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**Victimization, Coping, and Psychopathy: Associations with Violent Behavior
Among Female Offenders**

by

Donna L. Mailloux, B.A. (Hons.)

A thesis submitted to
the Faculty of Graduate Studies and Research
in partial fulfillment of
the requirements for the degree of

Master of Arts

Department of Psychology

Carleton University
Ottawa, Ontario

January 14, 1999

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Behavior Among Female Offenders"**

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Donna L. Mailloux

In partial fulfillment of the requirements for
the degree of Master of Arts

Dr. Kim Matheson, Chair

Dr. Adelle Forth, Thesis Supervisor

Carleton University
January 14, 1999

Abstract

A model was investigated linking experiences of victimization (physical/sexual) among 38 women offenders to violent behavior (self/other-directed) through two mediating factors: coping and psychopathy. Coping, measured using the COPE, refers to the cognitive and behavioral mechanisms employed to deal with stressful life experiences. Psychopathy, measured using the PCL-R, is a personality disorder consisting of a constellation of affective, interpersonal and behavioral characteristics. Women who reported experiencing physical and sexual abuse committed a greater frequency and variety of self/other-directed violent behaviors. A similar pattern emerged with those who used less functional coping styles. The PCL-R total and factor 2 scores were positively related to the frequency and versatility of other-directed violence. Only factor 2 was positively correlated with the frequency and versatility of self-directed violence. This research failed to support the role of coping and psychopathy as mediating variables in the relation between victimization and self/other-directed violence.

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Introduction

A review of the empirical research reveals that studies directed towards understanding women and crime is an exception rather than a rule. Despite recent improvements, the paucity of research that seeks to explain antisocial behavior by women persists to this day. There are three primary reasons why women have been neglected from criminological research. First, the lower incidence of women who come in contact with the criminal justice system suggests that the problem is not drastic enough to warrant empirical research attention. However, Bonta, Pang, and Wallace-Capretta (1995) have argued that a low incidence is an invalid rationale since other infrequent crimes, such as serial killing, have received significant research attention. Second, crimes committed by women tend to be less sensational than those committed by men, and as a result they are not placed at the forefront of mainstream forensic psychological research. Third, research on women and crime has perpetuated the stereotypical view that women engage in antisocial behaviors because of psychiatric abnormalities and therefore they have often been omitted from psychological research. As a result, women are a neglected minority in theory development and forensic psychological research.

An understanding of the magnitude of female offending can be influenced by the way in which crime rates are reported. For instance, using actual charges laid, women in 1993 accounted for 17% of all adult charges and 25% of all youth charges (National Crime Prevention Council Canada, 1995). Referring more specifically to violent crimes, adult women accounted for 11% of the violent charges in 1993 while young female offenders accounted for 24% (Trainor, Normand, & Verdon, 1995). The magnitude of the problem appears less dramatic when interpretations are based on rates of incarceration.

Women comprise only 3% of the federal and 9% of the provincial prison population (Canadian Center for Justice and Statistics, 1993) while 8% of all female youth dispositions in 1994/1995 were for secure custody (Dell & Boe, 1997). If incarceration rates were the sole criteria used in determining the relevance of studying female offending, the severity of the problem would be underestimated.

It has been suggested that the incidence of crimes committed by women is on the rise (Boe, 1997). In the six years from 1989 to 1995 the total federal prison population grew 22% while the total provincial prison population grew by 12% (National Crime Prevention Council Canada, 1997). This growth rate was exceeded by women provincially where admissions to institutions increased 19% (Trainor et al., 1995). Although Boe (1992) projected a 14% increase in federal admissions for women between 1992 and 1997, the actual increase was 6.7% (Boe, 1997). Concurrently, the proportion of total charges given to women increased steadily from 14% in 1987 to 17% in 1993 (Trainor et al., 1995) despite the fact that in 1994, for a third consecutive year, police reported crime declined by 5% (Canadian Centre for Justice and Statistics, 1995). For the upcoming years, Boe (1997) has forecasted that this increase in female offending will continue, anticipating a national increase of 19.4% by the year 2007.

Thus the statistics suggest that although women make up a relatively small proportion of the incarcerated population, they in fact commit a substantial proportion of the crime. Furthermore, not only are their rates of offending on the rise, but the frequency at which they are being incarcerated is growing faster than the general prison population. Given that crimes committed by women are increasing in frequency, the neglect of female offenders in mainstream forensic psychological research must be addressed. Thus,

the impetus of the current research is based in part on a) the changing trends of female offending and b) the paucity of research on this population.

Literature Review

The review of the literature will cover 3 primary areas. First, since more recent research has reported a high prevalence of victimization among women in prison, the literature review will highlight how these experiences are associated with antisocial behavior. Second, coping theory will be described and the literature reviewed with respect to its relevance to victimization and antisocial behaviors. Finally, psychopathy will be reviewed with particular attention to the construct, measurement, and incidence among females.

Victimization Experiences

A review of the literature clearly demonstrates that there are a disproportionate number of women in prison who come from backgrounds of sexual, physical, and/or psychological abuse. Approximately 34% of women in the general population have reported being physically abused while 39% have reported being sexually assaulted (Statistics Canada, 1993). Women who are incarcerated, however, report having experienced sexual (68%) and physical abuse (53%) at almost double the rate of the general population (Task Force on Federally Sentenced Women, 1990). In comparison to the general population and to male offenders, federally sentenced women are more likely to have experienced victimization that is violent, sexual, incestuous in nature, committed by numerous perpetrators, and extended over a longer period of time (Task Force on Federally Sentenced Women, 1990). This high prevalence of abuse experienced by female offenders, has led to the seemingly natural conclusion that antisocial behavior is

associated with victimization experiences. A brief review of the literature will support but also challenge this assumption.

The shockingly high incidence of victimization that was disseminated through the Task Force on Federally Sentenced Women (1990) has been replicated in a number of different studies. For instance, Tien, Lamb, Bond, Gillstrom, and Paris (1993) found that women at the Burnaby Correctional Center reported a 47% incidence of sexual abuse, 36% incidence of physical abuse, and a 39% incidence of psychological abuse. Furthermore, 81% of the women reported experiencing some form of abuse in their present relationship. These findings were supported more recently by Bonta et al. (1995) where 61% of federal female offenders reported past physical abuse and 54% past sexual abuse. Loucks (1995), breaking the experiences down into pre and post adolescent abuse, found that 62% of his sample of federally sentenced female offenders had experienced pre-adolescent sexual abuse, 80% pre-adolescent physical abuse, and 100% psychological abuse. Furthermore, post-adolescent sexual abuse was experienced by 72% while post-adolescent physical abuse by 61%. Throughout their lives, 80% of federally sentenced women reported experiencing at least one incident of sexual and 81% of physical abuse. Clearly, experiences of victimization are common occurrences in this population of women and one that warrants further investigation with respect to antisocial behavior.

Victimization and antisocial behavior

Although evidence in support of a link between victimization experiences in childhood and subsequent delinquent behavior is plentiful (Fagan & Wexler, 1987; Kruttschnitt, Heath, & Ward, 1986; McCord, 1983; Rivera & Widom, 1990), this relation

can be described as a correlation at best. Few authors have attempted to determine whether a pre or postdictive relation exists with antisocial behavior, especially among females.

Widom (1989c) criticized the literature in this area for being methodologically weak, lacking generalizability, and lacking relevance to policy. Using a specialized cohorts longitudinal design, Widom (1989a) found that females who were abused or neglected (defined as court substantiated cases in children less than 11 years old) were significantly more likely to have an adult arrest record than those who were not abused or neglected (16% vs. 9%, respectively), but not any more likely to have an adult criminal record for violent offenses (1.7% vs. 2.1%, respectively). However, it should be noted that even though the groups differed in terms of involvement in antisocial behaviors, the vast majority of the sample who had been abused/neglected were not involved in these activities. This suggests that other factors contribute to antisocial behaviors, especially those that are violent in nature.

Loucks (1995) broadened the definition of abuse to include physical, sexual and psychological abuse experienced in pre and post adolescence. He found that among 100 federally sentenced female offenders pre-adolescent sexual abuse correlated positively with institutional convictions, criminal violence, institutional violence, institutional behavioral problems, and self-harm while post-adolescent physical abuse correlated positively with institutional convictions, criminal violence, and self-harm. When these variables were entered into a stepwise regression analysis with other variables, they were meaningless postdictors. However, Loucks (1995) never investigated 2 possibilities: (1) that the variables entered into the regression were in fact mediating or suppressor

variables and (2) the possibility that present abuse (physical and/or sexual) was postdictive of violent behavior.

Victimization and self-harm

Self-harm involves a deliberate attempt to injure the self through a variety of methods such as head banging, cutting, burning, slashing, picking, and bone breaking. Self-harming behaviors differ from suicide attempts in that self-harm provides relief, is repeated more frequently, and has a greater communicative value (Pattison & Kahan, 1983). Research continues to link experiences of physical and sexual abuse to self-harming behavior both in community and incarcerated samples.

A study conducted with 44 women at the Prison for Women in Kingston (Heney, 1990) indicated that 59% of the women had engaged in some form of self-injurious behavior. Most of the women (50%) indicated that their behavior was the result of tensions within the prison while another 14% indicated that they did not know why they self-harmed. Of those women who had experienced childhood abuse (sexual and/or physical) 73% reported that they self-injured. The author concluded that the self-injuring behavior was a coping method adopted during incarceration as a replacement to the coping method they would normally use. Although this may in fact be true, information pertaining to their coping methods and self-injurious behavior prior to incarceration was not addressed during the interview.

Loucks (1995) defined self-harm broadly to include any event that resulted in physical harm to the self. The incidence of self-harm in his sample of 100 female offenders ranged from 18% in the previous incarcerations, 27% during the present incarceration, to 43% in the community. Overall, 54% of the women at the Prison for

Women in Kingston reported engaging in an incident of self-harm at some point in their life. Self-harm was found to be positively correlated with criminal convictions (.25), criminal violence (.24), pre-adolescent sexual abuse (.30), pre-adolescent physical abuse (.30), post-adolescent physical abuse (.23), and lifetime total abuse (.34).

Summary

Based on the most recent studies it appears that the relation between experiences of victimization and antisocial behaviors remains elusive. Since the vast majority of women who have been victimized are not involved in antisocial behaviors, it is safe to hypothesize that some factor or factors, when present, assume a mediating role which acts to increase the risk of participating in antisocial behaviors. Thus, even though experiences of victimization have not conclusively been causally linked to antisocial behavior it does not mean that a relation does not exist. In fact, experiences of victimization may contribute to the development of poor coping strategies that predispose an individual to engage in antisocial behavior. This path may be linked directly to the development of personality disorders; alternatively personality disorders may act as an additional mediating factor. If this path were in fact validated, then treating past and present histories of victimization would be warranted but certainly not sufficient.

Coping Theory

The theoretical framework of coping was originally defined by Lazarus (1966) and later refined by Lazarus and Folkman (1984). Coping theory refers to the cognitive and behavioral mechanisms an individual employs in an effort to deal with stressful life experiences. The focus of this theory is on coping strategies as the mechanism between stimulus (threat) and response (threat reaction). It is proposed that there exist three

processes: (1) the *first cognitive appraisal* refers to the perception of the threat to oneself, (2) the *secondary cognitive appraisal* considers the options in dealing with the threat, and (3) *coping* refers to the mitigation or elimination of the threat.

Lazarus thought that people coped with stress in two general ways. The first method is directed at removing the source of the stress and is called *problem-focused* coping. The second method is directed at eliminating the distress associated with the threat and is called *emotion-focused* coping. Although they both generally co-occur, Folkman and Lazarus (1980) suggested that problem-focused coping occurs more often when the individual believes that their efforts will be constructive, while emotion-focused coping is adopted when the individual believes the threat must be endured. Although theoretically interesting, these factors have proven to be somewhat simplistic leading others to suggest that coping strategies are more diverse (Carver, Scheier, & Weintraub, 1989).

It is thought that the success or failure of a coping mechanism is the determinant of emotional and behavioral outcomes (e.g., antisocial behavior). Thus, coping can be referred to as an adaptation in which some methods are more useful than others (Negy, Woods, & Carlson, 1997). For instance, problem-focused coping has been associated with lower levels of depression while emotional discharge and avoidance have been related to higher levels of depression and other dysfunctions (Billings & Moos, 1984; Cronike & Moos, 1984). Furthermore, being diagnosed with a personality disorder has been linked to less adaptive coping mechanisms (Perry, Lavori, Pagano, Hoke, & O'Connell, 1992) such as acting out, projective identification, and splitting in those with Borderline Personality Disorder (Perry & Cooper, 1985).

Coping measures

The primary scale used to test Lazarus' coping theory is the Ways of Coping Checklist in its original (Folkman & Lazarus, 1980) and revised format (Folkman & Lazarus, 1985). This empirically derived self-report measure was designed to assess a broad range of coping strategies, which were subsequently reduced to two types of general coping, problem and emotion focused. The individual is asked to recall a stressful event they have encountered in the last two months and then, using a yes/no format, indicate whether they attempted a number of different coping strategies. This scale has been criticized for its oversimplicity in the factor structure, ambiguity of the items, and its empirically derived constructs (Carver et al., 1989).

In response to the criticisms of the Ways of Coping scale, Carver et al. (1989) developed the COPE scale, which is theoretically based on Lazarus' view of coping. There are 15 conceptually distinct and theoretically derived subscales described in Table 1.

In a study assessing the reliability and validity of the COPE (Carver et al., 1989), all subscales reported good internal consistency (Cronbachs alpha above .6 for all but one scale, mental disengagement) and 6-week test-retest reliability suggesting a relatively stable measure of coping. The subscales demonstrated relatively weak intercorrelations suggesting that the subscales can be separated empirically. Two clusters emerged out of factor analysis: (1) *functional coping* which consists of active coping, planning, suppression of competing activities, restraint, positive reinterpretation and growth, seeking social support for instrumental and emotional reasons, and acceptance; and (2) *less functional coping* which consists of denial, behavioral and mental disengagement,

focus on and venting of emotions, and alcohol/drug use..

Table 1

Subscale Definitions of the COPE Questionnaire

Subscale:

Definition:

Active coping	Taking direct action.
Planning	Thinking about how to deal with the problem.
Suppressing competing activities	Putting competing activities aside.
Restraint	Consciously holding oneself back from confronting the problem until an appropriate time.
Instrumental social support	Seeking advice from others in order to obtain information.
Emotional social support	Seeking understanding from others.
Focusing on and venting emotions	Tendency to focus on the distress for an extended period of time.
Behavioral disengagement	Giving up.
Mental disengagement	Dissociating from the goal that the problem is interfering with.
Positive reinterpretation and growth	Emotional attachment to the problem is reframed in a positive light.
Denial	Refusal to admit the problem exists.
Acceptance	Acknowledgement that the problem exists.
Turning to spirituality	Tendency to use spirituality.
Alcohol/drug use	Uses alcohol and drugs to deal with the problem.
Humor	Deals with the problem by joking.

An overview of coping research

Researchers most often look for links between childhood background factors and outcome (e.g., witnessing wife assault as a predictor of future assaultive behavior); however, Porporino and Zamble (1984) found that coping strategies were more strongly associated with outcome measures than were background factors. The way in which people respond to problems (Zamble & Porporino, 1988), in addition to the severity of the threat, (Lazarus, 1966) differentiates successful from unsuccessful coping. For instance, some may deny while others actively cope with reality. The former has been demonstrated to be effective in those awaiting enemy attack (Bourne, 1970) while the latter is generally more effective overall (Anderson, 1977).

There exists an abundance of research investigating how people deal with the challenges they encounter, particularly in the literature on health and illness. Studies have long associated the accumulation of life events with the onset of illness (Holmes & Masuda, 1973) and the chronicity of the illness experienced (Wyler, Masuda, & Holmes, 1971). These findings have been replicated in those who have attempted suicide (Cochrane & Robertson, 1975; Paykel, Pruschoff, & Myers, 1975) and in male inmates (Masuda, Cutler, Hein, & Holmes, 1978) who report crisis proportions of life events in the year prior to incarceration or attempted suicide. There is some evidence to suggest, however, that how individuals cope with the increase in stressful life events is more important than the actual frequency or intensity of the stress (Lazarus & Launier, 1978; Lipowski, 1970).

Carver et al. (1989) asked a group of university students ($n = 978$) to complete the COPE scale with emphasis on how they usually dealt with the stressful experiences in

their life. They found that the students employed more functional coping strategies (planning and active coping) than they did less functional coping strategies (behavioral and mental disengagement). In this same sample, there was evidence of gender differences indicating women were more inclined to focus on and vent emotions and to seek social support (both instrumental and emotional) while men were more likely to use drugs and alcohol. Those who engage in antisocial behaviors may differ from university students in their greater use of less functional coping strategies.

Coping and offenders

The importance of coping skills in the commission of antisocial behaviors has been central to the work by Zamble and Porporino (1990). They have hypothesized that the maintenance of criminal activity can best be understood within the context of maladaptive coping skills, a theory they have termed the "Coping-Criminality-Hypothesis". Others have also found that when sex offenders who use less adaptive coping skills are presented with difficult situations, they are more likely to reoffend (Pithers, Marques, Gibat, & Marlatt, 1983).

Much of what is known about the coping ability of offenders deals with their experiences of incarceration. This arises out of the concern that incarceration will be detrimental to the coping skills required to reintegrate successfully into society. This assumption appears to be founded on a belief that offenders are adequate copers to begin with. It is more probable that offenders employed less functional coping strategies in general and that incarceration forces them to adopt alternatively poor coping strategies.

Not surprisingly, the paucity of research on coping with offenders has focused primarily on males. Generally, male offenders report deficiencies in their ability to cope,

with very few displaying any competence in adequately dealing with their problems (Zamble & Palmer, 1996). Although Zamble and Porporino (1988) report that their sample of male offenders ($n = 133$) directly confront their problems, their coping methods are mostly unplanned and impulsive even when the problems were long-term and required more forethought. Most of the time the offenders used the same coping responses repeatedly even when it was evident that they were ineffective. The association between poor coping on the outside and various lifestyle variables suggest a positive correlation with instability, sociability, passive activities, lack of planning, unemployment, non-directed activities, and lack of goals for the future.

As is the case for male offenders, more recent research on female offenders has focused on their adjustment while incarcerated. For instance, coping skills of 100 female federal offenders have been assessed as minimally effective meaning that although the women made attempts to deal with issues, they were ineffective at resolving them (Loucks & Zamble, 1994). Although one may argue that these results are due to the nature of the population or the length of the sentences being served, MacKenzie, Robinson, and Campbell (1989) found that time spent incarcerated had little impact on their coping skills. They interviewed 141 females who had been incarcerated for three different time period: (1) less than 48 months with sentences less than 2 years (short-sentenced/newly entered), (2) less than 48 months with sentences longer than 2 years (long-sentenced/ newly entered), (3) greater than 48 months with sentences longer than 2 years (long-term). Using a self-report questionnaire assessing situational problems and coping difficulties, all three groups of females had a similarly difficult time coping. The scale used in this study, however, assessed items that related to the person's emotional

well-being (e.g., feeling sorry for myself) as opposed to specific coping strategies.

More recently, comparing violent and nonviolent federal female offenders on factors related to case needs Blanchette (1997a) reported that the groups differed on a number of factors relating to coping. Violent women were less able to solve interpersonal problems, set realistic goals, cope with stress, resolve conflict, generate choices, or understand the feelings of others. A breakdown of the same sample of female offenders by security level suggests that differences exist (Blanchette, 1997b). In all cases minimum security women ($n = 72$) report less difficulties than medium ($n = 103$) and maximum security women ($n = 37$). For instance, 46% of minimum-security women reported difficulties coping with stress whereas 65% of the medium and 92% of the maximum-security women reported likewise. The primary methodological weakness of these reports is that the study was not designed to answer specific questions but rather used an already existing database to provide a descriptive analysis of the female offenders. From a list of over 400 yes/no questions that the inmates are required to answer as part of a standardized assessment, only particular questions were targeted for analysis. A large number of people conducting the assessments across the country, in addition to the use of closed ended questions, contributes to questions regarding the reliability and validity of the database.

Loucks (1995) assessed the coping behaviors of 100 federal female offenders focusing specifically on the use of substances and psychiatric and/or psychological treatment services both while in the community and incarcerated. Although Loucks (1995) concluded that women cope less effectively than men because they use psychological /psychiatric services more frequently than their male counterparts in

previous studies (52% vs. 19%), he neglected to recognize that this may be a function of gender role stereotypes. In fact, seeking help for problems may be an indication of *more* effective coping.

In the same sample of federal female offenders, Loucks (1995) also evaluated the types of prison stressors and the strategies the women employed in dealing with these stressors. In general, the women used reactive or problem-oriented methods that involved little long-term planning which would be expected given that incarceration is not amenable to long term goal-oriented problem solving. On average, most women were able to generate 2 or 3 alternative responses to their problems with those generating the greatest number being the most effective copers. Most women tended to avoid their problems although, given the high level of untrustworthiness in prison, this coping technique may primarily be a function of the prison environment. Contrary to what has been found in male offenders, coping efficacy did not add to the postdiction of violence or to criminal and institutional convictions, however it did add to the postdiction of self-harming behavior. These results may be a function of the inappropriateness of assuming that coping strategies for women in prison are equivalent to coping strategies employed outside of the institution.

Negy et al. (1997) found support for the findings in the Loucks' (1995) study whereby those women who employed more diverse coping strategies demonstrated better adaptation (higher self-esteem, lower anxiety, and less depression). Administering the COPE scale to 153 females incarcerated at a minimum security institution, those who were proactive, nonreactive, positive, accepting, planners, and religious reported being the least depressed, least anxious, and generally felt better about themselves. Whether the

women used emotion or problem focused strategies did not make a difference in terms of their ability to cope in prison.

Coping and victimization

Research has demonstrated that women who have been raped are better adjusted if they access social supports as a method of coping (Burgess & Holmstrom, 1979) and less adjusted if they use avoidant methods of coping (Wirtz & Harrell, 1987). However, very little information is available on the methods of coping employed by those who have been victimized in other ways and what impact they have on outcome measures, such as antisocial behaviors.

One study that is of particular interest to the present proposal is a retrospective study of 54 community based adult female childhood sexual abuse survivors (Leitenberg, Greenwald, & Cado, 1992). Coping was assessed using a self-report measure designed by the researchers and directed at assessing a number of coping strategies such as denial, emotional suppression, social and religious supports, to name a few. Overall, women who had been sexually abused tended to use denial and emotional suppression at a high frequency. Direct action related to the offender and spiritual and religious support were the least frequently employed. Increased severity of the abuse (father as the perpetrator, longer duration, greater force, higher level of physical intimacy), was accompanied by increased use of strategies such as “social supports”, “action related to the offender”, “spiritual comfort”, and “emotional suppression”. Denial was more often employed if the abuse took place at a younger age. Current distress was used as a measure of maladjustment and was predicted using the coping methods mentioned above. It was found that denial and avoidance were associated with the greatest amount of

psychological distress. Overall the coping methods accounted for 30% of the variability in psychological distress.

Himelein and McElrath (1996) focused on the cognitive protective factors at play in a sample of 20 females who had experienced child sexual abuse. In this qualitative study, the authors assessed adjustment (combination of levels of distress, psychological health, and well being) and then performed a content analysis on the cognitive coping strategies. They found that the resilient women used four coping methods more often than the non-resilient women: (1) refusing to dwell, (2) positive reframing, (3) disclosure, and (4) minimizing the impact.

Summary

It is evident from the literature that there is a need to examine general and specific coping strategies with female offenders. Some research has touched upon coping strategies used by female offenders while institutionalized. Although important for the management of offenders within the institution, the knowledge may provide little in the way of rehabilitation for women once they leave the institutions. While most research on victimization has assumed poor coping based on maladjustment outcome measures such as distress, research has just begun to investigate specific coping strategies and their effects on outcome measures. Smith and Pollack (1976) have suggested that attempts to reform offenders will only work if they are provided with coping strategies that enhance their ability to deal with the social and psychological stressors faced in the community by means other than deviance. The development of effective coping will become feasible only if research is directed at how offenders cope in the community, how coping may change as a function of incarceration, and how these specific strategies relate in a

predictive manner to antisocial behavior.

The Construct of Psychopathy

Psychopathy was first described by Phillipe Pinel (1806/1962), an early nineteenth-century French psychiatrist, who used the term “insanity without delirium” to describe those who appeared insane but whose ability to reason remained intact. Since that time, the term ‘psychopath’ has undergone many definitional transitions.

Sociopathy, antisocial personality disorder, dyssocial personality disorder, and psychopathy are often used interchangeably. Unfortunately, the multiplicity and inconsistent usage of the terms have complicated the understanding of psychopathy (Lilienfeld, 1994). The term "sociopath" is used most frequently by criminologists and sociologists. "Psychopath" is the term preferred by psychologists. Criminologists believe predominantly in social and environmental determinants while psychologists emphasize psychological, biological, and genetic determinants (Hare, 1993). Although the term psychopathy is most commonly used in North America, dyssocial personality disorder is used outside of North America as synonymous with psychopathy. Finally, antisocial personality disorder (APD) refers to a disregard for the rights of others and for normative lawful behavior that begins in childhood and persists into adulthood. Although APD is commonly used interchangeably with psychopathy, it comprises only one diagnostic component of psychopathy.

There is general agreement regarding the characteristics encompassed by psychopathy (Cleckley, 1976; Gray & Hutchison, 1964; Livesley, 1986; McCord & McCord, 1964; Meloy, 1988). Cleckley (1941) most vividly described the clinical profile of the psychopath, emphasizing the lack of cohesion between word and action as the most

common characteristic. Subsequently, Hare and his colleagues (Hare, 1970; Hare, 1980; Hare, 1991; Hart, Hare, & Harpur, 1992) refined the psychological profile of the disorder to include a constellation of interpersonal, affective, and behavioral characteristics. Thus, interpersonally, psychopaths are egocentric, manipulative, and dominant. Psychopaths display shallow affect and short-lived emotions, and show a lack of empathy and guilt. Behaviorally, psychopaths are described as sensation seeking, impulsive, and irresponsible.

Measurement of psychopathy

The method of assessing psychopathy has undergone several revisions over the past few decades, reflecting the increased knowledge and empirical interest surrounding this disorder. Presently, the most commonly used assessment tool is the Psychopathy Checklist in its original form (PCL; Hare, 1980) and the revised form (PCL-R; Hare, 1991). The PCL was designed to operationalize both the behavioral and the interpersonal and affective components of psychopathy (Hart & Hare, 1989). The original PCL consisted of 22 items while the PCL-R was shortened to 20 items (Hare et al., 1990). Furthermore there is a 12-item screening version (PCL: SV; Hart, Cox, & Hare, 1995) used primarily in non-forensic populations. Using a semi-structured interview, each item is scored on a 3-point scale reflecting the degree to which that item is represented across the lifespan. Using institutional and criminal records (or a collateral interview in non-forensic populations) as a means of validating the information obtained in the interview, a global score is obtained which reflects the degree to which that individual resembles a prototypical psychopath. There exists great debate over whether this score should be conceptualized as a continuous or a dichotomous construct. However, some recent

research supports the belief that psychopathy is indeed a discrete taxon (Cooke & Michie, 1997; Harris, Rice, & Quinsey, 1994).

Research with the PCL and the PCL-R has consistently identified 2 independent but correlated factors (see Table 2 for PCL-R items and factor structure; Hare et al., 1990; Harpur, Hakstian, & Hare, 1988). Factor 1 is a measure of the core interpersonal and affective features of psychopathy while factor 2 is a measure the behavioral features associated with an antisocial lifestyle. It is important that these factors be distinguished, as a review of the empirical research will demonstrate that they correlate differently with various external variables.

Table 2

PCL-R Items and Factor Structure

Factor 1	Factor 2
(1) Glibness/superficial charm	(3) Need for stimulation/proneness to boredom
(2) Grandiose sense of worth	(9) Parasitic lifestyle
(4) Pathological lying	(10) Poor behavioral controls
(5) Conning/manipulative	(12) Early behavioral problems
(6) Lack of remorse/guilt	(13) Lack of realistic long-term goals
(7) Shallow affect	(14) Impulsivity
(8) Callous/lack of empathy	(15) Irresponsibility
(16) Failure to accept responsibility	(18) Juvenile delinquency
	(19) Revocation of conditional release
Does not load on either factor:	
(11) Promiscuous sexual behavior	
(17) Many short term marital relations	
(20) Criminal versatility	

The reliability and validity of the PCL and the PCL-R has been demonstrated in various populations such as male forensic psychiatric patients (Hart & Hare, 1989), male offenders (Hare, 1991), male young offenders (Forth, Hart, & Hare, 1990), male and female Scottish offenders (Cooke, 1995), African-American male inmates (Kosson, Smith, & Newman, 1990), male and female substance abusers (Alterman, Cacciola, & Rutherford, 1993; Rutherford, Cacciola, & Alterman, 1992; Rutherford, Cacciola, Alterman & McKay, 1996), and female offenders (Loucks, 1995; Neary, 1990; Strachan, 1993). The incidence of psychopathy in these populations ranges from 15-30%. Hare (1996) suggested a 1% incidence in the general population.

Psychopaths are more likely to be convicted of a violent crime, to use a weapon, and to use instrumental forms of aggression than are nonpsychopaths (Cornell et al., 1996; Serin, 1991). Psychopaths generally spend more time in prison (Hare, McPherson, & Forth, 1988) and once released, they more often violate their conditions (Hart, Kropp, & Hare, 1988; Serin, Peters, & Barbaree, 1990) and return to prison at a faster rate than nonpsychopaths (Hart et al., 1988). In addition, studies using the PCL and the PCL-R suggest they are good predictors of general (Hart et al., 1988; Serin & Amos, 1995; Serin et al., 1990) and violent (Harris, Rice, & Cormier, 1991; Harris, Rice, & Quinsey, 1993; Serin, 1996) recidivism.

Psychopathy and females

Prior to the advent of the PCL, there was some interest expressed in the identification of psychopathy in females. For instance, Butler and Adams (1966) considered a psychopathic female to be one that was immature and impulsive whereas Cloninger and Guze (1970) required only 2 of several antisocial behaviors to be present.

Widom (1978), on the other hand, was more detailed in characterizing the female psychopath as one who was hostile, impulsive, and aggressive with poor socialization and low anxiety. Due to the inconsistency in diagnostic criteria used, the incidence of psychopathy in these samples ranged from 2% to 65%.

Even though research has generalized beyond the narrow vision of psychopathy as a construct only applicable in male adult offenders, little attention has been directed towards females. The paucity of research in this area has focused primarily on three populations: university students, substance abusers, and federal offenders. The studies that have included females in their sample will be briefly reviewed in an effort to highlight the need for further research.

University students. There are three published papers using a sample of female university students (Forth, Brown, Hart, & Hare, 1996; Levenson, Kiehl, & Fitzpatrick, 1995; Zagon, & Jackson, 1994) all of which suggest that females score lower than males on psychopathy rating scales. For instance, using a self-report version of the PCL (SRP-II), Zagon and Jackson (1994) found that males ($n = 48$) scored significantly higher on mean SRP-II total (235.3), factor 1 (34.6), and factor 2 (50.3) scores than females ($n = 101$; 214.2, 29.7, and 45.2, respectively). Levenson et al. (1995) used their own self-report scale to assess what they called primary (similar to factor 1) and secondary (similar to factor 2) psychopathy in a sample of males ($n = 135$) and females ($n = 346$). The results supported a trend for males scoring higher on primary psychopathy (33.0 vs. 27.6) and similar on secondary psychopathy (20.1 vs. 19.0).

In a sample of undergraduate students, Forth et al. (1996) assessed psychopathy using the PCL:SV and found that males ($n = 75$) scored consistently higher on total,

factor 1, and factor 2 than did females ($n = 75$; 6.4, 2.9, 3.5 vs. 2.7, .92, and 1.8, respectively). Using 18 as the diagnostic cutoff, 3% of the males compared to no females met the criteria for psychopathy. For women, psychopathy was found to correlate with self-reported measures of violent (.22) and nonviolent (.43) antisocial behaviors in addition to the versatility of antisocial behaviors (.45). Therefore, regardless of which instrument is used to assess psychopathy in an undergraduate population, males are more likely to display more of the prototypical characteristics of psychopathy than females.

Substance abusers. Preliminary studies with substance abusers have focused on determining sex differences in the PCL-R scores. For instance, Rutherford et al. (1992) found that 25 methadone maintained women scored lower on PCL-R total and factor scores than men ($n=19$) whereas Piotrowski et al. (1995) found no sex differences between their methadone maintained males ($n = 72$; $M = 21.3$) and females ($n = 30$; $M = 18.9$). Subsequently, Rutherford et al. (1996) assessed 58 female opiate addicts undergoing methadone treatment and found that their mean PCL-R total (13.8), factor 1 (5.6) and factor 2 (6.4) scores were considerably lower than results from a similar sample of males (17.9, 7.1, & 8.1, respectively; Alterman et al., 1993). Furthermore, number of arrests correlated positively with PCL-R total ($r = .42$), factor 1 ($r = .47$), and factor 2 ($r = .34$) scores while years incarcerated correlated with total ($r = .32$) and factor 1 ($r = .37$) scores. Although the correlations are similar to those found among male offenders (Hare, 1991), the relation between factor 1, years incarcerated, and number of arrests is quite surprising given that these correlations more commonly exist with factor 2 among males.

A diagnostic cutoff of 30 on the PCL-R is traditionally used for male offenders in determining a diagnosis of psychopathy. In non-incarcerated populations, however, a

lower cutoff of 25 has been employed. Using the lower cutoff level, Piotrowski et al. (1995) found that their males and females did not differ in the proportions diagnosed as psychopathic (21% vs. 19%, respectively). However, Rutherford et al. (1996) diagnosed only 10% of their sample of 58 methadone maintained women using the same cutoff. The different prevalence rates across the samples suggest that there may be some discrepancy at either the diagnostic level or the composition of the sample itself.

Forensic population. As a result of higher base rates of psychopathy in forensic populations, mean scores on the PCL-R are expected to be higher than in the non-forensic populations. Table 3 displays the PCL-R means, standard deviations, range, and prevalence rates for five studies of incarcerated women. Despite some variation in the results, particularly in the prevalence rates of women diagnosed as psychopaths, each study concluded that the PCL-R was a valid and reliable assessment instrument for this population. Since all five studies used the same instrument with relatively similar samples, the variation in base rates may be due in part to the different diagnostic cutoff scores used or to issues related to under or over scoring on the part of the assessor.

Three of the studies with female offenders (Neary, 1990; Salekin, Rogers, & Sewell, 1997; Tien et al., 1993) were interested primarily in the prevalence of psychopathy and its convergence and/or divergence with other disorders. Although these studies have contributed to the validation process of psychopathy as a construct among female offenders, they all failed to include antisocial behaviors as an outcome measure.

Table 3

Total and Factor Scores (Standard Deviations in Brackets) and Prevalence for the PCL-R

Study	<i>n</i>	Total	Factor 1	Factor 2	Prevalence (PCL-R cutoff)
Neary ('90)	120	21.13 (6.49)	9.26 (3.72)	10.40 (3.62)	39% (>25)
Tien et al. ('93)	74	22.70 (7.95)	8.20 (4.12)	11.34 (4.07)	23% (>29)
Strachan ('93)	75	24.31 (7.33)	9.93 (3.25)	10.90 (4.14)	31% (>29)
Loucks ('95)	100	18.01 (9.00)	8.10 (4.10)	8.10 (5.70)	11% (>29)
Salekin et al. ('97)	103	—	—	—	16% (>29)

Note. "—" scores not reported

Loucks (1995) and Strachan (1993) are the only authors thus far to empirically investigate the relation of psychopathy to numerous antisocial behavior variables in a female forensic sample. The relation between psychopathy and antisocial behavior variables in these studies revealed some expected patterns of relations and some which were unique to women. The expected patterns include a positive correlation between psychopathy and official criminal records of general and violent convictions (Loucks, 1995; Strachan, 1993) in addition to a positive correlation with institutional convictions, violence, and behavior problems (Loucks, 1995). In the Strachan sample of 75 female offenders either on probation or incarcerated, the PCL-R correlated .35 with the presence or absence of an official criminal record for violence. Loucks (1995) found a slightly higher correlation between the PCL-R and criminal violence (.46) and also with

institutional violence (.38). It should be emphasized however, that the correlation between psychopathy and violence in both Strachan's and Loucks' sample are based on official criminal records.

The total PCL-R scores have also been found to correlate positively with self-harm (Loucks, 1995; .39), but the PCL-R factor scores related differently with factor 2 (behavioral) significantly correlating at .40 while factor 1 (personality) was not statistically significant (.13). However, in the prediction of self-harm, none of the abuse variables entered the equation leaving only time incarcerated (.34), psychopathy (.37), coping efficacy (-.26), and mental health treatment in the community (.24) to explain 40% of the variability. Psychopathy, although a significant predictor of self-harm, was found to be a better predictor of violence directed towards others than violence directed towards the self.

The unique patterns of relationships among psychopathic women include a positive correlation with self-harming behaviors ($r = .39$; Loucks, 1995), a greater frequency of engaging in prostitution, giving up their children, and experiencing physical abuse in adulthood (Strachan, 1993). It is important to note that the relation between psychopathy (total and factor 2) and abdication of childcare remained strongly significant even when drug abuse and prostitution were statistically controlled.

Psychopathy and victimization

There exists some previous interest in the association between childhood experiences of abuse and psychopathy (Jenkins & Hewitt, 1944; McCord & McCord, 1959), however, few included females as part of their sample. Strachan (1993) was the first author to investigate the relation between experiences of victimization and

psychopathy in a sample of 75 federal female offenders. Additionally, she was also the first to expand the time frame in which the abuse could occur to include adult experiences of physical and sexual abuse. Overall, 31% of her sample reported having been physically and 46% reported having been sexually abused in childhood. Furthermore, 38% said that they had been sexually assaulted in either adolescence or adulthood and 68% reported having been physically abused in adulthood. Comparing the psychopaths to the nonpsychopaths, she found that these two groups did not differ with respect to self-reported childhood sexual or physical abuse, or on self-reported sexual abuse as an adult. However, psychopaths were more likely to report that they had been physically abused as adults.

In a prospective cohorts design, Luntz and Widom (1994) examined the role of childhood abuse/neglect in adults with Antisocial Personality Disorder (APD). Although significantly more of the 699 male and female subjects interviewed met the criteria for APD if they had been abused/neglected (14%) than the controls (7%), no differences were detected among the females (5% vs. 2.6%, respectively).

More recently, Weiler and Widom (1996) examined the role of psychopathy in the relation between childhood victimization and violence. They used a prospective matched groups design in a community-based sample of 1069 males and females. Looking at the females in the sample, the results suggest that the abused/neglected females ($n = 320$) had significantly higher mean PCL-R scores than the controls ($n = 212$; 7.0 vs. 4.6, respectively). Furthermore, female PCL-R scores predicted official and self-reported involvement in violent offending. Moreover, childhood experiences of victimization did not predict violent behavior once the PCL-R score was entered.

Psychopathy, therefore, may act as a mediator between experiences of victimization and violent behavior. What this means is that children who have experienced abuse/neglect may be at increased risk of developing psychopathic symptoms which in turn may predispose them to being at higher risk for participating in violent antisocial behaviors, a path that is theoretically interesting but was not tested in this study.

Summary

Although there appears to be consensus with respect to the applicability of psychopathy as a valid construct amongst women, the use of the PCL-R in its present form may not be the most valid means of assessing this construct. Overall, the total scale and the factor structures appear to be similar to male prisoners, however, some authors (Neary, 1990; Salekin et al., 1997; Strachan, 1993) have reported that particular items are not that relevant to women (e.g., juvenile delinquency and revocation of conditional release). Furthermore, Salekin et al. (1997) reported that the two-factor structure needs some refinement for females given that the items appeared to load differently from that traditionally found with males. More specifically, Salekin et al. (1997) suggest that amongst females “[factor 1] is characterized by lack of empathy or guilt, interpersonal deception, proneness to boredom, and sensation seeking, and [factor 2] is characterized by early behavioral problems, promiscuity, and adult antisocial behavior” (p. 582). Moreover, Rutherford et al. (1996) have suggested that the validity of factor 1 may be enhanced by broadening the definition of such behaviors as deceitfulness and callousness to more accurately reflect the expressions of women. Some examples of this might be ostracism, aloofness, slandering others, and initiation of rumors. Furthermore, the modification of irresponsibility to include behaviors such as childcare neglect (parental or

babysitting), using others to meet their own needs (e.g., financial, power, sex) may help to increase the validity of factor 2.

Conclusion

The literature review suggests that although the relation between experiences of victimization and antisocial behavior are positive, the predictive nature of the relation remains somewhat controversial. Furthermore, the literature on coping and female offenders suggests that women in prison as well as those who have been victimized both display deficits in their abilities to cope effectively. Although coping deficits may be more pronounced in those with personality disorders, particularly psychopathy, the limited research with female offenders has failed to address this issue. It has been suggested that both psychopathy and coping may act as mediators linking the relation between experiences of victimization and antisocial behaviors, specifically violence directed towards the self and others, however to date this question has not been addressed empirically or statistically.

Purpose and Rationale

Based on the controversy in the literature surrounding the relation between experiences of victimization and subsequent antisocial behaviors among females, one might be tempted to conclude that experiences of victimization are not viable treatment targets while incarcerated. However, what needs to be emphasized is that, not only has the definition of abuse been restricted in some research (e.g., yes/no response), but also even fewer researchers have used prediction models to determine the nature of the relation between victimization and antisocial behaviors. Those few studies that have used predictive models have failed to uncover meaningful relations between victimization and antisocial behaviors among females. In light of the importance placed on coping and behavior within the research literature, the primary deficiency of these studies may have been their failure to investigate the role of mediating factors, such as coping. Furthermore, research has failed to include not only the full spectrum of abuse but to more clearly define relevant time periods in which the abuse occurred. For instance, since there is a belief that some women are violent in response to their abusive partners, it makes sense to include adulthood as a time period in which the type and extent of present abuse can be identified.

The current study proposed to investigate a model that suggested that experiences of victimization (physical and sexual) were related to violent behavior (other and self-directed) through two mediating factors: (1) coping strategies and (2) psychopathy. The primary hypotheses of interest are indicated by the unidirectional straight arrows on the model design attached in Appendix A. This model predicted that physical and sexual abuse would have direct effects on other and self-directed violence and indirect effects

through both psychopathy and coping. It was proposed that this model be tested for the three different time periods of abuse (in childhood, adolescence, and adulthood) experienced by the women in an effort to determine whether the proximity of the abuse played some sort of causal role in the model.

Furthermore, this research was designed to address questions regarding (1) the relation between psychopathy and coping strategies and (2) the relation between violence and coping strategies. Since psychopaths are impulsive, lack insight, and fail to learn from their experiences, it was hypothesized that those who scored higher on the PCL-R would employ less diverse patterns of coping, more problem focused strategies, and a greater degree of less functional coping styles than those who scored lower on the PCL-R. This same pattern was expected for those who were violent but not as severely deficient as in those who were psychopaths. No specific hypotheses were formulated regarding the specific coping strategies employed by those who were abused, who were psychopaths, and who were violent. Thus, this part of the research was exploratory in nature.

This research intended to fill several gaps in the literature. To (1) uncover the role of mediating variables; (2) contribute to theory development; (3) address the issue of specific coping strategies; and (4) include the full spectrum of abuse experienced by women. The goal of the final model was to provide insight into the complex relation between experiences of victimization and subsequent violent antisocial behaviors in an effort to provide some tangible treatment targets.

Method

Participants

The sample consisted of 38 incarcerated female offenders at the Ottawa-Carleton Detention Centre, a provincial institution in Ottawa, Ontario. This institution is a remand center which houses individuals who are either awaiting court dates or have been sentenced to serve less than 2 years. All women admitted for a minimum of four days between June 19 and September 26, 1998 were approached to volunteer in the study. Of the 43 women who were asked to participate, 2 refused and 3 were transferred prior to completing the full battery of self-report questionnaires. The women were not compensated in any manner for their involvement in this research.

This sample ranged in age from 18 to 53 with a mean age of 30.45 ($SD = 7.53$). The majority of the sample was Caucasian (84.2%) while the remainder was Black (5.3%), Native (7.9%), or Lebanese (2.6%). Most of the women were single (44.8%) or divorced (28.9%) while the minority was either married (5.3%), common-law (10.5%), or widowed (10.5%). With the exception of one individual, most women were unemployed in the year prior to incarceration (97.4%). The majority of the women who were unemployed were collecting welfare (71.1%). Self-reports indicated that 31.6% of the women had been previously diagnosed by a community professional with attention deficit disorder ($n = 4$), multiple personality disorder ($n = 3$), bipolar disorder ($n = 3$), depression ($n = 1$), or borderline personality disorder ($n = 1$). Additionally, 73.7% presently reported abusing drugs and 44.7% alcohol.

The sample consisted of 26 women (68.4%) who had been sentenced (24 provincial and 2 federal transfers) and 12 that were on remand (31.6%). The index

offenses were 55.3% nonviolent and 44.7% violent. The most severe types of convictions were murder (10.5%), sex offenses (7.9%), assault (26.3%), theft (23.7%), drug related (23.7%), and breaches (7.9%). The average sentence length was 7.97 months ($SD = 17.06$). On average the women had 13.33 ($SD = 17.02$) previous convictions of which 36.8% were violent (65.8% had a charge or convictions for violence). The average length of stay in the institution prior to participating in this study was 85.19 days ($SD = 195.25$).

Measures

Victimization Scale. This scale was adapted from Loucks (1995) as a method of measuring experiences of physical and sexual abuse during three age periods: childhood (less than 12; Appendix B), adolescence (12 to 18; Appendix C), and adulthood (over 18; Appendix D). Items 1 to 10 represented the severity of the physical abuse experienced, and ranged from having something thrown at them to being injured badly enough to require medical attention. Items 11 to 22 represented the severity of the sexual abuse experienced and ranged from being forced to look at pornographic pictures to being raped with an object. The frequencies of these experiences were represented on a 5-point scale ranging from “never” (0) to “too often to count” (4) for each possible perpetrator within each of the 22 items. The inclusion of all possible perpetrators was an effort to capture the full extent of victimization experienced. The frequency was summed separately for the two types of abuse and then collapsed to provide a total victimization score that reflected the degree to which the person had been victimized.

The prevalence rates for physical abuse were calculated based on a minimum of ever being “hit with a fist, kicked or thrown down the stairs or against a wall”. Likewise, anyone that reported at a minimum being “involuntarily touched, caressed, kissed and/or

hugged in a sexual way” was considered to have been sexually abused. These cutoffs are similar in severity to what has been used in community samples (Widom, 1989c).

COPE (Carver et al., 1989; Appendix E). A 60-item self-report questionnaire that consists of 15 theoretically distinct coping strategies. The coping strategies are as follows: (1) active, (2) planning, (3) seeking instrumental social support, (4) seeking emotional social support, (5) suppression of competing activities, (6) religion, (7) positive reinterpretation and growth, (8) restraint coping, (9) acceptance, (10) focusing on and venting emotions, (11) denial, (12) mental disengagement, (13) behavioral disengagement, (14) alcohol/drug use and (15) humor. Each strategy is comprised of 4 items each ranging from 1 (I usually don’t do this at all) to 4 (I usually do this a lot). Thus, the total score for each strategy ranges from 4 to 16 with higher scores reflecting a greater tendency to employ that strategy. Strategies 1, 2, 3, 4, 5, 6, 7, 8, and 9 comprise the *functional coping* subscale (possible range of scores from 36 to 144) while strategies 10, 11, 12, 13 and 14 comprise the *less functional coping* subscale (possible range of scores from 20 to 80). Furthermore, strategies 4, 6, 7, 9, and 11 comprise the emotion-focused subscale (possible range of scores from 20 to 80) while strategies 1, 2, 3, 5, and 8 and comprise the problem-focused subscale (possible range of scores from 20 to 80).

To determine whether the diversity of coping strategies employed was related to any of the measures, the coping strategies were recoded in a similar manner to Negy et al. (1997). A score less than 12 on any strategy was considered a rarely used strategy and was recoded a ‘0’. A score greater than 12 was considered a frequently used strategy and was recoded a ‘1’. These values were summed across all 15 coping strategies such that higher scores reflected a greater coping repertoire (possible range of scores was 0 to 15).

The reliability and validity of the COPE has been reported in a sample of 978 undergraduates (Carver et al., 1989). Cronbach's reliabilities were high ranging from .63 (behavioral disengagement) to .92 (turning to religion) with mental disengagement the only subscale falling below .6 (.45). Furthermore, 6-week test-retest reliability for the subscales ranged from .42 to .89 while the intercorrelations amongst the scales ranged from -.29 to .69. These relatively low intercorrelations suggest that the coping strategies are distinct and can be empirically examined as separate constructs. The COPE scale was used to measure general coping strategies while in the community. This scale was chosen primarily to address a common criticism that past coping scales have not been broad enough to reliably measure coping responses (McCrae, 1984).

Hare Psychopathy Checklist - Revised (PCL-R; Hare, 1991). A 60-90 minute semi-structured interview designed to assess psychopathy in a forensic population. The PCL-R measures the degree to which a person displays the prototypical characteristics of psychopathy and covers the following areas: educational history, relationships, family of origin, adolescent and adult behavioral problems, employment and educational history, and psychological well being. The interview was modified slightly to include questions regarding parental practices and the extent of involvement in childrearing in an effort to facilitate the scoring of items such as irresponsibility. This information was used to score the individual on a 20-item scale which ranged in degree of severity from a 0 (item definitely does not apply) to a 2 (item definitely does apply). The items were then summed to provide an overall total score (possible range 0 to 40) and two factor scores, one representing affective/interpersonal styles (factor 1) and the other representing antisocial/irresponsible lifestyles (factor 2) characteristic of psychopathy. The PCL-R has

demonstrated high inter-rater reliability in at least two samples of female offenders, .94 in Neary's (1990) sample of 120 women inmates and .95 in Strachan, Williamson, and Hare's (1990) sample of 40 women inmates. Furthermore, internal consistency in both samples was good with alpha's of .77 and .79, respectively, in addition to adequate average inter-item correlations (.14 and .19, respectively).

Self-Report Violence Questionnaire. The 30-item self-report questionnaire (Appendix F) was developed by the researcher to determine the frequency with which individuals engage in a variety of violent behaviors (versatility). The first subscale (items 1 – 12) reflects violence directed towards others such as robbery, possession of a weapon, and verbal threats. The second subscale (items 13 – 30) reflects violence directed towards oneself such as self-harm, mutilation, and attempted suicide. Items within each subscale ranged in severity from threats to actual physical harm. Frequency of occurrence for each item was rated using six categories: 0, 1-2, 3-5, 6-10, 11-20, and greater than 21 times. Frequency categories were coded consecutively from 0 to 5. Composite subscale scores reflecting the degree of self-reported violence for each individual were then obtained by summing frequency codes across all relevant subscale items. The subscale scores could range from 0 to 60 for other-directed violence, and from 0 to 90 for self-directed violence. Subscale scores were obtained separately for two periods, lifetime and in the past year.

Prevalence rates for other-directed violence were calculated based on a minimum requirement of ever having "hit anyone with the intention of physical injury". Likewise, the prevalence for self-directed violence required at a minimum ever having "tried to hurt yourself".

In order to determine whether the women engaged in a variety of different types of violent behavior, the items that were not endorsed were recoded as '0', and items that were endorsed with a minimum frequency 1 were recoded '1'. The summed subscale scores therefore reflect the versatility of self-reported violent behaviors separately for self- and other-directed violence.

Balanced Inventory of Desirable Responding: Version 6 (BIDR; Paulhus & Reid, 1991). This instrument was used as a means of detecting self-deception and impression management in responding to the research questions. Self-deception refers to the propensity to be overconfident in one's judgements and give positively biased responses. Impression management refers to the propensity to overreport desirable behaviors and underreport undesirable behaviors. The BIDR is a 40-item (two subscales of 20 items each) self-report questionnaire scored on a 7-point scale where 1 indicates the item is not true while 7 indicates the item is very true. One point is given for each extreme response (6 or 7) and yields two scores ranging from 0 to 20 for the two subscales. A higher score suggests that the individual is giving an exaggerated desirable response. This instrument has shown good test re-test reliability ($r = .81$), internal consistency ($r = .83$), and concurrent validity ($r = .71$ to $.80$; Paulhus, 1990).

Procedures

Prior to recruitment of the volunteers, this research was approved by the ethics committee at Carleton University, Ottawa-Carleton Detention Center (OCDC), and the Ministry of the Solicitor General and Correctional Services.

In order to establish initial contact with the women and to explain the purpose of this research, a first visit to the women's dorm at OCDC was arranged. The prospective

participants were told that the purpose of the study was to assess the relation between antisocial behaviors, personality, and the way they dealt with stressful situations in their lives. They were informed that personal questions regarding their family life, relationships, history of sexual and physical abuse, employment, education, and criminal history would be asked. They were given the right to skip any question they did not want to answer and/or to withdraw at any time during the study. They were also told that the information was for research purposes only and that anything they said would be held in strictest confidence, that I was not affiliated with Correctional Service Canada or the Ministry of the Solicitor General, and that participation would not influence release decisions. After explaining the study, the information sheets (Appendix G) were distributed and the women were informed that their participation would be discussed on an individual basis. Women who were in segregation, in maximum security, or who were admitted following this meeting were contacted on an individual basis.

During the individual meetings the purpose of the study as outlined above was repeated. The women were encouraged to ask questions to ensure that their participation was based on an informed decision. Confidentiality was ensured and the limits clearly explained as outlined in the informed consent (Appendix H).

Upon agreement to participate, the women were asked how long they had been at OCDC to ensure that they had some degree of stability within the institution (a minimum of 4 days). They were also asked whether they considered themselves to be suicidal. In order to eliminate those who may have been at increased risk due to the sensitive nature of the questions in this research. The women's answers were validated with the information contained in their institutional files. Only one woman required more time

prior to participating because she was in an acute state of detoxification from cocaine. No women required to be screened out due to suicide risk.

The participants were asked to read and sign the informed consent. They were also asked to provide consent to access institutional files (Appendix I) and to videotape or audiotape the interview (Appendix J). Participants were informed once again of their right to withhold consent for any of the above without fear of reprisal. The interview began directly following the signing of the consent forms.

Due to time limitations within the institution and the impact of fatigue from the interview, the assessment was divided into two separate sessions. The first session consisted of the interview. The second required the completion of self-report questionnaires (victimization, COPE, BIDR, violence). The interview session always preceded the self-report questionnaires in an attempt to develop rapport with the participant and promote an honest and thorough completion of the questionnaires. In an effort to minimize the effects of responses to one questionnaire influencing the responses to another, the self-report questionnaires were randomly ordered. At the completion of the second session, the participant was debriefed (Appendix K).

Since the interview, victimization questionnaire, and self-report violence questionnaire contained highly sensitive personal material, the participants were reminded at the end of each session that they could access the services listed on the information sheet (e.g., psychologist, psychiatrist, rape crisis, Elizabeth Fry) if they required additional support. If they no longer had their information sheet another one was provided at this time. In addition, a week following the completion of their participation, the researcher contacted the participant to ensure that they were not experiencing distress

as a result of participating in the research. There was only one situation in which this occurred and the participant was already accessing the services to which she was referred.

Upon completion of both sessions, the participants' medical and institutional files were reviewed (Appendix L), the PCL-R scored, and the coding manual completed (Appendix M). All names were replaced with an ID number and the forms locked in an office at Carleton University.

Results

Descriptive Statistics

Table 4 lists the variables measured in this study along with their means, standard deviations, and prevalence rates. Note the sample of 36 for adult sexual, physical, and total victimization. Out of the 38 women, 2 were unable to recount their experiences of victimization after the age of 18 since they were 18 years of age at the time this study was conducted.

The prevalence rates for victimization reported in Table 4 remained relatively unchanged even when calculated using all items in the scale: 89.5% for total childhood abuse, 73.7% for total adolescent abuse, 84.2% for total adult abuse, and 94.7% for total lifetime abuse. The only exception was the prevalence rate for childhood physical abuse (84.2%).

The prevalence rates were quite high when other-directed violence was limited to aggressive behaviors. Equivalent prevalence rates were obtained when the minimum requirement included verbal threats to others (89.5%). Compared to their official criminal records, the self-reported prevalence was more than twice that of their convictions for violence (36.8%) and a third greater than a combination of charges and convictions for violence (65.8%). Versatility of other-directed violence indicated that the women had committed on average 5 out of a maximum of 12 different violent behaviors in their lifetime. The most frequently reported behaviors were verbal threats (78.9%), hitting someone with the intention of harm (73.7%), and assaults (68.4%). The least frequently reported violent behaviors were sexual offenses (0%), arson (7.9%), and murder (7.9%).

The prevalence rates of self-directed violence suggested that two-thirds of the

women had tried to harm themselves in their lifetime. The rates were similar even when the calculation was based on thoughts of self-harm (65.8%), actual self-harm (65.8%), or attempted suicide (60.5%). The versatility of self-directed violence indicated that on average the women tried 2 out of a maximum of 12 different ways to harm or kill themselves. The most frequently endorsed methods were overdosing on pills (50%), slashing (39.5%), hitting their heads against a wall (21.1%), or self-mutilation (21.1%). The least frequently endorsed methods were forcing foreign objects in to their vagina (0%), an intentional driving accident (0%), using a gun (2.6%), or smothering themselves (5.3%).

Using the more traditional cutoff of 30 for a diagnosis of psychopathy, 15.8% of this sample was considered psychopathic. A more liberal cutoff of 25 commonly used in the literature investigating the prevalence of psychopathy with substance abusing women (Piotrowski et al., 1995; Rutherford et al., 1992; Rutherford et al., 1996) would double the prevalence rate of psychopathy to 31.6%.

The mean scores for the BIDR were similar to what has been reported in samples of religious (Quinn, 1989) and undergraduate females (Paulhus, 1988). Self-deception among religious females was 7.3 ($SD = 3.1$) and in female undergraduates was 6.8 ($SD = 3.1$). Similarly, impression management among religious females was 8.9 ($SD = 3.2$) and female undergraduates was 4.9 ($SD = 3.2$).

Table 4.

Means, Standard Deviations and Prevalence for the Measured Variables

Variable ^a	Mean	Standard deviation	Prevalence %
Victimization			
Child sexual	10.11	14.24	68.4
Child physical	17.03	18.21	65.8
Total child abuse	27.13	29.59	84.2
Adolescent sexual	9.71	15.96	47.4
Adolescent physical	16.89	23.84	65.8
Total adolescent abuse	26.61	37.53	68.4
Adult sexual	12.69	18.76	55.3
Adult physical	23.19	20.42	84.2
Total adult abuse	35.89	37.21	84.2
Lifetime sexual	31.84	43.54	84.2
Lifetime physical	55.89	56.10	89.5
Total lifetime abuse	87.74	95.48	92.1
Psychopathy			
Total	19.26	8.23	
Factor 1	7.03	4.78	
Factor 2	9.95	3.91	
Baserate (≥ 30)			15.8
Baserate (≥ 25)			31.6
Coping			
Less functional	51.66	11.45	
Functional	95.74	17.19	
Problem	51.74	10.84	
Emotion	52.26	9.49	
Diverse	6.11	2.98	
Violence			
Self-directed past year	6.47	7.76	65.8
Self-directed lifetime	12.11	13.29	76.3
Self-directed versatility	1.82	1.96	
Other-directed past year	8.05	8.20	76.3
Other-directed lifetime	13.26	10.96	86.8
Other-directed versatility	5.05	3.16	
BIDR			
Total	11.37	6.55	
Impression management	5.11	3.81	
Self-deception	6.26	3.58	

^a $n = 38$ for each variable except adult sexual, physical and total victimization where $n = 36$.

Intercorrelations Within Each Scale

BIDR

Both the impression management and self-deception subscales of the BIDR were highly correlated with the total BIDR score (see Table 5). The intercorrelation between the subscales was consistent with the literature (Paulhus, 1984) which suggests that they should be moderately correlated (between .35 and .65). The scale demonstrated moderate internal consistency. Cronbach's alpha was .84 for the entire scale, .68 for the self-deception subscale, and .84 for the impression management subscale, consistent with Paulhus (1988). Mean inter-item correlations were relatively low for the whole scale (.11), self-deception (.09) and impression management (.20).

Table 5.

Intercorrelations Among the BIDR Subscales

	BIDR total	Impression management	Self-deception
BIDR total	1.00		
Impression management	.89**	1.00	
Self-deception	.88**	.53**	1.00

** $p < .01$.

Victimization scale

The intercorrelations displayed in Table 6 between child, adolescent, and adult physical and sexual abuse were consistently high (.55 or greater) suggesting that reports of physical or sexual abuse in childhood are extremely likely to be accompanied by reports of abuse in adolescence and adulthood. As a consequence, only the lifetime abuse

variable was used in subsequent analyses.

The scale demonstrated good internal consistency. Cronbach's alpha for lifetime measures of victimization was .98, .97 for lifetime physical abuse, and .96 for lifetime sexual abuse. The mean inter-item correlation was .41 for lifetime victimization, .53 for lifetime physical abuse, and .39 for lifetime sexual abuse.

Table 6.

Intercorrelation Among the Victimization Subscales

	1	2	3	4	5	6	7	8	9	10	11	12
1. Child sexual	1.00											
2. Child physical	.66	1.00										
3. Total child abuse	.89	.93	1.00									
4. Adolescent sexual	.73	.61	.72	1.00								
5. Adolescent physical	.64	.74	.76	.77	1.00							
6. Total adolescent abuse	.71	.73	.79	.91	.96	1.00						
7. Adult sexual	.55	.57	.62	.84	.69	.79	1.00					
8. Adult physical	.58	.64	.67	.71	.78	.79	.80	1.00				
9. Total adult abuse	.60	.64	.68	.81	.78	.83	.95	.95	1.00			
10. Lifetime sexual	.83	.67	.81	.94	.78	.90	.91	.78	.89	1.00		
11. Lifetime physical	.70	.86	.87	.77	.94	.92	.77	.89	.88	.83	1.00	
12. Total lifetime abuse	.79	.81	.88	.88	.91	.95	.86	.88	.92	.95	.83	1.00

Note. All correlations are significant at $p < .01$.

COPE

The means and standard deviations for this sample and the means reported for 1,030 undergraduate students in Carver et al. (1989) for the 15 coping strategies are listed in Table 7.

Table 7.

Means and Standard Deviations for the Coping Strategies

	Mailloux (1999)	Carver et al. (1989)	Sig. (.05)
Coping strategy	Mean (SD)	Mean (SD)	
Humor	9.68 (4.03)	-	
Functional subscale			
Acceptance	12.87 (2.35)	11.84 (2.56)	*
Active	10.26 (3.14)	11.89 (2.26)	*
Emotional social support	9.42 (3.07)	11.01 (3.46)	*
Instrumental social support	9.84 (3.03)	11.50 (2.88)	*
Planning	11.37 (3.15)	12.58 (2.66)	*
Positive reinterpretation	11.63 (3.36)	12.40 (2.43)	ns
Religion	10.08 (4.78)	8.82 (4.10)	ns
Restraint	10.16 (2.91)	10.28 (2.53)	ns
Suppressing competing activities	10.11 (2.89)	9.92 (2.42)	ns
Less functional subscale			
Alcohol & drugs	12.66 (4.70)	-	
Behavioral disengagement	8.50 (3.33)	6.11 (2.07)	*
Denial	8.26 (3.91)	6.07 (2.37)	*
Mental disengagement	10.50 (2.80)	9.66 (2.46)	ns
Venting emotions	11.74 (2.94)	10.17 (3.08)	*

Note. Possible range of scores for all strategies is from 4 to 16. '-' means not reported.

T-test were performed comparing the present sample to the undergraduate sample assuming heterogeneity of variance (due to large differences in sample size) and thus using a modified degrees of freedom (Welch-Satterthwaite solution). Important group differences emerged. The women offenders reported using more acceptance, behavioral disengagement, denial, and venting and using less active, emotional and instrumental social support, and planning.

The intercorrelations among the subscales of the COPE are presented in Table 8. As expected, the functional and less functional subscales were unrelated. In contrast, the emotion- and problem-focused subscales were significantly correlated suggesting that they may not be distinct constructs. Problem- and emotion-focused coping could not be treated as independent sources of information because they were highly intercorrelated with functional coping due to overlap in the scale items. Only the functional/less functional subscales of the COPE was used for subsequent analyses due to the greater uniqueness of information.

As expected, diversity of coping strategies was intercorrelated with the various subscales because diversity is calculated using all items within the scale. Since the purpose in investigating diversity was to understand how many different types of coping strategies the women used (rather than a style), it was decided to include this subscale regardless of the high intercorrelation.

Cronbach's alpha for the less functional subscale was .65 with a mean inter-item correlation of .27. Similarly, for the functional subscale Cronbach's alpha was .77 with a mean inter-item correlation of .27. Cronbach's alpha's for the strategies ranged from .46 (acceptance and mental disengagement) to .97 (alcohol and drug use). Moreover, inter-

item correlations ranged from .18 (acceptance and mental disengagement) to .88 (alcohol and drugs). The scale was not as internally consistent as previously reported in Carver et al. (1989)

Table 8.

Intercorrelations Among the Coping Subscales

	Functional	Less functional	Problem	Emotion	Diverse
Functional	1.00				
Less functional	-.14	1.00			
Problem	.89**	-.11	1.00		
Emotion	.76**	.20	.45**	1.00	
Diverse	.71**	.41*	.72**	.58**	1.00

* $p < .05$. ** $p < .01$.

PCL-R

Table 9 displays the patterns of intercorrelations for psychopathy. Factor 1 and factor 2 were within the range of expected correlations (.39 - .54) reported in Hare et al. (1990), replicating the stability of the PCL-R factors across different populations.

Cronbach's alpha was .86 for total scores, .89 for factor 1 and .76 for factor 2. Mean inter-item correlations were .24 for total scores, .50 for factor 1, and .26 for factor 2.

These results replicated what has been found in samples of male (Hare, 1991) and female (Neary, 1990; Strachan, 1993; Tien et al., 1993) offenders and supports the internal consistency of the scale.

Table 9.

Intercorrelations for the Psychopathy Checklist - Revised

	Total	Factor 1	Factor 2
Total	1.00		
Factor 1	.84**	1.00	
Factor 2	.81**	.41*	1.00

Note. Factor 1 represents an affective/interpersonal style and factor 2 represents an antisocial/irresponsible lifestyle.

$p < .05$. ** $p < .01$.

Self- and other-directed violence

The patterns of correlations among the subscales of the self-report violence questionnaire displayed in Table 10 suggest that those who report being violent towards others in their lifetime also report similar levels of violence towards others in the past year. Similarly, those who report having been violent towards themselves in their lifetime also report being violent towards themselves in the past year. These results are not surprising given that incidents of violence in the past year were included in lifetime estimates of violence. In an effort to prevent redundancy, subsequent analyses used lifetime measures of self- and other-directed violence.

Cronbach's alpha and mean inter-item correlations suggest the subscales are internally consistent. The alpha for other-directed violence was .88 and mean inter-item correlation was .40. The alpha for self-directed violence was .90 and mean inter-item correlation was .36.

Table 10.

Intercorrelations Among Self- and Other-Directed Violence

Violence	Other-directed violence		Self-directed violence	
	Lifetime	Past year	Lifetime	Past year
Other-directed violence				
Lifetime	1.00			
Past year	.78**	1.00		
Self-directed violence				
Lifetime	.47**	.31	1.00	
Past year	.21	.38*	.70**	1.00

* $p < .05$. ** $p < .01$.

Response Bias

The BIDR was used to determine whether respondents were completing the questionnaires in a manner that was purposely self-deceiving or that engaged in impression management. Table 11 demonstrates that the BIDR subscale scores were generally unrelated to the measured variables. Thus in general the women's answers were not biased. However, there were three meaningful correlations: (1) impression management and lifetime self- and other-directed violence, (2) impression management and versatility of self- and other-directed violence and (3) self-deception and less functional coping (see Appendix N for correlations between the BIDR and the different age periods for victimization). For correlational analyses involving these variables, self-deception or impression management was partialled out.

Table 11.

Correlation Between the BIDR Subscales and the Measured Variables

Measured variables	Impression management	Self-deception
Psychopathy		
PCL-R Total	-.01	.08
PCL-R Factor 1	.18	.22
PCL-R Factor 2	-.15	-.05
Violence		
Other-directed lifetime	-.31	.06
Versatility other-directed	-.39*	-.03
Self-directed lifetime	-.33	-.27
Versatility self-directed	-.27	-.24
Coping		
Functional	.22	.15
Less functional	-.23	-.38*
Diverse	.08	-.02
Victimization		
Lifetime sexual	-.11	-.07
Lifetime physical	-.04	-.07
Total lifetime abuse	-.07	-.07

* $p < .05$.**Impact of Victimization, Coping, and Psychopathy on Violence**

The primary purpose of this research was to investigate the relation between victimization and violence through two mediators, coping and psychopathy. A validation of this model would have required a sample size of at least 100 participants. The small sample size of 38 participants actually obtained precluded a full path analysis. This result section therefore focuses on the zero-order correlations for (1) victimization and violence, (2) coping and violence, and (3) psychopathy and violence. The subsequent section

entitled 'Exploratory Analyses Regarding Specific Coping Strategies' examines how violence, psychopathy and victimization relate to the use of specific coping strategies. The last section, entitled 'Path Analyses', provides two exploratory path analyses. One examines the mediating role of coping style in the relation between victimization and violence. The other examines the mediating role of psychopathy in the relation between victimization and violence.

Common practice recommends (Hays, 1994; Howell, 1992) that when performing numerous correlations the alpha level for rejecting the null hypothesis should be made more conservative. This procedure was not followed however, since the sample size was so small that meaningful effects might not have attained statistical significance. Although pointing to the importance of conventional significance levels in making generalizations, most statistical texts for the behavioral sciences emphasize that the theoretical meaning of the relations among variables is more important than strict statistical significance (Hays, 1994; Howell, 1992; Pedhazur, 1997). Despite its development in the context of multiple comparisons, Keppel's (1991) use of the "suspend judgements" category of statistical decision-making applies to these correlations. If correlation coefficients are compatible with previous research (correlations greater than .25) and/or are theoretically meaningful then they are discussed here as potentially important contributions to an understanding of victimization, coping, psychopathy, and violence. Caution should be exercised, however, requiring replication prior to formulating broad implications and definitive conclusions.

Relation of victimization with violence

Table 12 shows that the relation between lifetime victimization and self/other-directed violence is consistently positive. Whether the women have been physically or

sexually abused does not appear to affect the relation with self/other directed violence. The trends suggest that women who have been victimized in their lifetime may be at more risk of directing their violence inwardly rather than externally. Furthermore, the greater the extent of the victimization the greater variety of self and other directed behaviors they tend to engage in. For a detailed presentation of the correlations between self/other directed violence and the different age periods of victimization, see Appendix O.

Table 12.

Correlation Between Victimization and Violence^a

Victimization	Other-directed violence		Self-directed violence	
	Lifetime	Versatility	Lifetime	Versatility
Lifetime				
Sexual	.26	.22	.64**	.39*
Physical	.35	.36*	.60**	.45**
Total abuse	.32	.31	.65**	.44**

^a These are semi-partial correlations with impression management partialled out of violence.

* $p < .05$. ** $p < .01$.

Relation of coping subscales with violence

Table 13 depicts the correlations between the coping subscales and self/other-directed violence. No relation appears to exist between functional coping and lifetime or versatility of other-directed violence. This was also true for self-directed violence, however there was a negative correlation with versatility where those who had a greater repertoire of self-directed violent behaviors tended to use fewer functional coping styles. Regardless of the type of violence committed or its versatility, less functional coping

styles were associated with a greater degree of violence. Finally, diversity was not associated with violence suggesting that those who engage in violent behaviors do not tend to employ a diversity of coping strategies.

Table 13.

Correlation Between Coping and Violence^a

Coping subscales	Other-directed violence		Self-directed violence	
	Lifetime	Versatility	Lifetime	Versatility
Functional	.11	-.07	-.09	-.28
Less functional ^b	.32*	.26	.29	.27
Diverse	.20	.08	.10	-.14

^a These are semi-partial correlations with impression management partialled out of violence.

^b These are semi-partial correlations with self-deception partialled out of less functional coping.

* $p < .05$.

Relation of psychopathy with violence

A modified score for the PCL-R was used in correlations with other-directed violence in order to prevent inflated correlations. Items on the PCL-R that were directly associated with antisocial behavior, items 18 (juvenile delinquency) and 20 (criminal versatility), were excluded from each participants PCL-R total and factor 2 scores. As a result, the PCL-R total was prorated and scored out of 36 and factor 2 scored out of 16. The revised mean total PCL-R score was 17.47 ($SD = 7.52$) and factor 2 was 9.29 ($SD = 3.53$).

The PCL-R total and factor 2 scores were positively correlated with other-directed violence, both lifetime and versatility (Table 14) while factor 1 was unrelated. No relation was demonstrated between total PCL-R scores and self-directed violence (both

lifetime and versatility) primarily because of the differential association with the factor scores. Factor 2, however was positively correlated with self-directed violence, both lifetime and versatility. These results suggest the commission and repertoire of self- and other-directed violence may be more related to an antisocial, impulsive and irresponsible lifestyle than to an interpersonal and affective style.

Table 14.

Correlation Between Psychopathy and Violence^a

PCL-R	Other-directed violence		Self-directed violence	
	Lifetime	Versatility	Lifetime	Versatility
Total	.27	.27	.12	.04
Factor 1	.17	.17	-.08	-.16
Factor 2	.28	.33*	.27	.25

Note. Factor 1 represents an affective/interpersonal style and factor 2 represents an antisocial/irresponsible lifestyle.

^a These are semi-partial correlations with impression management partialled out of violence.

$p < .05$.

Exploratory Analyses Regarding Specific Coping Strategies

Relation to victimization

Appendix P displays the correlations addressing the exploratory hypothesis regarding victimization and the specific types of coping strategies employed. Regardless of the age period in which the abuse occurred, the use of alcohol and drugs as a means of coping accounts for anywhere between 6% (adult-sexual) and 11% (child-total) of the variability in victimization. Worthy of further investigation is a weaker trend with denial and restraint coping.

Relation to psychopathy

A secondary hypothesis proposed that individuals scoring higher on the PCL-R would use a greater number of less functional coping strategies but would exhibit less diversity in their selection of coping strategies compared to low PCL-R scorers. Table 15 shows that the PCL-R total and factor 1 scores were not related to the coping subscales. A pattern worthy of further investigation with larger sample sizes is the positive correlation of factor 2 with less functional coping but a negative correlation with the functional subscale.

Table 15.

Correlation Between Psychopathy and Coping Subscales

Coping subscales	PCL-R		
	Total	Factor 1	Factor 2
Functional	-.04	.00	-.16
Less functional ^a	.02	-.10	.13
Diverse	.07	-.04	.07

Note. Factor 1 represents an affective/interpersonal style and factor 2 represents an antisocial/irresponsible lifestyle.

^a These are semi-partial correlations with self-deception partialled out of less functional coping.

Appendix Q provides a more in-depth understanding of the above findings by displaying the correlations between psychopathy and the specific coping strategies. The coefficients suggest that psychopaths have a greater tendency to vent their emotions and are less likely to seek emotional support from others. Furthermore, the strong positive correlations with factor 2 suggest that they have a greater tendency to use alcohol and drugs to cope. Finally, worthy of further investigation with larger sample sizes is a trend

suggesting that psychopaths may tend to use more humor and planning and less instrumental social support and behavioral disengagement.

Relation to violence

Appendix R displays the correlations between violence and specific coping strategies. Regardless of the type of violence, using alcohol and drugs as a means of coping is highly correlated with both self- and other-directed violence. Worthy of further examination with larger sample sizes is a trend suggesting that those who engage in more other-directed violence (lifetime or versatility) may use less positive reinterpretation, and more planning and venting. For those who engaged in more self-directed violence, active coping and suppressing competing activities are less common coping strategies. Worthy of further investigation is a positive correlation with denial and emotional social support and a negative correlation with positive reinterpretation

Path Analyses

The unexpectedly small sample size obtained in this study precluded the proposed path analysis as outlined in Appendix A. Path analyses are permissible however, if the number of variables entered are kept to a minimum. Linear regression preferably requires 10 to 20 subjects per variable, however, less than 10 is acceptable if the effects are meaningful (Tabachnick & Fidell, 1996). Two exploratory post-hoc models were developed for path analysis based on theoretical rationale and on an examination of the strength of the zero-order correlations. These paths were modifications of the original model described in the "Purpose and Rationale". Although path weights change as a function of the variables included, these two simple models were used to examine the

possible mediating roles of two variables.

The variables chosen for inclusion into the 2 paths were lifetime total victimization and self- and other-directed violence with either less functional coping (model 1) or PCL-R factor 1 (model 2) acting as mediating variables. In fully recursive models such as these, path analysis decomposes the zero order correlations into direct and indirect effects thus permitting the investigation of mediating effects. A series of linear regressions were performed in order to obtain the standardized betas for each effect (represented by ρ in the diagrams).

Figure 1 represents the path model that incorporates less functional coping as a mediator between lifetime victimization and self- and other-directed violence. In this model the first step regressed other-directed violence (controlling for impression management) on lifetime victimization and less functional coping (controlling for self-deception). The second step regressed self-directed violence (controlling for impression management) on lifetime victimization and less functional coping. Finally, the third step regressed less functional coping on lifetime victimization.

The analysis demonstrated that less functional coping may act as a very mild mediator between lifetime victimization and self- and other-directed violent behavior. The indirect effect of lifetime victimization on other-directed violent behavior through less functional coping was .06 (i.e. $.22 \times .26$) and the direct effect was .26. Similarly, the indirect effect of lifetime victimization on self-directed violent behavior through less functional coping was .03 (i.e. $.22 \times .14$) and the direct effect was .61. These results may suggest that either victimization acts directly on violent behavior, or some other mediating variable, other than coping, better explains the relation.

Figure 1. Model with less functional coping as a mediating variable between lifetime victimization and self- and other-directed violence.

Figure 2 represents the path model that incorporates factor 1 of the PCL-R as a mediator between lifetime victimization and self- and other-directed violence. In this model the first step regressed other-directed violence (controlling for impression management) on lifetime victimization and factor 1. The second step regressed self-directed violence (controlling for impression management) on lifetime victimization and factor 1. Finally, the third step regressed factor 1 on lifetime victimization.

The analysis demonstrated that factor 1 does not mediate the relation between lifetime victimization and self- and other-directed violent behavior. The indirect effect of lifetime victimization on other-directed violent behavior through factor 1 was $-.03$ (i.e. $-.13 \times .21$) and the direct effect was $.35$. Similarly, the indirect effect of lifetime victimization on self-directed violent behavior through factor 1 was $.00$ (i.e. $-.01 \times .13$) and the direct effect was $.64$. These results again may suggest that either victimization acts directly on violent behavior, or some other mediating variable, other than factor 1, better explains the relation.

Figure 2. Model with PCL-R factor 1 as a mediating variable between lifetime victimization and self- and other-directed violence.

Discussion

The small sample size included in this research, in addition to the necessity to include meaningful but nonsignificant findings, requires that the results and implications be taken with caution. Although many of the findings replicated previous research despite the small sample size, further replication is necessary prior to relying on the results in formulating decisions or drawing conclusions regarding women offenders. Therefore, the following discussion will attempt to put forth some hypotheses for understanding the results while assuming that they are read with caution in mind.

This research offers preliminary support for the hypothesis that women offenders who have been physically and sexually victimized report committing a greater frequency and variety of self- and other-directed violent behaviors. Similarly those who used less functional coping strategies also exhibited enhanced violent behavior overall. Other-directed violent behavior displayed a tendency to increase with levels of psychopathy overall and with an antisocial and irresponsible lifestyle specifically. This type of lifestyle was also positively correlated with self-reported frequency and versatility of self-directed violence. This research failed to support the hypothesized mediating effects of coping and psychopathy in the relation between victimization and self/other-directed violence.

Prevalence Rates

This study extends our current knowledge regarding the prevalence of physical and sexual victimization among incarcerated women. The current findings demonstrate similar rates of abuse among provincially incarcerated women as compared to federally sentenced women (Bonta et al., 1995; Task Force on Federally Sentenced Women, 1990)

and higher rates than the general population (Statistics Canada, 1993). More specifically, preadolescent and lifetime prevalence rates for sexual and physical abuse replicated those found in research using similar methods for measuring abuse (Loucks, 1995). Despite differences in methodology used across the studies, the consistency in prevalence rates demonstrates that women offenders come from backgrounds in which abuse is common.

Comparisons of coping strategies in the current sample with those from previous studies is rendered difficult by the paucity of research on coping among female offenders in general, and with the COPE in particular. A caveat must be made before this issue is discussed. The mean subscale scores (functional/less functional and emotion/problem focused) all fell in the middle of their respective scales suggesting that the women in general may not engage in one style of coping at the expense of other styles.

Unfortunately, an examination of the extent to which all of these subscales were used as hypothesized was precluded by the high intercorrelations among the coping subscales. As such, the present research was only able to provide preliminary insight into the use of functional and less functional coping styles.

The prevalence of self-reported other-directed violence in this sample was substantially higher than their official criminal records. Twice as many women in this sample reported committing violent acts compared to frequencies based on official criminal convictions. The reported frequencies of violent acts was one third more than if charges of violence were considered in conjunction with criminal convictions. This suggests that official records underestimate the actual rate of violent behavior among women. However, the cutoff used to determine prevalence rates for the self-reported violence scale, when compared to the violent behaviors for which women are

incarcerated, may have been too liberal.

On average the women reported having committed 5 different types of other-directed violent behaviors ranging from verbal threats to murder. The vast majority of the behaviors, however, were of a minor nature such as verbally threatening, hitting, or assaulting someone. Few women in this sample reported engaging in seriously violent behaviors such as murder. These results again demonstrate that the overall prevalence of violent behaviors committed by women is high when consisting primarily of less serious forms of aggression. Therefore, an understanding of the magnitude of violent offending by women is very much influenced by the manner in which violence is defined.

High prevalence of self-directed violence was found in both the lifetime and past year. The prevalence was unaffected by the manner in which self-directed violence was defined. These results are consistent with other research on federally sentenced women (Heney, 1990; Loucks, 1995), demonstrating that provincially incarcerated women offenders may not differ in their rates of self-harming behaviors. Past research with women offenders has linked experiences of victimization with self-harming behaviors (Heney, 1990; Loucks, 1995). As such, the high rates of abuse in this sample may explain the high prevalence of self-harming behaviors since women have been reported to be more likely to focus their aggression on themselves (Dutton & Hart, 1992; Widom, 1989a).

On average the women reported attempting 2 different methods for harming themselves. The higher endorsement of behaviors that had communicative value (i.e. slashing, head banging, and self-mutilation) suggests they may be trying to manage or communicate their emotions (Pattison & Kahan, 1983). Consistent with research

highlighting gender differences in the manner in which suicide is attempted (Shneidman & Farberow, 1970), women in this sample used methods that were less definitive in fulfilling their goal (i.e. pills versus guns).

The self-reports of lifetime and versatility of self- and other-directed violent behavior were likely an underestimate in both frequency and severity. The correlations with the BIDR suggest that there was a propensity to underreport the violent behaviors that were considered undesirable. However, the similarity of the women's mean scores on the BIDR when compared to other populations (Paulhus, 1989; Quinn, 1988) contradicts the stereotypical view that people who are incarcerated lie and deceive to a greater extent than people who are not incarcerated. The agreement across the different populations implies that this sample of female offenders engaged in an equivalent degree of conscious lying, denying of negative attributes and behaviors, overconfidence in judgements, and sense of rationality as females who are religious or undergraduates (Paulhus, 1989; Quinn, 1988). The higher frequency of violent behaviors using the self-report measure compared to official criminal records suggests that the guarantee to confidentiality and the right to refuse/withdraw from participation without repercussions may have provided these incarcerated women with a context within which they felt comfortable talking about their experiences.

A comparison of specific coping strategies used by women offenders to those used by undergraduate students (Carver et al., 1989) suggests important population differences. Female offenders in this sample tended to rely more on strategies characterized by low functionality. They reported using more behavioral disengagement, denial, and venting emotions and less emotional and instrumental social support,

planning and active coping than undergraduate students. Presumably they also used more alcohol and drugs given the high prevalence of substance abuse problems in this sample. However, such a comparison is only hypothetical since Carver et al. (1989) did not provide mean substance abuse scores for the undergraduate sample. In contrast to non-offenders, a typical female offender in this sample was one who tended to cope by denying her problems, readily giving up on efforts to change, focusing on and venting her distress, and choosing to be a loner rather than rely on others for moral support or advice.

The differences in coping strategies between female offenders and undergraduate students might have been even greater had the responses of the female offenders not been affected by biases. Response patterns on the BIDR suggested that the women had a tendency to exaggerate their use of functional coping strategies (i.e., acceptance, active, and emotional social support) and underestimate their use of less functional coping strategies (i.e., denial, mental disengagement, and venting). Unlike Carver et al. (1989), women offenders may have been able to identify the strategies that were considered to be more desirable and endorse them accordingly. Although the face validity of the COPE could conceivably render the items susceptible to response bias, the tendency to censure undesirable behaviors and exaggerate positive ones may simply reflect the same type of evaluation apprehension observed in non-inmate populations (Walker, 1973). Unfortunately, direct comparisons with female non-inmates are not possible since no research has been done on the relation of the BIDR with the COPE.

The characteristics that define psychopathy are compatible with a criminal lifestyle. As such, women who are federally incarcerated should score higher on the PCL-R than women who are provincially incarcerated. Both of these populations should score

higher than community samples of women substance abusers. The distribution of PCL-R scores in this sample did in fact fall within this expected range of values. With the exception of Loucks (1995), all samples of federally sentenced women (Neary, 1990; Strachan, 1993; Tien et al., 1993) reported relatively higher total PCL-R scores than the present sample. Studies using community samples of substance abusing women (Piotrowski et al., 1995; Rutherford et al., 1992; Rutherford et al., 1996) have reported relatively lower total PCL-R scores than the present sample. The different distributions of total PCL-R scores should be accounted for by differences in factor 2 rather than factor 1. However, when compared to the other studies among female offenders the present results found factor 1 to be lower than expected. These differences may be due to the smaller sample size of this study which makes it's estimate of the population values more variable compared to previous studies that had considerably larger sample sizes (Loucks, 1995; Neary, 1990; Strachan, 1993; Tien et al., 1993).

The compatibility of the current results with previous research can also be examined using base rates of psychopathy. Base rates should be highest for federally incarcerated women and least for community samples, but midrange for provincially incarcerated women. Using the traditional diagnostic cutoff of 30 for a positive diagnosis of psychopathy, 15.8% of this sample met the criteria for psychopathy. This value was midway between that obtained for the other two populations (Neary, 1990; Piotrowski et al., 1995; Rutherford et al., 1992; Rutherford et al., 1996; Strachan, 1993; Tien et al., 1993) and consistent with the gender differences outlined in the introduction.

Victimization and Violence

Past research has shown that child abuse and neglect is correlated with a greater

disposition to engage in juvenile and adult antisocial behaviors (Alfaro, 1981; Bolton, Reich, & Gutierrez, 1977; Lewis, Pincus, Lovely, Spitzer, & Moy, 1987; McCord, 1983; Widom, 1989b; Widom, 1989c). Although these findings are consistent across retrospective (Lewis et al., 1987; Widom, 1989b; Widom, 1989c) and prospective studies (Alfaro, 1981; Bolton et al., 1977; McCord, 1983), they were obtained using male samples. The relation of victimization to antisocial behavior is more controversial when examined in women (Widom, 1989c) despite the well-documented high prevalence rates of victimization.

The primary findings of this research support the hypothesis that victimization at any point in a female offender's life is strongly related to increased self-reported indices of both self- and other-directed violence. The correlation is strongest with physical abuse, particularly in adulthood. These findings replicate previous research with females linking experiences of physical abuse to violent offending in adulthood (Husain, Annaserril & Harris, 1983; Jurik & Winn, 1990; Roundtree, Parker, Edwards, & Teddlie, 1982). It may be implied from these findings that the women are violent in response to their physically abusive partners. This is speculative, however, since motivational precursors to violent offending were not investigated. The retrospective nature of this design precludes any further speculation on the impact of different age periods of abuse on violent behavior. For this reason, lifetime measures are more relevant assessments of the relation between victimization and violence.

Previous research (Dutton & Hart, 1992; Widom, 1989a) suggests that females who were mistreated as children are more apt to direct their aggression inwards. In agreement with these findings, the current study suggests that women who have been

victimized direct their violence towards themselves to a greater extent than they direct it towards others regardless of when the abuse occurred, or what form the abuse took. Furthermore, experiences of victimization are related to versatility of self-directed violence suggesting that they use a variety of methods in trying to manage their emotional states. The pattern of correlations in this research was twice as strong as that found by Loucks (1995), a finding that may have been due to methodological differences in obtaining incidences of self-harming behaviors. Loucks (1995) correlated his victimization scale with institutional records of self-harming behaviors compared to this study's use of self-reported frequencies. Institutional records are likely to underestimate self-harming frequencies since admissions to this form of behavior often result in a period of segregation. Additionally, the women in this study may have been more open to admitting their self-harming patterns since the researcher was not affiliated with the institution.

Coping and Violence

Widom (1991) examined protective factors that would predict the avoidance of participating in antisocial behaviors for groups of girls and boys who had been maltreated in childhood. She found that being female played a significant role in avoiding future criminality. That is, more boys than girls who had been maltreated in childhood came in contact with the criminal justice system. Widom (1989d) and others (Dutton & Hart, 1992) explained the gender differences by suggesting that women who have been abused may in fact cope differently. The coping style they adopt would subsequently determine the probability of engaging in violent and aggressive behaviors directed towards themselves or others.

The hypothesis predicting that those who engaged in more violence would employ less diversity in their coping repertoires and a greater degree of less functional coping was partially supported. First, the variety of different methods of coping was unrelated to the frequency or versatility of violence. Therefore, violent behavior towards the self and others is not better understood by knowledge regarding the number of different coping strategies used. Second, women offenders who are violent towards themselves and others report using less functional coping styles supporting the second hypothesis. More violent women, therefore, used more disengaging strategies in coping with their stresses, such as giving up or distracting themselves, using drugs and alcohol, denial, and/or extensively focusing on their emotions.

These results compliment what has been found in other studies on female offenders using different methods of assessing coping styles. For instance, Blanchette (1997a) reported that violent women offenders were unable to generate choices, solve interpersonal conflicts, or understand the feelings of others, all of which converge with less functional coping styles. There are at least two possible explanations for these findings. First, women who are violent towards themselves and others may rely on less functional coping styles to cognitively deal with their violent reality. That is, they deny what they have done, they avoid thinking about it, they feel helpless, and escape through the use of drugs and alcohol. Second, it is equally possible that the ineffectiveness of their coping styles leads them to rely on violence as an alternative manner of coping. These explanations are highly speculative, however, as behavior is best understood within the context of occurrence. This study failed to investigate the motivations for violent offending or the context in which it occurred. Furthermore, the low reliability of

the COPE subscales raises concern regarding the ability of the COPE to accurately measure the dimensions of coping under investigation.

Psychopathy and Violence

Given the strong positive patterns of correlations between psychopathy and violence in past research among males (Hare, 1986; Hare & McPherson, 1984; Harris et al., 1989; Serin, 1991) and females (Loucks, 1995; Salekin et al., 1996; Strachan, 1993), the current findings extend the knowledge to include self-reported violent behaviors. The hypothesis predicting that those who scored higher on the PCL-R would engage in a greater frequency of self/other directed violence was supported. Higher PCL-R total and factor 2 scores were positively associated with greater frequency and versatility of violent behaviors. These results are consistent with studies using similar measures in samples of male young offenders (Forth & Burke, 1998) and female university students (Forth et al., 1996).

The positive correlation between lifetime self-directed violence and factor 2 replicates Loucks (1995) and may suggest those factors such as impulsivity, irresponsibility, and poor planning result in higher frequency and versatility of self-directed violence. The shallow and short-lived emotions displayed by psychopaths (factor 1) does not appear to render them susceptible to relying on self-directed violence as a means of managing or communicating their emotional needs.

Use of Specific Coping Strategies

An exploration of the hypotheses regarding victimization, violence, psychopathy and specific coping strategies provided some insight into the manner in which women offenders cope. Although the small sample size precluded comparisons among all of the

correlations displayed in Appendices S to U, some interesting patterns that are consistent with other results presented in this thesis are worth highlighting.

In general, the most common forms of coping in this population may be the use of alcohol and drugs, denial, and venting emotions, whether the women have been victimized, are violent, or are more psychopathic. This suggests that these specific forms of coping are more a function of their antisocial lifestyles than their experiences of abuse, their personality, or their propensity towards aggressive behavior. These results are consistent with comparisons previously made with undergraduate students (Carver et al., 1989).

More specifically, the negative trend with restraint coping in women who have been victimized in their lifetime suggests that they may be more likely to act impulsively (e.g., less likely to restrain) perhaps as a need to shun victimization and regain a sense of control over their lives. This, however, is speculation since motivations for employing specific coping strategies was not investigated.

The propensity to manipulate and con others is a defining characteristic of psychopathy and led to the hypothesis that psychopaths would endorse a greater diversity of coping strategies in an effort to achieve these means. The results of this study failed to support this hypothesis. In fact the number of coping strategies was unrelated to the affective, interpersonal, or behavioral characteristics encompassed by psychopathy and suggests that diversity of coping is not a defining feature of psychopathy.

It was further hypothesized that psychopaths would engage in a greater degree of less functional coping styles, however, the weak positive correlation with factor 2 failed to support this hypothesis. Consistent with this finding was a comparable but negative

correlation between factor 2 and the functional subscale. Future research should investigate these differential correlations in an effort to either lend support to or refute the suggestion made by Brown (1994) that psychopaths may not be effective copers.

The exploratory hypothesis investigating the coping strategies for psychopaths suggested they use fewer social support systems for obtaining advice, assistance, sympathy and understanding. Furthermore they are more likely to vent their emotions and use alcohol and drugs to cope. A trend worthy of future investigation suggests they may use more humor and planning and less behavioral disengagement, which supports the view that psychopaths are less likely to give up on their attempts to attain what they want. These coping methods are consistent with descriptions of psychopaths as individuals who are self-assured, loners by choice, and motivated by personal gain (Hare, 1991). Further investigations with larger sample sizes will help to determine whether these correlations do in fact differentiate psychopathic from non-psychopathic women.

Individuals who commit frequent violent acts towards others use coping strategies that create a negative view of their problems as well as a trend suggesting they may deal with stressors by venting and invoking step-by-step planning. These methods of coping best describe planned instrumental forms of aggression rather than reactive emotionally driven forms of aggression. If a violent individual sees the source of their stress in a more negative light then they may engage in more planning in their use of violence directed towards others. However, this explanation can only be hypothesized since measures of instrumentality and attributions of blame were not included.

Finally, those who engage in self-directed violence use coping strategies characterized by: (1) an inability to initiate direct forms of action, and (2) an inability to

avoid being distracted by other things. A trend worthy of future investigation suggests they may also have (1) an inability to see things in a positive light, (2) a greater reliance on emotional social supports, and (3) more denial. The greater reliance on social supports (the only functional strategy) implies that individuals who are self-harming may be trying to manage their emotions. The remaining methods of coping have likely proven ineffective and as a result the women are seeking relief through mutilation, self-harm, or even suicide. The reliance on self-directed violence as a method of coping might be reduced if these women were to use more functional coping strategies such as acceptance, restraint, and active coping.

Mediating Effects

The intention of investigating the proposed path diagram (Appendix A) was to determine the tenability of psychopathy and coping as mediators in a model derived to explain the relation between victimization and violence. The rationale for hypothesizing psychopathy as a mediator was based on a suggestion that some of the symptoms of psychopathy, such as conning, manipulation, lying and superficial charm (all characteristics of factor 1) might have first begun as coping mechanisms (Weiler & Widom, 1996). The resiliency of many who have been victimized, and the suggestion that coping strategies other than deviance are necessary to reform offenders (Smith & Pollack, 1976), provided the impetus for examining coping as a mediator.

Although the small sample size rendered it impossible to investigate the proposed path relations to the full extent, it was still possible to perform a restricted post-hoc analysis. Although this type of analysis inflates the probability of finding meaningful effects, it was thought to be an important contribution to the development of future

research. The selection of less functional coping and factor 1 as mediators was based primarily on theory and secondly on the strength of the zero order correlations.

The post-hoc path analyses suggested that the models were inconsistent with the data. The disconfirmation of the theory has two obvious implications. One, it may offer further support for the theoretical view of the intergenerational transmission of violence. This theory is founded in a social-learning perspective, which postulates that yesterday's victims of abuse are tomorrow's victimizers (Curtis, 1963; Feshbach, 1980; Straus, Gelles, & Steinmetz, 1980). Second, it may imply that variables other than coping or psychopathy act as mediators, such as attributions of blame.

Although these results may cast doubt on the validity of the model, several cautions are in order. First, it is possible that competing models are consistent with the data, for instance, victimization may have been a mediator between coping and violence. Second, the small sample size may have prevented an adequate examination of the effects. Third, the measures used may not have been the most sensitive to the psychological dimensions of interest. For instance, the COPE demonstrated poor internal consistency for the less functional coping style, which suggests it may not have reflected the dimension intended to be studied. Fourth, the magnitude of the regression coefficients are sensitive to the presence of other variables in the equation and as such the effects in a given model might have been different had the model been examined in its entirety as proposed.

Limitations of the Current Study

The major limitations of the current study are quite evident. First, this research was severely limited by the sample size. The unexpectedly small sample size to variable

ratio precluded a full investigation of the primary hypothesis regarding mediating variables. Further, the small sample size rendered the correlational analyses less stable for generalizability and required reliance on replication and meaning rather than on probability. As a result, the type and quantity of analyses performed were restricted in an effort to avoid overanalysis and the production of meaningless results. Nevertheless, meaningful effects emerged that, if replicated, may contribute to the growing body of knowledge on women offenders and provide relevant directions for future research.

Second, the retrospective nature of the design causes concern for the reliability of the data. Relying on memory for accounts of abuse that occurred, for some, over 40 years ago may have resulted in an under or overestimation of the actual prevalence and in recall bias (Mitchell & Jolley, 1996). This same limitation may have been a factor in reporting accounts of lifetime self- and other-directed violence.

Third, the inclusion of self-report measures always raises the issue of the validity of the results. Participants may take less care in responding accurately. They may have difficulty understanding the questions. And finally, they may be formulating a hypothesis concerning the purpose of the research and bias their responses accordingly. However, the inclusion of the BIDR was directed at minimizing this issue and resulted in a need to control for impression management and self-deception on a few occasions. Controlling for the BIDR simply strengthened existing relations.

Fourth, issues surrounding the limits of confidentiality are always present in samples of offenders. Many offenders within institutions have little faith in confidentiality and may fear the potential impact of participation on decisions regarding their future release. Given that only two individuals refused to participate, the impact of

this limitation was estimated to be minimal. Still others may have censored their disclosures due to discomfort with the material they were requested to discuss, or perhaps due to a belief that the researcher harbored ulterior motives for the study.

Finally, the lack of a control group and the use of provincially incarcerated women only, limit the generalizability of the research findings. A community based control group would have provided information regarding base rates in addition to increasing the variability in the measures of violence and victimization. The results of this study therefore may only be understood within the limits of provincially incarcerated women offenders and does not provide insight into federally sentenced women, women on community supervision, or non-offender populations.

Directions for Future Research

Before discarding the model that coping and psychopathy act as mediators in the relation between victimization and violence, several issues should be investigated. First, a larger sample size should be used in an effort to test the full model. This model should subsequently be cross-validated to ensure its validity in the population. Second, other potential mediating variables should be examined, such as attributions of blame, social support networks, and foster care placement. Third, other perhaps more sensitive measures for the variables could be used, for instance an interview format rather than self-report. Failure of the model despite these improvements may provide further support for the theoretical perspective that violence begets violence (Curtis, 1963; Dodge, Bates, & Pettit, 1990; Feshbach, 1980; Straus, Gelles, & Steinmetz, 1980).

Future research should investigate whether incarceration has an impact on the manner in which women cope. For instance, a repeated-measures design would direct the

offender to first answer according to the manner in which they cope in the community and then as they cope while incarcerated. Hypothetical scenarios similar to the Coping Situation Scale (Zamble, 1989) could be used to tap into the offenders ability to cope in a variety of similar situations both in the community and in the prison setting. This could be used in conjunction with the COPE to validate the results and to provide greater insight into the manner in which women offenders' cope.

Of equal importance is the inability to generalize the present research findings to other populations of women who come in contact with the criminal justice system. Future research should be directed at understanding the specific coping needs of women who are also in federal institutions and on community supervision. Using a cross-sectional method of investigation, the same experimental design could be administered to all three populations of women. This information would provide insights into whether the women within different correctional systems have similar coping deficits. Treatment planning could then more appropriately target the particular needs of the different populations of women offenders.

The current research was not intended to investigate all possible coping strategies and as such future research should explore additional forms of coping strategies. For instance strategies such as wishful thinking, seeking information, engaging in social comparisons, and assessing blame (Carver et al., 1989) may be relevant in understanding why women engage in antisocial behaviors.

Three possible methods could be used in order to answer the question regarding the effect of the age periods of abuse (childhood, adolescence, adulthood) on coping and violence. First, a prospective longitudinal design is the most valid and meaningful

manner to investigate this question. Children could be followed throughout their lifespan to determine incidents of abuse and how this impacts on the manner in which they cope and their involvement in antisocial behaviors. Second, a less labor intensive method would be to investigate a cross-section of individuals in the different developmental periods who have been abused and administer the coping and violence questionnaires. Third, a less reliable method would be to ask the women to recount their experiences of abuse in each developmental period and indicate how they coped and the extent of their violent behaviors during each of those developmental periods. Research designed to answer this question will then provide insight into whether coping and violence varies as a function of when the abuse occurred.

The high prevalence of abuse in populations of women offenders does not preclude the fact that many more women who have been abused do not come in contact with the criminal justice system. Whether these women use other forms of poor coping that does not result in patterns of offending, whether they have good coping skills, or whether there are other protective factors remains unanswered. Future research should incorporate a control group so that direct comparisons can be made across the populations.

Some personality disorders, such as borderline and histrionic personality disorder, are more frequently diagnosed among women compared to men in the general population (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 1994) and even more frequent in offender populations (Strachan, 1993). As such, it may be of future interest to expand the model to include assessments for characteristics encompassed by these disorders to determine if they differentially relate to

victimization, coping and violence.

Finally, an understanding of violent offending by women is best understood within the context in which the violence occurred. The addition of an interview or file review that is aimed at classifying women according to the degree of planning in their offenses, especially those of a violent nature, may enlighten the patterns of women offending. For instance, those who have an identifiable purpose other than in response to provocation or frustration would be classified as instrumental offenders. Reactive offenders would be those who committed their offenses within the context of a dispute or in self-defense. A clear definition, description and context of violent offending is necessary in order to represent the extent to which women are truly violent.

Implications and Conclusion

These preliminary research findings may add to the growing body of knowledge on female offenders and provide support for previous results disseminated in the literature. The replication of past research for the prevalence rates and patterns of correlations among the variables implies that this research is valuable and the non-significant correlations meaningful irrespective of the small sample size. Moreover, the findings contribute to a greater understanding of how women offenders cope with stress on a general level, an area that is relatively unexamined in the literature on women offenders. More specifically, the exploratory work on coping strategies provides impetus for future research and theory development in an effort to match treatment to the specific coping needs of the women.

In the very least, treatment for women offenders should address past and present experiences of abuse, irrespective of the system they are in (i.e., provincial or federal).

The replication of past research among women offenders endorses the reality that they experience a disproportionate amount of abuse in their backgrounds.

In a general sense, treatment for women offenders should address their use of coping strategies such as drugs and alcohol use, denial, and venting of emotions. These less functional coping strategies are relevant regardless of whether the women have been victimized, are psychopathic, or engage in high rates of self- or other directed violent. Zamble and Porporino (1990) have hypothesized that inadequate coping skills may be the central issue for continuation of antisocial behavior. Targeting these strategies for women offenders may help to reduce their risk of recidivism by relying less on deviance as a means of coping.

In a specific sense, women who have been victimized may benefit from learning to use more restraint coping. Psychopaths may benefit from learning to rely on others for support and using more behavioral disengagement. Finally, learning to use less planning and more positive reinterpretation may be helpful to those who are violent. Further research with larger sample sizes is required prior to placing too much emphasis on these recommendations.

The high prevalence of self-reported violence directed towards others as compared to official criminal records implies that the women are involved in more violence than their records indicate. This suggests that the addition of self-report measures of violence may enhance the accuracy of risk assessments. However, given the detrimental effects this information poses to the offender's correctional plan, the offender is unlikely to offer this information. At a minimum, these measures should be included in research with women offenders. If this is done, the definition of violence should be made

clear, a description of the type of violence committed should be provided, and the context in which the violence occurred should be reported in order to more accurately reflect the degree of violent offending.

In conclusion, the replication of past research and consistency with theory suggests that these findings are meaningful, despite the small sample size. Although the exploratory analyses are speculative, they provide a snapshot view of the manner in which women offenders cope, but more importantly provide relevant directions for future research. The need for more theory development and research on women offenders is self-evident. The overwhelmingly high prevalence of abuse among women offenders provides a strong impetus for future research investigating the relation between victimization and violence.

References

- Alfaro, J. (1981). Report on the relationship between child abuse and late socially deviant behavior. In R. J. Huner, & Y. E. Walker (Eds.), *Exploring the relationship between child abuse and delinquency* (pp. 175-219). Montclair, NJ: Allanheld, Osrum.
- Alterman, A. L., Cacciola, J. S., & Rutherford, M. J. (1993). Reliability of the Revised Psychopathy Checklist in substance abuse patients. *Psychological Assessment*, 5, 442-448.
- American Psychiatric Association. (1994). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed.). Washington, DC: Author.
- Anderson, C. (1977). Locus of control, coping behaviors, and performance in a stress setting: A longitudinal study. *Journal of Applied Psychology*, 62, 446-451.
- Billings, A. G., & Moos, R. H. (1984). Coping, stress, and social resources among adults with unipolar depression. *Journal of Personality and Social Psychology*, 46, 877-891.
- Blanchette, K. D. (1997a). Comparing violent and non-violent female offenders on risk and need. *Forum on Corrections Research*, 9, 14-18.
- Blanchette, K. D. (1997b). *Risk and need among federally-sentenced female offenders: A comparison of minimum-, medium-, and maximum-security inmates*. (Research Rep. No. R-58). Ottawa: Correctional Service Canada.
- Boe, R. (1992). *CSC offender population forecast for 1993 to 2002*. Ottawa: Correctional Service of Canada.
- Boe, R. (1997). *Review of the offender population forecast: Models, data and*

requirements – with provisional forecasts for 1998 to 2007 (Rep. No. R-59).

Ottawa: Correctional Service of Canada.

Bolton, F. G., Reich, J., & Gutierrez, S. E. (1977). Delinquency patterns in maltreated children and siblings. *Victimology*, 2, 349-359.

Bonta, J., Pang, B., & Wallace-Capretta, S. (1995). Predictors of recidivism among incarcerated female offenders. *The Prison Journal*, 75, 277-294.

Bourne, P. G. (1970). *Men, stress, and Vietnam*. Boston: Little, Browne, and Company.

Brown, S. L (1994). *Sexual aggression and psychopathy among incarcerated convicted rapists: Static, dynamic, and motivational precursors*. Unpublished masters thesis, Carleton University, Ottawa, Ontario, Canada.

Burgess, A. W., & Holmstrom, L. L. (1979). Adaptive strategies and recovery from rape. *American Journal of Psychiatry*, 136, 1278-1282.

Butler, E. W., & Adams, S. N. (1966). Typologies of delinquent girls: Some alternative approaches. *Social Forces*, 44, 401-407.

Canadian Centre for Justice and Statistics. (1993). *Adult correctional services in Canada, 1991-92* (Cat. No. 85-211). Ottawa, Ontario: Statistics Canada.

Canadian Centre for Justice and Statistics. (1995). *Canadian crime statistics 1994*. (Cat. No. 85-002). Ottawa, Ontario: Statistics Canada.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: A theoretically based approach. *Journal of Personality and Social Psychology*, 56, 267-283.

Cleckley, H. (1941). *The mask of sanity*. Saint Louis: The C.V. Mosby Company.

Cleckley, H. (1976). *The mask of sanity* (5th ed.). Saint Louis: The C.V. Mosby

Company.

- Cloninger, C. R., & Guze, S. B. (1970). Psychiatric illness and female criminality: The role of sociopathy and hysteria in antisocial women. *American Journal of Psychiatry*, 127, 303-311.
- Cochrane, R., & Robertson, A. (1975). Stress in the lives of parasuicides. *Social Psychiatry*, 10, 161-171.
- Cooke, D. J. (1995). Psychopathic disturbance in the Scottish prison population: The cross-cultural generalisability of the Hare Psychopathy Checklist. *Psychology, Crime and Law*, 2, 101-118.
- Cooke, D. J., & Michie, C. (1997). An item response theory analysis of the Hare Psychopathy Checklist-Revised. *Psychological Assessment*, 9, 3-13.
- Cornell, D., Warren, J., Hawk, G., Stafford, E., Oram, G., & Pine, D. (1996). Psychopathy in instrumental and reactive violent offenders. *Journal of Consulting and Clinical Psychology*, 64, 783-790.
- Cronike, R. C., & Moos, R. H. (1984). The role of predisposing and moderating factors in the stress-illness relationship. *Journal of Health and Social Behavior*, 25, 372-393.
- Curtis, G. C. (1963). Violence breeds violence-perhaps? *American Journal of Psychiatry*, 120, 386-387.
- Dell, C. A., & Boe, R. (1997). *Female young offenders in Canada: Recent trends* (Rep. No. B-18). Ottawa, Ontario: Correctional Service of Canada.
- Dodge, K. A., Bates, J. E., & Pettit, G. S. (1990). Mechanisms in the cycle of violence. *Science*, 250, 1678-1683.

- Dutton, D. G., & Hart, S. D. (1992). Evidence for long-term, specific effects of childhood abuse and neglect on criminal behavior in men. *International Journal of Offender Therapy and Comparative Criminology*, 36, 129-137.
- Fagan, J., & Wexler, S. (1987). Family origins of violent delinquents. *Criminology*, 25, 643-669.
- Feshbach, S. (1980). Child abuse and the dynamics of human aggression and violence. In J. Gerbner, C. J. Ross, & E. Zigler (Eds.), *Child abuse: An agenda for action*. New York: Oxford University Press.
- Folkman, S., & Lazarus, R. S. (1980). An analysis of coping in a middle-aged community sample. *Journal of Health and Social Behavior*, 21, 219-239.
- Folkman S., & Lazarus, R. S. (1985). If it changes it must be a process: A study of emotion and coping during three stages of a college examination. *Journal of Personality and Social Psychology*, 48, 150-170.
- Forth, A. E., & Burke, H. C. (1998). Psychopathy in adolescence: Assessment, violence, and developmental precursors. In D. J. Cooke, A. E. Forth, and R. D. Hare (Eds.), *Psychopathy: Theory, research and implications for society* (pp. 205-230). Dordrecht, The Netherlands: Kluwer Academic Publishers.
- Forth, A. E., Brown, S. L., Hart, S. D., & Hare, R. D. (1996). The assessment of psychopathy in male and female noncriminals: Reliability and validity. *Personality and Individual Differences*, 20, 531-543.
- Forth, A. E., Hart, S. D., & Hare, R. D. (1990). Assessment of psychopathy in male young offenders. *Psychological Assessment*, 2, 342-344.
- Gray, K. C., & Hutchinson, H. C. (1964). The psychopathic personality: A survey of

- Canadian psychiatrists' opinions. *Canadian Psychiatric Association Journal*, 9, 452-461.
- Hare, R. D. (1970). *Psychopathy: Theory and research*. New York: Wiley.
- Hare, R. D. (1980). A research scale for the assessment of psychopathy in criminal populations. *Personality and Individual Differences*, 1, 111-119.
- Hare, R. D. (1991). *The manual of the Hare Psychopathy Checklist-Revised*. Multi-Health Systems.
- Hare, R. D. (1993). *Without conscience: The disturbing world of the psychopaths among us*. New York: Pocket Books.
- Hare, R. D. (1996). Psychopathy: A clinical construct whose time has come. *Criminal Justice and Behavior*, 23, 25-54.
- Hare, R. D., Harpur, T. J., Hakstian, A. R., Forth, A. E., Hart, S. D., & Newman, J. P. (1990). The Revised Psychopathy Checklist: Reliability and factor structure. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 2, 338-341.
- Hare, R. D., & McPherson, L. M. (1984). Violent and aggressive behavior by criminal psychopaths. *International Journal of Law and Psychiatry*, 7, 35-50.
- Hare, R. D., McPherson, L. M., & Forth, A. E. (1988). Male psychopaths and their criminal careers. *Journal of Consulting and Clinical Psychology*, 56, 710-714.
- Harpur, T. J., Hakstian, A. R., & Hare, R. D. (1988). Factor structure of the Psychopathy Checklist. *Journal of Consulting and Clinical Psychology*, 56, 741-747.
- Harris, G. T., Rice, M. E., & Cormier, C. A. (1991). Psychopathy and violent recidivism. *Law and Human Behavior*, 15, 223-236.

- Harris, G. T., Rice, M. E., & Quinsey, V. L. (1993). Violent Recidivism of mentally disordered offenders: The development of a statistical prediction instrument. *Criminal Justice and Behavior*, 20, 315-335.
- Harris, G. T., Rice, M. E., & Quinsey, V. L. (1994). Psychopathy as a taxon: Evidence that psychopaths are a discrete class. *Journal of Consulting and Clinical Psychology*, 62, 387-397.
- Hart, S. D., & Hare, R. D. (1989). Discriminant validity of the Psychopathy Checklist in a forensic psychiatric population. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 1, 211-218.
- Hart, S. D., Hare, R. D., & Harpur, T. J. (1992). The Psychopathy Checklist: Overview for researchers and clinicians. In J. Rosen & P. McReynolds (Eds.), *Advances in psychological assessment* (Vol. 8, pp. 103-130). New York: Plenum.
- Hart, S. D., Cox, D. N., & Hare, R. R. (1995). *Manual for the Screening Version of the Hare Psychopathy Checklist-Revised (PCL-R: SV)*. Toronto: Multi-Health Systems.
- Hart, S. D., Kropp, P. R., & Hare, R. D. (1988). Performance of male psychopaths following conditional release from prison. *Journal of Consulting and Clinical Psychology*, 56, 227-232.
- Hays, W. L. (1994). *Statistics* (5th ed.). Forth Worth: Harcourt Brace College Publishers.
- Heney, J. (1990). *Report on self-injurious behavior in the Kingston Prison for Women*. Ottawa, Ontario: Correctional Service of Canada.
- Himelein, M. J., & McElrath, J. V. (1996). Resilient child sexual abuse survivors: Cognitive coping and illusion. *Child Abuse and Neglect*, 20, 747-758.

- Holmes, T. M., & Masuda, M. (1973). Life change and illness susceptibility. In J. P. Scott & E. C. Senay (Eds.), *Separation and depression: Clinical and research aspects* (pp. 161-186). Washington, D. C.: American Association for the Advancement of Science.
- Howell, D. C. (1992). *Statistical Methods for psychology* (3rd ed.). Belmont, California: Duxbury Press.
- Husain, A., Anasseril, D., & Harris, P. (1983). A study of young-age and mid-life homicidal women admitted to a psychiatric hospital for pre-trial evaluation. *Canadian Journal of Psychiatry*, 28, 109-113.
- Jenkins, R. L., & Hewitt, L. (1944). Types of personality structure in child guidance clinics. *American Journal of Orthopsychiatry*, 14, 84-94.
- Jurik, N. C., & Winn, R. (1990). Gender and homicide: A comparison of men and women who kill. *Violence and Victims*, 5, 227-242.
- Keppel, G. (1991). *Design and analysis: A researcher's handbook* (3rd ed.). Upper Saddle River, New Jersey: Prentice Hall.
- Kosson, D. S., Smith, S. S., & Newman, J. P. (1990). Evaluating the construct validity of psychopathy in Black and White male inmates: Three preliminary studies. *Journal of Abnormal Psychology*, 99, 250-259.
- Kruttschnitt, C., Heath, L., & Ward, D. (1986). Family violence, television viewing habits, and other adolescent experiences related to violent criminal behavior. *Criminology*, 24, 235-267.
- Lazarus, R. (1966). *Psychological stress and the coping process*. New York: McGraw-Hill Book Company.

- Lazarus, R., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York: Springer.
- Lazarus, R., & Launier, R. (1978). Stress-related transactions between person and environment. In L. A. Pervin & M. Lewis (Eds.), *Internal and external determinants of behavior* (pp. 287-327). New York: Plenum Press.
- Leitenberg, H., Greenwald, E., & Cado, S. (1992). A retrospective study of long-term methods of coping with having been sexually abused during childhood. *Child Abuse & Neglect*, 16, 399-407.
- Levenson, M. R., Kiehl, K. A., & Fitzpatrick, C. M. (1995). Assessing psychopathic attributes in a noninstitutionalized population. *Journal of Personality and Social Psychology*, 68, 151-158.
- Lewis, D. O., Pincus, J. H., Lovely, R., Spitzer, E., & Moy, E. (1987). Biopsychosocial characteristics of matched samples of delinquents and nondelinquents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 26, 744-752.
- Lilienfeld, S. O. (1994). Conceptual problems in the assessment of psychopathy. *Clinical Psychology Review*, 14, 17-38.
- Lipowski, Z. J. (1970). Physical illness, the individual, and the coping processes. *Psychiatry in Medicine*, 49, 91-102.
- Livesley, W. J. (1986). Trait and behavioral prototypes of personality disorder. *American Journal of Psychiatry*, 143, 728-732.
- Loucks, A. D. (1995). *Criminal behavior, violent behavior, and prison maladjustment in federal female offenders*. Unpublished doctoral dissertation, Queen's University, Kingston, Ontario, Canada.
- Loucks, A. D., & Zamble, E. (1994). Some comparisons of female and male serious

- offenders. *Forum on Corrections Research*, 6, 22-25.
- Luntz, B. K., & Widom, C. S. (1994). Antisocial personality disorder in abused and neglected children grown up. *American Journal of Psychiatry*, 151, 670-674.
- MacKenzie, D. L., Robinson, J. W., & Campbell, C. S. (1989). Long-term incarceration of female offenders: Prison adjustment and coping. *Criminal Justice and Behavior*, 16, 223-238.
- Masuda, M., Cutler, D. L., Hein, L., & Holmes, T. H. (1978). Life events and prisoners. *Archives of General Psychiatry*, 35, 197-203.
- McCord, J. (1983). A forty-year perspective on effects of child abuse and neglect. *Child Abuse and Neglect*, 7, 265-270.
- McCord, W., & McCord, J. (1964). *The psychopath: An essay on the criminal mind*. Princeton, NJ: Van Nostrand.
- McCrae, R. R. (1984). Situational determinants of coping responses: Loss, threat, and challenge. *Journal of Personality and Social Psychology*, 46, 919-928.
- Meloy, J. R. (1988). *The psychopathic mind: Origins, dynamics, and treatments*. Northvale, NJ: Aronson.
- Mitchell, M., & Jolley, J. (1996). *Research design explained*. NY: Harcourt Brace College Publishers.
- National Crime Prevention Council Canada. (1995, September). *Offender Profiles*. Ottawa, Ontario: Author.
- National Crime Prevention Council Canada. (1997, April). *Incarceration in Canada*. Ottawa, Ontario: Author.
- Neary, A. (1990). *DSM-III and Psychopathy Checklist assessment of antisocial*

- personality disorder in Black and White female felons*. Unpublished doctoral dissertation, University of Missouri, St. Louis.
- Negy, C., Woods, D. J., & Carlson, R. (1997). The relationship between female inmates' coping and adjustment in a minimum-security prison. *Criminal Justice and Behavior*, 24, 224-233.
- Pattison, E. M., & Kahan, J. (1983). The deliberate self-harm syndrome. *American Journal of Psychiatry*, 140, 867-872.
- Paulhus, D. L. (1984). Two-component models of socially desirable responding. *Journal of Personality and Social Psychology*, 46, 598-609.
- Paulhus, D. L. (1988). *Assessing self-deception and impression management in self-reports: The Balanced Inventory of Desirable Responding*. Unpublished manuscript, University of British Columbia, Vancouver, British Columbia.
- Paulhus, D. L. (1990). Measurement and control response bias. In J. P. Robinson, P. R. Shaver, & L. S. Wrightsman (Eds.), *Measurement of personality and social psychological attitudes* (pp. 37-41). San Diego: Academic Press.
- Paulhus, D. L., & Reid, D. B. (1991). Enhancement and denial in socially desirable responding. *Journal of Personality and Social Psychology*, 60, 307-317.
- Paykel, E. S., Pruscoff, B. A., & Myers, J. K. (1975). Suicide attempts and recent life events: A controlled comparison. *Archives of General Psychiatry*, 32, 327-333.
- Pedhazur, E. J. (1997). *Multiple regression in behavioral research* (3rd ed.). Fort Worth: Harcourt Brace College Publishers.
- Perry, J. C., & Cooper, S. H. (1985). Psychodynamics, symptoms, and outcome in borderline and antisocial personality disorders and bipolar type II affective

- disorder. In T. H. McGlashan (Ed.), *The borderline: Current empirical research* (pp. 21-41). Washington, DC: American Psychiatric Press.
- Perry, J. C., Lavori, P. W., Pagano, C. J., Hoke, L., & O'Connell, M. E. (1992). Life events and recurrent depression in borderline and antisocial personality disorders. *Journal of Personality Disorders, 6*, 394-407.
- Pinel, P. H. (1962). *A treatise on insanity*. New York: Hafner Publishing Company.
(Original work published 1806).
- Piotrowski, N. A., Tusel, D. J., Sees, K. L., Banys, P., & Hall, S. M. (1995).
Psychopathy, antisocial personality, and other personality disorders in opiate addicts: Assessment and treatment issues. *NIDA Research Monograph, Problems of Drug Dependence, Vol. 11*, Serial No. 158, p. 151.
- Pithers, W. D., Marques, J. K., Gibat, C. C., & Marlatt, G. A. (1983). Relapse prevention with sexual aggressors: A self control model of treatment and maintenance of change. In J. G. Greer & I. R. Stuart (Eds.), *The sexual aggressor: Current perspectives on treatment* (pp. 214-239). New York: Van Nostrand Reinhold.
- Porporino, F. J., & Zamble, E. (1984). Coping with imprisonment. *Canadian Journal of Criminology, 26*, 403-412.
- Quinn, B. A. (1989). *Religiousness and psychological well-being: An empirical investigation*. Unpublished doctoral dissertation, Wayne State University, Detroit.
- Rivera, B., & Widom, C. S. (1990). Childhood victimization and violent offending. *Violence and Victims, 5*, 19-35.
- Roundtree, G. A., Parker, A. D., Edwards, D. Q., & Teddlie, C. B. (1982). A survey of the types of crimes committed by incarcerated females in two states who reported

- being battered. *Corrective and Social Psychiatry and Journal of Behavior Technology, Methods, and Therapy*, 28, 23-26.
- Rutherford, M. J., Cacciola, J. S., & Alterman, A. L. (1992). The Psychopathy Checklist with women addicts. *NIDA Research Monograph, Problems of Drug Dependence, Vol. 1*, Serial no. 119, p.444.
- Rutherford, M. J., Cacciola, J. S., Alterman, A. L., & McKay, J. R. (1996). Reliability and validity of the Revised Psychopathy Checklist in women methadone patients. *Assessment*, 3, 145-156.
- Salekin, R. T., Rogers, R., & Sewell, K. W. (1997). Construct validity of psychopathy in a female offender sample: A multitrait-multimethod evaluation. *Journal of Abnormal Psychology*, 106, 576-585.
- Serin, R. C. (1991). Psychopathy and violence in criminals. *Journal of Interpersonal Violence*, 6, 423-431.
- Serin, R. C. (1996). Violent recidivism in criminal psychopaths. *Law and Human Behavior*, 20, 207-217.
- Serin, R. C., & Amos, N. L. (1995). The role of psychopathy in the assessment of dangerousness. *International Journal of Law and Psychiatry*, 18, 231-238.
- Serin, R. C., Peters, R. D., & Barbaree, H. E. (1990). Predictors of psychopathy and release outcome in a criminal population. *Psychological Assessment: A Journal of Consulting and Clinical Psychology*, 2, 419-422.
- Shneidman, E. S., & Farberow, N. C. (1970). Attempted and completed suicide. In E. S. Shneidman, N. L. Farberow, & R. E. Litman (Eds.), *The psychology of suicide*. New York: Science House.

- Smith, A. B., & Pollack, H. (1976). Deviance as a method of coping. *Crime and Delinquency*, 22, 3-16.
- Statistics Canada. (1993, November). *The Violence against women survey*. Ottawa, Ontario: Author.
- Strachan, C. E. (1993). *The assessment of psychopathy in female offenders*. Unpublished doctoral dissertation, University of British Columbia, Vancouver, British Columbia, Canada.
- Strachan, C. E., Williamson, S., & Hare, R. D. (1990). *Psychopathy and female offenders*. Unpublished manuscript, Department of Psychology, University of British Columbia, Vancouver, Canada.
- Straus, M., Gelles, R., & Steinmetz, S. K. (1980). *Behind closed doors: Violence in the American family*. Garden City, NY: Anchor Press.
- Tabachnick, B. G., & Fidell, L. S. (1996). *Using multivariate statistics* (3rd ed.). Northridge: Harper Collins College Publishers.
- Task Force on Federally Sentenced Women (1990). *Creating choices: Report on the Task Force on Federally Sentenced Women*. Ottawa, Ontario: Correctional Service Canada.
- Tien, G., Lamb, D., Bond, L., Gillstrom, B., & Paris, F. (1993). *Report on the needs assessment of women at the Burnaby Correctional Centre for Women*. Burnaby, British Columbia: BC Institute on Family Violence.
- Trainor, C., Normand, J., & Verdon, L. (1995). Women and the criminal justice system. In *Women in Canada: A statistical report* (3rd Ed.) (Statistics Canada cat. No. 89-503E, pp. 101-116). Ottawa, Ontario: Ministry of Industry.

- Walker, G. T. (1973). Behavior of temporary members in small groups. *Journal of Applied Psychology*, 58, 144-146.
- Weiler, B. L., & Widom, C. S. (1996). Psychopathy and violent behavior in abused and neglected young adults. *Criminal Behavior and Mental Health*, 6, 253-271.
- Widom, C. S. (1978). Towards and understanding of female criminality. *Progress in Experimental Personality Research*, 8, 245-308.
- Widom, C. S. (1989a). Child abuse, neglect, and adult behavior: Research design and findings on criminality, violence, and child abuse. *American Orthopsychiatric Association*, 59, 355-367.
- Widom, C. S. (1989b). The cycle of violence. *Science*, 244, 160-166.
- Widom, C. S. (1989c). Does violence beget violence? A critical examination of the literature. *Psychological Bulletin*, 106, 3-28.
- Widom, C. S. (1989d). The intergenerational transmission of violence. In N. A. Weiner & M. E. Wolfgang (Eds.), *Pathways to criminal violence* (pp. 137-201). Newbury Park, CA: Sage Publications.
- Widom, C. S. (1991). Avoidance of criminality in abused and neglected children. *Psychiatry*, 54, 162-174.
- Wirtz, P. W., & Harrell, A. V. (1987). Victim and crime characteristics, coping responses, and short- and long-term recovery from victimization. *Journal of Consulting and Clinical Psychology*, 55, 866-871.
- Wyler, A. R., Masuda, M., Holmes, T. H. (1971). Magnitude of life events and seriousness of illness. *Psychosomatic Medicine*, 33, 115-122.
- Zagon, I. K., & Jackson, H. J. (1994). Construct validity of a psychopathy measure.

Personality and Individual Differences, 17, 125-135.

Zamble, E. (1989). *Coping situations questionnaire: Form M*. Unpublished test. Queen's University, Kingston, Ontario, Canada.

Zamble, E., & Palmer, W. (1996). Prediction of recidivism using psychopathy and other psychologically meaningful variables. In D. J. Cooke, A. E. Forth, J. P. Newman, & R. D. Hare (Eds.), *International perspectives on psychopathy* (pp. 153-156). Leicester: The British Psychological Society.

Zamble, E., & Porporino, F. J. (1988). *Coping, behavior, and adaptation in prison inmates*. New York: Springer-Verlag.

Zamble, E., & Porporino, F. J. (1990). Coping, imprisonment, and rehabilitation: Some data and their implications. *Criminal Justice and Behaviour*, 14, 53-70.

MODEL

Appendix B

Research Questionnaire #1

Please answer these questions referring back to your **childhood (age 12 or under)**. Respond to every question by circling the frequency in which your mother and/or father committed the act listed. If some other person besides or in addition to your parents committed the listed act, please include them in "other" and tell us how they relate to you (e.g., stepparent, uncle, aunt, stranger, etc)

1. I was pushed, grabbed, or shoved by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

2. I was slapped by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

3. I was hit with a fist, kicked, or thrown down the stairs or against a wall by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

4. I was hit with an object by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

5. I was punished in inhumane ways (e.g., tied or locked up) by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

6. I was burned or bruised by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

7. I was threatened to be killed by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

8. A knife or a gun was used on me by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

9. I needed but did not get medical attention (e.g., stitches or cast) for wounds (e.g., broken bones or gashes) caused by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

10. I needed and received medical attention for injuries caused by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

11. I was forced to look at pornographic movies, magazines, or pictures by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

12. I had sexual pictures/movies taken of me against my will by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

13. I was forced to watch others participate in sexual activities by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

14. I was pressured to discuss details of my own sexual experiences by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

15. I was forced to listen to sexual things that I found disturbing by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

16. I was approached to participate in unwanted sexual activity but it did not take place or was not completed by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

17. I was involuntarily touched, caressed, kissed and/or hugged in a sexual way by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

18. I was forced to touch someone else in a sexual way by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

19. I was forced to perform sexual activities (not including intercourse and oral sex) against my will by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

20. I was forced to perform oral sex and/or have sexual intercourse by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

21. I was forced to participate in sexual activities involving more than 1 person by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

22. I was raped with an object by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

Appendix C

Research Questionnaire #2

Please answer these questions referring back to your **adolescence (13-17)**. Respond to every question by circling the frequency in which your mother and/or father committed the act listed. If some other person besides or in addition to your parents committed the listed act, please include them in "other" and tell us how they relate to you (e.g., stepparent, uncle, aunt, stranger, etc)

1. I was pushed, grabbed, or shoved by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

2. I was slapped by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

3. I was hit with a fist, kicked, or thrown down the stairs or against a wall by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

4. I was hit with an object by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

5. I was punished in inhumane ways (e.g., tied or locked up) by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

6. I was burned or bruised by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

7. I was threatened to be killed by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

8. A knife or a gun was used on me by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

9. I needed but did not get medical attention (e.g., stitches or cast) for wounds (e.g., broken bones or gashes) caused by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

10. I needed and received medical attention for injuries caused by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

11. I was forced to look at pornographic movies, magazines, or pictures by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

12. I had sexual pictures/movies taken of me against my will by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

13. I was forced to watch others participate in sexual activities by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

14. I was pressured to discuss details of my own sexual experiences by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

15. I was forced to listen to sexual things that I found disturbing by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

16. I was approached to participate in unwanted sexual activity but it did not take place or was not completed by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

17. I was involuntarily touched, caressed, kissed and/or hugged in a sexual way by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

18. I was forced to touch someone else in a sexual way by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

19. I was forced to perform sexual activities (not including intercourse and oral sex) against my will by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

20. I was forced to perform oral sex and/or have sexual intercourse by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

21. I was forced to participate in sexual activities involving more than 1 person by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

22. I was raped with an object by:

	Never	Once	A few Times	Many Times	Too often to count
Mother	0	1	2	3	4
Father	0	1	2	3	4
Partner: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

Appendix D

Research Questionnaire #3

Please answer these questions referring to your **adulthood (18 and older)**. Respond to every question by circling the frequency in which your mother and/or father committed the act listed. If some other person besides or in addition to your parents committed the listed act, please include them in "other" and tell us how they relate to you (e.g., stepparent, uncle, aunt, stranger, etc)

1. I was pushed, grabbed, or shoved by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

2. I was slapped by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

3. I was hit with a fist, kicked, or thrown down the stairs or against a wall by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

4. I was hit with an object by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

5. I was punished in inhumane ways (e.g., tied or locked up) by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

6. I was burned or bruised by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other:_____	0	1	2	3	4
Other:_____	0	1	2	3	4

7. I was threatened to be killed by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

8. A knife or a gun was used on me by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

9. I needed but did not get medical attention (e.g., stitches or cast) for wounds (e.g., broken bones or gashes) caused by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

10. I needed and received medical attention for injuries caused by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

11. I was forced to look at pornographic movies, magazines, or pictures by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

12. I had sexual pictures/movies taken of me against my will by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

13. I was forced to watch others participate in sexual activities by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

14. I was pressured to discuss details of my own sexual experiences by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

15. I was forced to listen to sexual things that I found disturbing by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

16. I was approached to participate in unwanted sexual activity but it did not take place or was not completed by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

17. I was involuntarily touched, caressed, kissed and/or hugged in a sexual way by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

18. I was forced to touch someone else in a sexual way by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

19. I was forced to perform sexual activities (not including intercourse and oral sex) against my will by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

20. I was forced to perform oral sex and/or have sexual intercourse by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

21. I was forced to participate in sexual activities involving more than 1 person by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

22. I was raped with an object by:

	Never	Once	A few Times	Many Times	Too often to count
Partner	0	1	2	3	4
Partner	0	1	2	3	4
Other: _____	0	1	2	3	4
Other: _____	0	1	2	3	4

Appendix E

COPE

We are interested in how people respond when they confront difficult or stressful events in their lives. There are lots of ways to deal with stress. Different stressful events obviously bring out somewhat different patterns of responding. On this questionnaire we are asking that you indicate how you **usually** respond to the problems or events you find stressful. Please use the following 4-point scale to respond to the following questions.

	1	2	3	4
	I usually <u>don't</u>
do this at all	I usually do this
<u>a little bit</u>	I usually do this
<u>a medium amount</u>	I usually do this
<u>a lot</u>
1)	1 2 3 4			
				I try to grow as a person as a result of the experience.
2)	1 2 3 4			
				I turn to work or other substitute activities to take my mind off things.
3)	1 2 3 4			
				I get upset and let my emotions out.
4)	1 2 3 4			
				I try to get advice from someone about what to do.
5)	1 2 3 4			
				I concentrate my efforts on doing something about it.
6)	1 2 3 4			
				I say to myself "this isn't real".
7)	1 2 3 4			
				I put my trust in a spiritual being.
8)	1 2 3 4			
				I laugh about the situation.
9)	1 2 3 4			
				I admit to myself that I can't deal with it and quit trying.
10)	1 2 3 4			
				I restrain myself from doing anything too quickly.
11)	1 2 3 4			
				I discuss my feelings with someone.
12)	1 2 3 4			
				I use alcohol or drugs to make myself feel better.
13)	1 2 3 4			
				I get used to the idea that it happened.
14)	1 2 3 4			
				I talk to someone to find out more about the situation.
15)	1 2 3 4			
				I keep myself from getting distracted by other thoughts or activities.
16)	1 2 3 4			
				I daydream about things other than this.
17)	1 2 3 4			
				I get upset and am really aware of it.

PLEASE TURN OVER THE PAGE AND CONTINUE

	1	2	3	4
	I usually <u>don't</u>	I usually do this	I usually do this	I usually do this
	do this at all	<u>a little bit</u>	<u>a medium amount</u>	<u>a lot</u>
18)	1 2 3 4	I seek spiritual guidance.		
19)	1 2 3 4	I make a plan of action.		
20)	1 2 3 4	I make jokes about it.		
21)	1 2 3 4	I accept that this has happened and that it can't be changed.		
22)	1 2 3 4	I hold off doing anything about it until the situation permits.		
23)	1 2 3 4	I try to get emotional support from friends or relatives.		
24)	1 2 3 4	I just give up trying to reach my goal.		
25)	1 2 3 4	I take additional action to try to get rid of the problem.		
26)	1 2 3 4	I try to lose myself for a while by drinking alcohol or taking drugs.		
27)	1 2 3 4	I refuse to believe that it has happened.		
28)	1 2 3 4	I let my feelings out.		
29)	1 2 3 4	I try to see it in a different light, to make it seem more positive.		
30)	1 2 3 4	I talk to someone who could do something concrete about the problem.		
31)	1 2 3 4	I sleep more than usual.		
32)	1 2 3 4	I try to come up with a strategy about what to do.		
33)	1 2 3 4	I focus on dealing with this problem, and if necessary let other things slide a little.		
34)	1 2 3 4	I seek sympathy and understanding from someone.		
35)	1 2 3 4	I drink alcohol or take drugs in order to think about it less.		
36)	1 2 3 4	I kid around about it.		
37)	1 2 3 4	I give up the attempt to get what I want.		
38)	1 2 3 4	I look for something good in what is happening.		
39)	1 2 3 4	I think about how I might best handle the problem.		
40)	1 2 3 4	I pretend that it hasn't really happened.		
41)	1 2 3 4	I make sure not to make matters worse by acting too soon.		

PLEASE TURN OVER THE PAGE AND CONTINUE

	1 I usually <u>don't</u> do this at all	2 I usually do this <u>a little bit</u>	3 I usually do this <u>a medium amount</u>	4 I usually do this <u>a lot</u>
42)	1 2 3 4	I try hard to prevent other things from interfering with my efforts at dealing with this.		
43)	1 2 3 4	I go to the movies or watch TV to think about it less.		
44)	1 2 3 4	I ask people who have had similar experiences what they did.		
45)	1 2 3 4	I feel a lot of emotional distress and I find myself expressing those feelings a lot.		
46)	1 2 3 4	I take direct action to get around the problem.		
47)	1 2 3 4	I try to find comfort in my spirituality.		
48)	1 2 3 4	I force myself to wait for the right time to do something.		
49)	1 2 3 4	I make fun of the situation.		
50)	1 2 3 4	I reduce the amount of effort I'm putting into solving the problem.		
51)	1 2 3 4	I talk to someone about how I feel.		
52)	1 2 3 4	I use alcohol or drugs to help me get through it.		
53)	1 2 3 4	I learn to live with it.		
54)	1 2 3 4	I put aside other activities in order to concentrate on this.		
55)	1 2 3 4	I think hard about what steps to take.		
56)	1 2 3 4	I act as though it hasn't even happened.		
57)	1 2 3 4	I do what has to be done one step at a time.		
58)	1 2 3 4	I learn something from the experience.		
59)	1 2 3 4	I seek spiritual guidance more than usual.		
60)	1 2 3 4	I accept the reality of the fact that it happened		

END

Appendix F

Self-Report Violence Questionnaire

I.D.#: _____

The purpose of this questionnaire is to determine how often you engage in antisocial and/or criminal behaviors. The following pages list some activities that you may or may not have engaged in. These behaviors vary from ones you may direct towards others to behaviors that you may direct towards yourself. When you fill out the questionnaire, we ask that you refer to **ALL** behaviors you have committed in your lifetime whether you have been charged for them or not. This information is under the same confidentiality agreement we made at the outset, that is an ID number will replace your name.

Here is an example:

EVER					Have you ever	LAST YEAR						
0	1-2	<u>3-5</u>	6-10	11-20	21+	started a fight?	0	<u>1-2</u>	3-5	6-10	11-20	21+

There are 2 columns that refer to the same question. Circle the number of times that you have committed that particular behavior **EVER** in your lifetime (left hand column) and then how many times you committed that behavior in the **LAST YEAR** (right hand column). For example, if in your lifetime you have started a fight 5 times then you would circle the frequency '3-5'. Then if this has only occurred once in the last year then you would circle the frequency '1-2' in the second column.

Please try to answer all of the questions. If you are uncomfortable with any of the questions, however, you have the right to skip it and proceed to the next. If there are any that are unclear to you please do not hesitate to ask the researcher.

EVER		LAST YEAR
0 1-2 3-5 6-10 11-20 21+	1. Have you ever intentionally verbally threatened anyone (e.g., bullying, extortion, etc.)?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	2. Have you ever hit anyone with the intention of physical injury?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	3. Have you ever physically injured anyone?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	4. Have you ever carried a weapon (e.g., gun, knife, etc.)?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	5. Have you ever threatened someone with a weapon?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	6. Have you ever injured someone with a weapon?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	7. Have you ever committed arson?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	8. Have you ever committed or assisted in a robbery or mugging?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	9. Have you ever attempted to or succeeded in engaging in sexual activities with anyone against their will?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	10. Have you ever assisted in an assault or murder?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	11. Have you ever assaulted anyone?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	12. Have you ever killed anyone?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	13. Have you ever thought about hurting yourself?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	14. Have you ever tried to hurt yourself?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	15. Have you ever thought about killing yourself?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	16. Have you ever tried to kill yourself?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	17. Have you ever been on suicide watch?	0 1-2 3-5 6-10 11-20 21+
0 1-2 3-5 6-10 11-20 21+	18. Have you ever been seen by a psychiatrist on the outside for attempted suicide?	0 1-2 3-5 6-10 11-20 21+

EVER**LAST YEAR**

0 1-2 3-5 6-10 11-20 21+

19. Have you ever overdosed on pills
or nonprescription drugs/alcohol?

0 1-2 3-5 6-10 11-20 21+

0 1-2 3-5 6-10 11-20 21+

20. Have you ever tried to starve yourself
to death?

0 1-2 3-5 6-10 11-20 21+

0 1-2 3-5 6-10 11-20 21+

21. Have you ever intentionally had a
driving accident?

0 1-2 3-5 6-10 11-20 21+

0 1-2 3-5 6-10 11-20 21+

22. Have you ever tried to hang yourself?

0 1-2 3-5 6-10 11-20 21+

0 1-2 3-5 6-10 11-20 21+

23. Have you ever used a gun against
yourself?

0 1-2 3-5 6-10 11-20 21+

0 1-2 3-5 6-10 11-20 21+

24. Have you ever tried to smother
yourself (e.g., car, oven)?

0 1-2 3-5 6-10 11-20 21+

0 1-2 3-5 6-10 11-20 21+

25. Have you ever hit your head against
a wall with the intention of hurting
yourself?

0 1-2 3-5 6-10 11-20 21+

0 1-2 3-5 6-10 11-20 21+

26. Have you ever slashed yourself?

0 1-2 3-5 6-10 11-20 21+

0 1-2 3-5 6-10 11-20 21+

27. Have you ever mutilated yourself?

0 1-2 3-5 6-10 11-20 21+

0 1-2 3-5 6-10 11-20 21+

28. Have you ever forced foreign objects
into your vagina in an attempt to hurt
yourself?

0 1-2 3-5 6-10 11-20 21+

0 1-2 3-5 6-10 11-20 21+

29. Have you ever purposely
burnt yourself?

0 1-2 3-5 6-10 11-20 21+

0 1-2 3-5 6-10 11-20 21+

30. Have you ever tattooed yourself
with the intention of self harm?

0 1-2 3-5 6-10 11-20 21+

Appendix G

Information Form

Personality, Antisocial Behaviors, and Coping in Females

This sheet is to provide you with information about the study on “personality, antisocial behaviors, and coping”. This research is being done for the purposes of a Master Thesis in Psychology. The primary researcher is Donna and the research assistant is Michelle. The reason this study is being done is to see whether your experiences of being sexually or physically abused, your personality, and the way you cope affects antisocial behaviors. This study is being done under the direct supervision of Dr. Adelle Forth at the Department of Psychology, Carleton University.

Women who agree to volunteer in this study will be asked to take part in two sessions. In the first session you will be asked to complete an hour and a half interview that will have questions about your childhood, your relationships, your work, your education, your family life, and your criminal history. You will also be asked questions about how you interact with others and how you feel in different of situations. In the second session you will be asked to complete a number of questionnaires which will have questions regarding your experiences of abuse, the way you deal with problems in your life, and the harm that you may have caused yourself or others.

It is very important that, should you choose to volunteer for this research project, you try to complete both sessions. I will ask you permission to audio or videotaped the interview in order for one other researcher to review portions of the tape, but will not be available to any personnel at the Ontario Ministry of the Solicitor General and Correctional Services, Ottawa-Carleton Detention Center, the Regional/National Parole Boards, and the caseworkers. None of the written or taped information will have any information from which you may be identified. I will remove your name from all documents and replace it with numbers so that you cannot be identified. I will guarantee that all information will be securely stored at Carleton University and under no circumstance will the Solicitor General have access to this information without your written consent.

Because some of the questions ask you to reveal information that is personal and possibly distressful, services are available that may help you. First of all, it is important that you know that at any time during the interview you may decide to skip any question you choose or withdraw all together. Should you choose to withdraw, your decision will in no way influence the manner in which you are treated by the Ontario Ministry of the Solicitor General and Correctional Services, Ottawa-Carleton Detention Center, the Regional/National Parole Boards, and the caseworkers.

Second, if I notice that before or during the interview you are quite distressed, I will ask you how you are doing, if you want to continue, and perhaps recommend that we postpone the interview to a time where you are feeling better. Finally, institutional and community resources are available for you to access. It is important for you to know that I can recommend you to use these resources but because of ministry rules I am not permitted to distribute institutional request forms. Therefore, it will remain your responsibility to follow through on the recommendations that I make. I will, however, follow-up with you a week after you have finished your participation in the study to make sure that you are okay.

If you have any complaints about the manner in which this research is being conducted, I recommend that you discuss it first with me personally (Donna) at 613-520-2600 ext. 1408. If you feel your concerns have not been properly addressed by the researcher you may contact the direct supervisor (Adelle) at 613-520-2600 ext. 1267, the chair of the Ethics Committee (Mary) at 613-520-2600 ext. 2664, or the chair of the Department of Psychology (Kim) at 613-520-2600 ext. 2648.

Institutional Contacts

Department of Psychology:

Dr. Larry Gauzas

Department of Psychiatry

Rape Crisis (Thursday afternoons 2 - 4)

Elizabeth Fry (Tuesday afternoons 2-4)

Chaplain:

Pat Brown (Mondays –Wednesdays)

Community Contact Numbers

Crisis Lines:

Ottawa Distress Centre	238-3311
Women's Centre	729-1119
Rape Crisis Centre	562-2333
Sexual Assault	234-2266
Assault Victims S.O.S. Femmes	1-800-387-8603

Shelters for Abused Women:

Gloucester Services for Abused Women	738-3762
Interval House	234-5181
Maison D'Amitie	747-0020
Nelson House	225-3129

Addictions Services:

Amethyst Women's Addiction Center	563-0363
Detoxification Center	241-1525
Harvest House Ministries	822-1158

Appendix H

INFORMED CONSENT

Project: The Assessment of Personality, Antisocial Behaviors, and Coping in Females.

Research Personnel: This research is being done for the purposes of a Master of Arts Thesis in Psychology at Carleton University in Ottawa, Ontario, Canada. Donna Mailloux is the principal investigator, and Dr. Adelle Forth is the faculty supervisor.

I am aware that the reason for informed consent is to make sure that I understand why the study is being done and how I will be involved. The informed consent must give enough information so that you can decide whether or not you want to participate. Please ask the researcher to clarify any questions you may have.

I have been told that an interview will cover the following areas: education and employment history, family background, substance use, relationships and criminal activities. I also understand that there will be 4 self-report questionnaires to do that will ask me questions about physical and sexual abuse, beliefs, violence, and the way I deal with problems. I understand that I do not have to answer any question that makes me feel uncomfortable and that I may drop out of the study at any time without any consequences on the way I am treated by the Ontario Ministry of the Solicitor General and Correctional Services, Regional/National Parole Boards, Ottawa-Carleton Detention Center, or my caseworkers.

I further understand that under no circumstances will any of the information I give be released to the Ontario Ministry of the Solicitor General and Correctional Services, the Parole Board personnel, or Ottawa-Carleton Detention Center without my signed consent. The information I share will be used for research purposes only and I will not be identified by name (i.e., a coded number will be used). I understand that confidentiality will be broken only if I disclose information regarding *specific* plans to harm myself or others, *specific* information concerning any physical or sexual abuse of children, or *specific* information regarding sexual abuse by health professional. I may talk about these issues in a general sense but should I begin to tell you specific details I will be reminded of the researchers obligations to report before continuing to talk about it.

Should I require further information regarding this study I can contact:
Donna Mailloux, principal investigator, 613-520-2600 ext. 1408
Dr. Adelle Forth, Faculty Advisor, 613-520-2600, ext. 1267

Should I have any concerns regarding the way this study was done I can contact:
Dr. Mary Gick, Chair of the Ethics Committee, 613-520-2600 ext. 2664
Dr. Kim Matheson, Chair of the Dept. of Psychology, 613-520-2600, ext. 2648

My signature below indicates that I have read the above and agree to take part in this study.

Name: _____ **I.D.#** _____ **Date:** _____

Signature (subject): _____ **Signature (researcher):** _____

Appendix I

CONSENT TO ACCESS INSTITUTIONAL FILES

I give permission for Donna Mailloux to access my institutional and medical files for the purposes of research only.

Name: _____

I.D.#: _____ Date: _____

Signature (Subject): _____

Signature (Researcher): _____

Appendix J

CONSENT TO VIDEOTAPE OR AUDIOTAPE THE INTERVIEW

I give permission to Donna Mailloux to tape the interview I am participating in. I understand that the tape will be used for research purposes only and will not contain any information (e.g., name, etc...) that may identify me. The only other reason any person may see/hear this tape is for the purposes of inter-rater reliability (determining if 2 people have similar assessments). I agree to *one* of the following:

Signing this form indicates my agreement for this interview to be **audiotaped**:

Researcher's signature: _____

Subjects signature: _____

Date: _____

I.D.#: _____

Signing this form indicates my agreement for this interview to be **videotaped**:

Researcher's signature: _____

Subjects signature: _____

Date: _____

I.D. #: _____

Appendix K

DEBRIEFING

We try our best to ensure that you have not been harmed in any way by taking part in this study. Apart from the actual way in which our questions were asked, we address the issue of harm by (1) allowing you the right to decide what you tell us, (2) ensuring that you know who you can talk to should you feel upset by your involvement, and (3) providing you with this written debriefing. Please feel free to contact any of the resources on the list that was provided to you before the study began and make sure that you take the time to read through the information on this page. If you have misplaced the information sheet I will be pleased to give you another one.

The purpose of this research was to examine how personality, experiences of being physically and /or sexually abused, and the way you deal with difficult situations in your life affects your involvement in antisocial activities. During this study you completed the following questionnaires: one on the way you deal with problems, one on your involvement in antisocial behavior, one on your attitudes, and one on your past experiences of physical and sexual abuse. Furthermore, you participated in an interview that was designed to assess a variety of personality characteristics. We were interested in the way you deal with difficult situations as we thought that having been abused might make it more difficult for you in dealing with stressful situations. What we hope to gain from this type of research is the development of better treatment aimed at helping you deal with your experiences of being abused and teaching you new methods of dealing with the difficulties that you may face in the community.

Thank you very much for taking the time to participate in this study. Your time, effort, and honesty are greatly appreciated. A week following your completion of this study I will contact you to see how you are doing and to remind you of the resources that you can access within the institution if you want to talk to anyone.

If you would like further information about this study please contact:

Donna
Dept. of Psychology
Carleton University
613-520-2600, ext. 1408

or

Adelle
Dept. of Psychology
Carleton University
613-520-2600, ext. 1267

If you should have concerns about the way in which the research was done that have not *first* been properly addressed by the researcher, please contact one of the following individuals:

Kim
Chair, Dept. of Psychology
Carleton University
613-520-2600, ext. 2648

or

Mary
Chair, Ethics Committee
Dept. of Psychology
Carleton University
613-520-2600, ext. 2664

Appendix L

File Information

DEMOGRAPHICS

Institutional ID #:

Subject ID#:

FPS#:

Age:

Date of Birth:

Ethnic background:

FAMILY BACKGROUND

Relationship with parents (past):

Relationship with parents (present):

Number of siblings:

Relationship with siblings (past):

Relationship with siblings (present):

Group/Foster care:

General Comments about quality of family life:

SEXUAL/PHYSICAL ABUSE

(if exact age is unavailable, indicate whether the person was a child, adolescent, adult)

Physical abuse (age, frequency, perpetrator):

Sexual abuse (age, frequency, perpetrator):

Any therapy or treatment received:

General comments: (feelings about the abuse, implications on behavior, etc)

EDUCATION

Last grade completed:

Problems (e.g., truancy, suspended, expelled):

Upgrading:

General comments about school behavior, future plans, attitude:

EMPLOYMENT HISTORY

Occupation (latest):
(include homemaker as employment)

Employment record (position, length – start with latest):

General comments (e.g., attitude):

FINANCES

How is this person presently supporting herself:

How was this person supporting herself in the past:

If she has any children, who and how does she support them:

General comments on her financial situation:

RELATIONSHIPS

Present relationship: (married, common-law, length):

Quality of the present relationship (abuse, separations, etc):

Past relationships (marriages, common-law, etc..)

Quality of these relationships (abusive):

Friends: (any indication of being a recluse or antisocial peers, etc..)

CHILDREN

Number of children: (ages)

Who are the children presently living with:

How much time has she lived with the children:
Have the children ever been removed from the home or given up?

Past and present contact:

General comments:

PSYCHIATRIC/PSYCHOLOGICAL REPORTS OR RESULTS

(Indicate whether they ever went to a psychiatrist or psychologist, how long, and why)

Childhood or adolescence:

Adulthood:

Diagnosed with mental/personality/behavioral disorders:

Ever received treatment (institutional or community based):

IQ test results:

Risk assessment test results (e.g., SIR, PCL, etc...)

General comments regarding overall attitude, well-being:

HEALTH

Present medication and diagnosis:

Any medical conditions:

Abortions:

SUICIDAL BEHAVIOR

Past suicide attempts:

Present suicide attempts:

Ever on suicide watch:

Self-mutilation:

General comments:

SUBSTANCE USE

(past and present)

Drugs:

Use (type, frequency, and age onset):

Addiction?:

General comments: (re. Sobriety, recovery)

Alcohol:

Use (type, frequency, and age onset):

Addiction?:

General comments:

Stoned or drunk at time of offense:

INSTITUTIONAL ADJUSTMENT

Adjustment: Chronic problems
 Behavior problems
 Slight problems
 Good
 Excellent

Institutional charges or misconducts (date, type, freq, outcome):

General comments: (how do others perceive this person, such as officers)

CRIMINOLOGICAL INFORMATION:

(try to photocopy RCMP history and put in file)

Young offender history:

Age first contact:

Date and type of offenses:

Adult history:

Number of aliases:

Past convictions (date, type, and time served):

Present offense

Charges and/or convictions:

Sentence:

Description of current offense:

Does the offender admit guilt or innocence:

What does the police report say:

How do they feel about their sentence:

General comments: (include whether offenses were committed with another individual or on their own)

History of breaching any conditions of release:

Note any inconsistencies between interview and file review:

Appendix M

Coding Manual

I. Background Information:

DEMOGRAPHIC		
I.D.#: _____	Date of Interview: _____	Interviewer: _____
FPS#: _____	Institutional #: _____	Location: _____
Sex: _____ (1 = female; 0 = male)		
Age: _____	DOB: _____	Ethnicity: _____

FAMILY BACKGROUND	
Parental divorce: _____	(0 = no, 1 = yes)
Age left home: _____	Behavioral problems: _____ (0 = no, 1 = yes)
Lived in group/foster care: _____	(0 = no, 1 = yes)
Truant from home: _____	(0 = no, 1 = yes)
Number of siblings: _____	Sexual abuse: _____ (0 = no, 1 = yes)
Physical abuse: _____	(0 = no, 1 = yes)
Current contact with parents: _____	(0 = no, 1 = yes)
Current contact with siblings: _____	(0 = no, 1 = yes)

EMPLOYMENT HISTORY	
Employment: _____	Ever legally employed: _____ (0 = no, 1 = yes)
Employed year prior to incarceration: _____	(0 = no, 1 = yes)
History of prostitution: _____	(0 = no, 1 = yes) Welfare: _____ (0 = no, 1 = yes)
Grade completed: _____	Upgrading: _____
School behavior: _____ (poor/good)	Truant from school: _____ (0 = no, 1 = yes)
Ever expelled/suspended: _____	(0 = no, 1 = yes)

RELATIONSHIPS	
Marital status: _____	(0=single, 1=c/l, 2= married, 3=d/s, 4=widowed)
Number of marriages/common-law relationships: _____	
Partner involved in crime: _____	(0 = no, 1 = yes)
Partner abusive: _____	(0 = no, 1 = yes)
Do they commit crime together: _____	(0 = no, 1 = yes)
Teen pregnancy: _____	(0 = no, 1 = yes) Number of abortions: _____
Number of Children: _____	
Number of fathers to the children: _____	
Children ever removed from home: _____	(0 = no, 1 = yes)

Children voluntarily given up: _____ (0 = no, 1 = yes)
 Who do the children live with: _____ (0=father, 1=parents, 2=grandparents, 3=cas,
 4=friends, 5=more than 1 of the above, 6=grown-up)
 Present contact with children: _____ (0 = no, 1 = yes)
 Maintains custody of children: _____ (0 = no, 1 = yes)

PSYCHOLOGICAL

Diagnosis of Personality/Mental Disorder: _____ (0 = no, 1 = yes) Label: _____
 Contact with psychologist/psychiatrist as child: _____ (0 = no, 1 = yes)
 Contact with psychologist/psychiatrist as adult: _____ (0 = no, 1 = yes)
 Contact with psychologist within institution (other than just for meds): _____ (0 = no, 1 = yes)
 Present stability: _____ (0=unstable, 1 =stable)
 Ever received psychological treatment: _____ (0 = no, 1 = yes)
 Type of treatment: _____ (0=anger management, 1=relaxation, 2 =)
 Presently on medication: _____ (0 = no, 1 = yes) Treating: _____

SUBSTANCE

Family history of alcohol abuse: _____ (0 = no, 1 = yes) Who: _____ (0=mom,
 1=dad, 2=stepmom, 3=stepdad, 4=more than 1)
 Family history of drug abuse: _____ (0 = no, 1 = yes) Who: _____ (0=mom,
 1=dad, 2=stepmom, 3=stepdad, 4=more than 1)
 Age 1st drug use: _____ Present drug abuser: _____ (0 = no, 1 = yes)
 Type of drug presently used: _____ (0=pot/hash, 1=coke, 2=heroin, 3=pills,
 4=poly)
 IV drug abuser: _____ (0 = no, 1 = yes)
 Age 1st alcohol use: _____ Present alcohol abuser: _____ (0 = no, 1 = yes)
 Ever substance abuse treatment: _____ (0 = no, 1 = yes)

PRESENT

Current Charges: _____ Current convictions: _____
 Number of violent charges/convictions: _____
 Date of Incarceration: _____
 Length of time in present institution: _____ (days)
 Type of Sentence Serving: _____ (0 = Community; 1 = Provincial; 2 = Federal,
 3=remand)
 Has the person been sentenced: _____ (0 = no, 1 = yes)
 Length of Sentence: _____ (months)
 Present Institutional misconducts: _____ (0 = no, 1 = yes) Total Number: _____ #violent: _____
 Staff reported behavioral/management problems: _____ (0 = no, 1 = yes)

PAST OFFENSES

Date of previous incarceration: _____ (dd-mm-yy)
 Length of Previous Incarceration: _____ (months)
 Date of Previous Release: _____ (dd-mm-yy)
 Length of time in community prior to this incarceration: _____ (months)
 Number of previous convictions: _____ Number of previous incarcerations: _____
 Number of previous violent convictions: _____
 Young offender record: _____ (0 = no, 1 = yes) Number of YO convictions: _____
 Type of YO convictions: _____
 Number of violent YO convictions: _____
 Time served as YO incarcerated: _____ (months)
 Past institutional misconducts: _____ (0 = no, 1 = yes) Total Number: _____ #violent: _____
 Total misconducts (add past & present): _____ Total violent misconducts: _____

II. Victimization Scale
Victimization scale #1
[Childhood]
Total Score: _____
 score code

mother = 0; father = 1;
 uncle = 2; partner = 3;
 partner = 4; aunt = 5;
 sister = 6; stepfather = 7;
 grandmother = 8; brother = 9;
 family friend = 10; friend = 11;
 stranger = 12;
 staff = 13; babysitter = 14;
 grandfather = 15; foster = 16;
 cousin = 17

Item 1: _____ Perpetrator: _____
 Item 2: _____ Perpetrator: _____
 Item 3: _____ Perpetrator: _____
 Item 4: _____ Perpetrator: _____
 Item 5: _____ Perpetrator: _____
 Item 6: _____ Perpetrator: _____
 Item 7: _____ Perpetrator: _____
 Item 8: _____ Perpetrator: _____
 Item 9: _____ Perpetrator: _____
 Item 10: _____ Perpetrator: _____

Total Physical Abuse: _____
Most frequent perpetrator: _____
Most severe perpetrator: _____

Item 11: _____ Perpetrator: _____
 Item 12: _____ Perpetrator: _____
 Item 13: _____ Perpetrator: _____
 Item 14: _____ Perpetrator: _____
 Item 15: _____ Perpetrator: _____
 Item 16: _____ Perpetrator: _____
 Item 17: _____ Perpetrator: _____
 Item 18: _____ Perpetrator: _____
 Item 19: _____ Perpetrator: _____

Item 20: _____ Perpetrator: _____
 Item 21: _____ Perpetrator: _____
 Item 22: _____ Perpetrator: _____

Total Sexual Abuse: _____

Most frequent perpetrator: _____

Most severe perpetrator: _____

Victimization scale #2
[Adolescence]

Total Score: _____
 score code

Item 1: _____ Perpetrator: _____
 Item 2: _____ Perpetrator: _____
 Item 3: _____ Perpetrator: _____
 Item 4: _____ Perpetrator: _____
 Item 5: _____ Perpetrator: _____
 Item 6: _____ Perpetrator: _____
 Item 7: _____ Perpetrator: _____
 Item 8: _____ Perpetrator: _____
 Item 9: _____ Perpetrator: _____
 Item 10: _____ Perpetrator: _____

Total Physical Abuse: _____

Most frequent perpetrator: _____

Most severe perpetrator: _____

Item 11: _____ Perpetrator: _____
 Item 12: _____ Perpetrator: _____
 Item 13: _____ Perpetrator: _____
 Item 14: _____ Perpetrator: _____
 Item 15: _____ Perpetrator: _____
 Item 16: _____ Perpetrator: _____
 Item 17: _____ Perpetrator: _____
 Item 18: _____ Perpetrator: _____
 Item 19: _____ Perpetrator: _____
 Item 20: _____ Perpetrator: _____
 Item 21: _____ Perpetrator: _____
 Item 22: _____ Perpetrator: _____

Total Sexual Abuse: _____

Most frequent perpetrator: _____

Most severe perpetrator: _____

Victimization scale #3
[adulthood]

Total Score: _____
 score code

Item 1: _____	Perpetrator: _____
Item 2: _____	Perpetrator: _____
Item 3: _____	Perpetrator: _____
Item 4: _____	Perpetrator: _____
Item 5: _____	Perpetrator: _____
Item 6: _____	Perpetrator: _____
Item 7: _____	Perpetrator: _____
Item 8: _____	Perpetrator: _____
Item 9: _____	Perpetrator: _____
Item 10: _____	Perpetrator: _____

Total Physical Abuse: _____

Most frequent perpetrator: _____

Most severe perpetrator: _____

Item 11: _____	Perpetrator: _____
Item 12: _____	Perpetrator: _____
Item 13: _____	Perpetrator: _____
Item 14: _____	Perpetrator: _____
Item 15: _____	Perpetrator: _____
Item 16: _____	Perpetrator: _____
Item 17: _____	Perpetrator: _____
Item 18: _____	Perpetrator: _____
Item 19: _____	Perpetrator: _____
Item 20: _____	Perpetrator: _____
Item 21: _____	Perpetrator: _____
Item 22: _____	Perpetrator: _____

Total Sexual Abuse: _____

Most frequent perpetrator: _____

Most severe perpetrator: _____

Total lifetime physical abuse (sum 1, 2, 3): _____

Total lifetime sexual abuse (sum 1, 2, 3): _____

Total lifetime abuse (sexual & physical collapsed): _____

Number of different sexual perpetrators: _____

Number of different physical perpetrators: _____

Self-Reported Violence Questionnaire

Code the following:

0 = 0
5

1-2 = 1

3-5 = 2

6-10 = 3

11-20 = 4

21+ =

Other-Directed Violence:

	Ever	In Past Year
Item #1:	_____	_____
Item #2:	_____	_____
Item #3:	_____	_____
Item #4:	_____	_____
Item #5:	_____	_____
Item #6:	_____	_____
Item #7:	_____	_____
Item #8:	_____	_____
Item #9:	_____	_____
Item #10:	_____	_____
Item #11:	_____	_____
Item #12:	_____	_____
Total:	_____	_____

Self-Directed Violence:

	Ever	In Past Year
Item #13:	_____	_____
Item #14:	_____	_____
Item #15:	_____	_____
Item #16:	_____	_____
Item #17:	_____	_____
Item #18:	_____	_____
Item #19:	_____	_____
Item #20:	_____	_____
Item #21:	_____	_____
Item #22:	_____	_____
Item #23:	_____	_____
Item #24:	_____	_____
Item #25:	_____	_____
Item #26:	_____	_____
Item #27:	_____	_____

Item #28: _____
 Item #29: _____
 Item #30: _____
 Total: _____

UCLA Coping Scale

Subscales:

Items:

1. Active Coping	5)_____	25)_____	46)_____	57)_____	Total_____
2. Planning	19)_____	32)_____	39)_____	55)_____	Total_____
3. Instrumental Social Support	4)_____	14)_____	30)_____	44)_____	Total_____
4. Emotional Social Support	11)_____	23)_____	34)_____	51)_____	Total_____
5. Suppress Competing Activities	15)_____	33)_____	42)_____	54)_____	Total_____
6. Religion	7)_____	18)_____	47)_____	59)_____	Total_____
7. Positive Reinterpretation	1)_____	29)_____	38)_____	58)_____	Total_____
8. Restraint	10)_____	22)_____	41)_____	48)_____	Total_____
9. Acceptance	13)_____	21)_____	60)_____	53)_____	Total_____
10. Venting Emotions	3)_____	17)_____	28)_____	45)_____	Total_____
11. Denial	6)_____	27)_____	40)_____	56)_____	Total_____
12. Mental Disengagement	2)_____	16)_____	31)_____	43)_____	Total_____
13. Behavioral Disengagement	9)_____	24)_____	37)_____	50)_____	Total_____
14. Alcohol/Drug Use	12)_____	26)_____	35)_____	52)_____	Total_____
15. Humor	8)_____	20)_____	36)_____	49)_____	Total_____

Functional coping: [Sum Items 1 – 9]:_____

Less functional coping: [Sum items 10-14]:_____

Problem-focused coping: [Sum items 1, 2, 3, 5 & 8]:_____

Emotion-focused coping: [Sum items 4, 6, 7, 9 & 11]:_____

Diverse Coping:

If item is scored a 1 or 2 interpret as a rarely used strategy

If item is scored a 3 or 4 interpret as a frequently used strategy

Any of the Total score/subscale that is less than 12:

Code 0

Any Total score/subscale that is greater than or equal to 12:

Code 1

1. Active Coping	Code_____
2. Planning	Code_____
3. Instrumental Social Support	Code_____
4. Emotional Social Support	Code_____

5. Suppress Competing Activities	Code _____
6. Religion	Code _____
7. Positive Reinterpretation	Code _____
8. Restraint	Code _____
9. Acceptance	Code _____
10. Venting Emotions	Code _____
11. Denial	Code _____
12. Mental Disengagement	Code _____
13. Behavioral Disengagement	Code _____
14. Alcohol/Drug Use	Code _____
15. Humor	Code _____
Sum:	_____

V-PCJ-R Interview

Factor 1:

Item 1: _____
 Item 2: _____
 Item 4: _____
 Item 5: _____
 Item 6: _____
 Item 7: _____
 Item 8: _____
 Item 16: _____
 Total: _____

Prorated: __/16 Percentile: _____

Factor 2:

Item 3: _____
 Item 9: _____
 Item 10: _____
 Item 12: _____
 Item 13: _____
 Item 14: _____
 Item 15: _____
 Item 18: _____
 Item 19: _____
 Total: _____

Prorated: __/18 Percentile: _____

Total: _____

Prorated: __/40 Percentile: _____

Psychopathy Diagnosis:

>29 code 2

21 – 28 code 1

<20 code 0

VI: BIDR

Items 2, 4, 6, 8, 10, 12, 14, 16, 18, 20, 21, 23, 25, 27, 29, 31, 33, 35, 37, 39, are negatively keyed

Self-Deception: (1 point for every item scored "6 or 7")

Item 1: _____

Item 2: _____

Item 3: _____

Item 4: _____

Item 5: _____

Item 6: _____

Item 7: _____

Item 8: _____

Item 9: _____

Item 10: _____

Item 11: _____

Item 12: _____

Item 13: _____

Item 14: _____

Item 15: _____

Item 16: _____

Item 17: _____

Item 18: _____

Item 19: _____

Item 20: _____

Total self-deception: _____

Impression Management: (1 point for every item scored 6 or 7)

Item 21: _____

Item 22: _____

Item 23: _____

Item 24: _____

Item 25: _____

Item 26: _____

Item 27: _____

Item 28: _____

Item 29: _____

Item 30: _____

Item 31: _____

Item 32: _____

Item 33: _____

Item 34: _____

Item 35: _____

Item 36: _____

Item 37: _____

Item 38: _____

Item 39: _____

Item 40: _____

Total impression management: _____

Total BIDR: _____

NOTE TO USERS

**Page(s) missing in number only; text follows.
Microfilmed as received.**

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UMI

Appendix N

Victimization	Impression management	Self-deception
Childhood		
Child sexual	-.07	-.15
Child physical	-.07	-.24
Total child abuse	-.08	-.22
Adolescence		
Adolescent sexual	-.15	-.08
Adolescent physical	-.06	-.03
Total adolescent abuse	-.10	-.05
Adulthood		
Adult sexual	-.11	-.02
Adult physical	-.04	-.01
Total adult abuse	-.08	-.02

Appendix O

Victimization	Other-directed violence		Self-directed violence	
	Lifetime	Versatility	Lifetime	Versatility
Childhood				
Sexual	.12	.12	.46**	.30
Physical	.27	.31*	.46**	.38*
Total abuse	.22	.25	.51**	.37*
Adolescence				
Sexual	.23	.15	.61**	.40*
Physical	.28	.28	.44**	.38*
Total abuse	.27	.24	.54**	.41*
Adulthood				
Sexual	.30	.29	.56**	.40*
Physical	.36*	.36*	.66**	.52**
Total abuse	.35*	.34*	.64**	.49**

* $p < .05$ ** $p < .01$.

Appendix P

Coping Strategies	Childhood			Adolescence			Adulthood			Lifetime		
	Sexual	Physical	Total	Sexual	Physical	Total	Sexual	Physical	Total	Sexual	Physical	Total
Acceptance	-.11	.01	-.05	-.01	.12	.07	.03	.04	.01	-.05	.07	.02
Active	-.07	-.22	-.17	-.12	-.05	-.08	-.11	.02	-.04	-.09	-.06	-.08
Alcohol/drug	.28	.32	.33*	.30	.30	.32	.24	.27	.27	.29	.31	.31
Behavioral disengagement	-.09	-.03	-.06	-.09	-.09	-.09	-.05	-.14	-.10	-.08	-.10	-.09
Denial	.30	.13	.23	.22	.20	.22	.14	.17	.17	.24	.19	.22
Emotional social support	-.06	.00	-.03	.20	-.01	.08	.28	.09	.19	.17	.02	.09
Humor	-.08	-.18	-.15	.07	.19	.15	.12	.20	.15	.05	.09	.08
Instrumental social support	-.09	-.14	-.13	.13	-.06	.02	.20	.05	.02	.10	-.05	.02
Mental disengagement	-.02	.16	.09	.15	.09	.12	.17	.13	.12	.11	.12	.12
Planning	-.14	-.12	-.14	.02	-.03	-.01	.01	.08	-.01	-.03	-.02	-.03
Positive reinterpretation	-.21	-.14	-.19	.02	.12	.08	.07	.05	.08	-.04	.01	-.01
Religion	-.17	.04	-.06	-.15	-.08	-.12	-.10	.03	-.12	-.16	-.03	-.09
Restraint	-.07	-.16	-.13	-.13	-.21	-.19	-.25	-.14	-.19	-.18	-.20	-.20
Suppressing competing	-.26	-.20	-.25	-.16	-.05	-.10	-.12	.05	-.10	-.20	-.07	-.13
Venting	.18	.09	.14	.28	.12	.19	.16	.19	.19	.22	.13	.17

* $p < .05$.

Appendix Q

Coping strategies	PCL-R		
	Total	Factor 1	Factor 2
Active	.08	.21	-.18
Acceptance	-.08	-.08	.02
Alcohol/drug	.12	-.21	.41*
Behavioral disengagement	-.23	-.16	-.24
Denial	-.14	-.17	-.07
Emotional social support	-.26	-.38*	-.04
Humor	.24	.18	.14
Instrumental social support	-.18	-.23	-.12
Mental disengagement	-.12	-.12	-.12
Planning	.14	.22	-.03
Positive reinterpretation	.05	.13	-.09
Religion	-.06	.00	-.19
Restraint	-.04	-.05	-.08
Suppressing competing activities	.10	.15	-.06
Venting	.35*	.14	.40*

Note. Factor 1 represents an affective/interpersonal style and factor 2 represents an antisocial/irresponsible lifestyle.

^a These are semi-partial correlations with self-deception partialled out of less functional coping.

* $p < .05$.

Appendix R

Coping strategies	Other-directed violence ^a		Self-directed violence ^a	
	Lifetime	Versatility	Lifetime	Versatility
Active	.16	-.05	-.26	-.35*
Acceptance	-.03	-.08	.03	.07
Alcohol/drug	.43**	.38**	.35*	.38**
Behavioral disengagement	-.08	-.04	.03	.06
Denial	.04	.05	.20	.16
Emotional social support	.09	.05	.23	.11
Humor	.01	-.07	-.07	-.10
Instrumental social support	.13	.05	.02	-.16
Mental disengagement	-.03	-.08	.15	.02
Planning	.23	.04	.01	-.20
Positive reinterpretation	-.13	-.23	-.20	-.29
Religion	-.04	-.13	-.07	-.07
Restraint	.12	-.03	.01	-.10
Suppressing competing	.00	-.04	-.21	-.31*
Venting	.20	.09	.18	-.04

^a These are semi-partial correlations with impression management partialled out of violence.

* $p < .05$. ** $p < .01$.