child or partner of the perpetrator) from a hypothetical inevitable disaster, to avoid the stigma of the attempted suicide or to help him get rid of a life that he considers to be awful and torturous and by this

logic he kills, expanding on his own self-destructive behavior. Suicide after the murder is considered a form of punishment for guilt (Menninger, 1933/1996, 1936). Case No50 (see case on p. 156) could be partially considered such a case. The offender killed his mother because he believed she was suffering in an attempt to save her from her excruciating life. Though after he did not commit suicide, but he rather killed his uncles and immediately after he got arrested.

However, it has been found that motivation is not always altruistic in the sense that it was mentioned above, but sometimes these homicides are associated with possessiveness and morbid jealousy, and often there is a history of chaotic relationships, chronic disharmony, physical violence, and repeated verbal threats (Douzenis, Ferentinou & Lykouras, 2005). Such a case is Case No19. He is a 52 years old man from Athens. As a child he was living with grandparents and his younger sisters. He got married and he used to work as an accountant as he had graduate university. At the age of 43 he attempted to kill with a knife his wife and his 6 years old son. He stated that prior to his crime he had a lot of nerve and he was bothered by various things. He usually broke out his anger and nerves in his family causing disharmony. He had suicidal ideation and he wanted to kill himself but first he attempted to kill his family telling them "I will kill myself and I will take you with me so you don't get sad". After the incident he got arrested and diagnosed for the first time with schizophrenia with main symptom auditory hallucinations of command.

10.7.4 CNE and Moral Emotions

10.7.4.1 CNE and Guilt

The guilt was measured in terms of trait and state guilt and moral standards. The analysis revealed that in terms of trait guilt that there is a significant negative

correlation with Displeased Victim; no significant correlation with Contradicted Revenger and last a significant positive correlation with Pleased Hero. The results revealed that those who perceive themselves as Displeased Victim have the lowest scores on trait guilt; which means they do not have an ongoing sense of guilt. Contrary, those who assigned themselves the Pleased Hero type have the highest scores in trait guild; which means they have guilt as a personality trait, otherwise they have guilt proneness.

In terms of state guilt the analysis revealed that there is a significant negative correlation with the Displeased Victim; no significant negative correlation with the Contradicted Revenger and last a significant positive correlation with the Pleased Hero. These results indicate that those who assigned themselves the Displeased Victim type had the lowest scores on state guilt; which means they do not experience guilt associated with the offence. Contrary, those who perceived themselves as Pleased Hero had the highest scores in trait guild; which means they experience guilt that is associated with a specific behavior or event and particularly the offence.

Last regarding moral standards the analysis revealed that there is no significant correlation with any particular CNE; which is an indication that moral standards are uncorrelated with the Criminal Narrative Experience and how everyone experienced the crime has anything to do with his moral principles. Criminal behaviour depends on the circumstances or the disorder and not in the inner moral standards.

The results indicate that those who perceive themselves as Displeased Victim had the lowest scores on trait and state guilt compared to those who assign themselves the Pleased Hero type have the highest scores in trait and state guild. This finding

could be possible explained in terms of their perceptions about the crime and their level of responsibility at it. Displeased Victim SOs does not consider themselves guilty of the crime as they describes themselves to be the victims of the situation who are helpless and confused. They do not take responsibility for their actions as the support there are other external factors (fate) that are beyond their control they; they also deny their implication in the crime which lifts individuals self up and alleviated the sense of guilt (Hakmiller, 1966; Wills, 1981). Additionally, according to Kubany, & Watson (2003) the individual will not experience guilt if s/he does not implicate himself or herself in the negative events (offence in the particular situation) no matter the negative emotions (distress and depression in the particular situation) may arise by the event.

These offenders may have developed a dissonance due to emotions of shame and guilt following the offence that got neutralized by cognitive techniques the individual develop such as denial of the offence, denial of the victim, denial of responsibility, revenge the wrongdoers and appeal to higher loyalties (Baumeister & Wotman, 1992; Miceli & Castelfranchi, 1998; Sykes & Matza, 1957). Spruin et al., (2014) in her research on MDO also found that different narrative roles implement such cognitive techniques. More specifically, she stated that the Victim denies the existence of another victim; the Reveneger seeks revenge from those have wronged him; the Hero perceives the crime as an action of greater good and appeals to higher loyalties and last Professional may deny injury and victims as he mostly carry out property crimes.

Last, lower guilt proneness correlates with higher scores on hostility, aggression and risky behavior (Bybee & Williams, 1994, 1996; Merisca & Bybee, 1994; Mosher, 1979; Stuewig et al., 2015; Tangney et al., 1992). That means that the

schizophrenic offenders who assigned themselves the Displeased Victim, as they scored low on trait guilt, may have more aggressive behaviours and there is an more elevated risk of future offences.

Contrary Pleased Hero SOs developed guilt as they take responsibility for their actions by supporting they acted like professionals in another day at “work”. They also support that they knew what would happen and what the consequences would be but they offended like it was their only choice. Moreover, they may feel guilty because of the pleasure they received from the offence which is reprehensible by society and itsis moral standards.

The schizophrenic offenders who described themselves as Pleased Heroes and experience guilt may proceed in reparative actions. When individuals recall experiences involving guilt, they describe themselves apologetically, with a sense of responsibility, feeling as if they have violated a moral code while wishing to behave differently (Tangney et al., 1996). This change in behaviour due to guilt can be explained by the Cognitive Dissonance theory (Festinger, 1962; Ghingold, 1981). The basic principle of the theory of cognitive dissonance is the need for one to maintain cognitive cohesion. The person tries in every way to reduce the negative senses that are tormenting and abusing him internally. This is achieved by avoiding some unwanted situations and behaviors that increase the negative senses. Likewise, in the case of guilt, the person is concerned about the violation of a rule and tries to reduce the level of the case by adopting the "right" behavior. Such an indication could be possibly associated with reduced of recidivism in crime; and it could be assumed that the offenders who experience guilt may have fewer possibilities to commit a crime again.

This positive effect of guilt has been reported in other research too and has been stated that those with emotions of guilt are motivated to make repairing actions; compensation behaviours towards the victim (Freedman et al., 1967). Also other research supports that individuals who experience the emotion of guilt have more empathy, regulate anger are more prone to reparative actions and helping behaviours in general in an attempt to lighten the weight of guilt, recover self-esteem, regain others' approval etc. (Baumeister et al., 1994, 1995; Carlsmith & Gross, 1969; Cunningham, Steinberg & Grev, 1980; Darlington & Macker, 1966; Hoffman, 1982; Rawlings, 1968; Regan, 1971).

10.7.4.2 Guilt in Correlation with Depression and Suicidal Ideation

The analysis revealed that trait guilt has a significant negative correlation with depression and a no significant correlation with suicidal ideation. State guilt has a significant negative correlation with depression and no significant correlation with suicidal ideation and last moral standards have a no significant correlation with both depression and suicidal ideation. The results indicate that in all CNE types the higher the depression the lower the trait and state guilt and reverse the lower the depression the higher the trait and state guilt.

The findings are considered quite interesting taking into account the multidimensional model of guilt which suggests that both negative emotions and guilt related cognitions must be present for guilt to occur. In case an event memory does not evoke negative emotions, the guilt cannot occurno matter how the individual interprets his role in the event (Chaplin et al., 1995; Kubany, & Watson, 2003; Lisak & Ivan, 1995; Marshall, Hudson, Jones, & Fernandez, 1995). For example, an individual will not be expected to feel guilty for his role in a serious offence (e.g.

homicide, attempted homicide, rape) if that person does not experience emotions of distress or depression by the memory of the event; even if he takes responsibility for the offence and knowing he has violated basic social principles. So it is interesting that Pleased Hero who does not experience negative emotions (depression) experiences guilt; while Contradicted Revenger who experience moderate to severe depression does not experience guilt.

Furthermore, these findings are opposite to the studies which support that the symptom of guilt is perceived as a feature of depression and it appears to be an element in the psychoanalytic (Freud, 1917/1957) and phenomenologic conceptualization of depression (Jaspers, 1963). A large bulk of research has described guilt as a major cause of depression and that both state and trait guild is positively associated with depressive symptoms (Alexander et al., 1999; Breslau & Davis, 1985; Ghatavi, Nicolson, MacDonald, Osher, & Levitt, 2002; Jarrett & Weissenburger, 1990; Stompe et al., 2001; Walters-Chapman, Price, & Serovich, 1995). The only explanation can be given in such opposition is that the nature of the participants and the positive and negative symptoms this disorder has may affect that well-established relationship between guilt and depression.

Only few recent studies agree with the present findings. Tangney et al. (2011) also found a negative correlation between guilt proneness and depression; with those having guilt proneness having also less depressive symptoms contrary to those having low guilt proneness. Additionally, Kim et al., (2011) reported that guilt is unrelated to depression in adults. These finding are in accordance with earlier studies which also failed to reveal a relationship between guilt and depression (Harrow, Colbert, Detre, & Bakeman, 1966; Harrow & Amdur, 1971; Prosen, Clark, Harrow, & Fawcett, 1983).

The results also revealed that suicidal ideation has no correlation with any aspect of guilt. This is also an interesting finding considering the literature that supports guilt to be associated with suicidal behavior (Alexander et al., 1999; Boye et al., 2002; Kemeny et al., 2004; Tangney et al., 2014; Quiles & Bybee, 1997; Zahn-Waxler, & Kochanska, 1990). Once again the nature of the schizophrenia disorder may affect that association. Also it is important to remember that in general the schizophrenic offenders under examination do not appeared to have suicidal ideation or suicidal behavior.

Last the finding that moral standards are not related neither with depression nor with suicidal ideation does not pose any particular interest at it is already known that moral principles are similar across individuals who experience depression or not (Ghatavi et al., 2002), contrary to old studies who reported differences in moral standards of depressed and not depressed individuals (Jarrett & Weissenberger, 1990; Prosen et al., 1983).

10.7.4.3 CNE and External and Internal Shame

The shame was measured in terms of external and internal shame. The analysis revealed that in terms of external shame there were found no significant correlation between inferiority and CNE. The analysis also revealed a significant positive correlation between emptiness and Displeased Victim and Contradicted Revenger but no significant correlation with Pleased Hero; which means that those who assigned themselves the Displeased Victim and the Contradicted Revenger had high scores on emptiness. Further there was found a significant positive correlation of mistakes with the Displeased Victim and Contradicted Revenger but no correlation of mistakes with the Pleased Hero; which indicated that those who perceived themselves as Displeased Victim and Contradicted Revenger had high scores on mistakes. Last,

the analysis revealed that in terms of total external shame there is a significant positive correlation with the Displeased Victim and Contradicted Revenger but no correlation between total external shame and the Pleased Hero; which indicated that those who perceived themselves as Displeased Victim and Contradicted Revenger had high scores on the scale of external shame.

To sum, these overall results of external shame indicated that those who assigned themselves the roles of Displeased Victim and Contradicted Revenger had high levels of emptiness, mistakes and in general external shame. Contrary those who perceived themselves as Pleased Heroes did not exhibit any sign of external shame in total or in any of its components.

In regards to internal shame, the analysis revealed that there is no significant correlation between characterological shame and any particular CNE and no significant correlation between behavioral shame and any particular CNE. The results also revealed that there is no significant correlation between bodily shame and Displeased Victim or Pleased Hero, but there was found a significant positive correlation with the Contradicted Revenger; which indicated that those who perceive themselves as Contradicted Revenger have high scores on bodily shame Last, the analysis revealed that in terms of total internal shame there is a significant positive correlation with the Displeased Victim but no correlation with Contradicted Revenger and Pleased Hero; which indicated that those who perceived themselves as Displeased Victim had high scores on the scale of internal shame in total.

To sum, overall results of internal shame indicated that those who assign themselves the roles of Displeased Victim have high levels of internal shame and those to perceived themselves as Contradicted Revenger had high levels of bodily

shame. Contrary those who perceive themselves as Pleased Heroes did not exhibit any sign of internal shame in total or in any of its components.

Unfortunately, there are no previous studies on the moral emotion of shame and criminal narrative experience and the findings can't be compared or contrasted. It could be only assumed for the Depressed Victim and the Contradicted Revenger that exhibit signs of both external and internal shame because they had a negative emotionality during crime commission they feel ashamed of their action and they consider it as a mistake. It could also be said that in terms of emptiness the negative emotionality the Depressed Victim experienced and the high depression levels the Contradicted Revenger has at the present time lead to that aspect of external shame.

Additionally it could be hypothesised that the experience of external shame, which refers to how others perceive them (Allan et al., 1994; Goss et al., 1994; Pinel, 1999) and internal shame, which refers on how one sees himself (Cheung et al., 2004; Gouva et al., 2016b; Gilbert, 1998; Gilbert & Procter, 2006; Matos et al., 2015; McKendry, 2014; Saggino et al., 2017; Thibodeau et al., 2012; Tracy et al., 2007; Ward, 2014)., may not be outcomes of the particular criminal narrative experience each one had regarding his/her crime, but more in the disorder they suffer from, the level of insight and the individual differences. May these offenders have higher level of insight and perceive themselves as defective and/or inadequate compared to the general population that does not suffer from schizophrenia; something that elevates the internal shame. In the same line, according to Goss et al. (1994) who supports that there is a positive correlation between internal and external shame, it could be assumed that when someone perceive himself as inadequate he expects others to see him the same way.

The finding that the schizophrenic offenders who assign themselves the Pleased Hero CNE do not exhibit any sign of either external or internal shame, is very interesting. Maybe their experience of the crime and their narrative about it does not leave any room for negative emotions like shame. As they perceive themselves masters of the environment and powerful, they do not perceive themselves inferior to other. Additionally, as they believe that the offence was their only choice and only thing they could do to protect their own back, may they do not believe they have done any mistakes.

These offenders do not perceive themselves as inferior, defective or inadequate and may have lower insight into their disorder. Additionally they do not care how others perceive them, and they are not interested or they do not experience internalized stigma, social exclusion or believe to have un-attracted self-image (Cheung et al., 2004; Corrigan et al., 2009; Gilbert, 1998; Gilbert & Procter, 2006; Gouva et al., 2016b; Matos et al., 2015; McKendry, 2014; Saggino et al., 2017; Thibodeau et al., 2011; Tracy et al., 2007; Yanos et al., 2008; Ward, 2014; Wilson et al., 2006).

Something very important to note is that someone who feels ashamed is more motivated to apologize and tries to re-establish social bonds. So it is perceived that SO on the Displeased Victim and the Contradicted Revenger themes may try to apologize to their victim, to their family or even to society in an attempt to strengthen or restore the social bonds. Contrary, Pleased Hero who does not experience shame will not try such a thing; that comes in contradiction with the results of Pleased Hero in guilt where found that this is the only king of offender who will be engaged in reparative behaviour.

10.7.4.4 External and Internal Shame in Correlation with Depression, Suicidal Ideation and Guilt

In terms of external shame, the analysis revealed that depression appears as a positive correlation with all the aspects of external shame which means the higher the depression the higher the external shame and its scales. At the same line, regarding internal shame, depression has a significant positive correlation with characterological shame, behavioural shame, total internal shame; which means the higher the depression the higher these scales. Contrary, it was found that there is no significant correlation with bodily shame.

Shame, like guilt, is frequently related to depression (Allan et al., 1994; Andrews, 1995; Andrews & Hunter, 1997; Andrews et al.,, 2002; Cheung et al., 2004; Fontaine et al., 2001; Harder et al., 1992; Stuewig & McCloskey, 2005; Tangney, Wagner, & Gramzow, 1992). Lewis (1986) was one of the first to support the role of shame in depression such as Hoblitzelle (1982) previously in an empirical study had found that shame is significantly correlated to depression. Ghatavi et al. (2002) stated that shame is affected by the severity of depressive emotions and other argued that shame can cause more depression compared to guilt because its maladaptive quality (Bryan et al., 2013; Gotlib & Abramson, 1999; Wright, O'Leary, & Balkin,1989).

Studies further revealed that depression is positively related with both external shame (Allan et al., 1994; Gilbert et al., 1996) and internal shame (Tangney et al., 1995). Additionally there is evidence that support that depressed individuals perceive themselves as inferior to others (Allan & Gilbert, 1995; Swallow & Kuiper, 1988) and incline to embrace more submissive than assertive behaviours (Allan & Gilbert, 1997; Arrindell et al., 1990; Forrest & Hokanson, 1975).

In a research conducted specifically on schizophrenia patients, there was found that there is an association between external shame and depression; and Keen George, Scragg and Peters (2017) proposed that association is present in schizophrenia patients because of the stigma that many schizophrenia patients experience which lead to depression. These finding converge with the work of Birchwood et al. (1993, 2000) and both research groups found that the depression in schizophrenia, after the patients diagnosis, is linked to the negative attitude such as humiliation, shame, shelf-blame and loss of social society has against psychotic patients (Iqbal, Birchwood, Chadwick, & Trower, 2000; Wood & Irons, 2016).

The analysis also revealed that in terms of external shame, the suicidal ideation is not correlated with inferiority, mistakes but it appears to have a significant positive correlation with emptiness and total external shame; which means the higher the SI the higher the emptiness and the total external shame. In terms of internal shame, depression had no significant correlation with behavioural shame, bodily shame and total internal shame but there was found a significant positive correlation with characterological shame; which means the higher the SI the higher the characterological shame.

This finding that indicate that only few aspects of external and internal shame are associated with suicidal ideation are in contrast with previous findings which regard shame as a main characteristic of many suicidal individuals (Orbach, 1997). Shame has been found to be strongly associated with suicidal ideation, suicidal plan and suicide attempts (Dutra et al., 2008; Hastings et al., 2000; Lester, 1998; Rudd et al., 2010). Also in a recent study which developed a suicide-specific measure, there was found that shame is positively correlated with suicidal ideation and is a predictive factor of suicide attempts (Rudd et al., 2010; VanDerhei et al. 2014). Even in a

current study on military mental health patients there was found shame might be especially important cognitive-affective experience associated with suicide risk (Bryan et al., 2013). This opposition between the present study's findings with results of previous finding may lie in the specific nature of the sample.

Last, the analysis revealed that in terms of external shame, the guilt in almost all of its aspects is not correlated with inferiority, emptiness, mistakes and total external shame. Only state guilt appeared a significant negative correlation with Mistakes and Total External Shame; which means the higher the state guilt the lower the Mistakes and the Total External Shame and vice versa. In terms of internal shame, guilt and almost all of its aspects had no significant correlation with characterological shame, behavioural shame, bodily shame and total internal shame. Only trait guilt was found to have significant negative correlation with bodily shame; which means the higher the trait guilt the lower the bodily shame and vice versa

The present study found there is no correlation between guilt and shame and even in some cases there is negative correlation. These findings contradict many theorists who argue that guilt and shame are highly correlated and can even be experienced at the same time (Bybee & Quiles, 1998; Tangney et aI., 1992). Speciffically, Tangney et al. (1992) is referred to guilt as "guilt fused with shame" (p. 476) to support that view. Tangney et al. (1992) also argued that "shame-free" guilt is more adaptive and leads to greater interpersonal function, compared to shame fused guilt which is considered to lead to more maladaptive behavioral and psychological outcomes such as remorse and self-contempt. Under that notion, schizophrenic offenders are favored that they do not experience shame and guilt at the same time because it would probably lead them to more maladaptive behavious such as "concealment", painful feelings and grater problems in psychopathology.

A last comment that may trigger more thoughts on the association between guilt and shame is the statement of Lewis (1995) who said that someone may feel ashamed because he is already feeling guilt but he cannot feel guilty because he is ashamed.

10.8 Theoretical and Practical Implications

The findings of the present study represent an important development in the understanding of crime committed by schizophrenic offenders and give and insight into their emotional state during the offence and after that. Therefore, it is generated a number of theoretical and practical implications.

The study successfully implemented the Criminal Narrative Experience framework proposed for non mentally disordered offenders in clinical populations. The study's findings revealed differences between schizophrenic offenders and criminal offenders in terms of their criminal behaviour, crime, motives and emotions and provided criminal narrative experience themes that could be a function of schizophrenic offenders. This is a valuable asset considering that until now there was no specific validated framework to interpret and elaborate more effectively on criminal offences committed by individuals suffering from schizophrenia within the discipline of Investigative Psychology.

The present study systematically explored issues related to the criminal behaviour of the schizophrenic offenders and offered an in depth understanding to the roles the assigned to themselves and the emotions they experienced during the crime commission. The research is of great importance considering that the schizophrenic offenders population is not widely researched and the fact that the information regarding the crime is generated directly by them adds to that importance. Their

narratives gave shape to their criminal action and therefore provided information to their inner motives and psychological processed which are key elements for better understanding their criminal behaviour (Ioannou et al., 2017; Presser, 2009; Youngs & Canter, 2011). The information obtained directly from schizophrenic offenders gives the most reliable in the description of how they experienced the situation both practically and emotionally and what really motivated them into the illegal act. All these under the light of the psychotic symptoms they experienced, of different type and intensity for each SCO; which can not be fully understood even by the scientific community and legal authorities. This context does not take into account whether schizophrenic offenders are telling the general truth of how the crime committed, but only examines the unique truth they are claiming.

Many research questions the possibility of predicting future behavior that could be classified as risky; and predicting future violent acts by mentally ill is extremely difficult. Though it could be suggested that a deeper understanding on how schizophrenia offenders experience their crimes and understanding their inner motivations for offending could inform risk management (Mortimer, 2010). The CNE can potentially aid in the risk factor identification by considering the circumstances surrounding the offence. For example, it is important to know if a schizophrenic offender perceives himself as a Displeased Victim, as hurting the person who he perceives as dangerous against him, it could temporarily relieve him from his delusions and prevent him from engaging again in aggressive behaviour. On the other hand, because the Displeased Victim does not admit he has committed an illegal act and does not consider himself being a part of it, may be vulnerable in re-offending if he finds himself in a similar situation under the notion that he is simply protecting himself. Contrary, someone who perceives himself as a hero where at the time of the

crime he was calm, had everything under control and considers that he did nothing special, presents clearly a higher risk of re-offending. The identification of such risk factors, the identification of different criminal narrative experiences and the detailed description of each one of them could help psychiatrists and psychologists to better understand the schizophrenic offenders' thoughts and needs in order to be able to prevent crime in such populations; and further develop more effective treatment programmes and social reintegration procedures for such populations who are doubly stigmatized.

In more detail, the Criminal Narrative Experience framework and the different themes revealed through the analysis could separate offender according their CNE and would allow the development and implementation of more targeted interventions. The psychologist can indentify the offenders' experiences and emotions in order to recognise their significance for the individuals. CNE could be a powerful tool to improve treatment efficacy (Ioannou et al., 2017). The treatment procedures could be focused on the psychotic symptoms and the emotions that led each offender who assignd different CNE to the crime; and based on them they could potentially formulate an effective psychotherapeutic treatment for each CNE. Under the same notion specific reintegration procedures could be formed for each CNE.

Except for the clinical implications, the present study also benefits legal authorities. In more detail, the description produced for each criminal narrative experience assist law enforcements agencies to deeper understand schizophrenic offenders' criminal behaviour and to identify more easily and effectively salient features of these offenders. The CNE proposed for the schizophrenic offenders in the present study, provided law enforcement agencies a new framework for thinking about an offence committed by SOs and enables them to produce inferences about

these crimes and consequently contribute to the decision making required in an investigation. In other words, the exploration of narrative roles and emotions conducted in the present study could possible contribute to the development of schizophrenic offenders profiling.

Another benefit for the law enforcement agencies is that the identification of different CNEs may have an impact on the interviewing process with schizophrenic offenders and may aid to develop or reform interrogation techniques. So interviews can be constructed based on the roles each offender enacted and the emotions he was experiencing during crime commission (Ioannou et al., 2017; Youngs & Canter, 2009). For each offender who assigned to himself a different CNE could possible used a different combination of questioning, confrontation, suggestion, and persuasion techniques to get the desirable results. For example, there should be a different way of questioning to someone who considers himself a Displeased Victim, as that SO does not consider himself responsible for the crime, and a totally different way of questioning to a SO who considers himself a Pleased Hero who thinks that the crime he committed is not something special, he thinks that he had to do it as he was on a mission and derived emotions of pleasure from his criminal action.

The study also explored the differences in background characteristics of schizophrenia offenders between the three criminal narrative experiences identified. This information may be used in determining whether the demographic characteristics, the psychiatric history or the criminal history could be a predictor of engagement into crime for a schizophrenic offender or could be an indicator for the development of a particular narrative experience. For example, age that found to have a significant correlation with CNE could function as factor of predicting the SOs' CNE. Investigation of the background characteristic in accordance with the CNE

could also be useful for law enforcement agencies which investigate crimes in practice. There is evidence that suggest that the way an offence is committed can be linked to the offenders' characteristics (Canter, 2000; Salfati, 2000). Information about how schizophrenia offenders commit their crimes could possible enable investigators to determine if a crime is committed by them or by someone else without a psychotic disorder. Furthermore, information obtained from the criminal history in conjunction with the CNE is of great importance as the legal authorities as they will facilitate their investigations. It is considered very effective to know whether SOs according to the CNE organized the crime in advance, if they took tools with them, if they had any eyewitnesses and if they were trying to conceal the crime and/ or cover their traces.The study further explored the emotional state of SOs after crime commission while they are in incarceration. The study revealed that schizophrenia offenders did not experience depression despite the fact that most of them experienced negative emotions while carrying out crime. The study also revealed no suicidal ideation among SOs. These finding contradicted the literature and propose that the SOs differs in the experience of these two aspects compared with other offenders or even with other mentally ill populations; and requires differed treatment strategies and that the attention in the population should be shifted in other aspects such as moral emotions.

Knowing a person's levels of moral emotions help to predict the likelihood that person will behave unethically. The study offers information on such an issue by identifying which offenders according to the CNE assign to themselves may have a tendency towards unethical and violent behaviour by examining the moral emotions of guilt and shame. It is proposed that SOs who experience guilt may accept personal responsibility over wrongdoing (Ahmed et al., 2001; Ahmed & Braithwaite, 2006)

and may tend to think, feel, and act ethically (Tangney & Dearing, 2002; Tangney et al., 2007; 2009, 2011) and take reparative actions to alleviate the guilt emotion and to improve themselves and their relationships with other (Fisher & Exline, 2010; Hall & Fincham, 2005; Woodyatt & Wenzel, 2014). Contrary, the SOs who experience shame have impaired sense of self and lack of self worth (Tangney & Fischer, 1995; Tangney et al., 2014; Tibbetts 2003) and tent to blame others and act aggressively (Tangney et al. 2014). Studies have found that guilt proness is a protective factor against violent behavior and recidivism; whereas shame proness is a risk factor of violent behavior and re-offending (Tangney et al., 2011, 2014). The identification of SO in terms of their CNE who experience shame could indicate the implementation of specific treatment techniques in the therapeutic treatment of SO in order to deal with the need of acceptance and approvals from others they need and to decrease the aggressive behaviour. This will help both the more effective treatment of SOs, will reduce re-offending and will allow a better and smoother reintegration into society after their discharge from the psychiatric hospital.

Schizophrenic offenders often need long-term hospitalization and psychological treatment that will help them to manage mental health problem and reduce the risk of recidivism. Taking into account all the information provided by the present research, regarding not only the criminal narrative experience but also the emotions of depression during hospitalization, the thoughts or intentions to harm oneself and the experience of moral emotions could give vital information that could be used in the treatment and rehabilitation processes. Creating more schizophrenia-specific treatment and rehabilitation programmed could aid to further crime prevention and relapses prevention (McGreevy, Steadman, Dvoskin, & Dollard, 1991; Wiederanders, 1992; Wiederanders, Broley, & Choate, 1997). It could help the

schizophrenia patient to develop insight into his illness, to adhere to antipsychotic medication during hospitalization and after it and to elevate his motivation to maintain psychiatric supervision after being discharged from the psychiatric hospital. All that would improve the patient's psychological and social well-being.

An intervention in order to be successful should give emphasis on the emotions experience and emotions regulation (Day, 2009). The present study provides a great amount on information SO's experience both during crime commission and after that. Effective treatment interventions might involve psychoeducating SOs in the functionality of emotions, especially of the negative ones in order to avoid their suppression (Agnew, 2001) or the offender's detachement from them (Baumeister et al., 1994). In such an intervention is learned to the offender that all emotions either positive or negative experienced by him can be healthy to the extent they enhance introspection and guide social behavior (Garofalo, & Velotti, 2017). It has been suggested that promoting the ability on reflecting upon emotions rather than acting on them could potentially decreased the risk of aggressive behavior and increase social adjustment (Garofalo, & Velotti, 2017).

The present study also tried to explain the criminal behaviour of a schizophrenic offender in an attempt to reduce social stigma which is accompanied with fear, prejudice and intolerance (Pescosolido et al., 2010; Rose et al., 2011). Schizophrenic offenders bear double stigmatization in society due to their dual identity as offenders and as mentally ill; and frequently encounter stigmatization, discrimination and social exclusion (Angermeyer et al., 2004; Brooker & Ullman, 2008; Corker et al., 2013; Henderson & Thornicroft, 2013; Lasalvia et al., 2013; Link et al.,1999; Martin, Pescosilido, & Tuch, 2000; Mezey et al., 2010; Mezey et al., 2012; Rose, et al., 2011; Thornicroft et al., 2009; TNS, 2007).

Stigma impacts many domains of the individual's life such as psychological well-being, treatment angagement, social adjustment and interpersonal relationships (Boardman et al., 2010; Clement et al., 2015; Rose et al., 2011; Thornicroft, Rose, Kassam, & Sartorius, 2007). Stigma represents lack of knowledge and problems in attitudes and behaviours (Thornicroft et al., 2007). Providing information to the public about schizophrenia offenders, their experiences, their though and their emotions may give them a more "human" identity and could aid to dispel widespread myths and prejudices and to the reduction of social stigma and consequently the self-stigma of such population. The social acceptance would lead with its turn to lower depressive symptoms and less suicidal thought among schizophrenia offenders (Lenzi, Colucci, & Minas, 2012; Taylor, 2010; Wray, Colen, & Pescosolido, 2011).

Last but not least, the number of the participants of the study, which by others could be perceived as a limitation because of its small number, at the present study is perceived as strength as it is representative of the population under examination. In Greece there are 155 mentally disordered offenders and the 134 of them are diagnosed with schizophrenia (Martinaki et al., 2018). The present study examined 64 schizophrenia offenders which account to the 47.8% of the overall schizophrenic offender population in Greece. Further, female participants in the study which were few in number, 10 in specific, also are a representative sample of the female schizophrenic offenders in Greece as there are only 21 SO in the psychiatric hospitals of Greece (Martinaki et al., 2018). Therefore, it could be said as the study has a representative sample and has used valid psychometric tools that the result can be generalized to the schizophrenic offender population in Greece and could be considered valid to use form other researchers worldwide for cross-cultural comparisons.

10.9 Limitations of the Present Study

While the findings of the present study are important and promising, there have also been identified some methodological issues.

First of all it should be noted, that from the sample were excluded SOs with co-morbidities and other serious health problem. The sample also did not included patients who had court cases at that time or those who were considered dangerous and were not allowed to be examined. If these individuals would be examined the results may have been differed.

A major limitation of the present study is that there were not excluded participants who had alcohol or substance abuse in the past despite the fact that it has been widely reported the positive association between substance abuse and criminality (Arseneault et al. 2000; Coid et al. 2006; Ditton, 2012; Elbogen & Johnson 2009; Fazel, Långström, Hjern, Grann, & Lichtenstein, 2009; Grann & Fazel, 2004; Hodgins, 1992, 1993; Steadman et al., 1998; Swanson et al., 1990). That limitation could not be avoided as if the research would exclude such individuals; the sample of the study would be decreased dramatically.

One possible methodological problem of the study is that the data collected by using self-report questionnaire. That from one hand has great importance as stated above but it also generates some concerns. All the information collected regarding the prticipants' demographic characteristics, psychiatric history and criminal history were cross-referenced with the official psychiatric and legal records. Whereas the data collected from the questionnaires and those collected from the discussions between

the researcher and the offender cannot be verified; and cannot be certified if the offenders concealed or exaggerated on information.

Another key methodological issue arises in such research in terms of the timing of depression which is unclear. So it cannot be ascertained whether emotional disturbance existed before the crime was committed or subsequently developed, probably due to the experience of criminal proceedings and imprisonment.

Last, an issue that needs specific attention is the schizophrenic offenders' memory regarding the offence. Despite the fact, they were asked to state the strength of their memory regarding the offence; there are possibilities of inaccuracies in their responses due to retrospective nature of the recall and due to cognitive deficits such as attention and memory impairments which are outcomes of the schizophrenia disorder. Also the present of other symptoms such as shallow effect, delusion, hallucinations and inability to perceive the reality could further add the concern regarding the accuracy of data collected. Therefore, it could be said that the participants only reported their interpretation of the events. Presser (2009) also argued that in terms of what happened the offenders' narratives are not concerned with the truth, but rather with the recall of the experience.

10.10 Proposals for Future Studies

Despite the bulk of information produced from the present study, there are many issues that need to be further explored regarding schizophrenic offenders in order to gain a deeper understanding on the various factors that may lead schizophrenia patients to crime; and the degree to which schizophrenia is responsible for the violent behavior.

It would be useful to attempt to replicate in whole or partially the present study in sample of schizophrenia offenders in order to verify the findings. Further studies should be conducted considering the demographic characteristic, the psychiatric history, the criminal history and the emotional state of SOs during incarceration to allow the comparison between the findings and the deeper and more valid understanding of the offending among schizophrenia patients. The studies could also be expanded in other mentally ill population that offend and even to explore for gender differences. In addition collecting data in other countries may also be of great importance. To investigate the different criminal narrative experiences of SOs worldwide, a cross-cultural investigation would be particularly useful; in order to create patterns of offending based on cultural difference.

One of the most powerful findings in the literature is that substance use increases the likelihood of aggressive behavior (Fazel et al., 2009; Grann, Danesh, & Fazel, 2008; Grann & Fazel, 2004; Pernanen & Heath, 1991), So a future study to cover the major limitation of the present one, it would be vital to investigate the role of substance abuse in the violent offending of schizophrenia patients; as it has been found that the more violent schizophrenia patients are those who use alcohol and substances in a systematic way, or even they have been diagnosed with co-morbid substance abuse (Adler, 1999; Elbogen & Johnson, 2009; Eronen et al., 1996; Laajasalo & Häkkänen, 2005; Meehan et al., 2006; Mullen, 1997; Nielssen et al., 2007; Scott et al., 1998; Smith & Hucker, 1994; Soyka et al., 1993; Soyka & Morhart-Klute, 2002; Steadman et al., 1998; Swanson, 1994; Swartz et al., 1998; Volavka & Swanson, 2010; Wessely, 1997); and that substance abuse cause more violence in psychiatric patients than any other factor (Swanson, 1994). It is very likely, that the SO with co-morbid substance abuse to report the more violent crimes as it has been

found that substance abuse on schizophrenia increase seventeen times the risk for homicide (McNamara & Finding, 2008); and may assign to themselves different narrative experiences than those who do not use substances.

It may would be also important to examine the weapon schizophrenia offenders used in their crimes and if that could be associated with CNE. In literature the majority of SO use sharp weapons such as knifes (Diourta-Tsitouridi, 2008; Golenkov et al., 2011; Häkkänen & Laajasalo, 2006; Steury & Choinski, 1995); and less frequently other blunt objects or firearms (El-Hadidy, 2012; Golenkov et al., 2011). Steury and Choinski (1995) stated that SOs choice of weapon reflects the impulsive nature of their offence. Easy access to a dangerous weapon was found to be associated with higher rates of aggressive behavior and attempted homicide (Martinaki et al., 2013).

Additional to that, it would be also efficient to explore the area of the body a SO injuries the most during the offence. It has been found that the majority of SO injuries more frequently their victim's face. It is possible that offenders, because of impaired emotion recognition in facial expression, perceive the face especially threatening (Mandal et al., 1998; Manor et al., 1999). Such as study, could possible give information about the offenders' perception and recognition of emotions and could aid police in the investigations and interpretation of a crime committed by a schizophrenic offender.

A future study to explore the relationship between psychotic symptoms and CNE would be vital as the empirical evidence on such an issue are sparse and equivocal (Witt et al., 2013); despite the fact that Link et al. (1999) has supported that no other demographic and socioeconomic factors except for the disorder play role in the violent behaviour of mentally disordered offenders. Other studies have also have

supported the role of different levels of psychiatric symptoms, and particularly the more active the symptoms the more responsible they are for patient's aggressive behaviour (Torrey, 1994; Zartaloudi, 2009). Also some authors have considered that psychotic symptoms like persecutory delusions might be associated with an increased risk of violent offending (Bentall & Taylor, 2006). Therefore, maybe those who are in a first-episode psychosis or in acute phase of the disorder experience more acute psychotic symptoms such as persecutory delusions during the offence act upon delirious defense and may assign a different CNE to themselves compared to those who are in a residual phase and may experience less positive and more negative symptoms.

It is also important to investigate the patient's perception of the victim's intentions, as investigating these beliefs may reveal psychotic beliefs or delusions (Meeham et al., 2006). Individuals diagnosed with schizophrenia have impairments in different aspects of social cognition (Sprong et al., 2007), including emotion perceptions and recognition and draw inferences about others thoughts, feelings and intentions (Frith, 1992; Zalla et al., 2006; Craig, Hatton, Craig, & Bentall, 2004; Herold, Tényi, Lénárd, & Trixler, 2002). These impairments add to the psychotic symptoms and may lead the schizophrenia patients to experience delusions of persecution or reference, making them believe that they are in danger or have been wronged by a specific other who want to harm them or auditory hallucinations warning them about the victim (Hafner & Boker, 1982; Erb et al., 2001; Laajasalo & Häkkänen, 2006; Nielssen et al., 2007). In such cases the SOs may act differently believing they are the victims of the situations and they are protecting their own back; giving rise to different criminal narrative experience.

It would be also important to examine in future research the association of someone's offending to his parents' mental illness. Studies have reported that parental mental illness, especially in combination with parental violent offending is associated with offspring's violent criminal involvement (Heston, 1966; Moffit, 1987; Tehrani et al., 1998). Therefore, future research should explore if the children living with a mentally disordered parents are more prone to criminal behaviour.

Further studies concerning co-morbidity would also be important as most studies report that the coexistence of two diagnostic categories increases the risk of developing dangerous behavior, especially if one of the two is a personality disorder (Martinaki et al., 2018). People with a personality disorder are ranked among those with violent behavior as they have a substantial inability to adapt to society, tend to be irresponsible, incapable or unwilling to create effective interpersonal relationships. Of particular interest is the antisocial personality disorder as many studies have supported that the presence of antisocial elements in personality is positively associated with misconduct and in particular violent behavior (Christodoulou et al., 2002; Zartaloudi, 2009).

Studies support than many times schizophrenia co-morbids with psychopathy (Hodgins et al., 1996; Newton-Howes, Tyrer, North, & Yang, 2008; Nolan et al., 1999; Rice & Harris, 1995; Tengström et al., 2000) and Abushua'leh and Abu-Akel (2006) found that schizophrenia patients with high psychopathic profile may exhibit violent behavior even after the improvement of their illness condition. Also a bulk of studies found psychopathy to be a predictor of future violence in schizophrenia patients (Bonta et al., 1998; Dolan & Davies, 2006; Fullam & Dolan, 2008; Hare, Clark, Grann, & Thornton, 2000; Harris, Rice, & Cormier, 1991; Heilbrun et al., 1998; Kroner & Mills, 2001; Majorek et al., 2009; Nolan et al., 1999, 2003; Pham,

Rémy, Dailliet, & Lienard, 1998; Rasmussen, Levander, & Sletvold, 1995; Rice & Harris, 1992; Shine & Hobson, 2000; Tengström, 2001; Tengström et al., 2000, 2004; Walters, 2003).

Schizophrenia patients with co-mobird psychopathy have shallow emotions and lack of empathy, guilt and remorse (Hare, 1991, 2003; Harpur, Hakstian, & Hare, 1988), exhibit non adherence to medication (Dolan & Davies, 2006; Kunz et al., 2004), more impulsive and violent behaviour (Fullam & Dolan, 2006; Hare, 1991, 2003; Nolan et al., 1999) and higher risk of recidivism (Hodgins et al., 2003; Moran et al., 2003; Tengström et al., 2000). Therefore, further research should be conducted to explore the differences in criminal activity between SO with and withouw psychopathic traits as it is assumes that they will offend in a different way and will assign to themselves CNEs that correspond to their psychiatric and emotional state. Also, information from such research could be used in risk management and crime preventions of schizophrenia offenders.

10.11 Conclusions

The present study made progress in validating the CNE framework for offending population proposed by Ioannou et al. (2017) through its application to schizophrenia offenders' population. Resulting themes were partially inconsistent as there were identified some differences in the representation of each theme; something that was expected considering the specific nature of the population under examination. Despite the differences the themes identified in the present study were similar in sense to the themes proposed by previous studies.

Nevertheless, the findings of the present study have theoretical and practical implication regarding the understanding of how schizophrenia offenders experience their crimes and what is their emotional state in terms of depression, suicidal thoughts and moral emotion during incarceration. These findings offer insight into crimes committed and emotions experienced by SOs providing valuable information to mental health professionals and law enforcement agencies to better understand the criminal behavior of these populations and to consider on the techniques and processed they use in a different and more informed way.

Mental illness and criminal offending stigmas are a major burden for schizophrenia offenders. Common stereotypes about offenders suffering from schizophrenia such as unpredictability and dangerousness, cause stigmatising beliefs and avoidant behaviours within the general population. Therefore, schizophrenia offenders have to cope with the distressing experience of crime, of psychosis and of the discrimination they face due to stigma perceived by their social environment.

The stigma remains indelible on the person who carries it and distrust, fear, avoidance, rejection, and discriminatory behaviors will follow him for the rest of his life; even if the SO take reparative actions, even if the psychotic symptoms recede, even in the case when a mentally ill individual proves that he can fulfill his social role, work and lead a normal social life.

Against all evidence which support the association between schizophrenia and violent offending, it should be noted that schizophrenia patients are one of the most vulnerable social groups and are therefore much more likely to be victims rather than perpetrators (Choe et al., 2008; Lurigio, Canada, & Epperson, 2013; Mind, 2007; Taylor, 2008; Walsh & Yun, 2013). Additionally, even when they offend, their

criminality contributes relativity little to overall societal violence as this and many other studies have suggested.

It is of great importance to note that individuals suffering from schizophrenia are not dangerous and do not pose a risk of violent behaviour in society; contrary to the widespread societies' misconception schizophrenia patients are dangerous to others. Patients suffering from schizophrenia can experience psychotic symptoms such as delusions and hallucinations in daily vases for many years without acting violent in response to them. Crime commission by a schizophrenia patient does not therefore mean that his act necessarily constitutes the uncontrolled and unjustifiable product of his disorder. Human behavior, and consequently crime, is characterized by complexity and is characterized by bio-psychosocial factors and by the way that such behavior is perceived and dealt with by the environment. Therefore, under no circumstances can mental illness be perceived as a static, fixed characteristic of a person and the cause of his or her criminal behavior (Peterson et al., 2014).

The study aimed to give a better insight into the criminal offending of schizophrenia patients and tries to inform the mental health professionals, the law enforcement agencies and the public about their thoughts, motives and emotions in an attempt to prevent the demonization of those who suffer from schizophrenia. Stigma reduction will have positive outcomes (Chatzoglou, 2010) for schizophrenia patients who have offended such as reduced experience of negative emotions such as hopelessness, depression, guilt, shame, lower risk of reoffending and increased self esteem and self-efficacy, commitment to treatment and adherence to medication, better social adjustment and inclusion and generally greater well-being.

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Appendices

Appendix A

Studies' findings which support there is an association between mental disorder and criminal violence.

Author/s	Year	Title	Sample	Results
Arnold-Williams, R., Vail, E., & MacLean, J.	2008	Mentally ill offender community transition program: Annual report to the legislature.	25 seriously mentally ill offenders	• Individuals participated in the Mentally Ill Offender – Community Transition Program (MIO-CPT) were significantly less likely to re-offend compared to the group of mentally ill offenders not participated in the program. • Of those participated in the MIO-CPT only 6.5% were involved in violent crimes 2 years after their release and the majority of them were related to drugs. • Mentally ill offenders who participated in the MIO-CPT, when the committed a new crime it appeared to be less severe compared to the comparison group. • Recidivism in mentally ill offenders participated in the MIO-CPT is correlated with depressive symptoms, suicidality, drug use and psychotic symptoms.
Arseneault, L., Moffitt, T. E., Caspi, A., Taylor, P. J., & Silva, P. A.	2000	Mental disorders and violence in a total birth cohort: results from the Dunedin Study.	961 young adults	• Individuals diagnosed with drug and/or alcohol dependence and with psychotic disorders were 1.9 to 3.8 times more likely to exhibit violent behaviours compared to the control group. • Individuals with one of these disorders or a combination of them were responsible for approximately fifth percent of the sample's violent crimes; with schizophrenia account to the 10%. • Among those with alcohol dependence the violent act is associated with substance use before the incident. • Among those with marijuana dependence the violent act is highly correlated with juvenile history of conduct disorder. • Last, among these with schizophrenia the violence is best explained by excessive positive symptoms and particularly of perceptions f threat and by history of conduct disorder.
Brennan, P. A., Mednick, S. A., & Hodgins, S.	2000	Major mental disorders and criminal violence in a Danish birth cohort.	358.180 subjects were drawn from a birth cohort of individuals born between January 1, 1944 and December	• There is a significant positive correlation between major mental disorders and criminal violence (odds ratios 2.00-8.8 for males and 3.9-23.2 for females). • Individuals with major mental disorder

			31, 1947 in Denmark.	who were hospitalized were accountable for and excessive percent of violent acts committed by the participants of the birth cohort. • From those been hospitalized, those with the highest possibilities to get arrested for violent crimes were males with organic psychosis and both males and females with schizophrenia.
Choe, J. Y., Teplin, L. A., & Abram, K. M.	2008	Perpetration of violence, violent victimization, and severe mental illness: balancing public health concerns.	Metanalysis with 31 articles relevant to violence perpetration and violent victimization retrieved from MEDLINE, PsycINFO, and Web of Science .	• Regarding the studies examined violence perpetration half of them had as sample inpatients; whose rates of violent perpetration was 17%-50% higher than the studies of other samples. • From studies examined outpatients, the outcome was that within the past six months to three years outpatients has perpetrated in a percentage of 2% to 13%, while they were victimized to a percent of 20% to 34%. • From studies examined both inpatients and outpatients there was revealed that a percentage of 12 to 22% was violence perpetrators within a period of the past six to 18 months; while percentage of 35% had been reported to be victims of violence during the past year.
Dunsieth Jr, N. W., Nelson, E. B., Brusman-Lovins, L. A., Holcomb, J. L., Beckman, D., Welge, J. A., ... & McElroy, S. L.	2004	Psychiatric and legal features of 113 men convicted of sexual offenses.	113 male sex offenders referred from prison, jail or probation to a residential treatment facility.	• The majority of the participants exhibited high prevalence of disorders from Axis I and II. The vast majority of them (85%) had been diagnosed with a substance use disorder a 74% has been diagnosed with a paraphilia; 58% has a mood disorder and 56% had antisocial personality disorder. Smaller percentages of the sample had an impulse disorder (38%); bipolar disorder (35%); depressive disorder (24%); anxiety disorder (23%) and eating disorder (9%). • Offenders diagnosed with a paraphilia had also a co-morbid diagnosis either of mood disorder, major depression, anxiety disorder, impulse control disorder or avoidant personality disorder. • Offenders with paraphilias spent less time in incarceration compared to those who had not been diagnosed with paraphilias. • Moreover who had not been diagnosed with paraphilias reported to have less victims, start offending in an older age and were less likely to be implicated in cases of incest or in sexual imposition of a minor. They also had only adult victims, criminal history of juvenile offenses and incidents of theft.

Erb, M., Hodgins, S., Freese, R., Müller-Isberner, R., & Jöckel, D.	2001	Homicide and schizophrenia: Maybe treatment does have a preventive effect.	268 individuals with schizophrenia who had committed or attempted homicide in the German state of Hessen from 1992 to 1996 and 276 individuals from the Federal Republic of Germany from 1955 to 1964 in comparison	• In both chronological cohorts schizophrenia is highly associated with increased risk of homicide. • In the older cohort schizophrenia increased that risk 12.7 times while in the more recent cohort which increased it 16.6 times. • Other factors associated with homicide are the non admission of chronic high-risk patients in appropriate services and he non admission in mental health facilities by the first psychotic episode.
Giovannoni, J. M., & Gurel, L.	1967	Socially disruptive behavior of ex-mental patients.	1,142 psychotic male veterans	• Psychotic male veterans exhibited higher rate of criminal activity especially for crimes against persons compared to results published from previous studies for mentally disordered criminals. • Type of disposition was associated to type of crime, and often involved return to mental health hospital with spending no time in jail. • A positive correlation identified between alcohol use problems and the commission of disruptive acts.
Hodgins, S.	1992	Mental disorder, intellectual deficiency, and crime. Evidence from a birth cohort.	A cohort composed of all 15117 persons born in Stockholm in 1953 and residing there in 1963.Only subjects living in Sweden at the end of the 30-year follow-up period were included in the analyses.	• Males diagnosed with a major mental disorder were two and a half times more likely to be registered for a criminal offence and four times for a violent offence compared to males without mental disorder or handicap. • Females diagnosed with a major mental disorder were five times more likely to be registered for a criminal offence and 27 times for a violent offence compared to females without mental disorder or handicap. • These subjects started having criminal behavior before the age of 18 and committed a series of major offences during their adult lives. • Males diagnosed with intellectual disability were three times more likely to offend and five times more likely to commit a violent offense compared to control group of males without mental disorder or handicap. • Females diagnosed with intellectual disability were four times more likely to offend and 25 times more likely to commit a violent offense compared to control group of females without mental disorder or handicap
Hodgins, S., Mednick, S. A., Brennan, P. A.,	1996	Mental disorder and crime: evidence from a Danish birth cohort.	358.180 individuals born between January 1, 1944, and December 31, 1947.	• Both males and females who had been admitted to mental health hospitals were more likely to have been convicted of a criminal offence compared to individuals

Schulsinger, F., & Engberg, M.			People who had been admitted to mental health hospital were assigned to a diagnostic category according to their diagnosis.	without psychiatric history. • The mentally disordered offenders who had been hospitalized committed all types and, on average the same amount of offences as the same sex control group.
Large, M., Smith, G., & Nielssen, O.	2009	The relationship between the rate of homicide by those with schizophrenia and the overall homicide rate: a systematic review and meta-analysis.	Systematic review and meta-analysis of population-based studies conducted in developed countries of homicide committed by persons diagnosed with schizophrenia.	• Rates of homicides committed by individuals diagnosed with schizophrenia were positively correlated with total homicide rates with $r=0.868$, $p<0.001$. • Using meta-analysis, only a small percentage (6.48%) of all homicide offenders had been diagnosed with schizophrenia.
Link, B. G., Andrews, H., & Cullen, F. T.	1992	The violent and illegal behavior of mental patients reconsidered.	232 psychiatric patients and 521 community sample	• Patients with mental disorders score higher than the community group on all measures regarding the expression of violent/illegal behavior. • The differences between the two groups do not lie on any sociodemographic variables, but only on the presence of psychotic symptoms of the psychiatric patients' group. • These differences revealed to be modest and were present only between the community sample and the particular patients experiencing psychotic symptoms and not generally all the mental health patients.
Monahan, J.	1992	Mental disorder and violent behavior. Perceptions and evidence.	Literature review	• It has been firmly supported by studies on mentally ill offenders compared to community samples or offenders without mental illness, that there is a significant positive correlation between mental disorder and violent behavior. • Sociodemogrophic factors pose no important role in this association. • Mental illness is a strong and significant risk factor for the expression of violent behavior.
Mullen, P. E.	1997	A reassessment of the link between mental disorder and violent behaviour, and its implications for clinical practice	Literature Review	• Studies have established a positive correlation between mental illness and tendency towards violence. • Active symptoms of mental illness have been identified as mediators of increased risk of violent behavior. • The most effective way to deal with the risk of violent behavior of mentally ill is to improve support, care and treatment provided to this population both in community and mental health services.

				• Individuals identified as high risk patients need to be targeted for priority and intensive treatment and follow-up. • There is need for better and sooner recognition and prevention of the risk of violence among mentally ill; and the development of strategies to manage effectively such patients.
Nielssen, O., Westmore, B. D., Large, M., & Hayes, R. A.	2007	Homicide during psychotic illness in New South Wales between 1993 and 2002.	88 individuals committed homicides during psychotic illness	• In the incidents of homicide, there were reported high rates of drug abuse and particularly of drugs known to induce psychotic illness. • Auditory hallucinations and delusional beliefs where the individual perceives s/he is in danger are the symptoms that have been positively correlated with lethal assaults. • The vast majority of the psychotic patients' victims are family members and close associates. A very small proportion has as victims strangers and others. • The majority of the homicides occurred during the first year of illness; and acute phase and especially first psychotic episode have been identified as the most significant risk factor of committing a lethal assault.
Rappeport, J. R., & Lassen, G.	1965	Dangerousness-arrest rate comparisons of discharged patients and the general population.	There were 708 mental patients from 1947, 2152 mental patients from 1957 and control group from general population.	• Regarding the offence or robbery, both mental patients chronological groups reported higher arrest rates compared to the general population. • There were no significant differences between the clinical groups and the general population regarding the offences of murder and negligent manslaughter. • The rates were almost equivalent between the mentally ill and the general population regarding the offence of aggravated assault. • In the older cohort individuals diagnosed with alcohol misuse and schizophrenia were responsible for at least the 1/3 of the offences. • In the cohort of 1957 individuals diagnosed with alcohol misuse and schizophrenia had pre-hospital arrest rate of only 4/100 while individuals diagnosed with paranoid personalities had arrest rate of 40/100.
Rappeport, J. R., & Lassen, G.	1966	The dangerousness of female patients: A comparison of the arrest rate of discharged	693 female mental patients in 1947 and 2,129 female mental patients in 1957 and control group from	• Female mental patients who have been hospitalized are more likely to be arrested for aggressive assault compared to the control group.

		psychiatric patients and the general population.	general population.	• Female offenders with psychiatric history have significant higher rate than the control group in aggravated assault offence, but there are no statistical differences on the offences of murder and robbery. • Women offenders have no implication with offences like negligent manslaughter or rape. • Female offenders diagnosed with alcohol abuse, mental deficiency, and antisocial personality disorder were more likely to offend and get arrested before their hospitalization; while female offenders diagnosed with manic-depression, neurotic disorders, and mental deficiency are more likely to offend after their hospitalization.
Silver, E., Felson, R. B., & Vaneseltine, M.	2008	The relationship between mental health problems and violence among criminal offenders.	17,248 cases from 280 state and 40 federal prisons	• Inmates with major mental disorder are more likely to commit assaultive violence act (21.5%) compared to the inmates without mental health problems (14.5) ($t = 7.60$, $p < .001$); and sexual offences in percentages of 9.3% and 4.9 respectively ($t = 7.57$, $p < .001$). • There is a modest correlation between mental health problem and offences against property, including armed robbery. • Regarding drug crimes, inmates with mental health problem were less likely to commit drug crimes (15,1%) than inmates without mental health problems (30.3%) ($t = 13.19$, $p < .001$). • The most common crimes among other types of crimes committed by mentally ill offenders are assaultive violence and sexual offenses.
Sosowsky, L.	1978	Crime and violence among mental patients reconsidered in view of the new legal relationship between the state and the mentally ill.	301 former state mental hospital patients and a control group of local county population	• Mental health patients have higher arrest rates for criminal behavior and violent offences compared to the control group. • Female mental health patients, between the ages 20-30 and of the nonwhite race have higher rates of arrest after committing a violent offence compared to the rest female sample. • Schizophrenia patients arrested for violent offences had higher mean number of arrests compared to the control group. • Contrary, schizophrenia patients had lower mean number of arrest of all offences compared to the nonpsychotic control group. • 25% of schizophrenia patients were arrested for violent offences compared to the 17% of the patients who have been diagnosed with a non psychotic disorder.

Steadman, H. J., & Cocozza, J. J.	1977	Selective reporting and the public's misconceptions of the criminally insane.	149 randomly selected blocks, from which 447 households were drawn, following the cluster sample design - a total of 413 households were interviewed	• Of the respondents 29% stated that people fear "a lot" the mentally ill patients who have been discharged; while a bigger percentage of 61% states that people fear "a lot" the mentally ill offenders. • These results exhibited the public's misconceptions that mentally ill offenders are "violent" and "dangerous". • Participants scored different populations as safe, harmless and non violent. General population scored a five out of seven (where 7 would be most safe, harmless and nonviolent); whole mentally ill offenders scored a two.
Swanson, J. W., Holzer III, C. E., Ganju, V. K., & Jono, R. T.	1990	Violence and psychiatric disorder in the community: evidence from the Epidemiologic Catchment Area surveys.	The data in this study are drawn from three of the five large surveys that made up the NIMH ECA project.	• Individuals who reported having violent behavior were younger, male, has lower socioeconomic status and the majority of them met DSM-III criteria for at least one psychiatric disorder. • Individuals diagnosed with alcohol or drug misuse were more than twice likely to exhibit violent behavior compared to individuals diagnosed with schizophrenia. • There was found a significant positive correlation between major mental illness and substance abuse.
Tehrani, J. A., Brennan, P. A., Hodgins, S., & Mednick, S. A.	1998	Mental illness and criminal violence	Literature review and analysis of family, twin and adoption studies	• Mentally ill individuals have higher rates of risk for committing a violent crime; and it is more likely their offences to be an outcome or recidivism. • Parents who have been diagnosed with a mental disorders and have been hospitalizes and also have committed a violent offence increase the risk of their children to commit also a violent offence. • Results from adoption studies suggest that parents diagnosed with a mental disorder transmit some biological characteristic which cause that increased risk of violent offending of their children. • That biological characteristic probably genetically predisposes their offspring towards violent offending.
Tiihonen, J., Eronen, M., & Hakola, P.	1993	Criminality associated with mental disorders and intellectual deficiency.	107 (98 males and nine females) of 140 offenders were examined by a forensic psychiatrist and control group.	• Male participants diagnosed with schizophrenia have seven times more increases risk to commit a homicide compared to control group. • Men diagnoses with a major affective disorder are about two times more likely to commit a homicide compared to men without mental disorder • Individuals diagnosed with a personality disorder are ten times more likely to

				commit a homicide compared to control group. • Especially, men diagnosed with antisocial personality disorder which is most of the times associated with alcohol dependence have 20 times more increased risk to commit homicide compared to the control group. • Female participants also exhibited higher risk rates compared to the control group, but the size of the sample was quite small to extract reliable results. • More than half of the entire criminal sample met the criteria of DSM-III-R for some personality disorder. • Besides schizophrenia and antisocial personality disorder, homicidal behavior is significantly positive correlated alcohol dependence.
Tiihonen, J., Isohanni, M., Räsänen, P., Koiranen, M., & Moring, J.	1997	Specific major mental disorders and criminality: A 26-year prospective study of the 1966 northern Finland birth cohort.	An unselected 1966 birth cohort (N=12,058) in Northern Finland was prospectively studied until the end of 1992.	• Males with alcohol-induced psychoses and those diagnosed with schizophrenia with co-morbid alcohol abuse have the highest offenses' prevalence. • More than the half of the offenders diagnosed with schizophrenia had also alcohol dependence problems. • Seven percent of the individuals committed a violent crime had been diagnosed with a psychotic disorder. • Male subjects diagnosed with schizophrenia had elevated risk of committing a violent offence, but there was found no high risk for other types of crimes.
Tiihonen, J., & Hakola, P.	1995	Homicidal behaviour and mental disorders	Forensic psychiatric examinations conducted on persons charged with a homicide during several years in Finland.	• Women who have been diagnosed with schizophrenia are 10 times more likely to commit homicide compared to general population; and men are 7 times more likely to commit homicide compared to the general population. • Among individuals diagnosed with alcohol abuse men were 16 time more likely, and women were 50 times more likely of committing homicide compared to the control group. • The mental disorders which have the highest positive association with homicidal behavior are schizophrenia, and the combination of alcoholism and personality disorders.
Torrey, E. F.	2011	Stigma and violence: isn't it time to connect the dots?.	Literature review	• Stigma against mentally ill individuals has been increased since the end of 19th century despite the scientific research which has increased the understanding of

				causes of mental disorders. • The violent acts committed by mentally ill individuals have been increased in the second half of 19th century; as evidence support that 1.7-3.6% of mentally ill have committed homicides during the first half of the century compared to 5.3-17.9% during the second half. • General population perceives mentally ill individuals as dangerous and violent; public's perception leads to mentally ill individuals' stigmatization. • Mental patients who committed violent acts were in a psychotic episode and in most of the times the first psychotic episode before they receive any effective treatment for the disorder they suffer. • Medication compliance plays a deterrent factor of committing a violent crime in mentally ill men. • Attempts in reducing violent behavior of mentally ill will have as a potential result the reduced stigma against that population.
Van Dorn, R., Volavka, J., & Johnson, N.	2012	Mental disorder and violence: is there a relationship beyond substance use?.	Data are from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), a twowave study (N = 34,653: Wave 1: 2001–2003; Wave 2: 2004–2005).	• Individuals diagnosed with a major mental disorder have higher possibilities of being violent compared to individuals without mental or substance use disorder. • Individuals with a mental disorder and a co-morbid substance use disorder have the highest risk of committing a violent act. • Other social and family factors like childhood abuse and neglect, household antisocial behavior, binge drinking and stressful life events have been associated with elevated risk of violence.
Volavka, J., Laska, E., &Baker, S.	1997	History of violent behaviour and schizophrenia in different cultures: analyses based on the WHO study on determinants of outcome of severe mental disorders	10l7 patients with schizophrenia who had their first-in-lifetime contact with a helping agency as a result of their psychotic symptoms	• The occurrence rate of assault from schizophrenia patients was three times higher in developing countries compared to the developed countries. • Violet assault is associated with positive psychotic symptoms like auditory hallucinations and furthermore with severe alcohol problems. • Schizophrenia patients with acute onset were more likely to commit a violent assault compared to those with a more insidious onset. • It was revealed a statistically significant positive correlation between drug use and assault commission in developing countries, but there was found no correlation in the developed ones. • Schizophrenia patients with severe alcohol problems were more likely to commit an

				assault compared to those with less serious or no alcohol problems.
Wallace, C., Mullen, P. E., & Burgess, P.	2004	Criminal offending in schizophrenia over a 25-year period marked by deinstitutionalization and increasing prevalence of comorbid substance use disorders.	Criminal records of 2,861 patients (1,689 of whom were male) who had a first admission for schizophrenia in the Australian state of Victoria in 1975, 1980, 1985, 1990, and 1995 were compared for the period from 1975 to 2000 with those of an equal number of community comparison subjects matched for age, gender, and neighborhood of residence.	• Schizophrenia patients had a greater total number of criminal convictions and were more likely to have implicated in an incidence of a violent offence compared to the control group. • In a period of 20 years the number of patients convicted for a violent offence increased; but a similar increase was also found among control group. • Within the 20 years period, schizophrenia patients also reported more substance abuse problems; with an increase from 8.3% to 26.1%. • Substances abuse problems have been identified as a risk factor of violence in schizophrenia as schizophrenia patients having substance abuse problems had more criminal convictions compared to those who do not use drugs.
Zitrin, A., Hardesty, A. S., Burdock, E. I., & Drossman, A. K.	1976	Crime and violence among mental patients.	867 patients from the Bellevue catchment area who were discharged from the psychiatric division of Bellevue Hospital.	• Psychiatric patients' arrest rates before and after their admission to the psychiatric hospital were higher compared to the arrest rates of general population in the same area. . • The 23.3% of the mentally ill patients had been arrested at least one time; and almost half of them 13.5% had been convicted for a nonviolent offence while the 9.8% had been charges with a violent offence commission. • Regarding arrest of violent offences half of the individuals from the total sample were schizophrenia patients. • Substance abuse (alcohol and drugs) patients were twice as large as the corresponding proportions in the total sample concerning both nonviolent and violent offences. • Only 10% of patients diagnosed with schizophrenia were arrested for violent offences; while the percentages for patients with alcohol abuse is 16%, for drug abuse patients 30% and for patients with other types of mental disorders 5%.

Appendix B

Diagnostic Criteria for Schizophrenia according DSM-V (APA, 2013)

A. Two (or more) of the following, each present for a significant portion of time during a 1 -month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions.
2. Hallucinations.
3. Disorganized speech (e.g., frequent derailment or incoherence).
4. Grossly disorganized or catatonic behavior.
5. Negative symptoms (i.e., diminished emotional expression or avolition).

B. For a significant portion of the time since the onset of the disturbance, level of function ing in one or more major areas, such as work, interpersonal relations, or self-care, is markedly below the level achieved prior to the onset (or when the onset is in childhood or adolescence, there is failure to achieve expected level of interpersonal, academic, or occupational functioning).

C. Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms (or less if successfully treated) that meet Criterion A (i.e., active-phase symptoms) and may include periods of prodromal or residual symptoms. During these prodromal or residual periods, the signs of the disturbance may be manifested by only negative symptoms or by two or more symptoms listed in Criterion A present in an attenuated form (e.g., odd beliefs, unusual perceptual experiences).

D. Schizoaffective disorder and depressive or bipolar disorder with psychotic features have been ruled out because either 1) no major depressive or manic episodes have

occurred concurrently with the active-phase symptoms, or 2) if mood episodes have occurred during active-phase symptoms, they have been present for a minority of the total duration of the active and residual periods of the illness.

E. The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition.

F. If there is a history of autism spectrum disorder or a communication disorder of child hood onset, the additional diagnosis of schizophrenia is made only if prominent delusions or hallucinations, in addition to the other required symptoms of schizophrenia, are also present for at least 1 month (or less if successfully treated).

Specify if:

The following course specifiers are only to be used after a 1-year duration of the disorder and if they are not in contradiction to the diagnostic course criteria.

First episode, currently in acute episode: First manifestation of the disorder meet ing the defining diagnostic symptom and time criteria. An *acute episode* is a time pe riod in which the symptom criteria are fulfilled.

First episode, currently in partial remission: *Partial remission* is a period of time during which an improvement after a previous episode is maintained and in which the defining criteria of the disorder are only partially fulfilled.

First episode, currently in full remission: *Full remission* is a period of time after a previous episode during which no disorder-specific symptoms are present.

Multiple episodes, currently in acute episode: Multiple episodes may be deter mined after a minimum of two episodes (i.e., after a first episode, a remission and a minimum of one relapse).

Multiple episodes, currently in partial remission

Multiple episodes, currently in full remission

Continuous: Symptoms fulfilling the diagnostic symptom criteria of the disorder are remaining for the majority of the illness course, with subthreshold symptom periods be ing very brief relative to the overall course.

Unspecified

Specify if:

With catatonia (refer to the criteria for catatonia associated with another mental disorder, pp. 119-120, for definition).

Coding note: Use additional code 293.89 (F06.1) catatonia associated with schizophrenia to indicate the presence of the comorbid catatonia.

Specify current severity:

Severity is rated by a quantitative assessment of the primary symptoms of psychosis, including delusions, hallucinations, disorganized speech, abnormal psychomotor be havior, and negative symptoms. Each of these symptoms may be rated for its current severity (most severe in the last 7 days) on a 5-point scale ranging from 0 (not present) to 4 (present and severe). (See Clinician-Rated Dimensions of Psychosis Symptom Severity in the chapter "Assessment Measures.")

Note: Diagnosis of schizophrenia can be made without using this severity specifier.

Appendix C

Diagnostic Criteria for Depression according DSM-V (APA, 2013)

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

Note: Do not include symptoms that are clearly attributable to another medical condition.

1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g.,
1. appears tearful). (**Note**: In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (**Note**: In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly every day.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).

8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understand able or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanie episode.

Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another med ical condition.

Coding and Recording Procedures

The diagnostic code for major depressive disorder is based on whether this is a single or recurrent episode, current severity, presence of psychotic features, and remission status. Current severity and psychotic features are only indicated if full criteria are currently met for a major depressive episode. Remission specifiers are only indicated if the full criteria are not currently met for a major depressive episode. Codes are as follows:

Severity/course specifier	Single episode	Recurrent episode*
Mild (p. 188)	296.21 (F32.0)	296.31 (F33.0)
Moderate (p. 188)	296.22 (F32.1)	296.32 (F33.1)
Severe (p. 188)	296.23 (F32.2)	296.33 (F33.2)
With psychotic features** (p. 186)	296.24 (F32.3)	296.34 (F33.3)
In partial remission (p. 188)	296.25 (F32.4)	296.35 (F33.41)
In full remission (p. 188)	296.26 (F32.5)	296.36 (F33.42)
Unspecified	296.20 (F32.9)	296.30 (F33.9)

*For an episode to be considered recurrent, there must be an interval of at least 2 consecutive months between separate episodes in which criteria are not met for a major depressive episode. The definitions of specifiers are found on the indicated pages.

**If psychotic features are present, code the "with psychotic features" specifier irrespective of episode severity.

In recording the name of a diagnosis, terms should be listed in the following order: major depressive disorder, single or recurrent episode, severity/psychotic/remission

specifiers, followed by as many of the following specifiers without codes that apply to the current episode.

Specify:

With anxious distress (p. 184)

With mixed features (pp. 184-185)

With melancholic features (p. 185)

With atypical features (pp. 185-186)

With mood-congruent psychotic features (p. 186)

With mood-incongruent psychotic features (p. 186)

With catatonia (p. 186). Coding note: Use additional code 293.89 (F06.1).

With péripartum onset (pp. 186-187)

With seasonal pattern (recurrent episode only) (pp.187-188)

Appendix D

Similarities and Differences between the MSc and the PhD

The dissertation of the MSc was a pilot study for the PhD thesis. In more detail in the MSc there were been used only two questionnaires (out of seven being used in the PhD) in order to be examined if they are applicable to Greek and mentally disordered population; as they were used only once for Greek population in the PhD thesis of the student Dedeloudis Sotirios and only once in mentally disordered population in British sample in the PhD thesis of the student Liz Spruin.

The similarities and differences between the MSc and PhD studies are presented in the following table:

Similarities	Differences
Theories In both studies there are being used theories and previous researches regarding mentally disordered offenders, the Criminal Narrative Experience (roles and emotions); the theory of Russell's Circumplex of Affect; and the theory regarding the Smallest Space Analysis.	Additional Theories being used in PhD: There are being used additional theories and previous research regarding depression, suicidal ideation, guilt and shame. Also all the theories and researches used in the MSc will be re-examined, re-evaluated and enhanced with more up to date information.
Research Objectives The research objectives regarding the Criminal Narrative Experience (roles and emotions) are the same in both researches	Additional Research Objectives in PhD: There have been formed additional objectives regarding the additional variables examined in the PhD research (depression. suicidal ideation, guilt and shame) and the combination of these.
Inclusion and Exclusion Criteria for participants: There were used exactly the same inclusion and exclusion criteria for the participants in both studies.	N/A
Demographic Data: In both studies there were used the same three forms to collect the background information about the demographics, the psychiatric history and the criminal history of the participants.	N/A
Sample There had been examined 33 participants only in the 2 questionnaires below. Their results of these 2 questionnaires are being used again in the PhD. As the sample is clinical forensic population and it is limited in Greece and the access is restricted; it was decided that it would be	Sample in PhD The 33 participants used in the MSc where additionally examined in the five questionnaires mentioned below. Further 31 new participants were examined in all seven questionnaires. The PhD has a total 64 participants.

not wise to exclude these participants; results from the PhD research.	
Questionnaires used in both studies: 1. Emotions Felt During Crime Questionnaire 2. Narrative Roles Questionnaire (NRQ)	Additional Questionnaires being used in PhD: 1. Beck Depression Inventory (BDI) 2. Suicidal Ideation Scale (SIS) 3. Guilt Inventory (GI) 4. Other as Shamer Scale (OAS) 5. Experience of Shame Scale (ESS)
Ethics and Deontology In both studies there were used the same three forms of ethics and particularly the same 1. Briefing Information Form 2.Consideration Form 3. Debriefing Information Form	N/A
Analysis In both researches there are being used both the SPSS and Hudap statistical packages. The demographic data are being analysed with the SPSS and the SSAs are being performed with the Hudap.	Analysis Extra data are being used for the analysis of demographics and the SSAs from the further participants examined. Additional there will be performed more analysis in the SPSS for the new variables and the correlation of the CNE and the new variables.

Appendix E

Part a Beck Depression Inventory (BDI) English Version

This questionnaire consists of 21 groups of statements. Please read each group of statements carefully, and then pick out **one statement** in each group that best describes the way you have been feeling during the past **two weeks, including today**. Circle the number beside the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. Be sure that you do not choose more than one statement for any group.

1	**0. I do not feel sad.** **1. I feel sad** **2. I am sad all the time and I can't snap out of it.** **3. I am so sad and unhappy that I can't stand it.**
2	**0. I am not particularly discouraged about the future.** **1. I feel discouraged about the future.** **2. I feel I have nothing to look forward to.** **3. I feel the future is hopeless and that things cannot improve.**
3	**0. I do not feel like a failure.** **1. I feel I have failed more than the average person.** **2. As I look back on my life, all I can see is a lot of failures.** **3. I feel I am a complete failure as a person.**
4	**0. I get as much satisfaction out of things as I used to.** **1. I don't enjoy things the way I used to.** **2. I don't get real satisfaction out of anything anymore.** **3. I am dissatisfied or bored with everything.**
5	**0. I don't feel particularly guilty** **1. I feel guilty a good part of the time.** **2. I feel quite guilty most of the time.** **3. I feel guilty all of the time.**
6	**0. I don't feel I am being punished.** **1. I feel I may be punished.** **2. I expect to be punished.** **3. I feel I am being punished.**
7	**0. I don't feel disappointed in myself.** **1. I am disappointed in myself.** **2. I am disgusted with myself.** **3. I hate myself.**
8	**0. I don't feel I am any worse than anybody else.** **1. I am critical of myself for my weaknesses or mistakes.**

	2. I blame myself all the time for my faults. **3. I blame myself for everything bad that happens.**
9	**0. I don't have any thoughts of killing myself.** **1. I have thoughts of killing myself, but I would not carry them out.** **2. I would like to kill myself.** **3. I would kill myself if I had the chance.**
10	**0. I don't cry any more than usual.** **1. I cry more now than I used to.** **2. I cry all the time now.** **3. I used to be able to cry, but now I can't cry even though I want to.**
11	**0. I am no more irritated by things than I ever was.** **1. I am slightly more irritated now than usual.** **2. I am quite annoyed or irritated a good deal of the time.** **3. I feel irritated all the time.**
12	**0. I have not lost interest in other people.** **1. I am less interested in other people than I used to be.** **2. I have lost most of my interest in other people.** **3. I have lost all of my interest in other people.**
13	**0. I make decisions about as well as I ever could.** **1. I put off making decisions more than I used to.** **2. I have greater difficulty in making decisions more than I used to.** **3. I can't make decisions at all anymore.**
14	**0. I don't feel that I look any worse than I used to.** **1. I am worried that I am looking old or unattractive.** **2. I feel there are permanent changes in my appearance that make me look unattractive** **3. I believe that I look ugly.**
15	**0. I can work about as well as before.** **1. It takes an extra effort to get started at doing something.** **2. I have to push myself very hard to do anything.** **3. I can't do any work at all.**
16	**0. I can sleep as well as usual.** **1. I don't sleep as well as I used to.** **2. I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.** **3. I wake up several hours earlier than I used to and cannot get back to sleep.**

17	**0. I don't get more tired than usual.** **1. I get tired more easily than I used to.** **2. I get tired from doing almost anything.** **3. I am too tired to do anything.**
18	**0. My appetite is no worse than usual.** **1. My appetite is not as good as it used to be.** **2. My appetite is much worse now.** **3. I have no appetite at all anymore.**
19	**0. I haven't lost much weight, if any, lately.** **1. I have lost more than five pounds.** **2. I have lost more than ten pounds.** **3. I have lost more than fifteen pounds.**
20	**0. I am no more worried about my health than usual.** **1. I am worried about physical problems like aches, pains, upset stomach, or constipation.** **2. I am very worried about physical problems and it's hard to think of much else.** **3. I am so worried about my physical problems that I cannot think of anything else.**
21	**0. I have not noticed any recent change in my interest in sex.** **1. I am less interested in sex than I used to be.** **2. I have almost no interest in sex.** **3. I have lost interest in sex completely.**

Part b Beck Depression Inventory (BDI) Greek Version

Αυτό το ερωτηματολόγιο αποτελείται από 21 ομάδες δηλώσεων. Σε παρακαλώ διάβασε κάθε ομάδα δηλώσεων προσεκτικά, και μετά διάλεξε **μια από τις δηλώσεις της** ομάδας που καλύτερα περιγράφει το πώς αισθάνεσαι κατά την διάρκεια **των δυο τελευταίων εβδομάδων συμπεριλαμβανομένης και της σημερινής ημέρας.** Κύκλωσε τον αριθμό δίπλα από την δήλωση που έχεις επιλέξει. Εάν παραπάνω από μια δηλώσεις σου ταιριάζουν, κύκλωσε τη δήλωση με τον μεγαλύτερο αριθμό. Σιγουρέψου ότι δεν διάλεξες παραπάνω από μια δήλωση σε κάθε ομάδα.

1	**0.Δεν αισθάνομαι λυπημένος** **1.Αισθάνομαι λυπημένος ή μελαγχολικός** **2α. Είμαι λυπημένος ή μελαγχολικός συνεχώς και δεν μπορώ να απαλλαγώ από αυτό** **2β.Είμαι τόσο μελαγχολικός ή δυστυχισμένος ώστε αυτό μου προξενεί πόνο** **3.Είμαι τόσο μελαγχολικός ή δυστυχισμένος ώστε δεν μπορώ να το αντέξω**
2	**0.Δεν είμαι ιδιαίτερα απαισιόδοξος ή αποθαρρυμένος για το μέλλον** **1.Αισθάνομαι χωρίς θάρρος για το μέλλον** **2α.Μου φαίνεται ότι δεν έχω τίποτα καλό να περιμένω από το μέλλον** **2β.Μου φαίνεται ότι δεν θα ξεπεράσω τις δυσκολίες μου** **3.Μου φαίνεται ότι το μέλλον είναι χωρίς ελπίδα και ότι τα πράγματα δεν μπορεί να φτιάξουν**
3	**0.Δεν αισθάνομαι αποτυχημένος** **1.Μου φαίνεται ότι είμαι αποτυχημένος περισσότερο από τους άλλους ανθρώπους** **2α.Αισθάνομαι ότι έχω πετύχει στη ζωή μου πολύ λίγα πράγματα άξια λόγου** **2β.Καθώς σκέπτομαι τη ζωή μου μέχρι τώρα το μόνο που βλέπω είναι πολλές αποτυχίες** **3.Αισθάνομαι ότι είμαι τελείως αποτυχημένος σαν άτομο**
4	**0.Δεν αισθάνομαι ιδιαίτερα δυσαρεστημένος** **1α.Αισθάνομαι βαριεστημένος σχεδόν όλη την ώρα** **1β.Δεν απολαμβάνω τα πράγματα όπως πρώτα** **2.Δεν με ευχαριστεί πια τίποτα**

	3.Αισθάνομαι δυσαρεστημένος με το κάθε τι
5	**0.Δεν αισθάνομαι ιδιαίτερα ένοχο τον εαυτό μου** **1.Πολλές φορές αισθάνομαι κακός ή χωρίς αξία** **2α.Αισθάνομαι πολύ ένοχος** **2β.Τον τελευταίο καιρό αισθάνομαι κακός ή χωρίς αξία σχεδόν όλη την ώρα** **3.Αισθάνομαι ότι είμαι πολύ κακός ή ανάξιος**
6	**0.Δεν αισθάνομαι ότι τιμωρούμαι** **1.Αισθάνομαι ότι κάτι κακό μπορεί να μου συμβεί** **2.Αισθάνομαι ότι τιμωρούμαι ή ότι θα τιμωρηθώ** **3α.Αισθάνομαι ότι μου αξίζει να τιμωρηθώ** **3β.Θέλω να τιμωρηθώ**
7	**0.Δεν αισθάνομαι απογοητευμένος από τον εαυτό μου** **1α.Αισθάνομαι απογοητευμένος από τον εαυτό μου** **1β.Δεν μου αρέσει ο εαυτός μου** **2.Σιχαίνομαι τον εαυτό μου** **3.Μισώ τον εαυτό μου**
8	**0.Δεν αισθάνομαι ότι είμαι χειρότερος από τους άλλους** **1.Είμαι αυστηρός με τον εαυτό μου για τις αδυναμίες μου** **2.Κατηγορώ τον εαυτό μου για τα λάθη μου** **3.Κατηγορώ τον εαυτό μου για κάθε κακό που μου συμβαίνει**
9	**0.Δεν μου έρχονται σκέψεις να κάνω κακό στον εαυτό μου** **1.Μου έρχονται σκέψεις να κάνω κακό στον εαυτό μου αλλά ποτέ δεν θα έκανα κάτι τέτοιο** **2α.Μου φαίνεται ότι θα ήταν καλύτερα να πέθαινα** **2β.Μου φαίνεται ότι η οικογένεια μου θα ήταν καλύτερα αν πέθαινα** **2γ.Έχω συγκεκριμένα σχέδια αυτοκτονίας** **3.Θα αυτοκτονούσα αν μπορούσα**
10	**0.Δεν κλαίω περισσότερο από το συνηθισμένο**

	1.Κλαίω τώρα περισσότερο απ' ότι συνήθως **2.Κλαίω συνεχώς, δεν μπορώ να το σταματήσω** **3.Άλλοτε μπορούσα να κλάψω αλλά τώρα μου είναι αδύνατο να κλάψω αν και το θέλω**
11	**0.Δεν είμαι περισσότερο εκνευρισμένος τώρα απ' ότι συνήθως** **1.Ενοχλούμαι ή εκνευρίζομαι περισσότερο απ' ότι συνήθως** **2.Αισθάνομαι διαρκώς εκνευρισμένος** **3.Δεν εκνευρίζομαι τώρα για πράγματα που με νευρίαζαν συνήθως**
12	**0.Δεν έχω χάσει το ενδιαφέρον μου για τους άλλους ανθρώπους** **1.Ενδιαφέρομαι τώρα λιγότερο για τους άλλους ανθρώπους απ' ότι παλαιότερα** **2.Έχω χάσει το περισσότερο ενδιαφέρον μου για τους άλλους ανθρώπους και τααισθήματα μου για αυτούς έχουν λιγοστέψει** **3.Έχω χάσει όλο το ενδιαφέρον μου για τους άλλους ανθρώπους και δεν νοιάζομαι καθόλου για αυτούς**
13	**0.Είμαι το ίδιο αποφασιστικός όπως πάντα** **1.Τελευταία αναβάλω το να παίρνω αποφάσεις** **2.Έχω μεγάλη δυσκολία στο να παίρνω αποφάσεις** **3.Δεν μπορώ να πάρω πια καμία απόφαση**
14	**0.Δεν μου φαίνεται ότι η εμφάνιση μου είναι χειρότερη από ποτέ** **1.Ανησυχώ μήπως μοιάζω γερασμένος και αντιπαθητικός** **2.Αισθάνομαι ότι έγινε τέτοια αλλαγή επάνω μου, ώστε να φαίνομαι αντιπαθητικός** **3.Μου φαίνεται ότι είμαι άσχημος και αποκρουστικός**
15	**0.Τα καταφέρνω στην δουλειά μου όπως και πρώτα** **1α.Χρειάζεται να κάνω ιδιαίτερη προσπάθεια για ν' αρχίσω κάποια δουλεία** **1β.Δεν τα καταφέρνω στην δουλειά μου όπως πρώτα** **2.Χρειάζεται να πιέσω τον εαυτό μου για να κάνω κάτι** **3.Μου είναι αδύνατο να εργαστώ**
16	**0.Κοιμάμαι τόσο καλά όσο συνήθως**

	1.Ξυπνώ το πρωί πιο κουρασμένος από άλλοτε **2.Ξυπνώ το πρωί 2-3 ώρες νωρίτερα από άλλοτε και δυσκολεύομαι να ξανακοιμηθώ** **3.Ξυπνώ νωρίς κάθε μέρα και δεν μπορώ να κοιμηθώ πάνω από 5 ώρες το 24ωρο**
17	**0.Δεν κουράζομαι ευκολότερα απ' ότι συνήθως** **1.Κουράζομαι τώρα ευκολότερα από πρώτα** **2.Κουράζομαι με το παραμικρό που κάνω** **3.Κουράζομαι τόσο εύκολα ώστε δεν μπορώ να κάνω τίποτα**
18	**0.Η όρεξή μου δεν είναι χειρότερη από άλλοτε** **1.Η όρεξη μου δεν είναι τόσο καλή όσο άλλοτε** **2.Η όρεξη μου είναι πολύ χειρότερη τώρα** **3.Δεν έχω πια καθόλου όρεξη**
19	**0.Δεν έχω χάσει σχεδόν καθόλου βάρος τον τελευταίο καιρό** **1.Έχω χάσει περισσότερο από 2 κιλά** **2.Έχω χάσει περισσότερο από 4 κιλά** **3.Έχω χάσει περισσότερο από 7 κιλά**
20	**0.Δεν με απασχολεί η υγεία μου περισσότερο από άλλοτε** **1.Με απασχολούν πόνοι ή βαρυστομαχιά ή δυσκοιλιότητα** **2.Με απασχολεί τόσο πολύ το πως αισθάνομαι ή το τι αισθάνομαι ώστε μου είναι δύσκολο να σκεφθώ τίποτε άλλο** **3.Είμαι εντελώς απορροφημένος με το τι αισθάνομαι**
21	**0.Δεν έχω προσέξει τελευταία καμιά αλλαγή στο ενδιαφέρον μου για το σεξ** **1.Ενδιαφέρομαι τώρα λιγότερο για το σεξ απ' ότι συνήθως** **2.Ενδιαφέρομαι πολύ λιγότερο τώρα για το σεξ** **3.Έχω χάσει τελείως το ενδιαφέρον μου για το σεξ**

Appendix F

Part a Suicidal Ideation Scale English Version

The following questions are referred in thoughts related with suicide and with harming yourself. Please circle the appropriate number above each statement, showing in what degree you believe this specific statement corresponds to the frequency or to the severity of these thoughts. There is no "right" or "wrong" answer. The degree which you experience what is described by the statements have to be your answer. The information you give are absolutely confidential.

	NEVER	***SELDOM***	***SOMETIMES***	***VERY OFTEN***	***ALL THE TIME***
1. How often you had thoughts of hurting yourself during the last year?	1	2	3	4	5
. How often do you think to give an end to your life?	1	2	3	4	5
3. How often you were thinking to give an end to your life the past year?	1	2	3	4	5

	NOT AT ALL SERIOUS			***THERE IS A SPECIFIC SUICIDE PLAN***
4. How serious were these thoughts of giving an end to your life the past year?	1	2	3	4

Part b Beck Suicidal Ideation Scale Greek Version

Οι παρακάτω ερωτήσεις αναφέρονται σε σκέψεις που έχουν σχέση με την αυτοκτονία και με το κάνει κανείς κακό στον εαυτό του. Παρακαλώ κυκλώστε τον κατάλληλο αριθμό κάτω από κάθε δήλωση που δείχνει σε ποιο βαθμό πιστεύετε ότι η συγκεκριμένη δήλωση αντιστοιχεί στη συχνότητα ή στη σοβαρότητα αυτών των σκέψεών σας . Δεν υπάρχουν "σωστές" ή "λάθος" απαντήσεις. Ο βαθμός με τον οποίο βιώνετε αυτό που εκφράζεται από τις δηλώσεις, θα πρέπει να είναι η απάντησή σας.. Οι πληροφορίες που δίνετε είναι απολύτως εμπιστευτικές.

	ΠΟΤΕ	***ΣΠΑΝΙΑ***	***ΜΕΡΙΚΕΣ ΦΟΡΕΣ***	***ΠΟΛΥ ΣΥΧΝΑ***	***ΟΛΗ ΤΗΝ ΩΡΑ***
1. Πόσο συχνά είχες σκέψεις να βλάψεις τον εαυτό σου τον τελευταίο χρόνο;	1	2	3	4	5
2. Πόσο συχνά σκέφτεσαι να δώσεις τέλος στη ζωή σου;	1	2	3	4	5
3. Πόσο συχνά σκέφτηκες να δώσεις τέλος στη ζωή σου τον τελευταίο χρόνο;	1	2	3	4	5

	ΚΑΘΟΛΟΥ ΣΟΒΑΡΕΣ			***ΥΠΑΡΧΕΙ ΕΝΑ ΣΥΓΚΕΚΡΙ-ΜΕΝΟ ΣΧΕΔΙΟ ΑΥΤΟΚΤΟΝΙΑΣ***
4. Πόσο σοβαρές ήταν αυτές οι σκέψεις του να δώσεις τέλος στη ζωή σου τον τελευταίο χρόνο;	1	2	3	4

Appendix G

Part a Emotions Felt During Crime questionnaire English Version

Please tell me how you felt **while you were committing the crime**. Indicate the extent to which you felt each of the following

I FELT…..

	NOT AT ALL	***JUST A LITTLE***	***SOME***	***A LOT***	***VERY MUCH INDEED***
1. lonely	1	2	3	4	5
2. scared	1	2	3	4	5
3. exhilarated	1	2	3	4	5
4. confident	1	2	3	4	5
5. upset	1	2	3	4	5
6. pleased	1	2	3	4	5
7. calm	1	2	3	4	5
8. safe	1	2	3	4	5
9. worried	1	2	3	4	5
10. depressed	1	2	3	4	5
11. enthusiastic	1	2	3	4	5
12. thoughtful	1	2	3	4	5
13. annoyed	1	2	3	4	5
14. angry	1	2	3	4	5
15. sad	1	2	3	4	5
16. excited	1	2	3	4	5

17. confused	1	2	3	4	5
18. miserable	1	2	3	4	5
19. irritated	1	2	3	4	5
20. relaxed	1	2	3	4	5
21. delighted	1	2	3	4	5
22. unhappy	1	2	3	4	5
23. courageous	1	2	3	4	5
24. contented	1	2	3	4	5
25. manly	1	2	3	4	5
26. pointless	1	2	3	4	5

Part b Emotions Felt During Crime questionnaire Greek Version

Πες μας για το ποιος ένιωσες κατά την διάρκεια της διάπραξης του αδικήματος. Ανάφερε το βαθμό στον οποίο αισθάνθηκες καθένα από τα ακόλουθα συναισθήματα:

ΕΝΙΩΣΑ…

	ΚΑΘΟΛΟΥ	***ΣΧΕΔΟΝ ΚΑΘΟΛΟΥ***	***ΛΙΓΟ***	***ΠΟΛΥ***	***ΠΑΡΑ ΠΟΛΥ***
1. Μοναχικός	1	2	3	4	5
2. Φοβισμένος	1	2	3	4	5
3. Αναζωογονητικός	1	2	3	4	5
4. Αυτοπεποίθηση	1	2	3	4	5
5. Αναστατωμένος	1	2	3	4	5
6. Ευχαριστημένος	1	2	3	4	5

7. Ήρεμος	1	2	3	4	5
8.Ασφαλής	1	2	3	4	5
9. Ανήσυχος	1	2	3	4	5
10. Μελαγχολικός	1	2	3	4	5
11. Ενθουσιασμένος	1	2	3	4	5
12. Σκεπτικός	1	2	3	4	5
13. Ενοχλημένος	1	2	3	4	5
14. Θυμωμένος	1	2	3	4	5
15. Λυπημένος	1	2	3	4	5
16. Διεγερμένος	1	2	3	4	5
17. Μπερδεμένος	1	2	3	4	5
18. Μίζερος	1	2	3	4	5
19. Εκνευρισμένος	1	2	3	4	5
20. Χαλαρός	1	2	3	4	5
21. Ευχαριστημένος	1	2	3	4	5
22. Δυστυχισμένος	1	2	3	4	5
23. Θαρραλέος	1	2	3	4	5
24. Ικανοποιημένος	1	2	3	4	5
25. Ανδροπρεπής	1	2	3	4	5
26. Άσκοπος	1	2	3	4	5

Appendix H

Part a Narrative Roles Questionnaire English Version

Please for the same crime, indicate the extent to which each of the statements below describes what it was like **while you were committing it**

	NOT AT ALL	***JUST A LITTLE***	***SOME***	***A LOT***	***VERY MUCH INDEED***
1. I was like a professional	1	2	3	4	5
2. I had to do it	1	2	3	4	5
3. It was fun	1	2	3	4	5
4. It was right	1	2	3	4	5
5. It was interesting	1	2	3	4	5
6. It was like an adventure	1	2	3	4	5
7. It was routine	1	2	3	4	5
8. I was in control	1	2	3	4	5
9. It was exciting	1	2	3	4	5
10. I was doing a job	1	2	3	4	5
11. I knew what I was doing	1	2	3	4	5
12. It was the only thing to do	1	2	3	4	5
13. It was a mission	1	2	3	4	5
14. Nothing else mattered	1	2	3	4	5
15. I had power	1	2	3	4	5
16. I was helpless	1	2	3	4	5
17. It was my only choice	1	2	3	4	5
18. I was a victim	1	2	3	4	5
19. I was confused about what was happening	1	2	3	4	5

20. I was looking for recognition	1	2	3	4	5
21.I just wanted to get it over with	1	2	3	4	5
22. I didn't care what would happen	1	2	3	4	5
23. What was happening was just fate	1	2	3	4	5
24. It all went to plan	1	2	3	4	5
25. I couldn't stop myself	1	2	3	4	5
26. It was like I wasn't part of it	1	2	3	4	5
27. It was a manly thing to do	1	2	3	4	5
28. For me it was just like a usual days work	1	2	3	4	5
29. I was trying to get revenge	1	2	3	4	5
30. There was nothing special about what happened	1	2	3	4	5
31. I was getting my own back	1	2	3	4	5
32. I knew I was taking a risk	1	2	3	4	5
33. I guess I always knew it was going to happen	1	2	3	4	5

Part b Narrative Roles Questionnaire Greek Version

Σε παρακαλώ, για το ίδιο αδίκημα, δείξε το βαθμό στον οποίο κάθε μία από τις παρακάτω προτάσεις περιγράφει πώς ήταν **όταν διέπραττες το αδίκημα.**

	ΚΑΘΟΛΟΥ	***ΣΧΕΔΟΝ ΚΑΘΟΛΟΥ***	***ΛΙΓΟ***	***ΠΟΛΥ***	***ΠΑΡΑ ΠΟΛΥ***
1. Ήμουν σαν επαγγελματίας	1	2	3	4	5
2. Έπρεπε να τοκάνω	1	2	3	4	5
3. 'Ηταν διασκεδαστικό	1	2	3	4	5
4. 'Ηταν το σωστό	1	2	3	4	5
5. 'Ηταν ενδιαφέρον	1	2	3	4	5
6. 'Ηταν σαν περιπέτεια	1	2	3	4	5
7. 'Ηταν ρουτίνα	1	2	3	4	5
8. Είχα τον έλεγχο	1	2	3	4	5
9. 'Ηταν συναρπαστικό	1	2	3	4	5
10. Έκανα μια δουλειά	1	2	3	4	5
11. Ήξερα τι έκανα	1	2	3	4	5
12. Ήταν το μονό που μπορούσα να κάνω	1	2	3	4	5
13. Ήταν μια αποστολή	1	2	3	4	5
14. Τίποτα άλλο δεν είχε σημασία	1	2	3	4	5
15. Είχα την δύναμη/εξουσία	1	2	3	4	5
16. Ήμουν αβοήθητος	1	2	3	4	5
17. Ήταν η μόνη μου επιλογή	1	2	3	4	5
18. Ήμουν το θύμα	1	2	3	4	5
19. Ήμουν μπερδεμένος για αυτό που συνέβη	1	2	3	4	5
20. Έψαχνα για αναγνώριση	1	2	3	4	5
21.Ήθελα άπλα να το ξεπεράσω	1	2	3	4	5

22. Δεν με ένοιαζε τι θα συμβεί	1	2	3	4	5
23. Αυτό που συνέβαινε ήταν άπλα μοίρα	1	2	3	4	5
24. Πήγαν όλα βάση σχέδιου	1	2	3	4	5
25. Δεν μπορούσα να σταματήσω τον εαυτό μου	1	2	3	4	5
26. 'Ηταν λες και δεν ήμουν μέρος του	1	2	3	4	5
27. 'Ηταν αυτό που έπρεπε να κάνει ένας άνδρας	1	2	3	4	5
28. Για μένα, ήταν άπλα μια μέρα δουλειάς	1	2	3	4	5
29. Ήθελα να πάρω εκδίκηση	1	2	3	4	5
30. Δεν ήταν και κάτι σημαντικό αυτό που συνέβη	1	2	3	4	5
31. Προστάτευα τα νώτα μου	1	2	3	4	5
32. Ήξερα ότι παίρνω ρίσκο	1	2	3	4	5
33. Υποθέτω ότι πάντα ήξερα τι θα συνέβαινε	1	2	3	4	5

Appendix I

Part a Guilt Inventory English Version

	STRONGLY AGREE	***AGREE***	***UNDICIDED***	***DISAGREE***	***STRONGLY DISAGREE***
1. I believe in a strict interpretation of right and wrong.	1	2	3	4	5
2. I have made a lot of mistakes in my life.	1	2	3	4	5
3. I have always believed strongly in a firm set of moral-ethical principles.	1	2	3	4	5
4. Lately, I have felt good about myself and what I have done	1	2	3	4	5
5. If I could do certain things over again, a great burden would be lifted from my shoulders.	1	2	3	4	5
6. I have never felt great remorse or guilt.	1	2	3	4	5
7. My goal in life is to enjoy it rather than to live up to some abstract set of moral principles.	1	2	3	4	5
8. There is something in my past that I deeply regret.	1	2	3	4	5
9. Frequently, I just hate myself for something I have done.	1	2	3	4	5
10. My parents were very strict with me.	1	2	3	4	5
11. There are only a few things I would never do.	1	2	3	4	5
12. I often feel "not right" with myself because of something I have done.	1	2	3	4	5
13. My ideas of right and wrong	1	2	3	4	5

are quite flexible.					
14. If I could live my life over again, there are a lot of things I would do differently.	1	2	3	4	5
15. There are many things I would just never do because I believe they are wrong.	1	2	3	4	5
16. I have recently done something that I deeply regret.	1	2	3	4	5
17. Lately, it hasn't been easy being me.	1	2	3	4	5
18. Morality is not as "black and white" as many people would suggest.	1	2	3	4	5
19. Lately, I have been calm and worry-free.	1	2	3	4	5
20. Guilt and remorse have been a part of my life for as long as I can recall.	1	2	3	4	5
21.Sometimes, when I think about certain things I have done, I almost get sick.	1	2	3	4	5
22. In certain circumstances, there is almost nothing I wouldn't do.	1	2	3	4	5
23. I do not believe that I have made a lot of mistakes in my life.	1	2	3	4	5
24. I would rather die than commit a serious act of wrongdoing.	1	2	3	4	5
25. I feel a strong need to live up to my moral values.	1	2	3	4	5
26. I often have a strong sense of regret.	1	2	3	4	5
27. I worry a lot about things I	1	2	3	4	5

have done in the past.					
28. I believe that you can't judge whether something is right or wrong without knowing the motives of the people involved and the situation in which they are acting.	1	2	3	4	5
29. There are few things in my life that I regret having done.	1	2	3	4	5
30. If I could relive the last few weeks or months, there is absolutely nothing I have done that I would change.	1	2	3	4	5
31. I sometimes have trouble eating because of things I have done in the past.	1	2	3	4	5
32. I never worry about what I do; I believe life will take care of itself.	1	2	3	4	5
33. At the moment, I don't feel particularly guilty about anything I have done.	1	2	3	4	5
34. Sometimes I can't stop myself from thinking about things I have done which I consider to be wrong.	1	2	3	4	5
35. I never have trouble sleeping.	1	2	3	4	5
36. I would give anything if, somehow, I could go back and rectify some things I have recently done wrong.	1	2	3	4	5
37. There is at least one thing in my recent past that I would like to change.	1	2	3	4	5
38. I am immediately aware of it when I have done something morally wrong.	1	2	3	4	5

39. What is right or wrong depends on the situation.	1	2	3	4	5
40. Guilt is not a particular problem for me.	1	2	3	4	5
41. There is nothing in my past that I deeply regret.	1	2	3	4	5
42. I believe that moral values are absolute.	1	2	3	4	5
43. Recently, my life would have been much better if only I hadn't done what I did.	1	2	3	4	5
44. If I had my life to begin over again, I would change very little, if anything.	1	2	3	4	5
45. I have been worried and distressed lately.	1	2	3	4	5

Part b Guilt Inventory Greek Version

	ΣΥΜΦΩΝΩ ΠΟΛΥ	***ΣΥΜΦΩΝΩ***	***ΕΤΣΙ ΚΑΙ ΕΤΣΙ***	***ΔΙΑΦΩΝΩ***	***ΔΙΑΦΩΝΩ ΠΟΛΥ***
1. Πιστεύω σε μια αυστηρή ερμηνεία του σωστού και του λάθους.	1	2	3	4	5
2. Έχω κάνει πολλά λάθη στη ζωή μου.	1	2	3	4	5
3. Ανέκαθεν πίστευα ακράδαντα σε μια σταθερή δέσμη αρχών ηθικής-δεοντολογίας.	1	2	3	4	5
4. Τον τελευταίο καιρό, έχω νιώσει καλά με τον εαυτό μου και ότι έχω κάνει.	1	2	3	4	5
5. Αν θα μπορούσα να κάνω ορισμένα πράγματα ξανά από την αρχή, ένα μεγάλο βάρος θα έφευγε από τους ώμους μου.	1	2	3	4	5
6. Ποτέ δεν ένοιωσα πολλές τύψεις ή ενοχές.	1	2	3	4	5
7. Ο στόχος μου στη ζωή είναι να την απολαύσω και όχι να ζω με βάση κάποιο αφηρημένο σύνολο ηθικών αρχών.	1	2	3	4	5
8. Υπάρχει κάτι στο παρελθόν μου που μετανιώνω βαθιά/πικρά.	1	2	3	4	5
9. Συχνά, απλά μισώ τον εαυτό μου για κάτι που έχω κάνει.	1	2	3	4	5
10. Οι γονείς μου ήταν πολύ αυστηροί μαζί μου.	1	2	3	4	5
11. Υπάρχουν μόνο μερικά πράγματα που ποτέ δεν θα τα έκανα.	1	2	3	4	5
12. Συχνά αισθάνομαι «όχι καλά»	1	2	3	4	5

με τον εαυτό μου, για κάτι που έχω κάνει.					
13. Οι ιδέες μου για το σωστό και το λάθος είναι αρκετά ευέλικτες.	1	2	3	4	5
14. Αν θα μπορούσα να ζήσω τη ζωή μου ξανά, υπάρχουν πολλά πράγματα που θα ήθελα να κάνω διαφορετικά.	1	2	3	4	5
15. Υπάρχουν πολλά πράγματα που θα ήθελα, απλά ποτέ δεν τα κάνω, γιατί πιστεύω ότι είναι λάθος.	1	2	3	4	5
16. Πρόσφατα έχω κάνει κάτι που μετανιώνω βαθιά/ πικρά.	1	2	3	4	5
17. Τον τελευταίο καιρό, δεν ήταν εύκολο να είμαι ο εαυτός μου.	1	2	3	4	5
18. Η ηθική δεν είναι «άσπρο ή μαύρο» όπως πολλοί άνθρωποι θα έλεγαν.	1	2	3	4	5
19. Τον τελευταίο καιρό, είμαι ήρεμος και ξέγνοιαστος.	1	2	3	4	5
20. Η ενοχή και οι τύψεις ήταν ένα μέρος της ζωής μου για όσο χρονικό διάστημα μπορώ να θυμηθώ.	1	2	3	4	5
21.Μερικές φορές, όταν σκέφτομαι κάποια πράγματα που έχω κάνει, σχεδόν αρρωσταίνω.	1	2	3	4	5
22. Σε ορισμένες περιπτώσεις, δεν υπάρχει σχεδόν τίποτα που δεν θα έκανα.	1	2	3	4	5
23. Δεν πιστεύω ότι έχω κάνει πολλά λάθη στη ζωή μου.	1	2	3	4	5
24. Θα προτιμούσα να πεθάνω παρά να κάνω κάποια σοβαρή άδικη πράξη.	1	2	3	4	5

25. Νιώθω μεγάλη ανάγκη να ζήσω τη ζωή μου βάση ηθικών αξιών.	1	2	3	4	5
26. Συχνά έχω μια ισχυρή αίσθηση μετάνοιας.	1	2	3	4	5
27. Ανησυχώ πολύ για πράγματα που έχω κάνει στο παρελθόν.	1	2	3	4	5
28. Πιστεύω ότι δεν μπορούμε να κρίνουμε αν κάτι είναι σωστό ή λάθος, χωρίς να γνωρίζουμε τα κίνητρα των ανθρώπων που εμπλέκονται και την κατάσταση βάση της οποίας δρουν.	1	2	3	4	5
29. Υπάρχουν μερικά πράγματα στη ζωή που μετανιώνω που έχω κάνει.	1	2	3	4	5
30. Εάν μπορούσα να ξαναζήσω τις τελευταίες βδομάδες ή μήνες, δεν υπάρχει απολύτως τίποτα που θα άλλαζα.	1	2	3	4	5
31. Μερικές φορές δυσκολεύομαι να φάω, για πράγματα που έχω κάνει στο παρελθόν.	1	2	3	4	5
32. Ποτέ δεν ανησυχώ για το τι κάνω. Πιστεύω ότι η ζωή «θα πάρει το δρόμο της» /«ξέρει τι κάνει».	1	2	3	4	5
33. Αυτή τη στιγμή, δεν αισθάνομαι ιδιαίτερα ένοχος για τίποτα που έχω κάνει.	1	2	3	4	5
34. Μερικές φορές δεν μπορώ να σταματήσω να σκέφτομαι πράγματα που έχω κάνει και θεωρώ λάθος.	1	2	3	4	5
35. Ποτέ δεν είχα προβλήματα ύπνου.	1	2	3	4	5

36. Θα έδινα τα πάντα αν, με κάποιο τρόπο, θα μπορούσα να πάω πίσω και να διορθώσω κάποια πράγματα που πρόσφατα έχω κάνει λάθος.	1	2	3	4	5
37. Υπάρχει τουλάχιστον ένα πράγμα στο πρόσφατο παρελθόν μου που θα ήθελα να αλλάξω.	1	2	3	4	5
38. Το αναγνωρίσω αμέσως όταν έχω κάνει κάτι που είναι ηθικά λάθος.	1	2	3	4	5
39. Τι είναι σωστό και λάθος εξαρτάται από την κατάσταση.	1	2	3	4	5
40. Η ενοχή δεν είναι ιδιαίτερο πρόβλημα για εμένα.	1	2	3	4	5
41. Δεν υπάρχει τίποτα στο παρελθόν μου που να μετανιώνω βαθιά/πικρά.	1	2	3	4	5
42. Πιστεύω ότι οι ηθικές αξίες είναι απόλυτες.	1	2	3	4	5
43. Πρόσφατα, η ζωή μου θα ήταν πολύ καλύτερη, μόνο εάν δεν είχα κάνει αυτά που έκανα.	1	2	3	4	5
44. Εάν άρχιζα την ζωή μου από την αρχή, θα υπήρχαν πολύ λίγα πράγματα που θα άλλαζα, αν όχι τίποτα.	1	2	3	4	5
45. Είμαι ανήσυχος και τεθλιμμένος/συντριμμένος τώρα τελευταία.	1	2	3	4	5

Appendix J

Part a Other As Shamer Scale (OAS) English Version

Read each statement carefully and circle the number to the right of the item that indicates the frequency with which you find yourself feeling or experiencing what is described in the statement.

	NEVER	RARE	SOMETIMES	FREQUENTLY	ALWAYS
1. I feel other people see me as not good enough.	0	1	2	3	4
2. I think that other people look down on me	0	1	2	3	4
3. Other people put me down a lot	0	1	2	3	4
4. I feel insecure about others opinions of me	0	1	2	3	4
5. Other people see me as not measuring up to them	0	1	2	3	4
6. Other people see me as small and insignificant	0	1	2	3	4
7. Other people see me as somehow defective as a person	0	1	2	3	4
8. People see me as unimportant compared to others	0	1	2	3	4
9. Other people look for my faults	0	1	2	3	4
10. People see me as striving for perfection but being unable to reach my own standards	0	1	2	3	4
11. I think others are able to see my defects	0	1	2	3	4
12. Others are critical or punishing when I make a mistake	0	1	2	3	4
13. People distance themselves from me when I make mistakes	0	1	2	3	4

14. Other people always remember my mistakes differently.	0	1	2	3	4
15. Others see me as fragile	0	1	2	3	4
16. Others see me as empty and unfulfilled	0	1	2	3	4
17. Others think there is something missing in me	0	1	2	3	4
18. Other people think I have lost control over my body and feelings	0	1	2	3	4

Part b Other As Shamer Scale (OAS) Greek Version

Ακολουθεί ένας κατάλογος δηλώσεων που περιγράφει το πώς μπορεί να νοιώθετε για το πώς σας βλέπουν οι άλλοι άνθρωποι. Διαβάστε κάθε δήλωση και βάλτε σε κύκλο τον αριθμό δεξιά που δείχνει τη συχνότητα με την οποία βρίσκεται τον εαυτό σας να νιώθει ή να βιώνει αυτό που περιγράφεται στη δήλωση.

	ΠΟΤΕ	**ΣΠΑΝΙΑ**	**ΜΕΡΙΚΕΣ ΦΟΡΕΣ**	**ΣΥΧΝΑ**	**ΠΑΝΤΑ**
1. Νιώθω ότι οι άλλοι με βλέπουν ως όχι αρκετά καλό.	0	1	2	3	4
2. Νομίζω ότι οι άλλοι με βλέπουν υποτιμητικά.	0	1	2	3	4
3. Οι άλλοι με ταπεινώνουν πολύ.	0	1	2	3	4
4. Νιώθω ανασφαλής σε σχέση με τη γνώμη των άλλων για μένα.	0	1	2	3	4
5. Οι άλλοι με βλέπουν σα να μην είμαι του ίδιου επιπέδου με εκείνους.	0	1	2	3	4
6. Οι άλλοι με βλέπουν σα μηδαμινό και ασήμαντο.	0	1	2	3	4
7. Οι άλλοι με βλέπουν σαν κάπως «ελαττωματικό».	0	1	2	3	4
8. Οι άνθρωποι με βλέπουν ασήμαντο συγκριτικά με τους	0	1	2	3	4

άλλους.					
9. Οι άλλοι αναζητούν τα λάθη μου.	0	1	2	3	4
10. Οι άνθρωποι με βλέπουν σα να παλεύω για την τελειότητα, δίχως όμως, να είμαι ικανός να φθάσω τα δικά μου σταθμά.	0	1	2	3	4
11. Νομίζω ότι οι άλλοι μπορούν να δουν τα μειονεκτήματά μου.	0	1	2	3	4
12.Οι άλλοι είναι επικριτικοί ή τιμωρητικοί, όταν κάνω ένα λάθος.	0	1	2	3	4
13. Οι άνθρωποι απομακρύνονται από εμένα, όταν κάνω λάθη.	0	1	2	3	4
14. Οι άλλοι πάντα θυμούνται τα λάθη μου.	0	1	2	3	4
15. Οι άλλοι με θεωρούν εύθραυστο.	0	1	2	3	4
16.Οι άλλοι με βλέπουν κενό και ανεκπλήρωτο.	0	1	2	3	4
17. Οι άλλοι νομίζουν ότι κάτι μου λείπει.	0	1	2	3	4
18. Οι άλλοι νομίζουν ότι έχω χάσει τον έλεγχο του σώματος και των συναισθημάτων μου.	0	1	2	3	4

Appendix K

Part a Experience of Shame Scale (ESS) English Version

Everybody at times can feel embarrassed, self-conscious or ashamed. These questions are about such feelings if they have occurred at any time in the past year. There are no 'right' or 'wrong' answers. Please indicate the response which applies to you with a tick.

	NOT AT ALL	*A LITTLE*	*MODERATELY*	*VERY MUCH*
1. Have you felt ashamed of any of your personal habits?	1	2	3	4
Have you worried about what other people think of any of your personal habits?	1	2	3	4
3. Have you tried to cover up or conceal any of your personal habits?	1	2	3	4
4. Have you felt ashamed of your manner with others?	1	2	3	4
5. Have you worried about what other people think of your manner with others?	1	2	3	4
6. Have you avoided people because of your manner?	1	2	3	4
7. Have you ever felt ashamed of the sort of person you are?	1	2	3	4
8. Have you worried about what other people think of the sort of person you are?	1	2	3	4
9. Have you tried to conceal from others the sort of person you are?	1	2	3	4
10. Have you ever felt ashamed of your ability to do thinks?	1	2	3	4
11. Have you worried about what other people think of your ability to do things?	1	2	3	4

12. Have you avoided people because of your inability to do things?	1	2	3	4
13. Do you feel ashamed when you do something wrong?	1	2	3	4
14. Have you worried about what other people think of you when you do something wrong?	1	2	3	4
5. Have you tried to cover up or conceal things you felt ashamed of having done?	1	2	3	4
16. Have you felt ashamed when you said something stupid?	1	2	3	4
17. Have you worried about what other people think of you when you said something stupid?	1	2	3	4
18. Have you avoided contact with anyone who knew you said something stupid?	1	2	3	4
19. Have you felt ashamed when you failed at something which was important to you?	1	2	3	4
20. Have you worried about what other people think of you when you failed?	1	2	3	4
21. Have you avoided people who have seen you fail?	1	2	3	4
22. Have you felt ashamed of your body or any part of it?	1	2	3	4
23. Have you worried about what other people think of your appearance?	1	2	3	4
24. Have you avoided looking at yourself in the mirror?	1	2	3	4
25. Have you wanted to hide or conceal your body or any part of it?	1	2	3	4

Part b Experience of Shame Scale (ESS) Greek Version

Όλοι, κατά περιόδους, μπορεί να έρθουν σε δύσκολη θέση, να νιώσουν συνεσταλμένοι ή να ντροπιαστούν. Αυτές οι ερωτήσεις αφορούν τέτοια συναισθήματα, εάν έχουν εμφανιστεί οποιαδήποτε στιγμή στο προηγούμενο έτος. Δεν υπάρχει καμία «σωστή» ή «λανθασμένη» απάντηση. Παρακαλούμε, διαβάστε προσεκτικά κάθε πρόταση και στη συνέχεια βάλτε σε κύκλο τον αριθμό που θεωρείτε ότι σας αντιπροσωπεύει περισσότερο.

	ΚΑΘΟΛΟΥ	***ΛΙΓΟ***	***ΜΕΤΡΙΑ***	***ΠΑΡΑ ΠΟΛΥ***
1. Έχετε νιώσει ντροπή για κάποια από τις προσωπικές σας συνήθειες;	1	2	3	4
2. Σας έχει απασχολήσει τι σκέπτονται οι άλλοι για τις προσωπικές σας συνήθειες;	1	2	3	4
3. Έχετε προσπαθήσει να κρύψετε ή να συγκαλύψετε κάποια από τις προσωπικές σας συνήθειες;	1	2	3	4
4. Έχετε νιώσει ντροπή για τη συμπεριφορά σας απέναντι στους άλλους;	1	2	3	4
5. Σας έχει απασχολήσει τι σκέπτονται οι άλλοι για τη συμπεριφορά σας απέναντί τους;	1	2	3	4
6. Έχετε αποφύγει ποτέ ανθρώπους εξαιτίας της συμπεριφοράς σας;	1	2	3	4
7. Έχετε νιώσει ντροπή για αυτό που είστε;	1	2	3	4
8. Σας έχει απασχολήσει τι σκέπτονται οι άλλοι για αυτό που είστε;	1	2	3	4
9. Έχετε προσπαθήσει να κρύψετε από τους άλλους αυτό που είστε;	1	2	3	4
10. Έχετε νιώσει ντροπή για τις ικανότητές σας;	1	2	3	4
11. Σας έχει απασχολήσει τι σκέπτονται οι άλλοι για τις ικανότητές σας;	1	2	3	4

12. Έχετε αποφύγει ανθρώπους, εξαιτίας της αδυναμίας σας να κάνετε κάποια πράγματα;	1	2	3	4
13.Έχετενιώσειντροπή, όταν κάνετε κάτι λάθος;	1	2	3	4
14. Σας έχει απασχολήσει τι σκέπτονται οι άλλοι για εσάς, όταν κάνετε κάτι λάθος;	1	2	3	4
15. Έχετε προσπαθήσει να κρύψετε ή να συγκαλύψετε πράγματα, τα οποία ντρέπεστε που έχετε κάνει;	1	2	3	4
16. Έχετε νιώσει ντροπή για κάτι ανόητο που είπατε;	1	2	3	4
17. Σας έχει απασχολήσει τι σκέφτηκαν οι άλλοι για εσάς, όταν είπατε κάτι ανόητο;	1	2	3	4
18. Έχετε αποφύγει την επαφή με οποιονδήποτε γνώριζε ότι είπατε κάτι ανόητο;	1	2	3	4
19. Έχετε νιώσει ντροπή, όταν αποτύχατε σε κάτι που ήταν σημαντικό για εσάς;	1	2	3	4
20. Σας έχει απασχολήσει τι σκέφτηκαν οι άλλοι, όταν αποτύχατε;	1	2	3	4
21.Έχετε αποφύγει ανθρώπους που σας είδαν να αποτυχαίνετε;	1	2	3	4
22. Έχετε νιώσει ντροπή για το σώμα σας ή κάποιο σημείο του;	1	2	3	4
23. Σας έχει απασχολήσει τι σκέπτονται οι άλλοι για την εμφάνισή σας;	1	2	3	4
24. Έχετε αποφύγει να κοιτάξετε τον εαυτό σας στον καθρέπτη;	1	2	3	4
25. Έχετε την επιθυμία να κρύψετε ή να συγκαλύψετε το σώμα σας ή κάποιο σημείο του σώματός σας;	1	2	3	4

Appendix L

Part a Briefing Information Form English Version

University of HUDDERSFIELD
Inspiring tomorrow's professionals

Criminal Narrative Experience and Emotional State of Schizophrenic Offenders

INFORMATION SHEET

You are being invited to take part in a study about The Criminal Narrative Experience and the Emotional State of Schizophrenic Offenders (SO). Before you decide to take part it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it me if you wish. Please do not hesitate to ask if there is anything that is not clear or if you would like more information.

What is the study about?
The purpose of this study is to examine the roles that the individuals diagnosed with a mental disorder and have also committed an offence assign to themselves when they commit a crime. Further emotions felt during the illegal act will be examined and more specifically the emotion of shame and guilt they have now considering the illegal act. Additionally the study will examine the level of depressive symptomatology and suicidal ideation.

Why I have been approached?
You have been asked to participate because you fulfil all the inclusion criteria that have been set by the researcher.

Do I have to take part?
It is your decision whether or not you take part. If you decide to take part you will be asked to sign a consent form, and you will be free to withdraw at any time of the processyou wish and for any reason with automatic withdrawn of your responses.In case you complete the questionnaires and you wish to withdraw later, you have a three months period available to withdraw your data. A decision to withdraw at any time, or a decision not to take part, will not affect your stay or your treatment in the psychiatric hospital.

What will I need to do?
If you agree to take part in the research you will be asked to fill a series of questionnaires which comprises 6 parts. You will also been asked to fill the demographic data and there will be a small interview with some questions about your psychiatric and criminal history. The whole interview will last approximatelly one and half hour, during which you can take a break whenever you want.

Will my identity be disclosed?
All information disclosed within the interview will be kept confidential, unless you indicate that you or anyone else is at risk of serious harm, in which case I would need to pass this information to the principle of the psychiatric hospital and your personal treating psychiatrist and psychologist.

What will happen to the information?
All information collected from you during this research will be kept secure and any identifying material, such as names will be removed in order to ensure anonymity. It is anticipated that the research may, at some point, be published in a journal or report. However, should this happen, your anonymity will be ensured, although it may be necessary to use your words in the presentation of the findings and your permission for this is included in the consent form.

Who can I contact for further information?
If you require any further information about the research, please contact me or my supervisors on:

Name: Christina Simitsi
E-mail: sim.christina92@gmail.com
Telephone: (+30) 6945272966

Supervisors

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Part B Briefing Information Form Greek Version

University of HUDDERSFIELD
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Εγκληματική Αφηγηματική Εμπειρία και Συναισθηματική Κατάσταση των Σχιζοφρενών Παραβατών

ΕΝΤΥΠΟ ΕΝΗΜΕΡΩΣΗΣ

Έχεις κληθεί να λάβεις μέρος σε μια έρευνα σχετικά με τις Αφηγήσεις και την Συναισθηματική κατάσταση των Σχιζοφρενών Παραβατών (Σ Π). Πριν αποφασίσετε να λάβετε μέρος είναι σημαντικό να καταλάβετε γιατί γίνεται η έρευνα και τι περιλαμβάνει. Παρακαλώ αφιερώστε χρόνο για να διαβάσατε τις παρακάτω πληροφορίες προσεκτικά και συζητήστε τες μαζί μου εάν το επιθυμείται. Παρακαλώ μην διστάσετε να ρωτήσετε αν υπάρχει κάτι που δεν είναι σαφές ή αν θέλετε περισσότερες πληροφορίες.

Γιατί γίνεται αυτή η μελέτη;
Ο σκοπός αυτής της έρευνας είναι να εξετάσει τους ρόλους που τα άτομα με κάποια ψυχική διαταραχή που έχουν διαπράξει κάποιο αδίκημα, είχαν αναθέσει στον εαυτό τους όταν διέπρατταν το αδίκημα αυτό. Επιπλέον εξετάζονται τα συναισθήματα που βίωσε κατά την διάρκεια της παράνομης πράξης και ποιο συγκεκριμένα τα συναισθήματα ντροπής και ενοχής που έχουν τώρα σκεπτόμενοι το αδίκημα που έχουν διαπράξει. Επιπλέον η έρευνα θα εξετάσει τα επίπεδα της καταθλιπτικής συμπτωματολογίας και του αυτοκτονικού ιδεασμού.

Γιατί προσεγγίστηκες;
Σας ζητήθηκε να συμμετάσχετε γιατί πληροίτε όλες τα κριτήρια συμμετοχής που έχουν τεθεί από τον ερευνητή.

Πρέπει να πάρω μέρος;
Είναι δική σας η απόφαση εάν θα λάβετε μέρος ή όχι. Αν αποφασίσετε να πάρετε μέρος θα σας ζητηθεί να υπογράψετε ένα έντυπο συγκατάθεσης, και θα είστε ελεύθερος να αποσυρθείτε από τη έρευνα ανα πάσα στιγμή και χωρίς αιτιολόγηση. Στην περίπτωση που συμπληρώσεις τα ερωτηματολόγια και επιθυμείς να αποσυρθείς αργότερα, έχεις διαθέσημο ένα χρονικό περιθώριο των τριών μηνών για να αποσύρεις τα δεδομένα σου. Η απόφαση σας να αποσυρθείτε ανα πάσα στιγμή ή να μην λάβετε μέρος εξ αρχής, δεν θα επηρεάσει την παραμονή σας ή την θεραπεία σας στο ψυχιατρικό νοσοκομείο.

Τι θα πρέπει να κάνω;
Εάν συμφωνήσετε να λάβετε μέρος στην έρευνα θα σας ζητηθεί να συμπληρώσετε μια σειρά ερωτηματολογίων που αποτελείται από έξι μέρη. Θα σας ζητηθεί επίσης να συμπληρώσετε τα δημογρφικά στοιχεία και θα υπάρξει μια μικρή συνέντευξη με ερωτήσει που αφορούν το ψυχιατρικό και εγκληματικό σας ιστορικό. Η όλη διαδικασία θα διαρκέσει περίπου μια μισή ώρα, κατά τη δάρκεια της οποίας μπορείτε να κάνετε διάλειμμα όποτε θέλετε.

Θα αποκαλυφθεί η ταυτότητα μου;
Όλες οι πληροφορίες που γνωστοποιούνται στο πλαίσιο της συνέντευξης θα παραμείνουν εμπιστευτικές, εκτός εάν δείχνουν ότι εσείς ή κάποιος άλλος βρίσκεται σε κίνδυνο σοβαρής βλάβης, οπότε θα χρειαστεί να περάσουν αυτές οι πληροφορίες στον διευθυντή του ψυχιατρικού νοσοκομείου και στον προσωπικό θεράποντα ψυχίατρο και ψυχολόγο.

Τι θα συμβεί με τις πληροφορίες;
Όλες οι πληροφορίες που συλλέγονται από εσάς κατά την διάρκεια αυτής της έρευνας θα φυλάσσονται με ασφάλεια, και κάθε αναγνωριστικό υλικό, όπως τα ονόματα θα αφαιρούνται ώστε να διασφαλειστεί η ανωνυμία. Αναμένεται ότι η έρευνα μπορεί, σε κάποιο σημείο να δημοσιευτεί σε ένα περιοδικό ή συνέδριο. Ωστόσο, στην περίπτωση αυτή, η ανωνυμίας σας είναι εξασφαλισμένη, αν και μπορεί να είναι απαραίτητο να χρησιμοποιηθούν κάποια από τα λόγια σας στην παρουσίαση των ευρημάτων και η άδεια σας για αυτό περιλαμβάνεται στο έντυπο συγκατάθεσης.

Με ποιον μπορώ να επικοινωνήσω για περισσότερες πληροφορίες;
Αν επιθυμείτε περισσότερες πληροφορίες σχετικά με την έρευνα, παρακαλώ επικοινωνίστε μαζί μου ή με την επόπτρια της διπλωματικής μου εργασίας:

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Επόπτες

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Appendix M

Part a Consideration Form English Version

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CONSENT FORM

Criminal Narrative Experience and Emotional State of Schizophrenic Offenders

It is important that you read, understand and sign the consent form. Your contribution to this research is entirely voluntary and you are not obliged in any way to participate, if you require any further details please contact your researcher.

I have been fully informed of the nature and aims of this research as outlined in the information sheet □

I consent to taking part in it □

I understand that I have the right to withdraw from the research at any time without giving any reason; and in case I want to withdraw my data from the research I have a period of three months to do so. □

I give permission for my words to be quoted (by use of pseudonym) □

I understand that the information collected will be kept in secure conditions for a period of ten years at the University of Huddersfield □

I understand that no person other than the researcher and the research's supervisors will have access to the information provided □

I understand that all information disclosed within the interview will be kept confidential, □

unless I indicate that me or anyone else is at risk of serious harm, in which case the researcher would need to pass this information to the principle of the psychiatric hospital and my personal treating psychiatrist and psychologist.

I understand that my identity will be protected by the use of pseudonym in the report and that no written information that could lead to my being identified will be included in any report. □

If you are satisfied that you understand the information and are happy to take part in this project, please put a tick in the box aligned to each sentence and print and sign below.

Signature of Participant:	Signature of Researcher:
_____	_____
Date:	Date:
_____	_____

(one copy to be retained by Participant / one copy to be retained by Researcher)

Part b Consideration Form Greek Version

University of HUDDERSFIELD
Inspiring tomorrow's professionals

ΕΝΤΥΠΟΣΥΓΚΑΤΑΘΕΣΗΣ

Εγκληματική Αφηγηματική Εμπειρία και Συναισθηματική Κατάσταση των Σχιζοφρενών Παραβατών

Είναι σημαντικό να διαβάσετε, να κατανοήσετε και να υπογράψετε το έντυπο συγκατάθεσης. Η συνεισφορά σας σε αυτή την έρευνα είναι εντελώς εθελοντική και δεν είστε υποχρεωμένοι με κανένα τρόπο να συμμετάσχετε. Εάν χρειάζεστε οποιαδήποτε περαιτέρω λεπτομέρεια παρακαλούμε επικοινωνήστε με τον ερευνητή.

Έχω ενημερωθεί πλήρως για την φύση και του σκοπούς της έρευνας, όπως αναγράφεται στο δελτίο πληροφοριών □

Συναινώ να συμμετέχω στην έρευνα □

Κατανοώ ότι έχω το δικαίωμα να αποσυρθώ από την έρευνα ανά πάσα στιγμή χωρίς να δώσω κάποιο λόγο και στην περίπτωση που επιθυμώ να αποσύρω τα δεδομένα μου από την έρευνα έχω ένα χρονικό περιθώριο τριών να το κάνω. □

Δίνω άδεια να χρησιμοποιηθούν τα λόγια μου σαν αποφθέγματα

(με την χρήση ψευδώνυμου) □

Κατανοώ ότι οι πληροφορίες που συλλέγονται υα κρατηθούν ασφαλείς για μια περίοδο πέντε χρόνων στο Πανεπιστήμιο του Huddersfield □

Κατανοώ ότι κανένας άλλος εκτός από τον ερευνητή και τον επόπτη δεν θα έχει πρόσβαση στης πληροφορίες που παρέχονται □

Κατανοώ ότι όλες οι πληροφορίες που αποκαλύφθηκαν κατά την συνέντευξη θα παραμείνουν εμπιστευτικές, με την εξαίρεση του εάν υποδείξω ότι εγώ ή κάποιος άλλος είναι σε ρίσκο σοβαρού κινδύνου, στην οποία περίπτωση ο ερευνητής θα πρέπει να δώσει τις πληροφορίες στον διευθυντή του ψυχιατρικού νοσοκομείου και στον προσωπικό θεράποντα ψυχίατρο ή ψυχολόγο. □

Κατανοώ ότι η ταυτότητα μου θα προστατεύεται με την χρήση ψευδωνύμου στην έρευνα

και ότι καθόλου πληροφορίες που οδηγούν στην αναγνώριση μου δεν θα συμπεριληφθούν στην έρευνα □

Εάν είστε ικανοποιημένοι ότι έχετε κατανοήσει τις πληροφορίες και είστε στην ευχάριστη θέση να λάβετε μέρος σε αυτή την έρευνα, παρακαλούμε βάλτε ένα σημάδι στο κουτί δίπλα από κάθε πρόταση και υπογράψτε παρακάτω.

Υπογραφή Συμμετέχοντα: _____ Ημερομηνία: _____	Υπογραφή Ερευνητή: _____ Ημερομηνία: _____

Appendix N

Part a Demographic Data Form English Version

DEMOGRAPHIC DATA

DATE……..…….

PARTICIPANT'S CODE……

GENDER: MALE……. FEMALE……..

DATE OF BIRTH……..AGE (IN YEARS)……..

PLACE OF BIRTH…….

ETHNICITY……

AS A CHILD YOU WERE LIVING WITH:

1. With my mum and dad
2. With just one of my parents
3. With my mum and step-dad
4. With my dad and step-mum
1. 5.With adopted parents
5. With foster parents
6. In a children's or community home
7. With other relatives…….
8. Other…….....

DO YOU HAVE BROTHERS OR SISTERS? 1. YES 2. NO

IF YES, SAY GENDER AND AGE

…….....……

MARITAL STATUS: 1.SINGLE 2. MARRIED 3.DIVORCED
4. SEPERATED 5.WIDOW

EDUCATION: 1. UNEDUCATED 2.PRIMARY SCHOOL
3. SECONDARY SCHOOL 4.HIGH SCHOOL

5.TEI/UNIVERSITY 6.POST-GRADUATE

7.OTHER……

OCCUPATION ……..…….

OTHER QUALIFICATIONS OR TRAINING (such as military training, sports skills, etc.)

……

Part b Demographic Data Form Greek Version

ΔΗΜΟΓΡΑΦΙΚΑ ΣΤΟΙΧΕΙΑ

ΗΜΕΡΟΜΗΝΙΑ…….…..…….

ΚΩΔΙΚΟΣ ΣΥΜΜΕΤΕΧΟΝΤΑ……

ΦΥΛΟ: ΑΝΔΡΑΣ……. ΓΥΝΑΙΚΑ……..

ΗΜΕΡΟΜΗΝΙΑ ΓΕΝΗΣΗΣ……..ΗΛΙΚΙΑ……..

ΤΟΠΟΣ ΓΕΝΗΣΗΣ…….

ΕΘΝΙΚΟΤΗΤΑ……..

ΣΑΝ ΠΑΙΔΙ ΕΜΕΝΕΣ ΜΕ:

1. Την μητέρα και τον πατέρα
2. Μόνο με ένα από τους γονείς
3. Με την μητέρα και τον πατριό μου
4. Με τον πατέρα και την μητριά μου
5. Με θετούς γονείς
6. Με ανάδοχους γονείς
7. Σε ορφανοτροφείο
8. Με άλλους συγγενείς……..
9. Άλλο…….....

ΕΧΕΙΣ ΑΔΕΛΦΙΑ? 1. ΝΑΙ 2. ΟΧΙ

ΕΑΝ ΝΑΙ, ΠΕΣ ΤΟ ΦΥΛΟ ΚΑΙ ΤΗΝ ΗΛΙΚΙΑ
…….....

ΟΙΚΟΓΕΝΕΙΑΚΗ ΚΑΤΑΣΤΑΣΗ: 1. ΑΓΑΜΟΣ-Η 2. ΠΑΝΤΡΕΜΕΝΟΣ-Η
3.ΔΙΑΖΕΥΜΕΝΟΣ -Η 4. ΧΩΡΙΣΜΕΝΟΣ -Η 5.ΧΗΡΟΣ-Η

ΕΚΠΑΙΔΕΥΣΗ: 1. ΑΓΡΑΜΜΑΤΟΣ 2.ΔΗΜΟΤΙΚΟ ΣΧΟΛΕΙΟ
3. ΓΥΜΝΑΣΙΟ 4.ΛΥΚΕΙΟ 5.ΤΕΙ/ ΠΑΝΕΠΙΣΤΗΜΙΟ
6.ΜΕΤΑΠΤΥΧΙΑΚΟ 7.ΑΛΛΟ……

ΕΡΓΑΣΙΑ …….…….

ΑΛΛΑ ΠΡΟΣΟΝΤΑ ‘Η ΕΚΠΑΙΔΕΥΣΗ (στρατιωτική εκπαίδευση, αθλητικές ικανότητες κτλπ.)
……

Appendix O

Part a Psychiatric History Form English Version

PSYCHIATRIC HISTORY

DIAGNOSIS……

AGE OF FIRST DIAGNOSIS……

BASIC SYMPTOMS…….....

…….

…….

ADMISSIONS IN PSYCHIATRIC HOSPITALS

1.YES 2.NO

HOSPITAL AGE/DURATION COMMENTS

(intentionally or unintentionally)

…… …….. ……

……. ……... ……

…….. ……... ……

HOW LONG HAVE YOU BEEN IN THE SPECIFIC PSYCHIATRIC HOSPITA?

……

PSYCHOTHERAPY 1.YES 2.NO

APPROACH OF PSYCHOTHERAPY.....

DURATION OF PSYCHOTHERAPY …….....

MEDICATION 1.YES 2.NO

PRESENT MEDICATION: ……...

……

Part b Psychiatric History Form Greek Version

ΨΥΧΙΑΤΡΙΚΟ ΙΣΤΟΡΙΚΟ

ΔΙΑΓΝΩΣΗ……

ΗΛΙΚΙΑ 1^{ΗΣ} ΔΙΑΓΝΩΣΗΣ……..

ΒΑΣΙΚΑ ΣΥΜΠΤΩΜΑΤΑ…….....

…….

…….

…….

ΕΙΣΑΓΩΓΗ ΣΕ ΨΥΧΙΑΤΡΙΚΟ ΝΟΣΟΚΟΜΕΙΟ 1.ΝΑΙ 2.ΟΧΙ

ΝΟΣΟΚΟΜΕΙΟ	ΕΤΟΣ/ΔΙΑΡΚΕΙ	ΣΧΟΛΙΑ (εκούσια ή ακούσια)
……	……..	……
…….	……...	……
……..	……...	…….

ΠΟΣΟ ΧΡΟΝΙΚΟ ΔΙΑΣΤΗΜΑ ΒΡΙΣΚΕΣΑΙ ΣΤΟ ΣΥΓΚΕΚΡΙΜΕΝΟ ΨΥΧΙΑΤΡΙΚΟ ΝΟΣΟΚΟΜΕΙΟ;

……

ΨΥΧΟΘΕΡΑΠΕΙΑ 1.ΝΑΙ 2.ΟΧΙ

ΨΥΧΟΘΕΡΑΠΕΥΤΙΚΗ ΠΡΟΣΕΓΓΙΣΗ.....

ΔΙΑΡΚΕΙΑ ΨΥΧΟΘΕΡΑΠΕΙΑΣ …….....

ΦΑΡΜΑΚΕΥΤΙΚΗ ΑΓΩΓΗ 1.ΝΑΙ 2.ΟΧΙ

ΠΑΡΟΥΣΑ Φ.Α. : ……...

……

……

Appendix P

Part a Criminal History Form English Version

CRIMINAL HISTORY

HOW OLD WERE YOU WHEN YOU WERE FIRST GIVEN AN OFFICIAL WARNING BY THE POLICE?

……

HOW OLD WERE YOU WHEN YOU WERE FIRST FOUND GUILTY OF A CRIME IN COURT?

…….

WHAT WAS THIS FOR?

……

ABOUT HOW MANY CONVICTIONS HAVE YOU GOT IN TOTAL?

……

WHAT DO YOU HAVE CONVICTIONS FOR? WHAT DIFFERENT TYPES OF CONVICTIONS THAT YOU HAVE?

…….

…….

ABOUT HOW MANY TIMES HAVE YOU BEEN UP IN COURT?

……

YOUR PARENTS/ GURDIANS/ SIBLINGS/ CARERS HAVE ANY CONVICTION?

1.YES 2. NO

IF YES, FOR WHAT REASON?

……

……

HAVE YOU BEEN TO A PRISON OR A YOUNG OFFENDER'S INSTITUTION BEFORE?

1.YES 2. NO

IF YES, HOW LONG YOU SAYED THERE? ……

WHAT CRIME DID YOY COMMIT AND YOU GET IN HERE?

……

WHAT IS YOUR PENALTY?

……

WHAT WERE THE EVENTS LEADING UP TO YOU COMMITTING THE CRIME?

……

WHAT TYPE OF PLACE OR PERSON DID YOU PICK?

……

WHO DID YOU GO WITH?

……

WHAT DID YOU TAKE WITH YOU?

……

WHAT DID YOU DO BEFORE YOU STARTED?

……

HOW DID YOU START THE CRIME?

……

HOW LONG DID THE INCIDENT LAST? ……

WAS THERE ANY EYEWITNESES?

1.YES 2.NO

IF YES, WHO……

HOW DID YOU GET OUT OR AWAY?

……

IS THERE ANY STUFF YOU LEAVE BEHIND THAT YOU COULD HAVE TAKEN?

1.YES 2.NO

IF YES, WHAT……

WHAT DID YOU DO AS SOON AS YOU GOT OUT OR AWAY?

……

DID YOU DO TO MAKE SURE YOU DIDN'T GET CAUGHT?

1.YES 2.NO

IF YES, WHAT……

HOW STRONG ARE YOUR MEMORIES OF THE INCIDENT? PLEASE TICK A BOX

VERY STRONG	STRONG	QUITE STRONG	WEAK	VERY WEAK

Part b Criminal History Form Greek Version

ΕΓΚΛΗΜΑΤΙΚΟ ΙΣΤΟΡΙΚΟ

ΠΟΣΟ ΧΡΟΝΩΝ ΗΣΟΥΝ ΟΤΑΝ ΣΟΥ ΕΓΙΝΕ Η ΠΡΩΤΗ ΣΥΣΤΑΣΗ ΑΠΟ ΤΗΝ ΑΣΤΥΝΟΜΙΑ;

……

ΠΟΣΟ ΧΡΟΝΩΝ ΗΣΟΥΝ ΟΤΑΝ ΓΙΑ ΠΡΩΤΗ ΦΟΡΑ ΚΡΙΘΗΚΕΣ ΕΝΟΧΟΣ ΓΙΑ ΚΑΠΟΙΟ ΕΓΚΛΗΜΑ ΑΠΟ ΤΟ ΔΙΚΑΣΤΗΡΙΟ;

…….

ΓΙΑΤΙ ΕΠΡΟΚΕΙΤΟ;

……

ΠΟΣΕΣ ΚΑΤΑΔΙΚΕΣ ΕΧΕΙΣ ΣΤΟ ΣΥΝΟΛΟ;

……

ΓΙΑ ΤΙ ΕΓΚΛΗΜΑΤΑ ΕΧΕΙΣ ΚΑΤΑΔΙΚΕΣ; ΤΙ ΔΙΑΦΟΡΕΤΙΚΥ ΤΥΠΟΥ ΚΑΤΑΔΙΕΚΕΣ ΕΧΕΙΣ;

…….

…….

ΠΟΣΕΣ ΦΟΡΕΣ ΕΧΕΙΣ ΠΑΡΑΣΤΑΘΕΙ ΣΤΟ ΔΙΚΑΣΤΗΡΙΟ;

……

ΟΙ ΓΟΝΕΙΣ/ ΑΔΕΛΦΙΑ/ ΚΗΔΕΜΌΝΕΣ/ ΦΡΟΝΤΙΣΤΕΣ ΣΟΥ ΕΧΟΥΝ ΚΑΘΟΛΟΥ ΚΑΤΑΔΙΚΕΣ;

1.ΝΑΙ 2. ΟΧΙ

ΕΑΝ ΝΑΙ, ΓΙΑ ΠΟΙΟ ΛΟΓΟ;

……

……

ΕΧΕΙΣ ΒΡΕΘΕΙ ΠΟΤΕ ΣΕ ΦΥΛΑΑΚΗ Ή ΣΕ ΑΝΑΜΟΡΦΩΤΗΡΙΟ;

1.ΝΑΙ 2. ΟΧΙ

ΕΑΝ ΝΑΙ, ΠΟΣΟ ΧΡΟΝΙΚΟ ΔΙΑΣΤΗΜΑ ΠΑΡΕΜΕΙΝΕΣ;

…….

ΤΙ ΕΓΚΛΗΜΑ ΔΙΕΠΡΑΞΕΣ ΚΑΙ ΒΡΕΘΗΚΕΣ ΕΔΩ;

……

ΠΟΙΑ ΕΙΝΑΙ Η ΠΟΙΝΗ ΣΟΥ;

……

ΠΟΙΟ ΕΙΝΑΙ ΤΑ ΓΕΓΟΝΟΤΑ ΠΟΥ ΣΕ ΟΔΗΓΗΣΑΝ ΝΑ ΔΙΑΠΡΑΞΕΙΣ ΤΟ ΕΓΚΛΗΜΑ;

……

ΤΙ ΤΥΠΟΥ ΜΕΡΟΣ Ή ΑΤΟΜΟ ΔΙΑΛΕΞΕΣ;

……

ΜΕ ΠΟΙΟΝ ΗΣΟΥΝ/ΠΗΓΕΣ ΜΑΖΙ;

……

ΤΙ ΠΗΡΕΣ ΜΑΖΙ ΣΟΥ;

……

ΤΙ ΕΚΑΝΕΣ ΠΡΙΝ ΞΕΚΙΝΗΣΕΙΣ;

……

ΠΩΣ ΞΕΚΙΝΗΣΕΣ ΤΗ ΔΙΑΠΡΑΞΗ ΤΟΥ ΕΓΚΛΗΜΑΤΟΣ;

……

ΠΟΣΟ ΔΙΗΡΚΗΣΕ ΤΟ ΠΕΡΙΣΤΑΤΙΚΟ; ……

ΥΠΗΡΧΑΝ ΑΥΤΟΠΤΗΣ ΜΑΡΤΥΡΕΣ;

1.ΝΑΙ 2.ΟΧΙ

ΕΑΝ ΝΑΙ, ΠΟΙΟΣ……

ΠΩΣ ΒΓΗΚΕΣ ΕΞΩ Ή ΔΙΕΦΥΓΕΣ;

……

ΥΠΑΡΧΟΥΝ ΠΡΑΓΜΑΤΑ ΠΟΥ ΑΦΗΣΕΣ ΠΙΣΩ ΣΟΥ ΕΝΩ ΜΠΟΡΟΥΣΕΣ ΝΑ ΤΑ ΠΑΡΕΙΣ ΜΑΖΙ ΣΟΥ;

1.ΝΑΙ 2.ΟΧΙ

ΕΑΝ ΝΑΙ, ΤΙ……

ΤΙ ΕΚΑΝΕΣ ΜΟΛΙΣ ΒΓΗΚΕΣ ΕΞΩ Ή ΔΙΕΦΥΓΕΣ;

……

ΕΚΑΝΕΣ ΚΑΤΙ ΓΙΑ ΝΑ ΒΕΒΑΙΩΘΕΙΣ ΟΤΙ ΔΕΝ ΘΑ ΠΙΑΣΤΕΙΣ;

1.ΝΑΙ 2.ΟΧΙ

ΕΑΝ ΝΑΙ, ΤΙ …….……

ΠΟΣΟ ΔΥΝΑΤΕΣ ΕΙΝΑΙ ΟΙ ΜΝΗΜΕΣ ΣΟΥ ΑΠΟ ΤΟ ΠΕΡΙΣΤΑΤΙΚΟ; ΒΑΛΕ Χ ΣΤΟ ΚΑΤΑΛΛΗΛΟ ΚΟΥΤΙ

ΠΟΛΥ ΔΥΝΑΤΕΣ	ΔΥΝΑΤΕΣ	ΜΕΤΡΙΕΣ	ΑΔΥΝΑΜΕΣ	ΠΟΛΥ ΑΔΥΝΑΜΕΣ

Appendix Q

Part a Debriefing Information Form English Version

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DEBRIEFING FORM

Criminal Narrative Experience and Emotional State of Schizophrenic Offenders

Dear participant,

The present form is to inform you thoroughly for the research you just participated, undertaken by a student of the Post-graduate programme PhD Investigative Psychology of the University of Huddersfield, Christina Simitsi.

Individuals with a mental disorder who have also committed an offence (MDO) are one of the populations that have not been extensively researched. That is probably because of the nature of the individuals and the strict regulation of the setting they are being held that do not permit any research to be conducted.

The purpose of this thesis is to contribute to and expand the body of knowledge about crime and mental disorders and challenge some of the reigning conceptions about this association.

The overall aim of this thesis is to investigate the experience of committing a crime and explore the narrative criminal experience of Schizophrenic Offenders (SO). The objectives are to examine the narrative roles SO act out during crime commission; to investigative emotions experienced by SO during crime commission; to explore whether the Criminal Narrative Experience (CNE) framework identified in other offenders can be applied to SO; to investigate the relationship of the CNE to levels of guilt and shame and finally to investigate the relationship of the CNE to depression and suicidal ideation

This study can offer insight into the motivations of crime acted by SO and has obvious implications in the understanding of suicides in the psychiatric facilities as well as in the mental health of the SOs in aeffort to predict future suicide attempts, to develop risk assessment techniques and preventive strategies and to provide information to improve rehabilitation of such populations.

Ethical and deontology reasons require you to be informed about your anonymity and your right to withdraw your results from the research even if it is already done within a period of three months.

Sincerely thank you for your time and your participation.

If you require any further information about the research, please contact me or my supervisor on:

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Part b Debriefing Information Form Greek Version

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ΈΝΤΥΠΟ ΤΕΛΙΚΗΣ ΕΝΗΜΕΡΩΣΗΣ

Εγκληματική Αφηγηματική Εμπειρία και Συναισθηματική Κατάσταση των Σχιζοφρενών Παραβατών

Αγαπητέ /ή συμμετέχοντα,

Το παρόν έντυπο έχει ως στόχο του να σε ενημερώσει πληρέστερα για την έρευνα που διεξάχθηκε, για την διδακτορική φοιτήτρια του PhD Investigative Psychology του Πανεπιστημίου Huddersfield, Χριστίνα Σιμιτσή, στην οποία μόλις έλαβες μέρος.

Τα άτομα με ψυχική διαταραχή που έχουν διαπράξει κάποιο αδίκημα (ΨΔΠ) είναι ένας από τους πληθυσμούς που δεν έχουν ερευνηθεί εκτενώς. Αυτό είναι πιθανώς λόγω της φύσης των ατόμων και τους αυστηρούς κανόνες στα ιδρύματα στα οποία κρατούνται, που δεν επιτρέπουν οποιαδήποτε έρευνα να διεξαχθεί.

Ο σκοπός της παρούσας έρευνας είναι να συνεισφέρει και να επεκτείνει την γνώση σχετικά με το έγκλημα και την ψυχική ασθένεια και να προκαλέσει μερικές από τις κυρίαρχες αντιλήψεις σχετικά με αυτή τη σχέση.

Ο γενικός στόχος αυτής της εργασίας είναι να διερευνήσει την εμπειρία της διάπραξης ενός εγκλήματος και να διερευνήσει την αφηγηματική εγκληματική εμπειρία των σχιζοφρενών παραβατών (ΣΠ). Οι στόχοι είναι να εξεταστούν οι αφηγηματικοί ρόλοι που διαδραματίζουν οι ΣΠ κατά τη διάρκεια της τέλεσης του εγκλήματος, να διερευνήσει τα συναισθήματα που βιώνουν οι ΣΠ κατά τη διάρκεια της τέλεσης του εγκλήματος, να διερευνήσει εάν το πλαίσιο της Εγκληματικής Αφηγηματικής Εμπειρίας (ΕΑΕ) που προσδιορίζεται σε άλλους παραβάτες μπορεί να εφαρμοστεί στους ΣΠ, να διερευνήσει τη σχέση της ΕΑΕ με τα επίπεδα της ενοχής και της ντροπής και τέλος να διερευνήσει τη σχέση της ΕΑΕ με την κατάθλιψη και τον αυτοκτονικό ιδεασμό.

Η μελέτη αυτή μπορεί να προσφέρει πληροφορίες για τα κίνητρα του εγκλήματος των ΣΠ και έχει προφανείς συνέπειες στην κατανόηση των αυτοκτονιών στις ψυχιατρικές εγκαταστάσεις καθώς και στην ψυχική υγεία των ΣΠ, προκειμένου να προβλεφθούν μελλοντικές προσπάθειες αυτοκτονίας, προληπτικών στρατηγικών και να παρέχουν πληροφορίες για τη βελτίωση της αποκατάστασης τέτοιων πληθυσμών.

Λόγοι ηθικής και δεοντολογίας επιβάλλουν να σου υπενθυμίσουμε ότι θα τηρηθεί απόλυτη εχεμύθεια ως προς τα προσωπικά σου δεδομένα και το δικαίωμα σου να

αποσύρεις τα αποτελέσματα σου από την έρευνα ακόμα και εάν έχει ολοκληρωθεί μέσα σε χρονικό διάστημα τριών μηνών.

Σε ευχαριστούμε θερμά για τον χρόνο σου και την συμμετοχή σου.

Εάν χρειάζεσαι περαιτέρω πληροφορίες σχετικά με την έρευνα, παρακαλώ επικοινώνησε μαζί μου ή με τους επόπτες μου:

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