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Projective risk variables in early adolescence and subsequent disinhibitory psychopathology

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ABSTRACT

The objective was to examine early adolescent projective risk indicators for the development of antisocial behaviour as related to adult personality traits, psychopathy, and violent behaviour over the life span. Assessment data included Rorschach (Rr) ratings (at age 11–14 years), personality inventories (EPQ-I and KSP scales), and a shortened Psychopathy Check List (PCL) (administered at age 32–40 years), obtained from a group of 199 male subjects; and smoking habits (at age 36–44 years) obtained from 125 of those subjects. Results, controlled for intelligence, indicated that the high and very high risk groups, as determined by level of total Rr risk scores, were (1) significantly higher on self-rated IVE Impulsiveness, the anxiety-related KSP Muscular Tension, and nonconformity traits, as compared to the low Rr risk group — the very high risk group also scoring significantly higher on the EPQ Psychoticism scale, related to aggressiveness and cruelty; (2) higher on clinically rated PCL total sum and factor scores; and (3) they were overrepresented among Ss with subsequent violent offence, and Ss with heavy smoking habits. The results are discussed in terms of the possible usefulness of psychodynamic oriented cognitive-emotional indicators in the search for underlying mechanisms in the development of disinhibitory psychopathology.

1. Introduction

When focusing on early indications of antisocial behaviour, an extensive research has adopted a developmental perspective discussing and examining persistent versus adolescent limited antisocial life paths (Moffitt, 1993, 2006; Rutter, 1997; Loeber & Stouthamer-Loeber, 1998; Nagin & Tremblay, 1999; Eklund & af Klinteberg, 2006). Different routes over the life span and underlying behaviour dimensions were suggested, in particular externalizing behaviours such as hyperactive behaviour, aggression, and opposition. Psychoanalytic theory emphasizes developing childhood ego functions, controlling impulses and affect, and tolerating anxiety and frustration (Rapaport, 1958), as interpreted from results assessed by the Rorschach inkplot test. Disturbed ego functions significantly affect the development of an individual's interpersonal relations and the ability to adopt and internalize societal rules (cf. Harter, 1999). Such ego disturbances, or 'ego weakness', were found in 'primary character disorders' and are associated with a higher risk for criminal behaviour later in life (Glueck & Glueck, 1950; cf Lewis, 1999).

Ego weaknesses have also been associated with neuropsychological/cognitive disturbances (Douglas, 1984), such as perceptual and motor hyperactivity and Attention Deficit Hyperactivity Disorder (ADHD according to American Psychiatric Association APA, 1994). Childhood hyperactivity-related behaviours were found to be connected to an increased 'vulnerability' or risk for adult

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antisocial behaviour and criminality (Loeber, Green, Lahey, Frick, McBurnett, 2000; Moffitt, 1990; Satterfield & Schell, 1997; af Klinteberg, 2002), and some evidence of genetic influence concerning neuropsychological disturbances, such as ADHD and related behaviour disorders, closely related to sensation seeking and impulsivity, was reported supporting persistence in behaviour problems (Comings, 1997; Plomin, Owen, & McGuffin, 1994; DeYoung et al., submitted for publication).

1.1. Psychopathy and psychopathy related characteristics

Psychopaths are deficient in their socialization functioning, cooperation, and self-control. They are inconsiderate and show lack of empathy; they are impulsive, and have difficulties in establishing attachments (Gacono & Meloy, 1994; Hare, Clark, Grann & Thornton, 2000; Meloy, 1992; Pardini, & Loeber, 2007; for a review of the term 'empathy', see Blair, 2005). Research on personality concepts and measures related to psychopathic behaviour have prominently emphasized interpersonal interactions and cognitive processes in the development of socialized behaviour. Psychopathy includes, however, also more general characteristics of personality, less directly related to interpersonal interactions, such as impulsiveness, thrill-seeking, and lack of long-term planning and goal-directed behaviour. Certain research results have led to the assumption that it is possible to trace signs of 'vulnerability' to development of antisocial behaviour and/or forms of disinhibitory psychopathology in normal healthy subjects (af Klinteberg, 1998; for a review, see Schalling, 1993). Thus, early adolescent intrapsychic processing as assessed in projective ratings was of interest to us to relate to subsequent personality, psychopathy and antisocial behaviour/violence.

1.2. Purpose of the present study

In accordance with theories of cognitive dysfunction as a risk factor for antisocial behaviour (Douglas, 1984; Gacono & Meloy, 1994), we hypothesized that indications of disturbed neuropsychological and ego functioning as measured by the Rr projective method variables at early adolescence would be associated with adult self-reported psychopathy related personality traits, clinical psychopathy ratings and criminal behaviour in terms of violence over the life span. Moreover, it was expected that total summarized risk ratings based on the projective variables and theoretically assumed by the clinicians to indicate high risk for antisocial behaviour, would possibly contribute to the prediction of adult psychopathy and violence over the life span. Smoking has been found to be strongly related to criminal behaviour and was therefore included in the study (Garpenstrand et al., 2002).

2. Method

2.1. Participants

Within the longitudinal research program 'Young Lawbreakers as Adults' (af Klinteberg, Humble & Schalling, 1992), the cohort consists of 287 boys between age 11 and 14 years: One hundred and ninety-two participants had committed one or more registered crime(s) between age 11 and 14 years and 95 participants belonged to the control group with no registered crime between the same ages. Controls were matched to the crime group subjects with respect to age, social group, family type, and residential area. Twenty-seven years later, 133 subjects of the 'crime group' and 66 of the control group were examined again. Attrition resulted from participants not being available or willing to be included in follow-up. There was no bias due to attrition: the group that dropped out was not significantly different from the group that stayed in at the original examination session ($p>0.05$), concerning presence/no presence of behaviour symptoms, below/above mean intelligence scores, intellectual qualifications, intellectual flexibility, or total/separated family type. Four years later all 199 males were invited to take part in a medical examination including health measures (reported elsewhere) and information on smoking habits. The invitation was accepted by 125 subjects and seventy-eight of them belonged to the former delinquent groups (for further information, see Alm et al., 1996). Age range for the psychological follow-up was 32–40 years; and for the medical examination 36–44 years.

2.2. The Rorschach test

A projective method instrument, the Rorschach (Rr) instrument, was administered to all subjects at the age of 11–14 years. The protocol/records were coded according to a Klopfer/Beck (determinant/location scoring) format commonly used in Sweden during the seventies (Klopfer, 1954; Janson & Dagberg, 1996). The clinicians then went on to rate each record blind to early criminal activity group and according to their variable scheme. In doing so they used all the info in the Rr protocol with their clinical experience and understanding to arrive at their ratings. The data used in this study are these global ratings.

Thus, according to the psychodynamic evaluation system used, in which the considerations were formulated, the individual psychological concepts and variables were not expected to be directly related to criminality or antisocial behaviour. Instead, combinations of variables were considered as risk factors for antisocial behaviour. The total risk for antisocial behaviour was constructed by the clinicians, based on information of insufficiencies and disturbances in the variables of anxiety, aggressivity, ego strength, and mental health. For *anxiety*, the risk for antisocial behaviour was assessed on the basis of the following three anxiety variables: alertness for anxiety, anxiety cathexis, and anxiety tolerance. Free-floating anxiety was assumed to give the highest risk for antisocial behaviour in contrast to neurotic or psychotic anxiety, indicating a lesser risk. Anxiety tolerance was also assumed to be importantly related to risk for antisocial behaviour: weak tolerance for anxiety, even at a low degree of anxiety was regarded to indicate risk for 'acting out', mostly in terms of antisocial behaviour. *Aggressivity*, in turn, was as well assumed to constitute a risk for antisocial behaviour. For evaluating the risk for