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Domestically and Generally Violent Forensic Psychiatric Outpatients

Personality Traits and Behavior

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A group of 63 domestically violent patients and a group of 103 generally violent patients at a Dutch forensic psychiatric outpatient clinic are examined with regard to personality traits and problem behaviors to develop treatment programs for domestically violent patients. The domestically violent patients are more unstable from a psychological viewpoint but not more inclined to anger than the average Dutch male. They report less anxiety in situations in which criticism can be given but more anxiety in situations in which someone can be given a compliment. When comparing domestically violent patients with generally violent patients, domestically violent patients score lower on anger as disposition and on aggressive behavior than the generally violent patients do. However, both groups do not differ from each other in their score on the dimension of psychopathy.

Keywords: *forensic psychiatry; domestic violence; personality traits*

It has only been in recent years that a policy has been conducted in the Netherlands whereby police or the judiciary forced offenders of domestic violence to be assisted or treated by social workers or ambulant forensic psychiatry. As a result, the number of domestically violent patients at forensic

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psychiatric outpatient clinics has increased so strongly that specific group treatments had to be developed for this target group (Warnaar & Wegelin, 2003). Because there is still a lack of insight into the dynamic criminogenic factors of Dutch domestically violent patients, these treatment programs have usually been composed on the basis of international publications.

Andrews and Bonta (2003) stated that a treatment program is only effective if it intends to change the dynamic criminogenic factors and if it considers the risk of recidivism of the participants. They stated that the following objectives were important for a treatment program: increasing emotional control, increasing prosocial skills, and reducing antisocial attitudes. With regard to the risk of recidivism, they were of the opinion that delinquents with a great risk of recidivism had to be offered a much more intensive program than delinquents with a low risk of recidivism.

A problem with the research on criminogenic factors is that concepts such as violence, aggressive behavior, and hostility are often used interchangeably in literature without any further description (Norlander & Eckhardt, 2005). In this article, aggressive behavior is taken to imply conduct causing (mental or physical) harm to others (Berkowitz, 1993). Violence is seen as a specific form of aggressive behavior that mainly involves the infliction of physical harm (Browne & Howells, 1996). With aggressive behavior, we make a distinction between reactively and proactively or instrumentally aggressive behavior (Dodge, 1991). Reactively aggressive persons were described by Dodge, Lochman, Harnish, Bates, and Petit (1997) as emotional, defensive, and hot-tempered, and proactively aggressive persons as calculating, offensive, and cold blooded. Anger and rage refer to emotions that are displayed as a reaction to an (alleged) provocation and that manifest themselves in behavior such as staring, talking loud, and standing too close. With hostility, we refer to the inclination to attribute negative intentions to others (Blackburn, 1993). A personality trait concerns one of the Big Five personality domains (Hoekstra, Ormel, & De Fruyt, 1996), whereas the term *psychopathy* refers to using others in an insensitive and unscrupulous way in combination with a chronic unstable and antisocial lifestyle (Hare, 1991). An antisocial or dependent personality disorder refers to classification on Axis II of the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition (*DSM-IV*; American Psychiatric Association, 1994).

There have been various international publications about the psychological characteristics of the population domestically violent offenders. A review of the literature about domestically violent offenders by Schumacher, Feldbau-Kohn, Slep, and Heyman (2001) resulted in psychological risk

factors such as personality disorders, substance abuse, anger, hostility, lack of relation-specific assertiveness, and attitudes that excuse physical violence against a partner. Norlander and Eckhardt (2005) evaluated 33 studies through a meta-analysis and concluded that domestically violent offenders experienced more anger and hostility than nonviolent men with relational problems. However, Maiuro, Cahn, Vitaliano, Wagner, and Zegree (1988) found that there was no difference between domestically violent offenders and nondomestically violent offenders in anger and hostility, measured with the Buss-Durkee Hostility Inventory. Tolman and Bennett (1990) confirmed this conclusion—namely that domestically violent offenders have more problems with hostility and anger than nonviolent men but that they do not differ in this from generally violent men.

There are also indications that domestically violent offenders have a lack of social skills. According to Holtzworth-Munroe (1992) and Wilkinson and Hamerschlag (2005), these offenders often have problems with situations in which jealousy, control, power, intimacy, competence, and dependence play a great role, because they do not have the appropriate social or communicative skills. Maiuro, Cahn, and Vitaliano (1986) did not find any difference between a group of domestically violent offenders and a control group of nonviolent men with relational problems in limit-setting skills (e.g., refusing a request), but they found differences in approaching skills (e.g., making a request to someone). Tolman and Bennett (1990) are of the opinion that this in particular concerns problems with making requests in a noncompulsive way.

In international literature, there has been a much greater focus on the characteristics of different types of domestically violent offenders. For example, the study of Gottman et al. (1995) resulted in a distinction between Type 1 offenders, who are not only aggressive against their partner but also against others, and Type 2 offenders, who are almost only aggressive against their partner. The researchers did not only use self-report questionnaires but also registered overt behavior and physiological changes during a relational conflict. During the relational conflict the heartbeat of Type 1 offenders was reduced, whereas it increased with Type 2 offenders. Type 1 offenders did not show any anger or rage, whereas Type 2 offenders did. Tweed and Dutton (1998) further examined these two subgroups, which they referred to as “instrumental” (Type 1) and “impulsive” (Type 2). They found that Type 1 offenders in particular had an antisocial profile and Type 2 offenders had a more borderline profile on the Millon Clinical Multiaxial Inventory–II. As was the case in the study of Gottman et al. (1995), Type 1 offenders reported less anger and more physical violence than Type 2 offenders. A more recent study by Edwards, Scott, Yarvis, Paizis, and Panizzon (2003) compared

impulsive and instrumental domestically violent offenders. It showed that the first group had a borderline personality disorder relatively more often and the second group had an antisocial personality disorder relatively more often. The impulsive group had problems with assertiveness, the instrumental group with empathy.

Many authors advocated a classification according to three types instead of two. Saunders (1992), for example, makes a distinction according to "family-only," "emotionally volatile," and "generally violent" offenders; Holtzworth-Munroe and Stuart (1994) according to "family-only," "dysphoric/borderline," and "generally violent/antisocial" offenders; and Hamberger, Lohr, Bonge, and Tolin (1996) according to "nonpathological," "passive aggressive-dependent," and "antisocial" offenders. The "general violent" or "antisocial" domestically violent patients were in general the most violent type. Cavanaugh and Gelles (2005) summarized these typologies by referring to "low-risk," "medium-risk," and "high-risk" offenders, respectively, whereby they categorized Type II of Gottman et al. (1995) under the "medium-risk" and Type I under the "high-risk" offenders. Dutton (2006) noted that the high risk offenders also included men with psychopathic traits, who in particular used instrumental violence inside and outside the family.

The above-mentioned typologies do not correspond with the distinction between domestically violent offenders and generally violent offenders as made elsewhere in literature (e.g., Polaschek, 2006), where generally violent offenders are persons who have been sentenced for a nondomestically and nonsexually violent offense. However, generally violent patients as a rule also behave aggressively or violently against their partner. According to the above-mentioned typologies, all violent patients should actually be considered as domestically violent patients. In this article, we therefore describe domestically violent patients as the group of offenders who have been court-ordered to follow outpatient treatment because of a domestically violent offence; we also describe generally violent patients as the group of offenders who have been court-ordered to follow compulsory treatment because of a nondomestically and a nonsexually violent offence.

Recently, the psychological characteristics of Dutch forensic psychiatric patients who committed generally violent offenses have been examined. Hornsveld, Nijman, and Kraaimaat (2008) found that the scores of the outpatients differed from those of the average Dutch population on the Big Five personality domains neuroticism (higher), openness (lower), agreeableness (lower), and conscientiousness (lower). The patients scored higher on the disposition to anger than a norm group. They reported less social anxiety than a norm group in situations in which criticism can be given and more social

anxiety in situations in which you express your appreciation of another person. They also gave criticism significantly more often than the norm group, but they expressed their appreciation of others significantly less often.

For the further development of treatment programs for domestically violent patients, an explorative study was carried out on personality traits and problem behaviors of a group of domestically violent patients at a Dutch forensic psychiatric outpatient clinic. For this purpose, both the domestically and generally violent patients were first compared with norm groups. Based on literature, the above-mentioned study, and clinical findings, it was expected that the domestically violent patients would score higher than the norm group on neuroticism and anger as disposition. It was assumed that they would report less social anxiety and more frequently exhibited social skills than the norm group in situations where criticism can be given. In situations where someone can be complimented, they would report more social anxiety and less frequently exhibited social skills than the norm group. Next, a comparison was made between this group of domestically violent patients and a group of generally violent patients. It was expected that the first group would score lower on psychopathy and neuroticism but higher on agreeableness and conscientiousness. With regard to social anxiety and social skills in situations in which criticism or a compliment can be given, no differences between both groups were expected.

Method

Patients

The study was conducted among 63 domestically violent and 103 generally violent forensic psychiatric outpatients. The domestically violent patients had been court ordered to follow outpatient treatment because of domestic violence or had been referred to the outpatient center (Het Dok Forensic Psychiatric Outpatient and Daytreatment Center at Rotterdam) by the police as part of a municipal project aiming to stop domestic violence. In court-ordered patients, based on examination by a psychiatrist and/or psychologist, the judge had established a connection between a “deficient mental development or mental disorder” and the committed domestic violence. The average age of the domestically violent patients was 37.32 years ($SD = 11.55$; range = 19 to 60 years). Their main diagnosis was physical abuse of an adult on Axis I or an antisocial or dependent personality disorder on Axis II (American Psychiatric Association, 1994).

All generally violent outpatients were obliged to follow treatment, because the judge had established a connection between a “deficient mental development or mental disorder” and the committed nondomestic and non-sexual violence. The average age of the generally violent patients was 28.88 years ($SD = 8.87$; range = 19 to 56 years). Their primary diagnosis was an antisocial personality disorder on Axis II of the *DSM-IV* (American Psychiatric Association, 1994).

Measures

The Psychopathy Checklist–Revised (PCL-R; Hare, 1991; Dutch version: Vertommen, Verheul, De Ruiter, & Hildebrand, 2002) is a checklist with 20 items for measuring psychopathy with two factors: “callous and remorseless use of others” (Factor 1) and “chronically unstable and antisocial lifestyle” (Factor 2). Items are rated as follows: 0 = *does not apply*, 1 = *applies to some extent*, and 2 = *applies*. The PCL-R score of the domestically violent outpatients was determined on the basis of file study, whereas the PCL-R score of the generally violent outpatients was determined on a structured interview and file study as well.

The NEO Five Factor Inventory (NEO-FFI; Costa & McCrae, 1992; Dutch version: Hoekstra et al., 1996) has 60 items and measures the Big Five personality domains of neuroticism, extraversion, openness, agreeableness, and conscientiousness. Participants score the NEO-FFI on a 5-point Likert-type scale from *entirely disagree* to *entirely agree*. In a Dutch sample of 135 “normal” adults, test–retest reliabilities for the subscales after 6 months turned out to be .82, .87, .81, .75, and .80, successively.

The Zelf-Analyse Vragenlijst (ZAV; Van der Ploeg, Defares, & Spielberger, 1982) is a Dutch version of the Spielberger State-Trait Anger Scale (Spielberger, 1980). Ten trait items were used from this questionnaire to determine disposition to anger. Items have to be scored according to how one “feels on the whole” using a 4-point Likert-type scale: 1 = *entirely not*, 2 = *a bit*, 3 = *rather much*, and 4 = *very much*. Test–retest reliability for the 10 trait items was .78 in a sample of 70 “normal” Dutch adults.

The Aangepaste Versie van de Picture-Frustration Study (PFS-AV; Hornsveld, Nijman, Hollin, & Kraaimaat, 2007) is an instrument for measuring hostility. For this, patients have to write down their reactions to 12 pictures of ambiguous and provocative interpersonal situations. Answers are scored on a 7-point Likert-type scale, ranging from 1 = *not at all hostile* to 7 = *extremely hostile*. Cronbach’s α in this study was .76, test–retest reliability .66, and interrater reliability .77.

The Aggressive Vragenlijst (AVL; Meesters, Muris, Bosma, Schouten, & Beuving, 1996) is a Dutch version of Buss and Perry's (1992) Aggression Questionnaire with four subscales (i.e., Physical Aggression, Verbal Aggression, Anger, and Hostility). Participants have to score the 29 items using a 5-point Likert-type scale running from 1 = *entirely disagree* to 5 = *entirely agree*. Meesters et al. (1996) found a test-retest reliability of .76 in a sample of 71 Dutch university students. In this study, we used only the total score of the AVL.

The Novaco Anger Scale (NAS; Novaco, 1994) used in this study was a translation of a provisional version with 48 items in Part A and 25 items in Part B. Patients only have to complete Part A, where they indicate the extent to which an anger-inciting situation has a bearing on them. Items must be scored on a 3-point Likert-type scale: 1 = *never true*, 2 = *sometimes true*, 3 = *always true*. Cronbach's α of Part A was found to be .95, and test-retest reliability was found to be .85.

Patients evaluated 35 interpersonal situations in the Inventarisatielijst Omgaan met Anderen (IOA; Van Dam-Baggen & Kraaimaat, 2000; Inventory of Interpersonal Situations [IIS]; Van Dam-Baggen & Kraaimaat, 1999) in which they first have to indicate how much anxiety they would experience (social anxiety) in these situations and then how often they will actually perform the behavior described (social skills) if the situation arises. The five subscales in this questionnaire, both for social anxiety and social skills are the following: Giving Criticism, Giving Your Opinion, Giving Someone a Compliment, Making Contact, and Appreciating Yourself. In this study, only the subscales Giving Criticism and Giving Someone a Compliment were used, because it appeared from a previous study (Hornsveld, Nijman, & Kraaimaat, 2008) that only these subscales differentiate between violent patients and normals. Test-retest reliability of these subscales was studied in a group of 55 normal Dutch adults and appeared to be .84 and .55, successively, for the Social Anxiety subscales and .86 and .72, successively, for the Social Skills subscales.

Regarding personality traits, the scores on the NEO-FFI were compared with those of "men over the age of 17" from the norm group, derived from a broadly based population sample (Hoekstra et al., 1996). Both groups were also compared with a norm group of "randomly selected male residents of Leiden between the ages of 16 and 71" (Van der Ploeg et al., 1982) on disposition to become angry (ZAV Scale). The patients could be compared to a norm group ranging in age between 16 and 80 years, on the basis of reported problem behavior in the area of social anxiety and social skills (IOA; Van Dam-Baggen & Kraaimaat, 2000).

Procedure

The self-report questionnaires were administered individually to the domestically violent patients prior to or during the first part of their treatment program when no attention had yet been devoted to specific problem behavior such as aggressive behavior or limited social skills. The generally violent outpatients were measured individually before the start of their treatment program. Participation in the study was voluntary.

Results

Comparison With Norm Groups

Regarding the comparison of the patients with norm groups, the average scores of the patients on the NEO-FFI, ZAV, and IOA were compared (two-tailed) with the average scores of norm groups by means of one-sample *t* tests, during which a Bonferroni correction was applied for α (.05/9 comparisons = .006). Compared with the norm groups, the domestically violent patients only scored significantly higher on neuroticism [NEO-FFI: $t(62) = 3.90$; $p < .006$], lower on social anxiety in situations in which criticism can be given [IOA: $t(57) = -6.11$; $p < .006$] and higher on social anxiety in situations in which someone can be given a compliment [IOA: $t(57) = 2.88$; $p < .006$]. As expected, the generally violent patients scored significantly higher on neuroticism [NEO-FFI: $t(102) = 6.39$; $p < .006$], lower on agreeableness [NEO-FFI: $t(102) = -6.48$; $p < .006$], lower on conscientiousness [NEO-FFI: $t(102) = -3.16$; $p < .006$], and higher on anger as disposition [ZAV: $t(102) = 7.35$; $p < .006$] than the standard groups. The generally violent patients also reported less anxiety [IOA: $t(102) = -8.11$; $p < .006$] and more skills [IOA: $t(102) = 5.13$; $p < .006$] in situations in which criticism can be given.

Comparison Between Both Groups

For a comparison between the domestically violent and the generally violent outpatients, ANCOVAs were carried out, during which an age correction was made because of a significant average age difference between both groups [$t(164) = -5.31$; $p < .001$]. For the α , .004 was applied because of the number of comparisons (.05/14 comparisons = .004).

Contrary to expectations, the domestically violent patients only scored significantly lower on Factor 2 of the PCL-R, on anger as disposition and on aggressive behavior (measured with the AVL) than the generally violent

Table 1
Domestically Violent Outpatients Compared With Generally Violent Outpatients, Controlled for Age

Measurement Instruments	Factors or Subscales		Domestically Violent Outpatients (N = 63)		Generally Violent Outpatients (N = 103)		ANCOVA (F)	Age (F)
			M (SD)	M (SD)	M (SD)	M (SD)		
PCL-R	Total		17.18 (7.83)	19.24 (5.65)	$F(2, 163) = 2.75$	$F = 1.98$		
	Factor 1		9.57 (4.63)	10.15 (3.38)	$F(2, 163) = 0.48$	$F = 0.18$		
	Factor 2		7.05 (3.78)	8.70 (3.36)	$F(2, 163) = 6.16^{**}$	$F = 4.43^*$		
NEO-FFI	Neuroticism		33.30 (7.53)	34.70 (8.10)	$F(2, 163) = 1.59$	$F = 1.94$		
	Agreeableness		41.46 (5.13)	38.74 (5.89)	$F(2, 163) = 5.54$	$F = 1.84$		
	Conscientiousness		44.16 (5.48)	43.36 (6.23)	$F(2, 163) = 0.71$	$F = 0.71$		
ZAV	Disposition		18.22 (6.44)	22.95 (7.61)	$F(2, 163) = 8.28^{**}$	$F = 0.00$		
	Total		30.19 (5.87)	34.34 (11.44)	$F(2, 163) = 4.66$	$F = 3.40$		
	Total Part A		81.07 (20.10)	94.39 (19.70)	$F(2, 163) = 8.27^{**}$	$F = 0.27$		
PFS-AV	Total		83.95 (15.26)	94.19 (20.32)	$F(2, 163) = 5.38$	$F = 0.08$		
	AVL		14.43 (5.44)	14.51 (5.11)	$F(2, 158) = 0.79$	$F = 1.58$		
	IOA Social anxiety		6.75 (3.67)	6.09 (2.74)	$F(2, 158) = 1.86$	$F = 2.25$		
NAS	Giving Criticism		20.23 (5.58)	20.99 (5.31)	$F(2, 158) = 0.93$	$F = 1.22$		
	Giving Someone a Compliment		15.43 (3.00)	14.84 (3.64)	$F(2, 158) = 1.25$	$F = 1.53$		
	Giving Criticism							
IOA Social skills	Giving Criticism							
	Giving Someone a Compliment							
	Giving Criticism							

Note: PCL-R = Psychopathy Checklist-Revised; NEO-FFI = Five Factor Inventory; ZAV = Zelf-Analyse Vragenlijst; PFS-AV = Aangepaste Versie van de Picture-Frustration Study; AVL = Agresie Vragenlijst; NAS = Novaco Anger Scale; IOA = Inventarisatielijst Omgaan met Anderen. Five domestically violent patients were omitted to complete the IOA.

* $p < .05$. ** $p < .004$. (two-tailed)

patients. There was a trend toward a higher score on agreeableness ($p = .005$) and a lower score on aggressive behavior measured with the NAS ($p = .006$). Both groups did not differ significantly from each other in scores on social anxiety and social skills in situations in which criticism can be given and in situations in which someone can be given a compliment (Table 1).

For a further analysis, the PCL-R Total Score was correlated with the score on the self-report questionnaires. With the domestically violent patients a significant negative correlation ($-.35$; $p < .05$) was established with social anxiety in situations in which criticism can be given (IOA). With the generally violent patients a significant negative correlation ($-.21$; $p < .05$) was established with agreeableness (NEO-FFI) and a significant positive correlation ($.23$, $p < .05$) with social skills in situations in which criticism can be given (IOA).

Discussion

Domestically violent patients at a Dutch forensic psychiatric outpatient clinic were more unstable from a psychological viewpoint but not more inclined to anger than the average Dutch person. They tend to give criticism easier but find it difficult to give compliments. With regard to social skills, the domestically violent patients do not differ from the average Dutch person. Compared with the generally violent patients, the domestically violent patients scored lower on anger as disposition and on aggressive behavior than the generally violent patients. With the domestically violent patients, psychopathy was negatively related to social anxiety in situations in which criticism can be given; with the generally violent patients, there was a negative correlation between psychopathy and agreeableness and a positive correlation between psychopathy and giving criticism. Both groups did not differ in their total score on the dimension of psychopathy measured with the Psychopathy Checklist-Revised. Hildebrand, Hesper, Spreen, and Nijman (2005) found that the PCL-R predicts recidivism just as well as the Historical, Clinical, and Risk Management (HCR-20; Webster, Douglas, Eaves, & Hart, 1997).

The results of this study must be interpreted with the necessary caution, especially because self-report questionnaires were used. These instruments have as a disadvantage that scores can be influenced by the tendency to give socially required answers (Bech & Mak, 1995) and by the limited understanding of the respondents of their own social functioning (Hollin & Palmer, 2001). A second limitation of the results is that the used questionnaires were not designed for relation-specific behavior. Domestically violent

patients might differ more from norm groups in social anxiety and social skills if a questionnaire had been used with relation-specific situations instead of the IOA. Third, the investigated groups of patients were not representative for domestically and generally violent patients at a forensic psychiatric outpatient clinic. It mainly concerned patients who were indicated for a cognitive-behavioral treatment program.

There are indications for a relation between psychopathy and the form of the displayed aggressive behavior (Blair, 2001). For example, Cornell et al. (1996) found that delinquents with a low score on psychopathy displayed relatively more reactively aggressive behavior and that delinquents with a high score on psychopathy displayed relatively more proactively aggressive behavior. Hornsveld, Hollin, Nijman, and Kraaimaat (2007) found that for patients with a low psychopathy score, aggressive behavior is positively related to social anxiety and negatively related to social skills. In patients with a high score on psychopathy, this connection was not found.

Psychopathy does not only seem to be related to the form but (as operationalization of risk of recidivism) also to the diversity of the displayed violent behavior. According to Cavanaugh and Gelles (2005), domestically violent offenders with a high risk of recidivism also commit other violence than domestic violence, and according to Hanson and Bussière (1998), sexually violent offenders with high risk of recidivism also commit other violence than just sexual violence. This means that violent offenders with a high risk of recidivism display different forms of violent behavior in different situations. Therefore, it is probably fairly arbitrary whether they come into conflict with the law because of domestically, sexually, or generally violent behavior.

The number of investigated domestically violent patients was too small to examine whether patients with a low score on psychopathy displayed reactively aggressive behavior relatively more often and patients with a high score on psychopathy displayed proactively aggressive behavior relatively more often. In addition, the number of patients with a PCL-R score of 26 or higher (in Europe, the cutoff score for being a psychopath or not) was too small both in the group of domestically violent patients and in the group of generally violent patients to be able to draw a well-considered conclusion about possible agreements between domestically and generally violent psychopaths.

For the time being, we think that it is advisable to base the treatment program to be followed by domestically violent patients on the dimension of psychopathy as an indication of recidivism risk and not on a typology. Possibly, domestically violent patients with a low psychopathy score have to follow a relatively short program, aimed at reducing reactively aggressive

behavior in relation-specific situations. On the other hand, domestically violent patients with a high psychopathy score must be obliged to follow an intensive program for generally violent patients for the reduction of aggressive behavior inside and outside the home. More research in a larger group of domestically violent patients is necessary to examine whether empirical support can be found for differentiation in treatment programs as proposed here. However, such a differentiation is only possible with a thorough (risk) assessment prior to the indication. Unfortunately, this is not yet common practice in the Netherlands.

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