False confessions to police and their relationship with conduct disorder, ADHD, and life adversity

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ABSTRACT

Attention deficit hyperactivity (ADHD) symptoms and life adversity have been associated with the reporting of false confessions to crime, but it is not known if these predict false confessions beyond conduct disorder. The participants were 11,388 students in further education in Iceland, who completed a questionnaire anonymously in class. Current ADHD symptoms were measured by the Barkley Current Symptom Scale. Conduct disorder was measured by the Oregon Adolescent Conduct Disorder Screen. Emotional lability was measured by items from the Symptom Check List-90. Negative life events and victimisation from group bullying were measured as indicators of life adversity. Out of 10,749 participants who provided information about interrogation and false confessions, 2104 (19.6%) reported having been interrogated at a police station as a suspect, and of those 261 (12.4%) reported having given a false confession to the police. Logistic regression showed that after controlling for gender, age and emotional lability both ADHD and negative life events predicted false confession above that of conduct disorder. The findings suggest that suspects' resilience to resist pressure from police and peers is weakened by their condition rather than their false confession representing irresponsible and delinquent behaviour associated with conduct disorder.

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1. Introduction

In recent years we have developed greater understanding about factors that lead suspects to falsely confess to crimes during interrogation (Gudjonsson, 2003; Kassin et al., 2010). The emerging evidence is that the reasons for false confessions are multifaceted, but they usually involve two key factors: (a) custodial and interrogative pressure, and (b) psychological vulnerabilities (Gudjonsson & Pearse, 2011). With respect to psychological vulnerabilities, some groups of individuals are considered particularly vulnerable to giving a false confession during interrogation, including suspects with learning disabilities (Gudjonsson, 2010; Gudjonsson & MacKeith, 1994; Perske, 2008), Attention Deficit Hyperactivity Disorder symptoms (ADHD) (Gudjonsson, Sigurdsson, Einarsson, Bragason, & Newton, 2008), persons actively involved in delinquency and criminal offending (Gudjonsson, Sigurdsson, Asgeirsdottir, & Sigfusdottir, 2006; Sigurdsson & Gudjonsson, 2001), a history of life adversity (Gudjonsson, Sigurdsson, Sigfusdottir, & Asgeirsdottir,

2008; Gudjonsson, Sigurdsson, & Sigfusdottir, 2009a,b, 2010) and emotional lability (Gudjonsson, Sigurdsson, Young, Newton, & Peersen, 2009).

What has not been established empirically from previous research is the potential interplay between these factors in predicting false confessions or the relationship between conduct disorder and false confession, yet this is likely to be an important mediating factor due to its strong association with offending and irresponsible behaviour in young persons (e.g. Lynam, 1996; Young, Misch, Collins, & Gudjonsson, 2011) and antisocial personality disorder (Gudjonsson, Sigurdsson, Bragason, Einarsson, & Valdimarsdottir, 2004). Persons with conduct/antisocial personality disorder are considered vulnerable to giving false confessions due to their disregard for telling the truth and delinquent lifestyle (Gudjonsson, 2003).

ADHD is associated with conduct disorder (Waschbusch, 2002) and both ADHD and conduct disorder are associated with bullying behaviour and mental health problems (Bacchini, Affuso, & Trotta, 2008). Do ADHD symptoms and history of life adversity predict false confessions among young persons being interrogated beyond that of conduct disorder? Gudjonsson, Sigurdsson, Einarsson, et al. (2008) found that 41% of prisoners with ADHD symptoms reported a history of false confession in comparison to 18% of non-ADHD

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prison controls. A further analysis of this data revealed that ADHD symptoms were a significant predictor of false confessions above antisocial personality disorder (Gudjonsson, Sigurdsson, Einarsson, Bragason, & Newton, 2010). This suggests that the high rate of false confessions reported among the ADHD group was not significantly mediated by their antisocial personality disorder. The same may hold true for conduct disorder among young persons who are symptomatic for ADHD.

The strong association previously reported between false confessions and life adversity suggests that life adversity may have an independent relationship with false confessions above that of conduct disorder and ADHD (Gudjonsson, Sigurdsson, Sigfusdottir, et al., 2008). Thus we also wished to examine whether life adversity predicts false confessions above the presence of conduct disorder and ADHD symptoms.

In summary, the aim of the present study is to investigate the relative contribution of three types of psychological vulnerabilities to giving a false confession to police: conduct disorder, ADHD, and history of life adversity. In the present study we assessed life adversity using two measures; a measure of negative life events and a measure of victimisation from group bullying. In view of the comorbidity between ADHD symptoms and emotional lability, symptoms of anxiety and depression will be controlled for in the analyses. We test two hypotheses. Hypothesis 1 is that conduct disorder, ADHD and life adversity are all significant predictors of false confessions. Hypothesis 2 is that both ADHD symptoms and life adversity predict false confessions above that of conduct disorder after controlling for gender, age and emotional lability.

2. Method

2.1. Participants

The sample was comprised of 11,388 students in further education in Iceland (upper secondary school) and 95% of the sample fell in the age group 16–24 years (range 15–25; 3.6% did not indicate their age). All 40 colleges of further education in Iceland were represented and the current sample included 70.5% of all students registered in the colleges at the time of the data collection, which took place in November 2010, apart from one school where the data collection took place in January 2011. There were 5439 (47.8%) boys and 5837 (51.3%) girls (112 participants did not indicate their gender).

2.2. Measures

A questionnaire was developed to ask respondents about their family circumstances, education, mental health problems, antisocial behavior, constructive leisure activities and attitudes.

The key measures used in the current study were as follows:

2.2.1. The Oregon adolescent depression project conduct disorder screen (OADP-CDS; Lewinsohn, Rohde, & Farrington, 2000)

This is a six item self-report screen of adolescent conduct behaviours rated on a 4-point Likert scale ('never', 'sometimes', 'often', 'always') providing a total score ranging between 6 and 24. The OADP-CDS has been shown to have good internal consistency, test–retest reliability, and good screening efficiency for detecting lifetime conduct disorder (Lewinsohn et al., 2000). The authors of the scale recommend a cut-off score of 10 or higher as an indicator of the presence of conduct disorder. In the present study, the OADP-CDS was also used as a continuous measure.

2.2.2. Barkley current symptoms scale (Barkley, 1998)

This measure corresponds with DSM-IV criteria for ADHD symptoms. Each of the 18 items, nine items relating to inattention and nine items to hyperactivity/impulsivity, are scored on a 4-point rating scale for frequency of symptoms experienced during the previous six months. Scores ranged between 0 and 27 for each of the two subscales (inattention and hyperactivity/impulsivity) and 0–54 for the Total scale.

In the current study, a screening diagnosis for ADHD symptoms was obtained if six or more of the nine inattention or hyperactivity/impulsivity items were endorsed as either 'often' or 'very often'. In addition, the two subscales and the Total scale were used in the current study as continuous measures.

2.2.3. Questions about ADHD diagnosis and medication

The participants were specifically asked 'Have you been diagnosed with ADHD?' and 'Are you currently on medication for ADHD?' (Both answers endorsed as either 'Yes' or 'No').

2.2.4. Bully victim scale

This measure was developed by the Icelandic Institute for Educational Research and Icelandic Centre for Social Research and Analysis and used in previous research (Gudjonsson, Sigurdsson, & Sigfusdottir, 2010; Sigfusdottir, Gudjonsson, & Sigurdsson, 2010). It is comprised of three items, which were preceded by the following question: 'During the last 12 months, how often have you...?'.

(a) Been individually teased by a whole group of people.
(b) A group attacked you and hurt you when you were alone.
(c) Been in a group that was attacked by another group.

Each item was rated on a five-point scale ('Never', 'Once', 'Twice', '3–4 times', '5 times or more'). The possible range of scores falls between 0 and 12 providing a continuous measure. A score of 0 versus 1 or higher (a categorical score) was used to distinguish those with no history of being subjected to group bullying (i.e., 0 = 'Never' obtained with regard to a, b and c above) from those with a history of bullying (i.e., a score of 1 or above).

2.2.5. Negative life events scale (Gudjonsson et al., 2009b)

Participants were asked to endorse (yes/no) the following 12 items selected to represent stressful life events: You have experienced a serious accident, You have suffered serious illness, Your parents are divorced or separated, You have had serious arguments with your parents, You have witnessed a serious argument between your parents, You have witnessed physical abuse at home involving an adult, You have experienced physical abuse at home involving an adult, Your parent or sibling has died, Your friend has died, You have been rejected by friends or boyfriend/girlfriend and You have been expelled from school, and You have experienced sexual abuse. Scores ranged between 0–12.

2.2.6. Emotional lability

Twenty-two items, 12 somatisation/anxiety and 10 depression items, were chosen from the Symptom Check List-90 (SCL-90; Derogatis, Lipman, Covi, & Rickels, 1971). The items were rated on a four-point frequency scale ('never', 'seldom', 'sometimes' and 'often') to indicate severity of symptoms (Sigfusdottir, Farkas, & Silver, 2004). The items from the somatisation, anxiety and depression scales were combined into one scale in the current study (labelled 'emotional lability').

2.2.7. Police interrogation and confessions questionnaire (Gudjonsson, Sigurdsson, Sigfusdottir, et al., 2008)

Participants were asked about their experiences of police interrogation, confessions and false confessions as follows: