The measure of victimization experience and trauma symptomatology among protective custody inmates at Washington State Penitentiary: Implications for returning persons to general population

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Introduction

Since the inception of protective custody (PC) units in American prisons in the 1960's the population of prisoners so housed has continually increased. PC is an expensive housing setting for the State that, due to it's high level of security and separation, provides limited programming for persons housed there. Correctional institutions have a two fold purpose for seeing persons housed in PC units transition out. The first is cost, the second is greater ease in the provision of programming essential for the successful transition of offenders back to the community.

Though one would not expect prisoners to be concerned about the first reason, the second reason seems to be a convincing one to want to live in a general population (GP) setting. Nevertheless, many prisoners refuse to voluntarily leave PC units. It is as if they have found a 'comfort zone' from which they are afraid to leave. The question is, how do we get persons housed in PC to choose to check out? Are they really afraid to go, or are they manipulating the system to gain privileged housing?

The literature that has attempted to describe PC inmates has been sparse at best and is often restricted to demographic, physiological and offense descriptions. This profiling has had limited success in reducing or contributing to the management of PC units.

There is some evidence that PC inmates exhibit a higher incidence of psychological maladjustment or history of mental illness than their GP counterparts. The PC population includes many inmates who have experienced or have been threatened with various forms of victimization

prior to incarceration as well as while in prison. It is possible that such victimization has led such inmates to believe that they are unable to be housed outside of a PC setting. The literature provides descriptions of management of PC units, a profile of types and severity of prison victimization, the link between fear of victimization and emotional wellness among prisoners, and the relationship between past victimization and the fear and promotion of future victimization. I believe that this literature suggests the need for further profiling of persons housed in PC. Persons housed in PC may have experienced a higher degree of reactive symptomatology to victimization than those in GP. Symptomatology such as a visceral fear of returning to GP and inability to avoid victimization. Perhaps this is the key to why these inmates prefer the protective environment of PC units. If this is so, it has implications for the type of programming that would be most successful in treating PC inmates and returning them more speedily and effectively to lower cost GP settings.

Protective custody

Researchers and corrections administrators have recognized a steady increase in the number of incarcerated persons who are defined as unable to do their time in GP and hence are being housed in PC. In the United States the number of persons housed in PC in state and federal prisons rose from 2.3% of the incarcerated population in 1978 to an estimated 6.2% in 1982 (Gendreau,P., Tellier, M.-C., & Wormith, J. S., 1985). In Canada the rate has similarly increased from 2.5% in 1972, 6.8% in 1978 to 9% in 1986 (Gendreau et al., 1985; Wormith, J. S., Tellier, M.-C., & Gendreau, P., 1988).

Many explanations are given concerning why certain inmates appear unable to be housed in GP and why the number in PC is steadily rising. These

include descriptions of changes in prison administration and prison climate, judicial and court related changes, physical and demographic characteristics of PC inmates, increases in prison violence and drug trafficking, mental health de-institutionalization, breakdown of the inmate code of conduct, and a host of others. Most of these suggestions are found as assumptions within the literature. Very little research has been presented to date to explain the increasing demand for PC housing (Wormith, J. S., Tellier, M.-C., & Gendreau, P., 1988).

PC housing is an administrative nightmare for corrections officials. The need to protect a certain group of inmates has created the establishment of self-contained, highly staffed living units that have become a prison within a prison. Separate dining areas and other facilities are constructed to serve these units or elaborate schemes are devised to escort and separate PC inmates from others while they travel to other parts of the institution to gain access to already existing facilities and programs (Henderson, 1992).

Inmates so housed have begun asserting that they have the right to programming that is available to their counterparts in GP. It is likely that the courts will continue to support such claims. The principle guiding such decisions affirms that PC inmates must have access to programs which closely approximate those found in GP. Modifications to program type and access is only to be made in ways that are required to meet legitimate correctional needs (Henderson, 1992). Such decisions have resulted in high cost single cell housing, increased access to recreational programming and the development of parallel rehabilitative and vocational programming for persons housed in PC (Fields, 1996).

The lack of programming available in protective custody, the cost of such housing and other management problems PC persons present to

correctional institution make managing PC a problem. It is for this reason that the reintegration of PC inmates back to GP is one of the main goals of PC programming (Henderson, J.D. & Phillips, R. L., 1991). It is in the interest of corrections administrators to better understand the profile of persons in PC in an effort to more quickly facilitate their movement into GP settings. Such profiling of persons in PC is sparse at best (Pierson, 1989) and is often restricted to demographic, physiological and offense descriptions (Perez & Hageman, 1982). This profiling has had limited success in reducing or contributing to the management of PC units. However PC profiling research has served to deconstruct the stereotype that a PC inmate is younger, smaller, weaker and more effeminate than their counterparts in GP. Neither do PC inmates differ significantly on the basis of previous criminal history.

The present study is aimed at contributing to this small body of PC inmate profiling literature. Specifically the goal is to determine the level of victimization experience and trauma symptomatology among a sample of PC inmates. This study starts with the assumption that trauma symptomatology is a significant factor in the profile of PC inmates. Since PC units are designed to shelter inmates from the hostile and unfriendly environment of prison, those who find themselves in these units are either greater targets of prison victimization or they are unable to cope with the standard diet of violence and trauma which is the reality of prison life. The inability to cope may be linked to their victimization response.

Prison Victimization

Violence and victimization is a significant part of prison culture. These are not random acts which should be expected within a society of convicted felons, but calculated acts which are an integral part of a prisons organic

system of social control (Cooley, 1995; Toch, H., Gibbs, J. J., Seymour, J., & Lockwood, D., 1992).

Victimization is a process that is defined as "a predatory practice whereby inmates of superior strength and knowledge of inmate lore prey on weaker and less knowledgeable inmates" (Fisher, 1961, p. 89). Such acts may manifest as mild to dramatic forms of harassment such as the theft of cigarettes or coffee from a vulnerable inmate, or in threats of violence meant to extort large sums. Victimization may be a means of pressuring an inmate to have their relatives and friends smuggle drugs or other contraband into the institution. The ultimate victimization however seems to be the threat of sexual assault. Toch, et al. (1992) describe this most graphically:

> The extreme form of inmate victimization is homosexual rape, which is not as frequent in prisons as people think. . . . Though rape is literally not at issue in most victimization of inmates, it is figuratively always involved. It lurks. . . as the ultimate penalty, the most extreme form of power that may be held over the victim. . . .
>
> The aim of victimization is complex, and we can describe and illustrate it later. The apparent or superficial object of victimization is sexual exploitation, and it is sex that the aggressor most often demands of the victim. . . . It is more likely that the nature of the aggressor's threat is incidental to his real purpose, which is to be threatening. The latter assumption suggests that the medium in inmate victimization is in fact its message, that the aim of the activity is to provoke stress and to make stress visible. The gain of such interactions would be that implied by Fisher's definition: to "demonstrate" the aggressor's "superior strength and knowledge" and to pinpoint the victim as "weaker and less knowledgeable." The aim succeeds best where victims are unfamiliar

with the arena of testing, which includes violence and its threatened deployment (pg. ??).

Toch et al., (1992) go on to describe patterns of inmate victimization, profiling aggressors, targets and non-targets by ethnicity, commitment county, use of personal force in commitment offense, and history of mental health intervention and suicide attempts. They also describe what is called culture shock or transition stress which new commitments experience as they enter the prison system. The physical and interpersonal setting can have a bewildering, disorienting and even intimidating effect on new inmates making them more susceptible to victimization; immediately the environment itself begins to create a sense of vulnerability.

This intimidating behavior is meant to press the new inmate into revealing quite quickly what their status will be. This leads to the target's response: Will it be fight or flight? Flight may lead an individuals to seek protection from peers, seek sanctuary from guards (leading to PC) or lead to isolation and circumscription of activities in the pursuit of safety.

It can be supposed that the fight or flight response to the initial and subsequent tests of imprisonment is somehow related to the experiences of victimization and psychopathology that persons experience both prior to and during imprisonment. In other words, one's response to victimization is directly related to whether or not one has already adopted a victim mentality.

Victimology

The study of prison victimization can be compared to the long history of the study of victimology in general. This controversial field of psychological inquiry suggests that an unhealthy symbiotic relationship exists between a crime victim and their perpetrator. The scientific pursuit of this relationship

first gained prominence with the work of Beniamin Mendelsohn as early as the 1940's. A criminal defense attorney, Mendelsohn seemingly pioneered the tactic of systematic inquiry into the personality and even social relations of the victims of crimes in order to build defenses for his clients. This utilitarian, and perhaps mercenary purpose became a widespread subject of interest within the fields of criminology, forensic medicine and psychology (Mendelsohn, 1974; Kutash, 1984). Victimology continues as a field of interest and tends to focus on several categories of victims, duration and frequency of victimization and characteristics of victims (Kutash, 1984; Silverman, 1974).

In discussions of categories of victims, victimologists have tended to investigate the degree to which a victim has played a role in their victimization. One such categorization described the differences as a simple diad: a situational (i.e. no fault victim) versus a promotional (i.e. a victim who has consciously or unconsciously invited victimization) victim. In this description the situational victim is said to be victimized. The promotional victim is said to be victiming (Kutash, 1984). Silverman (1974) outlines more complex schemes of victimologists which turn this diad into a multiphase continuum.

Measurements of victimization frequency is also a component of victimology. Silverman (1974) describes single victimage as a one time event, prolonged victimage as an ongoing exposure to aggression such as in the case of child abuse or domestic violence, and frequent victimage in which a person is the subject of multiple forms of aggression from various aggressors under varying circumstances.

It is interesting that discussions of characteristics of victims seems to be tied to the category of victim. In a reprint of an earlier work, Von Hentig (1984), an early victimologist and contemporary of Mendelsohn, makes this

differentiation and explains the relationship between victim and victimization in the following way:

> . . . we can frequently observe a real mutuality in the connexion [sic] of perpetrator and victim, killer and killed, duper and dupe. Although this reciprocal operation is one of the most curious phenomena of criminal life it has escaped the attention of socio-pathology. There is a new form of grouping, casual or permanent. When these elements meet, it is likely that a novel compound is set up in the world of human relations, explosive and big with ruinous conflicts.
>
> There is probably a corresponding relation among beasts of prey and preyed creatures in the animal world. The difference rests upon the fact, that the attributes of the beasts of prey are adjustments to the foibles of their booty, whereas the human victim in many instances seems to lead the evildoers actively into temptation. The predator is - by varying means - prevailed upon to advance against the prey. If there are born criminals, it is evident that there are born victims, self-harming and self-destroying through the medium of a pliable outsider. (p. 45)

very interesting quote

Kutash (1984) lists behavioral and psychological characteristics in terms of psychological victim disorders. Acute and chronic situational victim syndromes (ASVS and CSVS) are those conditions affecting situational victims as a result of the act of victimization. These consequential conditions are described as similar to reactive stress disorders of the posttraumatic and acute type (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, 1994).

The psychological conditions ascribed to promotional victims are described as causal or primary to the act of victimization. In this category

Kutash (1984) lists three disorders: Impulsive promotional victim disorder (IPVD), compulsive promotional victim disorder (CPVD) and characterologcial promotional victim disorder (ChPVD). Each of these conditions is said to be caused by past experiences of trauma or victimization that has weakened the ego and created an unhealthy need and practice of casting oneself in the role of victim.

IPVD is described as a transient condition in which a person reacts to present psychological stressors by immediately endangering themselves by acting in a manner that makes them vulnerable to victimization. This action may be motivated either consciously or unconsciously. This description is similar to impulse control disorders in which irresistible urges are acted upon resulting in pleasure, gratification or anxiety reduction (DSM-IV, 1994).

CPVD is very similar to IPVD though early experiences are said to have produced infantile feelings of anxiety or guilt and that the compulsive actions or behaviors are more chronic. CPVD can be paralleled in some ways to obsessive-compulsive disorder (OCD) which is dominated by obsessive thoughts of unworthiness, anxiety and guilt and compulsions which draw victimization as a method of relief from the emotional symptomatology. Like OCD, the person recognizes this as a disorder, the condition is distressing and alien (DSM-IV, 1994).

The characterological nature of ChPVD makes it more akin to a personality disorder in which a person experiences an enduring pattern of cognition and behavior that equates gratification of basic emotional needs with physical or psychological pain. Such a person may consciously or unconsciously seek and develop a lifestyle in which they are symbiotically paired with one or several aggressors. Aspects of this condition could fit

neatly into the diagnostic description of borderline, histrionic or dependent personality disorders (DSM-IV, 1994).

Though the present study will not specifically investigate the occurrence of these disorders the discussion does suggest a strong relationship between early exposure to victimization, the development of psychological disorders which make one vulnerable to future victimization, and resulting victimization. In a prison environment it is not hard to see that such persons would find themselves to be frequent victims.

The possibility of the development of victimization disorders might explain the placement of victimized person within a PC setting in two ways: (a) Those suffering from ASVS and CSVS may be experiencing significant adjustment problems which make them unable to adapt to prison life. This mal-adjustment motivates such persons to seek out the more protected setting of PC placement. (b) Those suffering from the promotional victim disorders would find themselves to be frequent victims in a prison setting that is so densely populated with aggressors. Such repeated victimization could lead to PC admission as either a self-referral or as an administrative placement initiated for the sake of the security of the institution (Henderson & Phillips, 1991). Regardless of which mechanism causes the placement, the underlying issues are similar, unresolved victimization leading to PC placement.

Following this hypothesis the present study seeks to add to the existing profile of PC inmates in two fashions: (a) By detailing the victimization experience of PC inmates and (b) by providing a measure of their current victimization symptomatology.

If the relationship between victimization incidence and symptomatology bears up under testing the implications for PC programming is clear; treatment to resolve victimization specific disorders. It is ultimately

up to the treating clinician to decide whether such treatment follows a trauma debriefing model in the case of recent victimization, consists of cognitive behavioral therapy to desensitize the inmate to trauma and re-orient him to productive activity, or emphasizes ego reconstructive therapy in the case of the treatment of characterological deficits (Scott & Stradling, 1992). In such individual cases thorough diagnosis will lead to more effective treatment. Similarly, on a systemic level more thorough profiling of the population of PC inmates should lead to better policy development, management and choice of services offered in PC settings.

That programming, in the form of counselling intervention, can facilitate the effective return of a PC inmate to a general population setting, is an underlying belief that has motivated this present study. As mentioned earlier there is little to be found in the literature regarding counselling the PC inmate.

In one of the rare but interesting case studies found Hook-Wheelhouwer (1991) describes how one inmate with both a pre-offence and institutional history of victimization was able to deal with past victimization and related shame and anger through the use of art therapy. After resolving his victimization symptomatology, this inmate was able to sense a new inner strength that effected his body language and social presentation. Though he continued to worry about sexual victimization, he returned to GP and the programming that setting offered and began to make constructive plans for his life in prison. Clearly, this case study exhibits a link between historical victimization, institutional victimization, placement in PC, fear of GP, successful treatment of victimization and reintegration to GP.

Method

Setting

Washington State Penitentiary (WSP) is a state correctional facility which houses approximately 2500 inmates. It consists of maximum, medium, and minimum custody housing units situated on approximately 100 acres of land. The Special Housing Unit (SHU) consists of a housing block that is located in the maximum security section, i.e. behind the walls. This unit houses 3 categories of inmates: Death row (approximately 15 inmates), mental health (approximately 80 inmates) and PC (approximately 150 inmates). Detailed description of the penitentiary, its history and development is omitted here since descriptions exist elsewhere both in professional and popular literature (e.g. Barak, 1978).

PC inmates are housed on five tiers of this housing unit in one and two man cells. Though mental health inmates and PC inmates interact regularly, death row inmates are completely segregated from the others.

Subjects

The subjects for this study are 30 inmate who will be randomly selected from among the approximately 150 PC inmates housed at WSP SHU. No attempt will be made to select for crime, length of incarceration or other characteristics. Subjects will be randomly sampled by tier however. There is some belief that separate tiers have distinguishable differences due to management decisions regarding cell assignment and the influence of particularly notorious inmates. To control for this, six inmates will be randomly selected from each tier to balance this effect. To accomplish this each inmate on a tier will be assigned a number according to the number of

inmates housed on the tier (ex. 1 to 30). Using a Texas Instruments Scientific Calculator (TI-85) the range of numbers will be randomly sequenced with its random number generator. Inmates will be approached according to this sequence until 6 participants are confirmed from each tier. Since there are 5 tiers which house P.C. inmates this will result in a total sample of 30. If an inmate drops out of th screening once confirmed, the next inmate on the randomly sequenced list will be approached to replace them.

Procedure

Inmates selected to participate in the study will be called out to meet with the interviewer in the counselling office in the unit. This office is designed for mental health counselling contact. The interviewer is a thirty year old, African Canadian male who, at the time of writing, is serving as a Correctional Mental Health Counselor (CMHC) within the SHU. Though PC inmates are familiar with the interviewer, they would not have been clients of the interviewer whose normal work is confined to treatment of mentally disordered offenders who are housed on separate tiers within the unit.

The project will be explained simply by reviewing the letter of introduction prepared for this purpose (see Appendix A). Inmates who choose to participate will be asked to sign the Interview Consent Form attached and will have the choice of completing the interview immediately or re-scheduling. Those who refuse will be thanked and returned to their cell. Those who wish time to think about participating will be called out within a week to determine their level of participation.

In return for participating in the study a standard letter of thanks will be sent to the inmate and copied to their central file (see Appendix B). Though of no monetary value, such a letter can be used by inmates as proof of their

willingness and ability to cooperate with correctional staff. In environment where little rehabilitative programming is available, many inmates are eager for documentation that is evidence that they are doing something positive.

In order that documentation is completely untraceable to inmates, no identifying information will be left on the interview schedules. This will make giving feedback to the inmates regarding their specific information impossible. Once the study is complete a bound copy of the results will be donated to the WSP library for general inmate consumption. Inmates will also be informed of the mental health resources available to them within the penitentiary. Referrals to appropriate services will be made as requested.

Research Instruments

Those who agree will participate in a two part interview. The first section will consist of a structured interview following the Victimization Screening Questionnaire (see Appendix C). This sixteen item interview schedule is adapted from that developed by Cooley (1995). This modified tool is meant to determine the level of victimization experienced by the inmate over the life span including events occurring in childhood, while incarcerated as a juvenile, as an adult in the community, and as an incarcerated adult. The definition of child for the purpose of this study is consistent with State of Washington guidelines which differentiate between child and adult offenders, i.e. "any individual who is under the chronological age of eighteen years" (Basic Juvenile Court Act, 1996).

Victimizations were limited to events that involved purposeful acts committed by other persons. Specific victimization incidents include robbery, physical assault or threat thereof, theft, vandalism, and sexual assault and threat thereof. Demographic data is limited on this form. Because of the

relatively small population of this PC unit it was determined that confidentiality could not be assured if age and race were combined.

The second section of the interview will be dedicated to the completion of the Trauma Symptom Inventory (Briere, 1995). This instrument will be used to gain a normed measure of trauma symptomatology. This instrument is best described by the paragraph which leads the introduction section of its professional manual:

> The Trauma Symptom Inventory (TSI) is a 100-item test of posttraumatic stress and other psychological sequelae of traumatic events. It is intended for use in the evaluation of acute and chronic traumatic symptomatology, including, but not limited to, the effects of rape, spouse abuse, physical assault, combat, major accidents, and natural disasters, as well as the lasting sequelae of childhood abuse and other early traumatic events. The various scales of the TSI assess a wide range of psychological impacts. These include not only symptoms typically associated with Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD), but also those intra- and interpersonal difficulties often associated with more chronic psychological trauma. The TSI contains 3 validity scales and 10 clinical scales (Briere, 1995b, pg. 1).

Appendix A: Letter of Introduction/Consent Form

Introduction

Hello, my name is Robert S. Wright. Thank you for agreeing to see me. I am a graduate student from Walla Walla College and currently work as a CMCH at WSP, SHU. I am involved in a research project which seeks to profile certain aspects of prisoners' experience. It is my hope that this study may encourage increased programming within PC units resulting in inmates being returned more effectively and safely to the programming and increased freedom available in GP settings. You have been randomly selected to participate in this project. I am completely responsible for the project and am receiving no funds from anyone to conduct this study.

I would like to ask you a few questions about types of victimization that occur in prison and on the street. Specifically I would like to ask if you have ever been a victim and where. I would also like you to fill out a questionnaire that is meant to test the extent to which such events may have affected you.

Some of the questions I am going to ask are very personal and may cause you some discomfort. I can assure you that the information that you share during this interview will not be shared with anyone. Neither will your name, D.O.C. number or other identifying information be listed on any document that lists what you shared. During our discussion, you may wish to talk about family members, other inmates or staff. Please DO NOT give me first or last names. Though you will receive no payment or official benefit for participating, after completing the related questionnaires a letter of thanks will be sent to you and copied to your central file.

This project has been approved through DOC and WSP chain of command. If you have any question regarding the reasons for this study, its legitimacy or you experience any emotional or other distress as a result of this meeting please contact the CMHUS of SHU by means of a kite.

Interview Consent Form

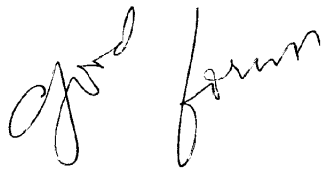
I, _____, (D.O.C.. no.) _____, agree to participate in the project described above on the condition that all information I provide will be completely confidential and anonymous, and that the information I provide will be used for research purposes only. I understand that my participation is completely voluntary and that I may withdraw from participating at any time without prejudice.

_____ _____

Interviewer Respondent

_____

Date



Appendix B: Letter of Thanks

Date

Dear _____ _____, DOC#_____;

Thank you so much for participating in my study entitled:

The measure of victimization experience and trauma symptomatology among protective custody inmates at Washington State Penitentiary: implications for returning persons to general population.

By meeting with me for approximately 1 hour and completing the Victimization Screening Questionnaire and the Trauma Symptom Inventory, you have assisted me in this important study which "may encourage increased programming within PC units resulting in inmates being returned more effectively and safely to the programming and increased freedom available in GP settings".

If in the future you have any questions about this study, your participation in it, and/or its publication, I would encourage you to contact the CMHUS of SHU. Again, thank you for your cooperation and participation in this very important study.

Sincerely,

Robert S. Wright, MSW (cand.), RSW (Nova Scotia)
CMHC-II, Washington State Penitentiary, SHU

Appendix C: Victimization Screening Questionnaire

First, I would like to take some basic demographic information:

Age: _____ Height: _____

Weight: _____ Instant offense: _____

Total years incarcerated: (juvenile)_____ (adult)_____

Time served in PC: _____

Time left to serve: _____

State where you grew up: _____

Now I would like to ask you about some incidents that may have happened to you. I would like you to tell me where the events occurred and how old you were at the time. I don't need any details of the event. Please do not use first or last names.

1) Robbery

Has anyone ever taken something from you by use or threat of force or did anyone attempt to take something from you by use or threat of force?

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated
Yes	_____	_____	_____	_____
No	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

2) Robbery count

How many times did an event like this occur.

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated
Number	_____	_____	_____	_____

Continuous (Volunteered)	_____	_____	_____	_____
NA	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

3) Physical assault

An assault has occurred if you were kicked, slapped, punched, hit with an object, stabbed or shot. Were you ever assaulted?

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated
Yes	_____	_____	_____	_____
No	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

4) Physical assault count

How many times did an event like this occur?

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated
Number	_____	_____	_____	_____
Continuous (Volunteered)	_____	_____	_____	_____
NA	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

5) Threat of assault

Has anyone ever threatened to assault you?

	As a Child	In Juvie	Adult	Adult

			On Streets	Incarcerated
Yes	_____	_____	_____	_____
No	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

6) Threat of assault count

How many times has an event like this occurred?

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated
Number	_____	_____	_____	_____
Continuous (Volunteered)	_____	_____	_____	_____
NA	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

7) Theft

Aside from the incidents mentioned above, did anyone ever take any property that belonged to you?

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated
Yes	_____	_____	_____	_____
No	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

8) Theft count

How many times did an event like this happen to you?

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated

Number	_____	_____	_____	_____
Continuous (Volunteered)	_____	_____	_____	_____
NA	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

9) Vandalism

Besides from the incidents mentioned above, did anyone deliberately damage or destroy any property that belonged to you or was issued to you?

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated
Yes	_____	_____	_____	_____
No	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

10) Vandalism count

How many times did an event like this occur?

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated
Number	_____	_____	_____	_____
Continuous (Volunteered)	_____	_____	_____	_____
NA	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

11) Sexual assault

A sexual assault has occurred if you were touched or rubbed in a sexual way or were forced to touch or rub yourself or someone else in a sexual way, were

forced to perform or receive masturbation, oral sex, anal sex or vaginal sex against your will. Were you ever sexually assaulted?

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated
Yes	_____	_____	_____	_____
No	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

12) Sexual assault count

How many times were you sexually assaulted?

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated
Number	_____	_____	_____	_____
Continuous (Volunteered)	_____	_____	_____	_____
NA	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

13) Threat of sexual assault

Did anyone ever threaten to sexually assault you?

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated
Yes	_____	_____	_____	_____
No	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

14) Threat of sexual assault count

How many times were you threatened with sexual assault?

	As a Child	In Juvie	Adult	Adult

			On Streets	Incarcerated
Number	_____	_____	_____	_____
Continuous (Volunteered)	_____	_____	_____	_____
NA	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

15) Provision of service

Have you ever received counseling to deal with the aftermath of any of these incidents?

	As a Child	In Juvie	Adult On Streets	Adult Incarcerated
Yes	_____	_____	_____	_____
No	_____	_____	_____	_____
DK	_____	_____	_____	_____
NR	_____	_____	_____	_____

16) Total number of incidents: _____

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Item Booklet

John Briere, PhD

Please read all of these instructions carefully before beginning. Mark all of your answers on the accompanying answer sheet and write only where indicated. DO NOT write in this item booklet.

On the answer sheet, please write your name, the date, your age, your sex, and your race in the spaces provided.

This questionnaire contains 100 items describing experiences that may or may not have happened to you. Please circle the one answer that best indicates how often each of the following experiences have happened to you **in the last 6 months**.

Circle 0 if your answer is NEVER; it has not happened at all in the last 6 months.	(0) 1 2 3
Circle 1 or 2 if it has happened in the last 6 months, but has not happened often.	0 (1) 2 3
	0 1 (2) 3
Circle 3 if your answer is OFTEN; it has happened often in the last 6 months.	0 1 2 (3)

If you make a mistake or change your mind, **DO NOT ERASE**! Make an "X" through the incorrect response and then draw a circle around the correct response.

Please answer each item as honestly as you can. Be sure to answer every item. You can take as much time as you need to finish the TSI.

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0	1	2	3
Never			Often

In the last 6 months, how often have you experienced:

1. Nightmares or bad dreams
2. Trying to forget about a bad time in your life
3. Irritability
4. Stopping yourself from thinking about the past
5. Getting angry about something that wasn't very important
6. Feeling empty inside
7. Sadness
8. Flashbacks (sudden memories or images of upsetting things)
9. Not being satisfied with your sex life
10. Feeling like you were outside of your body
11. Lower back pain
12. Sudden disturbing memories when you were not expecting them
13. Wanting to cry
14. Not feeling happy
15. Becoming angry for little or no reason
16. Feeling like you don't know who you really are
17. Feeling depressed
18. Having sex with someone you hardly knew
19. Thoughts or fantasies about hurting someone
20. Your mind going blank
21. Fainting
22. Periods of trembling or shaking
23. Pushing painful memories out of your mind
24. Not understanding why you did something
25. Threatening or attempting suicide
26. Feeling like you were watching yourself from far away
27. Feeling tense or "on edge"
28. Getting into trouble because of sex
29. Not feeling like your real self
30. Wishing you were dead
31. Worrying about things
32. Not being sure of what you want in life
33. Bad thoughts or feelings during sex
34. Being easily annoyed by other people
35. Starting arguments or picking fights to get your anger out

0	1	2	3
Never			Often

In the last 6 months, how often have you experienced:

36. Having sex or being sexual to keep from feeling lonely or sad
37. Getting angry when you didn't want to
38. Not being able to feel your emotions
39. Confusion about your sexual feelings
40. Using drugs other than marijuana
41. Feeling jumpy
42. Absent-mindedness
43. Feeling paralyzed for minutes at a time
44. Needing other people to tell you what to do
45. Yelling or telling people off when you felt you shouldn't have
46. Flirting or "coming on" to someone to get attention
47. Sexual thoughts or feelings when you thought you shouldn't have them
48. Intentionally hurting yourself (for example, by scratching, cutting, or burning) even though you weren't trying to commit suicide
49. Aches and pains
50. Sexual fantasies about being dominated or overpowered
51. High anxiety
52. Problems in your sexual relations with another person
53. Wishing you had more money
54. Nervousness
55. Getting confused about what you thought or believed
56. Feeling tired
57. Feeling mad or angry inside
58. Getting into trouble because of your drinking
59. Staying away from certain people or places because they reminded you of something
60. One side of your body going numb
61. Wishing you could stop thinking about sex
62. Suddenly remembering something upsetting from your past
63. Wanting to hit someone or something
64. Feeling hopeless
65. Hearing someone talk to you who wasn't really there
66. Suddenly being reminded of something bad
67. Trying to block out certain memories
68. Sexual problems
69. Using sex to feel powerful or important
70. *Violent dreams*

0	1	2	3
Never			Often

In the last 6 months, how often have you experienced:

71. Acting "sexy" even though you didn't really want sex
72. Just for a moment, seeing or hearing something upsetting that happened earlier in your life
73. Using sex to get love or attention
74. Frightening or upsetting thoughts popping into your mind
75. Getting your own feelings mixed up with someone else's
76. Wanting to have sex with someone who you knew was bad for you
77. Feeling ashamed about your sexual feelings or behavior
78. Trying to keep from being alone
79. Losing your sense of taste
80. Your feelings or thoughts changing when you were with other people
81. Having sex that had to be kept a secret from other people
82. Worrying that someone is trying to steal your ideas
83. Not letting yourself feel bad about the past
84. Feeling like things weren't real
85. Feeling like you were in a dream
86. Not eating or sleeping for 2 or more days
87. Trying not to have any feelings about something that once hurt you
88. Daydreaming
89. Trying not to think or talk about things in your life that were painful
90. Feeling like life wasn't worth living
91. Being startled or frightened by sudden noises
92. Seeing people from the spirit world
93. Trouble controlling your temper
94. Being easily influenced by others
95. Wishing you didn't have any sexual feelings
96. Wanting to set fire to a public building
97. Feeling afraid you might die or be injured
98. Feeling so depressed that you avoided people
99. Thinking that someone was reading your mind
100. Feeling worthless