

INMATE SEXUAL ASSAULT: THE PLAGUE THAT PERSISTS

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As the population of incarcerated inmates continues to swell to record proportions in the United States, the problem of inmate sexual assault continues to occur. Although no one is immune from such attacks, there are known characteristics that place inmates at increased risk of victimization. The trauma of inmate sexual assault is devastating and pervasive, with complex medical, physical, psychological, and social consequences that must be carefully managed in an interdisciplinary manner. In addition, the recognition that correctional staff of all disciplines may also victimize inmates complicates the management of this process. Mental health staff members are in a key role to shape and contribute to staff training efforts, administrative policies and procedures, and sound intervention protocols that are necessary to respond to individual inmate victims and to ensure safety and security within correctional institutions.

THE AMERICAN CORRECTIONAL SYSTEM STRETCHED BEYOND ITS CAPACITY

As an increasing number of Americans are being incarcerated in the nation's prisons, jails, and correctional facilities—1.86 million (Beck, 2000), the horror of sexual victimization while incarcerated continues to affect countless individuals. Mental health professionals who serve inmates (both juvenile and adult) within correctional facilities and upon release to the community are in a unique position to address this problem in a number of ways.

Although the problem of inmate sexual assault has been known and examined for the past 30 years, the body of evidence has failed to be translated into effective intervention strategies for treating inmate victims and for ensuring improved correctional practices and management. The situation is further complicated by problems faced by most correctional institutions. Although the rate of incarceration in the United States has doubled within the last decade alone (Bureau of Justice Statistics, 1995), most penal settings are operating well beyond their rated capacity, with problems of overcrowding, understaffing, and inadequate resources being common (Beck & Mumola,

1999; Clark, 1994; U.S. Department of Justice, 1999b). As a result, inmate sexual assault, called by some to be the “extra punishment anyone sentenced to prison can expect” (Weiss & Friar, 1974), continues to terrorize certain inmates.

THE INCIDENCE OF INMATE SEXUAL ASSAULT REMAINS UNKNOWN

The actual extent of prison sexual assault is still unknown. The incidence of inmate sexual victimization is quite variable and difficult to predict with accuracy (Dumond, 1992). The research remains sharply divided in epidemiological analysis (Donaldson, 1995). A recent analysis of the Nebraska prison system by Struckman-Johnson, Struckman-Johnson, Rucker, Bumby, and Donaldson (1995, 1996) revealed fairly high rates of forced/coerced sexual activity in confinement (medium/maximum—22% of male prisoners; 16% minimum). The same study noted that the problem appeared to be aggravated in larger prison systems with more crowded inmate populations with greater ethnic diversity. Cotton and Groth’s (1982) observation appears to still retain its validity: “Available statistics, must be regarded as very conservative at best, since discovery and documentation of this behavior are compromised by the nature of prison conditions, inmate codes and subculture and staff attitudes” (p. 48).

The problem is further complicated by the complex social-psychological milieu of the incarcerated setting. Coerced sexual assault may take many forms, on a continuum ranging from trading sex for protection (“hooking up”) to brutal gang rape (Donaldson, 1993, 1995; Stop Prisoner Rape, 1993). There is a general joining of social status and sexual behavior while incarcerated, which leads many inmates to be cast in a role that can be extremely humiliating.

SOME INMATES MAY BE AT INCREASED RISK OF SEXUAL VICTIMIZATION

Contrary to popular perception, it must be understood that *no* inmate is immune from sexual victimization. This being said, certain groups of inmates appear to be more vulnerable. They include (a) young, inexperienced; (b) physically small/weak; (c) inmates suffering from mental illness and/or developmental disabilities; (d) middle-class, not “tough” or “street-wise”; (e) not gang affiliated; (f) known to be homosexual or overtly effeminate (if male); (g) convicted of sexual crimes; (h) violated the “code of

silence” or “rats”; (i) disliked by staff/other inmates; (j) previously sexually assaulted (Cotton & Groth, 1982, 1984; Donaldson, 1993, 1995; Dumond, 1992, 1995; Lockwood 1978, 1980; Scacco, 1975, 1982). The issue of race has also been identified (Lockwood, 1980, 1994; Knowles, 1996; Wooden & Parker, 1982), especially in those settings with disproportionate racial populations and high racial tension.

RESPONDING TO VICTIMS OF INMATE SEXUAL ASSAULT IS COMPLEX AND DIFFICULT

The effects of sexual victimization are pervasive and devastating, with profound physical, social, and psychological components (Cotton & Groth, 1982, 1984; Fagan, Wennerstrom, & Miller, 1996; Kupers, 1997). These effects are magnified in captivity. The perpetrator's actions and beliefs profoundly influence the psychology of the victim (Herman, 1992), and some inmates experience a systematic, repetitive infliction of psychological trauma, physical/sexual assault, continuation of terror, helplessness, and fear (Toch, 1992). Whatever an inmate victim chooses to do regarding the sexual assault (reporting the crime, seeking protective custody, protective pairing), it has a profound impact on their future life while incarcerated (Donaldson, 1993; Kupers, 1997). In addition to the physical harm, there are risks of HIV+/sexually transmitted diseases (STDs), medical injuries, post-traumatic stress disorder (PTSD), depression, suicidal ideation, loss of social status in the incarcerated community, labeling, and stigmatization. In addition, they may be vulnerable to further victimization.

Clinicians who respond to inmate victims should be acutely aware of the sequelae of sexual victimization, both physically and psychologically (see Cotton & Groth, 1982, 1984; Fagan et al., 1996; Lockwood, 1978, 1980; Scacco, 1975, 1982). It is interesting that many mental health clinicians may be more familiar with treating sexual predators than understanding and treating victims of sexual assault.

An interdisciplinary approach to care, with special attention to confronting the risk of suicide and to ensuring the ongoing safety and well-being of the inmate following the intervention must be achieved. Clinicians must be prepared to intercede with security, classification, and administrative staff to effectively manage victim care. *Standard P-57 Sexual Assault* of the National Commission on Correctional Health Care (1997) should be universally adopted in all correctional settings. Another exemplary, comprehensive model to emulate is *PS 5324.04 Sexual Abuse/Assault Prevention and Intervention Programs* (updated December 31, 1997) of the Federal Bureau of

Prisons (1997) that can be accessed at <http://www.bop.gov/progstat/53240104.html>.

The issue of HIV and STD bears additional comment. As noted by Hammett, Harmon, and Maruschak (1999), inmates have disproportionately high rates of infectious disease, substance abuse, high-risk sexual activity, and other health care problems. Although the rate of transmission of HIV/AIDS by coerced sexual assault against inmates is unknown, all victims of sexual assault of inmates while incarcerated face the possibility of an "unadjudicated death sentence" ("Breaking the Silence," 1995), a significant subversion of the intent of the criminal justice system.

INMATE SEXUAL VICTIMIZATION BY STAFF—A CANCER OFTEN OVERLOOKED

The issue of sexual misconduct/abuse/assault by staff on male and female inmates is also an important issue to address. To be sure, most correctional staff members are not involved with such abusive behavior, yet a small minority of staff have inflicted serious harm on inmates. The boundaries between staff and inmates can sometimes get confused in the alienating and negative environment of the prison milieu. Therefore, some staff, who are vulnerable may become manipulated and, as a result, may have inappropriate sexual contact with inmates. Even if the exchange between staff and inmate is "consensual," it represents a barrier that cannot be breached. When allegations of sexual misconduct by staff are made, careful investigation must be performed to rule out false complaints or inmate manipulation, which can destroy a correctional staff's career.

It has also become increasingly apparent that women in confinement face substantial risk of sexual assault by a small number of ruthless male correctional staff members, who use terror, retaliation, and repeated victimization to coerce and intimidate confined women (Amnesty International, 1999; Baro, 1997; Coomaraswamy, 1999; Human Rights Watch, 1996, 1998; Smith, 1998; U.S. Government Accounting Office, 1999). Concerns about this issue led the National Institute of Corrections (U.S. Department of Justice, 1999a) to solicit submissions for the development of "*A training curriculum for investigating allegations of staff sexual misconduct with inmates.*" Such abuses are intolerable. They are fundamental violations of incarceration and defile the guiding principles of correctional environments ("the care, custody, and control of inmates"). Mental health clinicians must be willing to entertain such complaints and act aggressively to pursue justice to protect and treat inmates so victimized. In addition, all correctional institutions

incarcerating women should adopt the standards and practice of the Georgia Department of Correction (National Broadcasting Company, 1999).

CONTINUITY OF INMATE VICTIM CARE IS DIFFICULT

The nature of the incarcerated setting itself complicates continuity and thoroughness of care for the victim. Many inmates face transfer to different institutions, often unexpectedly. It is vital that treating clinicians ensure ongoing care of inmate victims if and when they are transferred from one institution to another. There should also be clear differentiation between the needs of the inmate victim who will be released within a short period of time and those who will be incarcerated for an extended period of time. Clinicians need to plan their treatment strategies accordingly (Dumond, 1992, 1995; Fagan et al., 1996). Finally, inmate victims, upon release, whether to parole or to the community, should be provided competent, community intervention and/or treatment.

CORRECTIONAL STAFF TRAINING IS VITAL

Mental health professionals also have an opportunity to have an impact on correctional staff and their attitudes, which, unfortunately, may exacerbate the victimization experience for inmates. Gardner (1986) identified that education and age were factors in correctional officers' attitudes about inmate victims. Eigenberg's (1989) disturbing analysis of officers employed in the Texas Department of Correction found that half of the officers surveyed engaged in victim blaming and that many were apt to define rape victims as prostitutes and believed that homosexuals "cry rape" if they are caught during the act of intercourse.

In a later amplified analysis, Eigenberg (1994) focused on staff training as a key ingredient to proactively and responsibly dealing with counterproductive staff attitudes. Staff training programs such as those operating in the Massachusetts Department of Correction (Dumond, 1994) and the Federal Bureau of Prison are important contributions to increasing the professional response toward this issue. (See also an insightful analysis by Dallou [1996] in *Corrections Today* and Donaldson [1993] in *Prisoner Rape Education Program: Overview for Administrators and Staff*.) Staff development officers and trainers may also wish to use an excellent resource video titled *The Correctional Officer: Recognizing and Preventing Closed-Custody Male Sexual Assaults* (AIMS Media, 1995).

There are no panaceas for such a complex and difficult phenomenon as inmate sexual assault while incarcerated. Mental health practitioners will be increasingly involved in dealing with this issue and in forging more responsive treatment strategies for individual victims themselves and in helping institutions respond more affirmatively. We are in a pivotal role to shape the training efforts of correctional staff and to improve and enhance the classification system for identifying at-risk inmates. Administrators, government officials, and security staff will look for, and expect, clinicians to give them insight into this often misunderstood and ill-managed problem. Our inaction in this vital arena portends dire consequences for corrections and American society itself.

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