

PRISON SEX

PRACTICE AND POLICY

EDITED BY
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THE TREATMENT OF SEXUAL ASSAULT VICTIMS

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Within U.S. jails and prisons, inmate sexual assault is a devastating and overwhelming scourge that remains largely unabated, under-reported, and ignored. Although the problem has been known for centuries, there has been an inconsistent response among all correctional professionals, including medical and mental health practitioners. Very early in the correctional history of the United States, many observers began to identify the problem of sexual violence being perpetrated against inmates. The Reverend Louis Dwight, founder of Boston's Prison Discipline Society, was one of the first to investigate conditions in state prisons in the first half of the nineteenth century. Considered one of the best sources of information about prison life in that era (Allen and Simonsen, 1998), Dwight presented a report on April 25, 1826, in which he stated that after visiting "most of the prisons . . . between Massachusetts and Georgia," he found "melancholy testimony to establish one general fact, viz., that boys are prostituted to the lust of old convicts." Dwight further pleaded: "Nature and humanity cry aloud for redemption from this dreadful degradation" (Katz, 1976: 27). Since then, many voices have been raised in indignation and concern.

Since the mid-1960s, there has been considerable attention to systematically identify inmate sexual assault (Cotton and Groth, 1982, 1984; Davis, 1968; Dumond, 1992, 2000; Lockwood, 1978, 1980a, 1992; Nacci and Kane, 1983, 1984a, 1984b; Scacco, 1975, 1982; Struckman-Johnson and Struckman-Johnson, 1999, 2000a, 2000b; Struckman-Johnson et al., 1995, 1996; Toch, 1992a, 1992b; Wooden and Parker, 1982). Despite these examinations, the incidence of inmate sexual victimization in U.S. correctional institutions remains unknown

and the treatment of inmate victims has been largely ineffective and, in many cases, nonexistent. The impact of this terrible crime upon its unwitting victims is catastrophic and pervasive. All correctional staff must respond with timely, comprehensive, and effective treatment to help in healing these wounded victims.

The predominant ethic among staff is the care, custody, and control of inmates. This often involves a depersonalization and cultivation of an "us" versus "them" mentality (which is also mimicked by inmates). Among inmates, those individuals for whom society holds the greatest contempt (e.g., murderers) command the highest respect and fear. Such settings are also dominated by the realization that perception is reality. It does not matter what is accurate. It is what the institution (staff and inmates) perceives that dictates the interpersonal and social dynamics (Dumond, 1992).

Changes in inmate population, especially in size and composition, have made the correctional officer's job more difficult and life threatening (Tonry and Petersilia, 2000). The increasing commitment of younger, more violent, more radical and unpredictable prisoners has heightened the danger level in all prisons (Ross, 1991). Incarcerated settings are societies that value aggression, power, and loyalty—many of the attributes often associated with masculinity in society (Dumond, 1992; Nacci and Kane, 1983; Scacco, 1982; Wooden and Parker, 1982). Correctional staff often adopt an attitude that is similar to that of machismo—in its negative connotation: appearing impenetrable, unaffected by violence and fear, and capable of maintaining the facade of control. Prison is a place where kindness is weakness and where all of the players, both staff and inmates, share the environment of confinement and isolation from the rest of community life.

Ross (1991) noted that U.S. prisons today are a dangerous place to work and live, more so than in any other time. There were seventy-nine homicides in 1998 and sixty-eight homicides in 2000 in adult prisons nationwide and 8,094 inmate-on-inmate assaults requiring medical attention (Camp and Camp, 1998, 2001). More troubling about these statistics is the recognition that inmate violence is routinely underreported (Reid, 1991). Additionally, corrections officials note with increasing concern the spillover effect of gang violence from the community into the institutions themselves.

THE PRISON SUBCULTURE—LIFE BEHIND BARS

The prison setting is a closed society with both formal and informal stratification and role expectations. Zimbardo and his colleagues (1973)

dramatically illustrated the role that prisons have in shaping behavior, even in a mock prison environment. After six days, the study was discontinued when five of the ten "prisoners" developed psychological symptomology and the group as a whole developed a "perverted" symbiotic relationship. How more profound and overwhelming is the real world of incarceration, a subculture with its own language, hierarchy, and stratification?

Prison stratification is complex. It includes a combination of personal characteristics, the crime for which one is convicted, and the perceptions of others. The patterns and perceptions about an inmate will often shape the treatment that they will receive from other inmates and correctional staff. The sexual identity of an inmate also helps to define the inmate's orientation within the prison society (Bowker, 1980; Dumond, 1992; Knowles, 1999; Wooden and Parker, 1982). There is a general joining of social status and sexual behavior in prison that leads many inmates to choose, albeit unknowingly/unwillingly, the role of either victim or aggressor, as a means of survival in the subculture of incarceration (see Dumond [1992, 2000] for a discussion of this issue).

THE EFFECTS OF SEXUAL ASSAULT/VICTIMIZATION

The crisis of being a sexual assault victim is pervasive, devastating, and global. It affects the victim physically, emotionally, socially, and spiritually. Sexual victimization causes a psychological disequilibrium from a situation that cannot be avoided and for which a person cannot use their normal problem-solving resources. Burgess and Holmstrom (1974a, 1974b, 1975) developed the first working model to understand the physical and psychological annihilation of sexual assault. They identified the "rape trauma syndrome" (RTS), characterized by an acute phase of disorganization, followed by reorganization and resolution, which has since been adopted as a nursing diagnosis by the Fourth National Conference on the Classification of Nursing Diagnoses (Burgess, 1985). The sequela of sexual victimization has physical, cognitive, social, behavioral, and psychological components, yet during incarceration, sexual victimization has additional effects on victims. This model has been an important adjunct to understanding the impacts on sexual assault victims as well as improving the response of practitioners treating them.

The first psychiatric formulation of traumatic stress was developed by Mott (1919) to describe shell shock and battle fatigue experienced by combat veterans in World War I. The American Psychiatric

Association adopted "general stress reactions syndrome" to describe the reaction to extreme stress that evoked fear in otherwise normal individuals in its first *Diagnostic and Statistical Manual of Mental Disorders* (1952). The reaction was considered fleeting and reversible, and no specific symptoms were described. The syndrome was eliminated from the *DSM-II* (1968) but was reintroduced in the *DSM-III* (1980) as "post-traumatic stress disorder" (PTSD) to describe the reactions of individuals to a wide range of traumatic events, including war, combat, and victimization. Future refinements in diagnostic precision in future editions of the *DSM* (1987, 1994, 2000) have improved our understanding of PTSD. Both diagnoses are currently in use—PTSD being usually diagnosed by psychiatric and psychological staff while RTS is being used by nursing professionals.

Each diagnosis provides aspects of the victimization experience that are essential to treating the problem. PTSD tends to focus on the cognitive and psychological aspects, while RTS includes behavioral aspects as well. Both describe the same phenomenon, which is vital to understanding the complexity of the experience. The rape survivor endures a life-changing event whose impact is destructive (Ruch, Chandler, and Harter, 1980) and may even include a lifetime of pain and suffering after only one event (Allison and Wrightsman, 1993). It should also be noted that victims may suffer from PTSD/RTS even in incidents when a sexual assault has only been attempted (Ruch and Leon, 1983).

For victims of any traumatic assault, there is always the lack of control accompanied by physical pain, suffering, and threat of further harm or death that is concomitant with the assault. Victims often articulate shock and disbelief, panic, and fright. The major task during the attack is survival. A host of coping strategies can be employed by victims, including fighting back, bargaining, focusing on the rapist, mental escaping, and compliance. Although these may aid in some cases, they may equally exacerbate the situation. Understanding the victim's coping strategies is invaluable to treatment, as it can improve the recovery time of the rape survivor (Lennox and Gannon, 1983). It is important to understand the range of strategies that victims may employ, because what a victim appears to do may in no way reflect their actual intention or motivation. These are crucial issues in educating staff, who may conclude erroneously that a victim submitted voluntarily to a sexual assault, when, in fact, the victim's actions were motivated by survival needs.

VICTIMIZATION IN PRISON

The effect of sexual victimization in prisons and jails has been shown to be even more devastating due to the unique structure of incarceration that increases the impact on victims. In situations of captivity, the perpetrator often becomes the most important person in the life of the victim. Ironically, as noted by Mariner (2001), sexual assault victims may be coerced, threatened, and intimidated into long-term sexual slavery and continuous degradation in order simply to survive. Over time, the perpetrator's actions and beliefs profoundly influence the psychology of the victim (Herman, 1992). Especially in incarcerated settings, victims may experience a systematic, repetitive infliction of psychological trauma, as well as the continuation of terror, helplessness, fear, and lack of autonomy. Toch (1992a) identified the double bind facing inmates. Although an inmate who fights earns respect from other inmates and staff, the inmate is seen as a troublemaker, and that may affect his parole. These pressures produce confusion, disorientation, and discomfort, especially in potential victims.

Prisons are so volatile that fear alone has been identified as a chief measure of well-being (McCorkle, 1993a). Even reports of rape in prison have a dramatic impact on inmates, especially those new to prison (Jones and Schmid, 1989). The worry and constant alert to being assaulted—and being victimized—can result in a whole host of psychophysiological conditions that can lead to asthma, ulcers, colitis, and hypertension (McCorkle, 1993a, 1993b). For youth in prisons, in particular, daily survival and avoiding victimization become the predominant activities in the prison jungle (Eisikovits and Baizerman, 1982; Maitland and Sluder, 1996; Rideau, 1992).

Groth, Burgess, and Holmstrom (1977) identify three major methods used to assault victims: entrapment, intimidation, and physical force. These tactics have been described more extensively by Struckman-Johnson and Struckman-Johnson (2000a, 2000b) and Struckman-Johnson et al. (1996) as either force tactics or pressure tactics. Force tactics include threat of harm, being scared by perpetrator size/strength, being physically held down, and having a weapon present. Pressure tactics include persuasion, bribes, blackmail, threats to withdraw love, and use of alcohol/drugs. Most inmate targets of sexual coercion reported the use of at least one force tactic (Struckman-Johnson and Struckman-Johnson, 1999, 2000a, 2000b; Struckman-Johnson et al., 1996).

Perpetrators also utilize five major psychological components to engage victims: (1) conquest and control, (2) revenge and retaliation, (3) sadism and denigration, (4) conflict and counteraction, and (5) status and affiliation (Groth, Burgess, and Holmstrom, 1977). This information is vital to comprehending the seductive and manipulative nature of the "grooming," and communicating these strategies to potential victims is a key preventative strategy.

SEXUAL VICTIMIZATION AS A MALE

In addition to the ravages of prison, male sexual assault victims face additional humiliation, which further complicates their potential for recovery. Dumond (1992) reviewed nine key studies that examined the impact of sexual victimization on males in particular. The vast majority of these studies were conducted in prison/incarceration settings because few male victims report such abuse in community life. Male victims of sexual assault experience not only the more traditional rape trauma syndrome as described by Burgess and Holmstrom (1974a, 1974b, 1975), with its concurrent features of post-traumatic stress disorder, but also a number of other issues that exacerbate the victimization experience (Anderson, 1981; Calderwood, 1987; Mezey and King, 1989).

The rape trauma syndrome identified that rape victims can manifest two response styles: expressive and controlled (Burgess and Holmstrom, 1974a, 1974b). Kaufman et al. (1980) noted that 79 percent of the men sexually assaulted in free society manifested a controlled response, characterized by being calm, controlled, and/or subdued. This can be very deceptive to correctional staff, who may assume that the overwhelming crisis of a rape should precipitate a more expressive response. These staff may subsequently interpret a subdued, emotionless response as evidence that a forced sexual assault did not take place. However, given the dynamics of the prison subculture and the emphasis on control, aggression, and masculinity, it is entirely consistent that most male rape victims in incarcerated settings would be guarded in their overt manifestation of trauma (Donaldson, 1993b; Wooden and Parker, 1982).

The devastation of sexual assault is profound and life changing for both men and women. However, the male sexual assault victim faces some specific challenges that need to be identified and addressed:

- Male victims experience higher rates of fear, anxiety (especially while incarcerated), suicidal thoughts, social disruption, and attitudinal change.
- Male victims have an increased likelihood of having been the victim of multiple assaults by multiple assailants, experiencing more physical trauma, and being held captive longer.
- Most male victims experience concern about their masculinity, and, in the prison community, fear of reprisal and loss of social status.
- Male victims appear to suffer more dramatic victimization, especially in incarcerated settings, in part because of the devaluation of the two primary areas of male identity: sexuality and aggression.
- Male victims appear to experience a devalued sense of their manhood, that is, their sexuality, as well as competence and security.
- Traditional gender role stereotypes contribute to lack of responsiveness toward male rape victims, and gaps in services often prevent men from getting the services they need.
- Social institutions often are involved in a second assault experience on male victims in their denial of the legitimacy of their experiences and the reinforcement of harmful gender role socialization.

With younger male victims, there may also be considerable confusion regarding their sexual identity. One of the strategies that predators often use is to attempt to get the victim to ejaculate. A common myth about male rape is that men cannot become excited or ejaculate under coercion. Groth and Burgess (1980) have demonstrated that men can be physiologically sexually aroused by a variety of emotions, including pain, fear, and anger. When this occurs, as noted by Groth, Burgess, and Holmstrom (1977) and Struckman-Johnson (1991), there is considerable confusion and questioning of the victim's sexual orientation. Additionally, victims in such situations are more likely to blame themselves and feel intense guilt and shame.

IMPEDIMENTS TO DISCLOSURE OF SEXUAL ASSAULT

Without even considering incarcerated settings, disclosure of sexual assault for any victim is a most difficult endeavor. Many patients are

reluctant to discuss victimization with health care providers because of two primary reasons:

1. Victims often perceive that providers are not knowledgeable or sympathetic to the problems they experience, and they fear that disclosure will add to further victimization, humiliation, shame and a sense of blame.
2. Victims, in discussing the assault, may experience discomfort, pain, and panic symptoms, re-experiencing the helplessness of fear of assault. (Fruend, 1991)

This is further compounded by factors related to the ecology and ethos of incarceration. It has often been believed by inmates and staff alike that there are few real "victims," that most sexual behavior in incarceration is consensual. The literature that examines sexual victimization often does not clearly distinguish between consensual homosexuality, prostitution, and rape (Eigenberg, 1994). Struckman-Johnson et al. (1995) have identified that "incarcerated inmates who are sexually assaulted may be viewed as somewhat deserving or responsible for their fate because of the crimes committed against society" (3).

A poll of 400 registered voters in Massachusetts conducted by KRC Communications Research, and reported in the *Boston Globe* on May 17, 1994, noted that 50 percent agreed that society accepts inmate sexual assault as part of the price criminals pay for committing crimes (Sennott, 1994). Herein lies one of the most difficult issues to confront. It is the case that incarcerated inmates do engage in sexual behavior willingly and that it is sometimes difficult to differentiate the validity of an inmate's complaint of sexual victimization. Nonetheless, medical and mental health practitioners must be extremely careful to create the environment for disclosure by inmate victims and not create the chilling effect that apparently continues to exist in incarcerated settings.

Struckman-Johnson et al. (1995, 1996) reported that of the target victims identified, only 29 percent of the inmates told at least one staff person in either an administrative or nonadministrative position. (It is interesting to note that 18 percent reported their assault to counselor/clergy and 10 percent to medical staff.) When asked to identify the reasons for their nondisclosure, target victims identified, in order of importance: (1) fear that perpetrator(s) would kill or injure them; (2) the feeling that staff would not believe them, would laugh at them, or would do nothing about it; and (3) shame and embarrassment. Other

reasons identified were the belief that reporting would cause more problems and make prison life more difficult, and the fear of being placed into protective custody. Follow-up studies by Struckman-Johnson and Struckman-Johnson (1999, 2000a, 2000b) revealed similarly low rates of disclosure to prison officials.

It is critical, therefore, that practitioners avoid what Symonds (1980) calls the "second injury" to victims: the perceived rejection by or lack of support from staff and/or the institution and the conscious and/or conscious/unconscious projection of feelings of blame onto the victim. Lockwood (1995, 1996) and Toch (1992a, 1992b) also emphasize the necessity for custodial staff to learn and understand the grave problems experienced by inmate victims and refer these inmates to medical and mental health staff.

MEDICAL INTERVENTION IN SEXUAL VICTIMIZATION INCIDENTS

Recognizing that there is the potential for serious, even lethal injury to all victims of sexual assault, especially in incarcerated settings, the first priority must be to treat imminent injuries and minimize life-threatening events. The immediate initial focus of correctional staff when managing an inmate victim must be to address the sequelae of brutal victimization, which can include bleeding, head trauma, anal tears/fissures, oral gagging/vomiting, venereal diseases(s), HIV/AIDS, shock, and suicidal thoughts/tendencies. Each correctional institution has its own particular protocol in responding to medical emergencies. Large state prisons and jails, for example, may have well-equipped and -staffed medical facilities that are able to respond to medical emergencies. Smaller prisons and jails, however, may be unable to provide appropriate medical care. As such, emergency medical care may be required from a local or designated community hospital, which requires an established procedure for medical transfer of inmates.

Transporting an inmate could potentially complicate the medical intervention of incarcerated victims. Security is a key factor to be considered when any inmate is removed from the incarcerated setting, for there is an inordinately high incidence of inmates attempting or completing escapes from emergency rooms (Topham, 1999). As a result, enhanced security procedures initiated to intervene with victims may compromise the privacy and confidentiality of the victim/patient.

Correctional security staff should adopt the model of confidentiality and professional respect in their monitoring of inmate victims in external medical settings.

For purposes of discussion, medical and mental health treatment will be divided into four distinct phases: (1) immediately upon disclosure after the assault, (2) within seventy-two hours, (3) short-term intervention, and (4) long-term intervention. Table 5.1 outlines the key action steps to be undertaken by medical and mental health staff following identification and/or disclosure of inmate sexual victimization.

Emergency room practitioners should perform a comprehensive medical examination on the inmate victims and execute the appropriate treatment for injuries sustained as a result of the sexual assault. All sexual assault victims face medical risks that include sexually transmitted diseases, other communicable diseases, and HIV/AIDS (Beers and Berkow, 1999; Cotton and Groth, 1984). Be advised, however, that while the presented action steps are based upon the experience and training of a number of researchers and clinicians, correctional staff must conform to the established protocols of their own institutions.

Sexually Transmitted Diseases

Because inmates tend to have higher risk lifestyles and behaviors, preventative STD testing and treatment are vital (Widom and Hammett, 1996). Powelson and Fletcher (2000) note the variety of sexually transmitted diseases that are present in incarcerated populations and identify some of the tests involved. For example, the Raid plasma reagent test is a blood test used to detect syphilis, to which some inmates are reluctant to submit. However, the Ligase chain reaction test used to detect gonorrhea and chlamydia is a urine test that is less invasive (Powelson and Fletcher, 2000). Therefore, using less invasive tests and making prisoners aware of the procedures and risks are necessary for the inmate's peace of mind.

Other Communicable Diseases

Unfortunately, other communicable diseases abound in prison, including tuberculosis (TB) (MacIntyre, Kendig, and Kummer, 1999) and hepatitis B (DeNoon, 1999). Ninety to 95 percent of primary TB infections go unrecognized (Beers and Berkow, 1999). This appears especially true in correctional settings as well (MacIntyre, Kendig, and Kummer, 1999). Hepatitis C virus has also been identified as a major public health risk, with 30 to 40 percent of the 2 million inmates poten-

Table 5.1 Key Medical and Psychological Intervention, Defined by Time

	Key Responsibilities
Immediately upon disclosure/following sexual assault	<ul style="list-style-type: none"> • Triage: Determine level of trauma—if life threatening or acute, immediately secure victim, medically stabilize, and secure emergency transfer to emergency medical facility. If non-life threatening, secure victim, treat injuries, and provide treatment within institutional hospital. • Attention should be focused on bleeding, head trauma, treating ancillary injuries suffered during the attack (including anal tears/fissures and vaginal tears/injuries), oral gagging and vomiting, shock, and suicidality. Records should carefully document both general and genital trauma, objective clinical findings, subjective victim statements, and behavioral observations. Evaluation, testing, and prophylactic treatment for sexually transmitted diseases (STDs), pregnancy (females), and HIV-positive/AIDS should also be initiated. • If external medical agency is used, secure appropriate medical/psychiatric historical information from victim's medical record for assessment/consideration by hospital staff. Recommendations and treatment of external facility should be followed by institutional medical staff upon inmate's return to prison/jail facility.
Within seventy-two hours	<ul style="list-style-type: none"> • Complete sexual assault evidence collection kit, including securing authorization, collection of foreign materials, undergarments, clothing, debris, pubic hair combings, pulled pubic hairs, vaginal swabs and smears, rectal swabs and smears, oral swabs and smears, pulled head hairs, known saliva and blood samples, careful anatomical drawings, detailed history, and assault information. Preserve evidence appropriately using proper collection techniques, maintaining closely scrutinized and documented chain of custody. Photograph all injuries. • Perform complete mental status examination, noting affect, behavior, verbal responses, body language, cognitive processing, and emotional responses. Carefully assess suicidal risk. Inquire specifically about prior suicide attempts and current feeling states. Note confusion, shock, disbelief, or severe depression. If necessary, secure psychiatric consultation and prophylactic psychiatric medication as required. Contract for inmate safety and prepare victim for PTSD/RTS symptomology. Perform crisis counseling and supportive services. Carefully record all findings, preserve inmate safety, especially upon return to setting. • If medically necessary, negotiate in-patient hospital admission, addressing security issues. • Negotiate family contact/notification and other ancillary support as appropriate (clergy, etc.). All clinical staff should preserve inmate confidentiality, treat inmate victims with respect, provide encouragement and reassurance, and follow through on commitments to patients.
Short-term follow-up	<ul style="list-style-type: none"> • Provide ongoing medical follow-up treatment as required—continue medications, change dressings, evaluate healing of wounds, continue medical treatment initiatives as necessary. • Provide follow-up on results of STD and HIV-positive testing and provide continued prophylaxis. Initiate supportive counseling and education to patient regarding STDs and HIV-positive/AIDS.

(continues)

Table 5.1 continued

	Key Responsibilities
Long-term follow-up	<ul style="list-style-type: none"> • Continue close mental health supervision, including ongoing crisis counseling to focus on self-identity, survival and coping skills, and ventilation of feelings and life goals and issues. • Continued assessment of suicidality, depression, PTSD symptoms, and mental status. Mental health staff should be available regularly; psychiatric evaluation/monitoring should continue. • Continue monitoring of medical issues, including STD evaluation and six-month HIV/AIDS testing up to eighteen months following sexual assault. Continue appropriate medical treatments. • Continue mental health intervention, including ongoing counseling and support, with attention to PTSD symptomology, mental status, sexual identity, and coping skills responses. • Differentiate treatment for inmates incarcerated for short-term period vs. long-term period. • Ensure continuity of medical and mental health care for inmate victims within institutions and upon inmate's transfer to other institutions. • Make appropriate follow-up clinical referrals for inmates upon release to community.

tially infected, most prior to incarceration (Reindollar, 1999). These diseases are affected by high-risk behaviors (drug use and high-risk sexual behaviors). Medical staff should evaluate the presence of these diseases in inmate sexual assault victims and treat accordingly.

HIV/AIDS

HIV and AIDS continues to represent a deadly threat to inmate sexual assault victims. DeGroot, Hammett, and Scheib (1996) note that the HIV seropositivity rate is ten- to 100-fold higher among inmates than in the general population, with the rate of female inmates higher than male inmates. Maruschak (1999) reported that 3.5 percent of all female state prison inmates were HIV-positive, compared to 2.2 percent of male state prisoners. More recent evidence (DeGroot, 2001) has suggested that incarcerated women are three times more likely to be HIV-infected than incarcerated men, representing an "epidemic behind the walls." The most recent HIV incidence data available indicate that 25,483 U.S. state and federal prisoners were HIV-positive in 1998 (Cusac, 2000).

In 1999, AIDS accounted for 10.1 percent (324) of all the inmate deaths in adult state and federal prisons (Camp and Camp, 2001). For at least some inmates, sexual assault while incarcerated was the precipitating cause of their contracting HIV and facing a foreshortened future as

a result (*Corrections Compendium*, 1995). The potential for an "unadjudicated death sentence" as a result of sexual assault is an extremely troubling and disturbing consequence (*Corrections Compendium*, 1995: 14).

Due to legal and ethical requirements, responding medically to the potential risk of HIV/AIDS requires the inmate victim's consent to test for the disease. Medical staff should carefully advise and inform the patient of their rights and instruct about the risks and benefits of pursuing HIV/AIDS testing and prophylactic treatment. Following supportive counseling and upon the informed consent of the victim, medical staff should suggest the collection of blood samples during the initial examination, to be followed up ninety and 180 days later (Beers and Berkow, 1999; Huffman, 2000).

SEXUAL ASSAULT NURSE EXAMINERS INITIATIVE

The last (but certainly not the least) medical consideration involves the process of collecting forensic evidence from sexual assault victims in order to potentially prosecute inmate predators. The sexual assault nursing examiner initiative was created nearly thirty years ago to build a system of quality care that is consistent, humane, and supportive (Mawn, 1999). Nurses are specially trained and certified to provide crisis intervention, patient evaluation, collection and documentation of forensic evidence, and provision of necessary treatment. These nursing specialists also provide victim advocacy, referrals to ancillary care, and provide expert court testimony in criminal prosecutions, if they are pursued.

Standard medical protocol requires patients to be acquainted with the process, to have the steps carefully illustrated, and to secure appropriate informed consent from sexual assault victims. The use of standardized sexual assault evidence collection kits (also referred to as rape kits) are a vital ingredient to successful prosecution and are seen as especially valuable in prison/jail sexual assaults, which are often not successfully prosecuted because of lack of appropriate evidence (Cotton and Groth, 1982, 1984; Fagan, Wennerstrom, and Miller, 1996; Nacci and Kane, 1984a, 1984b). Ninety percent of the city, county, state, and federal law enforcement agencies, crime laboratories, and hospital personnel use sexual assault evidence collection kits manufactured by Tri-Tech, Inc., of Southport, North Carolina. This has greatly increased standardization and reliability of sampling and evidence collection.

However, due caution is also required. Correctional medical personnel have the primary duty of treating inmate victims—requiring institutional correctional staff to perform the tasks of collecting forensic evidence may actually contaminate the integrity of the relationships between inmate victims and medical staff. As a result of this concern, the National Commission on Correctional Health Care (1997) has promulgated standards of care in cases of sexual assault. The standards specifically prohibit correctional institutional medical (and mental health) staff from participating in forensic evidence collection, citing that subsequent staff credibility, neutrality, and caring may be severely compromised. The commission suggests two alternatives: the use of external agencies to perform such tasks or the use of institutional staff (with permission of the inmate victim) who will not be involved in a therapeutic relationship with the inmate (National Commission on Correctional Health Care, 1997).

Because sexual victimization is a profound and devastating event in the inmate's life, medical staff may uncover previously untreated medical and/or psychiatric problems. For a variety of reasons, such symptomology may not have been identified earlier, and the inmate victim has been untreated. Careful attention must be paid to counterbalancing the need for ongoing treatment for the identified medical/psychiatric problems; the victim's willingness, ability, and consent for such treatment; and even communicating these findings to medical/mental health staff at the institution where the inmate victim will be housed.

It is vital that clearly defined and clinically appropriate strategies be implemented to ensure the continuity of care between the hospital providing treatment to inmate victims and the institution to which the inmate victim will return. In some cases, there is even a concern for the ongoing safety of the victim upon return to the institution, and this is an issue that must be carefully reviewed and appropriate action initiated.

Several models may be appropriate for adoption. The Federal Bureau of Prisons (1997) has established an extremely thorough protocol, *PS 5324.04 Sexual Abuse/Assault Prevention and Intervention Programs* (updated December 31, 1997), that city/county/state correctional departments may wish to examine. The Massachusetts Department of Correction (2001a) has also established a comprehensive strategy to address these issues. Its *103 DOC 520 Inmate Sexual Assault Response Plan* is a carefully designed protocol that outlines specific action steps to be taken by correctional staff in responding to alleged incidents of inmate sexual assault in conjunction with the designated medical setting.

Additionally, ongoing dialogue has been established to resolve difficulties that may result from some of the aforementioned issues. This is especially important because medical and mental health staff cannot make the immediate, practical decisions that custodial administrators can regarding housing, inmate placement, movement to a new facility, and so on.

MENTAL HEALTH INTERVENTION ISSUES

There are several major mental health issues that can follow inmate sexual assault: suicide; PTSD; and other psychiatric disturbances, including exacerbation of existing mental illnesses and dissociative disorders. Each of these issues represents a major area of concern for correctional medical and mental health staff.

Suicide

Called the "crisis behind bars" (Danto, 1981), suicide is the most serious concern following an inmate sexual assault. Suicide in jails is the second leading cause of death following illnesses/natural causes (excluding AIDS), with 283 deaths by suicide in 1993 (Perkins, Stephan, and Beck, 1995). In prisons nationwide, suicide was the third leading cause of death in 1999, with a total of 324 inmate deaths by suicide (Camp and Camp, 2001). Toch and Kupers (1999) maintain that the situation of inmate rape, coupled with the overcrowding, brutality, and violence, constitutes a mental health crisis for all inmates, but particularly for the mentally ill.

An increasing number of mentally ill inmates continue to enter U.S. prisons and jails. In fact, Harrington (1999) notes that between 60,000 and 100,000 of the annual jail admissions in the United States are mentally ill. Torrey (1997) has identified that in some states, the number of mentally ill who are incarcerated exceed the number of mentally ill who are institutionalized in state psychiatric hospital facilities. As suggested by Harrington (1999), confinement institutions of all types (lockups, jails, and prisons) have become the new "Bedlams" of the twenty-first century.

A number of researchers have documented that suicide is the option for some sexual assault victims to cope with the increased fear, stress, and anxiety, especially for men (Bland et al., 1990; Dooley, 1990; Haycock, 1991; Lockwood, 1980a; Wiggs, 1989; Wooden and Parker,

1982). Recent research conducted by Struckman-Johnson and Struckman-Johnson (1999, 2000a, 2000b) and Struckman-Johnson et al. (1995, 1996) in Midwestern prisons continues to document the manifestation of suicidal ideation among inmate sexual targets. Given the dynamics of incarcerated settings, such observations are predictable. If an inmate victim believes they will continue to be sexually targeted and victimized, and, if no tangible relief exists, suicide may appear to be the only rational option to some inmates. For this reason, inmate sexual assault victims (and targets) should be considered at imminent risk of suicide until seen and evaluated by mental health professionals (Donaldson, 1993b). Throughout the intervention, the mental health practitioners should carefully assess and inquire about suicidal ideation in inmate victims in each and every interaction, for the full impact of the sexual victimization may not be manifest until some later period.

Post-traumatic Stress Disorder/Rape Trauma Syndrome

Many sexual assault victims experience the debilitating effects of post-traumatic stress disorder/rape trauma syndrome as a direct result of their victimization. In fact, about one-third of all female rape victims developed PTSD at some point in their lifetimes following victimization, with female rape victims being 6.2 times more likely to develop PTSD than women who had not been abused (Boudreaux et al., 1998). Even though this data describes female victims, there is ample evidence that male rape victims experience similar degrees of PTSD (Anderson, 1981; Calderwood, 1987; Cotton and Groth, 1982, 1984; Groth and Burgess, 1980; Kaufman et al., 1980; Lockwood, 1978; Mezey and King, 1989). Donaldson (1993b) has noted that correctional settings may employ mental health practitioners who are conversant and knowledgeable about treating mental illness and offenders but who may be unaware of the nature of sexual victimization and its impact on inmates. Anecdotally, several victims have reported that when they have consulted correctional mental health practitioners, many of these professionals were inadequately prepared to meet the psychological needs of sexual assault victims. As a result, many victims have reported that what should have been an opportunity for coping and healing has actually resulted in further alienation and isolation.

Mental health practitioners should become familiar with RTS and treating PTSD, employing the most current recommended techniques to help ameliorate the problem. Several researchers have emphasized the

role of victim coping strategies and defenses as having a dramatic impact upon recovery (Lennox and Gannon, 1983; Marton, 1988). Consequently, clinicians should utilize an educational approach in their therapeutic interventions, tangibly helping inmate victims to master sensible and manageable coping strategies and understand their unique character style and associated defenses. Cognitive-behavioral therapy has also been shown to be extremely helpful in assisting victims manage and modify PTSD symptomology, as elucidated by Foa and Rothbaum (1997) and Rothbaum (2000).

Finally, because PTSD symptomology can be global and devastating, conjoint therapeutic interventions may be the most effective. The efforts of the Post-traumatic Stress Disorder Alliance has established concrete protocols that show great promise and are valid especially in correctional settings (Beyzarov, 2000). Foa, Davidson, and Frances (1999) recently promulgated expert consensus guidelines on the treatment of PTSD, which included psychotherapeutic as well as psychopharmacological interventions.

Other Psychiatric Disorders

As previously noted, there is a growing number of inmates in U.S. correctional facilities who already have been diagnosed with mental illness. Ditton (1999) has noted that the estimated rate of mentally ill inmates may be as high as 16 percent in state prisons and jails and more than 7 percent in federal prisons. Chelala (1999) reported a total of 283,800 inmates in U.S. prisons who had some form of mental illness. Mental health clinicians should carefully review inmate victim medical and mental records and scrupulously inquire about prior mental health treatment, psychiatric hospitalizations, prior suicidal attempts, and psychiatric medication. Careful attention should be noted to prior diagnoses of major depression (recurrent), PTSD, and psychoses. Also important is the recognition of the number of inmates reporting incidents of prior abuse (physical and sexual). Harlow (1999) has documented the relatively large number of inmates (18.7 percent state prison, 16.4 percent jail, and 9.5 percent federal) reporting abuse prior to their incarceration, including between 7 and 16 percent of inmates reporting prior sexual abuse. Prior physical and sexual abuse can exacerbate the traumatic experience of sexual assault victims and can complicate their recovery (Burgess, 1985; Burgess and Holmstrom, 1974a, 1974b).

Many inmate victims may have personal characteristics and/or have

committed crimes that have made them less sympathetic and credible. Without even realizing it, correctional mental health practitioners may not adequately confront their own transference/countertransference issues, and they may exacerbate the psychological injury to inmate victims (Donaldson, 1993b). Therefore, all correctional mental health practitioners must be well versed in the impact of sexual victimization on inmates, as well as the complex relationship of treatment within the confines of a correctional setting. It is often the case that appropriate treatment cannot occur independently of providing for the safety and security needs of the victim. Clinicians may be required to intervene with security, classification, and administrative staff on behalf of their inmate victims to ensure the basic safety needs of their patients (Dumond, 1992).

Furthermore, if inmate victims will be moved from one incarcerated setting to another, it is essential that there be ongoing continuity of care. This can sometimes be difficult in institutional settings that may not always notify mental health officials in a timely fashion. Strategies must be initiated to include mental health in the classification process and the transition to new institutional settings to ensure that continued care will be afforded to victims.

Other clinical issues are important to consider. As noted by Herman (1992) and Turner (1992), reactions to sexual torture over an extended period of time may elicit a variety of responses in victims. For example, in victims who experienced childhood sexual victimization, revictimization during incarceration may exacerbate and reinitiate the feelings of helplessness and hopelessness, and increase suicidal ideation. In addition, some victims may experience dissociative reactions when there has been extreme, long-term victimization.

Care should also be taken to identify the premorbid psychiatric condition of patients. Those who have had prior psychiatric disturbance are likely to re-experience symptomology (Burgess and Holmstrom, 1974a, 1974b). Clinicians should carefully monitor patient behavior, affect, and feeling states, be aware of symptoms of acute decompensation, and treat patients accordingly. This may also be manifest in victims who have experienced repeated, ongoing victimization, either with the same perpetrator or with additional perpetrators. To survive, victims may anesthetize themselves with substances, and experience pathologic changes in identity (Herman, 1992), sexual disturbances, depression, and lack of wholeness (Turner, 1992). The emotional "processing," as identified by Turner (1992), requires a calm, unhurried approach that often exceeds the traditional fifty-minute hour session.

Anticipatory preparation and behavioral rehearsal are key ingredients to the healing that incarcerated victims require. All sexual assault victims experience symptomology that may leave them feeling as if they are going crazy. By helping to prepare for such experiences, victims may be empowered to better manage their responses to victimization and to minimize the likelihood of revictimization. Use of strategies such as those identified in the manual and tapes of the *Prisoner Rape Education Program* (Donaldson, 1993b, 1997) are important adjuncts to therapeutic intervention.

Regarding an inmate victim's sentence status, individuals who will be released within a short period of time will need information on securing support in the community, dealing with family and friends regarding their victimization experience, and learning how to reintegrate their lives and sexual identity. If the inmate victim will be serving an extended period of incarceration, careful attention should be paid to assisting the inmate victim to learn the skills and techniques of managing their incarceration safely. Additionally, depending on the individual circumstances of the inmate victim, there may need to be extended mental health intervention and continued emotional processing. Should the tragic experience of HIV/AIDS transmission be experienced, there may even be the need for hospice work (Dubler, 1998).

INTERDISCIPLINARY INTERVENTION

The management of inmate sexual assault victims cannot be effectively undertaken without the active and positive involvement of all correctional staff, including administrators, security, classification, and other members of the correctional team (Cotton and Groth, 1982, 1984; Donaldson, 1993b; Dumond, 1992; Fagan, Wennerstrom, and Miller, 1996). Everyone plays an integral role in the process, and all members are vital to ensuring a just and efficient response to inmate victims. Table 5.2 provides guidelines particularly to correctional security and investigative staff, as well as classification staff, in supporting and strengthening the response to inmate sexual assault victims.

Correctional staff must participate in pursuing prosecution (when appropriate) and in ensuring the ongoing safety and security of inmate victims. Each staff member is key to the process—everyone, from administrator to correctional officer, plays an important role in mediating the often destructive impact of inmate sexual assault. It is only with

Table 5.2 Key Correctional and Classification Interventions, Defined by Time

	Key Correctional and Investigative Responsibilities	Key Responsibilities of Classification
Immediately upon disclosure following sexual assault	<ul style="list-style-type: none"> Identify the victim, initiate emergency first aid if necessary, remove victim to a safe, secure environment until able to transfer to medical unit within facility. Notify administration. Secure medical treatment as soon as possible. Get basic information and document same. Secure crime scene; begin evidence collection (cells area, physical evidence, victim's clothing, medical evidence) with careful attention to labeling and chain of custody. Photograph. Isolate and secure aggressor(s), keeping victim and offenders separate. Collect evidence from suspect, clothing, weapons, with careful focus on labeling and chain of custody. Photograph. Gather witness statements (inmate and staff) and document carefully. Mirandize alleged offenders and begin interrogation procedures. 	<ul style="list-style-type: none"> Evaluate needs of victim in terms of most appropriate placement; initiate classification review process and recommend short-term placement options to preserve victim safety. If alleged offenders are identified, note inmate record regarding enemies and ensure that placement not jeopardize inmate victim in this/another institution. Negotiate securing of victim's property from cell, especially if victim is to be held in another location or transferred to the hospital or another prison setting. Assist victim in notifying family and/or friends for support and assistance; help secure other institutional support from clergy, property, etc.
Short-term follow-up	<ul style="list-style-type: none"> Determine appropriate placement conjointly with victim, attempting to not be punitive. Ensure victim safety and security at all times. Cooperate with law enforcement and refer to prosecuting attorney for case disposition. Maintain confidentiality and avoid victim stigma. Carefully document all findings for prosecution. Evaluate ongoing risks to inmate victim and promote environmental changes as necessary. 	<ul style="list-style-type: none"> Determine appropriate placement with inmate victim, and assess options (i.e., protective custody, housing/setting transfer) and implications of placement. Always ensure victim safety and security. Convene disciplinary board to respond to complaints against alleged offenders. Assist victim to secure all necessary services to ensure optimum coping. Ensure thorough documentation of events to reduce future victimization.
Long-term follow-up	<ul style="list-style-type: none"> Preserve inmate safety during incarceration. Facilitate successful completion of prosecution. Develop long-term placement plans and negotiate safe environments for inmate victims upon release to the community. 	<ul style="list-style-type: none"> Continue to maintain inmate safety. Monitor inmate placement throughout institution. Support victim through prosecution. Make appropriate discharge referrals.

professionalism, dedication, and knowledge that true improvement in correctional management can be undertaken.

CONCLUSION

Effective management of inmate sexual assault continues to be a challenge, and due to the complex and changing nature of corrections, it may actually be more difficult at the dawn of the twenty-first century. Issues such as dramatic increases in inmate populations, the increase in mental illness, substance abuse, HIV/AIDS, and continued overcrowding and scarcity of resources have all contributed to the problem.

Despite years of research, the actual incidence of inmate sexual abuse in U.S. correctional settings remains unknown. Recent research, however, employing large sample sizes and universal surveying of state correctional systems, may provide a reasonable and sound assessment of the incidence. The effects of inmate sexual assault are global, devastating, and pernicious. Multiple victimizations, continued confinement, sexual slavery, and lack of treatment may increase the impact of victimization. Many sexual assault victims experience suicidal ideation, post-traumatic stress disorder, rape trauma syndrome, and increased psychiatric disturbances. However, positive and active interventions can help to mediate and effectively treat these symptoms.

All correctional staff play an important role in the process. Each member of the correctional team brings their own unique skill, experience, and function to the process. By utilizing empirical data, fostering state-of-the-art interventions, establishing clear, concise protocols, and increasing staff training and communication, it may be possible to effectively respond to the crisis of inmate sexual assault.