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INTRODUCTION

On the fifth of February 2015 the law “On probation” (ЗУ “Про пробацію”, 2015) was passed in Ukraine. The main task of the law is criminal law humanization, reduction of recidivism, as well as the resocialization of offenders released from prison. The law also establishes different probation programs that are aimed to help offenders change their criminal way of life into socially beneficial and accepted behavior. Among these areas of assistance from the government, the law provides help in resolving such issues as getting an education, getting employed, as well as resolving physical and mental health problems.

At the same time, although the law establishes this government function, there is still no clear understanding on how this help should be provided, what are the ways and methods of psychological assistance and help to this category of people.

Drawing on the experience of other countries, where the legislative framework identifies the ways of psychological and psychotherapeutic work with the offenders (Smith, Petibon, 2005; Igoumenou, 2020), we believe that researches on the issues related to mental health problems of people committed a crime in Ukraine is currently necessary and relevant.

Western studies of this topic provide sad statistics on the problems of mental health among the offenders. According to the World Health Organization, up to 40 per cent of convicted in Europe suffer from various forms of mental illness, and their risk of committing suicide is seven times higher than the same indicator within the general population. The offenders usually have much higher levels of drugs and alcohol abuse (WHO, 2010; Hartwell, 2004; Ramsay et.al., 2011).

It is rarely reported in the Ukrainian society and media that in order to prevent crimes and recidivism it is important for us to think not only about the ways to punish these people, but the ways to provide psychological treatment for them. Our research

is a way to highlight and draw attention to this issue by demonstrating the current situation in Ukraine. The offenders on probation are at a high risk of developing mental health problems, but due to the lack of research in this area we do not have the clear information about their mental problems and so we cannot provide adequate psychological help and psychotherapeutic treatment.

Important questions that we as psychologists working with offenders must consider are: What are the most common mental health problems people on probation have? and What might be the most effective ways to assess their mental health problems so to provide the adequate and well-timed psychological help and treatment?

Thus, studying mental health problems among people on probation is only the first step and aims to further develop principles of psychotherapy with this category of patients.

Objects of the study: mental health

Topic of the study: offenders' on probation subjective perception of the symptoms of common mental health disorders in comparison with people from general population

At the beginning of the study, we had the following **hypothesis**: 1. People who have committed a criminal offence and are on probation are characterized by a higher prevalence of various symptoms of common mental health disorders, compared to the adults who have never convicted crimes. 2. Offenders on probation are characterized by a lower level of psychological flexibility, compared to the adults who have never committed a crime. 3. Offenders who have committed a crime which is considered more grave have more severe symptoms of mental health disorders compared to those, who committed minor offenses; 3. Offenders who have committed crimes several times have more severe symptoms of mental health disorders than those who have been convicted for the first time.

The objectives of the study:

1. To find out the prevalence of mental health problems among probationers, the most common mental, physical health problems, interpersonal and social difficulties they face, to learn about the factors that affect criminal behavior and the psychotherapy principles that should be taken into account while working with this population.
2. To develop a research plan and select a diagnostic toolkit for assessing the mental health characteristics of the offenders on probation.
3. To perform a comparative analysis between the symptoms of mental health disorders among probationers and the group of the general population, as well as the symptoms of mental health disorders of probationers who have committed grave and minor offenses.
4. To develop practical recommendations of psychotherapy with offenders on probation based on the results of the study.

Participants of the study: 34 male offenders from 19 to 54 years old (the average age is 30 years old) who are currently on probation in the District office of the Probation Center in Kyiv participated in the study. 34 male adults from 21 to 51 years old (the average age is 33 years old) from the general population, who have never been convicted of a crime. The study with probationers was carried in face-to-face manner individually in the probation center. The study with the participants of the control group was carried on by spreading the questionnaires in online form.

General scientific methods were used in the study such as analysis, synthesis, induction, deduction and modelling; *the empirical method of conducting research* - tests, and *mathematical-statistical methods* of processing the research results – descriptive statistics, correlation, comparative, and cluster analysis.

Research Methods: Psychopathological symptom severity questionnaire (SCL-90-R), The Short Form Health Survey (SF-36) questionnaire, The Acceptance and Action questionnaire (AAQ-II), The Outcome questionnaire (OQ). The questions about the age, marital status, the presence of the children were included in our study

for both groups. Additionally, the questions about the criminal records history were included in the forms that participants of the experimental group had to fill in.

Scientific novelty of the results obtained: 1. For the first time in Ukraine it was shown that the probationers can be divided into two groups: those, who report about high prevalence of mental health problems and struggle from more limitations associated with the physical health; and those who don't report on any mental or physical health difficulties. According to our study, the number of probationers who don't report on their mental health difficulties prevail in several times. We suppose that it can be one of the reasons why probationers don't seek for psychotherapy help. 2. Understanding of the aspects of assessment is deepened, based on the results of the study. It was established that the offenders don't tend to report on their mental health difficulties and mostly deny them which must be considered while planning further researchers. 3. Our understanding of planning and conducting psychotherapy interventions was deepened. Due to the tendency to deny their emotional, interpersonal and social difficulties even if they have difficult living situations, substance abuse or the fact that they have been convicted on a crime - this group of patients can be considered difficult to work with therapeutically.

The practical significance of the results obtained: the results of the study can be used to formulate recommendations for providing assessment, psychological help and psychotherapeutic work with offenders on probation in Ukraine.

The structure and the scope of the paper. The paper consists of an introduction, three chapters, conclusions, a list of references (91 titles) and appendix on 31 pages. The paper presents a total of 15 figures. The total volume is 113 pages, the main content is 71 pages.

CHAPTER 1
THEORETICAL BASIS OF MENTAL HEALTH AMONG OFFENDERS ON PROBATION

1.1 Overview of mental health problems among offenders on probation

The problem of mental health of the offenders is extremely urgent even despite the fact that for many years and even centuries, scientists have been thinking about the factors that contribute to the fact that one person chooses criminal behavior while the other one lead a law-abiding life. Studies show that a significant proportion of people who commit crimes experience at least one mental health problem.

According to the results of the survey conducted in The UK in 2012 39% of offenders under probation have mental health problems (Centre for mental health, 2012).

Thus, prevalence studies in many countries indicate that 10-15 per cent of convicts suffer from severe and long-term mental disorders such as schizophrenia, split personality and autism (WHO,2010).

According to research held by Claire E. Ramsay and colleagues held in the USA among all incarcerated individuals, 10% of federal prisoners, 15% of state prisoners, and 24% of local jail inmates reported symptoms that met criteria for a psychotic disorder. In a convenience sample of individuals with a known serious mental illness who had been incarcerated, some 87% had a schizophrenia-spectrum disorder About 11% had psychotic disorders - ten times the level of the general population (Ramsay et.al., 2011).

Many studies were carried on to evaluate the prevalence of anxiety and affective disorders in this population (e.g. Hodgins, De Brito, Chhabra , Cote, 2010; Vermeiren, 2003). The study conducted in Canada in 2010 has shown that two-thirds of prisoners suffer from anxiety disorders and half of them started to feel the symptoms of anxiety before they turned 16 years old (Hodgins, De Brito, Chhabra ,

Cote, 2010). Another study that was conducted among juvenile offenders showed that 52% of male and 72% of female young offenders have anxiety disorders (Timmons-Mitchell, Brown, Schulz, Webster, Underwood, Semple, 1997).

Depressive disorders are also common among the offender population and proved to have the connection with a delinquent behavior (Pulay, et al. 2008; Fazel, et al., 2015). In the study conducted in 2008 in the USA (Langhinrichen-Rohling, Rebholz, O'brien, O'farril-Swails, Ford, 2008) male youth offenders had to self-report whether they have ever been diagnosed with the depression. The results has shown that 24,8% of the participants had this diagnoses (Langhinrichen-Rohling, Rebholz, O'brien, O'farril-Swails, Ford, 2008). DSM-IV (American Psychiatric Association, 2000) states that depressive disorder is characterized with lowering interest in most of activities, feelings of worthlessness, repeating thoughts of death and some other symptoms that cause significant difficulties in the life (American Psychiatric Association, 2000). It was shown in the studies that individuals who experience these symptoms are more vulnerable to get involved in violent crimes (Fazel, et al., 2015)

Even though the foreign researches drag the attention to the mental health problems among offenders and to the importance of assessing these people on time so to be able to provide adequate treatment, the studies that are aimed to understand the prevalence of mental health problems among probationers in Ukraine are very rare. It means that in our country this problem is denied and as a result, the people who might need the treatment don't get it on time. Studies have shown that untreated psychosis or other mental health problems have a poorer response to treatment if not treated on time (Buckley, Noffsinger, Smith, Debra, Hrouda., Knoll, 2003). Consequently, the number of reoffending in Ukraine have the potential to increase and the crimes might be getting more severe. It was found that after serving their sentence, people with diagnosed mental health disorder according to DSM IV are at 70% more likely to return to prison at least once than those who are not diagnosed with a psychiatric disorder. Among those who were previously incarcerated the rates

of recidivism were 50% and 230% higher for those diagnosed with psychiatric disorders than for those who didn't have this diagnosis (Marr, Corinne et. al., 2019).

Criminal behavior is also very often associated with substance abuse disorders. Drug and alcohol-related charges were the most commonly reported reason for incarceration in this sample, comprising 23.7% of all charges in the USA (Claire E. Ramsay et.al., 2011).

In relation to substance use, patients who had been incarcerated reported an earlier age at initiation of cannabis use, and history of incarceration was significantly associated with the presence of alcohol and cannabis dependence or abuse at the time of initial hospitalization.

The most common problem is that offenders who have substance abuse disorders are usually diagnosed alongside with mental illness. Comorbidity rates and multiple diagnoses are very high in this category of individuals: 72% of people on probation in The UK who were diagnosed with a mental disorder were also diagnosed with substance use disorder. Dual diagnoses such as personality disorders, alcoholism, drug addiction with multiple illnesses are widespread among prisoners. People with multiple illnesses are most likely to be depressed and anxious. They also are more likely to be homeless, to violate probation after release, and commit the crimes again (Hartwell, 2004). This brings to increase the potential of rearrests as their social situation and inability to find a job due to the criminal record history and substance abuse disorder, can propel this group into criminal behavior as a strategy to survive. These people commit crimes 4 times more often than those who doesn't take drugs or alcohol. (Kelly, et al, 2012). The studies conducted in Ukraine with the aim to understand the connection between the criminal behavior and substance abuse disorders have shown that the highest indicators of the crimes in a state of alcohol or drug intoxication were established among the offenders who committed violent crimes (70%), 64% of offenders committed crimes connected with drug trafficking. It shows how the intoxication influences the criminal behavior. (Сердюк, Марковська, 2008).

To sum up, substance abuse disorders have an influence on the life of offenders. Due to their dependence on alcohol and drugs they are less likely to find an employment and to get high salary. This fact might lead them to find a way to survive in stealing and even murdering. It was also proved that the state of substance intoxication is very common among offenders who have been arrested during or just after committing a crime. Which means that substance abuse can be considered not only the problem that leads to criminal behavior but the reason to commit a crime as well as they have less control of their actions and impulses (Sattar, 2001). It was also shown that almost two-thirds of accidental death and about one-third of suicide death of the offenders were the result of alcohol and drug use (Sattar, 2001).

There are probation programs in Ukraine aimed to reduce the level of substance abuse disorders among the probationers but again, they don't really consider all the factors that are connected to the criminal behavior choice. Probation programs are based on the principles of motivational counseling and techniques of cognitive-behavioral interventions. Despite the fact that these techniques have proved their effectiveness among this population to some extent, they are not considered psychotherapeutic and do not involve profound changes in the consciousness of the offender. (Бойко-Бузиль, 2019). This means that these programs rather teach the offenders to reduce the amount of alcohol and drugs used, instead of deep understanding what brings the criminal to use drugs and to commit a crime, whether it is a survival strategy, the need, the way to escape problems and responsibility due to the personality traits, mental problems or childhood traumatic experience.

Studies show that people who commit crimes have also problems with their physical health condition. Statistics show that in most of the European and Central Asian Countries the number of HIV infection among prisoners are much higher than those who have never been imprisoned (WHO, 2010). HIV/AIDS epidemics in developing countries usually start among injecting drug users - a proportion of the population that is very prevalent in prisons (Rich et al., 2001).

Another common physical health problem among this category of people is the spread of tuberculosis. As noted on the World Health Organization website, tuberculosis outbreaks in prisons have been reported in many Eastern European countries since the 1990s, and its strains, most often transmitted in prisons, are drug-resistant or combined HIV diagnosis. The incidence of tuberculosis with widespread drug resistance among prisoners is higher than among those who don't have criminal background. (WHO,2010).

The problems in mental and physical health of the offenders is associated with their way of living, social and interpersonal problems. Patients with a history of incarceration had completed fewer years of education and had poorer premorbid academic functioning than those who had not been incarcerated. (Claire E. Ramsay et.al., 2011)

A survey conducted by the Nordic Penitentiary Services (Graham L.,2007) indicates that most of the prisoners have never worked. Also, a large number of such people have left the school without even getting the basic qualification. About 14% of them are homeless or without temporary residence. Approximately 55% of people on probation are unemployed and/or have low educational level and difficulties in finding employment (Solomon, Silvestri, 2008).

These people lack trust and mentors who don't have criminal background. Their lives are chaotic and their physical and mental health and social life are very impoverished.

People who have been convicted of a crime are very likely to be unemployed not only because of their poor academic background and limited work experience but also due to the unwillingness of the employers to hire workers with previous criminal record history. According to the study of H.J. Holzer and colleagues (Holzer, Raphael, Stoll, 2003) ex-offenders are considered to be the least reliable group in the eyes of employers, who tend to check their criminal record history before hiring them (Holzer, Raphael, Stoll, 2003).

Traumatic childhood experience, social and interpersonal problems, difficulties in resocialization and finding an employment after being released from prison alongside with health and mental problems and substance abuse, all these factors lead to another important problem - the suicide and death rates among incarcerated offenders and those on probation.

Studies indicate that individuals under probation are characterized by a high level of suicidal behavior. The rates of suicidal behavior are 9 times higher than overall indicators in the general population (Solomon, E. and Silvestri, A., 2008). It’s important to note that the risk of committing a suicide is higher for those who are serving sentences without imprisonment (46%) compared to those serving prison sentences (3%). This shouldn’t be surprising since drugs and alcohol are more accessible to those who aren’t imprisoned. Also, people who serve the sentence on probation still remain or go back if they were released, in the same living situation, have to find a job and have to be at the same unsatisfied personal relationship (Solomon, E. and Silvestri, A., 2008).

In these studies, it is particularly emphasized that deaths among people under probation usually took place after being released from the prison. Within four weeks of their release, more than a quarter had died. Within 12 weeks of release, more than half of deaths occurred, and in just in 24 weeks just under three-quarters of all deaths occurred. The largest proportion of deaths were due to accidents, but a large part also involved suicide. (Solomon, E. and Silvestri, A., 2008).

Probation in Ukraine is at early stage of development and there are not enough official data that represent the association between mental health problems, substance abuse disorders and suicidal rates among this population in our country. For this reason, we consider it appropriate to draw attention to the results of foreign studies regarding high levels of death and suicidal behavior among probationers in other countries and we think that this problem should be examined in further studies.

Based on the studies conducted we can conclude that people who have committed crimes are in the risk group as they are more likely to have mental and

physical illnesses, due to many factors such as maltreatment in childhood, not appropriate social environment, lower quality and level of education and life combined with widespread substance abuse disorders. These factors increase the risk of committing violent crimes as well as recidivism and suicide among this population.

All these factors are very important to be taken into account because the support for the people on probation, prevention of recidivism, their resocialization after releasing from prison, restoration of their well-being should be conducted through providing the adequate medication, psychological treatment and assistance in meeting their social needs and physical and mental health problems.

The Law of Ukraine "On Probation" (ЗУ "Про пробацію", 2015) states that supervisory and penitentiary probation involves individually planned work to solve many problems that offenders meet, such as providing necessary social, psychological, legal, medical and educational services and conduction probation programs. Such probation programs include training aimed at changing criminal thinking, overcoming abusive behavior and preventing the use of psychoactive substances.

On the other hand, the law does not include the psychotherapy work with the offenders in the list of probation programs and there are no information and studies that would answer the question if they need psychotherapeutic help, which includes investigation of their internal conflicts, motives for criminal behavior, working on early childhood traumas and more - and how this work should be conducted.

Despite the recognition of high prevalence of the mental health problems among probationers in the foreign studies, in Ukraine they are usually considered as people who have behavior problems, lack of impulse control but not those who need the psychotherapy. Due to the denying of their mental health difficulties from the government and clinicians, they don't receive the treatment at all or go through different programs that are aimed to "change their behavior" instead of treating their

internal problems and conflicts or, which is more likely, just are punished without understanding what caused the decision to commit a crime.

1.2 PSYCHOLOGICAL FACTORS AFFECTING CRIMINAL BEHAVIOUR

1.2.1 Reasons for criminal behavior within a framework of theories of crime and delinquency

During centuries, many attempts have been made to explain why some people commit crimes and others do not. This issue is one of the most discussed not only in the field of psychology, but also in criminology, sociology, penitentiary psychology, psychiatry and anthropology.

In recent years, science has emerged in several major areas that have explored the characteristics of criminals: biological (anthropological), psychological, socio-psychological and sociological (Brown, Serin, Fourth, Bennell, Pozzulo, 2016).

The founder of the anthropological direction was the Italian scientist Cesare Lombroso. For many years, he observed the prisoners and concluded that there was a criminal type of person. He believed that the explanation of criminal behavior lies in the shape of a person’s head or other features of appearance and that the inner, psychological world of the criminal type was atavistic and possesses the qualities of the primitive people. This idea was widely discussed at that time, but after all it was disproved (Brown, Serin, Fourth, Bennell, Pozzulo, 2016).

Sigmund Freud’s theory on aggression was also originated from a biological understanding of human being. At the beginning of his career, Freud saw aggression as a component of sexual instinct (Freud, 1905). In 1920 in his work “Beyond the pleasure principle" he stated that aggression is not a component of sexual instinct but a separated instinct, a force that operates at all levels (Freud,1920). Establishing the

existence of aggressive impulses means that the criminal is not rational and doesn't really control these impulses but has unconscious sources of motivation and is driven by uncontrolled irrational forces.

The understanding of aggression and violence and their origin since Freud has constantly been revised depending on the approach and theoretical school of different researchers. For instance, Melanie Klein understood aggression to be instinctually in origin and destructive (Кляйн, 1946); on the other hand, Donald Winnicott wrote about two types of aggression. He distinguished aggression as a normal development that is necessary for separation from the caregiver. On the other hand he noted, that there is pathological aggression as a reaction to environmental trauma and loss (Винникотт, 1971).

The motives of the criminal behavior can also be explained by the context of Alfred Adler's theory, which instead of aggressive craving placed the superiority complex and associated with it inferiority complex in the first place. Feelings of inferiority can transform the complex of superiority and make the person choose criminal behavior. (Адлер, 1929)

Supporters of the sociological approach indicate that criminal behavior is mostly caused by the interaction of the individual with the conditions of life and activity of the subject (Филиппова, 2013). This idea was supported by psychoanalyst Erich Fromm, who stated that "hostility" and destructiveness, the desire of power and the desire for submission, alienation, self-glorification tendencies, avarice, desire for sensual pleasures and fear of these desires - all these and many other cravings and fears that can be found in a person, develop reactions to certain life circumstances. None of these features is inherited by a person. The lifestyle due to the peculiarities of the economic system becomes a fundamental factor that determines the nature of man, because the need for self-preservation prompts the person to accept the conditions in which he or she has to live. (Фромм Э., 1941)

Modern researches point to the formation of criminal behavior as a set of various factors that in one way or another affect the individual. Among these factors,

they name the personality and his or her vulnerability to the influence of certain factors, especially features of socialization, economic factors, the experience of traumatic events, the influence of the environment and others. In order to understand the impact of these factors on the person's choice of criminal behavior, we will discuss them below.

1.2.2 Specific factors that have the potential to affect on criminal behavior

The role of developmental trauma in the formation of criminal behavior

The results of psychological studies of offenders indicate that almost 90% of this sample had the history of traumatic experience and losses (Boswell, G., 1996). Childhood trauma often includes physical and sexual abuse, losses, neglect and other traumatic life events.

Many studies (e.g. Duke, Pettingel, McMorris, Borowsky 2010; Reavis, Looman, Franco, Rojas, 2013;) have proved that traumatic childhood experience is highly associated with further criminal behavior. Reavis and collegues have found that the men who reported about being sexually abused in the childhood were 45 times more likely to threaten or abuse their life partners many years after (Reavis, Looman, Franco, Rojas, 2013). In the study carried on in 2010 among high-school students in USA the authors Duke and collegues found that traumatic childhood experience is remarkably associated with further interpersonal violence, such as bullying, physical fighthing, dating violence, as well as self-destructive behavior (. Duke, Pettingel, McMorris, Borowsky 2010).

Very important role in understanding childhood trauma and its influence on the life of the person plays attachment theory that was invented by John Bowlby (Bowlby, 1990). Experiencing the loss of a caregiver the child can have several reactions as for: separation anxiety, sadness, feelings of loss of protection. It should be noted that the loss doesn't necessarily means actual death or abandonment, but

also any action which lead to the loss of love for the caregiver: threats, violence, maltreatment, abuse, neglect etc. (Bowlby, 1990).

Bowlby was the first to associate attachment difficulties with crime in 1944 (Newrith, Meux, Taylor, 2006). As Newrith and colleagues note, in Bowlby's paper "Forty-four juvenile thieves" he stated that antisocial behavior in a group of patients, who he described as having an affectionless character, had its origins in early disorders of attachment, arising from the pathological effects of prolonged and early separation (Newrith, Meux, Taylor, 2006).

Even though he emphasized on prolonged separation, the study that was conducted in 2010 and revised Bowlby's work found that in the histories he presented there were also evidence of neglect and maltreatment before, during and/or after their separation (Follan & Minnis, 2010).

Bowlby's attachment theory was not accepted by many of his colleagues and was criticized due to the oversimplification of psychodynamic mechanisms (Bretherton, 1992). Yet, he attracted attention to the importance of relationship between the child and the mother and provided a great contribution in the development of other theories, for example the theory of mentalization by Peter Fonagy, that used attachment theory as a basis which will be discussed below.

Exposure to domestic violence as a factor influencing on criminal behavior

There are some studies that were conducted to understand if observing violence between parents in early childhood influenced somehow on the emotionality and further criminal behavior in adulthood.

The research conducted in 2014 (McKee, Payne, 2014) reported that witnessing domestic violence as a child had no effect on the level of emotionality in adults. Neither they found the connection between being hit as a child and the level of emotionality. The only one variable - gender - showed a statistically significant difference in the results: it was shown that females who had the experience of being physically hurt got higher emotionality scores than men (McKee, Payne, 2014).

On the other hand, earlier study (Murrell, Christoff, Henning, 2007) that was conducted among offenders who were arrested for domestic violence showed that general violence (meaning violent acts towards someone other than partner) increased in the group where participant had been exposed to violence during their childhood. Those who were abused in the childhood were more likely to be abusive towards own children when they are adults. As the authors noted, that the results of their study prove the previous findings that children who have been abused or exposed to the violent acts in the family are more likely to become violent when they are adults and that children who have been abused often become child abusers. They also add that thise who were abused as children are more likely to abuse when they are adults then those who were not abused themselves but only were exposed to the violence (Murrell, Christoff, Henning, 2007).

At the same time the researchers note that according to their study exposure to the violence as a child did not influence on nonviolent criminal behavior, which contradicts previous studies on this topic, such as the study of Graham-Bermann and Levendosky 1998 and Widom and White 1997, which showed that witnessing abusive behavior were connected with increasing the number of legal problems and arrests (Murrell, Christoff, Henning, 2007).

We can see from these studies that the researches on this topic are quite contradictory. On the one hand, they show the influence of observing violence as a child on violent behavior in adulthood. At the same time, there are no direct connection found between exposure to the domestic violence and emotionality which might lead to the criminal behavior. We assume that nonviolent criminal behavior isn't really associated with the exposure to the violence in the family, but those who witnessed violence during their childhood are at higher risk to commit violent crimes when they are adults.

Estela Welldon in her work "Playing with Dynamite: A Personal Approach to the Psychoanalytic Understanding of Perversions, Violence, and Criminality" (Уэлдон, 2017) notes that there are many variables, including different levels of

exposure to the violence and different coping strategies that lead to different consequences. People who have been exposed to violence might struggle with obsessive memories, aggressiveness, hyperactivity, emotionless and a number of other problems that may arise immediately or later. She agrees that the exposure to violence will more likely provoke same violent behavior later. (Уэлдон, 2017)

Citing studies of other authors (Wolak et.al.,1988) she notes that children who were the witness of domestic violence are likely to be aggressive, cruel to animals, they are predisposed for acting out, infantilism, and attention deficit disorder. They also think that these children grow up with deep misunderstanding of meaning of love and intimacy.

At the same time, Weldon notes (Уэлдон, 2017), that even though there children are in a risk of being deeply affected by exposure to violence, there are such factors as plasticity of mental development and coping strategies, manifesting differently in each case. As the authors Fabienne Glowacz and Michel Born (Glowacz, Born, 2015) note, some people are resilient to the circumstances that might influence on the criminal behavior. The factors that help the children to adjust to these circimstances in a successful manner might be family members, school peers, community and due to them, even if the child experienced some difficult situations and traumas, he or she might not choose the delinquent behavior. That's why not everyone who have ever been exposed to violence or been abused, will become an abuser in future. In reality, this experience can later get another direction. Traumatic experience can be the source of creative energy, searching for new possibilities and widening perspectives.

The influence of social environment on delinquent behavior

Social connections of a child or adolescent are also considered as a factor for criminal behavior in the literature.

For example, Antonian and Eminov point out that the identity of the offender is a product of the society (Антонян, Эминов, 2015). The authors state: “A person isn’t

born a person, but becomes it only in the course of a social life, so it is impossible to form a personality outside of the society" (Антонян, Эминов, 2015, p.107). This means that the individual is not born a criminal, but becomes a criminal as a result of the influence of unfavorable social environment.

The authors emphasize on the importance of socialization of any personality: "Primary socialization plays a particularly important role in the formation of a personality when the child is still unconsciously acquiring images, patterns and behavior, typical adults' reactions (usually parents') on the problems" (Антонян, Эминов, 2015, p.110). When the child grows older he or she imitates the behavior. It should be noted that the child's acquisition of adults' reactions does not occur automatically, but when the child has emotional contact with an adult and trusts this person. If the relationship between the child and the parents are cold and there's no attachment between them then the influence of the parents on the child's behavior reduces (Антонян, Эминов, 2015).

There were also studies conducted to investigate whether the structure of the family might influence on the further delinquent behavior of the child (Burt,1925; Slawson, 1923, Jones, 2008). Some studies carried out in 1920-s in USA showed that people who grew up in single-parent families were over-represented in the offender population (Jones, 2008). Giving as an example some researches of those years (Burt,1925; Slawson, 1923) David W. Jones notes that back that time it was common to emphasize on the importance of the presence of both parents in the family for normal child development and avoiding the formation of their criminal behavior in future (Jones, 2008).

However, the conclusion regarding the absence of one parent as a significant factor for development of delinquent behavior since then was disproved. (Jones, 2008, McCord, 1991). In 1990 Joan McCord (McCord, 1991) carried out the longitudinal study that proved weak association between single parenting and criminal behavior of the child. It was shown by the results that what really affects the choice of further criminal behavior is the variable that the author called "mother

competence" which he explained as a category consisted of 4 factors: Mother's consistency, self-confidence, her affection and her role in the taking care of a child (McCord, 1991). The highest criminal rates had the boys who were raised by the mothers who had "low competence". The "father competence" also found to be crucial in the development of the child. That brought the author to the conclusion that children who were raised in one-parent family do have higher risk of criminal behavior formation, but not because of the structure of the family but due to the less probability to have at least one competent parent, so parenting style is more associated with criminal behavior (McCord, 1991).

The environment outside the family also has a great impact on the child's behavior. But unfavorable social environment doesn't necessarily mean that the child will choose criminal behavior. It is very important to consider what kind of relationship with the environment the child has, under what influences from the environment this child is, what biological features the child possesses: "The effect of the environment are perceived depending on what are the psychological properties of the child they refract, what genetic traits he or she has". (Антонян, Эминов, 2015)

The psychologist Velikotskaya (Великоцкая, 2014) citing the research of Thomas A.M. and his work "Parent and Peer Influences: Their Role in Predictive Adolescent Moral Values and Delinquent Behavior" notes that researches showed social connections with peers to have more influence on the adolescent's behavior than moral values of parents. Thomas (Thomas, 2011) suggests that if the adolescent has positive moral attitudes due to the education in the family, he or she is less likely to fall into the criminal situation. On the other hand, if a teenager has weak social ties with peers and becomes a part of an antisocial group, then he or she will most likely choose to continue a criminal behavior, no matter what moral values he or she was guided by before. According to the author, this is because a teenager who has weak social ties with peers, feels insecure and that's why is more likely to accept the "moral code" of asocial peers and would rather prefer to gain the status in the group than to establish his or her own rules based on own moral values. This means that

criminal behavior, in this case, becomes a way to get social identity and be accepted in the group which is especially important at the time of adolescence (В.Е. Эминов, Ю.М. Антонян, 2015).

The effect of violent media content and video games on the criminal behavior

One of the factors that might affect the criminal behavior, as it is discussed in the literature, is exposure to the violent media content and violent video games.
Today this issue is widely discussed in the literature, as every year there are hundreds of films and video games produced, that on the point of some authors are able to provoke aggressive behavior in children and influence on the choice of criminal behavior in the future (Newson, 1994)

The children are considered to be a special group of viewers who may be more vulnerable to such content (Browne, Herbert,1997), so the question whether watching such films affects the choice of criminal behavior is important.

This topic is controversial and there is no consensus among researchers. Some authors believe that such content has a very unwelcome effect on children and adolescents and can be a driving factor in violent behavior (Newson, 1994). The supporters of this idea note that in the movies children can observe and learn violent and unlawful conduct and as a result bring it into the real life.

On the other hand, there are those who point out that there is insufficient evidence to suggest that watching such movies or playing games can do any harm. These authors emphasize that the accusation of aggressive content that it influences the choice of unlawful behavior is a disregard and simplification of the problem, since the formation of criminal behavior is a complex process and involves many other factors, such as biological vulnerability, life in a disadvantaged environment and problems in the family **(**Carter, 2003**)**

Some authors (Browne, Pennell 1999) take the position that the relationship between such content and subsequent criminal behavior depends on the child's personality traits.

Finally, most researchers (Pennell, Browne, 1999) conclude that watching movies with aggressive content can affect different people in various ways: it can desensitize those who do not have violent inclinations and thus they become more tolerant of high levels of violence in their environment, on the other hand, for those people who had initial violent tendencies, it can cause the desire to imitate what they see and bring it to real life. This means, that the main role in this issue is played by the primary tendency to aggressive behavior. After all, not everyone who perceives violence and aggression through the media will become aggressive and for some people it can be even the way to cope and process internal aggressiveness. However, 3-10% of those who view such content are at risk and exposure to it isn't recommended (Pennell, Browne, 1999).

The impact of video games with violent content also gets much of attention in the scientific discussions. There are authors (Anderson et.al 2010) who believe that the actions that the child virtually commits through the game character and who the child identifies himself or herself with, teaches to commit aggressive acts in real life, as if the child trains to kill and commit other violent acts (Anderson et.al 2010). Besides, these authors emphasize that such games provoke antisocial thoughts, that can be transformed into real actions.

If to consider, that the recent studies conducted in the United States among young people under 18 years old state that 88% of young people in this group play video games, the conclusion that this fact can lead to criminal behavior is worrying. (Gentile,2009). However, other findings support different idea. The researchers Paul J.C. Adachi and Teena Willoughby (Adachi, Willoughby, 2011) compared the levels of aggression in children after games with aggressive and nonaggressive content and concluded that the level of aggression after playing games with violent content was insufficient to conclude that they are associated. At the same time, the authors noted

that in those games where children had to compete with each other their level of aggression increased markedly. Authors came to the conclusion that what really matters in the provoking aggressiveness is not filling the game with violent content, but having the feeling of competition with others.

Mentalization deficits and reflective functioning

The factors that we named above are considered to be risk factors that might lead to committing a crime. At the same time, some researchers (e.g. Fonagy,2011) argue that even though exposure to media violence and playing violent video games, interpersonal problems, exposure to domestic violence, abuse and neglect and many others that are discussed in the literature are all associated factors and yet, many people who went through these factors don't become offenders, and some people who have never faced these problems become extremely violent. (Fonagy, 2001)

Fonagy notes that the most important feature that we see in any offender is the "inability to mentalize which means that this person doesn't have the capacity to think about mental states of others and of oneself" (Fonagy, 2001 p. 15).

This ability normally develops in early childhood from the feelings of secure attachment to the caregivers. This kind of attachment can be created if a mother gives form and meaning to her child's subjective experience of his emotional world, affective and intentional states by facial and vocal mirroring and playful interactions. This mirroring helps her child to understand his own emotions and provides the beginning of a symbolic system and representations that will form his sense of selfhood, which leads to the capacity of self-regulation (Винникотт, 1971; Bowlby, 1990; Fonagy, 2001).

Fonagy states that during the normal development the mind develops in the context of attachment relationship with caregivers along a somatic-symbolizing continuum. However, difficulties in the attachment system that might appear, as well as environmental traumas and constitutional factors - inherited biological

predispositions - may interfere this normal process, so the child's capacity to mentalize is compromised and might lead to the predominance of more primitive modes of subjective experience and defensive mechanisms, such as splitting and projective identification, and in the worst cases - violent acts toward others (Fonagy, 2001).

Fonagy claims that “violent individuals have an inadequate capacity to represent mental states - to recognize that their own and others’ reactions are driven by thoughts, feelings, beliefs and desires.” (Fonagy, 2001 p. 15). These are the people who most probably, were psychologically neglected even if they got proper physical care. The author summarizes that these people don’t experience their mind as their own and can’t reflect their feelings and intentions adequately (Fonagy, 2001).

Incapacity to understand the mental states of other people reduces a person’s sense of responsibility for this person’s own actions and in result ignore and misinterpret the consequences of their actions on others. Furthermore, due to the limited reflective functions the offender dehumanize the victim and treats him or her as an object but not a person (Yakeley, 2012).

There are many factors discussed in the literature that are believed to have an impact on the person’s choice to commit a criminal act. Among these factors the most important are exposure to violence in the family, exposure to violent media content and violent video games, childhood traumas. At the same time it was noticed that many people who passed through one or more of these factors don’t choose to act violently and don’t become offenders. We believe that there can’t be one answer on what exactly creates a criminal offender.

On the other hand, the most recent studies prove that the main trait that all the people who committed crimes had was the incapacity for mentalization, which means that they didn’t have the understanding and capacity to reflect on their feelings and intentions properly and those of others. These people have difficulties in understanding what is internal and external reality and get confused by other people’s actions and reactions. The incapacity to regulate affective states and difficulties in

self-reflection and self-observation might be the ground for increasing impulsivity and criminal behavior.

1.3 Psychological treatment and psychotherapy of probationers

The question of whether it is possible to reduce the level of crime and recidivism through psychological work with offenders has been debated in foreign literature for many decades.

In the 1931 Association for the Scientific Treatment of Delinquency and Crime was established with the main aim to show scientifically that there are better ways to deal with offenders than incarceration (Gibson, (2009).

The founders' of the Association goals were to research the causes of crime and its prevention, to establish clinics for diagnosis and treatment of delinquency and crime, and to handle educational roles about delinquency and crime (Centre for crime and justice studies, 2010). This association was mostly oriented to psychoanalytical approaches in working with offenders.

At the same time, not all the researchers believed that psychological work with offenders may bring any results. In 1974 American sociologist R.Martinson wrote a work named "What works? Questions and answers about prison reform" concerning the problems in the rehabilitation programs with offenders (Martinson,1974). In this paper, Martinson came to the pessimistic conclusion that offenders' treatment is not effective and doesn't bring any results. His work was aimed to investigate the effectiveness of treatment by checking the levels of recidivism after interventions. The results of these studies proved his idea that even though there were some exceptions, the efforts that have been made had no impact on recidivism and thus were not effective (Martinson,1974).

In spite the fact that this opinion was widely disseminated and supported at that time, there were still those who continued to work on the development of correctional and rehabilitation programs for convicted and imprisoned people.

Even though there is a large body of literature and research on this topic today, there are still many gaps in understanding of what is the most effective interventions and treatment while working with the offender population and empirical data on the ways how to work with them is lacking.

Different approaches that are considered effective while working with this population range from the behavioral to psychoanalytic treatment. Behaviour approaches target observable problems of the offenders, such as motivation, actions, perception (Gandreu, Ross, 1984; Hollin, McMurran, 2002; Craig, Dixon, Gannon, 2013). Psychoanalytic treatment of offenders concentrate on deeper but abstract so not that easily to be observed issues, as psychological traumas, internal conflicts, relations with objects (Fonagy, 2001; Уэлдон 2017; Stukenberg, 2011; Yakeley, 2012).

Since 1980s there were researches conducted in the USA that were aimed to examine the effectiveness of cognitive behavioral treatment of this category of patients. (Galietta, 2010). Citing the study of Andrews and colleagues, Michaele Galieta notes that they highlighted three principles for effective treatment in correctional setting - risk, need and responsivity. Risk principle means that there should be a match between intensity of treatment and the risk for re-offense and if the risk is high, the patient should get more intensive treatment. The need principle postulates that the treatment should assess and target dynamic factors related to the crime. And the responsivity means the probability of the patient's responding to intervention. These authors distinguish two types of responsivity - general, which means that cognitive and behavior treatment has been proved to be most effective in work with offenders, and specific responsivity which means that during the treatment specific factors of the patient, such as his culture, cognitive abilities that should be considered which increases the effectiveness of the treatment. As an example, the author provides the treatment where the therapist builds up motivation of the patients who were mandated to treatment (Galietta, 2010).

One of the recommended (Berzins, Trestmann, 2004) cognitive behavioral models to work with offender population is a dialectical behavior therapy that is aimed to work with targeted behaviors in individual therapy and group skills training. Individual therapy is aimed to help the patient identify his or her affects and use new coping strategies. During group therapy the patients learn new skills as emotional regulation, distress tolerance etc. and practice them between the sessions (Berzins, Trestmann, 2004).

Among psychoanalytic schools that work with this group of patients the most commonly used are mentalization-based treatment (Bateman, Fonagy, 2013) and transference-focused psychotherapy (TFP) (Йоманс, Кларкин, Кернберг 2016).

TFP is a highly structured group treatment based on the Otto Kernberg theory of object relations approach. It is important to note that TFP is designed to work mostly with borderline personality disorders, which means that the patients are characterized as unstable, impulsive individuals, experiencing feelings of emptiness and fear of abandonment, using less mature self defenses (mostly projection and projective identification) and lack of a stable sense of self and prone to acting-out, self harm and difficulties in interpersonal relationship. (Кернберг, 2000) This model assumes that the interventions are made in “here and now” way, investigating what is happening between the patient and the therapist in the process of treatment. This way of intervention which is based on analyzing transference and countertransference is aimed to integrate splitted representations of self and others and, ideally, helps patients to create stable and more complex sense of self and the object. Recent studies were conducted on the adaptation TFP for offender population and showed positive results on their personality dimensional scores (Fontao, Pfafflin, Lamott, 2006).

Mentalization based treatment developed by Fonagy and Batemen is being used mostly for violent offenders with a diagnosis of antisocial and borderline personality disorder (Bateman, Fonagy, 2013). The ability to mentalize according to the authors of this theory is one of the most important aspects of self-identity,

interpersonal relationship and social functioning. Mentalization based treatment integrates cognitive and relational components in the context of attachment relationships. This treatment is aimed on developing the capacity to mentalize, i.e. to understand and interpret one's own internal feelings and emotions and those of others (Bateman, Fonagy, 2013). During the treatment mentalization techniques are used, such as interventions that help the patient to concentrate on the affect and to connect internal states of mind to his or her actions. These interventions as well must focus on the present situation and inner states of the patient rather than discovering the history of the patient. This treatment is also conducted in the form of group therapy which allows the patients to have the safe environment and learn how to experience, reflect and express their emotions in the in the secure atmosphere as well as to understand and confront on other participants' and therapist's inner states and develop the capacity for interpersonal relationship. Mentalization treatment also helps the participants to replace acting out unbearable mental states with reflection and understanding of their internal world (Bateman, Fonagy, 2013).

Before starting the psychotherapy with an offender as well as with people who have never committed crimes first diagnostic assumptions might be important to be done. If the person is diagnosed with severe mental disorders most likely he or she will need psychopharmacology as a complementary support to treatment and so psychiatrist might be added to the treatment process (Yakeley, 2012).

One of the problems that is discussed in the literature is whether group or individual therapy is more appropriate for working with the offenders. Weldon (Уэдлон, 2017) claims that this question should be answered considering the personality of the patient, his or her history, personality traits, the features of psychopathology and many other factors.

Thus, Weldon notes that while deciding whether the group therapy is appropriate one of the important factors should be considered is childhood and family relationship. The patients that have never had the experience of reliable relationship in the family, who grew up in the big family where they didn't get enough of

personal attention, or families with financial and emotional difficulties will not gain much effect with the group therapy. Also, the patients who were adopted, whose mothers rejected them after the sibling's death and didn't help to mourn will rather struggle in the process of group therapy then have results out of it (Уэлдон, 2017).

On the other hand, Welldon states that in case of the therapy with violent offenders or those who had too close relationship with one or both of their parents group therapy might be more effective than individual work with the therapist because it can give more opportunities to express their aggression towards the parental figure more openly (Уэдлдон, 2017).

At the same time in mentalization based treatment the recommended format of the therapy is group therapy not regarding the personality traits and history of the offender. However, the individual sessions are offered to the patients in case they have to reflect on the problems that they might experience in the group (Bateman, Bolton & Fonagy, 2013). Batemen and collegues consider this format of treatment as the most appropriate for this population due to the fact that this way the offenders are more likely to be understood and accepted by their peers if to compare with the individual therapy where they have to interact with the person who most likely came from the different socio-cultural context and is not perceived as someone who can understand them. (Bateman, Bolton & Fonagy, 2013).

In our opinion the offender's early experience and family situation has to be taken into account while considering whether the group or individual therapy will be more effective for this exact individual. At the same time the group therapy is more likely to be used with this population considering the fact that it gives more opportunities to the patients to reveal their feelings and emotions in the secure atmosphere that they more likely have never had before. The group format allows them to try new kind of relationship with the people experiencing the same problems as they do. As was mentioned above, many of the offenders came from disadvantaged background and families where they were neglected or abused. Due to this fact, individual therapy will more likely provoke perceiving the therapist as the

punishing and neglecting paternal figure which might lead to the regression and acting out as well as reoffending. Thus, the format should be chosen carefully and with regard of specific traits of the patient.

It's clear that working with offenders, especially those who committed violent crimes can be challenging and the therapist working with this category of patients should pay the price - to sacrifice rigid psychotherapeutic principles that should be modified from what we call classic psychoanalytic treatment. First of all, the psychotherapist who works with these patients should think about the setting which is obviously different if to compare with usual psychoanalytic treatment. The therapy should take place safely and where such issues as risk, boundaries and disclosure of information must be taken into account (Yakeley, 2012).

Such issue as treatment techniques must be also modified. As it is mentioned by
Yakeley (Yakeley, 2012) the intensity of the treatment should be lowered due to the incapacity of most of these patients to tolerate high frequency of sessions. Secondly, such a useful tool while working with neurotic patient as silence during the session, should be reconsidered as it can be perceived as persecutory and increase the level of anxiety. For the same reason, it is recommended to avoid too much free associating and too early interpreting unconscious conflicts and phantasies as well as transference interpretations, especially when it comes to negative transference. The interpretations at the beginning of the therapy should be rather focused on "here and now", as for what the patient might feel and think, what is happening at the session, what the therapist feels etc. (Yakeley, 2012).

The work, especially at the beginning of the treatment should be focused on building a strong and reliable working alliance with the therapist, strengthening the ego structure of the patient and mentalization techniques that are aimed at helping the patient to connect his or her internal states of mind to his/her behavior actions, and focusing on the affect (Bateman, Bolton & Fonagy, 2013).

It’s also essential for the therapist to monitor his own countertransference reactions and feelings in order to not be involved in the enactments with the patient (Stukenberg, 2011). To prepare to work with this category of patients it is useful for the therapist to analyze his or her own wish for working, whether it will be possible to avoid judgmental feelings and be empathetic (Yakeley, 2012). For this reason constant supervisions might be crucial.

1.4 Theoretical model of mental health of probationers

According to the studies mentioned above there are many factors that have the potential to influence on the mental health of the offenders. Among those factors, we discussed developmental trauma which includes sexual, physical abuse, neglect from the caregivers, the loss of a parent or both of them and other important life events; unfavorable social environment and the influence of violent media content on the person.

At the same time, it is important to note, that not all the children that had trauma during their childhood or grew up in disadvantageous social environment will be influenced by those factors and will have problems with their mental health that can lead to the criminal behavior.

We believe that whether the person will choose the law-abiding way of life or become an offender depends on his or her capacity to mentalize and reflective functioning of this person.

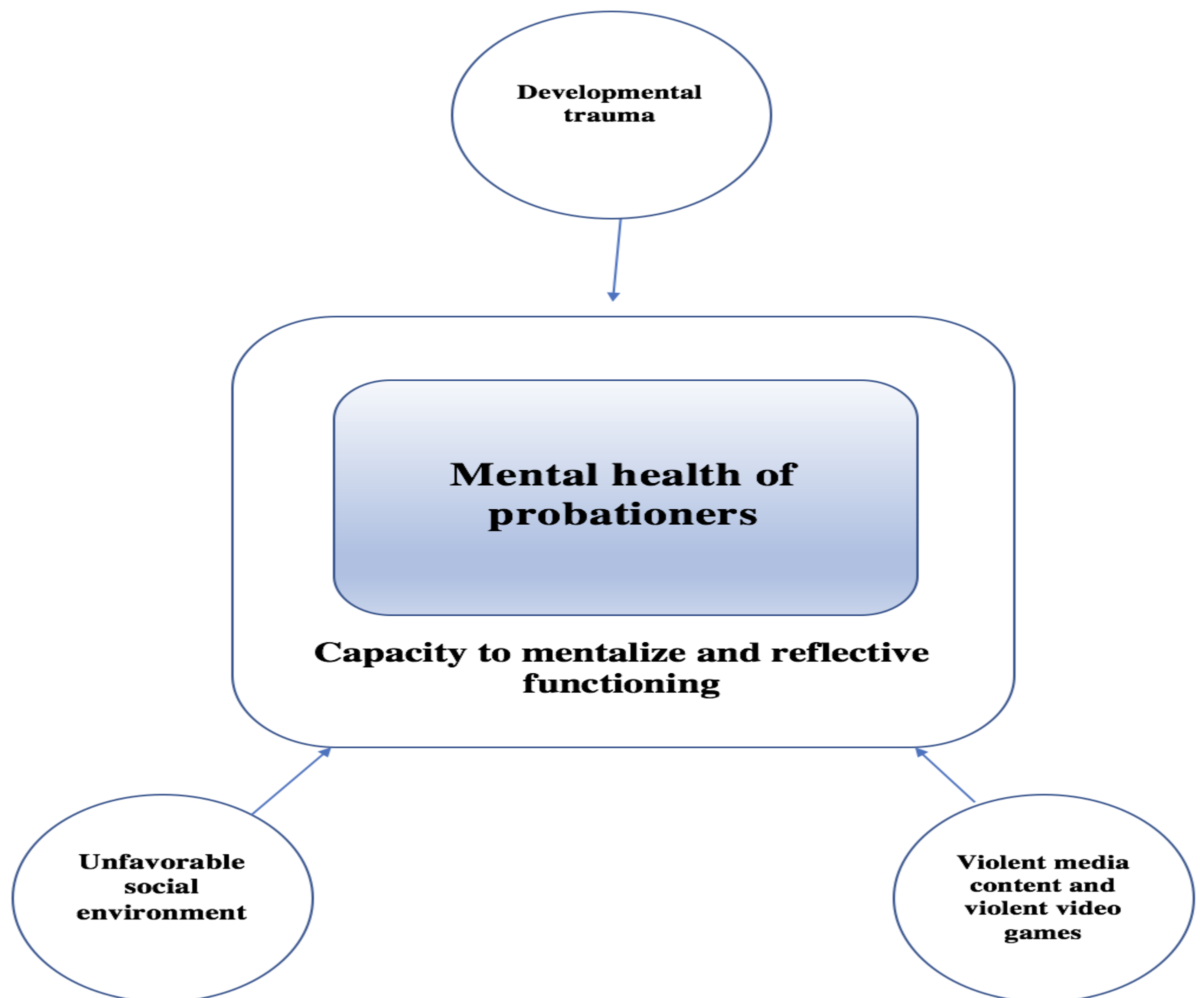


Fig. 1.1 Theoretical model of mental health of probationers

Even if the person went through difficult and traumatic situations, if he or she has the capacity to reflect on this experience, understand own feelings, emotions that this situation provoked and digest these feelings, the influence of those factors will be reduced or excluded. Thus, it is very important that during the assessment of the probationers the therapist asks about childhood life events that might be traumatic for the individual and that the therapy with probationers target on the reflective functioning and increase their mentalization capacity.

The ability to mentalize also implies the understanding of the need of help from others, which means that when the person feels the frustration about certain life events, even if she or he cannot process this frustration alone, the person will apply for the help from others, including psychotherapy. However, if the person isn't

capable to mentalize and to identify the feelings, doesn't understand or accept them, or denies the emotions that traumatic experience provokes, he or she will not feel the need for help and consequently will not seek for the therapy.

Conclusion to the first chapter

The offender population is considered as a high risk group of people as they are more likely to have mental and physical illnesses, due to many factors such as maltreatment in childhood, not appropriate social environment, lower quality and level of education and life combined with widespread substance abuse disorders. These factors increase the risk of committing violent and non-violent crimes as well as the risk of recidivism and suicide among this population.

The most discussed factors that have the potential to affect the criminal behavior are childhood traumas, exposure to domestic violence, social environment. Some factors though remain being controversial and are not proved to have direct association with criminal behavior, such as exposure to violent media content and playing violent video games. At the same time, many researchers state (Bowlby, 1990; Bateman, Fonagy, 2001) that the most important factor that influence on the choice of delinquent behavior is attachment disruptions that might lead to the difficulties in mentalizing and reflective capacity.

For this reason, psychotherapy with the offenders should be conducted with the target to develop this capacity and provoke to reflect and understand the individual's own feelings and emotions as well as those of others.

Working as a therapist with offenders who enact their feelings, conflicts and distress through criminal behavior because of the incapacity to reflect on them and not usually are motivated to be in therapeutic process is challenging. But any professional who chose to do this job should remember that his or her expectations of therapy should be limited. The main aim of the psychoanalytic treatment while working with offenders is strengthening the Ego and development of the psychic functioning and capacity to tolerate and manage the internal states as fears, remorse,

guilt, loss, anxiety. The patients should learn how to replace acting out of these feelings with thinking and analyzing them. However, the therapist should be prepared for the repeated patient's regressions to more primitive subjective states during the therapy and for increasing the risk of aggressive acting-outs and reoffending.

The most recent studies have shown the effectiveness of mentalization-based therapy (MBT) in this population. The aim of MBT is to develop a mentalizing capacity, which means the capacity of the person to understand own and others' mental states.

Along with the process of growing of the capacity to mentalize, person's cognitive and behavioral changes happen as the consequences of the understanding of the internal states. It happens indirectly, as a side effect because MBT isn't aimed to alternate the behavior directly (Fonagy, 2001).

The decision of what format and setting would be the most effective for the patient should be considered regarding his or her personal traits and life history as some settings might have the opposite effect and lead to the regression and returning to criminal behavior.

CHAPTER 2
EMPIRICAL STUDY OF MENTAL HEALTH AMONG THE OFFENDERS ON PROBATION

2.1 Procedure of the study

The Study lasted for a month and a half from the first of March till the fifteenth of April 2020. The first part of the research was conducted in The District Probation Center in Kyiv where offenders who are on probation were filling in a printed questionnaires. The second part of the research was conducted from the beginning of April where the control group had to fill out the online form with the same methodologies.

The work was organized in the following stages:

I. Selection and development of methods

At the beginning of the study, a number of techniques were selected to assess the mental and physical health of people on probation. We then selected the most relevant to understand how speeded are the mental health problems among offenders on probation comparing to the general population, what are the most common mental health problems among probationers and what problems and difficulties should the therapy focus on.

Also, the questionnaire was developed that consisted of questions about their age, gender, marital status, the presence of children and the information about their criminal records.

The online survey provided the respondents with a detailed description of the questionnaire completion.

II. Conducting a study that included:

- filling in the questionnaires with the experimental group in the Probation Center
- distributing the online survey among people of a control group who have never had criminal records and collecting the data from the form

III. Data processing

Data obtained using standardized techniques and constructed scales were calculated according to the keys and entered into a spreadsheet of Statistica

IV. Description of the results of the study

The results of the study were interpretations obtained from the statistical analysis.

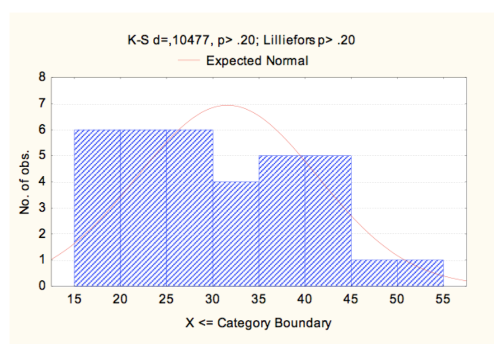
2.2. Participants

The study was conducted within one month from the beginning of March till the beginning of April 2020.

There were two groups of study - experimental and control group. Data were collected using appropriate diagnostic techniques.

The experimental group consisted of 34 men who committed a crime and are on probation in The district Probation center in Kyiv. The minimum age of people of this group is 19 years old and the maximum is 54 years old with the average point of 31,6 years old.

The control group of the study consisted of 34 men who agreed to complete the proposed methodologies on-line and have never been convicted of a crime. The minimum age of the person in control group was 21 years old and the maximum age was 51, with the average value 35.



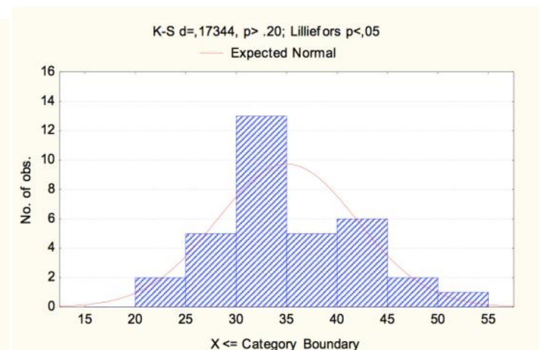


Fig. 2.1 The age of the experimental group Fig. 2.2 The age of the control group

Characterizing their marital status among participants in the experimental group it can be specified that 77% of them are not married, 18% are married and 5% are divorced. 44% of them have children and 56% don't.

Among all the men in the control group 31% are single, 12% men are divorced, 53% are married and 4% of men noted that they are in a relationship and live with their partner but not still married. 52% of men noted that they have children and 48% that they don't.

If to compare the experimental and the control group by the criteria of marital status we can note that two times more men from the control group are not in the relationship (82%) comparing to men in the control group (43%). The percentage of

those who have children though is not very different in both groups: 44% in the experimental group and 52% in the control group.

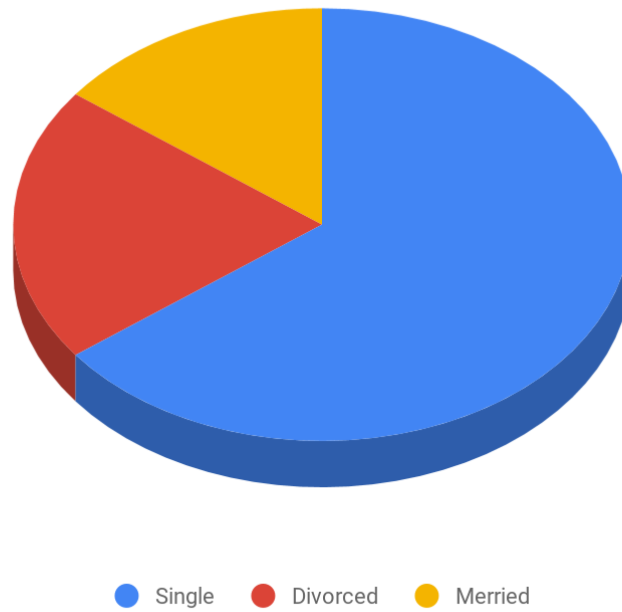


Fig. 2.3 Marital status of the men from the experimental group

Among the representatives of the experimental group 26 people (70%) committed a crime for the first time and 8 (30%) had a criminal history in the past.

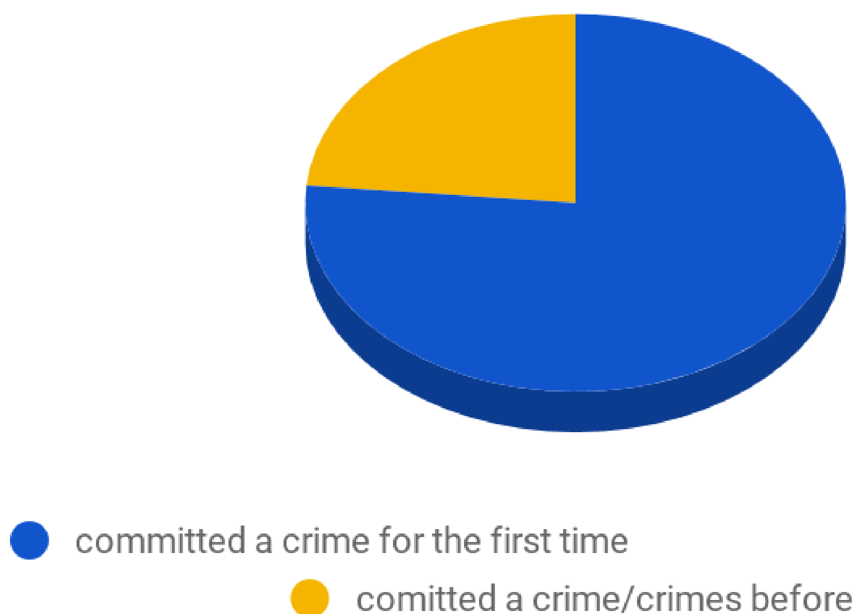


Fig 2.4 Previous criminal records history of probationers

If to compare the severity of crimes they committed, 18% (6 people) committed grave offences, 67% (22 people) committed medium grave offences, and 15% (5 people) committed crimes that can be considered as minor offences. This classification was made according to the current legislation of Ukraine.

According to the Criminal code of Ukraine (Кримінальний кодекс України, 2001), all the crimes depending on the gravity and the severity of punishment can be classified into minor offences, medium offences, grave offences and special grave offences. A minor criminal offence means that a punishment for the person who committed it might be imprisonment for a term up to two years or more lenient penalty. A medium grave offence means that the punishment should be imprisonment up to five years and a grave criminal offence means and offence that entails responsibility in the form of imprisonment for a term up to ten years. More severe crimes, special grave offences, might entail the punishment in the form of imprisonment for a term more than 10 years or a life sentence.

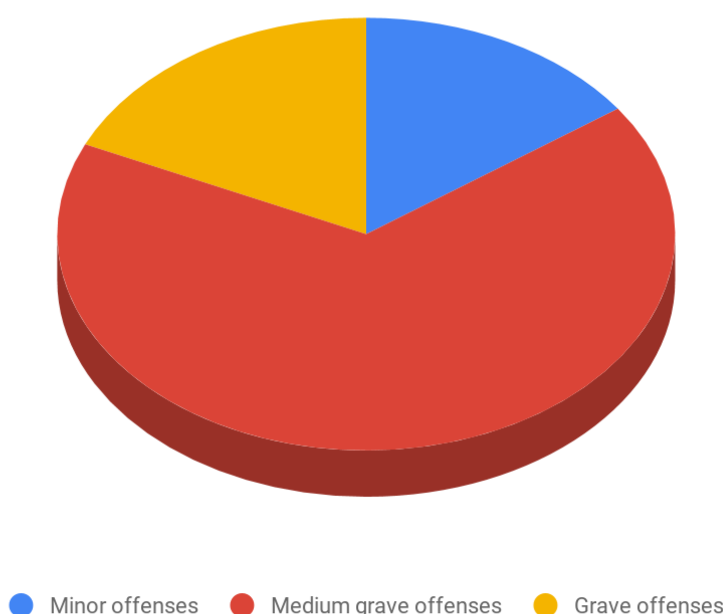


Fig. 2.5 Experimental group distribution according to offense gravity

According to the Criminal code of Ukraine, crimes can be also classified by subject matter. In our experimental group, we had part of "crimes against the person" (3), those are the crimes that tend to injure another person's body. Many crimes committed can be grouped as crimes against property (19) and another group of crimes (6) consisted of the criminal offences related to the circulation of narcotics, psychotropic substances, their analogues or precursors.

2.3 Methods

In the study methodologies that determine the features and symptoms of mental and physical health problems were applied. Also, the participants of the study had to fill in the questionnaire that included questions about their age gender, marital status, the presence of children. The experimental group also had to answer questions about their criminal recordings as for what kind of crime they have committed and whether it was for the first time they were convicted.

To measure subjective psychopathology the Symptom-checklist-90 revised was used. It is a commonly used self-assessment tool with a wide range of mental disorders and symptom intensity and was developed by Leonard R. Derogatis. (Derogatis, 1992.)

The SCL-90 has been tested in different settings, including community and psychiatric outpatient and inpatient samples. It is commonly used as an indicator of change in symptoms and as a treatment outcome measure (Rytilä-Manninen et. al., 2016).

This methodology was standardized for the Russian population by specialists of the Russian Institute of Psychology of the Russian Academy of Science in conjunction with the psychophysiological laboratory Harvard Medical School led by R. Pitman. It was tested on the Russian sample of 1466 subjects. With the exception

of the paranoid scale (Cronbach alpha 0,35), all scales of the Russian version of the test showed high reliability (Cronbach alpha from 0,7 to 0,89). Test-retest reliability coefficients were obtained in a sample of 94 patients in a psychiatric clinic and ranged from 0, to 0,9 (Гаранян, 2016). This checklist contains 90 items and yields nine scores for primary symptom dimensions: somatization, obsessive-compulsive behavior, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism.

Somatization (SOM). Disorders called somatization reflect distress arising from the sensation of bodily dysfunction. This includes complaints recorded on the cardiovascular, gastrointestinal, respiratory and other systems. The components of the disorder are also headaches, other pains and discomfort of the muscles, and in addition - somatic equivalents of anxiety. All these symptoms and signs may indicate the presence of a disorder, although the may be a manifestation of real somatic disease.

Obsessive-compulsive scale (O-C). This scale contains the questions relating to thoughts, impulses and actions that the individual experiences as continuous, irresistible and alien to the self of the person.

Interpersonal Sensitivity (INT). This scale represents a person's feeling of personal inadequacy and inferiority, especially when a person compares himself/herself to others. Self-condemnation, a sense of anxiety, and marked discomfort in the process of interpersonal interaction characterize the manifestations of this syndrome. In addition, individuals with high interpersonal sensitivity scores reported a heightened sense of self-awareness and negative expectation about interpersonal interaction and any communication with other people.

Depression (DEP) scale represents a wide range of clinical depression symptoms such as signs of lack of interest in life, a lack of motivation and loss of vital energy. It also includes feelings of hopelessness, thoughts of suicide and other cognitive and somatic correlates of depression.

Anxiety (ANX). Anxiety disorder consists of a series of symptoms and signs that are clinically associated with a high level of manifest anxiety. The definition includes common symptoms, such as nervousness, tension, trembling as well as panic attacks and feelings of violence. as signs of anxiety, this includes cognitive components, including feelings of danger, fear and some somatic anxiety correlates.

Hostility (HOS) includes thoughts, feelings or actions that manifest a negative affective state of anger. the items include all three attributes that reflect qualities such as aggression, irritability, anger and resentment.

Phobic anxiety (PHOB). It is defined as a persistent reaction of fear to certain people, places, objects or situations, which is characterized as irrational and inadequate with respect to the stimulus, leading to avoiding behaviour. Items related to the presented disorder are aimed at the most pathognomic and destructive manifestations of phobic behaviour.

Paranoid ideation (PAR). This scale represents the symptoms of paranoid behaviour as a form of impaired thinking. The most important characteristics of projective thoughts, hostility. suspicion, fear of losing independence, illusions are considered as the main signs of this disorder and the choice of questions is focused on the presentation of these signs.

Psychoticism (PSY). The psychoticism scale includes questions indicating an avoidable, isolated, schizoid lifestyle, symptoms of schizophrenia, such as hallucinations or hearing voices. The psychoticism scale is a graduated continuum to the obvious evidence of psychoticism. In addition it can be useful for detecting coarse aggravation, simulation and careless filling of the checklist - if the person marked high points on it in the absence of obvious psychotic symptoms.

The Short Form (SF) - 36 Health Survey was used in the study to measure the quality of offenders' lives. SF-36 was developed on the basis of a large study of the outcomes of diseases (Medical outcomes Study), conducted in the USA in the 80s passed century. The author is John E. Ware (Ware,1987).

In 1999 the questionnaire was validated by the analytical staff of the Sector of the Interethnic Center for the Study of Quality of Life in St.Petersburg, which was used to study the quality of life of 2114 residents of St. Petersburg. The results of the study showed high consistency with the quality characteristics of data from studies conducted in other countries. The Russian version of the SF-36 questionnaire has reliable psychometric properties and is acceptable for conducting population-based studies of the quality of life in Russia (Новик., Ионова, 2002).

SF-36 consists of 36 questions divided into scales which are:

1. physical functioning (PF), that represents the ability to withstand physical exertion and the extent to which health limits exercise (self-service, walking, climbing stairs, etc.)
2. physical role functioning (RP), that reflects the effect of physical condition on daily activities, such as work performance in daily activities;
3. bodily pain (BP) reflects the intensity of pain and its effect on everyday activities;
4. general health perceptions (GH) represents the patient’s assessment of his or her currents health status and treatment prospects.
5. vitality (VT), that represents general activity, a feeling of being full of strength and energy or, conversely, exhausted.
6. social role functioning (SF) defines the degree to which a physical or emotional state limits social activity and communication.
7. emotional role functioning (RE) characterizing the impact of emotional state on daily activities
8. mental health (MH) - self-assessment of mental health that characterizes mood (the presence of depression, anxiety, general indicator of positive emotion)

The scales from 1 to 4 characterize a person’s assessment of his or her physical health and scales from 5 to 8 represent the main parameters of mental health.

The Acceptance and Action Questionnaire (AAQ-II) was used in the study to measure the level of avoidance and psychological flexibility. The questionnaire was proved to have good psychometric properties in many countries, such as Italy, Colombia, Greece, Spain (Ruiz, Suárez-Falcón, Cárdenas-Sierra, Durán, Guerrero, K., & Riaño-Hernández, 2016). . The internal consistency of AQQ-II showed good results with an Cronbach alpha 0,85 (Bond et al., 2011).

The test includes 7 statements that patients have to grade from 1 (never true) to 7 (always true) depending on how often they have the thoughts and feelings described in the statement. This questionnaire demonstrated reliability and validity and was adapted in many countries (Bond et al., 2011).

The OQ was used in the study to assess the mental health level. This questionnaire is designed to measure:

1. symptoms of psychological disorders (mainly depression and anxiety);
2. interpersonal problems
3. functioning in relevant social roles.

It has been proven that OQ-45 has adequate reliability and validity in both clinical contexts and across US and Western regulatory groups. (Lambert et.al. 1996). The internal consistency of OQ-45 is 0.993 and the 3-week retest reliability index is 0,4 (Lambert, Burlingame, et al., 1996). It also has been demonstrated that OQ-45 has high accompanying validity ratios ranging from 0.55 to 0. when combined with SCL-90-R, Beck Depression Scale, Interpersonal Problem Scale Inventory and the Social Adjustment Scale.

Adaptation of the OQ questionnaire in Ukraine proved that OQ-45 had adequate re-testing reliability after 2 weeks (r=0.4). The internal consistency of “r” in the sample showed the result of 0.94. (Карпенко, Войтенко, Миколайчук, Мединська, 2012)

The questionnaire of 45 questions, rated on a 5-point scale (0 - never, 1- infrequently, 2 - sometimes, 3- often, 4 - almost always). The range of possible OQ total scores is from 0 to 180. The higher the score they get, the more severe the

mental impairment is. High scores indicate that the subject has an inherently high level of psychological problems (presence of pathopsychological symptoms, interpersonal relationships problems and role functioning problems) however they have the necessary resources to solve them independently.

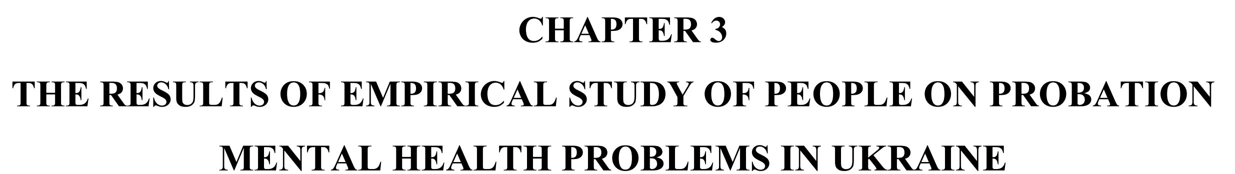
The OQ questionnaire reports three subscale scores:

1. Symptom Distress (SD). It is composed of items that have been found to reflect the symptoms of adjustment disorders, affective disorders, anxiety disorders, and stress-related illnesses. A high score indicates that patients are bothered by these symptoms and low scores indicate either absence or denial of symptoms. (Lambert, Gregersen, Burlingame, 2004.)
2. Interpersonal Relationship (IR). This subscale assesses marriage and family difficulties, loneliness, conflicts with others. (Lambert, Gregersen, Burlingame, 2004.)
3. Social Role Performance (SR). this scale measures the extent to which difficulties fulfilling workplace, student or home duties are presented (Lambert, Gregersen, Burlingame, 2004.)

Conclusions to the second chapter

In this chapter two groups of the study were presented - experimental and control groups. The experimental group consisted of people who committed a crime and are on probation, the control group consists of people who have never been convicted on a crime. Both groups are similar in age and gender.

In accordance with the aims of the study, methodologies to assess the mental and physical health of people were selected and described.



CHAPTER 3

THE RESULTS OF EMPIRICAL STUDY OF PEOPLE ON PROBATION MENTAL HEALTH PROBLEMS IN UKRAINE

The third chapter of the paper is devoted to describing the results of psychological research on mental health problems among offenders on probation.

The primary data obtained from the subjects were recorded in a Statistica program spreadsheet, where they further were processed using statistical methods, such as descriptive statistics, comparative, correlation and cluster analysis.

In the empirical part of this paper, we aimed to find answers to the following questions:

1. Do offenders on probation have problems in their mental health? If so, then what is the percentage of the people who struggle from these problems and might potentially need psychotherapy?
2. Is there any difference between the mental health indicators of the general population group and the group of offenders on probation?
3. Are there any correlations between the mental health of offenders and their way of life, e.g. marital status, history of substance abuse, physical health, the gravity of the crime they committed and criminal records history?

With this purpose, the primary data was added to the spreadsheet and was processed using statistical methods of data analysis. Comparative, correlation, cluster analyses were done. The results received are described in this chapter and the features of offenders on probation mental health are presented.

3.1 Prevalence of the symptoms of common mental health disorders among probationers

Using Shapiro-Wilks criteria we, first of all, checked if there is a normal data distribution between the scales of the study to understand whether we have to use parametric or non-parametric criteria for the further analysis. We found out that most of the scales are not normal distributed so we chose to use non-parametric criteria in the following analysis. (Apendix B)

To understand whether the mental health of offenders on probation is different from the general population who have never been convicted on a crime we have compared the indicators of their mental health using Mann-Whitney criteria. (Appendix B).

It was found that between these two groups there were significant differences in the indicators of the following scales: Interpersonal sensitivity, depression, hostility, bodily pain, general physical health and symptom distress. There also was a statistical difference in the scale that represents the problems with substance abuse.

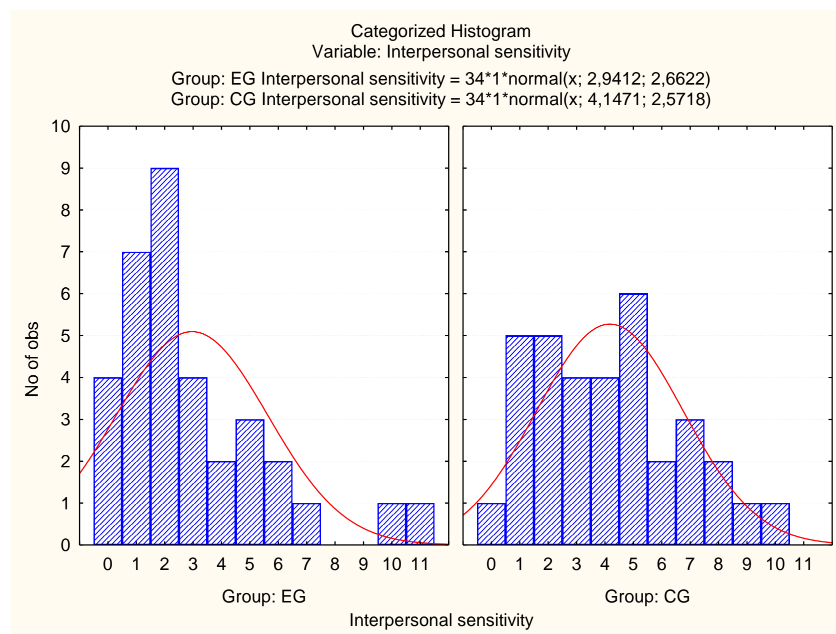


Fig. 3.1 The indicators of the scale of interpersonal sensitivity

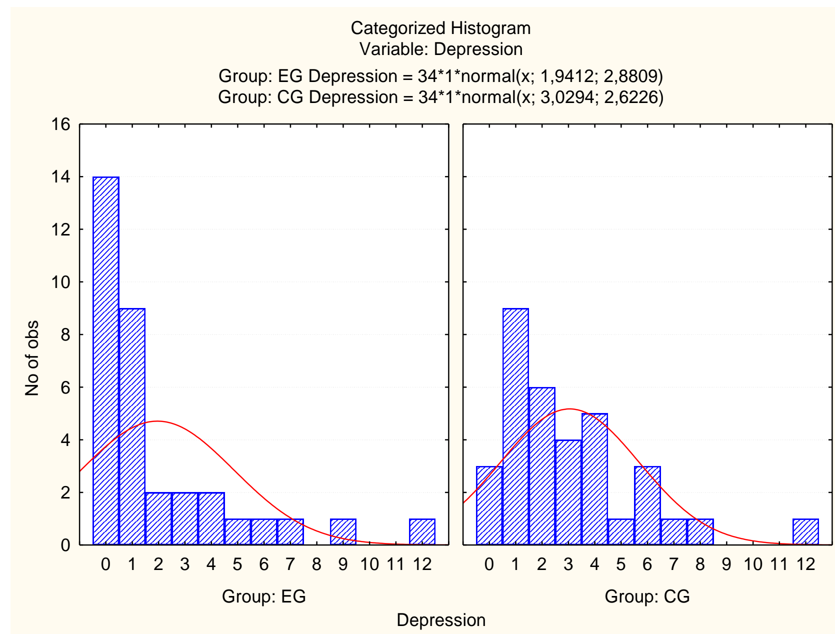


Fig. 3.2 The indicators of the scale of depression

The scales that represent interpersonal sensitivity and depression show that the experimental group is less susceptible to depressive states and interpersonal sensitivity than the control group. Most of the participants in the experimental group noted that they don't have feelings of dissatisfaction with others, shyness in communication with others, sensitivity and the feeling that others don't understand them - the statements that might show their interpersonal sensitivity. Most of them also reported that they don't have the feeling that they lost their sexual interest, they don't have thoughts of committing suicide and feelings of losing interest in life - questions that might reflect their depressive states. At the same time, participants of the control group were more diverse in their answers: most of them admitted that from time to time they might have feelings of personal inadequacy, inferiority and discomfort in the process of interpersonal interactions. Many of them have also acknowledged a lack of interest in life, motivation and loss of vital energy which represents signs of depression symptoms.

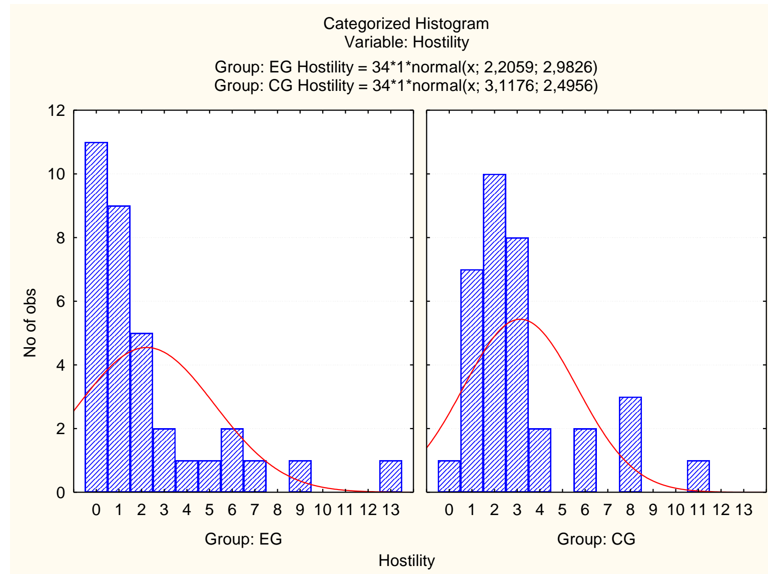


Fig. 3.3 The indicators of the scale of hostility

The difference in the results of hostility assessing also shows that most of the representatives of the control group admitted thoughts, feelings and actions that might be the signs of aggression, irritability and anger sometimes or often, while the participants of the experimental group mostly answered that they don’t notice the signs of these states. There were some representatives of the experimental group who reported the feelings of anger and impulsivity but most of them were reporting the absence of these feelings.

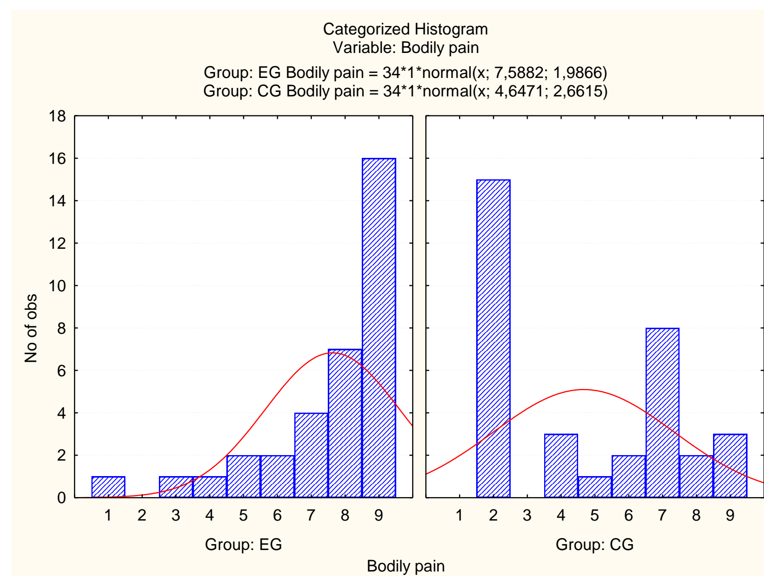


Fig. 3.4 The indicators of the scale of bodily pain

The scale that showed that the participants of the experimental group experience more disturbance than those in the control group is the scale of bodily pain.

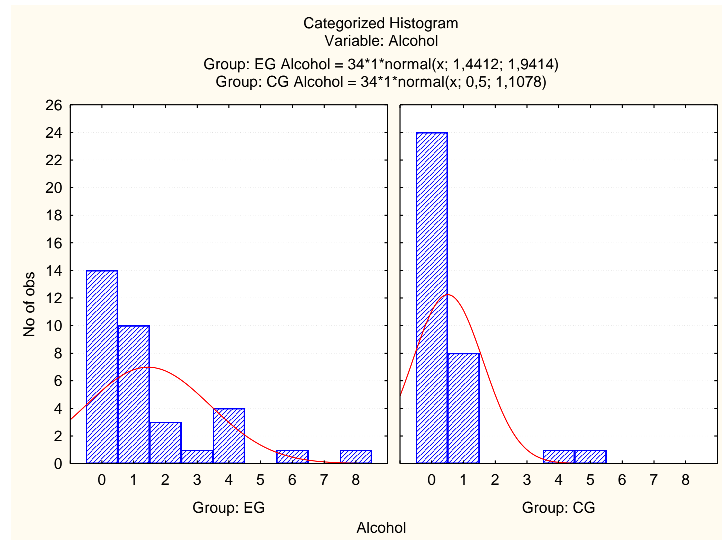


Fig. 3.5 The indicators of the scale of alcohol abuse

The scales that reflect the tendency for alcohol and drug abuse demonstrated higher levels of this problem in the group of people who are on probation.

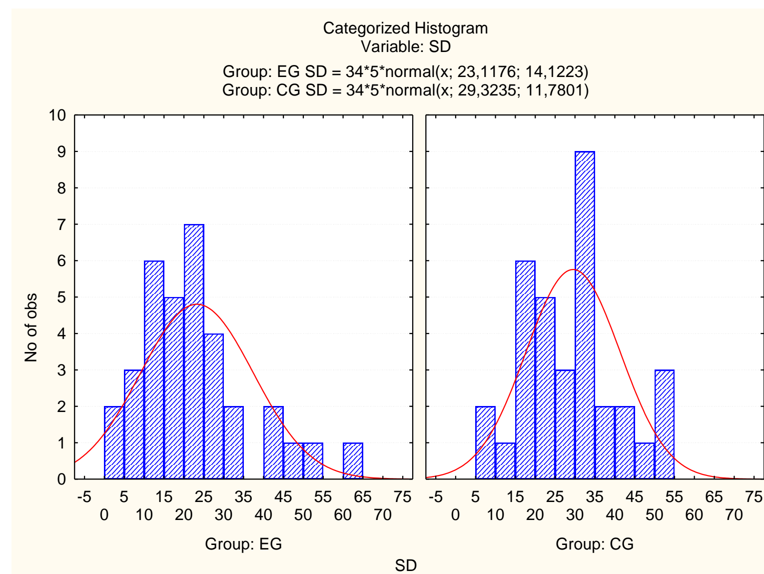


Fig. 3.6 The indicators of the scale of symptom distress

The scores of the Symptom distress scale have also reflected the tendency of the experimental group to report lower severity of symptomatology comparing to the control group. In contrast to them, the participants of the control group demonstrated higher scores for this scale which reflect their disturbance by symptoms of depression and anxiety.

3.2 Psychological flexibility of probationers

The comparative analysis was conducted on the scale of psychological flexibility on the Mann-Witney criteria. The results are presented in the appendix (Appendix B). There were no significant differences found. Thus, the results of the study have not shown that the probationers experience more problems with negative emotional states or feel more discomfort then the general population. Most of the participants of the experimental group reported that they don’t experience the fear of their feelings and emotions or struggle from the incapacity to control their thoughts, painful memories were reported not to be an obstacle for living satisfying life and the participants didn’t feel that they manage the life problems worse than others.

3.3 The features of mental health among probationers according to the offense gravity

One of the hypothesis that we had at the beginning of the study was that the subjective perception of the mental health condition among offenders who committed more severe crimes will differ from those probationers who committed minor crimes.

This hypothesis was studied with comparative analysis using Mann-Witney criteria. The study didn’t show that probationers who have committed more severe crimes reported on more mental and physical health difficulties then those who committed minor crimes.

3.4 The features of mental health among probationers according to the previous criminal record history

Another hypothesis that we had at the beginning of the study was that probationers who were convicted on a crime previously experience more mental and physical health disturbances than those who committed a crime for the first time. This hypothesis was checked by comparative analysis using Mann-Witney criteria. There were no significant differences found between the groups. The participants who had previous criminal record history and those who have been convicted on a crime for the first time reported on their mental and physical health problems mostly negatively.

3.5 The correlation between different indicators of the scales that represent difficulties in physical and mental health among probationers

The correlation analysis that represents connections in physical and mental health scores in both groups reflected that in the group of general populations, physical health is very strongly associated with emotional health while there is no much connection between physical health condition and mental wellbeing in the group of offenders. The only scale that reflected the correlation between health problems and the mental condition of the experimental group was the bodily pain scale. We can see that bodily pain is strongly correlated with such scales as somatization, interpersonal sensitivity, anxiety, hostility, flexibility and symptom distress.

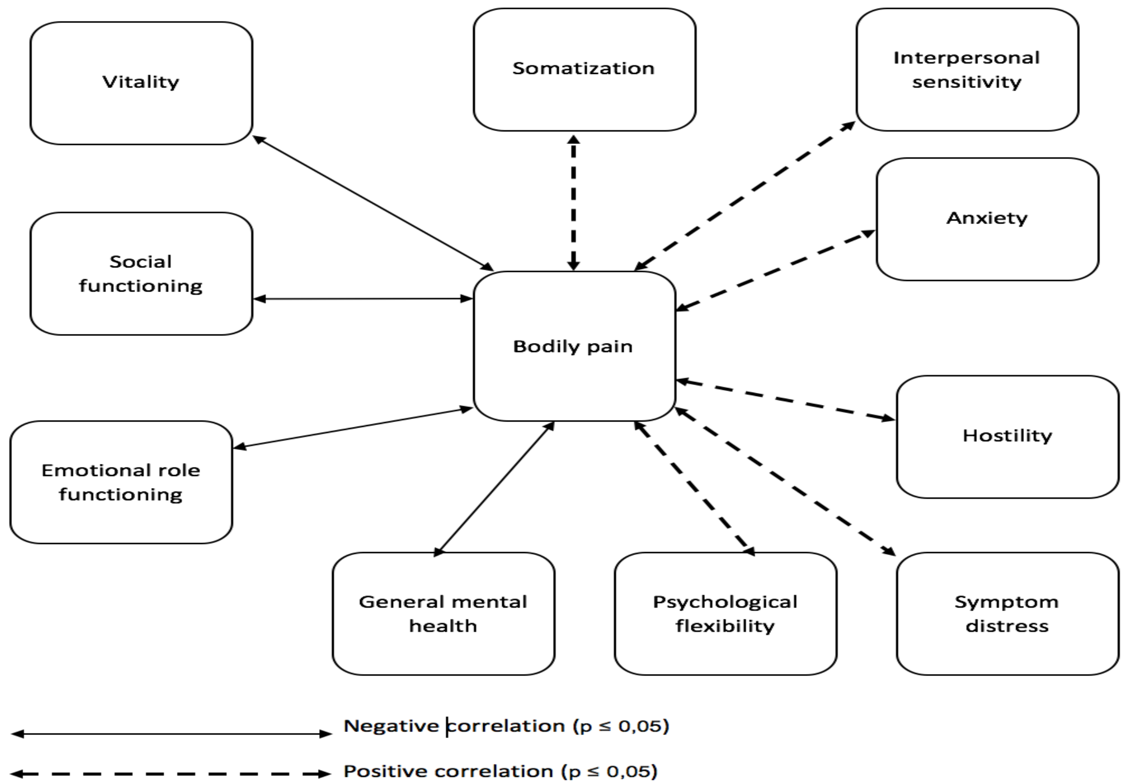


Fig. 3.7 correlation constellation: correlation between bodily pain and mental health scales in the group of probationers

The correlation analysis between bodily pain and the scales that represent mental conditions in the control group we can see that bodily pain scale has the connection only with Social functioning scale.

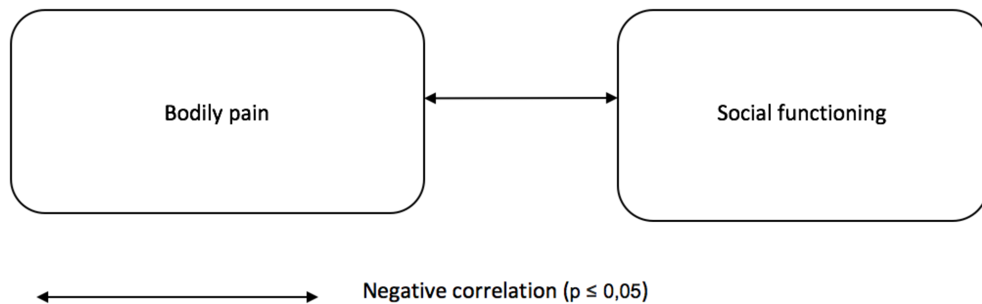


Fig. 3.8 correlation constellation: correlation between bodily pain and social functioning in the control group

At the same time in the control group there are correlations with the other scales representing mental and physical health. Such as there are connections between the scales

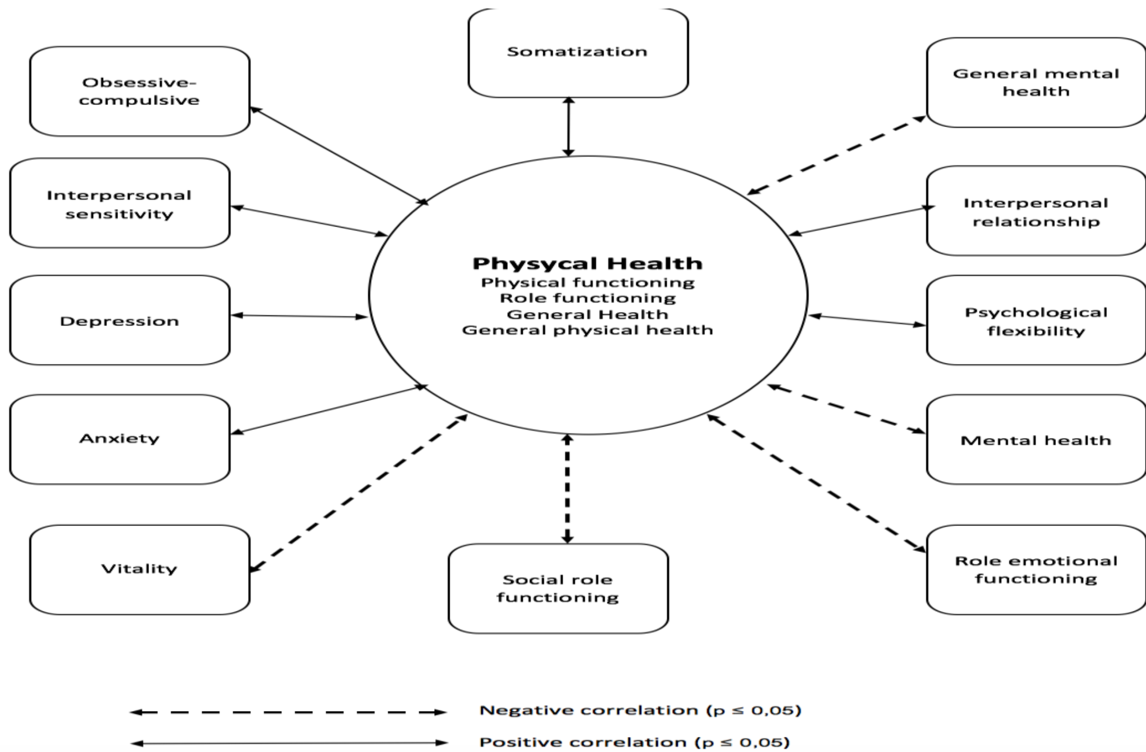


Fig. 3.9 Correlation between the scales that represent mental and physical scales in the control group

3.6 Separation of the participants who could potentially feel the need in psychotherapy.

The cluster analysis was conducted to separate the participants in both groups who could potentially feel the need to consult a psychotherapist. This has been made using K-means clustering according to the reported disturbances with the symptoms of mental health and somatic problems. This way two groups were separated with higher and lower indicators of the scales (Appendix F,G)

The cluster analysis represented that 7 out of 34 offenders reported and acknowledged their mental and physical health problems (Appendix F), while the number of those who admitted being bothered by the symptoms of different mental and physical health conditions in the control group was 13 out of 34 (Appendix G).

Conclusion. The results of the study didn't show that probationers experience more severe symptoms of common mental health disorders. They report on their symptoms as stress, anger, fear, bad mood interpersonal problems and other difficulties statistically less often than the participants that represent the general population. They also give more monotonous answers on the questionnaires in comparison with the participants of the control group whose answers were more diverse.

There were no significant differences found in the perception of mental health symptoms among probationers who have committed more severe crimes comparing to those who committed minor crimes, as well as between groups of probationers who have previous criminal record history and those who were convicted on a crime for the first time.

3.7 Discussion

Criminal offenders on probation are the risk group as it is well known and represented in the literature and a significant number of studies that they have many struggles and problems in the quality of life, such as many of them have worse living conditions, lower level of income, most of them have problems with employment due to their way of life, substance abuse and level of education (Hartwell, 2004; Claire et al., 2011; Ghiasi, Singh, 2020). Many studies have also proved that this category of people have problems in interpersonal relationship (Sattar, 2001). All these factors are believed to have a great impact on their mental and physical health and emotional vulnerability.

Nonetheless, our study represented that comparing the indicators of the scales that reflect conditions in the physical and mental health of offenders on probation and the general population we can see that the participants of the group of people who have never committed crimes reported higher disturbance of mental and physical health problems. According to the results of our study, most of the examined

offenders on probation don't feel or/and don't report much discomfort with their mental and physical health.

At the beginning of the study we had three hypotheses. First of all, we expected the indicators of mental health problems among probationers to be higher than in the control group. The results of our study didn't prove this hypothesis.

We also expected to see higher discomfort of mental health problems among the offenders who committed more severe crimes, as well as those who committed crimes repeatedly. These hypotheses were not proved either: there were no significant difference shown between those probationers who committed crimes for the first time and those who already had previous criminal record history; neither there were difference found between those who committed minor crimes and those who committed grave crimes.

The lack of statistical significance among the key variables of our interest was not expected since according to the previous studies and the theoretical background this population struggle from a big number of distortions in their intimate, interpersonal and social lives (Hartwell, 2004; Claire et al., 2011; Ghiasi, Singh, 2020). We know that most of these people have unsatisfied cultural, educational background, most of them also experience difficulties in interpersonal relationship and suffer from physical diseases, HIV and substance abuse disorders which doesn't let us accept the idea that they don't really have difficulties in their mental health (WHO,2010;Rich., Holmes, Salas , Macalino, Davis, Ryczek, Flanigan, 2001).

From these results, we can conclude that the offenders on probation are not inclined to report about their mental health problems and have tendency to fill in the questionnaires answering mostly negatively, while in the control group the answers were much more diverse. Therefore, we consider other alternatives on why the study showed such results. We offer the following explanations for this:

1. the tendency to answer the questions in the tests mostly in a negative way (i.e. to deny their problems) can be explained by the high intensity

of resistance and the use of the defensive mechanisms. In this case, the answers that they give are the result of their unconscious motives.

2. the probationers are conscious and aware of their difficulties and discomfort concerning their mental health, but they don't tend to report about their mental health condition and intentionally try to manipulate the results in order to pretend that they don't have mental health problems. This can be explained by the fear of stigmatization and exposure and condemnation by the society which is represented by the psychologist who conducts the study. This way the probationers consciously defend their Ego from unbearable feelings of shame.
3. the offenders can't recognize and consequently report their internal mental states. The explanation to this might lie in alexithymia and the disability to reflect and metalize. In this case, they might really feel the discomfort that their mental and physical problems bring but they either can't name them and/or recognize any disturbance.

We will discuss all the possibilities below.

1. The use of the defense mechanisms in the offenders population was studied in some researches. Such a research for example, was conducted in Russia where they assessed the use of defense mechanisms in a population of repeat offenders (Бовин, 2018)

The results of the study demonstrated a significant difference in the intensity of using such defenses as projection, denying and intellectualization between offenders and general population.

This study proved that leading defensive mechanism that offenders use the most is projection. That means that people who committed crimes more often than the general population attribute unacceptable thoughts desires and feelings to other people protecting themselves from the awareness of these traits in them this way. It's important to note that due to this defense, it might be very difficult for the offenders to accept their own responsibility for committing a crime, explaining their behavior

with other factors such as injustice of the world, a mistake, the behavior of the victim or simply misunderstanding which means that somebody else made an error and that's why they were convicted.

This defense mechanism was obvious while talking to the offenders on probation while assessing them. The most common answer for the question “Why are you here?”, was usually directing the responsibility on the external world as “My friend pushed me to steal items from the shop”, “They didn’t pay me salary so I couldn’t buy food”, “My brother made me angry” etc.

The use of projective identification in this population is also very common (Кернберг, 2000). However the intensity of use of this mechanism depends on the patient’s psychopathology. Projective identification is a primitive defense mechanism that can be characterised as a projection of unbearable feelings and emotions that cannot be contained in a normal processing into the object and as a result the person really feels as experiencing these feelings and emotions that were projected (Кернберг, 2000).

The second most commonly used defense mechanism according to the study mentioned above (Бовин, 2018) is intellectualization. This defensive mechanism helps them to master inner conflicts and affective states and eliminate anxiety and fears by abstract reasoning and philosophizing (Potter, 2007). In this case, they avoid taking decisions and replace the actions with just talking. During the study, they left the impression, of cold people, that try to keep the distance and don’t really have emotions.

Another defense mechanism that proved to be commonly used by the offender population is denial, which means that they tend to reject to recognize some reality, their feelings, desires thoughts and emotions so they don’t accept them as their own (Бовин, 2018).

Denial is one of the main obstacles to successful therapy and can cause problems in assessing and treatment (Бовин, 2018). During the interviews these sample demonstrated the tendency to deny their problems and their responsibility for

the criminal acts they committed, and as a consequence denied the need in treatment and desire to change. Yet denying might be difficult to overcome because it protects the Ego from the pain of disclosure of probationers' inner world and their intimate life.

The use of the defense mechanisms mentioned above could have been observed while they were filling in the questionnaires and during the communication with some participants from the sample. Projection, intellectualization and denial are not only the factors that might lead to the reoffending but are also a great obstacles in the assessment and treatment.

2. The feelings of shame and the fear of exposure among the offender population.

This is another reason that might explain why the offenders tend to hide their actual feelings and emotions and don't report on them during the psychological assessment.

As it is noted in the literature (Stukenberg, 2001), the therapist, whether in a prison or probation center, is usually perceived by the offender as an authority figure, because this person is identified with the legal system. Assessing or treating offenders, the psychologist might become an externalized conscience for them (Stukenberg, 2001).

In our opinion, the feeling of shame in front of the psychologist who is perceived as a government representative – the paternal object who has the authority to judge and to punish – can be rooted in early interpersonal relationship with the objects from the offender's childhood.

Melanie Klein (Кляйн, 1946) stated the importance of early childhood relationship between the mother and the child and her capacity to digest the infant's feelings so the baby learns how to tolerate frustration. Projective identification is an important form of communication between the mother and the baby which leads to the child's ability to introject his mother's capacity to tolerate the frustration. If the mother is not capable to digest the communication and returns "raw" frustration to

the baby serious consequences might occur and the child can fail to develop the tolerance of psychic pain (Кляйн, 1946).

As Hyatt-Williams states, Melanie Klein contradicted Freud's view of criminals as those who have weak superego and noted that they have persecutory superego instead, which is internalized as a result of a failure to contain and digest unstable and frustrating enactments with caregivers (Hyatt Williams, 1998). These punitive figures are then internalized and become the part of a child.

Hyatt Williams who worked with the murderers in USA prisons, noted that offenders are guided by the persecutory anxiety that they are not able to bare and try to expel it through projective identification. Their destructive impulses and fantasies could not be adequately contained and remained in a primitive and toxic form (Hyatt Williams, 1998). Using the projective identification in an object relationship the person later projects this frustrating feeling into the object who is perceived punitive and persecutory, which might be resolved in the devaluation of the object or enacting aggressive impulses towards the object to protect the Ego (Hyatt Williams, 1998).

As Stukenberg (Stukenberg, 2011) notes that committing a crime the offender is acting as omnipotent who has the right to punish or harsh others and this way to be on the authority place. When the offender is convicted and sent to the prison or probation center the roles are exchanged: he or she becomes the one who is being punished by the authority figure. This brings the fear of exposure because the more the government representative knows about him, the stricter can be the punishment of this figure (Stukenberg, 2011).

The theory of mentalization can be also mentioned here. As it is noted by Bateman and Fonagy (Bateman, Fonagy, 2013) if the caregiver is not able to give the child the feeling of secure attachment, to contain and mirror the child's feelings and emotions, the child doesn't develop a representation of his own experience and neither form the secure internal representation of an object. Consequently the child might internalize the image of an object as an alien and builds up his identity around this "bad" object which pushes the child to defend his fragile self-representation from

this internal object. Fonagy and Bateman called this and "alien self" and noted that such self-representation activates the need to project bad features of self into others in order to pretend that a self doesn't contain unacceptable aspects and to use aggression against these aspects introjected. This way they can keep the stability of their mind and self-esteem (Bateman, Fonagy, 2013). The offenders tend to control the other in their interpersonal relationship and are always require respect and obedience from those around them (Stukenberg, 2011). In case of refusal from the object to obey these needs and to be the recipient of these projections, these feelings provoke the feeling of shame and confusion that cannot be maintained which can lead to aggressive feelings and behavior in order to defend the Ego structure from these feelings. (Yakeley, Meloy, 2012)

3. Alexithymia and mentalization deficits as an obstacle to assessing and treatment of offenders on probation.

Alexithymia is one form of emotional-expressive disturbance which manifests itself in difficulties in identifying and labeling emotional feelings and distinguishing them from the accompanying bodily sensations, a limited imaginative capacity and an externally oriented style of thinking (Vanheule, Verhaeghe, Desmet, 2010).

Having conversation with people who are on probation it can be noticed that they experienced difficulties in explaining their feelings and emotions. Most of them even don't want to talk about that, but those who could, seemed to be very confused while describing their internal states. Thus, the questions as "Have you felt calm and peaceful?", "Have you been a happy person?", "Did you feel tired?" either were difficult for them to answer or they gave very polar responses as "All the time" or "Never", like there were nothing in between (e.g. "sometimes", "most of the time" etc.).

We think that might be an evidence of difficulties in understanding their own internal feelings and emotions. This conclusion is also supported by the literature that studied the levels of alexithymia among offender population. (Byrne, et al., 2016). Many representatives of the offender population struggle in understanding their

emotional and physical senses. They might feel discomfort very intensively but still it will be unclear for them. As it is noted in the literature, these feelings may give rise to dysfunctional and destructive behavior (Vanheule,Verhaeghe, Desmet, 2010).

It is also noted in the studies that even though in these patients The Empathising System and Theory of Mind might function properly, they have difficulties with *integrating* cognitive interpretations of emotional experience and the bodily sensations associated with these experiences (Bateman, Fonagy, 2012). Alexithymia is also known as a usual trait in substance abuse disorders which has shown to be present in our study (Vanheule,Verhaeghe, Desmet, 2010).

The concept of alexithymia is very close one to mentalization theory, which covers some of the same ground as alexithymia but includes the idea of impaired thinking and expression on affective states (Bateman, Fonagy, 2012).

Mentalization is the capacity to understand one's own inner states, feelings, emotions which in case of normal development increases in intersubjective relationship between primary caregiver and the child states (Bateman, Fonagy, 2012). If the mother (or another attachment figure) is able to provide secure attachment to the child, demonstrate the child that she perceives her baby as separate person with his/her own feelings, emotions, desires and helps to symbolize these feelings the child's awareness of his or her own mental states increases and he becomes able to distinguish them and to understand those of others (Yakeley, 2012).

There were many studies conducted (Bateman; Bolton; Fonagy, 2013; Yakeley, 2012; Möller, Falkenström, Larsson, Holmqvist, 2014) in order to assess the capacity to mentalize in the offender population. The results of these studies have proven that most of the people committed crimes have distortions in this area. They simply can't reflect and distinguish what they feel and what the other person might feel or want.

Suggestions for the therapy of probationers

It's very important first of all to consider whether the therapy is mandatory or the probationer decided to receive it by his or her own. This issue seems to have

much of importance due to the motivation of the offender to be in a treatment and consequently what results might be expected.

In Ukraine there are no standards provided regarding psychotherapy of probationers, nor the rules and specific principles of this therapy. The current Ukrainian legislation (ЗУ «Про пробацію», 2015) establishes that with the aim of reducing reoffending and provide assistance for the resocializing of the offenders released from the prisons probation programs are used. These programs are aimed to teach the probationers to control their emotions , to increase the motivation, to tolerate their distres and are conducted with the use of cognitive behaveioral group skills trainings (Бойко-Бузиль Ю. (2019). However, as was mentioned above most of the offenders were proved to have the history of childhood traumatic experiences, being neglected or abused and, in our opinion, teaching this individuals the ways to control their emotions will not have the positive outcomes. This opinion can be supported by the studies that have shown little effect of cognitive-behaviour interventions in decreasing reoffending among the offenders (Babcock; Green; Robie, 2004; Marques, Wiederanders, Day, Nelson, van Ommeren, 2005).

The therapy of offenders should be different from the one of general population. First of all, it is usually mandatory so the patients don’t really accept it and the therapist should be ready to meet a great resistance.

Secondly, as we can see from the results of this study, the offenders don’t really feel the disturbance and discomfort with their mental health or they just don’t report about difficulties they meet. This means that the great part of work the therapist will probably have to do is to make them to start to recognize their feelings and emotions and to be able to reflect on them and to interpret those of other people.

Consequently, if there were initial self-report assessments made and most of the patients reported that they don’t feel any mental health problems, the goal of this stage in the therapy would become not the lowering of the indicators of emotional and mental disturbance, how it could be during the treatment with the general

population, but increasing those indicators as a result of making them conscious and more acceptable for the offenders on probation.

It should be noted that the therapist doesn’t have to have much expectations from this work. The main aim of the treatment should be strengthening the Ego and the development of psychic functioning and capacity to tolerate and manage the internal states that used to be unbearable and unacceptable for them. The work, especially at the beginning of the treatment should be focused on building a strong and reliable working alliance with the therapist, strengthening the Ego structure of the patient and increasing of mentalizing capacity that are aimed at helping the patient to connect his or her internal states of mind to his/her behavior actions, and focusing on the affect.

The therapist should be also prepared that this work will be challenging due to the offenders’ tendency to regress to more primitive mental states which might increase the risk of acting out and reoffending.

The general principles of usual psychoanalytic therapy mostly have to be revised. First of all, the therapist should remember that the place for the therapy is different. The treatment is held in the hospitals, or probation centers which brings more secure environment for the therapist however it might also bring some difficulties if to perceive these institutions as an “object” that is strict has the authority to punish.

The setting of the therapy might be modified as well. It is not recommended to work intensively due to this population incapacity to handle high frequency of sessions. Also it must be noted that such a useful tool which is widely used in the therapy of neurotic patients as silence, might be perceived by the offenders as persecutory and increase the level of anxiety so it must be reconsidered as well.

The is recommended to be concentrated on the issues that appear “here and now”, free associations must be avoided especially at the beginning of the therapy (Yakeley, 2012).

The interpretations shouldn’t concern unconscious conflicts and phantasies and mostly should focus on what the patients think, feel right at the moment of the therapy. The transference interpretations also should be avoided, especially in case of negative transference.

The therapist working with this population has to be very aware and conscious about his or her countertransference feelings in order not to be involved in the enactments with the patients. Due to the very common defense mechanisms this population use, such as projection, projective identification, idealization and devaluation, the therapist’s feelings during the treatment might range from impotence, helplessness and ineffectiveness to omnipotence and the feeling of being authoritarian and punitive. As it was mentioned above, they very often see the therapist as a punitive and authority figure. This might lead to the therapists’ identification with this figure which results in enactments in the therapy. For this reason constant supervisions might be very important.

To prepare to work with this category of patients it is useful for the therapist to analyze his or her own wish for working, whether it will be possible to avoid judgmental feelings and be empathetic.

The most widely recommended form of the therapy with this population (Bateman, Bolton, Fonagy, 2013; Йоманс, Кларкин, Кернберг, 2016; Уэлдон, 2017) is group therapy because it helps the patients to reflect on their feelings and emotions in the secured environment during the interactions with other members of the group. At the same time this form of the therapy might be not useful and appropriate for some categories of patients due to their life history. For example, those who were abandoned by their mother in the early childhood might feel very frustrated during the group therapeutic work. Thus, before taking a decision what form of therapy would be more appropriate for the specific patient his or her life history and personality traits might be taken into account.

Conclusion to the third chapter

The study carried on in The Center of Probation in Kyiv has shown that comparing to the group of general population the probationers tend to report less discomfort of mental health problems. The only scale in which the data has shown that the offenders were not satisfied with their health was the scale that represented the bodily pain which was found to be highly associated with mental health scales.

The probationers also tend to reply on the questions mostly negatively or affirmatively, while the participants in general population had more divers answers, such as “sometimes”, “from time to time”, etc.

We also found that the connections between the scales that represent mental and physical health in general population is much higher and diverse, while in the group of probationers the indicators of mental and physical health are to be disconnected from each other.

We assumed that the probationers that participated in our study didn’t tend to report about their mental health discomfort. The explanation of this fact in our opinion lies into three possibilities: more intensive use of the defense mechanisms by probationers than in general population; shame and the fear of exposure that can be explained by the transference that the probationers tend to develop towards the authority figures; alexithymia and mentalization deficits that are proved to be among this population.

Taking into account these factors, that have the potential to affect the assessment as well as psychotherapy of the probationers, we have suggested different ways to overcome these obstacles that might be helpful for further studies in this field, such as including into the assessment of probationers clinical interviews and OPD and developed main principles of psychotherapy with this population.

CONCLUSIONS

The problem of mental health among probationers is very relevant in Ukraine today. After creating the law “On probation” in 2015 our country set the course on the criminal law humanization, resocialization of offenders who have been released from the prisons and reducing recidivism. At the same time, even though the problem of mental health among people committed a crime is widely discussed in the foreign countries, Ukrainian science doesn’t pay much attention to this problem. There is a range of programs conducted that are aimed to change the behavior of offenders but the ways to assess and to deal with the deep psychological disturbances of offenders don’t get much attention in the studies and the practice. Which we believe to be a gap due to the high prevalence of mental and physical health problems in this population according to the foreign studies.

Forensic psychotherapy is aimed to understand what are the risks of the offenders’ mental health problems, to assess their mental states and to find the principles and ways to help them with these problems. Our study can be considered as a first step on this way.

This study showed that the offenders more often report on their physical discomfort rather than mental health problems. In our country, there is still a believe that it is better not to report on psychological disturbances due to the fear of stigmatization and that might be one of the explanations why this population mostly answered negatively on the questions concerning their mental health problems. Another explanation might lie in the intensity of their defense mechanisms and/or inability even to notice and to reflect on mental discomfort. This can be explained by the use of defense mechanisms, alexithymia and mentalization deficits.

It should be considered in further studies that this population doesn’t tend to report and accept their mental health problems. That means that the assessment should be supported with the clinical interviews where the psychologists have to pay attention to the unconscious products of the psychic of offenders, such as the way they talk about themselves and others, whether they are able to understand and reflect on their inner states, what are the defense mechanisms they use, what are their personality traits.

During the assessment of the probationers the clinical interview and Operationalized psychodynamic diagnostic (OPD) is recommended to be conducted in order to assess their unconscious conflicts, feeling and emotions since the self-assessment measures have limitations and are easy to manipulate the scores in one way or another.

As it is widely discussed in the recent foreign studies that most of the offenders had attachment difficulties and traumas in their childhood and that might be the reason for choosing the way of criminal behavior. It is important to ask the probationers of their childhood traumatic experience that may bring the light to their actual inner states and the choice for criminal behavior. Consequently, it might be also crucial to consider in further studies and to assess their attachment styles. Our study has shown that most of the offenders have problems with reflecting their feelings and thoughts and many of them report on physical pain instead. It must be important to assess their reflective functioning in the further studies, levels of alexithymia and attachment Fonagy and Bateman (Bateman, Fonagy, 2013) recommend Adult Attachment Interview (AAI) as a tool to assess reflective functioning. Toronto Alexithymia Scale might bring the light to such probationers’ problems as difficulties in identifying feelings, describing feelings and external oriented thinking.

It is also important to note that due to the unsatisfied relationship with their caregivers it might be difficult for psychologists and psychotherapists to establish reliable relationship with them. Due to their defense mechanisms, they tend to

devalue the psychologist and to perceive him or her as unstable and unreliable figure from their childhood who is rather punitive and persecutory than understanding. This might bring obvious limitations in the assessment and treatment of these people. To overcome these obstacles the psychologists and psychotherapists should be patient and ready to such a challenging work. It is crucial for the therapist to analyze constantly his or her own countertransference feelings and to be aware of the limitations of the therapy.

The main aim of the therapy with the offenders who have struggles in reflecting on their internal feelings and emotions might be to make them conscious to them. That means that the indicators of the scales of self-reported methods of assessments that represent their mental health problems will get higher. The increase of the indicators will show that they became more aware with their internal discomfort. If to compare with the general population the success in the therapy might be represented by lowering these indicators.

The assessment of mental health among the offenders is also crucial while taking the decision about what setting in the therapy should be the most effective for them. Their life history, personal traits and pathology should be taken into account to reach the aims of the therapy.

Psychoanalytic approach suggests that in order to reduce the level of criminality and reoffending we have to understand the crime and the person who committed it. It’s crucial to understand what goes on in the inner world and unconscious phantasies of these people. Welldon, citing Winnicott (Уэлдон, 2017), states that there is a hope in antisocial behavior. It means that the offender committing a crime is also asking to be noticed, seen and heard - something that he probably has never had before. The analyst working with the offender have to concentrate on the questions as “Why the offender committed this exact criminal act?” and “What pain is behind this act?”. Every offender, as well as any other person, keeps his or her own history inside that needs to be heard before being punished for.

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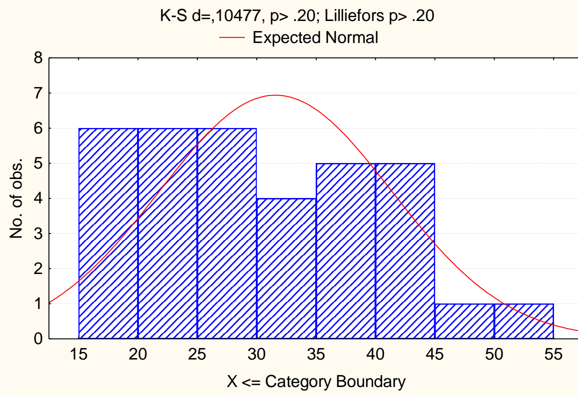
APPENDIX

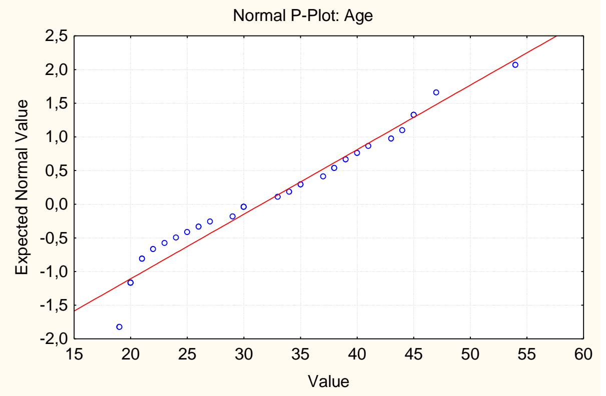
Appendix A

The description of men on probation and men of control group

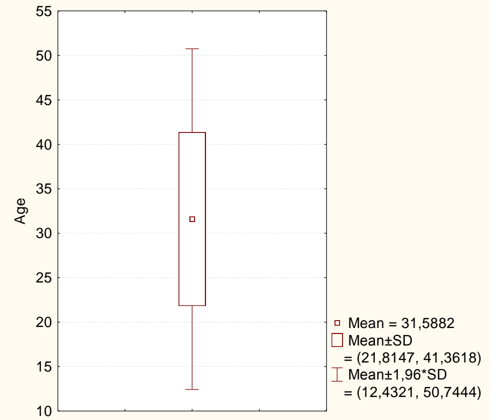
The age of men on probation – experimental group

Summary: Age



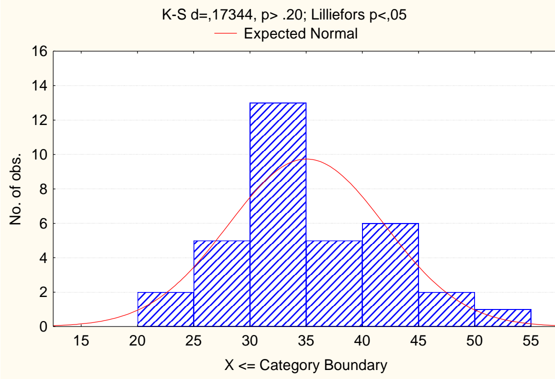


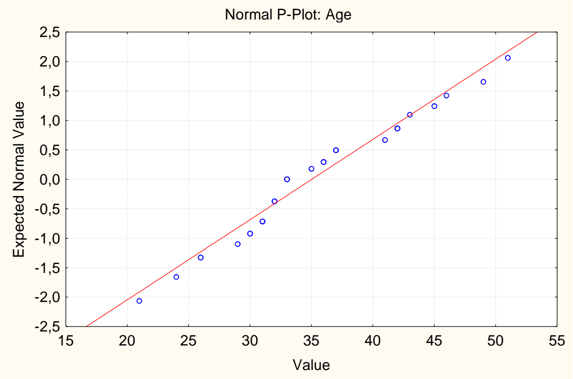
Summary Statistics:Age
Valid N=34
Mean= 31,588235
Median= 30,000000
Minimum= 19,000000
Maximum= 54,000000
Std.Dev.= 9,773550



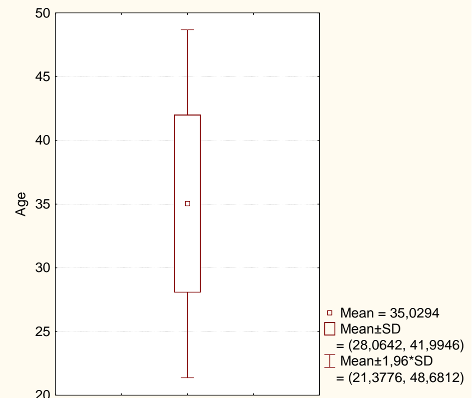
The age of men from control group

Summary: Age





Summary Statistics:Age
Valid N=34
Mean= 35,029412
Median= 33,000000
Minimum= 21,000000
Maximum= 51,000000
Std.Dev.= 6,965218



	N	Mean	Median	Minimum	Maximum	Std.Dev.
EG	34	31	30	19	54	10
CG	34	35	33	21	51	7

Marital Status

	Single	Divorced	Married	Other
EG	22	7	5	-
CG	10	4	17	3

The presence of children

	Children	Without children
EG	14	20
CG	17	16

Offense gravity

	Minor offences (art. 128, 162, 309 p.1)	Medium grave offenses (art. 185, p 2,3; 186 p. 1,2; 309 p.2; 259)	Grave offenses (art. 121,1, 286 p.2, 289)
EG	5	22	6

Appendix B

The features of data distribution between the scales

Scale	Shapiro-Wilk W, p
Somatization	W=,84950, p=,00000
Obsessive-compulsive	W=,90798, p=,00014
Interpersonal sensitivity	W=,91218, p=,00021
Depression	W=,79776, p=,00000
Anxiety	W=,77013, p=,00000
Hostility	W=,83095, p=,00000
Phobic	W=,67206, p=,00000
Paranoid Ideation	W=,86015, p=,00000
Psychotism	W=,53894, p=,00000
Physical Functioning	W=,56112, p=,00000
Role-Physical Functioning	W=,62792, p=,00000
Bodily pain	W=,79003, p=,00000
General Health	W=,91875, p=,00040
General Physical Health	W=,87369, p=,00001
Vitality	W=,96889, p=,10084
Social Functioning	W=,85096, p=,00000
Role Emotional	W=,79239, p=,00000
Mental Health	W=,94022, p=,00356

General Mental Health	W=,95336, p=,01563
AAQ II	W=,93951, p=,00329
Alcohol	W=,70097, p=,00000
SD	W=,96383, p=,05446
IR	W=,97442, p=,19668
SR	W=,97146, p=,13780

For most of the scales $p \leq 0,05$, thus the data is not normally distributed. Only for sone of the scales $p \geq 0,05$ and are normally distributed.

Thus, for further statistical analysis we will use nonparametrical criteria.

Appendix C

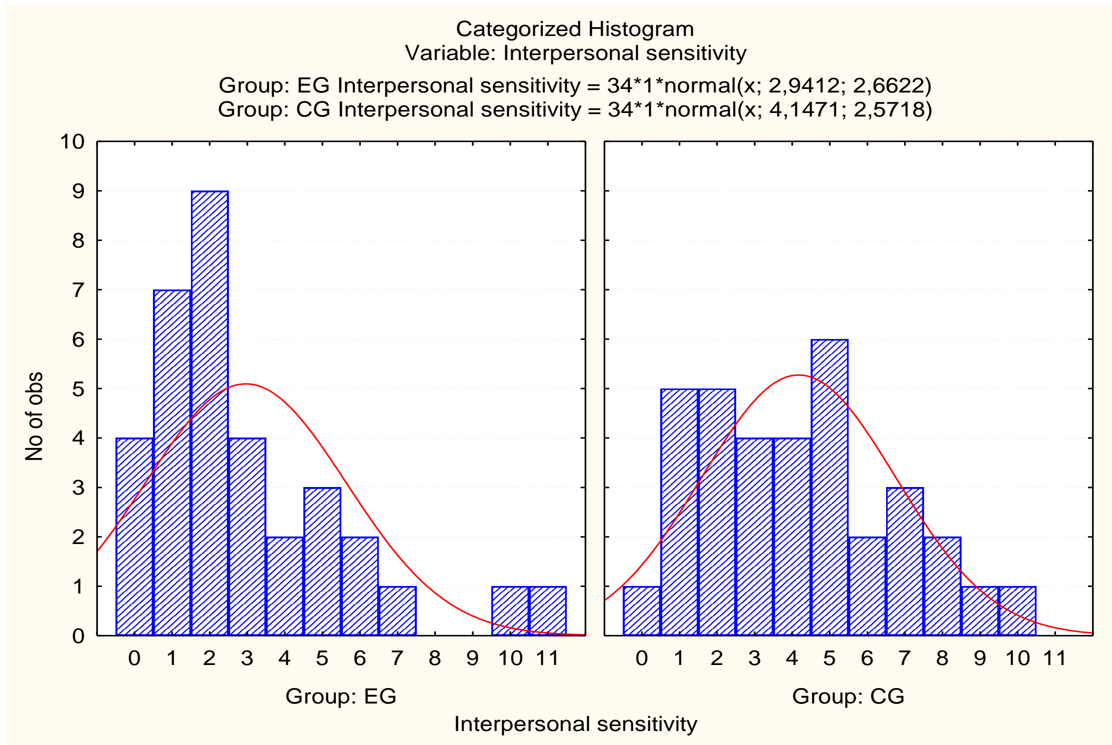
Comparison of men on probation with men from the control group on the Mann-Whitney criteria

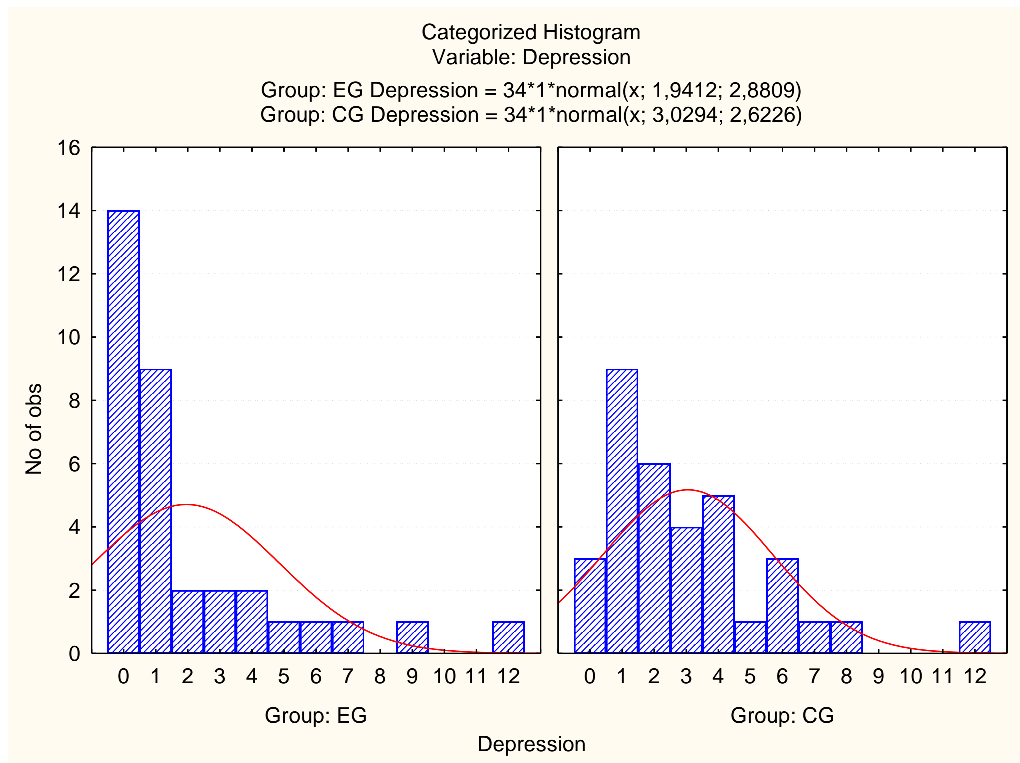
Mann-Whitney U Test (Spreadsheet52) By variable Group Marked tests are significant at p <,05000

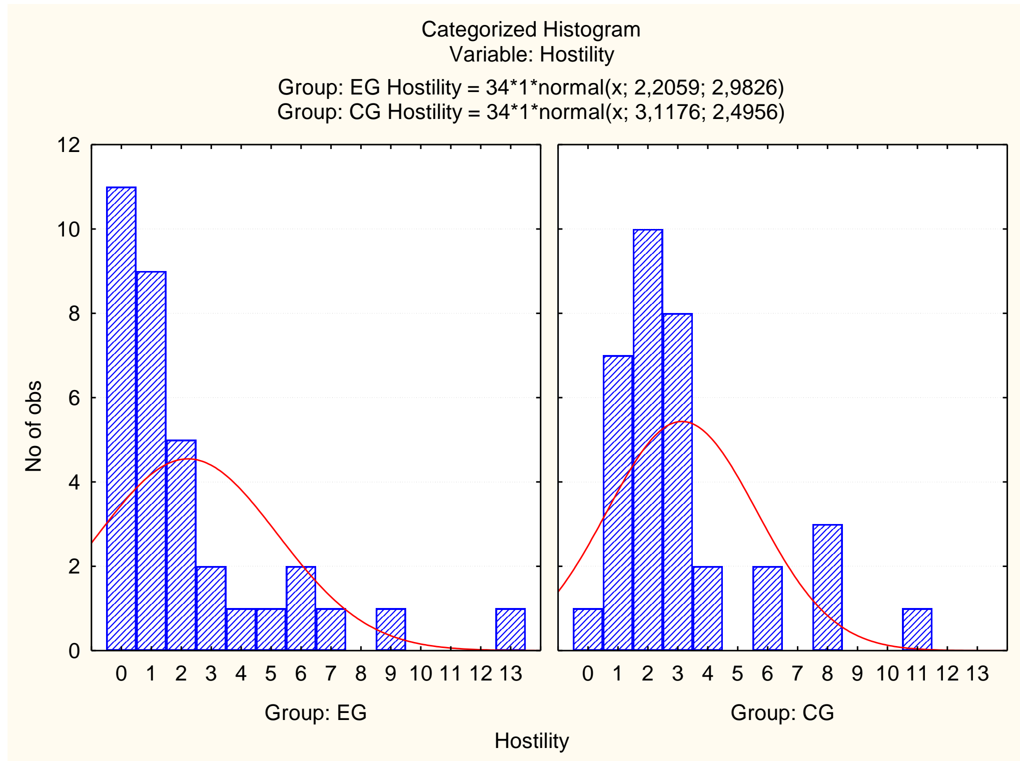
	Rank Sum - EG	Rank Sum - CG	U	Z	p-level	Z - adjusted	p-level	Valid N - EG	Valid N - CG	2*1sided - exact p
Somatization	1051,500	1294,500	456,5000	-1,49026	0,136156	-1,50707	0,131794	34	34	0,136847
Obsessive-compulsive	1042,000	1304,000	447,0000	-1,60679	0,108102	-1,63020	0,103061	34	34	0,109807
Interpersonal sensitivity	998,000	1348,000	403,0000	-2,14647	0,031836	-2,16772	**0,030181**	34	34	0,031702
Depression	957,500	1388,500	362,5000	-2,64323	0,008212	-2,69445	**0,007051**	34	34	0,007628
Anxiety	1046,000	1300,000	451,0000	-1,55773	0,119299	-1,60767	0,107908	34	34	0,121260
Hostility	960,000	1386,000	365,0000	-2,61256	0,008987	-2,65624	**0,007902**	34	34	0,008546
Phobic	1168,0	1178,0	573,00	-	0,9510	-	0,9469	34	34	0,9562

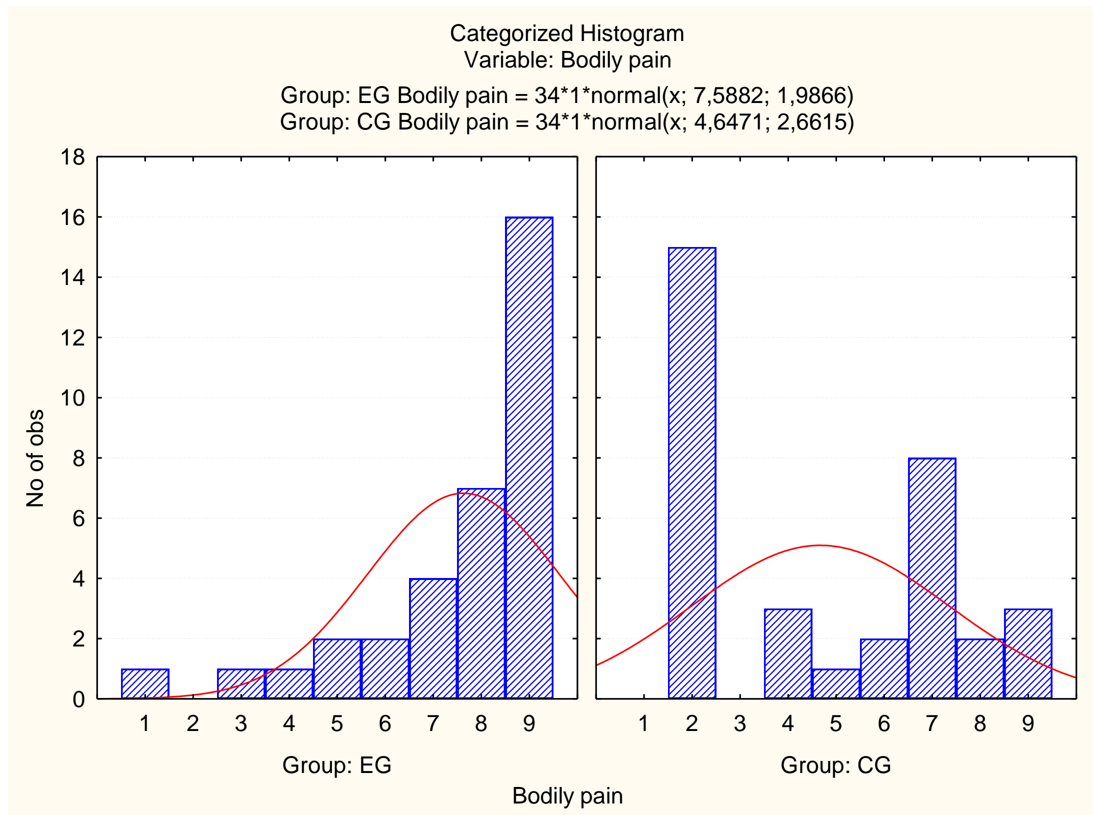
	00	00	00	0,06133	98	0,06653	56			76
Paranoid Ideation	1304,000	1042,000	447,0000	1,60679	0,108102	1,63409	0,102241	34	34	0,109807
Psychotism	1205,000	1141,000	546,0000	0,39250	0,694691	0,48062	0,630790	34	34	0,701042
Physical Functioning	1160,000	1186,000	565,0000	-0,15945	0,873313	-0,16624	0,867970	34	34	0,878946
Role-Physical Functioning	1139,500	1206,500	544,5000	-0,41090	0,681149	-0,48227	0,629617	34	34	0,683048
Bodily pain	1533,500	812,500	217,5000	4,42173	0,000010	4,51445	**0,000006**	34	34	0,000004
General Health	1222,000	1124,000	529,0000	0,60101	0,547832	0,60408	0,545794	34	34	0,554271
General Physical Health	1335,500	1010,500	415,5000	1,99315	0,046246	1,99925	**0,045582**	34	34	0,045760
Vitality	1163,500	1182,500	568,5000	-0,11652	0,907238	-0,11696	0,906895	34	34	0,907851
Social Functioning	1156,500	1189,500	561,5000	-0,20238	0,839619	-0,20750	0,835623	34	34	0,840659
Role	1197,0	1149,0	554,00	0,294	0,7684	0,3179	0,7505	34	34	0,7745

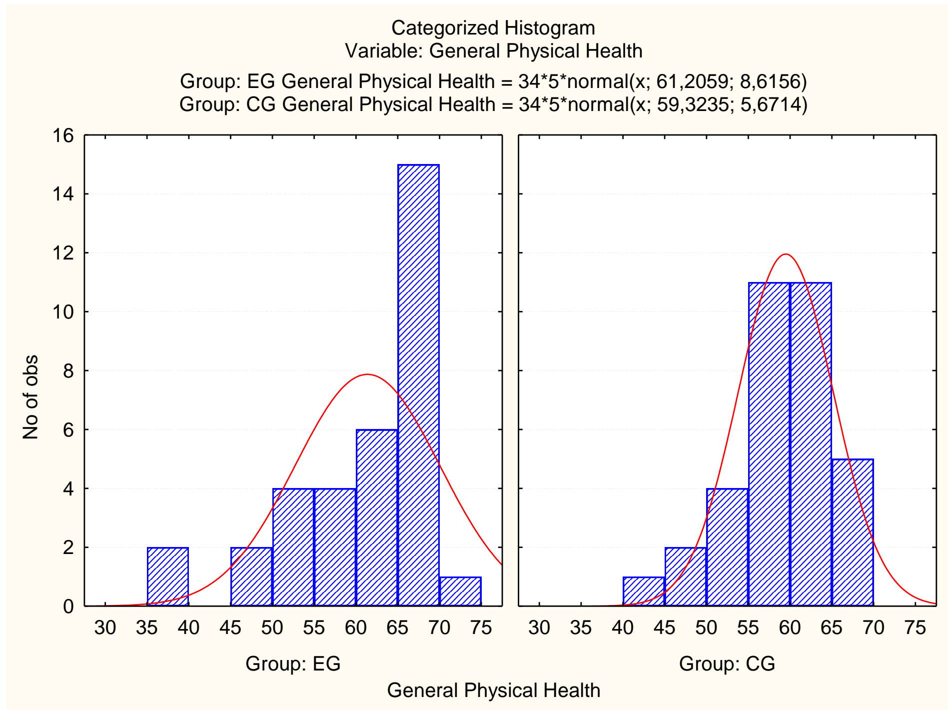
Emotional	00	00	00	37	73	8	02			94
Mental Health	1215,000	1131,000	536,0000	0,51515	0,606446	0,51642	0,605564	34	34	0,612917
General Mental Health	1184,000	1162,000	567,0000	0,13492	0,892674	0,13508	0,892545	34	34	0,898201
AAQ II	1038,500	1307,500	443,5000	-1,64972	0,099002	-1,65459	0,098009	34	34	0,099215
Alcohol	1369,000	977,000	382,0000	2,40405	0,016215	2,67676	**0,007434**	34	34	0,015809
SD	983,000	1363,000	388,0000	-2,33046	0,019783	-2,33215	**0,019694**	34	34	0,019423
IR	1109,500	1236,500	514,5000	-0,77886	0,436061	-0,78002	0,435381	34	34	0,438517
SR	1166,000	1180,000	571,0000	-0,08586	0,931579	-0,08613	0,931364	34	34	0,936877

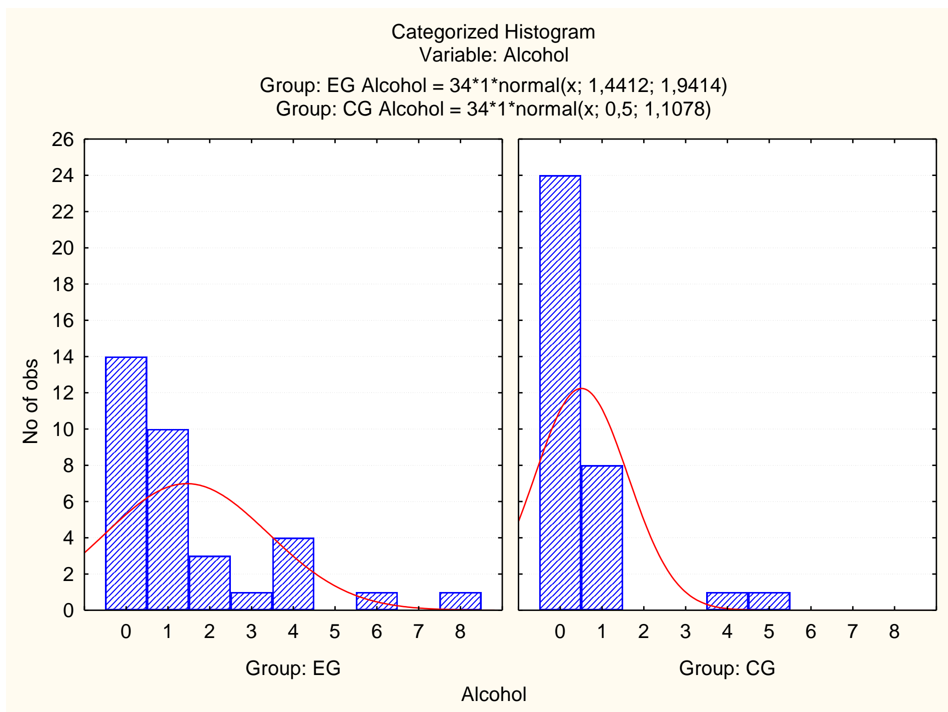

Categorized Histogram
Variable: Interpersonal sensitivity
Group: EG Interpersonal sensitivity = 34*1*normal(x; 2,9412; 2,6622)
Group: CG Interpersonal sensitivity = 34*1*normal(x; 4,1471; 2,5718)
No of obs
Group: EG
Group: CG
Interpersonal sensitivity

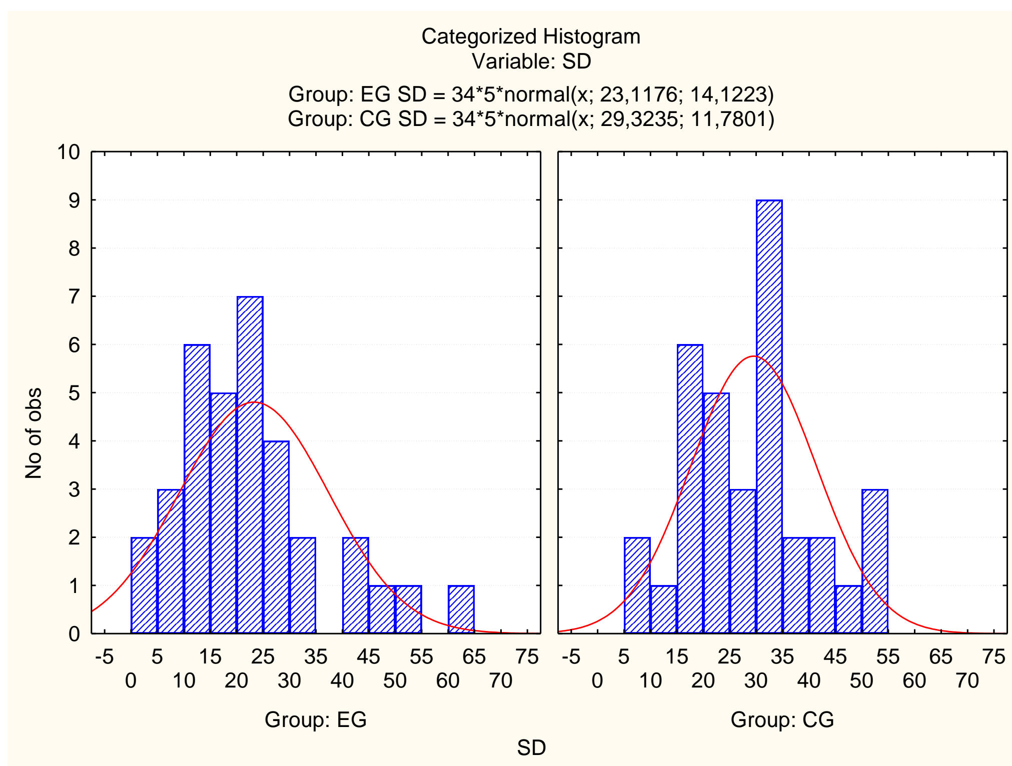

Categorized Histogram
Variable: Depression
Group: EG Depression = 34*1*normal(x; 1,9412; 2,8809)
Group: CG Depression = 34*1*normal(x; 3,0294; 2,6226)
No of obs
Group: EG
Group: CG
Depression


Categorized Histogram
Variable: Hostility
Group: EG Hostility = 34*1*normal(x; 2,2059; 2,9826)
Group: CG Hostility = 34*1*normal(x; 3,1176; 2,4956)
No of obs
0
2
4
6
8
10
12
0 1 2 3 4 5 6 7 8 9 10 11 12 13
0 1 2 3 4 5 6 7 8 9 10 11 12 13
Group: EG
Group: CG
Hostility


Categorized Histogram
Variable: Bodily pain
Group: EG Bodily pain = 34*1*normal(x; 7,5882; 1,9866)
Group: CG Bodily pain = 34*1*normal(x; 4,6471; 2,6615)
No of obs
0
2
4
6
8
10
12
14
16
18
1 2 3 4 5 6 7 8 9
1 2 3 4 5 6 7 8 9
Group: EG
Group: CG
Bodily pain


Categorized Histogram
Variable: General Physical Health
Group: EG General Physical Health = 34*5*normal(x; 61,2059; 8,6156)
Group: CG General Physical Health = 34*5*normal(x; 59,3235; 5,6714)
No of obs
0
2
4
6
8
10
12
14
16
30 35 40 45 50 55 60 65 70 75
Group: EG
30 35 40 45 50 55 60 65 70 75
Group: CG
General Physical Health


Categorized Histogram
Variable: Alcohol
Group: EG Alcohol = 34*1*normal(x; 1,4412; 1,9414)
Group: CG Alcohol = 34*1*normal(x; 0,5; 1,1078)
No of obs
0
2
4
6
8
10
12
14
16
18
20
22
24
26
0 1 2 3 4 5 6 7 8
Group: EG
0 1 2 3 4 5 6 7 8
Group: CG
Alcohol


Categorized Histogram
Variable: SD
Group: EG SD = 34*5*normal(x; 23,1176; 14,1223)
Group: CG SD = 34*5*normal(x; 29,3235; 11,7801)
No of obs
Group: EG
Group: CG
SD

Appendix D

The results of correlation analysis between the scales of mental and physical health for offenders on probation

Spearman Rank Order Correlations (Data_EG) MD pairwise deleted Marked correlations are significant at p <,05000

	Physical Functioning	Role-Physical Functioning	Bodily pain	General Health	General Physical Health
Somatization	-0,021372	-0,158403	**-0,652039**	**-0,425580**	**-0,372535**
Obsessive-compulsive	-0,179748	-0,295114	-0,092794	-0,179861	-0,228539
Interpersonal sensitivity	0,079821	-0,276429	**-0,311106**	-0,290416	-0,296382
Depression	-0,131978	-0,237841	-0,252747	**-0,323711**	**-0,347210**
Anxiety	-0,238148	-0,220055	**-0,395606**	**-0,361752**	**-0,395932**
Hostility	-0,024939	-0,130166	**-0,442467**	-0,297410	-0,278750
Phobic	-0,187532	-0,028258	-0,138433	0,077536	-0,107824
Paranoid Ideation	-0,070733	-0,255333	-0,308834	-0,319264	-0,293362
Psychotism	0,001837	-0,319382	-0,084390	-0,126443	-0,175093
Vitality	0,271523	**0,367796**	**0,340921**	**0,571319**	**0,541859**
Social Functioning	-0,003047	0,259218	**0,329264**	0,259836	0,215385
Role Emotional	0,249066	**0,566077**	**0,335908**	**0,358730**	**0,444225**
Mental Health	0,296313	0,446332	0,284183	0,381015	0,485286
General Mental	0,281329	**0,467871**	**0,324660**	**0,492290**	**0,530275**

Health					
AAQ II	**-0,523121**	-0,188314	**-0,446666**	-0,343290	**-0,482033**
Alcohol	-0,283615	-0,290317	0,040231	-0,125656	-0,229129
SD	**-0,401240**	-0,300027	**-0,424309**	**-0,535540**	**-0,596256**
IR	-0,145944	-0,205264	-0,111857	-0,262780	-0,222641
SR	-0,296120	-0,214259	-0,298984	**-0,453773**	**-0,476166**

Appendix E

The results of correlation analysis between the scales of mental and physical health among men in the control group

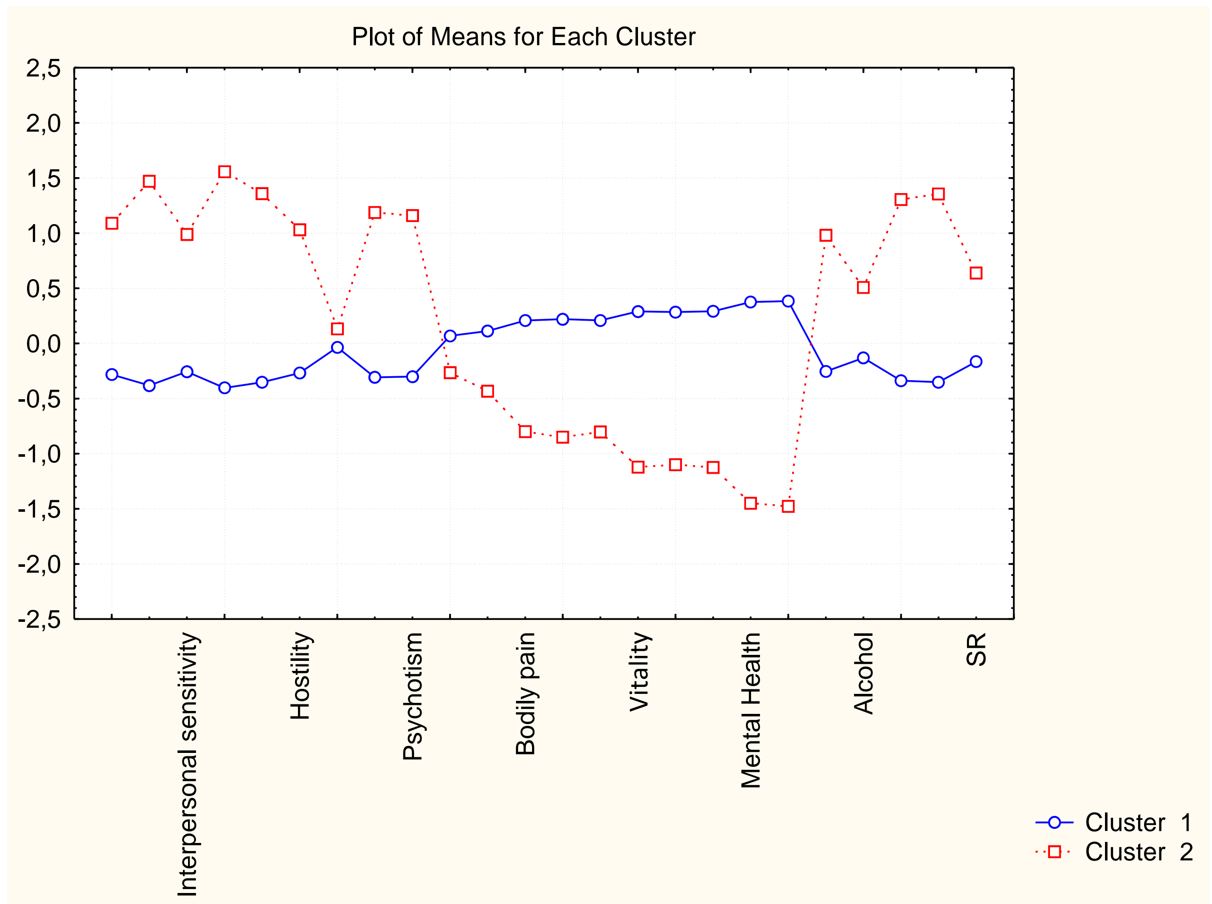
Spearman Rank Order Correlations (Data_CG) MD pairwise deleted Marked correlations are significant at p <,05000

	Physical Functioning	**Role-Physical Functioning**	**Bodily pain**	**General Health**	**General Physical Health**
Somatization	**-0,453423**	**-0,332544**	-0,206419	**-0,391662**	**-0,495028**
Obsessive-compulsive	**-0,550461**	**-0,359368**	-0,297966	**-0,397902**	**-0,536688**
Interpersonal sensitivity	**-0,402084**	**-0,340928**	-0,316187	**-0,382575**	**-0,495726**
Depression	**-0,464971**	**-0,407709**	-0,266291	**-0,592500**	**-0,639341**
Anxiety	**-0,409271**	**-0,375930**	-0,206145	**-0,449788**	**-0,518186**
Hostility	**-0,466143**	-0,219317	-0,165785	**-0,375512**	**-0,422110**
Phobic	-0,168065	-0,201630	-0,208165	-0,138934	-0,250263
Paranoid Ideation	**-0,431732**	-0,119495	-0,028980	-0,282804	-0,261029
Psychotism	-0,113960	0,049580	0,017354	0,101037	0,050753
Vitality	**0,464733**	**0,512949**	0,321213	**0,467163**	**0,587359**
Social Functioning	**0,357833**	**0,461806**	**0,488239**	**0,580027**	**0,731693**

Role Emotional	**0,424835**	**0,433239**	0,135240	**0,439079**	**0,442529**
Mental Health	**0,487352**	**0,539802**	0,066047	**0,360309**	**0,414125**
General Mental Health	**0,508250**	**0,572480**	0,237120	**0,508351**	**0,594337**
AAQ II	**-0,557924**	**-0,423806**	0,010654	**-0,427202**	**-0,409661**
Alcohol	**-0,051001**	0,182108	0,108422	-0,199472	-0,050583
SD	**-0,603145**	-0,485064	-0,152239	**-0,504194**	**-0,554857**
IR	**-0,346399**	**-0,419216**	0,043976	**-0,398263**	**-0,372862**
SR	**-0,478401**	-0,294648	-0,171610	**-0,382271**	**-0,410001**

Appendix F

Cluster analysis of the men on probation who could potentially need psychotherapeutic treatment



Results of comparative analysis of scales in physical and mental health from 2 clusters

Mann-Whitney U Test (Data_EG) By variable NewVar Marked tests are significant at p <,05000

	Rank Sum - Group 1	Rank Sum - Group 2	U	Z	p-level	Z - adjusted	p-level	Valid N - Group 1	Valid N - Group 2	2*1sided - exact p
Depression	381,5000	213,5000	3,50000	-3,87585	0,000106	-4,05923	**0,000049**	27	7	0,000003

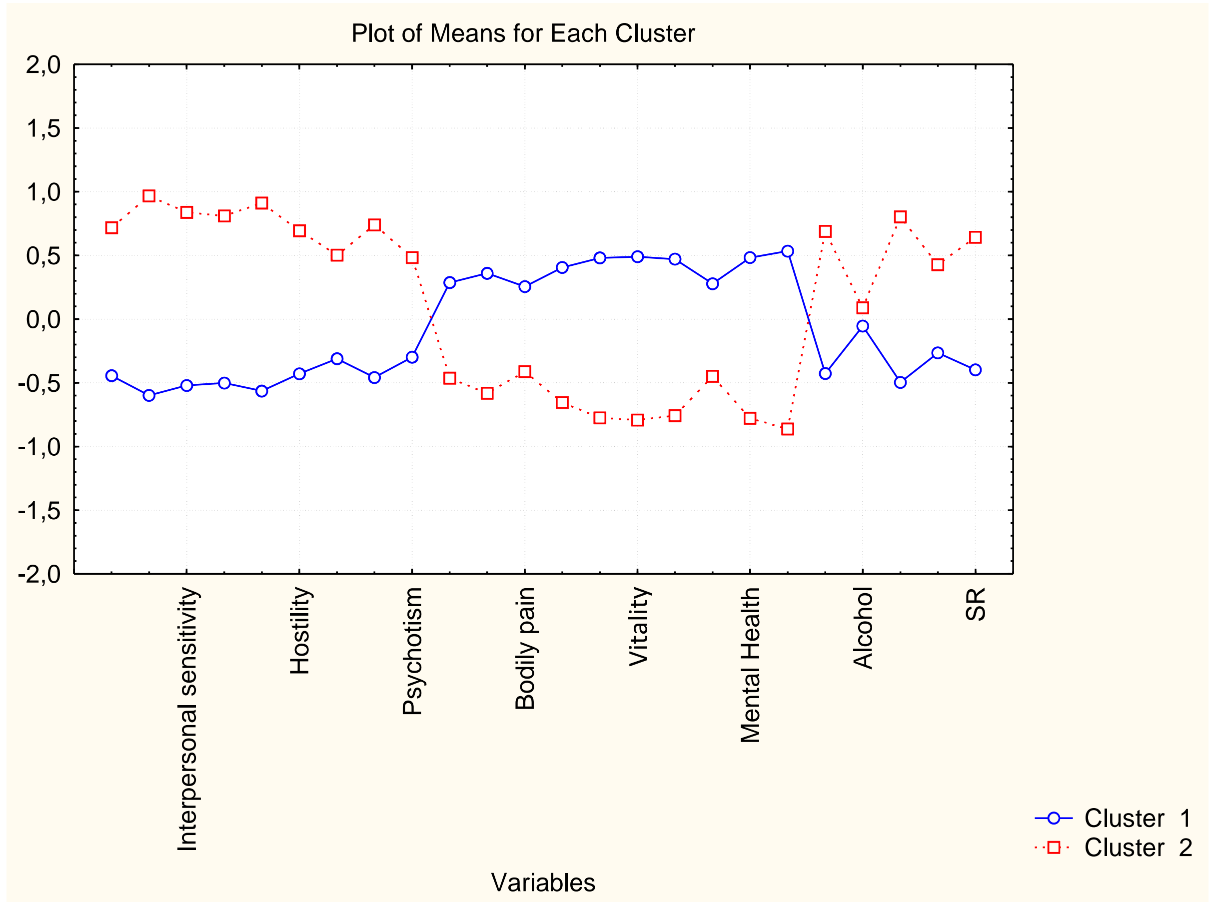
Anxiety	396,0000	199,0000	18,00000	-3,25827	0,001121	-3,45883	**0,000543**	27	7	0,000438
Hostility	420,0000	175,0000	42,00000	-2,23607	0,025348	-2,30060	**0,021415**	27	7	0,024313
Phobic	452,0000	143,0000	74,00000	-0,87313	0,382592	-0,94183	0,346280	27	7	0,402731
Paranoid Ideation	402,0000	193,0000	24,00000	-3,00272	0,002676	-3,03110	**0,002437**	27	7	0,001543
Psychotism	429,0000	166,0000	51,00000	-1,85274	0,063920	-2,23193	**0,025620**	27	7	0,066239
Physical Functioning	488,0000	107,0000	79,00000	0,66017	0,509144	0,69362	0,487921	27	7	0,531242
Role-Physical Functioning	498,5000	96,5000	68,50000	1,10739	0,268128	1,27003	0,204075	27	7	0,274900
Bodily pain	506,0000	89,0000	61,00000	1,42682	0,153631	1,51609	0,129499	27	7	0,163363
General Health	526,0000	69,0000	41,00000	2,27866	0,022688	2,30541	**0,021144**	27	7	0,021471
General	518,50	76,500	48,500	1,959	0,0500	1,9795	**0,0477**	27	7	0,0484

Physical Health	00	0	00	22	88	9	**50**			78
Vitality	545,5000	49,5000	21,50000	3,10920	0,001876	3,12475	**0,001780**	27	7	0,000847
Social Functioning	544,5000	50,5000	22,50000	3,06661	0,002165	3,14596	**0,001656**	27	7	0,001041
Role Emotional	538,5000	56,5000	28,50000	2,81106	0,004938	3,11531	**0,001838**	27	7	0,003182
Mental Health	561,5000	33,5000	5,50000	3,79067	0,000150	3,80582	**0,000141**	27	7	0,000007
General Mental Health	563,5000	31,5000	3,50000	3,87585	0,000106	3,88030	**0,000104**	27	7	0,000003
AAQ II	418,0000	177,0000	40,00000	-2,32125	0,020274	-2,33467	**0,019561**	27	7	0,018908
Alcohol	454,5000	140,5000	76,50000	-0,76665	0,443289	-0,80672	0,419829	27	7	0,451860
SD	403,0000	192,0000	25,00000	-2,96013	0,003075	-2,96307	**0,003046**	27	7	0,001863
IR	390,0000	205,0000	12,00000	-3,51382	0,000442	-3,52407	**0,000425**	27	7	0,000091

SR	427,5000	167,5000	49,50000	-1,91663	0,055286	-1,92251	**0,054542**	27	7	0,053917

Appendix G

Cluster analysis of the men from control group who could potentially need psychotherapeutic treatment



Results of comparative analysis of scales in physical and mental health from 2 clusters

Mann-Whitney U Test (Data_CG) By variable NewVar Marked tests are significant at p <,05000

	Rank Sum - Group 1	Rank Sum - Group 2	U	Z	p-level	Z - adjusted	p-level	Valid N - Group 1	Valid N - Group 2	2*1sided - exact p
Depression	259,0000	336,0000	28,0000	-3,84508	0,000121	-3,90305	**0,000095**	21	13	0,000036
Anxiety	246,0000	349,0000	15,0000	-4,305	0,000017	-4,3904	**0,000011**	21	13	0,000001

				78		4				
Hostility	277,0000	318,0000	46,0000	-3,20718	0,001341	-3,28621	**0,001016**	21	13	0,000879
Phobic	314,5000	280,5000	83,5000	-1,87824	0,060349	-2,07357	**0,038120**	21	13	0,059651
Paranoid Ideation	273,5000	321,5000	42,5000	-3,33122	0,000865	-3,46596	**0,000528**	21	13	0,000471
Psychotism	310,5000	284,5000	79,5000	-2,01999	0,043385	-2,51713	**0,011832**	21	13	0,042216
Physical Functioning	447,0000	148,0000	57,0000	2,81736	0,004842	2,96110	**0,003066**	21	13	0,004025
Role-Physical Functioning	424,0000	171,0000	80,0000	2,00228	0,045256	2,41395	**0,015781**	21	13	0,046125
Bodily pain	417,5000	177,5000	86,5000	1,77192	0,076408	1,81471	0,069569	21	13	0,076194
General Health	451,5000	143,5000	52,5000	2,97683	0,002913	2,99196	**0,002772**	21	13	0,002084
General Physical Health	471,0000	124,0000	33,0000	3,66788	0,000245	3,67576	**0,000237**	21	13	0,000097

Vitality	471,5000	123,5000	32,5000	3,68560	0,000228	3,71322	**0,000205**	21	13	0,000080
Social Functioning	466,0000	129,0000	38,0000	3,49069	0,000482	3,59696	**0,000322**	21	13	0,000241
Role Emotional	420,5000	174,5000	83,5000	1,87824	0,060349	2,00162	**0,045326**	21	13	0,059651
Mental Health	464,0000	131,0000	40,0000	3,41981	0,000627	3,43269	**0,000598**	21	13	0,000339
General Mental Health	479,0000	116,0000	25,0000	3,95139	0,000078	3,96018	**0,000075**	21	13	0,000019
AAQ II	271,0000	324,0000	40,0000	-3,41981	0,000627	-3,44946	**0,000562**	21	13	0,000339
Alcohol	340,5000	254,5000	109,5000	-0,95684	0,338649	-1,16212	0,245190	21	13	0,343598
SD	262,0000	333,0000	31,0000	-3,73876	0,000185	-3,74420	**0,000181**	21	13	0,000066
IR	306,5000	288,5000	75,5000	-2,16175	0,030638	-2,16589	**0,030320**	21	13	0,029196
SR	280,0000	315,0000	49,0000	-3,100	0,001930	-3,1156	**0,001835**	21	13	0,001368

				87		6				

Appendix H

If there is any difference between the indicators of mental health among offenders that were convicted for the first time and recidivists?

Mann-Whitney U Test (Data_EG) By variable Засудж повт Marked tests are significant at p <,05000

	Rank Sum - Group 1	Rank Sum - Group 2	U	Z	p-level	Z - adjusted	p-level	Valid N - Group 1	Valid N - Group 2	2*1sided - exact p
Somatization	442,5000	152,5000	91,5000	-0,50750	0,611805	-0,51576	0,606022	26	8	0,618489
Obsessive-compulsive	441,0000	154,0000	90,0000	-0,56840	0,569765	-0,57912	0,562512	26	8	0,590593
Interpersonal sensitivity	450,0000	145,0000	99,0000	-0,20300	0,839136	-0,20621	0,836630	26	8	0,857921
Depression	449,5000	145,5000	98,5000	-0,22330	0,823303	-0,23386	0,815090	26	8	0,826788
Anxiety	447,0000	148,0000	96,0000	-0,32480	0,745333	-0,34479	0,730251	26	8	0,765340
Hostility	451,5000	143,5000	100,5000	-0,14210	0,887001	-0,14620	0,883763	26	8	0,889273
Phobic	457,0000	138,0000	102,0000	0,08120	0,935283	0,08759	0,930204	26	8	0,952426
Paranoid	442,50	152,50	91,500	-	0,6118	-	0,6084	26	8	0,6184

Ideation	00	00	0	0,50750	05	0,51230	44			89
Psychotism	458,0000	137,0000	101,0000	0,12180	0,903058	0,14673	0,883347	26	8	0,920787
Physical Functioning	479,5000	115,5000	79,5000	0,99470	0,319884	1,04509	0,295981	26	8	0,326704
Role-Physical Functioning	444,5000	150,5000	93,5000	-0,42630	0,669890	-0,48891	0,624906	26	8	0,675867
Bodily pain	475,0000	120,0000	84,0000	0,81200	0,416793	0,86280	0,388250	26	8	0,436135
General Health	468,0000	127,0000	91,0000	0,52780	0,597639	0,53399	0,593346	26	8	0,618489
General Physical Health	473,5000	121,5000	85,5000	0,75110	0,452594	0,75891	0,447909	26	8	0,460210
Vitality	473,5000	121,5000	85,5000	0,75110	0,452594	0,75486	0,450336	26	8	0,460210
Social Functioning	485,5000	109,5000	73,5000	1,23830	0,215607	1,27034	0,203965	26	8	0,220402
Role Emotional	485,5000	109,5000	73,5000	1,23830	0,215607	1,37232	0,169963	26	8	0,220402
Mental Health	485,5000	109,5000	73,5000	1,23830	0,215607	1,24325	0,213778	26	8	0,220402

General Mental Health	486,0000	109,0000	73,0000	1,25860	0,208177	1,26004	0,207655	26	8	0,220402
AAQ II	440,5000	154,5000	89,5000	-0,58870	0,556064	-0,59210	0,553784	26	8	0,563261
Alcohol	466,0000	129,0000	93,0000	0,44660	0,655165	0,46994	0,638399	26	8	0,675867
SD	445,5000	149,5000	94,5000	-0,38570	0,699720	-0,38608	0,699436	26	8	0,705277
IR	427,5000	167,5000	76,5000	-1,11650	0,264210	-1,11975	0,262820	26	8	0,270129
SR	434,0000	161,0000	83,0000	-0,85260	0,393883	-0,85522	0,392433	26	8	0,412768

Appendix I

If there is a difference in indicators of mental and physical health among offenders on probation according to marital status?

Mann-Whitney U Test (Data_EG) By variable Marital status Marked tests are significant at p <,05000

	Rank Sum - p	Rank Sum - o	U	Z	p-level	Z - adjusted	p-level	Valid N - p	Valid N - o	2*1sided - exact p
Somatization	47,00000	31,00000	16,00000	0,24360	0,807541	0,24888	0,803456	7	5	0,876263
Obsessive-compulsive	44,50000	33,50000	16,50000	-0,16240	0,870991	-0,16502	0,868931	7	5	0,876263
Interpersonal sensitivity	38,00000	40,00000	10,00000	-1,21800	0,223226	-1,24438	0,213360	7	5	0,267677
Depression	44,50000	33,50000	16,50000	-0,16240	0,870991	-0,16871	0,866024	7	5	0,876263
Anxiety	45,00000	33,00000	17,00000	-0,08120	0,935283	-0,08436	0,932774	7	5	1,000000
Hostility	48,00000	30,00000	15,00000	0,40600	0,684744	0,41632	0,677179	7	5	0,755051
Phobic	39,50000	38,50000	11,50000	-0,97440	0,329860	-1,06148	0,288474	7	5	0,343434
Paranoid Ideation	45,00000	33,00000	17,00000	-0,08120	0,935283	-0,08251	0,934243	7	5	1,000000

Psychotism	45,00000	33,00000	17,00000	-0,08120	0,935283	-0,09686	0,922838	7	5	1,000000
Physical Functioning	50,00000	28,00000	13,00000	0,73080	0,464903	0,78638	0,431646	7	5	0,530303
Role-Physical Functioning	53,00000	25,00000	10,00000	1,21800	0,223226	1,45288	0,146257	7	5	0,267677
Bodily pain	46,50000	31,50000	16,50000	0,16240	0,870991	0,17405	0,861828	7	5	0,876263
General Health	43,00000	35,00000	15,00000	-0,40600	0,684744	-0,40815	0,683167	7	5	0,755051
General Physical Health	50,50000	27,50000	12,50000	0,81200	0,416793	0,81342	0,415977	7	5	0,431818
Vitality	52,00000	26,00000	11,00000	1,05560	0,291153	1,05931	0,289460	7	5	0,343434
Social Functioning	37,00000	41,00000	9,00000	-1,38040	0,167466	-1,40264	0,160724	7	5	0,202020
Role Emotional	42,00000	36,00000	14,00000	-0,56840	0,569765	-0,68313	0,494525	7	5	0,638889
Mental	51,500	26,500	11,500	0,974	0,3298	0,9778	0,3281	7	5	0,3434

Health	00	00	00	40	60	2	63			34
General Mental Health	48,50000	29,50000	14,50000	0,48720	0,626118	0,49151	0,623063	7	5	0,638889
AAQ II	50,00000	28,00000	13,00000	0,73080	0,464903	0,73727	0,460958	7	5	0,530303
Alcohol	47,00000	31,00000	16,00000	0,24360	0,807541	0,25748	0,796810	7	5	0,876263
SD	50,50000	27,50000	12,50000	0,81200	0,416793	0,81342	0,415977	7	5	0,431818
IR	50,00000	28,00000	13,00000	0,73080	0,464903	0,73859	0,460159	7	5	0,530303
SR	46,50000	31,50000	16,50000	0,16240	0,870991	0,16297	0,870542	7	5	0,876263

Appendix J

If there are associations between crime gravity and problems in physical and mental health?

Spearman Rank Order Correlations (Data_EG) MD pairwise deleted Marked correlations are significant at p <,05000

	Offence gravity

Somatization	-0,240862
Obsessive-compulsive	0,104984
Interpersonal sensitivity	-0,208362
Depression	0,067376
Anxiety	0,026510
Hostility	0,053103
Phobic	0,053632
Paranoid Ideation	0,025196
Psychotism	-0,127394
Physical Functioning	-0,014274
Role-Physical Functioning	**0,476822**
Bodily pain	0,175496
General Health	-0,044871
General Physical Health	0,098542
Vitality	0,089184
Social Functioning	0,258196
Role Emotional	0,018205
Mental Health	0,168288
General Mental Health	0,149040
AAQ II	0,007351
Alcohol	-0,286511
SD	-0,109980
IR	-0,017292
SR	-0,067552