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The Validity of Self-Reported Criminal Arrest History Among Clients of a Psychiatric Probation and Parole Service

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ABSTRACT Self-report data have consistently demonstrated acceptable reliability and validity in prior studies by exhibiting high correlations with other criterion related measures of criminal frequency and arrest history. Mental health factors and substance abuse factors are suspected to affect the quality and accuracy of self-reported data. This analysis sought to examine the impact of major mental illness and substance abuse factors on the validity of self-reported criminal history data as given by clients of a psychiatric probation and parole service. After controlling for socio-demographic variables, the number of officially recorded arrests, high number of lifetime hospitalizations and overall years spent in jail significantly explained the number of self-reported arrests. The predominance of the official record in explaining self-reported arrest history suggests that self-reported arrest history data given by a psychiatric offender population is as valid as that given by general offender populations. Substance abuse factors and mental illness factors did not affect the quality and accuracy of self-reported arrest history. *[Article copies available for a fee from The Haworth Document*

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Self-report has been the dominant technique used for measuring criminal behavior since its introduction in the 1950s by Short and Nye (1957). Self-report data have consistently demonstrated acceptable reliability and validity in prior studies by exhibiting high correlations with other criterion related measures of criminal frequency and arrest histories (Farrington, 1973; Hardt & Hardt, 1977; Horney & Marshall, 1992; Huizinga & Elliott, 1986; Maddux & Desmond, 1975; Mieczkowski, 1990; Weiss, 1998). Nevertheless, the representativeness of self reported individual criminal behavior of actual criminal behavior is wholly contingent on the level of disclosure offered by the respondent. Specific subject characteristics are of particular concern given the potential for features such as substance abuse or mental illness to impact the respondent's ability or willingness to be truthful. This examination will explore the effects of major mental illness and substance abuse factors on the validity of self-reported criminal history data as given by clients of a psychiatric probation and parole service. While acceptable levels of the validity of self-report data among general offender populations has been repeatedly supported, the applicability of these findings to offenders with mental illness has not yet been sufficiently examined.

EMPLOYMENT OF SELF-REPORT DATA

The continued regard for self-report as a sound measure of criminal history is based on the growing awareness of the limitations of official records (Hindelang, Hirschi & Weis, 1981). The primary limitation of official records as a data source is the narrowness of the event description. Criminal events are generally reduced to charges or police reports, omitting important information, such as the extent of victim injury, precedents, victim-offender relationship, presence or absence of drugs or alcohol and mental status of the offender (Convit, O'Donnell & Volavka, 1990). Self-report data provide a more comprehensive

overview of the event and allows the incorporation of pertinent contextual factors.

A second major criticism of official records refers to their limited tally of observed behaviors which omit the scope and frequency of undetected criminal acts. Self-report is employed as a means of probing more fully the precursors, habitual behaviors and related events which reflect actual rates of individual criminality not associated with official detection.

Lastly, official records are regarded as frequently inaccurate due to human error. Records can be lost, incorrectly recorded during data entry or assigned to the wrong individual. These types of chance errors most often result in under-reporting of criminal history when based on official records. Regardless of these limitations, official records may be the best available criterion to measure the validity of alternative sources of criminal history. The correspondence between two data sources is recognized as a measure of concurrent validity.

Mental illness and substance abuse are suspected to influence the quality and truthfulness of self-report data, suggesting that affected respondents are not competent to provide accurate reports of their experiences and behaviors. Given the reliance of offender research on self-report data to generate directions for public policy and funding for intervention strategies, the validity and limitations of such data need to be comprehensively examined for applicability to various offender types and for the effects of offender characteristics.

Influence of Mental Illness on Self-Report of Criminal Activity

The range of correlations found between self-report of criminal activity and official reports of criminal activity in the general offender population vary between .66 (Wyner, 1977) and .80 (Hindelang et al.). Convit and colleagues (1990) found the concurrent validity between the self-reported criminal activity of psychiatric inpatients with their official records to be significantly better than chance alone, but not as high as that of non-psychiatric respondents. Convit's small sample (N = 41) limits explanation of certain findings. For those subjects reporting criminal arrests where none were officially recorded, all of these were diagnosed with schizophrenia. As there were only nine subjects in this group, it is not clear whether diagnosis of schizophrenia is responsible for the lack of correlation or whether a larger sample could expand the

range of possible explanations and provide support for other factors influencing the validity of self-report by persons with schizophrenia.

Further, the experience of psychosis may affect the respondent's recall. Both memory and interpretation of past events can be distorted as a function of inconsistent reality testing and cognitive deficits. While Weiss and colleagues (1998) found high concurrent validity between self-report of substance use patterns and urinalyses in non-psychotic dually diagnosed subjects in a treatment setting, others have found limitations to the self-reports of psychotic patients (Shaner et al., 1993). Symptomatic respondents may exhibit difficulties processing and responding to requests for detailed information, invalidating many of their responses to interview or questionnaire items. Questions are still raised as to the competence of persons with severe mental illness to participate in research as fully informed, consenting participants. Exploring this population's capacity to provide accurate self-report data informs the larger debate regarding the utility of including persons with mental illness as competent voices in mental health research. The extent to which specific mental illness diagnoses affect self-report data has not been addressed in prior research.

The Influence of Substance Abuse on the Validity of Self-Report

Professional practitioners have made proverbial the saying, *How can you tell when a junkie is lying? His lips are moving*. Such traditional wisdom, however, is not supported by the empirical literature regarding the self-report of substance abusers. Maddux and Desmond (1975) described the correspondence between two independent data sources with self-report components of twelve life history variables of chronic heroin users. Their findings demonstrated high correspondence between sources on most variables, except the number of lifetime arrests and number of treatment encounters. The authors conclude that overall, heroin/opioid users report valid information in a self-report format. However, due to the dynamics of their addiction, some may under-report certain information as a result of their reliance on denial and minimization as primary defense mechanisms. Conversely, drug users in treatment settings may over-report abuse frequency in an effort to expedite and secure treatment services.

Mieczkowski's (1990) review of the literature on validity of self-reported drug use in criminal justice settings noted that cocaine use is less likely to be accurately reported than marijuana and heroin use.

The tendency to under-report cocaine use in criminal justice settings is supported by Feucht, Stephens and Walker (1994) and later replicated by Mieczkowski (1997). Criminal justice settings, as opposed to treatment settings, provide a disincentive to honest reporting where admission of drug use may have more negative than positive consequences, such as disciplinary action, violation of probation or parole, or a return to court or jail. The costs and benefits of truthful reporting are salient dynamics in the assessment of self-report validity of substance abuse data (Babor, Brown & DelBoca, 1990).

Objectives of the Present Analysis

The present analysis examined the impact of mental illness and substance abuse factors on self-report data of criminal history among psychiatric probationers and parolees. Sociodemographic characteristics, official criminal history record, clinical psychiatric factors and substance abuse factors were employed as explanatory variables. One objective of the present analysis was to extend the applicability of prior validity research on general offender self-report to the psychiatric offender population. The second objective was to determine the extent to which mental illness and substance abuse factors explained discrepancies between the self-reported data and official record data, when controlling for sociodemographic characteristics. Thirdly, the analysis sought to identify specific categories of major mental illness most likely to effect over- or under-reporting of arrest history.

METHODS

Setting

The study consecutively sampled persons who were assigned to psychiatric probation and parole (PPP) in the court of a large city. Because the psychiatric probation and parole unit is a specialized law enforcement unit rather than clinical facility, clients are neither diagnostically assessed nor treated for psychiatric disorders. Clients are referred to the psychiatric probation and parole units from a number of sources for a variety of reasons, including being or having been treated for a mental illness. Clients may be assigned to this unit who do not

have any psychiatric illness, and who have never been in psychiatric treatment. Consequently, there is likely to be an optimum variance in psychiatric diagnoses, mental health treatment history, criminal history, and criminal behavior.

This setting afforded an opportunity to assess the relationship of mental illness, substance abuse and criminal factors among a criminally involved population. Clients could be on probation, parole, or both probation and parole. Because these were county level probation and parole units, parole cases were for sentences of less than 2 years. Sentences of 2 years or longer are supervised by the state parole board. Thus, in this setting, the population supervised on parole was similar to those supervised on probation in terms of criminal involvement. In addition, officers managed both probation and parole cases in a similar fashion.

Sample

Each subsequent new admission to PPP was approached for consent to participate in the study. New clients were defined as those individuals who were new to PPP; returning to the community from an imprisonment, but continuing to be supervised by PPP; or current clients who acquired a new conviction and probation sentence.

A research worker was stationed daily at PPP to conduct screening interviews for eligibility to participate in a study examining incarceration of individuals with a major psychiatric diagnosis. In addition to taking referrals from officers, the research worker monitored the intake logs and the client sign-in sheets for new clients to be approached for consent to the screening portion of the study. One hundred and eleven potential participants refused consent for the screening. This represents a 25% rate of refusal. Refusers did not differ from those who consented by age, ethnicity, gender, or the interaction of gender and ethnicity. Sample recruitment began in February 1995 and concluded by July 1997, at which point a sample of 250 eligible participants was obtained.

At the initiation of sampling, PPP had 874 clients being served by 10 probation officers. Twenty-seven percent of these PPP clients were female, 70% were African-American, 3% Hispanic (there was a specialized Hispanic unit serving many Spanish-speaking clients), and 1% Asian or other. As indicated by Table 1, the sample appears to be

V ***Table 1: Socio-Demographic, Clinical and Criminal History Characteristics of the Sample***

Variable	**N**	**n**	**%**
Ethnicity			
African American	249	161	64.7
White	249	57	22.9
Hispanic/Latino	249	20	8.0
Asian/Mixed/Other	249	11	4.4
Male	249	182	73.1
No prior psychiatric hospitalization	247	72	29.1
Now on psychiatric medication	250	139	56.3
	N	M	SD
Age	247	34.56	9.09
Years of education	249	11.13	2.40
Age at first arrest	247	23.45	20.10
Number of juvenile arrests	242	1.67	3.55
Total time spent in jail (years)	248	2.08	2.90

representative of the caseload of PPP regarding sociodemographic characteristics.

Interviews

The screening and baseline interviews collected data on basic sociodemographic characteristics, and the history and recent status of psychiatric treatment, criminal arrest, criminal behaviors and substance abuse factors. Lifetime diagnosis based on the DSM-III-R was derived from the Quick Diagnostic Interview Schedule, or Q-DIS (Bucholz, Marion, Shayka, Marcus & Robins, 1996), a computerized version of the lengthier Diagnostic Interview Schedule (DIS). The DIS is a highly structured standardized interview that was developed to make diagnoses by three systems, including the DSM-III-R, and can be administered by clinicians or lay interviewers. It has been extensively used in a number of studies, including the Epidemiological Catchment Area Study (Bovings, Helzer, Croughan & Ratcliffe, 1981; Spengler & Wittchen, 1988). The Q-DIS can be administered more quickly than the DIS, without sacrificing accuracy, by classifying respondents as

cases or non-cases as soon as it can be determined whether a diagnosis can be made. These screenings employed the Depression, Mania, Schizophrenia, and Anti-social Personality portions of the Q-DIS. The interviewer read Q-DIS items to participants and entered their responses directly into the computerized program using a notebook computer. Eligibility for the study was then determined based on the Q-DIS lifetime diagnosis of schizophrenia or a major affective disorder, and respondents' voluntary consent to participate further.

In the interview, clients were asked their age at the time of their first arrest, number of juvenile arrests, number of lifetime arrests and for an estimate of the total amount of time spent in jail in their life. Regarding substance abuse, respondents were asked ''Do you think you have a problem with alcohol or drugs like wanting to stop using them and not being able to do so?'', whether they were using drugs or alcohol at the time of their arrest and specific usage patterns in the past thirty days. In corresponding interviews, probation officers were asked if they viewed the client as having a drug or alcohol problem and to rate the severity of the client's current substance use, ranging from abstinence to severe dependence. Table 2 summarizes the prevalence and variance of substance abuse factors in this sample.

Table 2: Substance Abuse Factors

Variables	N	n	%
Officer reports client to have a drug problem	248	32	12.8
Officer reports client to have an alcohol problem	248	30	12.1
Officer reports client to have problems with alcohol and drugs	248	41	16.4
Officer reports client has no problem with substance abuse	248	145	58.0
Client reports any alcohol or drug problem	250	41	16.4
Client reports using more than one substance in the past 30 days	250	45	18.0

Official Record Data

The official criminal arrest record for each respondent was accessed via the municipal court's computerized Court History File (CHF). The CHF lists the arrests of each participant within the county since 1965, including date of arrest, charges incurred, court disposition and probation and parole violations.

Perfect correlation between self-reported arrests and officially recorded arrests is not expected. Subjects may have arrests in surrounding counties or states not recorded in the CHF. This effect may be somewhat mitigated by the size of the municipality, which is a major urban center with an extraordinarily large jurisdiction. Furthermore, this particular population's reliance on and involvement with county social service agencies may well minimize mobility. Regular arrest incidents recorded in the CHF spanning 10, 20 and 30 years also supports characterization of this sample as relatively stationary, though local lifetime arrests outside the municipality are not accounted for in the official data. Furthermore, the CHF does not include juvenile arrest records. The official record data collected were limited to charges incurred from the age of 18 and above. Both of these limitations are standard to most official record reviews. Therefore, the results of this analysis are likely to be highly comparable to previous findings using official criminal records.

Analysis

Three analyses were conducted. The first analysis sought to extend the applicability of prior validity research on general offender self report to the psychiatric offender population. The number of lifetime arrests recorded in the Court History File (CHF) served as the official report which was correlated with self reported number of lifetime arrests. As the official report recorded only adult arrests, the variable, self reported lifetime arrests, was adjusted by subtracting the number of self reported juvenile arrests from the self-reported number of lifetime arrests to more accurately equate the question posited to respondents regarding lifetime number of arrests ("how many times have you been arrested in your lifetime?") with the number of adult arrests recorded in the CHF.

The second analysis sought to determine the extent to which mental illness and substance abuse factors explained discrepancies between

the given self-report data and official record data, when controlling for sociodemographic characteristics. Hierarchical block regression analysis was used to model an explanation for discrepancies between an official record source and self-report data. While controlling for sociodemographic characteristics and accounting for the official criminal record, the impact of lifetime diagnosis, treatment history, substance abuse and criminal history on the remaining self-reported arrests were assessed. Preliminary analysis helped to delete non-significant clinical psychiatric, substance abuse and criminal history variables. Therefore, the conceptual blocks included only the strongest predictors in the final analysis. These blocks were constructed as follows:

1. *Sociodemographic characteristics:* Variables were age, male gender, African American ethnicity and years of education. African American was chosen as the indicator variable to represent ethnicity because it was the largest ethnic group in the sample.
2. *Official report:* The actual number of arrests recorded in the Court History File composed the official report variable. Given the skewed distribution, the variable was constructed as the number of officially reported lifetime arrests with negative inverse transformation.
3. *Diagnoses from Q-DIS:* Variables were overall indicators of Schizophrenia, Depression, Mania, and Antisocial personality disorder.
4. *Treatment history:* Variables were high number of lifetime hospitalizations, constructed as hospitalization events greater than the median of the sample (M = 2), and probation officer assessment of medication compliance.
5. *Substance abuse:* Variables were self-reported problems with drugs, alcohol or both.
6. *Criminal history:* Variables were self-reported estimate of total time spent in jail or prison in life and ever arrested as a juvenile.

The dependent variable, self-reported lifetime arrests, constructed as the number of self-reported lifetime arrests minus the number of self-reported juvenile arrests, was highly skewed. A negative inverse transformation achieved a normal distribution while maintaining statistical comparability to the official report data.

The third analysis sought to identify specific categories of major mental illness most likely to effect over- or under-reporting of arrest

history. The sample was divided according to Q-DIS diagnoses. Those subjects with more than one diagnosis were included in more than one subsample. The distribution of Q-DIS diagnoses is reported in Table 3. For each group, a correlation between self-reported number of arrests and official report of number of arrests was used to determine differences between groups and to measure the magnitude and direction of the discrepancies between official report and self-report records. Six variables were constructed to describe under-reporting and over-reporting. For each category the degree of discrepancy between the

Table 3: Regression Analysis Explaining Validity of Self-Reported Lifetime Arrests

Variables	**Standardized betas (As blocks of variables were entered)**					
	Step 1	Step 2	Step 3	Step 4	Step 5	Step 6
Male gender	.258***	.206***	.212***	.212***	.210***	.207***
Age	.219***	.077	.076	.073	.070	.049
Extent of education	−.190**	−.077	−.075	−.079	−.081	.069
African American	.003	−.037	−.039	−.047	−.048	.042
Official number of arrests		.536***	.505***	.489***	.484***	.447***
Schizophrenia diagnosis			−.023	−.004	−.010	.009
Depression diagnosis			−.078	.058	.064	.053
Mania diagnosis			.082	.087	.085	.069
Antisocial diagnosis			.044	.035	.029	.015
Extent complies with medication (PO report)				.117	.113	.096
High number of lifetime hospitalizations				−.109	−.110	−.073
Reported any drug or alcohol problem (self-report)					−.32	.17
Estimated total time incarcerated in life						.135
Ever arrested as a juvenile						.090
R^2	.158	.406	.422	.436	.437	.460
F	9.648	28.063	16.319	13.986	12.803	11.939
(df)	(4,206)	(5,205)	(9,201)	(11,199)	(12,198)	(14,196)
R^2 for change		.249	.016	.014	.001	.023
F for change		85.828	1.379	2.437	.319	4.240
(df)		(1,205)	(4,201)	(2,199)	(1,198)	(2,196)

official report and self-report record is described as differences of one, two, and three or more arrests. Frequencies of each category were used to describe the trends of under- or over-reporting detected in each group.

RESULTS

The first analysis sought to establish correlations between self-report data and official record data within a population of psychiatric offenders comparable to those found in prior research within the general offender population. In this sample of 250, the correlation between self-reported number of lifetime arrests and official report number of lifetime arrest was .669, significant at level $p < .01$.

The second analysis sought to examine the impact of mental illness and substance abuse factors on self-report data of criminal history. A hierarchical block regression analysis was used to model an explanation for self-report of number of lifetime arrests. Following the entry of sociodemographic controls, officially reported arrests were entered as the sole predictor in the second block to explain most of the variance in the dependent variable, self-reported arrests. Given the generally high correlations between self-report and official report of arrest history reported in the literature, and the significant correlation found in this sample ($r = .669$, $p < .01$), it was correctly predicted that the official record would explain most of the self-report data.

It was expected that diagnosis would be the next most powerful explanatory block, followed closely by substance abuse factors. However, in this sample of psychiatric probationers and parolees, clinical factors had no significant explanatory power regarding self-reported arrest history data. Active symptomology was thought to perhaps be a better indicator than lifetime diagnosis of the respondents ability to provide accurate self-report data at the point of measurement. To test this, a block of variables reflecting active anxious, depressive and psychotic symptoms was entered, and substances used in the past thirty days. None of these variables added significantly to the model and the block was therefore eliminated.

In the fourth block, a high number of lifetime hospitalizations significantly contributed to explanation of self-reported arrests. Block five indicates that a problem with drugs or alcohol was not related to the validity of self-report data. The original block included severity of

substance abuse problem as rated by the probation officer and type of substance used. Neither contributed significantly to the explanatory power of the block and were thus eliminated in the final model. In block 6, total time spent in prison or jail in life emerged as the most significant explanatory variable other than the official record.

After all blocks of variables were entered, the resulting analysis was statistically significant, $F(14, 196) = 11.94$, $p < .001$, explaining 46% of the variance in self-reported arrest data. Table 3 summarizes the results of the analysis as each block of variables was entered. This table indicates that the largest portion of variance was explained by the official record data (25%). The only remaining criminal history variable of statistical significance ($p < .01$), total amount of time spent in jail or prison in life, explained an additional 2% of the variance. In the final model, the significant factors beyond the official record which accounted for the accuracy of self-report data were high number of lifetime hospitalizations, total time incarcerated in life and having been arrested as a juvenile.

In the third analysis, specific categories of major mental illness were examined for differential effects on over- or under-reporting of arrest history. Though mental illness factors were statistically insignificant in the final model, the third analysis was conducted to describe the limited effects of mental illness diagnosis on the validity of self-report. Table 4 summarizes the tendencies to over- and under-report within major mental illness categories, and presents the categorical correlations within each group. The lowest correlation between self-reported number of arrests and officially recorded number of arrests was found among subjects diagnosed with schizophrenia ($r = .600$), though this statistic was still significant at $p < .01$. The relationship between schizophrenia and under-reporting by one arrest was statistically significant, $^2 = 4.38$, $p < .05$. This significance disappeared when under-reporting was measured by a discrepancy of two or more arrests. Subjects diagnosed with antisocial personality disorder had a tendency to significantly over-report their arrest history by three or more arrests ($r = .197$, $p < .01$).

For each diagnostic category, the median number of self-reported arrests was lower than the median number of officially reported arrests. Table 4 summarizes the results for each diagnostic category. In the entire sample ($N = 250$), 50.4% under-reported their number of arrests by one, however, only 17% qualified as under-reporters when

V *Table 4: Over- and Under-Reporting by Diagnostic Groups*

	Antisocial	Depression	Schizophrenia	Mania	All
	n = 124	n = 199	n = 68	n = 18	N = 250
Correlation between official and self-report	.707**	.674**	.600**	.669**	.669**
Median # of recorded arrests	4.0	4.0	5.0	4.0	4.0
	Range = 145	Range = 145	Range = 30	Range = 30	Range = 145
Median # of self-reported arrests	3.0	2.0	4.0	3.0	3.0
	Range = 76	Range = 76	Range = 76	Range = 76	Range = 76
Over-reporters by 1	37.8 %	29.1%	29.3%	30.5%	29.5%
Under-reporters by 1	46.2%	46.3%	56.4%	55.8%	50.4%
Over-reporters by 2	34.2%	25.1%	25.0%	27.2%	24.6%
Under-reporters by 2	14.9%	15.1%	21.9%	18.5%	19.2%
Over-reporters by 3	29.8%	22.3%	21.9%	22.8%	21.4%
Under-reporters by 3	14.0%	13.4%	18.8%	16.3%	17.0%

this variable was measured as under-reporting by three or more arrests. Similarly, 29.5% over-reported their lifetime arrests by one. This number decreased to 21% when over-reporting was measured by a discrepancy of three or more.

DISCUSSION

Among sociodemographic characteristics, males with less education reported more lifetime arrests, consistent with established trends regarding the characteristics of criminality. The official criminal record of arrests accounted for most of the self-reported criminal activity, reflecting the high correlation between self- and official-report found in this sample and comparable to that found in general offender populations, suggesting that neither mental illness nor substance abuse factors contribute to self-report error in a psychiatric offender population beyond that found in a general offender population.

A high number of lifetime hospitalizations significantly contributed to explaining self-report validity. The reason for the contributory power of this variable may be associated with the utilization of hospitaliza-

tion as a response to some disruptive mental health symptoms, rather than arrest. If a particular individual is more likely to be hospitalized than incarcerated for symptomatic behaviors, his/her arrest rate will be lower. As variables with low frequencies are easier to recall than variables with high frequencies, (Maddux & Desmond, 1975) a low number of arrests will be self-reported with greater accuracy. Therefore, individuals with more hospitalizations tend to have fewer arrests, making it easier to recall the number of arrests. High number of hospitalizations is significantly correlated with having a lifetime diagnosis of schizophrenia ($r = .261$, $p < .01$) and mania, ($r = .157$, $p < .05$), suggesting that in this sample, these diagnostic categories are more likely to experience repeated hospitalizations.

Total time spent in prison or jail in life emerged as the most significant explanatory variable other than the official record. As demonstrated by Farrington (1973), petty crimes and misdemeanors tend to be committed more frequently, and thus are not reported with the accuracy of more memorable, felonious crimes. As longer prison/jail terms may be taken as indicators of more serious crimes, it is possible that those who have spent more time in jail or prison have more accurate recall due to a smaller number of arrests, although for more serious crimes. Time in jail or prison may also function to decrease the number of arrests by incapacitating the offender and decreasing the offender's opportunity to incur additional charges. Few members of this sample experienced long periods of incarceration, with 67.3% incarcerated for up to a year, 25% experiencing incarceration for one to five years, 8% for five to ten years, and 3% for more than ten years with twenty years being the maximum time reported in this sample.

In the second analysis, specific categories of major mental illness most likely to effect over- or under-reporting of arrest history were examined. The findings did not support Convit's (1990) findings, which, in a psychiatric sample, all nine subjects diagnosed with schizophrenia over-reported their arrest history. In this sample, subjects diagnosed with schizophrenia and mania were slightly more likely to under-report their arrest history than subjects diagnosed with either depression or antisocial personality disorder. Under-reporting may affect validity as a function of social desirability and the attempt to present one's self in the best light. All diagnostic groups featured more under-reporters than over-reporters. In this sample, it is likely that much of the under-reporting may also be attributed to measure-

ment error, as the percent of under-reporters in the entire sample is reduced to 17% from 50% when under-reporters are identified as omitting three or more arrests. The percentage of over-reporters, however, is not diminished when measured ordinally.

The lack of an association of mental health, substance abuse or treatment factors with discrepancies between official record and self-report arrest history data suggests that offenders who feature these characteristics are no more or no less competent than offenders in the general population to provide accurate, useful self-report data regarding their criminal activity. The correlations between official record and self-report arrest history data found in this sample are comparable to those found in studies examining the validity of self-report in general offender samples.

In the third analysis, specific categories of major mental illness were examined for differential effects on over- or under-reporting of arrest history. The only significant relationship that was found was between diagnosis of antisocial personality disorder and over-reporting. As diagnosis of antisocial personality disorder and number of juvenile arrests was correlated in this sample ($r = .202$, $p < .01$), it is likely that the subsample of under-reporters with antisocial personality disorder is not accurately differentiating juvenile from adult arrests, resulting in an inflated number of self-reported adult arrests. Given the clinical characteristics of antisocial personality disorder, these individuals may also have less internal motivation to meet social desirability standards, and with a pathological candor, will report a wide range of criminal activities without feeling pressure to minimize illicit or deviant behaviors. Another possible explanation is the greater tendency for anti-social personalities to adhere to a deviant identity construct which can be showcased in a research setting. For the entire sample, however, the general tendency was towards slight under-reporting.

The small margin of over-reporting is consistent with the known limitations of the official report data which may reflect fewer than the actual arrests. One of these limitations is the omission of juvenile arrests in the CHF. Another salient limitation of officially recorded arrests is the documentation of only those arrests occurring within the municipality. Overall, the rates of correlation between self-report and official report of arrest history for each diagnostic group and for the entire sample was comparable to those found in the general population when using similar measures. These findings further suggest that no

additional error is contributed by either mental illness or substance abuse factors in a psychiatric offender population. This analysis supports arguments in favor of the validity of self-reported criminal history data documented in prior research and further, it incorporates the psychiatric offender population as equal stakeholders into the debate. Mental illness and substance abuse factors, historically generating skepticism regarding the validity of self-report data, appear to have little additional impact on the rates of error already associated with this method of data collection. In fact, substance abuse factors and mental illness factors are salient features of the entire population of adults on probation in the United States. In 1995, 61.2% of all probationers participated in some form of special supervision program, 8% of those in psychological or psychiatric counseling conditions and 37% of those in alcohol or drug treatment (Bonczar, 1997). The impact of mental illness and substance abuse factors on the validity of self-report can, therefore, be considered relevant to the general offender population which features these characteristics. Confidence in the capacity for the severely mentally ill to participate in social research as competent subjects and authorities on their own experiences is enhanced by these results which equate the quality and accuracy of psychiatric offender self report data with general offender self-report data.

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