Self-Stigma and Peer Interactions in Corrections-based Therapeutic Communities

Thesis

Presented in Partial Fulfillment of the Requirement for the Bachelor of Science in Social Work

In the College of Social Work at The Ohio State University

By

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Undergraduate Program in Social Work

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Abstract

Therapeutic Communities (TCs) are residential substance abuse treatment programs that are built around a mutual aid model in which residents live in the same physical space and learn through peer interactions. Research on those with substance abuse issues has found that this population reports increased social withdrawal (Can et al., 2015), as well as higher levels of internalized stigma surrounding this identity (Corrigan et al., 2006), which may pose a problem for TCs. This project investigated how one's perception of self predicts the likelihood that they will be identified as a role model by their peers in a corrections-based TC. We hypothesized that self-stigma would be negatively correlated with the number of times one was listed as a role model.

Participants (n=162) included female residents of the Tapestry TC at the Ohio Reformatory for Women and male residents of the Oasis TC at Pickaway Correctional Institution. Participants were given several survey instruments to complete: a 31-question survey regarding self-stigma, the ACEs (Adverse Childhood Experience) questionnaire, and an 8-question social network survey regarding who they interact with in the TC.

Data was analyzed using a negative binomial regression with the number of times a participant was named as a role model as the dependent variable. Results showed that two variables; average self-stigma score and current phase in the TC, were statistically significant. In the initial model self-stigma score had a *p*-value of 0.005.

When the independent variable of current TC phase was added, the *p*-value for self-stigma score rose to 0.043 while the current phase *p*-value was < .001. A Spearman's rho test to found that there was a weak negative correlation between one's self-stigma score and one's current phase in the TC (r = -0 .171, p = .034).

In line with expectation, results showed that those with higher self-stigma scores were less likely to be named as role models by their peers. However, some of this relationship is explained by the negative correlation between self-stigma and phase of the resident. The direction of causality in this relationship is unclear. These results could indicate that those with high levels of self-stigma leave the therapeutic community earlier in the process or that self-stigma is reduced as a TC member progresses through the therapeutic process. Further research is needed to examine the role that stigma plays in the effectiveness of therapeutic community treatment for substance use.

Dedication

This study is dedicated to the currently incarcerated men and women who participated in this research, as well as the millions of people who have found themselves stuck in the criminal justice system.

Acknowledgements

I would like to thank the members of Tapestry Therapeutic Community at the Ohio Reformatory for Women and the members of Oasis Therapeutic Community at Pickaway Correctional Institution for their participation in this project. I would also like to thank my advisor, Dr. Keith Warren, for not only his dedication to this project, but for continuously challenging me to do more than I thought possible. This experience was truly transformative to my growth as a student and future professional, and it wouldn't have been possible without your guidance and mentorship along the way. I also would like to thank Uwe Wernekinck for his willingness to dive into this project, and his significant contribution to nearly every aspect of the finished product.

Curriculum Vitae

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Fields of Study

Major Field: Social Work

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Chapter 1: Statement of Research Topic

The purpose of this project is to investigate the impact that internalized stigma has on peer interactions within corrections-based therapeutic communities (TCs). A combination of various theoretical concepts such as "community as method" and a mutual aid model (De Leon, 1995), TCs are built around the idea that treatment and subsequent recovery is facilitated through the formation of community (De Leon, 2000; Harvey, 2005). Yet, research on those with substance abuse issues has found that this population reports increased social withdrawal (Can et al., 2015), as well as higher levels of internalized stigma surrounding their identity as a substance abusers (Corrigan et al., 2006). This internalized stigma could erode the effectiveness of a community-based treatment program for substance abuse individuals. This project uses two survey instruments to measure the degree to which participants feel internalized stigma and the types of relationships they have with fellow TC members.

It is the goal of this project to assess a potential correlation between these variables, as a means of adding to the conversation around best practices for substance abuse treatment within a correctional setting. It is also hoped that information gained through this project will help to identify ways to reduce the effects of internalized stigma on incarcerated individuals, and more specifically incarcerated individuals combatting substance abuse issues, as this population has a heightened level of vulnerability. The broad goal of this project is to meaningfully contribute to the literature on therapeutic communities to further improve this ever-evolving community-centered program structure.

The proposed project entails the administration of a survey instrument within two corrections-based TCs that assesses levels of internalized stigma as well as participants' peer interactions. It is hoped that this project will shed light on a characteristic, that being self-stigma,

that may be directly impacting the overall effectiveness of therapeutic communities for individuals with substance abuse issues.

The specific research questions associated with this project include:

> How does one's level of internalized stigma impact the quality of their relationships with peers?
>
> To what degree does internalized stigma impact overall social functioning within a treatment program?

Chapter 2: Literature Review

With the criminalization of drugs, and in turn the application of heavy sentencing, the U.S. prison population has skyrocketed to 2.3 million people filling up our prisons and jails as of 2019. Statistics show that, "the number of people behind bars for nonviolent drug law offenses increased from approximately 40,000 in 1980 to 450,000 in 2016 (The Sentencing Project, 2018). Additionally, since 1996 the number of incarcerated individuals either medically diagnosed with addiction or otherwise involved in substance misuse rose 43% to 1.9 million inmates in total (CASA, 2016). In a study done by CASA Columbia at Columbia University, it was discovered that while 65% of inmates meet the medical criteria for having a substance use disorder, only 11% of those individuals receive treatment (CASA, 2016). These stark numbers indicate the need to ensure that treatment options that are available to incarcerated individuals are as effective as possible, in turn contributing to long-term recovery and reduced recidivism.

Used as a rehabilitative treatment model, therapeutic communities (TCs) are described as "[a place] where individuals who want to facilitate a change in their substance use… can reside as a community" (Best et al., 2016). Typically consisting of group sessions, individual counseling, meetings, and other group activities, TCs are residential programs that emphasis expectations and subsequent rewards as a means of encouraging pro-social behaviors towards recovery (National Institution on Drug Abuse, 2015). Primarily utilizing self-help principles, TCs are operated in a way that allows learning to be completed through peer interactions (Vandevelde et al., 2004) while also working to provide a sense of belonging and promote responsible agency amongst members of the TC (Pearce et al., 2012). These communities are structured around "clear and consistent rules" (Vandevelde et al, 2004), while also utilizing a system of "pushups" and "pullups" in which TC members are expected to affirm and correct

their peers throughout the therapeutic process. Corrections-based therapeutic communities are common as there is a severe overlap between incarceration and substance use given the continued criminalization of drug use. Research conducted on gender differences in corrections-based substance use treatment program reentry and retention found that correctional treatment programs have higher retention rates of both men and women than community-based programs (Pelissier, 2004). These findings indicate the importance of providing efficient treatment options to incarcerated individuals, as their chance of treatment completion is greater. Further speaking to gender difference in treatment outcomes, a 2003 study that investigated differing treatment needs for men and women found that women entering TCs are more likely to report histories of abuse, have more severe drug use histories and mental health impairments than men (Messina et al, 2003). Another study also found that therapeutic communities were more effective than cognitive behavioral therapy interventions in reducing drug use, criminal activity, exposure to trauma, and increasing mental health outcomes for women one year after being released from prison (Sacks et al, 2012). These findings indicate the unique disadvantages women may face in entering TC communities, the need to acknowledge gender differences in implementing a TC model, and the benefit of effectively implementing gender-sensitive TCs in correctional settings.

Best et al. (2016) explain, "The power of the [therapeutic] community rests on the importance of peer influence and commitment to the community, underpinned by a strong mutual help and growth philosophy." Based on theories such as Friedkin's Social Influence Network Theory (1998) which suggest that individuals who are similar to one another (in this case through their substance use) will be socially tied, and through these ties, will influence the values, attitudes and behaviors of one another (Prell, 2015), TCs operate under the assumption that the shared identity of TC members will allow them to connect and consequently provide

much needed social support throughout the recovery process. Role models are an integral part of therapeutic communities, as peer interaction and influence serve as the foundation for the treatment process. In shifting attitudes, beliefs, and behaviors, the understanding of how the TC operates and what is expected is garnered from older TC members (De Leon, 2000). As role models, they demonstrate these behaviors regularly, and in turn serve as supports and educators for those who are just beginning treatment.

Self-stigma, which is synonymous with internalized stigma, is described as, "…the product of the internalization of shame, blame, hopelessness, guilt and fear of discrimination" (Corrigan et al., 2006), and refers to one's perception of self and the degree to which labels impact their self-identity. Based on the heavy stigmatization that surrounds substance abuse and incarceration, the potential for the development of self-stigma and altered self-image is undeniable among this population. Research has shown that stigma tends to result in identification within a group that promotes in-group and out-group status, meaning that "it may be that patients with lower levels of self-stigma resist identification as a person with addiction and may therefore lose out on peer support in the recovery community" (Luoma et al, 2014). In the case of treatment, this reality completely undermines the structure of the therapeutic process.

In a 2015 study entitled "Social Functioning and Internalized Stigma in Individuals Diagnosed with Substance Use Disorder", it was found that there was a significant negative correlation between social functioning and internalized stigma. Additionally, of the participants, who were all diagnosed with substance use disorder according to DSM-V and currently receiving inpatient treatment at Gaziantep University Şahinbey Research and Practice Hospital, 43.8% demonstrated a significant level of internalized stigma while another 41% showed a moderate level (Can et al., 2015). Indicating the reality of internalized stigma in the

experience of a substance abusing individual, an important question is raised regarding the effectiveness of the TC model. It has been found that internalized stigma is a predictor of lower social functioning ability and adherence to treatment programming (Can et al., 2015). Additionally, those combatting substance abuse issues report fewer social interactions, lower cognitive abilities, as well as poor social skills (Can et al., 2015). Results of this study found that "substance use disorder had negative moderate effects on social functioning", and SUD was found to most significantly impact the following social functioning subscales: pro-social activities, recreational activities, social withdrawal and independence-level performance (Can et al, 2015) Highlighting the vulnerability of this population, as well the evident impact of stigma on overall functioning, this information poses a potential challenge in utilizing a group-based model in treating those with substance use disorder. Yet, it is unknown how self-stigma may impact TC members' peer interactions and ability to function in a TC environment.

Chapter 3: Methodology

Research Design

The research design of the project consists of two pencil-and-paper survey instruments which were completed by participants during a single half hour session. Researcher attended morning meeting at two corrections-based TCs to invite residents to participate in the project. After researchers explained the nature of the project, residents who chose to consent were given the necessary survey materials. Up to two hundred participants were eligible to be enrolled in the study, and accommodations were available for those who wished to participate and may require additional accessibility resources.

Sample

Two corrections-based therapeutic communities were included in the project; Tapestry Therapeutic Community at the Ohio Reformatory for Women, and OASIS Therapeutic Community at Pickaway Correctional Institution. Tapestry serves 90 alcohol/drug dependent women. A similar number of drug/ alcohol dependent TC members are served at OASIS at Pickaway Correctional Institution. By utilizing these two respective TCs for the purposes of this project, data was be collected from both incarcerated men and women with substance abuse issues. In total 162 TC members participated in the study.

Measurement and Instrumentation

The first instrument that was used in this study consisted of questions from sections 1 and 2 of the self-stigma scale used in the 2012 study, "Self-Stigma in Substance Abuse: Development of a New Measure" by Jason Luoma et. al. Section 3 of the scale, entitled "Stigma Avoidance and Values Disengagement" was not included as the questions were not relevant to the aims of this research study. Section 1 includes statements that describe thoughts or feelings

and ask participants to rate how often the experience the described thought/feeling using a 5-point scale of "Never or almost never", "Rarely", "Sometimes", "Often" and "Very Often". Section 2 of the first instrument has 9 statements, and asks participants to select, "the number that indicates how many people you think would react to you as described". Another 5-point scale, the response options are, "Few People (0-20 percent)", "Some People (20-4- percent)", "Many People (40-60 percent", "Most People (60-80 percent)" and "Almost Everyone (80-100 percent).

The second instrument consists of eight question that were specifically developed for this study. Six of the questions measure social network connections by asking participants to list up to 5 TC family members with whom they have been involved in a particular interaction, a seventh question asks participants to list TC peers whom they regard as role models, and an eighth asks participants to rate how likely they are to join the alumni club when they leave the TC on a scale of 1 to 10.

Finally, participants were given the Adverse Childhood Experience (ACE) questionnaire (Felitti, Andra, Nordenberg et al. 1998), a measure of events that occur in childhood that is known to correlate with a variety of mental health, physical health and substance abuse problems. In addition to the survey, researchers asked participants to give us access to their scores on the Ohio Risk Assessment System (the programs use the prison intake version, but staff generally just refer to this as the ORAS) and the Texas Christian University Drug Screen.

Chapter 4: Results

Participants (*N*=162) included 87 male residents (53.7% of total) and 75 female residents (46.3% of total). The average age was 36.46 years (*SD*=8.79, *Min=18, Max=63, Mean=36.46*). In total, 167 individuals consented to participate but because of missing names, 5 survey responses were excluded from the data set. Data analysis was conducted using a negative binomial regression model. Since role model status (*SD= 5.014, Min=0, Max=33, Mean= 2.73)* is a count variable, our data was right skewed which can be seen in Figure 1.

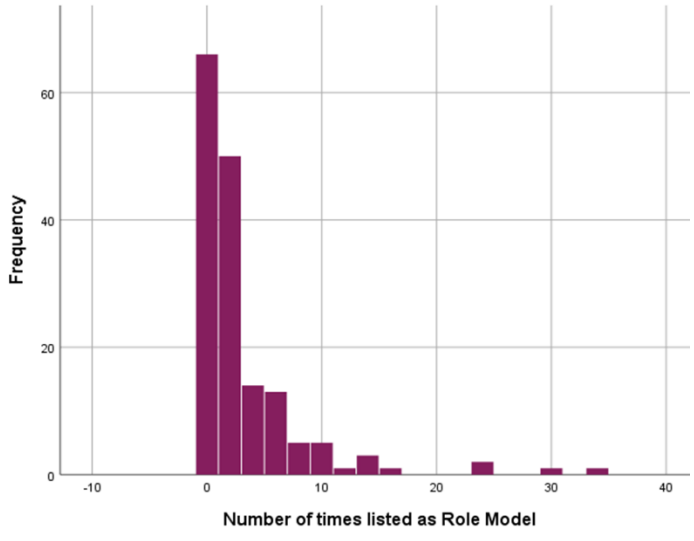

***Figure* 1: Distribution of Dependent Variable**

Two models were run with role model status as the dependent variable. ACE Score was not included in Figure 2 and 3, as it was statistically insignificant. In the first model (see Table 1), age of resident did not predict role model status (*B*= .023, *SE*= .0166, 95% CI [-.009, .056], *Wald Chi-Square*= 2.000, *p*= .157). Gender of the participant also did not predict role model status (*B*= .397, *SE*= .2780, 95% CI [-.148, .942] *Wald Chi-Square*= 2.037, *p*= .154). However,

average self-stigma score (*SD= 77347, Min= 1, Max= 4.75, Mean= 2.8575)* was found to predict role model status (*B*= -.428, *SE*= .1523, 95% CI [-.727, -.130], *Wald Chi-Square*= 7.914, *p*= .005).

***Table* 1: Negative Binomial Regression Excluding TC Phase**

Parameter Estimates

Parameter	B	Std. Error	95% Wald Confidence Interval		Hypothesis Test		
			Lower	Upper	Wald Chi-Square	df	Sig.
(Intercept)	.737	.9185	-1.063	2.537	.643	1	.423
Age of Resident	.023	.0166	-.009	.056	2.000	1	.157
Self Stigma Score	-.428	.1523	-.727	-.130	7.914	1	.005
Gender of the Participant	.397	.2780	-.148	.942	2.037	1	.154
(Scale)	1[a]						
(Negative binomial)	1[a]						

Dependent Variable: Number of times listed as Role Model

Model: (Intercept), Age of Resident, Average Self Stigma Score, Gender of the Participant

a. Fixed at the displayed value.

In the second model (see Table 2), current phase was added as an independent variable. Age of resident remained statistically insignificant (*B*= .020, *SE*= .0187, 95% CI [-.017, .057], *Wald Chi-Square*= 1.136, *p*= .286), as did gender of the participant (*B*= .318, *SE*= .2430, 95% CI [-.158, .795], *Wald Chi-Square*= 1.718, *p*= .190). Current TC phase was found to predict role model status (*B* = .556, *SE* = .1330, 95% CI [.295, .817, *Wald Chi-Square*= 17.463, $p < .001$). Adding residents' phase in the TC weakened the relationship between self-stigma score and role model score (*B* = -.290, *SE* = .1429, 95% CI [-.570, -.010], *Wald Chi-Square*= 4.112, *p* = .043).

***Table* 2: Negative Binomial Regression Including TC Phase**

Parameter	B	Std. Error	95% Wald Confidence Interval		Hypothesis Test		
			Lower	Upper	Wald Chi-Square	df	Sig.
(Intercept)	-.902	.8850	-2.637	.833	1.039	1	.308
Age of Resident	.020	.0187	-.017	.057	1.136	1	.286
Self Stigma Score	-.290	.1429	-.570	-.010	4.112	1	.043
Gender of the Participant	.318	.2430	-.158	.795	1.718	1	.190
Current Phase in TC	.556	.1330	.295	.817	17.463	1	.000
(Scale)	1[a]						
(Negative binomial)	1[a]						

Dependent Variable: Number of times listed as Role Model

Model: (Intercept), Age of Resident, Average Self Stigma Score, Gender of the Participant, Current Phase in TC

a. Fixed at the displayed value.

Spearman's rho revealed a weak negative correlation between self-stigma and current phase in the TC (r = -.171, p = .034), which can be seen in Figure 2), indicating a mediator effect.

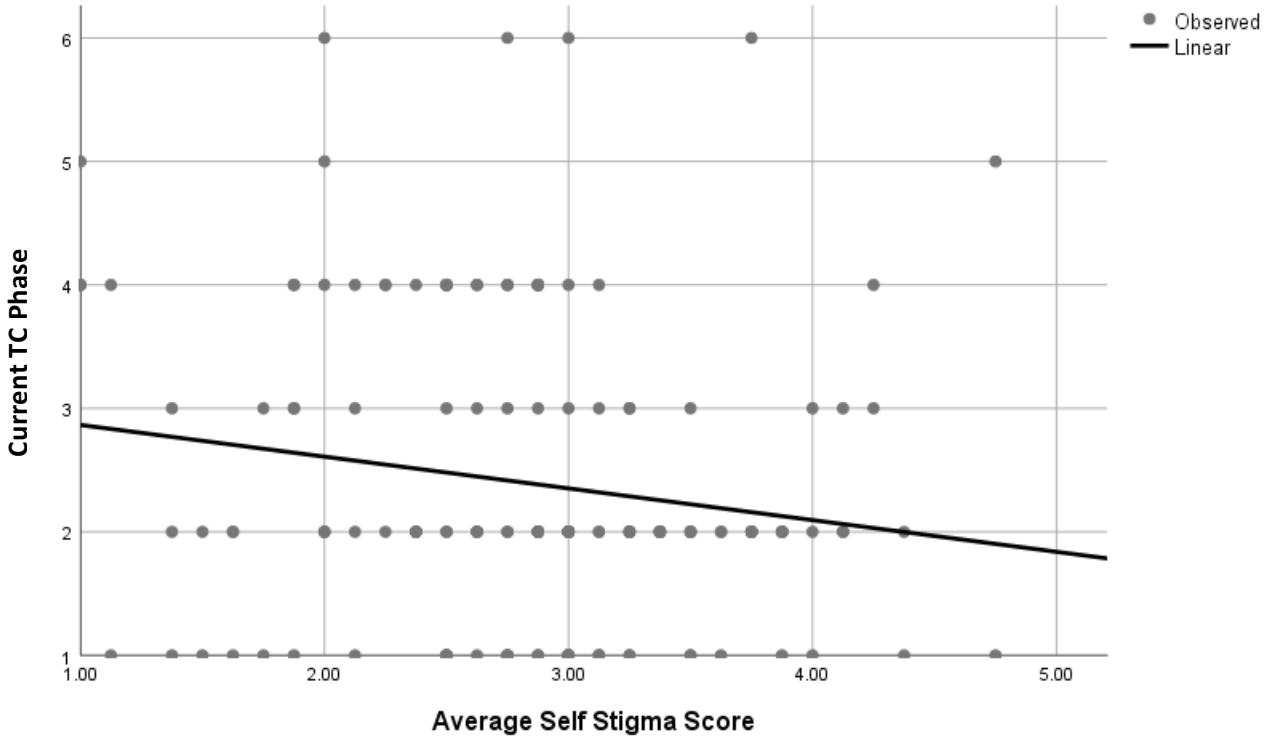

***Figure* 2: Correlation of Self Stigma and Current Phase in the TC**

Chapter 5: Discussion

Results support the hypothesis that those with higher substance-abuse self-stigma are less likely to be rated as role models by peers. Neither race nor gender were found to influence who was rated as a role model. Self-stigma was also negatively correlated with the phase that residents achieve. This relationship appears to partially mediate the link between self-stigma and peer perception of role model status. This research study indicates a need to further analyze the role of self-stigma in treatment as it presents different set of challenges for both participant and clinicians. Although self-stigma was found to negatively correlate with current phase in the TC, as noted, it is unclear the direction of this relationship. The fact that phase mediates this relationship is of considerable potential interest. However, this could mean one of three things: as residents advance through the program, their self-stigma is reduced, (phase compensations for self-stigma), self-stigma slows progression through the program, which in turn influences role model status, or people with high levels of self-stigma are more likely to leave the program entirely and never reach a higher phase.

With these potential implications, our findings suggest that self-stigma does have an impact on treatment, and with that in mind, acknowledgement of and active engagement with the concept of self-stigma in the treatment process is essential moving forward. The clinical implications of these findings point in several directions. Several ways of engaging with program participants about what self-stigma is, how it affects them, and how it may affect treatment outcomes would be to talk about it in group, use a survey instrument to track self-stigma as participants enter and progress through the program, encourage participants with high levels of self-stigma to engage more actively in programming, assign research assignments on self-stigma

to TC members, and partner participants identified as having high levels of self-stigma with those identified as having low self-stigma.

In speaking to limitations, the survey was conducted at two Ohio corrections-based Therapeutic Communities, meaning it is not clear the extent to which these findings are generalizable. Additionally, in measuring role model status, it is implied that residents have a clear idea of what this means yet with the subjectivity of "role model", there is room for error centered around differing interpretations. However, the error may well be random—different people have somewhat different ideas, but there is no consistently wrong idea floating around. This would tend to make the relationships in the models somewhat weaker. Notice also that the fact that thirty or more participants listed a couple of peers suggests that there is some consistency in the peer judgments. Incidentally, you could argue that we crowd sourced the question, and crowd sourcing often works well, a phenomenon known as the wisdom of the crowd. (Surowiecki, 2004). Also, because of the cross-sectional nature of our survey, as it was administered at a single point in time, we do not have the data needed to know the direction of the relationship between self-stigma and phase in the program.

The continuation of this research has several future directions. A longitudinal study in which participants' self-stigma score is measured when they enter the TC and throughout their treatment may provide clarity on the temporal ordering of the relationship between TC Phase and self-stigma score. Additionally, a self-stigma intervention could be used in which one group is actively receiving programming around self-stigma while a control group does not may shed light on the impact of self-stigma on treatment outcomes. Another interesting direction would be to more deeply examine differences in self-stigma in men and women by investigating both the

quality and content of their self-stigma, and the ways in which gender roles may impact the type of self-stigma one possesses.

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Appendix A: Consent Form

The Ohio State University Consent to Participate in Research

Study Title: Internalized Stigma and Peer Interactions in Corrections-based Therapeutic Communities

Researchers: Keith Warren, Jordan Whealdon

Sponsor:

This is a consent form for research participation. It contains important information about this study and what to expect if you decide to participate.

Your participation is voluntary.

Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate. If you decide to participate, you will be asked to sign this form and will receive a copy of the form.

Purpose:

The purpose of this study is to learn more about the feelings TC members have about themselves and also the way in which TC family members support each other.

Procedures/Tasks:

If you consent to take part in this study we will ask you to take a twenty-nine question survey. Some of the questions will be about yourself and others will be about help that you have given to other TC family members or received from other TC family members. You may skip any question that you do not want to answer.

With your consent, we will also be accessing your records to collect additional demographic information.

Duration:

The survey will take approximately twenty minutes to complete. You may leave the study at any time. If you decide to stop participating in the study, there will be no penalty to you, and you will not lose any benefits to which you are otherwise entitled. Your decision will not affect your future relationship with The Ohio State University.

Risks and Benefits:

There are no physical risks involved in participation. Some questions may cause some emotional discomfort. Also, some of them ask about pushups, pull-ups or advice you may have given to or received from other family members. You may decline to answer any given question, and may leave the survey incomplete without any loss of benefits.

There are no benefits to you personally from the study, although you may enjoy thinking about help you've given or received. This study may help others to make better use of TCs and it may help staff to improve TCs, so other people may benefit.

Confidentiality:

Efforts will be made to keep your study-related information confidential. However, there may be circumstances where this information must be released. For example, personal information regarding your participation in this study may be disclosed if required by state law. Also, your records may be reviewed by the following groups (as applicable to the research):

- Office for Human Research Protections or other federal, state, or international regulatory agencies;
- The Ohio State University Institutional Review Board or Office of Responsible Research Practices;
- The sponsor, if any, or agency (including the Food and Drug Administration for FDA-regulated research) supporting the study.

Incentives:

There are no incentives for participating in this study.

Participant Rights:

You may refuse to participate in this study without penalty or loss of benefits to which you are otherwise entitled. If you are a student or employee at Ohio State, your decision will not affect your grades or employment status.

If you choose to participate in the study, you may discontinue participation at any time without penalty or loss of benefits. By signing this form, you do not give up any personal legal rights you may have as a participant in this study.

An Institutional Review Board responsible for human subjects research at The Ohio State University reviewed this research project and found it to be acceptable, according to applicable state and federal regulations and University policies designed to protect the rights and welfare of participants in research.

Contacts and Questions:

For questions, concerns, or complaints about the study, or you feel you have been harmed as a result of study participation, you may contact **Keith Warren at warren.193@osu.edu.**

For questions about your rights as a participant in this study or to discuss other study-related concerns or complaints with someone who is not part of the research team, you may contact Ms. Sandra Meadows in the Office of Responsible Research Practices at 1-800-678-6251.

Signing the consent form

I have read (or someone has read to me) this form and I am aware that I am being asked to participate in a research study. I have had the opportunity to ask questions and have had them answered to my satisfaction. I voluntarily agree to participate in this study.

I am not giving up any legal rights by signing this form. I will be given a copy of this form.

Printed name of subject	Signature of subject
	AM/PM Date and time
Printed name of person authorized to consent for subject (when applicable)	Signature of person authorized to consent for subject (when applicable)
Relationship to the subject	AM/PM Date and time

Investigator/Research Staff

I have explained the research to the participant or his/her representative before requesting the signature(s) above. There are no blanks in this document. A copy of this form has been given to the participant or his/her representative.

Printed name of person obtaining consent	Signature of person obtaining consent
	AM/PM Date and time

Appendix B: Adverse Childhood Experience Questionnaire

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   ① Yes ② No — If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   ① Yes ② No — If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   ① Yes ② No — If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   ① Yes ② No — If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   ① Yes ② No — If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   ① Yes ② No — If yes enter 1 _____

7. Was your mother or stepmother:

   Often pushed, grabbed, slapped, or had something thrown at her?

   or

   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?

   or

   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   ① Yes ② No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?

   ① Yes ② No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?

   ① Yes ② No If yes enter 1 _____

10. Did a household member go to prison?

    ① Yes ② No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score

Appendix C: Therapeutic Community Resident Survey

Therapeutic Community Resident Survey

Name _____

Date when you entered the TC _____

Age _____

Is this your first TC experience? ① no ② yes

What is your current phase? ① ② ③ ④

Race/Ethnicity:

① European American
② African American
③ Latino/Latina
④ Native American
⑤ Asian
⑥ Other

For this section, we use the term "substance problem" or "problem with substances" to refer to any problems that you have experienced as a result of your use of drugs or alcohol.

Section 1

Below is a list of statements describing thoughts or feelings that you may have from time to time or that may be familiar to you. Most of these statements describe thoughts and feelings that are generally painful or negative in some way. Try to be as honest as you can in responding.

As you see it now, please rate how often you have the thoughts or experiences listed below. Use the scale below to make your choice. Please circle only one number and not in between numbers.

		Never or almost never	Rarely	Sometimes	Often	Very often
1.	*I have the thought that* a major reason for my problems with substances is my own poor character.	①	②	③	④	⑤
2.	*I have the thought that* I should be ashamed of myself.	①	②	③	④	⑤

3.	*I have the thought that* I deserve the bad things that have happened to me.	①	②	③	④	⑤
4.	*I have the thought that* I can't be trusted.	①	②	③	④	⑤
5.	*I feel* inferior to people who have never had a problem with substances.	①	②	③	④	⑤
6.	*I feel* out of place in the world because of my problems with substances.	①	②	③	④	⑤
7.	*I have the thought that* I've permanently screwed up my life by using drugs.	①	②	③	④	⑤
8.	*I feel* ashamed of myself.	①	②	③	④	⑤

Section 2

Please read each statement below and circle the number that indicates how many people you think would react to you as described. Please use the scale below.

		Few People (0-20 percent)	**Some people (20-40 percent)**	**Many people (40-60 percent)**	**Most People (60-80 percent)**	**Almost Everyone (80-100 percent)**
1.	People think I'm worthless if they know about my substance use history.	①	②	③	④	⑤
2.	People around me will always suspect I have returned to using substances.	①	②	③	④	⑤
3.	People without a substance use history could never really understand me.	①	②	③	④	⑤

4.	A job interviewer wouldn't hire me if I mentioned my substance history in a job interview.	①	②	③	④	⑤
5.	If someone were to find out about my history of substance use, they would expect me to be weak-willed.	①	②	③	④	⑤
6.	People would be scared of me if they knew about my substance abuse history.	①	②	③	④	⑤
7.	If someone were to find out about my history of substance use, they would doubt my character.	①	②	③	④	⑤
8.	People will think I have little talent or skill if they know about my substance history.	①	②	③	④	⑤
9.	People think the bad things that have happened to me are my fault.	①	②	③	④	⑤

Section 3

In this section, please name anywhere from zero to five people ***who have helped you*** by giving you pushups, pull-ups or advice. We are collecting this information so that we can understand how members of the TC family help each other. When answering questions about the TC family, please only include fellow residents and not staff.

Please name anywhere from zero to five members of the TC family who ***have given you pushups*** that you thought helped you.

1.
2.
3.
4.
5.

Please name anywhere from zero to five members of the TC family who ***have given you pull-ups*** that you thought helped you.

1.
2.
3.
4.
5.

Please name anywhere from zero to five members of the TC family who ***have given you advice*** about your recovery and other important life issues.

1.
2.
3.
4.
5.

In this section, please name anywhere from zero to five people ***whom you have helped*** by giving pushups, pull-ups or advice.

1.
2.
3.
4.
5.

Please name anywhere from zero to five members of the TC family ***to whom you've given a pushup*** that you thought helped them.

1.
2.
3.
4.
5.

Please name anywhere from zero to five members of the TC family ***to whom you've given a pull-up*** that you thought helped them.

1.
2.
3.
4.
5.

Please name anywhere from zero to five members of the TC family ***to whom you've given advice*** about recovery and other important life issues.

1.
2.
3.
4.
5.

Now, please name anywhere from zero to five members of the TC family ***whom you consider to be role models***.

1.
2.
3.
4.
5.

Finally, on a scale of 1 to 10, how likely are you to become involved with the alumni club once you leave the TC?

①	②	③	④	⑤	⑥	⑦	⑧	⑨	⑩
extremely unlikely									extremely likely