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THE IMPORTANCE OF A CRIMINAL RECORD FOR INDIVIDUALS INVOLVED IN CRIMINAL ACTS PRODUCED BY VIOLENCE

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Abstract: Aggression is the manifestation of some type of intentional behaviour, aimed at harming another person or obtaining a tangible reward for the aggressor. Aggressive behaviour is often attributed to people with mental disorders or those with a criminal history. It is attempting to assign a substrate on which to graft such behaviour, although its aetiology is multifactorial and widely debated at the international level. Thus, to define the aetiology of aggression and to highlight the risk factors involved, we conducted a study on patients involved in violent criminal acts.

Material and method. We conducted a comparative study between two groups of people involved in criminal events using violence or an aggressive behaviour. One of the batches consists of 100 inmates who committed a criminal act through aggression, and the second batch consists of 100 people with psychiatric pathology who also committed a criminal act through aggression. The two groups included those with criminal records and those with no prior history of this nature. Both groups of people were examined with psychiatric forensic expertise. As a way of assessing aggressive behaviour and possible risk factors, we used the STAXI-2 (State Trait Anger Expression) and EPQ (Eysenck Personality Questionnaire) tools. The data obtained was analyzed using the SPSS platform, where we conducted comparative studies to highlight the differences between the frequencies of the samples.

Results. There are no major differences between the patients of the two groups in terms of gender distribution. The chi-square test (0.509; p=0.476) indicates that there are no statistically significant differences regarding the environment of origin of the two groups. The results obtained at those two evaluation instruments used to evaluate pathologic traits did not show an increased influence of the psychiatric pathology on presence of the aggressive behavior. Instead, both tests showed a correlation between the criminal record and the development of an aggressive behaviour. In this situation STAXI-2 showed a significative result related by p =0.011 for AX-I, p=0.012 for AC-O, p=0.007 for AC-I and p=0.008 for AX-I.

Conclusions. The impact of the criminal record on aggressive behaviour is more significant compared to the psychiatric pathology.

Keywords: Aggressive behaviour, criminal record, STAXI-2, EPQ.

INTRODUCTION

Aggressive behaviour is a destructive, intentional type of behaviour aimed at harming another person or causing material, psychological, or moral damage. There are various forms of aggression, ranging from violence, the most famous of which takes the form of domestic violence, to serious bodily injuries, robberies, rapes or even murders. These manifestations are often preceded by states of anger, threat, frustration or impulsivity, most of which occur amid a need for affirmation or revenge, externalized physically or verbally [1]. At the same time, any behaviour with aggressive implications is classified according to DSM-5 as a disorder of disruptive behaviour, impulse control and conduct [2].

The aetiology of aggression is still discussed, but according to the literature, it has been established that it is influenced by various factors, the most famous of which are genetic, biopsychosocial, educational, pathological, behavioural or criminal antecedents. Of these, we would like to emphasize the impact that criminal history has on the development of aggressive behaviour and whether the existence of a psychiatric

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pathology is able to influence such behaviour [3].

Aggressive behaviour can be present from birth and influenced positively or negatively throughout life depending on the experiences experienced. The existence of a criminal record could be a risk factor in the development of such behaviour [4].

One of the most important theories involved in the aetiology of aggressive behaviour is the biopsychosocial theory, which comprises a general system comprising macrosystems such as those at the molecular level and macrosystems represented by economic or political structures that influence human behaviour [5]. Biologically, there are already multiple theories that connect aggressive behaviour with certain biological changes. The most well-known of these are central nervous system disorders, especially those in the prefrontal area or metabolic disorders, especially those with cardiovascular impact, but also diseases with toxicological implications represented by alcohol consumption or nicotine exposure [6–8].

From a socio-cultural point of view, a study conducted in this regard by Streissguth, Barr, Kogan, and Bookstein [9] highlighted the importance of the social, family, and educational environment, but also of the experiences lived, especially of pathological or behavioural antecedents. Thus, attention is drawn to the external support provided by the family and the entourage, with the role of avoiding the development of aggressive behaviour or psychosocial dysfunction, on a pre-existing biological condition. Without such support, the consequences would most probably have been different in nature. Therefore, stable environments with moral, social and psychological support reduce the negative effects of a biological vulnerability that would predispose to aggressive behaviour [10]. A study conducted in England by Raine, Venables, & Williams in 1995 [3], demonstrated that an inappropriate environment with tendencies toward antisocial behaviour in adolescents inevitably leads to later criminal behaviour, but adolescents who were not exposed to an antisocial attitude did not develop such criminal behaviour. Another Dutch study conducted by Brennan in 1997 [11] found that young people from an inadequate social environment, through the fact that one parent has a criminal history, developed normal adult behaviour, although there was this risk factor, the protective role is represented by the autonomous capacity for reasoning, thinking and awareness [12, 13].

The way to assess aggressive behavior

The manifestation, expression, and control of anger as a predisposing factor of aggressive behaviour can be evaluated by using the anger expression inventory as a state and also as a STAXI-2 trait (State-trait anger expression inventory 2). This test was developed specifically to assess anger, anger expression, and how they contribute in association with other medical, psychiatric, or psychological disorders. The way to assess aggressive behaviour using this anger-focused tool is to use 57 items grouped on 6 scales, 5 subscales and an anger expression index, which provides an aggregate measurement of how to express and control anger. In relation to the validity of the test tool, it should be taken into account that the person examined answered the questionnaire applied on their own and that the responses may be influenced by certain external factors such as stressful events that have occurred in the last period, differences in the experimental expression of aggressive behaviour or adjusting responses so as not to be perceived as a violent individual [14].

Expressing and controlling anger are defined terms with four main components:

1. The external expression of anger (AX-O) involves the expression of it uncontrollably toward other people or objects in the person's environment. This expression can be outsourced verbally or physically by hostile or extremely violent actions. It targets both people and objects that are around the angry individual, whether or not they are related to the source that caused the condition. The higher the score on this scale, the more obvious the externalization of negative experiences will be.

2. The inner expression of anger, (AX-I) consists of anger directed inward – holding back or suppressing feelings of anger. These people usually suppress their feelings of nervousness, anger, and aggression so much that they end up with anxiety, self-blame, or even depression, generated by the statements of others about the causal event.

3. External Anger Control (AC-O) is based on controlling anger by preventing it from being expressed, both verbally and physically, to other people or objects in the environment. People with a high score on this scale are very psychologically preoccupied with preventing any externalization of anger or aggressive behaviour in order not to be perceived otherwise by the people around them. These people have associated emotional issues and awareness of their own feelings. A high score on this scale along with an average score on the AC-I scale characterizes a person who has an intense state or feeling of anger or nervousness, and yet turns to extremely strong self-control in order not to

exteriorize or manifest in front of others.

4. Internal Anger Control (AC-I) refers to the control of suppressed anger by inducing calmness or relaxation when this occurs [15].

Given the implications of this tool in the forensic field as well as in the psychiatric field, we opted for its application in this paper to people involved in aggressive behaviour in criminal events. Although Sttaxi-2 may not be the last available tool for measuring aggressive behaviour, it has ratings for all levels, including control. Each test has certain limitations, but I considered it to be the most complex, complete and applicable to the population of interest in the present study [16].

Another tool that can be used to evaluate psychopathological personality traits in adults is the Eysenck Personality Questionnaire (EPQ). This instrument uses a questionnaire with 106 items to be answered positively or negatively, providing at the end a detailed report used as the basis for interpreting the obtained scores. The structural scales of the EPQ are divided into main scales and secondary scales. The main scales include Neuroticism (N), Psychoticism (P) and Extraversion (E). Subscales include: Lying (L), Addiction (A), and Criminality (C).

Neuroticism (N) scale refers to the stability or instability of emotions. The scale itself has the role of identifying certain strong neurotic accents with emotional instability, embodied in pathology like depression, anxiety, or phobias, which require unconditional emotional support. So this scale evaluates the emotional disbalance of a person.

Psychoticism (P) as a scale, highlights a hardness in thinking with a lack of empathy for those around. Strictly related to the name of the scale, in term, it should not be confused with psychiatric symptomatology, within this test it represents a trait. A high score on this scale defines a person who does not integrate, does not adapt, is lonely, lacking feelings, empathic, insensitive with an increased degree of hostility towards others.

Extraversion (E) is a scale that differentiates between the introvert and the extrovert being the extreme limits of the scale's assessment, as any person must and does fall somewhere between the two extremes. A high score on this scale describes the "typical" extrovert as a dynamic, sociable person who needs other people to feel at ease, does not like solitude, likes risk, loves fun, is funny, resourceful, but he has a tendency for aggression, quickly losing his temper and patience, which is why he is not always a responsible person. At the opposite pole is the introvert [17].

The scale represented by Lie (L) has the role of evaluating the individual's tendency to distort the responses of the instrument, being an extremely important scale, by making the difference between a real or a projected image of the evaluated person. Addiction (A), that scale of the instrument that highlights behaviors related to dependence on certain substances or some excessive behaviors. The Crime Scale (C) is a predictor of criminality and recidivism. By combining the results of this scales, we can extract some ideas about the aggressive behaviour, psychological well-being, or some psychotic traits of a person. This tool for measuring psychopathological traits is frequently used in prisons as a means of monitoring recidivism [18].

Forensic psychiatric expertise

Aggressive behaviour resulting from traumatic wounds is the most common form of forensic examination. The vast majority of people involved in an aggression event are subsequently directed by the prosecution bodies to a forensic institution. Most of the time, the injured persons turn to the assessment of traumatic injuries, and the aggressors establish the psychic capacity within psychiatric forensic expertise.

Forensic psychiatric expertise is the forensic tool at the disposal of the legal institution through which one can establish the psychic capacity of a person and implicitly the legal responsibility [19]. Therefore, the two notions of psychic capacity and legal responsibility are closely connected and interconnected. Legal responsibility is defined as the ability of a person to assume the obligations arising from the Commission of an unlawful act, which infringes the rules of law, with the consequence of applying a legal sanction in relation to his prohibited actions or inactions, over which he could decide freely, without constraint, representing the social-negative or anti-legal consequences of them. Whereas the mental capacity of the person in criminal cases is interpreted in the form of discernment, medically catalogued as being the possibility of conceiving the plan of action, its stages of development, as well as awareness of the consequences of its perpetration. In this regard, people who have aggressive behaviour fall within this description and a possible causal link between the committed act and a possible pathological disorder of a psychiatric nature must be established. Among mental pathologies that are a risk factor in the development of aggressive behaviour, we mention schizophrenia, bipolar disorder, borderline disorder or addictions. The existence of a criminal record can be

an additional risk factor in the onset or worsening of aggressive behaviour [20].

MATERIAL AND METHOD

This study included the assessment of two groups of patients implicated in aggressive events. The first batch of 100 patients with diagnosed psychiatric pathology, involved in violent aggression events, was evaluated within a psychiatric forensic expertise.

Inclusion criteria for patients in this group:

- involvement in an aggression caused by violence

-Psychiatric diagnosis according to the diagnostic criteria ICD-10 and DSM V;

-Age 18-70 years;

-Evidence of informed consent.

Exclusionary criteria for patients in this group:

-Refusing to participate.

-Engaging in an event where there is no violence.

-Absence of diagnosed psychiatric pathology.

-Neurological pathology.

The second group of 100 patients without a diagnosed psychiatric condition involved in violent aggression events, that were also evaluated within a psychiatric forensic expertise.

Inclusion criteria for patients in this group:

- Involvement in an aggressive event produced by violence.

-Assessment in a legal or court establishment.

-Age 18-70 years.

-Evidence of informed consent.

Exclusionary criteria for patients in this group:

-Refusal of participation.

-Engaging in an event that does not involve violence.

-The presence of diagnosed psychiatric pathology.

The data of the study were collected at the time of the psychiatric forensic expertise and were considered to analyze the educational level, age, addictions, background, marital status or family impact, data which were corroborated with the criminal history of the two groups. The evaluation of aggressive behaviour was made by using the Staxi-2 and EPQ questionnaires with the expression of major components related to the existence of a criminal history. The statistical analysis was performed with the help of the SPSS program, using the t-test for independent group samples and the χ^2 .

RESULTS

To verify the equivalence of the two groups of subjects, the distributions of the variables related to the demographic characteristics of the samples included in the study were analyzed. Regarding the gender distribution, the patients with psychiatric pathology and the control group without psychiatric pathology are comparable in terms of male to female ratio. The chi-square test was applied to determine whether the groups were equivalent with a value of $\chi 2 = 1.45$. There are no differences between the patients of the two groups in terms of gender distribution, the patients in the study group and those in the control group are compatible in terms of the male/female ratio.

The minimum age in both groups is 20 years and the maximum age in the case of the group without psychiatric pathology is 67 years, respectively 74 years in the case of the group with psychiatric pathology. The average age is 41 (40.8) years in the case of the group without psychiatric pathologies and 45 in the case of the group with psychiatric pathologies. As for the distributions of the two groups, they present the characteristics of a normal within the statistically accepted limits of ±1.96. Levene's test of equality of variances indicates a coefficient of 1.606 at a significance threshold of 0.207. This result indicates the absence of statistically significant differences in the variance of the two groups, the means being also very close. Thus, an equivalence can be concluded on those two groups from the perspective of age.

The frequency data indicates the share of the rural environment in the case of 41% of the subjects without psychiatric pathology and 46% of those with psychiatric pathologies. The urban environment predominates in 59% of subjects without psychiatric pathology and 54% in those with psychiatric pathology. The chi-square test (0.509; p=0.476) indicates that there are no statistically significant differences regarding the environment of origin of the two groups.

Just by assessing the aggressive behavior between the two study groups, using STAXI-2 and EPQ there were no statistically significant differences between the means of the instruments results. Which underlines the fact that psychiatric pathology does not have an extreme role in determining aggressive behavior. Even if there were no statistically significant differences, we must mention the fact that there is a tendency for higher means in the case of people with psychiatric pathology for each scale of those two instruments. Thus, for the Staxi-2, in the group with psychiatric

pathology, an increase in the scales represented by the feeling of anger, verbally expressed anger, external control of anger and implicitly the general index of aggression was highlighted. And for the EPQ of the scales represented by neuroticism, psychoticism and crime. However, these variations were not sufficient to make a correlation between aggressive behavior and psychiatric pathology.

Regarding aggressive behavior according to criminal history data indicates the trend of higher means in the case of persons with a criminal record in both groups for each scale of aggressive behavior, assessed by Staxi-2 and EPQ instruments.

The frequency table indicates the share of the existence of a criminal record in the case of 75% of the subjects without psychiatric pathology, and 76% of those with psychiatric pathology (Table 1). 24% of the subjects without psychiatric pathology and 24% of those with psychiatric pathology do not have a criminal record. The chi-square test (0.027; p=0.869) indicates that there are no statistically significant differences regarding the existence of a criminal record in the two groups.

In both groups, Staxi-2 showed a high level on the scales represented by internal control of anger, external control, internal expression of anger and aggression index in people with criminal records, as it can be seen in Table 2. We can say the fact that, within both groups, people with a criminal history have a much more pronounced aggressive behavior compared to people without a criminal history. We can also emphasize that the impact of criminal antecedents in the development of aggressive behavior is more important than that of psychiatric pathology.

Comparing the same impact of the criminal

Table 1. Distribution of subjects according to their criminal record

			Psychiatric Pathology NO	Psychiatric Pathology YES	χ^2	P
Criminal record	YES	N	75	76	0.027	0.869
		%	75.0%	76.0%		
	NO	N	25	24		
		%	25.0%	24.0%		

Table 2. Impact of criminal record on aggressive behavior, by STAXI-2 evaluation

	Patients with psychiatric patology				Patients without psychiatric patology				F	p
	with criminal record N=76		without criminal record N=24		with criminal record N=75		without criminal records N=25			
S-Ang	23.5526	8.85949	24	8.33536	23.7867	8.17593	20.84	5.2016	0.278	>.05
S-Ang-F	59.0132	16.65693	60.4583	17.12608	59.7467	16.05657	54	10.80895	0.218	>.05
S-Ang/V	8.6316	3.44032	8.375	3.11814	8.6133	3.63873	6.84	1.8412	0.709	>.05
S-Ang/P	56.2237	12.77456	55.2083	11.56449	56.16	13.49078	49.48	6.86246	0.714	>.05
T-Ang	7.8553	3.6504	8.1667	3.23925	8.0133	3.51635	7.4	2.73861	0.021	>.05
T-Ang/T	57.4211	17.15985	58.7917	15.27424	57.8	15.26434	55.32	12.82485	0.066	>.05
T-Ang/R	7.0658	2.97248	7.4583	2.68618	7.16	2.38826	6.6	1.75594	0.146	>.05
AX-O	58.7895	17.47556	62.7083	18.56008	60.4667	16.03319	57	13.33854	0.003	>.05
AX-I	21.9211	7.40047	20.0417	6.11825	19.3067	5.83784	18.52	6.05613	6.528	0.011
AC-O	56.8158	14.84112	53.0833	12.2365	51.6133	11.67568	50.04	12.11225	6.456	0.012
AC-I	8.5921	3.49544	7.625	3.33379	7.4267	2.737	6.48	1.98158	7.308	0.007
AX Index	55.2632	13.05615	51.7083	12.43585	50.9733	10.21786	47.48	7.47284	7.11	0.008

Table 3. Impact of criminal record on aggressive behaviour, by EPQ evaluation

	Patients without psychiatric patology					Patients with psychiatric patology			
	Criminal record	N	Mean	Std. Deviation	Std. Error Mean	N	Mean	Std. Deviation	Std. Error Mean
Extraversion	NO	25	13.6400	3.88244	.77649	24	12.5000	5.01303	1.02328
	YES	75	14.4933	3.79321	.43800	76	13.6974	5.36661	.61559
Neuroticism	NO	25	8.9600	6.83423	1.36685	24	12.0833	5.10683	1.04243
	YES	75	12.2667	5.48051	.63284	76	14.1053	5.72848	.65710
Psyhoticism	NO	25	7.7600	4.38064	.87613	24	8.9583	4.46707	.91184
	YES	75	9.0667	3.56914	.41213	76	10.1842	5.06678	.58120
Lie	NO	25	13.8000	4.35890	.87178	24	12.5833	3.57426	.72959
	YES	75	11.2933	4.27049	.49311	76	11.7500	3.98372	.45696
Addiction	NO	25	9.4800	6.61513	1.32303	24	11.0000	5.38113	1.09842
	YES	75	12.4667	5.71705	.66015	76	13.2368	5.93042	.68027
Crime	NO	25	11.6000	6.65833	1.33167	24	13.7500	5.49506	1.12167
	YES	75	15.1733	5.78762	.66830	76	16.5132	6.21931	.71340

record EPQ tool also revealed significant differences between the patients with a criminal record and those without a criminal record in both studied groups, especially on the scale of neuroticism, psychoticism and crime.

Thus, it can be concluded that people with a criminal record tend to commit a criminal act by violence much more frequently than those without a criminal record. These data reflect a potential association of aggressive behavior with criminal history (Table 3).

DISCUSSION

The association between criminal records and aggressive behavior is known and supported by other studies. STAXI-2 is also one of the tools frequently used to determine behavioral disorders in people known to have a criminal history, especially prisoners [14]. A study carried out on 302 prisoners highlighted a recidivism rate of 37.4% using the STAXI-2 as a measurement tool. In this study, the major scales modified were the same as in the present study, being represented by internal and external anger control, inner expression, and anger index [21]. Also with regard to recidivism, the STAXI-2 questionnaire was used in the period immediately following the release of some prisoners, and statistically significant increased values were highlighted in the anger expression-in, anger expression out, and anger control in, immediately after release up to 3-4 weeks. This study reinforces the results obtained regarding the impact of criminal history [22]. In the case of people involved in criminal acts, we observed something very interesting, namely that the state of anger is opposite related to impulse control which means that the patient with a criminal record is more concerned with controlling anger impulses than with the manner of expressing it [23]. The percentage of psychiatric patients living in urban/rural areas is similar with other study on psychiatric population in Romania [24].

In the case of the EPQ, a similar study carried out on prisoners regarding the impact of psychiatric pathology on psychopathological traits reveals changes in the scales of psychoticism and lying. Related to the present study where psychoticism, neuroticism and crime scales were noted [25].

The impact of criminal records on crime is also supported by another study that evaluates criminal history as a major risk factor in aggressiveness and by default criminality [26, 27]. The alcohol consumption has behavior consequences and a major impact in the development of antisocial behavior [28, 29]. Another similar study mentions that the psychopathological features captured by the EPQ in people with a criminal history do not differ from those of people who consume alcohol. Low values of extraversion, but also high values of psychoticism and neuroticism were highlighted in a German study conducted on 122 prisoners, characterized both by aggression and low self-confidence status [27].

In conclusion, although there are multiple factors that influence aggressive behavior and it is difficult to determine the contribution of each one, we can strongly state that criminal history is one of the major factors involved.

The impact of psychiatric pathology in the development of aggressive behavior even if it is assumed to be major, it seems that it does not bring many influences in this regard, or at least not as many compared to the criminal records or alcohol consumption.

In addition to the criminal history, another extremely important factor that we mention as a limitation of this study is the consumption of alcohol and psychoactive substances.

We consider that some prophylactic measures are necessary in the behavioral field when we talk about aggression in people with a criminal history.

Conflict of interest

The authors declare that they have no conflict of interest.

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