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Childhood Maltreatment, Coping, and Coping Self-Efficacy among Offenders

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CHILDHOOD MALTREATMENT, COPING, AND COPING SELF-EFFICACY AMONG OFFENDERS

A thesis submitted in partial fulfillment of the requirements for the degree of Master of Science at Virginia Commonwealth University

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Abstract

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This study explored the relationship between childhood interpersonal trauma and coping self-efficacy, coping styles, and emotion regulation difficulties among male and female offenders in detention and diversion centers (N = 183). The coping-relapse model of recidivism posits that offenders' coping ability plays a pivotal role in successful reentry (Zamble & Quinsey, 1997). Past research reveals that childhood maltreatment is associated with avoidant coping and emotion regulation difficulties, which could negatively impact reentry (e.g., Cloitre et al., 2009; Min, Farkas, Minnes, & Singer, 2007). The relationship between childhood maltreatment and coping self-efficacy has not been addressed. This study found that childhood interpersonal trauma was significantly related to emotion regulation difficulties (r = .20), but not coping self-efficacy, active coping, or avoidant coping. Coping self-efficacy was significantly related to

emotion regulation difficulties (r = -.61), active coping (r = .60), and avoidant coping (r = -.30). Research and practice implications are discussed.

Childhood Maltreatment, Coping, and Coping Self-efficacy among Offenders

If Bandura's (1986) assertion --that human functioning is reciprocally determined by environmental, behavioral, and personal factors-- holds true, then offenders must possess strong personal and behavioral resources in their quest for successful reentry. Offenders are reentering and attempting to transition back to society at record levels. For example, over 725,000 people leave prison annually (West & Sabol, 2009) and nearly 5,100,000 offenders live in their communities under supervision of community corrections programs like probation and parole (Glaze & Bonczar, 2009). Offenders typically come from disadvantageous environments where they face obstacles such as high rates of unemployment, significant family instability, and exposure to traumatic circumstances, including abuse (James & Glaze, 2006). Similarly, offenders often face other environmental, behavioral, and personal obstacles. They confront job screening for criminal records, limited financial resources and assistance upon reentry, battles with substance abuse, difficulties accessing health care and locating housing outside the correctional system, dealing with the impact of their return on their families and community, etc. (Maruna, 2001; Travis, Solomon, & Waul, 2001). Furthermore, offenders must often work to develop positive social networks that they lack in their communities. The personal cognitive, affective, and motivational processes of offenders, therefore, loom as critically important in their reentry. In other words, offenders must possess strong intrapersonal resources if they are to overcome the challenges they face upon reentry. This paper will focus on internal, personal challenges faced by offenders as they contemplate behavioral responses to environmental obstacles upon reentry to society.

Past research has supported the critical importance of coping skills resources for offenders' successful reentry to society (Brown, Amand, & Zamble, 2009). Furthermore,

research reveals that interpersonal trauma, particularly in childhood, negatively impacts coping skills (Min, Farkas, Minnes, & Singer, 2007) and shows that offenders suffer from high rates of childhood interpersonal trauma (e.g., Bradley & Davino, 2007; Weeks & Widom, 1998). The coping-relapse model of recidivism highlights the importance of offenders' appraisals of their self-efficacy at coping with challenges upon release (Zamble & Quinsey, 1997), as well as high rates of recidivism or return to the correctional system (Langan & Levin, 2002). Self-efficacy theory similarly highlights the importance of coping self-efficacy in the initiation and success of coping efforts by offenders (Bandura, 1997). While some research has studied the relationship between childhood interpersonal trauma and coping methods, research is lacking on the potential relationships among childhood abuse and neglect and coping self-efficacy.

Lazarus and Folkman (1984) discussed coping as a voluntary response to environmental stressors. Many possibilities exist for different types of coping responses; however, Lazarus and Folkman highlight coping responses that either proactively address the problem or address problematic emotions associated with the problem. Other researchers also note the possibility of coping by seeking out social support (Skinner, Edge, Altman, & Sherwood, 2003). Zamble and Quinsey (1997) noted the importance of successful coping methods for offenders reentering society and subsequently developed a model for offenders' return to society. Their coping-relapse model of recidivism posits that offenders' ability to respond to environmental stressors helps determine whether or not they return to criminal behavior (Zamble & Quinsey). The model was developed from a longitudinal study that differentiated those who desisted from crime from those who persisted with, or returned to, criminal behaviors. Furthermore, the coping-relapse model asserts that before actual coping responses to such stressors occur, offenders conduct a cognitive and affective appraisal of their ability to respond to the situation, thus linking the coping-relapse model of recidivism with self-efficacy theory.

Bandura (1997) developed the construct of self-efficacy as representing people's beliefs that they can successfully complete a specific task and/or achieve a specific goal. The greater the self-efficacy an individual possesses in a particular domain, the more likely he or she is to initiate behavior to accomplish a goal for that domain (Bandura). In the context of offenders and self-efficacy, for instance, the more coping self-efficacy an offender possesses for carrying out coping methods that proactively address a problem, the more likely that offender actually will behave in a way that addresses the problem. Past research also supports the assertion that self-efficacy leads to better performance in the domain of interest (e.g., Martinez et al., 2010; Grigorenko et al., 2009). Self-efficacy, therefore, appears critically important to successful coping for offenders, and coping appears as an especially crucial factor in successful reentry for offenders.

Given the importance of coping and coping self-efficacy in offender reentry, experiences of offenders that significantly impact these constructs warrant attention. Trauma research with offenders reveals that they suffer from higher rates of childhood interpersonal trauma than individuals in the general population(Bradley & Davino, 2007; Weeks & Widom, 1998). Other research shows that childhood interpersonal trauma leads to deficits in emotion regulation, social skills, and attention (Cloitre et al., 2009; Herman, 1992). Some gender differences exist with regard to the experience of such trauma, particularly with higher rates of childhood sexual abuse among women; and, this study will note those differences as they appear in supporting studies. The deficits from childhood interpersonal trauma can be linked to coping skills mentioned above (e.g., obtaining social support and focusing on and addressing a problem) as well as with the cognitive and affective appraisal of coping self-efficacy. Past research, with non offender samples, specifically has addressed the relationship between childhood interpersonal trauma and coping methods. The research found that greater reported experiences of childhood interpersonal

trauma indicate significantly greater use of avoidant coping methods that do not address the problem (Min et al., 2007). As previously noted, however, research is lacking on the relationship between childhood trauma and coping self-efficacy. Furthermore, the relationship between childhood trauma and avoidant coping has not been replicated with offender samples.

This study, then, will walk through the following progression when reviewing the literature. Substantial numbers of offenders, a considerable percentage of whom suffered from childhood interpersonal trauma, are returning to society (e.g., Bradley & Davino, 2007; Weeks & Widom, 1998; West & Sabol, 2009). A significant number of offenders who reenter society return to the correctional system (Langan & Levin, 2002). This phenomenon of high recidivism calls attention to the importance of studying reentry. During reentry, offenders will face environmental challenges, and coping skills, along with coping self-efficacy, can assist them in addressing these challenges. Their experiences with childhood interpersonal trauma, however, may lessen their coping skills and coping self-efficacy. In concert with the preceding path through the literature, this current study intends to replicate and expand on past findings relating to childhood interpersonal trauma, coping, and coping self-efficacy among offenders. The study expects to find that relatively high rates of such trauma will again be reported by offenders and that higher levels of past exposure to childhood interpersonal trauma will be associated with more avoidant coping styles rather than active coping styles. This study also intends to add to the literature on offenders and trauma by exploring the relationships between childhood interpersonal trauma and coping self-efficacy and between coping self-efficacy and coping styles among offenders. The literature review will further explore how self-efficacy theory (Bandura, 1997) appears to support an expectation that higher levels of past exposure to childhood interpersonal trauma will relate to lower coping self-efficacy and that lower coping self-efficacy will relate to more avoidant coping styles instead of active coping styles.

Review of Literature

Offender Recidivism and Reentry and Related Costs and Challenges

As noted above, offenders are returning to society at record levels and a large percentage of those offenders are returning to the correctional system. Concern over both prisoners' reentry into society and their possible return to prison has risen alongside the increase in overall incarceration rates in America (Travis et al., 2001). The Pew Center on the States (2008) reported that over 1 in 100 Americans are incarcerated in prisons and jails, and reports also have shown that U. S. incarceration rates have increased more than sevenfold since the 1970's and continue to rise (Public Safety Performance Project, 2007). Furthermore, over 725,000 people are released from prison annually back into society (West & Sabol, 2009). Of those who are released, research reveals that many return to prison (Langan & Levin, 2002). For example, the most recently released Bureau of Justice Statistics study on recidivism, a construct that generally refers to a return to the correctional system by offenders, found over 67% of sampled state inmates were rearrested within three years (Langan & Levin, 2002).

Reentry and recidivism bear high costs for society. High rates of recidivism mean increased threats to public safety (Travis et al., 2001). In addition, recidivism drives up already high corrections fiscal costs. From 1982 to 2006 nationwide spending on corrections grew from over $9 billion to over $68 billion (Bureau of Justice Statistics, 1988; Bureau of Justice Statistics, 2008), illustrating both the high costs at present and the dramatic increase in corrections spending. Both reentry and recidivism exist as social costs that impact families and communities of offenders (Travis et al., 2001). For instance, the Bureau of Justice Statistics found that in 1999 63% of federal prisoners and 55% of state prisoners were parents of minor children (Mumola, 2000). The Pew Center on the States (2009) also reported a compelling finding that 1 in 31 Americans are under correctional supervision as a whole, including

incarceration in prisons and jails and community corrections mechanisms such as probation and parole. As previously noted, at year end 2008 nearly 7,500,000 adults were under correctional supervision (Glaze & Bonczar, 2009; Sabol, West, & Cooper, 2009). Offender reentry and its associated costs to society, therefore, are significant phenomena in America.

In addition to the costs borne by society, offenders also confront their own considerable costs and challenges upon returning to society. Offenders themselves have identified pressing reentry concerns over employment barriers: (a) receiving education, training, and programming (e.g., for substance abuse), (b) navigating requirements of the correctional system upon release, and (c) adjusting to changed social and family networks, among other concerns (Shivy et al., 2007). Travis et al. (2001) also researched obstacles faced by reentering offenders. They found that offenders contend with substance abuse, mental illness, and infectious disease, and that these problems can present simultaneously for individual offenders. Furthermore, offenders face employment barriers from such factors as social stigma and reduced job force participation (Travis et al., 2001). They also confront difficulties obtaining housing, as they tend to possess limited financial resources upon reentry and are often barred from certain governmentally assisted housing problems. In response to the escalating presence, costs, and challenges of reentry and recidivism both for society and individual offenders, researchers have sought to understand the processes and variables underlying these phenomena in an effort to improve offender reentry.

Coping-relapse Model of Recidivism

Both theory and quantitative findings support the importance of coping skills in confronting environmental obstacles for the significant numbers of offenders reentering society. Zamble and Quinsey (1997), in particular, developed a coping-relapse model of criminal recidivism that seeks to portray, with accuracy, the processes of reentry and recidivism and

highlight dynamic variables in those processes that are amenable to change. Their model emphasizes the importance of coping skills, dysphoric emotional states, and perceptions of life problems, among other factors, as a result of their studying and interviewing 311 federal, male, repeat offenders in Canada. In this study, offender participants primarily had been reconvicted of assault, robbery, or burglary offenses within one year of their previous release and were compared to a small sample of nonrecidivists (N = 36). Zamble and Quinsey found that inmates' emotional states deteriorated over time after their release. They posited that the recidivism process typically began with an environmental stimulus, such as an interpersonal problem, a financial concern, an employment difficulty, or a substance abuse related issue, which challenged the offender's coping skills.

The offender then cognitively and affectively appraised the situation and evaluated their self-efficacy in responding to the environmental trigger (Zamble & Quinsey, 1997; see below for similarity to Lazarus and Folkman (1987) model). This appraisal was influenced in part by the individual's ability to regulate emotions. If the offender perceived the trigger as a threat, then negative emotions, such as anger, and increased perceptions of stress normally ensued. Furthermore, some recognition of a situation's severity typically resulted. Zamble and Quinsey found that recidivists reported a significantly greater presence of such environmental problems, and also regarded the problems they encountered as significantly more serious than did nonrecidivists. The offender then made some effort to address the situation even if that effort resulted in avoidance of the situation. Individuals' coping abilities and emotional states, therefore, were found to affect the adequacy of their response to the situation. Given results of past studies suggesting relatively poor coping skills in offenders as compared to nonoffender populations (e.g., Hughes & Zamble, 1993; Loucks & Zamble, 1994), the coping-relapse model asserts that offenders will often not successfully address the environmental stressor. If efforts to

address the trigger are indeed unsuccessful, a deteriorating cycle of thoughts and emotions can result. This cycle, then, can lead to a resumption of criminal activity.

The coping-relapse model of recidivism suggests the existence of both static and dynamic factors in the preceding cognitive and affective appraisal of the environmental stimulus (Zamble & Quinsey, 1997). Static factors are similar to the idea of subject variables in psychology (Leary, 2008). They include personality and past behavior (e.g., age of first arrest, number of previous arrests) judged as relatively constant, whereas dynamic factors include behavioral patterns more amenable to change: as in coping skills and social support. Zamble and Quinsey intended to add to existing actuarial prediction models of criminal recidivism that emphasized static variables not changeable by community supervision workers (i.e., probation and parole officers). In their 1997 study, Zamble and Quinsey found that, after controlling for age and total number of prior criminal convictions, it was the dynamic variables, including perceived emotional health, perceived status of relationships with family and friends, and depressed, angry, lonely, dysphoric, positive, and dysphoric emotional states, that significantly predicted recidivism. Hence, Zamble and Quinsey recommended that community supervision workers monitor offenders' cognitive and affective states and how they react to potential environmental stressors. Risk assessment procedures for offenders have evolved to include a continuum of factors from static, established variables such as the age of first arrest to dynamic, extremely malleable variables such as perceptions of threat (Andrews, Bonta, & Wormith, 2006) in line with Zamble and Quinsey's (1997) recommendations.

Although dynamic risk factors now are included in predictive models of recidivism, dynamic factors still lag behind static factors in their emphasis in the literature. Andrews et al. (2006) assert that dynamic risk factors may lead to substantial improvements in predictive criterion validity of recidivism risk assessments and specifically identify Zamble and Quinsey's

model (1997) as a potential breakthrough in risk assessment (along with the work of Hanson & Harris, 2000; Quinsey, Coleman, Jones, & Altrows, 1997). Andrews et al. also expect such dynamic risk factors to double and perhaps triple the variance explained by recidivism risk assessments based on recent findings. As one indication of the promise of dynamic factors, Hanson and Morton-Bourgon (2009), in a meta-analysis from over 118 different samples of male sexual offenders, found that combining dynamic and static risk factors outperformed models with just static risk factors in predicting recidivism. Sexual offenders are, however, a relatively unique population.

Zamble and Quinsey's (1997) model, therefore, highlights both the importance of dynamic variables such as coping skills in response to environmental stressors, and the ability to work through problematic thoughts and emotions. Again, the presence of unsettling thoughts and emotions after the cognitive and affective appraisal of the trigger can set off a degenerative cycle that may ultimately result in criminal behavior. An improved ability to regulate problematic thoughts and emotions could prevent such a cycle. Furthermore, the ability to adopt appropriate coping skills for the environmental trigger also could avert this degenerative process.

Risk-Need-Responsivity (RNR) Model

The coping-relapse model of recidivism, which highlights the importance of coping in offender reentry, shares key similarities both with criminal justice models for rehabilitating offenders and with theory advanced by coping researchers. Similarities with a leading criminal justice theory will be detailed first. Criminal justice researchers also have acknowledged the importance of dynamic risk factors. More of their attention has been given to the Risk-Need-Responsivity (RNR) model for rehabilitating offenders to combat recidivism (Andrews & Bonta, 2010) than the coping-relapse model. This RNR model looks to target higher risk offenders who possess criminogenic needs.

Criminogenic needs in the RNR model represent both static and dynamic risk factors, with an emphasis on dynamic factors, and include the "big four" (Andrews & Bonta) risk factors of criminal history, procriminal attitudes, antisocial personality (which includes low self-control), and procriminal associates. In addition, poor social achievement (e.g., education and employment), poor family/marital relations, substance abuse, and a lack of prosocial leisure/recreation pursuits augment the big four to form a "central eight" (Andrews & Bonta). In response to the identification of criminogenic needs, the RNR model recommends intervention strategies based on cognitive social learning theory. Noncriminogenic needs include poor self-esteem, vague feelings of emotional discomfort (e.g., unspecified anxiety), major mental disorder, lack of ambition, victimization history, fear of official punishment, and lack of physical activity.

This study will map onto the RNR model as it explores the relationship between the noncriminogenic need of victimization history, specifically childhood interpersonal trauma, and criminogenic needs such as poor social relations and lack of emotional self-control. Andrews and Bonta (2010) acknowledge that noncriminogenic needs may be related to criminogenic needs. A greater understanding of such a possible relationship may aid in treatment of offenders (e.g., treatments for childhood abuse that lead to improvements in emotion regulation, etc.). Criminal justice researchers, therefore, can view this study as an effort to extend a well regarded criminal justice model of recidivism that also incorporates dynamic risk factors of recidivism. The coping-relapse model, then, bridges both criminal justice and psychological models of coping and reentry.

Coping-relapse Model as Related to Lazarus and Folkman's (1987) Transactional Theory

The coping-relapse model of recidivism, as previously mentioned, also bears similarity to a leading theory of coping. The model strongly resembles Lazarus and Folkman's (1987)

transactional theory that emphasizes stress, appraisal, and coping. In fact, Zamble and Quinsey (1997) explicitly noted the degree of congruence between the models. In transactional theory a stressful stimuli from the environment leads someone to a primary appraisal to determine whether that stimuli is a potential harm, threat, and/or challenge. In response to the primary appraisal, a person conducts a secondary appraisal to evaluate whether action can address the harm, threat, and/or challenge and what coping strategies might be successful if action is pursued. Lazarus and Folkman describe this model as a system with interactive effects and relationships. For example, they note that whereas the initial emotional appraisal can impact the selection of coping strategies, the effect of the coping strategies also can influence the person-environment relationship and affect the resulting emotions upon reappraisal of that relationship (Folkman & Lazarus, 1988). Emotions, therefore, can affect coping strategies, and coping strategies can serve as a mediator of emotions. Dunkel-Schetter, Folkman, and Lazarus (1987) also note that the type of strategy employed can impact the presence and type of social support someone receives, which in turn affects the person-environment relationship. In this regard, Lazarus and Folkman's model echoes the Zamble and Quinsey coping-relapse model wherein environmental triggers or stimuli set a cognitive and affective appraisal process in motion that leads to differential selection of coping responses. Both of these models, and their accounts of the person-environment relationship, reflect Bandura's (1997) emphasis on interaction with environmental (as well as behavioral and personal) factors as part of reciprocal determinism of human functioning.

In response to environmental challenges, people can employ different coping strategies. Lazarus and Folkman (1984) highlight two broad categories of coping responses: problem-focused and emotion-focused coping. In problem-focused coping, an individual strives to address or change specific aspects of the problem to counter the threat. In emotion-focused coping, the

individual instead turns his or her attention to managing upsetting emotions that result from their appraisal of the problem. Lazarus and Folkman also view coping as a volitional or voluntary response to stressors. Other coping researchers have suggested additional coping categories. A major review of the coping literature by Skinner et al. (2003) examined 34 factor-analytic investigations of both adult and child-adolescent coping and found three strategies that appeared most often. Problem solving approaches, similar to problem-focused coping, appeared more frequently than any other coping strategy. Such approaches sought to eliminate sources of stress. Avoidance approaches, employed to withdraw from sources of stress either physically or psychologically, were the next most popular approaches. The third most popular strategy, seeking social support, strives to increase human support to diminish stress. This study, in particular, will look at problem-focused or more active coping approaches, emotion-focused coping, social support coping, and avoidance coping as potential coping responses.

Additional Empirical Support for the Importance of Coping in Reentry

Whereas the coping-relapse model of recidivism provides a theoretical basis, spurred by empirical results, for the importance of coping in reentry, additional quantitative study results support the value of coping. Brown et al. (2009), for example, used the coping-relapse model of recidivism in conducting a 3-wave study over 3 months that illustrated the importance of coping skills, social support, and negative affect in predicting recidivism. The study tracked 136 adult male Canadian offenders from minimum, medium, and maximum security prisons. Both static and dynamic variables were assessed in relation to recidivism among the sample. The dynamic variables were divided into those relating to the appraisal of environmental triggers (e.g., perceived stress levels and positive and negative affect) and those relating to the response to such triggers (e.g., strong social support and positive coping ability). Over the three months of examining the predictor variables, and up to a year of tracking recidivism, it was negative affect,

strong social support, and positive coping ability that significantly predicted the absence of recidivism, or desistance from criminal behavior. Also predictive were perceived global stress, perceived problem index, expected positive value of crime, and substance abuse problems. Furthermore, Brown et al. found that strong social support and positive coping ability significantly improved, while negative affect significantly decreased during the three months time for those who desisted. On the other hand, positive affect was not significantly related to desistance nor did it significantly change over time for desisters. Brown et al. concluded that dynamic variables, which potentially are amenable to intervention, are crucial to understanding the process of recidivism. Brown et al. also found that dynamic predictors combined with static predictors were more effective than static predictors alone, consistent with Andrews et al.'s (2006) expectations.

As noted by Andrews et al. (2006), however, relatively few other studies have incorporated dynamic risk factors of criminal recidivism. Hanson and Harris (2000) and Quinsey et al. (1997) also have studied dynamic risk factors among specialized offender groups. Hanson and Harris studied 409 sexual assault offenders, including 208 sexual offense recidivists and 201 nonrecidivists. Again, it is important to remember that sexual offenders are a relatively unique, yet not insignificant, subgroup of the overall prison population (James & Glaze, 2006). Yet this study did contribute to the literature on dynamic factors in a correctional sample. Hanson and Harris found that poor social influences, as a stable dynamic variable, and anger, as a dynamic variable, served as significant predictors of recidivism, emphasizing the importance of problematic emotions and social support in the recidivism process. Just as Hanson and Harris found dynamic variables to significantly predict recidivism, so did Quinsey et al. (1997) in their study of mentally disordered offenders that compared 60 recidivists to 51 nonrecidivists at one and six-month intervals. Quinsey et al. found two categories of significant dynamic predictors of

recidivism: one consisting of noncompliant behavior and procriminal sentiment and the other consisting of psychiatric and dysphoric mood symptoms, including social withdrawal. Once again, in a specialized offender population, social support and affective variables emerged as significantly associated with recidivism.

Jacoby and Kozie-peak (1997) performed another longitudinal study that specifically addressed social support, both before and after release, for mentally ill inmates from Ohio state prisons making the transition to the community. Although their subjects were limited to prisoners identified as mentally ill, this population also is not insignificant to the overall prison population (James & Glaze, 2006; Scott, 2001). Jacoby and Kozie-peak found that social support was significantly correlated with higher quality of life after release from prison, but not significantly related to criminal recidivism or psychiatric hospitalization after release. Although criminal recidivism justifiably receives significant attention as a measure of success, quality of life also can serve as an import measure beyond the baseline of recidivism.

The above studies, therefore, provide further support for the importance of coping, including social support and emotion regulation, in the offender reentry process. The coping-relapse model of recidivism also points toward the importance of offenders' appraisal of their coping self-efficacy.

Importance of Self-efficacy

The concept of self-efficacy, especially coping self-efficacy, receives relatively sparse attention in both the criminal justice and psychology literature as related to offenders. In order to better understand the potential import of self-efficacy for offenders coping with challenges upon reentry, aspects of self-efficacy theory will be related to the concept of coping self-efficacy, beginning with the sources of self-efficacy. Furthermore, a later section of this literature review will discuss the existing research in the psychology literature.

Self-efficacy develops through four main sources (Bandura, 1994), and apparent connections between those sources and experiences of offenders subjected to childhood maltreatment will be noted. Mastery experiences serve as the most influential source, wherein individuals realize actual success in certain domains (Bandura). The mastery experiences of overcoming obstacles serve to strengthen self-efficacy and render it less prone to deterioration. In light of trauma research findings, which will be discussed in greater detail later in this review of literature, childhood trauma predicts poor regulation of emotion, poor social skills, and a reduced capacity for problem-focused coping (i.e., poor mastery experiences in these domains) (Cloitre et al., 2009; Herman, 1992), self-efficacy for these constructs will likely suffer. Vicarious observation of others' mastery behavior serves as a second source of self-efficacy, in line with Bandura's social cognitive theory. An individual, then, can model observed behavior. To the extent children observe caretakers that perform poorly with these constructs (e.g., parents of offenders whom abuse their children rather than regulate their emotions), the children's self-efficacy will further deteriorate. Social persuasion exists as a third source of self-efficacy (Bandura). Others can persuade an individual that he or she possesses certain abilities through their use of language, affect or behaviors Social persuasion can weaken self-efficacy, however, more readily than enhance it (Bandura). Where verbal abuse exists by parents of offenders, it appears more likely that social persuasion would serve as a negative rather than positive influence. Somatic and emotional states serve as the fourth noted source of self-efficacy (Bandura). For example, people often infer that they possess poor ability in some task, such as public speaking, when they experience a stressful physiological and emotional response such as sweating and anxiety while carrying out that task. Bandura also conceives of self-efficacy as developed over the lifespan through these four sources. Infants, for example, can develop self-efficacy in their interactions with family members. Other developmental sources of self-efficacy

include peers, schools, adolescent transition, relationships, careers, and parenthood, among others. Self-efficacy, therefore, is not a static construct.

Self-efficacy not only reveals how traumatic childhood experiences could affect the coping self-efficacy of offenders; the theory also indicates that the relative presence of coping self-efficacy will e influence whether offenders engage their coping skills and sustain their efforts after setbacks (Bandura, 1994). Self-efficacy beliefs impact cognitive, motivational, affective, and selection processes; and, people with higher levels of self-efficacy are more likely to engage tasks proactively (Bandura, 1997). For example, offenders with high self-efficacy for addressing environmental stressors are more likely to set goals for their behavior in such situations, and persist in those efforts despite initial failures. They simply possess more confidence in their ability to overcome obstacles. Conversely, those with less self-efficacy are more likely to adopt avoidant responses to stressors. Self-efficacy, therefore, influences cognitive appraisals of situations, which in turn influence motivation (Bandura, 1997). Motivation can develop through people's sense of agency or causal attribution to their behavior, through positive expectations, and through goals. Positive self-efficacy can cognitively stimulate all of these motivational factors. Furthermore, beliefs of self-efficacy serve to diminish negative emotional responses, such as stress and depression, which arise in response to environmental challenges (Bandura, 1997). Offenders possessing higher levels of coping self-efficacy, therefore, also will tend to possess greater motivation to try to overcome obstacles and less negative affect that would lead them to avoid such a response. Self-efficacy can also open up additional options to respond to such challenges as a person's belief in their ability to respond to challenges increases.

Bandura's (1997) conceptualization of self-efficacy fits well within the coping-relapse model of recidivism (Zamble & Quinsey, 1997). The coping-relapse model specifically incorporates an appraisal of self-efficacy, or perceived ability to successfully respond to

environmental stressors. Strong self-efficacy could affect the ultimate outcome of efforts to address those stressors in at least three ways (Bandura). A heightened sense of perceived self-efficacy could lessen the perceived threat level of a stressor. If an offender possesses high self-efficacy for handling a challenge, his or her perception of the threat level will be lower than if he or she possessed low self-efficacy. Such self-efficacy, then, has been shown to reduce levels of stress and anxiety in response to challenges (Bandura). Lower levels of stress and anxiety leave people better able to initiate and maintain responses to challenges, thus increasing the potential for successful responses to those stressors. Moreover, heightened self-efficacy can lead to improved thought control which, in turn, can lead to better regulation of emotions and behavior (Bandura). This improved control and regulation can diminish the deteriorating cycle of thoughts and emotions spelled out in the coping-relapse model. Apart from its theoretical value in understanding the coping-relapse model of recidivism, numerous studies have shown self-efficacy to predict positive functioning across a wide domain of specific behavioral constructs such as smoking cessation (Martinez et al., 2010), academic success (Grigorenko et al., 2009), alcohol abstinence (Demmel, Nicolai, & Jenko, 2006), and job search results (Saks, 2006), among other constructs.

Self-efficacy, then, serves as an impetus for actually employing coping behavior whenever coping skills are developed. According to self-efficacy theory it is important to measure perceived personal efficacy in addition to measuring actual ability in the domain of interest (Bandura, 1997). Bandura noted that perceived self-efficacy determined whether coping behavior would be initiated. In other words, an offender could possess a coping skill but not employ it due to a lack of self-efficacy. Successful interventions, therefore, should address both behavioral improvement and a corresponding increase in self-efficacy. The relative presence of coping self-efficacy in released offenders looms as critically important to successful reentry in

addition to the importance of their relative levels of coping skills in responding to environmental stressors. It appears crucial, then, that offenders both possess coping skills and self-efficacy in those skills in order to successfully reenter society and respond to challenges.

Studies of Offenders and Self-efficacy

Although an examination of self-efficacy theory reveals the potentially important role coping self-efficacy may play in offender reentry, a literature search for self-efficacy with offenders and/or inmates reveals surprisingly scant existing research. A search of the PsycINFO, PsycArticles, and Psychological and Behavioral Sciences database for "self-efficacy" and either "prisoners," "inmates," or "offenders" resulted in over 80 unique hits. A scan of all those articles, however, revealed that only one operationalized coping self-efficacy similar to the methods employed in this study. Scheyett et al. (2010) studied 101 HIV-infected inmates in North Carolina prisons, and found that 44% appeared depressed. Depression, in turn, significantly predicted low coping self-efficacy scores as measured by the Coping Self-Efficacy (CSE; Chesney, Neilands, Chambers, Taylor, & Folkman, 2006) scale. This study indicated a link between depression and coping self-efficacy, but did not explore childhood maltreatment or coping styles.

In the other studies authors tend to operationalize self-efficacy in rather broad terms, not as associated with specific behavioral domains. For example, Friestad and Hansen (2005) found that self-efficacy (again at a more general level) was a significant predictor of mental distress and mental health problem among Norwegian prisoners. They measured self-efficacy, however, with the generalized self-efficacy scale (Schwarzer, 1993), which Bandura (1997) suggests is inadequate because it is not situation specific. Jackson and Innes (2000) also found that demographic variables of time served, prior education, and employment (i.e., before incarceration) were significant predictors of voluntary inmate participation in self development

programs, but that self-efficacy was not a significant predictor of such participation for 178 male medium-security Federal inmates. Self-efficacy, however, was operationalized by a one question measure asking participants whether they could learn to better control their behavior. Again, this operationalization of self-efficacy departs from a tight, domain specific effort, and this departure detracts from the study's findings. The concept of self-efficacy, however, is meant to address specific domains (Bandura). The specific domains that were occasionally cited, other than the first study highlighted in this paragraph, were not particularly germane to this study such as the self-efficacy of condom use (e.g., Stephens, Braithwait, Conerly, & Brantley, 2006).

Maruna (2001) provides another example of work on self-efficacy and offenders that does not tightly define self-efficacy; however, Maruna's work does cover important ground in linking even a general notion of self-efficacy to desistance from criminal behavior upon reentry into society. In his landmark study, Maruna interviewed ex-prisoners who either were desisting from or persisting in criminal behavior. Maruna found that the desisters possessed a strong sense of personal agency, a critical component of Bandura's (1986) notion of self-efficacy. The desisters better articulated plans for the future (devoid of criminal activity) and conveyed more confidence in their ability to realize those plans than the persisters, thus exhibiting perceived self-efficacy. Although Maruna mentions social support, coping abilities, and emotion regulation at various points, these concepts are not explicitly tied together and linked with self-efficacy. Maruna's work, however, does serve to underscore the importance of the general concept of self-efficacy in desisting from criminal behavior.

Effects of Childhood Trauma

As the literature appears to support the assertion that coping and coping self-efficacy impact offenders' navigation of environmental challenges upon reentry, factors that negatively impact coping and coping self-efficacy merit attention. Childhood interpersonal trauma, whose

prevalence among offenders will be discussed in a later section, appears to impact the important dynamic resources of social support, emotion regulation, and coping highlighted above that are crucial in responding to environmental triggers. Following is a more detailed discussion of the effects of childhood maltreatment. This review will refer to concepts such as PTSD and complex trauma with an intent to discuss how childhood maltreatment impacts coping and related resources and how childhood maltreatment impacts these resources apart from possible subsequent adult maltreatment.

The symptoms of childhood trauma are complex and extend beyond isolated PTSD symptoms. Victims of childhood interpersonal trauma have shown symptoms related to disorders of extreme stress not otherwise specified (DESNOS) and PTSD symptoms (van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Roth, Newman, Pelcovitz, van der Kolk, and Mandel (1997), for example, found among a sample of traumatized individuals and community residents that victims of prolonged interpersonal trauma, especially trauma experienced at a younger age (before age 14), were more likely to experience problems with affect and impulse regulation, memory and attention, self-perception, interpersonal relations, somatization, and systems of meaning. The presence of symptoms beyond PTSD in victims of childhood trauma carries important treatment implications. Cloitre, Koenen, Cohen, and Han (2002) suggest that DESNOS related symptoms, such as problems of emotion regulation, dissociation, and interpersonal relations, should often take priority over PTSD symptoms because of their potential for greater functional impairment.

Research also suggests that trauma rarely occurs in isolation, especially among victims of childhood abuse (Kessler, 2000). Trauma researchers have posited that experience with repeated, sustained, or different forms of trauma leads to Complex Posttraumatic Stress Disorder (Herman, 1992) that includes typical posttraumatic stress symptoms and problems with affect regulation

and interpersonal difficulties such as dissociation, high anxiety around others, and aggressive or avoidant social behavior (Cloitre et al., 2009). Cloitre et al. examined this connection between cumulative trauma and symptom complexity in a sample of adult women presenting for treatment related to symptoms of trauma. They found that cumulative trauma (inclusive of sexual abuse, physical abuse, neglect, emotional abuse, and the absence of the participant's mother for childhood trauma) in childhood, but not adulthood, was predictive of symptom complexity in areas of PTSD symptoms and problems with emotion and interpersonal regulation. Briere, Kaltman, and Green (2008) also found, in a sample of female college students, a linear relationship between cumulative trauma of various types (including rape, attempted rape, other sexual contact, and physical abuse, but no specifically identified forms of neglect or emotional abuse) experienced before age 18 and symptom complexity. In addition, they found that childhood rape and physical abuse were unique predictors of symptom complexity. These studies, therefore, have found a developmental component to the effects of trauma. Childhood interpersonal trauma predicts a wider breadth of symptoms than trauma suffered as an adult (Briere et al., Cloitre et al.). In particular, childhood trauma appears to predict PTSD related symptoms as well as symptoms of difficulty in self-regulatory areas such as emotion regulation, social relations, and attention (Herman). Problems in interpersonal relations, for instance, can manifest in behavior that is over-aggressive or avoidant (Cloitre et al.).

A review of the literature on childhood trauma and coping reveals substantive work on childhood maltreatment and coping methods, but an absence of work on childhood maltreatment and coping self-efficacy. Min et al. (2007) examined the relationship between childhood abuse and neglect and avoidant coping, substance abuse, and psychological distress in adulthood, among other variables. In particular, they studied 285 mothers giving birth in a large, urban teaching hospital that had been screened as at risk for drug use. They found that higher levels of

childhood trauma were directly related to the use of avoidant coping strategies, as well as greater psychological distress and substance abuse and less education. In addition, they found that childhood trauma was significantly related to lower levels of education and that avoidant coping styles were a partial mediator of the relationship between childhood trauma and greater psychological distress and substance abuse.

These researchers operationalized childhood maltreatment by way of the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) and avoidant coping by the COPE (Carver, Scheier, & Weintraub, 1989). Simons, Ducette, Kirby, Stahler, and Shipley (2003) also found that sexual abuse, physical abuse, and emotional abuse positively and significantly predicted the use of avoidance coping in 112 women in residential and outpatient drug and alcohol treatment programs. In addition, they found that all three forms of abuse significantly predicted drug use in the past 30 days, but only emotional abuse significantly predicted alcohol use severity. In another study done with drug users, Hyman, Paliwal, and Sinha (2007) looked at childhood maltreatment, coping strategies and perceived stress among 91 men and women at an inpatient research and treatment facility. They found that greater levels of childhood maltreatment were significantly related to greater use of avoidance coping strategies and greater perceived stress. Furthermore, they found no significant relationship between severity of childhood maltreatment and the use of emotion-focused or problem-focused coping strategies. Again, childhood maltreatment was operationalized by the CTQ and coping strategies by the COPE.

The research that has been conducted on trauma and coping self-efficacy examines coping self-efficacy's role in recovery from trauma rather than trauma's potential impact on coping self-efficacy. As an example of past research on trauma and coping self-efficacy, Benight and Bandura (2004) found perceived coping self-efficacy to serve a mediating role in recovery

from trauma, such as natural disasters and adult sexual assaults. Self-efficacy theory, however, appears to also support the notion that trauma, particularly childhood maltreatment, negatively impacts coping self-efficacy. As noted above, self-efficacy depends on a sense of personal agency (Bandura, 1997). Trauma researchers view childhood interpersonal abuse as contributing to a diminished sense of agency (Cook et al., 2005), however, as the child's attempt to address stressors are met with abuse and/or neglect from caretakers. Furthermore, as detailed below, offenders suffer from comparably high rates of childhood trauma. Environmental events such as childhood abuse and neglect, then, occur regardless of the child's behavior, thus diminishing or preventing development of a sense of agency (Bandura). Beyond a sense of agency, trauma also appears to negatively impact major sources of self-efficacy as previously noted. Past maltreatment, then, may diminish offenders' coping self-efficacy.

Childhood Trauma among Offenders

After noting the effects of childhood interpersonal trauma on important dynamic resources such as coping and coping self-efficacy, it also is important to consider the high rates at which offenders suffer from childhood maltreatment, as well as any significant gender differences in forms of maltreatment. Among studies of male offenders, Weeks and Widom (1998) found an overall prevalence rate of 68% for childhood physical abuse, sexual abuse, and neglect among New York state inmates; and, Dutton and Hart (1994) noted individual prevalence rates of 31% for physical abuse, 11% for sexual abuse, and 13% for neglect among Canadian inmates. Among female offenders, Bradley and Davino (2007) and Browne, Miller, and Maguin (1999) found reported prevalence rates of 79% and 59% for childhood sexual abuse and 62% and 70% for physical abuse for South Carolina and New York inmates, respectively. In addition, Bradley and Davino's study addressed the repeated nature of childhood trauma for many female offenders as 26% of those who reported sexual abuse also reported more than 100 incidents

perpetrated by one person. Other studies have contemporaneously assessed rates of childhood maltreatment for male and female offenders. Higher rates of reported sexual abuse by females have emerged as a consistent finding (Driessen, Schroeder, Widman, von Schonfeld, & Schneider, 2006; Harlow, 1999; McClellan, Farabee, & Crouch, 1997).

The high rates of childhood maltreatment suffered by offenders also appear to hold up when compared both to similarly conducted self-report studies (Scher, Stein, Asmundson, McCreary, & Forde, 2001) and more stringently conducted studies of community samples (Sedlak et al., 2010). One of the more stringent studies, the Fourth National Incidence Study of Child Abuse and Neglect (NIS-4), found confirmed (i.e., not self-reported) overall prevalence rates in America for both childhood abuse and neglect ranging from 1.71% to 3.95% (Sedlak et al.). Boys and girls again differed significantly in sexual abuse, with girls suffering from higher rates. Reported rates of childhood abuse and neglect beyond offender samples again highlight the seriousness of high rates of maltreatment reported by offenders.

Despite the high prevalence of childhood maltreatment among offenders, limited research exists on the potential relationship between such maltreatment and criminal recidivism. The research that does exist reveals mixed findings. For example, Benda (2005) found childhood sexual and physical abuse predictive of recidivism among male and female boot camp graduates, but Lowenkamp, Holsinger, and Latessa (2001) found neither childhood sexual abuse nor childhood physical abuse significantly predicted criminal recidivism in state felony offenders. The potential relationship between childhood maltreatment and recidivism, nevertheless, appears noteworthy given repeated findings of a high prevalence of childhood maltreatment among offenders.

A review of the literature reveals some important connections between childhood maltreatment and offender reentry and recidivism with room for further study. Offender reentry

and recidivism loom as significant phenomena, both in terms of the numbers of adults reentering society and the impact borne by society from their return. As these offenders face environmental stressors upon release, the coping-relapse model of recidivism and related research indicate that dynamic variables such as coping skills, social support, and emotion regulation significantly impact offenders' success in addressing these challenges. Research also highlights that exposure to childhood interpersonal trauma may negatively impact such variables and reveals that offenders suffer from higher rates of childhood maltreatment. Self-efficacy and social learning theory indicate that offenders exposed to significant childhood trauma are likely to possess lower levels of self-efficacy for coping, an indication this study intends to examine. People who possess higher self-efficacy in a specific behavioral domain are more likely to exercise that behavior, thus lower levels of coping self-efficacy would not bode well for offenders addressing environmental stressors. This study, therefore, seeks to address the following hypotheses based on the preceding literature review:

Hypotheses

Hypothesis 1: Higher participant scores on the CTQ, a measure of childhood interpersonal trauma, will be related to lower scores on the CSE, a measure of coping self-efficacy, suggesting that higher levels of childhood maltreatment will be related to lower levels of coping self-efficacy.

Hypothesis 2a, b: Higher scores on the CTQ will be related to higher scores on both the COPE (2a), a measure of situational coping styles, subscale for avoidance coping and the DERS (2b), a measure of difficulties in emotion regulation. Past research reveals that increased levels of childhood maltreatment predict increased use of avoidance coping and increased difficulties in regulating emotions.

Hypothesis 3: Participant CSE scores will correlate negatively with scores on both the COPE subscale for avoidance coping and the DERS. Low levels of coping self-efficacy will relate to participant preferences to employ avoidant coping strategies and to participant difficulties in regulating emotions.

Hypothesis 4: Coping self-efficacy will mediate the relations between scores on the CTQ and scores on the DERS, COPE subscale for avoidance coping, and COPE subscale for active coping. Based on self-efficacy theory, childhood maltreatment should negatively impact coping self-efficacy, which in turn should lead to difficulties in emotion regulation and a preference for avoidant coping methods over active coping methods. Multiple regression methods will be used to test this group of hypotheses (Baron & Kenny, 1986; Frazier, Tix, & Baron, 2004; Holmbeck, 1997).

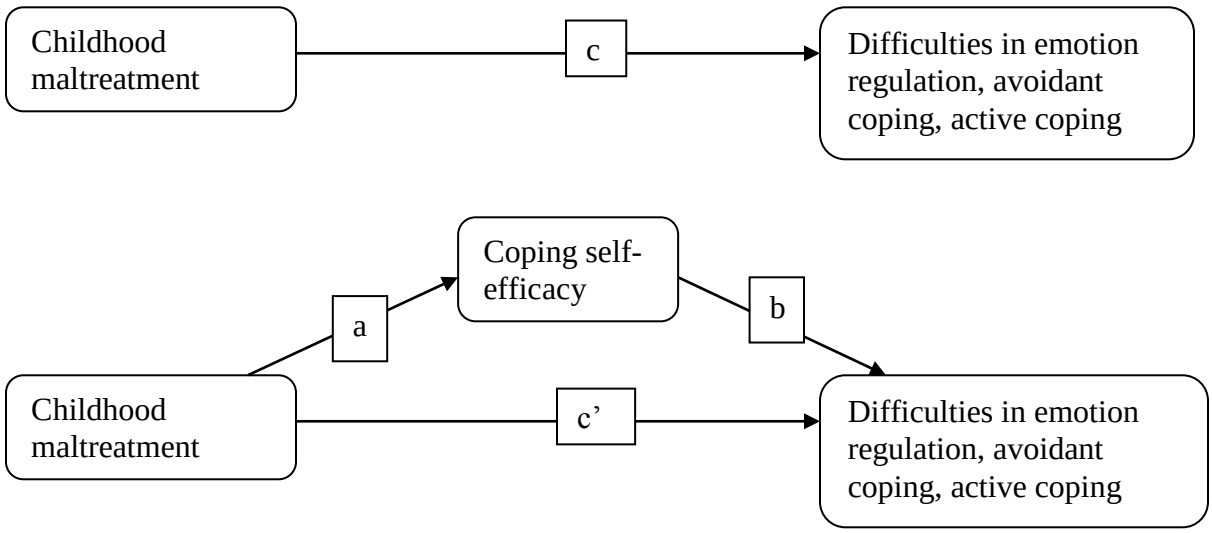

Figure 1. Coping self-efficacy as the mediator between childhood maltreatment and difficulties in emotion regulation, avoidant coping, and active coping.

Exploratory Hypothesis 1: Higher scores on the CTQ will be related to lower scores on the COPE subscale for active coping. This hypothesis has not been supported by past research.

Exploratory Hypothesis 2: Participant CSE scores will correlate positively with scores on the COPE subscale for active coping. Again, this hypothesis has not been supported by past research.

Method

Participants

The study enrolled 183 participants who were male (45.4%) and female (54.6%) offenders residing in 2 detention and 3 diversion centers in the state of Virginia. Detention and diversion centers provide 5 to 7 month residential programs for nonviolent felons, convicted as adults, who have been screened as physically and emotional appropriate for the programs. Diversion centers emphasize working on paid jobs. In contrast, detention centers provide work opportunities to offenders, but emphasize military discipline with fewer privileges. The participants ranged in age from 19 to 55 (M = 31.66, SD = 8.20). As for race/ethnicity, 60.7% of the participants self-reported as Caucasian, 33.3% as African American, 3.3% as Other, 1.1% as Latino/a, and 0.5% as Asian American (1.1% did not list their race/ethnicity). The study did not employ any exclusion criteria because detention and diversion centers have inclusion/exclusion criteria built into their admissions standards.

Design

The present study used self-report questionnaires, and the design was cross-sectional.

Measures

Demographics. Participants were asked to provide the following information: Department of Corrections identification number, date of birth, gender, ethnicity, marital status, number of children, age at first arrest, total number of arrests, age at first conviction, total number of convictions, nature of current and previous convictions, lifetime months under correctional supervision, highest level of education completed, last job held prior to current

conviction, job or career goal upon release, job or career expectation upon release, best job ever held, and total months worked. These data allow for a thorough description of study participants.

Childhood trauma. The Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1998) was used to assess offenders' levels of childhood maltreatment (see Appendix A). The CTQ is a 28-item questionnaire which includes five subscales: childhood physical abuse (CTQ-CPA), childhood sexual abuse (CTQ-CSA), childhood emotional abuse (CTQ-CEA), childhood emotional neglect (CTQ-CEN), and childhood physical neglect (CTQ-CPN). There are five items for each subscale plus an additional three-item minimization/denial scale. Responses are gathered using a 5-point scale (1 = *never true* and 5 = *very often true*). Previous research has demonstrated good internal consistency for the subscales, with Cronbach's alpha values ranging from .66 to .92 (Bernstein & Fink). The CTQ has also been found to correlate highly with therapist ratings of maltreatment and has demonstrated content, construct, and concurrent validity. Higher scores represent greater exposure to childhood trauma. In the present study, observed Cronbach's alpha coefficients were .84 (CTQ-CPA), .97 (CTQ-CSA), .87 (CTQ-CEA), .90 (CTQ-CEN), .75 (CTQ-CPN), and .94 (CTQ).

Coping self-efficacy. Coping Self-Efficacy (CSE; Chesney et al., 2006) was used to measure offenders' confidence in implementing appropriate coping behavior when confronted by life obstacles (see Appendix B). Chesney et al. developed this 26-item CSE, in collaboration with Albert Bandura. Three factors underlie the scale: use of problem-focused coping, ability to stop unpleasant emotions and thoughts, and ability to secure support from friends and family. Responses are gathered using an eleven-point scale (anchor points on the scale are 0 = *cannot do at all*, 5 = *moderately certain can do*, and 10 = *certain can do*). Strong internal consistency and test-retest reliability were found for all three factors (Cronbach's alpha from .80 to .91) and the scale overall (Cronbach's alpha of .95). Test-retest reliabilities after three months ranged from

.52 to .68 for the three factors. Chesney et al., in their study with a sample of 348 HIV-seropositive men who had sex with men, found the CSE to possess concurrent validity for current ways of coping and predictive validity for less psychological distress and greater psychological well-being. Higher scores represent greater coping self-efficacy.

Colodro, Godoy-Izquierdo, and Godoy (2010) conducted another study of the CSE with a United Kingdom based community sample of 182 participants (121 women, 58 men, and 3 of unknown sex). They found a Cronbach's alpha of .94 for the overall scale, with a range of .85 to .91 for Cronbach's alpaha for the subscales, and adequate construct validity for the CSE as compared to another scale measuring coping with stress self-efficacy. In addition, they found that women and healthy participants had significantly higher scores on coping self-efficacy with social support than men and nonhealthy people, respectively. No other significant differences for gender and health status were noted. In the present study, observed Cronbach's coefficient alphas were .94 (problem-focused), .91 (stop unpleasant thoughts and emotions), .79 (secure support from friends and family), and .96 (CSE).

Coping styles. The COPE (Carver et al., 1989) was used to measure how offenders respond to environmental stressors (see Appendix C). Offender responses fell either within active coping strategies (via the active, planning, and positive reframing subscales) or avoidant coping strategies (via the denial, behavioral disengagement, and mental disengagement subscales). Offenders responded to items on the COPE with respect to how they handle situations that are stressful or difficult. Responses for 24 items are gathered on a 4-point scale (1 = *I don't do this at all* and 4 = *I do this a lot*). Carver et al. found extensive support for the estimated reliability and validity of the COPE. Higher scores reflect greater use of each of the coping strategies. In the present study, observed Cronbach's coefficient alphas were .87 (active coping) and .78 (avoidant coping).

Difficulties in emotion regulation. The Difficulties in Emotion Regulation Scale (DERS; Gratz & Roemer, 2004) was used to measure offenders' difficulties in regulating their emotions. The DERS assesses six dimensions of emotion dysregulation: (a) lack of awareness of emotional responses, (b) lack of clarity of emotional responses, (c) nonacceptance of emotional responses, (d) limited access to emotion regulation strategies perceived as effective, (e) difficulties controlling impulses when experiencing negative emotions, and (f) difficulties engaging in goal-directed behaviors when experiencing negative emotions. Offenders indicated how often the items apply to themselves. Responses for 36 items are gathered on a 5-point scale (1 = *almost never (0–10%)*, 2 = *sometimes (11– 35%)*, 3 = *about half the time (36–65%)*, 4 = most *of the time (66–90%)*, and 5 = *almost always (91–100%)*. Gratz and Romer found a Cronbach's alpha of .93. Additionally, the DERS showed good test–retest reliability over a period ranging from 4 to 8 weeks (r = .88), and test–retest reliability of DERS subscales were .69 for nonacceptance, .69 for goals, .57 for impulse, .68 for awareness, .89 for strategies, and .80 for clarity. In the present study, the Cronbach's alpha of the DERS was .94.

Procedure

Informed consent for the study was conducted in a small group format in available rooms at the selected detention and diversion centers. Participants were informed that the study involved answering questions on past experiences, including questions about abuse and neglect, and their self confidence in certain types of coping. Study personnel were on hand to provide a brief description of the research project and to answer any questions on the study and informed consent. Recruitment took place once approval had been received from both University Institutional Review Board and the VADOC Human Subject Research Review Committee (HSRRC). In order to recruit participants, advertising posters were displayed in prominent locations in Virginia Department of Corrections detention and diversion centers. The posters had

sign up sheets available for interested potential participants. Due to ethical concerns, center staff were told to use a previously approved script pointing detainees and divertees' attention to the posters if the staff was questioned about the study. Center staff received a memo detailing these instructions (see Appendix E). Interested participants who arrived on the day of testing were given a memo that explained that they would be asked to provide informed consent before receiving the study's measures. If the participants provided their informed consent, they were then given all four measures. The measures were counterbalanced to address order effects. Study investigators read the measures aloud to participants, who were also able to read the measures on their own. Study personnel also worked with detention and diversion center staff to ensure adequate facilities for participants to fill out the measures while keeping their responses private from other study participants and center staff.

Testing Mediation Effects in Multiple Regression

This study employed multiple regression methods to test the mediation hypotheses offered (Baron & Kenny, 1986; Frazier et al., 2004; Holmbeck, 1997). Holmbeck outlined four steps to support a proposed mediation model. First, a significant correlation should exist between the predictor and outcome variables. Second, the predictor should also be significantly related to the proposed mediating variable. Third, the mediator should be significantly related to the outcome variable, while controlling for the effects of the predictor on the outcome. Fourth and finally, the strength of the relationship between the predictor and outcome should be significantly reduced with the addition of the mediator into the model. A full mediation model is present if the inclusion of the mediator reduces the correlation between the predictor and outcome to a level not significantly different from zero. A partial mediation model is present if the correlation between the predictor and outcome, while significantly reduced by inclusion of the mediator, remains significant. This study carried out these steps to test the mediated regression models

proposed in the hypotheses. For the model to hold, childhood trauma must be shown to be significantly correlated with difficulties in emotion regulation, active coping, and avoidant coping (see Path c in Figure 1). Then, childhood trauma must be shown to be associated with coping self-efficacy (see Path a in Figure 1). Next, coping self-efficacy must be shown to be significantly associated with difficulties in emotion regulation, active coping, and avoidant coping (see Path b in Figure 1), after controlling for the effects of childhood trauma. Finally, the inclusion of coping self-efficacy in the model must significantly reduce the strength of the relation between childhood trauma and difficulties in emotion regulation, active coping, and avoidant coping by comparing Path c' to Path c in Figure 1.

Results

This chapter provides the results from a number of data analyses, including preliminary data analyses and specific hypothesis testing. Where applicable, confidence intervals (CI) and null hypothesis statistical significance testing (NHST) will be reported.

Preliminary analyses

Before testing the hypotheses proposed in this study, preliminary analyses were run to examine potential order effects between alternative formats of the questionnaire as well as the relationship between important demographic variables and the variables of interest in this study: childhood maltreatment, coping self-efficacy, coping styles (active and avoidant), and emotion regulation. Reported childhood trauma was found to be skewed (1.44) and kurtotic (1.737), so a log transformation was performed (after which: skewness = 0.74, kurtosis = -0.33). Going forward, results for childhood trauma will refer to log transformed scores, unless otherwise noted. In addition, responses were imputed for blank items as the average response for all other participants, on all the questionnaires, if the participant had filled in at least 80% of the items for that questionnaire.

In order to reduce family-wise error, the error rate for each analysis was adjusted to alpha = .01. The 99% confidence interval, instead of 95%, therefore, is listed, unless otherwise noted.

Order effects. A one-way analysis of variance (ANOVA) was run to examine the effects of alternative ordering on childhood maltreatment, coping self-efficacy, coping styles (active and avoidant), and emotion regulation. None of the *F* values were significant at the .01 level. Thus, the ordering of the questionnaires did not appear to significantly affect the participants' responses.

Effects of demographic variables. The effects of the demographic variables of gender, age, and ethnicity were examined.

Gender. Independent sample t-tests were run to test the effects of gender. No gender effects were found on experiences with overall childhood trauma, coping self-efficacy, avoidant coping, active coping, or difficulties in emotion regulation. On the subscales (not log transformed) of emotional neglect, physical neglect, emotional abuse, physical abuse, and sexual abuse, women reported significantly higher levels of sexual abuse than men (CTQ-CSA; $x\text{-bar}_{diff}$ = 4.58, CI = 2.37 – 6.80, $p < .001$). On the other subscales there were no significant differences.

Age. Bivariate correlational analyses were run to examine the effects of age on childhood trauma, coping self-efficacy, avoidant coping, active coping, and difficulties in emotion regulation. None of the Pearson correlation coefficients were significant. Thus age was not included in further analyses.

Ethnicity. An ANOVA was run to examine the effects of ethnicity on childhood trauma, coping self-efficacy, avoidant coping, active coping, and difficulties in emotion regulation. The resulting *F* values were not significant for childhood trauma, avoidant coping, active coping, or difficulties in emotion regulation. The *F* value associated with coping self-efficacy ($F(4, 172) = 8.88$, $p < .001$) was, however, statistically significant. Hence, African

American participants reported significantly higher levels of coping self-efficacy than Caucasians (x-bar$_{diff}$ = 42.08, CI = 21.64 – 62.53, p < .001). Only 8 other participants (1 Asian American, 2 Latino/as, and 5 Others) with different reported ethnicities were included in the analysis of coping self-efficacy, thus rendering a comparison of African Americans and Caucasians the comparison of interest.

Intercorrelation matrix and descriptive statistics. Bivariate correlational analyses were run for all primary variables of interest. Pearson correlation coefficients are displayed in Table 1. The results of these analyses will be discussed further when reviewing results of hypothesis testing. Table 2 provides the means and standard deviations for the primary variables.

Table 1

Intercorrelation Matrix with the Primary Variables

Variables	*CTQ*	*CSE*	*DERS*	*COPE-Ac*	*COPE-Av*
CTQ	1.0				
CSE	-.15	1.0			
DERS	.20**	-.61***	1.0		
COPE-Ac	-.14	.60***	-.50***	1.0	
COPE-Av	.11	-.30***	.51***	-.33***	1.0

Note. CTQ = Childhood Trauma Questionnaire total score; CSE = Coping Self-Efficacy total score; DERS = Difficulties in Emotion Regulation Scale total score; COPE-Ac = COPE, active coping subscale; COPE-Av = COPE, avoidant coping subscale

** p < .01 (2-tailed). *** p < .001 (2-tailed).

Table 2

Descriptive Statistics

	Mean	*SD*	*Range*
CTQ	42.61	18.89	25 - 112
CSE	172.44	51.73	18 – 260
DERS	74.65	23.63	36 - 142
COPE-Ac	35.75	6.91	16 – 48
COPE-Av	24.19	6.29	12 - 39

Note. CTQ is not log transformed in the above table.

Hypothesis Testing

Childhood trauma and outcome variables. As seen in the intercorrelation matrix, childhood trauma scores (CTQ) were significantly and positively correlated with difficulties in emotion regulation (DERS), but were not significantly positively correlated with avoidant coping or negatively correlated with active coping or coping self-efficacy. Thus, hypothesis 2b was supported, but hypotheses 1 and 2a and exploratory hypothesis 1 were not supported.

Coping self-efficacy and outcome variables. Again, as seen in the intercorrelation matrix, coping self-efficacy was significantly negatively correlated with difficulties in emotion regulation and avoidant coping and significantly positively correlated with active coping. Thus, hypothesis 3 and exploratory hypothesis 2 were supported.

A mediation model of childhood trauma on difficulties in emotion regulation and active and avoidant coping. Coping self-efficacy was hypothesized as the mediator between childhood trauma and difficulties in emotion regulation, active coping, and avoidant coping. As detailed in the method section, the four-step approach for mediated regression models was taken to test these hypotheses (Baron & Kenny, 1986; Frazier et al., 2004; Holmbeck, 1997). The

Pearson correlations noted above only support the first condition for the relationship between childhood trauma and difficulties in emotion regulation, not for childhood trauma and avoidant and active coping. Childhood trauma, however, is not significantly correlated with coping self-efficacy, thus failing the second condition. Note that if the third step had been taken (with a hierarchical regression where difficulties in emotion regulation was regressed on childhood trauma and coping self-efficacy was entered on the second block), coping self-efficacy was significantly associated with difficulties in emotion regulation after controlling for the effects of childhood trauma ($\beta = -.61$, $p < .001$). Nonetheless, hypothesis 4 was not supported.

Discussion

In the midst of increasing numbers of offenders returning to society, research has begun to address dynamic factors possibly amenable to change in an effort to reduce recidivism and increase successful reentry (Brown, Amand, & Zamble, 2009; Glaze & Bonczar, 2009; West & Sabol, 2009). Offenders' past experiences with violence and victimization have also received increased attention (e.g., James & Glaze, 2006). Past research has explored the connection between childhood interpersonal trauma and dynamic variables such as coping styles and emotion regulation (e.g., Cloitre et al., 2009; Min et al., 2007), although not with offenders. Past research, however, has failed to explore the relationship between childhood interpersonal trauma and coping self-efficacy, and self-efficacy constructs have received scant attention in correctional psychology literature. This study, then, sought to find support for a relationship between past experiences of childhood interpersonal trauma and the dynamic factors of coping self-efficacy, coping styles, and emotion regulation among offenders, as reported by offenders in community corrections. The rest of this discussion section will focus on specific findings from this study, limitations of this study, and implications for research and practice informed by the present study.

Childhood maltreatment and its relations to the other primary variables

Consistent with this study's hypotheses, childhood maltreatment was significantly positively related to difficulties in emotion regulation. As the offenders in this study reported greater exposure to childhood interpersonal trauma they also reported greater emotion dysregulation. This study, then, adds to previous findings that show childhood abuse and neglect to negatively impact the ability to regulate emotions (Cloitre et al., 2009; Roth et al., 1997). The current study, however, did not confirm previous findings revealing that childhood maltreatment has a significant positive relationship with avoidant coping (Hyman et al., 2007; Min et al., 2007; Simons et al., 2003). This result will be discussed in light of reported levels of childhood maltreatment on the CTQ. As with other studies, though, no significant relationship was found between childhood maltreatment and active coping (Hyman et al., 2007). In particular, this study sought to support a relationship between childhood interpersonal trauma and coping self-efficacy, consistent with research on childhood trauma (e.g., Cloitre et al., 2009) and self-efficacy theory (Bandura, 1997). The negative relationship found, however, was not significant, thus suspending efforts in this study to explore a proposed mediating effect of coping self-efficacy on the relationship between childhood trauma and difficulties in emotion regulation with this sample. The study, then, provided some limited support for the importance of addressing childhood abuse and neglect as it impacts important variables for reentry.

The reported levels of childhood trauma on the CTQ were of particular interest. The mean scores noted in this study slightly exceeded those found in a recent community sample in the American Southeast (Thombs et al., 2007), providing further support that experiences with childhood trauma are a significant phenomenon among offenders (Bradley & Davino, 2007; Browne et al., 1999; Dutton & Hart, 1994; Weeks & Widom, 1998). Of particular note in the current study was the positively skewed and kurtotic distribution of reported levels of childhood

abuse and neglect. Such a distribution may have resulted from a defensive response style and/or may be addressed by an increased sample size. An increased sample size and/or the absence of a possibly defensive response style could shed more light on the proposed mediating effect of coping self-efficacy on the relationship between childhood trauma and difficulties in emotion regulation and could help to replicate previous findings, not found in this study, of a positive relationship between childhood trauma and avoidant coping. In addition, the absence of a normal distribution for reported levels of childhood trauma and the subsequent transformation further complicate relationships between childhood trauma and the other variables of interest. Nonetheless, experiences with childhood abuse and neglect appear to be not uncommon among offenders and worthy of further study. Furthermore, the study confirmed past research revealing that women tend to report more frequent experiences with childhood sexual abuse (e.g., Dressen et al., 2006).

Coping self-efficacy and its relation to the other primary variables

Again, while coping self-efficacy was not significantly related to childhood trauma, it was significantly related to the criterion variables of difficulties in emotion regulation, active coping, and avoidant coping. The latter results were consistent with self-efficacy theory (Bandura, 1997), which details how self-confidence that one can enact certain behaviors with desired results will lead to those behaviors' actual enactment, and were consistent with expectations formed from the research literature on self-efficacy (e.g., Chesney et al., 2006). In this case, the participants' self-efficacy in their ability to stop unpleasant thoughts and emotions, use problem-focused coping skills, and secure support from friends and family appeared positively related to their self-reported use of active coping skills and negatively related to their self-reported use of avoidant coping skills and difficulties in emotion regulation. As noted in the literature review, this study adds to the limited body of research of self-efficacy for the

correctional population. It also provides one measure, coping self-efficacy, that significantly relates to at least three other measures that appear important for reentry success according to the coping-relapse model of recidivism (Zamble & Quinsey, 1997) and past studies of reentry (Brown et al., 2009; Hanson & Harris, 2000; Quinsey et al., 1997).

Limitations

This study had a number of limitations. For instance, the study design did not address interpersonal trauma experienced as an adult, although research has found that such childhood trauma often leads to similar adult trauma (Kessler, 2000) and that offenders can experience trauma in correctional facilities (e.g., Beck, Harrison, Berzofsky, Caspar, & Crebs, 2010). Research also reveals, though, that the effects of childhood interpersonal trauma can remain significant beyond adult trauma (Cloitre et al., 2009). Interpersonal trauma suffered as an adult, however, could have shared variance with childhood interpersonal trauma on measures of coping self-efficacy, active coping, avoidant coping, and difficulties in emotion regulation.

Additionally, this study had a gender balance that was inconsistent with the community corrections population as a whole (Glaze & Bonczar, 2010) where women, for instance, comprised 24% of all probationers and 12% of all parolees at year-end 2009. At the one female building visited, over 90% of the women in the facility participated while the three male buildings visited had roughly three times the number of potential participants but less actual participants. Although, as noted above, a significant gender difference was only noted on one total questionnaire score, a more representative gender distribution could have led to more generalized findings. In addition, the study could have benefited from additional participants to provide more power for the results.

This study was also constrained by employing only one method of data collection: self-report questionnaires. The study could have benefited from other means of assessing the

constructs of interest (e.g., through reports of others, medical records, specific behavioral observations, etc.). The study also could have benefited from additional self-report measures for the constructs of interest to provide additional support for the study's results.

Implications for practice

This study highlights the importance of addressing offenders' experiences with childhood trauma and their coping self-efficacy, especially as they are preparing for reentry. Given the significant experiences with childhood trauma reported by this study's participants, the significant relationship between those traumatic experiences and difficulties in emotion regulation, and the importance of emotion regulation in reentry (e.g., Brown et al., 2009), practitioners may consider targeting treatment of childhood trauma for at least some reentering offenders. Cook, Dinnen, Rehman, Bufka, and Courtois (2011) conducted a recent study with a sample of 216 practicing psychologists that highlighted the significant time such psychologists devote to trauma, including childhood interpersonal trauma, and the psychologists' desire and need for additional education and training in therapy for trauma. Therapists in the correctional system, then, would seem to especially benefit from such increased education and training from entities such as the National Center for PTSD and the National Child Traumatic Stress Network and resources on treating trauma from researchers and practitioners like Courtois and Ford (2009). Such training (e.g., Courtois & Ford) includes treatment approaches to improve emotion regulation skills. Treatment for offenders would also benefit from targeting coping skills and education on successful coping skills interventions. For example, Puffer et al. (2011) ran a coping skills group intervention that significantly reduced traumatic stress and risky sexual behavior and increased coping skills in HIV-infected women with histories of childhood sexual abuse. Coping self-efficacy should serve as an important outcome of reentry preparation efforts, as coping self-efficacy significantly related to active coping, avoidant coping, and difficulties in

emotion regulation and those skills significantly impact reentry (e.g., Brown et al.; Zamble & Quinsey, 1997). In addition, practitioners would be well served to track advances in research of childhood interpersonal trauma, coping self-efficacy, and coping skills, especially among offenders.

Implications for research

The results of this study suggest promising future directions for research and confirm the importance of current research efforts on interpersonal trauma experienced by offenders. The prevalence of childhood interpersonal trauma reported by offenders in this study, confirm that efforts to research this phenomenon and its implications for offenders (e.g., Bradley & Davino, 2007; James & Glaze, 2006; Wolff & Shi, 2010) should continue. In particular, increased research participants, especially male participants, could provide support for a mediation model where coping self-efficacy mediates the relationship between childhood interpersonal trauma and difficulties in emotion regulation. Future research would also do well to track actual recidivism figures from study participants and tie them to constructs of interest in this study, especially childhood interpersonal trauma and coping self-efficacy. In addition, future research could continue to add to the literature and understanding of offenders' self-efficacy at coping with reentry. Research on reentry preparation efforts (e.g., therapeutic efforts, job training, etc.) could track the relationship between those efforts and coping self-efficacy, given the significant relationship found in this study between coping self-efficacy and important dynamic reentry related variables. Future research could also try to replicate and explore the higher levels of coping self-efficacy reported by African Americans than Caucasians. Lastly, future research could address other limitations in this study, such as examination of adult interpersonal trauma and additional methods and questionnaires for measuring the constructs of interest.

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Appendix A

Childhood Trauma Questionnaire

For each of the following items, circle a number from 1 - 5, using the scale below.

	Never True	Rarely True	Sometimes True	Often True	Very Often True
When I was growing up, I didn't have enough to eat.	1	2	3	4	5
When I was growing up, I knew that there was someone to take care of me and protect me.	1	2	3	4	5
When you were growing up, people in your family called you things like stupid, lazy, or ugly.	1	2	3	4	5
When I was growing up, my parents were too drunk or high to take care of the family.	1	2	3	4	5
When I was growing up, there was someone in my family who helped me feel that I was important or special.	1	2	3	4	5
When I was growing up, I had to wear dirty clothes.	1	2	3	4	5
When I was growing up, I felt loved.	1	2	3	4	5
When you were growing up, you thought your parents wished you had never been born.	1	2	3	4	5
When I was growing up, I got hit so hard by someone in my family that I had to see a doctor or go to the hospital.	1	2	3	4	5
When I was growing up, people in my family hit me so hard that it left me with bruises or marks.	1	2	3	4	5

	Never True	Rarely True	Sometimes True	Often True	Very Often True
When I was growing up, I was punished with a belt, a board, a cord, or some other hard object.	1	2	3	4	5
When I was growing up, people in my family looked out for each other.	1	2	3	4	5
When I was growing up, people in my family said hurtful or insulting things to	1	2	3	4	5
When I was growing up, I believe I was physically abused.	1	2	3	4	5
When I was growing up, I got hit or beaten so badly that it was noticed by someone like a teacher, neighbor, or	1	2	3	4	5
When I was growing up, I felt that someone in my family hated me.	1	2	3	4	5
When I was growing up, people in my family felt close to each other.	1	2	3	4	5
When I was growing up, someone tried to touch me in a sexual way, or tried to make me touch them.	1	2	3	4	5
When I was growing up, someone threatened to hurt me or tell lies about me unless I did something sexual with them.	1	2	3	4	5
When I was growing up, someone tried to make me do sexual things or watch sexual things.	1	2	3	4	5
When I was growing up, someone molested me.	1	2	3	4	5
When I was growing up, I believe that I was emotionally abused.	1	2	3	4	5
When I was growing up, there was someone to take me to the doctor if I needed it.	1	2	3	4	5
When I was growing up, I believe that I was sexually abused.	1	2	3	4	5
When I was growing up, my family was a source of strength and support.	1	2	3	4	5

Appendix B

Coping Self-Efficacy Scale

When things aren't going well for you, or when you're having problems, how confident or certain are you that you can do the following:

For each of the following items, write a number from 0 - 10, using the scale above.

When things aren't going well for you, how confident are you that you can:	**Cannot do at all**					**Moderately certain can do**					**Certain can do**
1. Keep from getting down in the dumps.	0	1	2	3	4	5	6	7	8	9	10
2. Talk positively to yourself.	0	1	2	3	4	5	6	7	8	9	10
3. Sort out what can be changed, and what can not be changed.	0	1	2	3	4	5	6	7	8	9	10
4. Get emotional support from friends and family.	0	1	2	3	4	5	6	7	8	9	10
5. Find solutions to your most difficult problems.	0	1	2	3	4	5	6	7	8	9	10
6. Break an upsetting problem down into smaller parts.	0	1	2	3	4	5	6	7	8	9	10
7. Leave options open when things get stressful.	0	1	2	3	4	5	6	7	8	9	10
8. Make a plan of action and follow it when confronted with a	0	1	2	3	4	5	6	7	8	9	10
9. Develop new hobbies or recreations.	0	1	2	3	4	5	6	7	8	9	10
10. Take your mind off unpleasant thoughts.	0	1	2	3	4	5	6	7	8	9	10
11. Look for something good in a negative situation.	0	1	2	3	4	5	6	7	8	9	10
12. Keep from feeling sad.	0	1	2	3	4	5	6	7	8	9	10
13. See things from the other person's point of view during a heated argument.	0	1	2	3	4	5	6	7	8	9	10

When things aren't going well for you, how confident are you that you can:	**Cannot do at all**					**Moderately certain can do**					**Certain can do**
14. Try other solutions to your problems if your first solutions	0	1	2	3	4	5	6	7	8	9	10
15. Stop yourself from being upset by unpleasant thoughts.	0	1	2	3	4	5	6	7	8	9	10
16. Make new friends.	0	1	2	3	4	5	6	7	8	9	10
17. Get friends to help you with the things you need.	0	1	2	3	4	5	6	7	8	9	10
18. Do something positive for yourself when you are feeling discouraged.	0	1	2	3	4	5	6	7	8	9	10
19. Make unpleasant thoughts go away.	0	1	2	3	4	5	6	7	8	9	10
20. Think about one part of the problem at a time.	0	1	2	3	4	5	6	7	8	9	10
21. Visualize a pleasant activity or place.	0	1	2	3	4	5	6	7	8	9	10
22. Keep yourself from feeling	0	1	2	3	4	5	6	7	8	9	10
23. Pray or meditate.	0	1	2	3	4	5	6	7	8	9	10
24. Get emotional support from community organizations or resources.	0	1	2	3	4	5	6	7	8	9	10
25. Stand your ground and fight for what you want.	0	1	2	3	4	5	6	7	8	9	10
26. Resist the impulse to act hastily when under pressure.	0	1	2	3	4	5	6	7	8	9	10

Appendix C

COPE

There are lots of ways to try to deal with stress. This questionnaire asks you to indicate what you generally do and feel, when you experience stressful events. Obviously, different events bring out somewhat different responses, but think about what you usually do when you are under a lot of stress.

What do you generally do and feel when you experience stressful events?	**I Don't Do This At All**	**I Do This A Little Bit**	**I Do This A Medium Amount**	**I Do This A Lot**
1. I try to grow as a person as a result of the experience.	1	2	3	4
2. I turn to work or other substitute activities to take my mind off things.	1	2	3	4
3. I concentrate my efforts on doing something about it.	1 1	2 2	3 3	4 4
4. I say to myself "this isn't real."	1	2	3	4
5. I admit to myself that I can't deal with it and quit trying.	1	2	3	4
6. I daydream about things other than the problem.	1	2	3	4
7. I make a plan of action.	1	2	3	4
8. I just give up trying to reach my goal.	1	2	3	4
9. I take additional action to try to get rid of the problem.	1	2	3	4
10. I refuse to believe that it has happened.	1	2	3	4
11. I try to see it in a different light, to make it seem more positive.	1	2	3	4
12. I sleep more than usual.	1	2	3	4
13. I try to come up with a strategy about what to do.	1	2	3	4
14. I give up the attempt to get what I wanted.	1	2	3	4
15. I look for something good in what is happening.	1	2	3	4
16. I think about how I might best handle the problem.	1	2	3	4
17. I pretend that it hasn't really happened.	1	2	3	4
18. I go to the movies or watch TV to think about it less.	1	2	3	4

What do you generally do and feel when you experience stressful events?	I Don't Do This At All	I Do This A Little Bit	I Do This A Medium Amount	I Do This A Lot
19. I take direct action to get around the problem.	1	2	3	4
20. I reduce the amount of effort I was putting into solving the problem.	1	2	3	4
21. I think hard about what steps to take.	1	2	3	4
22. I act as though it hasn't even happened.	1	2	3	4
23. I do what has to be done one step at a time.	1	2	3	4
24. I learn something from the experience.	1	2	3	4

Appendix D

Difficulties in Emotion Regulation Scale

Please indicate how often the following statements apply to you by writing the appropriate number from the scale below on the line beside each item:

1----------2----------3----------4----------5

almost never (0-10%)	sometimes (11-35%)	about half the time (36-65%)	most of the time (66-90%)	almost always (91-100%)

_____ 1) I am clear about my feelings.

_____ 2) I pay attention to how I feel.

_____ 3) I experience my emotions as overwhelming and out of control.

_____ 4) I have no idea how I am feeling.

_____ 5) I have difficulty making sense out of my feelings.

_____ 6) I am attentive to my feelings.

_____ 7) I know exactly how I am feeling.

_____ 8) I care about what I am feeling.

_____ 9) I am confused about how I feel.

_____ 10) When I'm upset, I acknowledge my emotions.

_____ 11) When I'm upset, I become angry with myself for feeling that way.

_____ 12) When I'm upset, I become embarrassed for feeling that way.

_____ 13) When I'm upset, I have difficulty getting work done.

_____ 14) When I'm upset, I become out of control.

1----------2----------3----------4----------5

almost never (0-10%)	sometimes (11-35%)	about half the time (36-65%)	most of the time (66-90%)	almost always (91-100%)

_____ 15) When I'm upset, I believe that I will remain that way for a long time.

_____ 16) When I'm upset, I believe that I'll end up feeling very depressed.

_____ 17) When I'm upset, I believe that my feelings are valid and important.

_____ 18) When I'm upset, I have difficulty focusing on other things.

_____ 19) When I'm upset, I feel out of control.

_____ 20) When I'm upset, I can still get things done.

_____ 21) When I'm upset, I feel ashamed with myself for feeling that way.

_____ 22) When I'm upset, I know that I can find a way to eventually feel better.

_____ 23) When I'm upset, I feel like I am weak.

_____ 24) When I'm upset, I feel like I can remain in control of my behaviors.

_____ 25) When I'm upset, I feel guilty for feeling that way.

_____ 26) When I'm upset, I have difficulty concentrating.

_____ 27) When I'm upset, I have difficulty controlling my behaviors.

_____ 28) When I'm upset, I believe that there is nothing I can do to make myself feel better.

_____ 29) When I'm upset, I become irritated with myself for feeling that way.

_____ 30) When I'm upset, I start to feel very bad about myself.

_____ 31) When I'm upset, I believe that wallowing in it is all I can do.

_____ 32) When I'm upset, I lose control over my behaviors.

_____ 33) When I'm upset, I have difficulty thinking about anything else.

_____ 34) When I'm upset, I take time to figure out what I'm really feeling.

_____ 35) When I'm upset, it takes me a long time to feel better.

_____ 36) When I'm upset, my emotions feel overwhelming.

Appendix E

Memorandum to DOC Staff

To: DOC Institutional Staff

From: Dr. Shivy

Date: March 28, 2010

Subject: Directing Detainees and Divertees' Attention to "Past and Present Experiences of Detainees and Divertees"

Thank you, in advance, for helping to make this project "**Past and Present Experiences of Detainees and Divertees**" a reality.

This memo provides some guidelines for helping detainees or divertees to learn about our study. It is extremely important that you follow these guidelines to the letter. Our permission to do this study depends on everyone following these instructions.

The most important thing to keep in mind is that **your role is limited to drawing detainees or divertees' attention to the study.**

1. Please post our informational flyers freely – in areas where this is permitted. Please check with supervisors from your institution before posting flyers.

2. Please feel free to call detainee or divertee attention to the informational flyers.

3. Here is what you can say about the study:

   "Did you see the flyers that were posted about a new research study? Faculty from Virginia Commonwealth University are conducting a study, and they would like your help. They are interested in detainees or divertees' past experiences, the way they cope, and their self-confidence with certain types of coping. Look for the flyers that recently have been posted."

4. The purpose of approaching detainees and divertees about the study should only be to draw their attention to the informational flyers.

Vita

David Benjamin Guion was born on November 8, 1978, in Jerusalem, Israel, and is an American citizen. He graduated from James River High School, Midlothian, Virginia in 1997. He received his Bachelor of Science in Commerce from the University of Virginia, Charlottesville, Virginia in 2001 and subsequently worked as a public accountant for 6 years. He received a Master of Arts in Counseling from Asbury Theological Seminary in 2008.