

Running head: NATIVE AND NON-NATIVE VIOLENT MALE ADOLESCENT OUTPATIENTS

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An evaluation of behavioural and personality differences between native and non-native male adolescents in the Netherlands ordered into treatment in a forensic psychiatric outpatient clinic, and their non-violent peers.

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Abstract

Background: *In a previous study of the dynamic criminogenic needs of violent outpatients we did not differentiate between native and non-native adolescents, but differences between personality traits and problem behaviours may require adaptations to any treatment programme.*

Aim: *To compare, in the Netherlands, native and non-native adolescents with and without a violence history on personality traits and problem behaviours.*

Methods: *Forty-eight native and 71 non-native violent male adolescents were recruited from consecutive referrals to a forensic outpatient clinic after a violent offence and compared with randomly selected male youths in secondary vocational schools, but without a violent history, 82 of whom were from Dutch and 79 from non-Dutch descent. Each took part in an individual interview to complete a range of personality and behavioural rating scales.*

Results: *Native and non-native adolescent outpatients did not differ from each other on any measure. Overall, the outpatients scored higher than the students on hostility but not aggressive behaviour, but there were differences within the student group according to descent, with the native students having higher on agreeableness scores and lower hostility and aggressive behaviour scores than the students of non-Dutch descent.*

Conclusion: *Our study suggested that any differences in behavioural or personality traits seen in the general adolescent population according to descent are not reflected in a violent offender group of similar age. It therefore seems unlikely to be necessary to run different treatment programmes for native and non-native adolescent offenders.*

Key words: forensic psychiatry, violent adolescents, dynamic criminogenic needs, country of birth

INTRODUCTION

In the absence of a treatment programme for violent forensic psychiatric inpatients with an antisocial personality disorder in the Netherlands, in 2001, we developed the Aggression Control Therapy (ACT; Hornsveld, Nijman, Hollin, & Kraaimaat, 2007a), based on Goldstein Glick, and Gibbs' (1998) Aggression Replacement Training. Forensic psychiatric patients in the Netherlands are defined as offenders for whom the court has established a connection between a psychiatric disorder on the one hand and a felony on the other. This ruling is based on an evaluation by a psychiatrist and/or psychologist.

Although originally meant for inpatients, after some time ACT was also made available to the increasing number of violent offenders with a conduct or an antisocial personality disorder who were referred to our outpatient clinic for obligatory treatment. Early evaluation of the therapy indicated that those outpatients receiving it reported significantly less aggressive behaviour at the end of the therapy, while they did not change during the waiting list condition (Hornsveld, Nijman, & Kraaimaat, 2008)..

Especially in the four largest Dutch cities, the composition of the population has changed, mainly since the arrival of immigrants in the seventies from Surinam, Netherlands Antilles, Turkey, Morocco and Cape Verdi. As a result, an increasing number of violent adolescents of non-Dutch descent (second generation) are referred to a forensic psychiatric outpatient clinic for compulsory treatment. Junger-Tas (1997) concluded that in the Netherlands "members of minority groups are overrepresented among offenders and that disparities result in part from behavioural differences when they find themselves in the criminal justice system" (p. 259). In addition, our clinical impression was that adolescent outpatients differed in their presentation: native outpatients could admit in general that they had anger problems, while most non-native outpatients denied that they feel socially incompetent.

Andrews & Bonta (2003) have developed the concept of dynamic criminogenic needs; these

include a history of antisocial behaviour, antisocial personality pattern and substance abuse. Such needs were studied recently among Dutch populations, including adolescent offenders. Vreugdenhil (2003), for example, studied 204 offenders between 12 and 18 years old and diagnosed conduct disorders in three-quarters of them, and substance abuse in 55%. Most of these youths (63%) had committed a non-sexually violent crime and ethnic minorities were overrepresented with 24% Surinamese boys, 4% Antilleans, 22% Moroccans, 7% Turks, and 19% boys with another ethnicity. Bulten (1998) carried out a study among a group of 200 Dutch male adolescent detainees. About one third of them were violent offenders between 18 and 24 years old. Substance abuse was established in 75% and an antisocial personality disorder in 42% of the detainees. Compared to the general Dutch population, the adolescent detainees were more emotionally unstable, more extravert, more hostile and more dominant. They also had a greater need to seek thrills.

A few studies have also been carried out on the prevalence of crime among related populations of Dutch adolescents of different ethnicity. For example, on the basis of officially registered crime, self-report research and victim studies Junger et al (2001) found that non-native adolescents, on average, displayed more serious and violent criminal behaviour than native Dutch youths. They found that the same factors contributed to an increased risk of recidivism for native and non-native adolescents, that is to say, socioeconomic status, age, place of residence, home situation, behavioural problems at school, religiosity and leisure activities. However, these risk factors contributed in a different degree to an increased risk of recidivism according to ethnic group. Growing up in a single-parent family, for example, was related to violent behaviour with Surinamese, but not with native Dutch, Moroccan and Turkish adolescents.

Blom et al (2005) investigated a group of 163,000 persons who, in 2002, were registered with the police as a suspect in a criminal investigation. Of these suspects, 37.5% were of non-native origin. Non-native youths were registered more frequently as a suspect than native

youths. In particular Antilleans and Moroccans between 12 and 17 years old were suspected of 3.5 times as many violent offences as native youths. A national study among non-criminalised students of 12 to 20 years old revealed that the use of violence is frequent among them (Junger et al, 2001). Among students too, non-native boys were involved more frequently in violence than native boys. Of the native boys 24% indicated that they had used physical violence in the last 12 months, but among Surinamese boys this was 37%, among Antillean boys it was 40%, among Turkish boys 41% and among Moroccan boys 48%.

In our previous study of violent outpatients, we did not differentiate between adults and adolescents or between patients of native and non-native descent (Hornsveld et al, 2008). It may be, however, that there are differences in personality traits and problem behaviours between these groups, which may indicate different dynamic criminogenic needs possibly leading, in turn, to the necessity for modifications of targeted treatment programmes.

Our aim in this study, therefore, was to explore the traits and behaviours of native and non-native male adolescents on a forensic psychiatric outpatient clinic, and compare those with native and non-native adolescents at a similar level of education but who were not violent offenders. For these purposes, we defined adolescents as people of 15 to 21 years old. Non-native adolescents are defined as youngsters who are born in the Netherlands and who have at least one parent who was born in Surinam, the Dutch Antilles, Turkey, Morocco or Cape Verde, and were immigrants from there. Our hypothesis was that there would be different patterns of problem behaviour and adverse personality traits among the native and non-native patients, and thus that patients from each group could differ from their native and non-native community peers in different ways.

METHOD

Participants

One hundred and nineteen violent male adolescents were recruited from consecutive

referrals for compulsory treatment in a forensic psychiatric outpatient clinic in Rotterdam and 161 male students without such a criminal record were randomly selected from secondary vocational schools. In the Netherlands, the court can require offenders to undergo outpatient treatment as (a) an added condition with punishment for offences to which imprisonment for three years or less applies, (b) an alternative to punishment for offences to which an imprisonment for six months or less applies, (c) part of a penal programme, and (d) while under supervision by a youth protection agency.

Measures

Measurement instruments were chosen according to whether a reliable and valid Dutch version was available and whether they had been designed or validated which for persons of 15 years or older.

The *Psychopathy Checklist-Revised* (PCL-R: Hare, 1991; Dutch version: Vertommen, Verheul, De Ruiter, & Hildebrand, 2002) is a checklist for measuring psychopathy and is completed on the basis of a structured interview and file study. The checklist has two factors: “callous and remorseless use of others” (Factor 1) and “chronically unstable and antisocial lifestyle” (Factor 2). We scored the PCL-R for patients younger than 18 according to the instructions of Forth et al (1990).

The *NEO-Five Factor Inventory* (NEO-FFI: Costa & McCrae, 1992; Dutch version: Hoekstra et al, 1996) is a 60-item, self-report measure of the Big Five personality domains of neuroticism, extraversion, openness, agreeableness, and conscientiousness.

The *Zelf-Analyse Vragenlijst* (ZAV: Van der Ploeg et al, 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.

The *Aangepaste Versie van de Picture-Frustration Study* (PFS-AV: Hornsveld et al, 2007b) 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 by a research assistant on a seven-point Likert scale, ranging from 1 = "not at all hostile" to 7 = "extremely hostile."

The *Agressie Vragenlijst* (AVL: Meesters et al, 1996) is a Dutch version of Buss & Perry's (1992) Aggression Questionnaire with 29 items that measure various types of aggressive behaviour, i.e. physical aggression, verbal aggression, anger, and hostility.

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 had to complete part A on situation specific anger.

The *Inventarisatielijst Omgaan met Anderen* (IOA: Van Dam-Baggen & Kraaimaat, 2000; IIS: Van Dam-Baggen & Kraaimaat, 1999). Patients evaluate 35 interpersonal situations, indicating how much anxiety they would experience (social anxiety) in these situations and then how often they would actually perform the behaviour described (social skills) if the situation occurred. The five subscales in this questionnaire, for both social anxiety and social skills, are: 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, since it appeared from a previous study (Hornsveld, 2005) that only these subscales differentiate violent patients from healthy comparison subjects.

Procedure

The questionnaires were submitted individually to the outpatients prior to the Aggression Control Therapy. The outpatients received a fee of € 5 for this. The students completed the

questionnaires in class and received a fee of € 10.

RESULTS

General characteristics

The average age of the violent adolescents was 16.93 years ($SD = 1.48$; range 15-20 years). N (40.3%) were native and n (59.7%) were non-native. In Rotterdam about 50% of all residents are of non-Dutch descent. Most of the patients were still in secondary vocational education. All had a main diagnosis of (oppositional-defiant) conduct disorder on axis I or, if they were 18 years or older, an antisocial personality disorder on axis II of the DSM-IV (American Psychiatric Association, 1994). These classifications were not only based on the psychiatric and/or psychological evaluation on which the court had decided to forensic psychiatric treatment, but also on the evaluation of an experienced clinical psychologist during the intake interview. During the study there was only one forensic psychiatric outpatient facility at Rotterdam, so we made the assumption that this studied group of adolescent outpatients is representative of the wider population of violent adolescents who are referred to a forensic psychiatric outpatient clinic for obligatory treatment in a major Dutch city.

The students attended schools for secondary vocational education in Rotterdam. Their average age was 17.35 years ($SD = 1.08$; range 16-20 years). They were, therefore, significantly older as a group than the offender-patients ($F(3,276) = 5.45$; $p < 0.001$). N (50.9%) were native and n (49.1%) were non-native. Patients and students were subdivided into four subgroups: (1) native patients ($n = 48$), (2) non-native patients ($n = 71$), (3) native students ($n = 82$) and (4) non-native students ($n = 79$). The subgroups were compared with each other through ANCOVA's, because of the age differences. Considering the number of comparisons, a Bonferroni correction was applied with $\alpha = 0.004$ ($0.05 : 13$ comparison). When these ANCOVA's resulted in an interaction effect and subgroups were compared with each other, 0.006 was applied for the α ($0.05 : 8$ comparisons).

Personality traits

No significant major differences were found between the native and non-native patients on the NEO-FFI domains of neuroticism, agreeableness or on anger as a trait (ZAV). When comparing the native patients with native students, the native patients scored significantly higher on the disposition towards anger [ZAV: $F(2,127) = 6.07$; $p < 0.006$], and significantly lower on agreeableness [NEO-FFI: $F(2,158) = 12.59$; $p < 0.006$].

Insert Table 1 about here

Problem behaviours

When comparing the patients with the students, a significant major effect was established on hostility (PFS-AV). The patients scored higher on this than the students. Compared with the students, the patients reported significantly less social anxiety (IOA Social anxiety) and in situations where a compliment can be made. In addition, they also reported more social skills (IOA Social skills) in situations where criticism can be given. When comparing native adolescents with non-native adolescents, a main effect was that the native patients reported significantly more social skills (IOA Social skills) than the non-native patients in situations where someone can be made a compliment.

Again, no significant differences were found between the native and non-native patients on any measure. The native patients scored higher on hostility [PFS-AV: $F(2,127) = 21.17$; $p < 0.006$] and on the social skill giving criticism [IOA Social skills: $F(2,127) = 6.46$; $p < 0.006$] than the native students. A comparison of the non-native patients with the non-native students resulted in a significantly lower score on anger [NAS: $F(2,147) = 5.70$; $p < 0.006$] for the non-native students. Compared with the non-native students, the non-native patients also reported, significantly less social anxiety [IOA Social anxiety: $F(2,147) = 11.28$; $p < 0.006$] and more social skills [IOA Social skills: $F(2,147) = 5.91$; $p < 0.006$] in situations

where someone can be given a compliment (Table 2).

Insert Table 2 about here

When comparing the native students with the non-native students, it appeared that the native students scored significantly lower on hostility [PFS-AV: $F(2,158) = 7.30$; $p < 0.006$] and lower on aggressive behaviour [NAS: $F(2,158) = 7.41$; $p < 0.006$] than the non-native students. Compared with the non-native students, the native students also reported significantly less social anxiety [IOA Social anxiety: $F(2,158) = 7.88$; $p < 0.006$] and more social skills [IOA Social skills: $F(2,158) = 18.50$; $p < 0.006$] in situations where someone can be given a compliment.

DISCUSSION AND SUMMARY

Against prediction, there were no significant differences between the native and non-native patients in any of the problem behaviours or personality traits measured. There were, however, some differences between native and non-native students, generally in the direction of the native students being more sociable (more agreeable, and with less social anxiety and more social skills than the non-natives). This latter finding may be explained by the low socioeconomic status of the non-native students compared with the native students, and most immigrants in the Netherlands fall into the lower socioeconomic groups (Hawkins, Laub, & Lauritsen, 1998; Junger-Tas, 1997).

Overall, the outpatients scored higher on hostility, although not aggressive behaviour, than the students and also indicated that they experienced less anxiety in situations where criticism can be given. These findings suggest that a cognitive-behavioural treatment programme should focus on managing hostility and improving social confidence and skills, regardless of native or non-native status. A comparison between the native and non-native students revealed that the native students scored higher on agreeableness, lower on hostility

and lower on aggressive behaviour than the non-native students. Therefore, we advocate cognitive-behavioural programmes such as Aggression replacement Training (Goldstien, Glick, & Gibbs, 1998) or Aggression Control Therapy (Hornsveld, Nijman, & Kraaimaat, 2008) for students on at those schools (natives and non-natives) who have anger control problems or who lack adequate social skills.

Differences elicited between native patients and students compared with the differences between non-native patients and non-native students reflect the differences among the students. Native patients were more angry, hostile and critical than native students, but non-native patients were more agreeable and less aggressive than non-native students. Perhaps there is a higher threshold for taking native adolescents into compulsory treatment than there is for non-native adolescents. It has also been suggested that non-native patients cope with the criminal justice system by making a favourable impression on the officials or professionals they have to deal with (e.g. Kayser, 1999).

There were a number of limitations on our study. First, the data from the patients were obtained during a base-line evaluation trial of a cognitive-behavioural group therapy, and mainly self-report questionnaires were used. This may have biased responses, for example if the participants thought they had to present themselves in certain ways in order to be able to show benefit from the treatment programme. Alternatively, they may have preferentially chosen socially desirable answers (Bech & Mak, 1995) or had a limited understanding of their own behaviour by the investigated persons (Hollin & Palmer, 2001). If so, within the patient group at least, any biases seem to have been operating in the same direction for the native and non-native participants. A second limitation was that this evaluation was not primarily designed to investigate dynamic *needs*, and extrapolation from self-reported behaviour or personality traits may not be entirely justified. Again, however, this problem would have affected native and non-native participants equally. Thirdly, the non-native patients came from different ethnic population groups, individually too small for separate

analysis. It may be that some features which would have potentially distinguished the native and non-native participants cancelled each other out within the over-arching non-native grouping.

We came to the preliminary conclusion that different treatment programmes for native and non-native violent outpatients are not necessary, since we did not find any differences in traits and behaviours between native and non-native outpatients. However, it is in our opinion still advisable to pay special attention to the influence of ethnic and cultural factors on need for treatment during intake interviews with violent adolescents (Borra et al, 2002).

Information from the intake interview will make a more individual approach possible for each patient if necessary.

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Table 1. Comparisons of traits between patients with students and native with non-native adolescents, controlled for age.

Measurement instruments	Factors or subscales	Native persons (N = 130)	Non-native persons (N = 150)	ANCOVA (F)			
		M (SD)	M (SD)	Patients (N = 119) vs. students (N = 161)	Native (N = 130) vs. non-native adolescents (N = 150)	Interaction	Age
PCL-R	Psychopathy				0.04		0.13
	Patients	18.72 (5.55)	18.40 (5.86)				
	Use of others				3.46		0.58
	Patients	9.26 (3.14)	10.40 (3.47)				
	Antisocial lifestyle				5.19*		0.05
	Patients	9.09 (2.86)	7.73 (3.14)				
NEO-FFI	Neuroticism			0.48	0.05	0.09	2.68
	Patients	30.05 (9.56)	29.58 (7.06)				
	Students	30.24 (7.42)	31.00 (6.72)				
	Agreeableness			0.97	0.61	10.60***	12.95***
	Patients	38.50 (4.88)	40.51 (4.59)				
	Students	40.86 (4.80)	38.14 (4.44)				
ZAV	Trait anger			4.28*	0.00	7.29**	0.75
	Patients	20.93 (7.78)	18.60 (6.43)				
	Students	17.06 (4.50)	19.33 (6.22)				

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.004$ (two-sided). Note: PCL-R = Psychopathy Checklist-Revised; NEO-FFI = NEO Five Factor

Inventory; ZAV = Zelf-Analyse Vragenlijst.

Table 2. Comparisons of problem behaviours between patients with students and native with non-native adolescents, controlled for age.

Measurement instruments	Factors or subscales	Native persons (N = 130)		Non-native persons (N = 150)		ANCOVA (F)			
		M (SD)	M (SD)	M (SD)	M (SD)	Patients (N = 119) vs. students (N = 161)	Native (N = 130) vs. non-native adolescents (N = 150)	Interaction	Age
PFS-AV	Hostility					10.14***	0.08	34.43***	0.30
	Patients	37.44 (12.41)	33.37 (11.06)						
	Students	27.28 (4.72)	30.65 (6.56)						
AVL	Aggression					1.62	0.66	5.03*	4.13*
	Patients	89.19 (22.20)	81.19 (17.77)						
	Students	80.70 (15.78)	84.70 (16.25)						
NAS	Anger					0.15	0.03	9.22***	3.68
	Patients	91.73 (18.09)	84.93 (19.17)						
	Students	85.85 (12.26)	93.04 (15.10)						
IOA, Social anxiety	Giving criticism					26.19***	1.54	1.19	0.21
	Patients	13.88 (6.11)	13.89 (5.65)						
	Students	16.43 (4.29)	18.00 (4.59)						
	Giving compliment					13.98***	5.58*	4.04*	0.71
	To patients	7.42 (3.95)	7.47 (4.22)						
	Students	8.23 (4.30)	10.57 (3.56)						
IOA, Social anxiety	Giving criticism					8.60***	0.93	4.04*	0.62

Patients	22.56 (5.22)	20.89 (5.49)				
Students	19.65 (3.78)	20.22 (4.41)				
Giving compliment			1.47	12.11***	13.01***	0.12
Patients	14.23 (3.42)	14.35 (3.58)				
Students	15.28 (2.68)	12.26 (3.52)				

* $p < 0.05$; ** $p < 0.01$; *** $p < 0.004$ (two-sided). Note: PFS-AV = Aangepaste Versie van de Picture-Frustration Study; AVL =

Aggressie Vragenlijst; NAS = Novaco Anger Scale; IOA = Inventarisatielijst Omgaan met Anderen.