The Impact and Recovery of Prisoner Rape

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Presentation Outline and Goals

This presentation will review a number of issues regarding the treatment of sexual assault victims in incarcerated settings. It will survey an overview and history of the issue of sexual assault in prisons, jails, juvenile facilities and police lock-ups; explore the short and long term effects on victims of sexual assault, both while incarcerated and upon release; and examine effective interventions to treat victims of sexual assault while incarcerated. The goals include:

1. To explore the incidence of inmate sexual assault in American corrections.
2. The examine prison sub-culture, and its impact upon the inmate victim, his/her response to the sexual abuse, and unique problems encountered in treating victims of such abuse.
3. To ascertain the differing "definitions" of rape, sexual assault and sexual abuse, its history and the known incidence in incarcerated settings.
4. To become familiar with inmate victim coping strategies.
5. To understand rape trauma syndrome and posttraumatic stress disorder.
6. To comprehend the major physical and medical interventions which must be addressed, including immediate care, sexually transmitted diseases, other communicable diseases, HIV+/AIDS and forensic evidence collection
7. To consider the emotional/psychological and social impact of sexual victimization on incarcerated victims, and also to consider other factors, including gender.
8. To know how to respond to victims immediately after the assault, over the short-term and the long term.

Correctional Institutions in the United States: A View At the Dawn of the 21st Century.

At the opening of the twenty-first century, American corrections is poised upon despair. Despite centuries of development, and decades of systematic study and professional management, a cancer has gone untreated, and has overtaken the ability of American corrections to provide safe and humane treatment for its charges, in direct opposition to the Constitution's 8th Amendment guarantee against "cruel and unusual punishment." In the opening months of 2001, startling headlines have flooded the national media with cries of concern and calls for reform. Morse (2001: 21) detailed that "savage prison gang rapes turn many run-of-the-mill prisoners into violent felons - in waiting." Lehrer (2001: 24) opined that "prison rape maybe America's most ignored crime problem."

In April 2001, the Supreme Court of Canada rebuked the American criminal justice system by unanimously ruling to block the extradition of four men of accused of a multimillion-dollar telemarketing scam to the United States. The Court held that the reason for this action was that Pennsylvania prosecutor, Gordon Zubrod, had violated the Canadian Charter of Rights guarantee to life, liberty and security of the person in 1997 by announcing a " 'sinister' threat that they would be subjected to homosexual rape in prison if they tried to fight extradition" (Tibbetts, 2001: A8).

Two international organizations also raised the alarm about sexual violence in America's prisons. Amnesty International issued *Broken Bodies, Shattered Minds: Torture and Ill-Treatment of Women* (Amnesty International, 2001) and Human Rights Watch promulgated *No Escape: Male Rape in U.S. Prisons* (Mariner, 2001). What is most disturbing about these two

reports is not simply the fact that they document horrific sexual violence upon American inmates by other inmates, but by correctional custodial staff as well. Until two years ago, as noted by Goering (2001: 18), "sexual abuse of prisoners by correctional officials was not even a criminal offense in 14 states."

Adding to this concern has been the flood of incarcerated inmates pouring into American correctional institutions, derailing any attempt at providing sound, safe, therapeutic environments. Sadly, the United States currently ranks **first** worldwide in the number of inmates it currently incarcerates [1,933,503 in 2000] and in its imprisonment rate per 100,000 population. Due to the mass release of prisoners in Russia, , exceeding Russia [Russia 687/100,000; U.S. 699/100,000] (Walmsley, 1999; Gardner, 2000, Beck & Harrison, 2001). [Even if, as noted by Mariner (2001: 346), China's reported rate is "severely underestimated," its resident population is exceedingly large, and its resultant rate of incarceration is lower.] By 2001, the number of incarcerated persons in the United States has exceeded 2 million: on December 31, 2000, the overall number of incarcerated persons in the United States was an astounding **2,071, 686 persons**, a 39.2% increase since 1990 alone (Beck & Harrison, 2001).

At mid-year 2000, Beck (2001), reported an increase in the incarceration rate in the United States to 701/100,000 Americans. What makes these statistics even more troubling is the realization, as noted by Schiraldi, Ziedenberg and Irwin (1999), that most of the growth (77%) of the prison population in the United States from 1978 through 1996 has been through incarceration of nonviolent offenders. Consequently, life behind bars for many Americans has become increasingly brutal and hostile. As such, American corrections may be entering a period of simply ***warehousing violence***, (the title of a participant-observer socio-anthropological study of the United States Penitentiary at Lompoc, CA undertaken by M.S. Fleischer in 1988), with only a modest commitment to rehabilitation in a safe and secure environment.

INMATE SEXUAL ASSAULT: WHAT IS IT? HOW LONG HAVE WE KNOWN ABOUT IT? HOW OFTEN DOES IT OCCUR IN INCARCERATED SETTINGS? AND WHO IS MOST VULNERABLE?

What Is Inmate Sexual Assault and How Is It Defined? In dealing with issue of inmate sexual assault, one must be aware of the fact that the definition of what this actually means is itself a problem. How is "***sexual assault***" defined? Can a man be raped? Is forced oral or anal sex considered rape? These kinds of questions reflect the general confusion and misunderstanding which exists. Over the years, the definitions of terms such as "***rape,***" "***sexual assault,***" "*sodomy,*" "*sexual abuse*," "*coercive sex*" have taken on expanded meanings, which can even differ depending upon which perspective you are employing (medical, legal, etc.). While there has been an attempt to more accurately define rape and sexual assault, in order to reflect a more precise understanding of this phenomenon, these definitions continue to confound, frustrating attempts to effectively intervene with victims.

In both common language and in the medical arena, there has been a transition from a singular definition of rape ["sexual intercourse with a woman forcibly against her will"] (Webster's General Dictionary, 1974) to one that is **gender neutral** (can be male or female), and one that

generally includes the following **elements** [the specific facts that must be proven beyond a reasonable doubt to support a conviction (Brown, Esbensen & Geis, 1996)]: 1) **unlawful**; 2) **penetration of any orifice**; 3) **against a person's will**; 4) with the **use of threat or force**.

However, in the legal arenas, there is still no consensus on the definition of rape. While many states employ the specific four elements noted above (such as *Massachusetts General Law, Chapter 265, §§ 22*), not every state utilizes this definition or elements, nor does the *United States Penal Code*. Brown, Esbensen & Geis. (1996), using an adaptation of Klotter (1994), notes that the common law definition and elements of the crime, remain "the act of having unlawful carnal knowledge by a man of a woman, forcibly against her will" whose elements include "1. unlawful; 2. carnal knowledge (or sexual intercourse); 3. by force or fear, and 4. without the consent or against the will of the female (Brown et al., 1996: 42). Even the Federal Bureau of Investigation has maintained this archaic definition of rape in the *Uniform Crime Reports*, which has been the standard for the reporting of criminal offenses by local police, organized by states, since 1930.

Such discrepancies result in the inability to establish national standards for arrest and prosecution
of rape cases in the community and especially in incarcerated settings. For purposes of accuracy, one should employ the two most clearly defined definitions of the terms: the language of the ***United***
States Code and the definitions currently being utilized in the **National Incident-Based Reporting System (NIBRS)**. The *United States Code*, which is the criminal offense code utilized for crimes committed in "special maritime and territorial jurisdictions of the United States or in a Federal prison"
(*US Code: Title 18, Chapter 109-A)*, was revised in 1985 to eliminate "rape" and to employ various
degrees of "sexual abuse" which are clearly defined and articulated. This is important for criminal justice professionals to note: if an inmate is sexually abused while in a Federal Bureau of Prisons facility, the *United States Code, Title 18, Chapter 109A* should apply, specifically ***18 USC §§ 2241-2248.***

The National Incident-Based Reporting System (NIBRS) grew out of the need for the FBI and the Bureau of Justice Statistics to better understand the specific incidence of crime in the United States. Developed and field tested from 1982-1988, final guidelines were adopted and endorsed by a wide variety of local, state and federal criminal justice agencies and associations. By 1996, 10 states
have been certified, and a number of others are in the process. The NIBRS is now published as a special edition of the *Uniform Crime Reports* [the *Uniform Crime Reports, NIBRS Edition*] (Federal
Bureau of Investigation, 2001).

If an inmate sexual assault occurs in a city or county jail or a state prison, the criminal justice professional should consult the specific statutes of the state, as state law take precedence. It should be noted that the specific criminal statutes of each state may differ from the *NIBRS* definitions

provided here. Researchers, on the other hand, continue to struggle to determine exact, systematic definitions of sexual assault and may wish to utilize the specific language employed by Struckman-Johnson, Struckman-Johnson, & Rucker (1996) and Struckman-Johnson & Struckman-Johnson (2000a, 2000b).

This discussion of **"consent"** is further confused by the dynamics of life within a correctional institution. Unfortunately, many inmates come into the prison environment without an adequate understanding of the complex socio-political structure - and, as such, many inmates may find themselves in jeopardy. An inmate may unwittingly take items from other inmates, not realizing that they will now be "indebted" to the provider of these goods (Bowker, 1980, Scacco, 1982). Repayment for the used goods, which are often "doubled" or "tripled," can then become problematic - the new inmate must re-pay his benefactor with sexual favors. In addition, some inmates may be coerced into trading sexual favors for protection, known as "hooking up" in prison jargon (Cotton & Groth, 1982, Wooden & Parker, 1982, Dumond, 1992). While some observers argue that inmates who trade their bodies for protection do so willingly, most analysts agree that protective pairing, is anything but consensual (given the fact that, outside the coercive conditions of confinement, these individuals would never agree to such arrangement. We can then conceptualize sexual assault within correctional institutions as a continuum, from consensual sexual conduct to gang rape.

The Prison Subculture - Life Behind Bars

The prison/incarcerated setting is a closed society with both formal and informal stratification and role expectations. Zimbardo and his colleagues (1973) dramatically illustrated the role 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 whole developed a "perverted" symbiotic relationship. In a later analysis, Zimbardo & Ruch (1975) noted that "the abnormal personal and social behavior of both groups is best viewed as a product of transactions with an environment which supports such behavior". How more profound and overwhelming is the real world of incarceration, a subculture with its own language, hierarchy and stratification.

For staff, the predominant ethic 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). For inmates, those individuals 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 which dictates the interpersonal and social dynamics (Dumond, 1992).

Buchannon et al. (1988) note with concern that the incidence of inmate violence has "taxed
correctional resources already strained by prison overcrowding and conservative fiscal policies". Changes in inmate population, especially in size and composition, have made the correction officer's
job more difficult and life threatening (Wickman, 1985; Tonry & Petersilia, 2001). The increasing
commitments of younger, more violent, more radical and unpredictable prisoners has heightened the
danger level in all prisons (Ross, 1991).

Incarcerated settings are societies which value aggression, power and loyalty - many of the
attributes often associated with "masculinity" in society (Wooden & Parker, 1982; Scacco, 1982; Nacci & Kane, 1983; Dumond, 1992). Correctional staff often adopt an attitude which 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.

Dangerous Environs

Ross (1991) noted that prisons today are a dangerous place to work (and live), more so than
in any other historical period of American penitentiaries. From 1984 through 1989, there were 390
prisoners murdered while incarcerated (Corrections Compendium, 1989). The 1990s saw a continuation of prisoner against prisoner attacks, killings and gang related violence (Corrections Compendium, 1991). Even though in the 1990s, there has been a slight decline in the rate of homicide in comparison to all inmate deaths (4.0% in 1989 to 2.0% in 1999, there were 79 homicides
in 1998 and 68 homicides in 2000 in adult prisons nationwide and 8,094 inmate-on-inmate assaults
requiring medical attention (Camp & Camp, 1998, 2001). Increasingly troubling about these statistics
is the recognition that inmate violence is routinely underreported (Reid, 1991). Additionally, In fact,

corrections officials note with increasing concern the "spill-over" effect of gang violence from the
community into the institutions themselves.

Prison stratification is complex: it includes a combination of personal characteristics, the crime for
which one is convicted, and the perception of others. The patterns and perceptions about an inmate
will often shape the treatment which he will receive from other inmates and correctional staff. The
sexual identity of an inmate also help to define the inmate's orientation within the prison society
(Bowker, 1980; Wooden & Parker, 1982; Dumond, 1992; Knowles, 1999). There is a general joining
of social status and sexual behavior in prison - leading 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, for a discussion of this issue.)

How Often Does Inmate Sexual Assault Occur: A Known Problem whose Incidence is Unknown

Despite numerous attempts to understand the epidemiology of the prison sexual assault, the actual incidence of inmate sexual assault in the United States is still unknown (Dumond, 1992, 2000). An extensive review of the literature on the epidemiology of inmate sexual assault can be found in Dumond (1992) and Knowles (1999), which has been supplemented by more recent research (Struckman-Johnson & Struckman-Johnson, 1999, 2000a, 2000b; Hensley, 2000). While most of these studies focused on male sexual victimization, the incidence of inmate sexual assault is quite variable and difficult to predict with accuracy. The reported rates of inmate sexual assault have varied: studies published in the year 1982 were remarkably different: Nacci & Kane (1982) identified as few as 0.3% raped in federal prisons, while Wooden & Parker (1982) reported 14% of all prisoners as "having been pressured into having sex against their will".

More recent analyses have failed to yield any more definitive results. Tewksbury (1989) surveyed 137 inmates in an Ohio correctional facility and found that 92.6% of the inmates were never exposed to sexual threats or coercion, while in a survey of the sexual activities of 106 inmates in a Delaware prison, Saum, Surratt, Inciardi & Bennett (1995) found only 1 inmate who reported being raped while incarcerated. They subsequently concluded that the nature and frequency of sexual contact in prison was not widespread, and what sexual activity did occur was consensual rather than rape. It is to be noted, however, that in Saum et al. study, face-to-face interviews were conducted, with a population that was largely (92%) African American. The majority of the studies which have been conducted have suggested racial factors, with African Americans being overrepresented as sexual predators to white inmate victims (see Dumond, 1992, Knowles, 1999). Hensley (2000), conducting 174 face-to-face interviews in 3 male Okalahoma correctional facilities, found that while 13% of the inmates reported having been sexually threatened by other inmates, only 1.3% had been raped while incarcerated.

On the other hand, research conducted by Cindy Struckman-Johnson and her associates since 1995 (1995, 1996, 1999, 2000a, 2000b) found much higher rates of reported victimization. In an anonymous survey of 1,800 men and women in the Nebraska prison system, with 516 respondents, Struckman-Johnson, Struckman-Johnson, Rucker, Bumby & Donaldson (1995, 1996) found that 22% (101) of the male prisoners and 7% (3) of the female prisoners had been "pressured or forced to have sexual contact (touching of genitals, oral, anal or vaginal sex)" against their will (Struckman-Johnson et al., 1996: 70). Concomitantly, the researchers conducted a separate survey of 714 correctional administrators, unit managers, security and treatment staff. 39% (214) responded and the average estimate of coercive sexual contact was 15%, validating the 19% of inmates reporting such behavior. There were variations of reports by institutional facility, level of security, and sex of the inmates. Cindy & David Struckman-Johnson (1999, 2000a, 2000b) followed up their initial Nebraska study with large scale studies of several anonymous Midwestern prison facilities, and continued to demonstrate relatively significant rates of sexual coercion and forced sexual assault in these prisons.

Because there has been such variability in reported incidence, it is important to examine in more detail the findings of this research. **Table I** identifies the findings of research since 1968.

Insert Table I Here

Making sense out of the discrepancies can be difficult. Saum et al. (1995) have noted that the answer may lie in alternate strategies of surveying such behavior, as well as lack of clarity in definition of what constitutes coercive sexual behavior, and differences among institutions. Eigenberg (2000: 435) posits three explanations: 1) many of the studies are small, convenience samples. 2) Many researchers fail to clearly delineate between the sexual behavior (rape, prostitution, consensual homosexuality). 3) There has been a reluctance among researcher and correctional staff to acknowledge that inmates do not report sexual assaults.

Mariner (2001: 138) adds to the debate by considering four (4) possibilities. 1) The incidents described in the studies may, in fact, be measurements of different types of behavior, which are specifically defined by the ascribed definitions (noted was the fact that in some studies, physical force had to be present in order to qualify as "rape"). 2) Different methodologies - inmate interviews vs. anonymous surveys - may promote more or less disclosure, and could account for widely divergent estimates. 3) There may, in fact, be "significant differences in victimization rates among prison systems, and from prison to prison within a given jurisdiction" reflecting the variations in inmate populations, as substantiated in the Human Rights Watch report. 4) There are differences in correctional management and supervision practices which reflect a variable "level of attention to or tolerance of the problem." Mariner (2001) suggests that the last factor, may, in fact, be the most important determinant of inmate sexual assault, intimating that when correctional staff and administrators recognize the problem, take steps to prevent it and respond swiftly and affirmatively, inmate sexual assault can be significantly reduced.

Even with the variation in reported rapes, most of the studies completed have noted that there is a fairly high rate of sexual pressure within American correctional facilities (see Table I). When one considers the convoluted dynamics of incarceration, the admonition of Cotton & Groth in 1984 that the "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" appears to retain its validity (Eigenberg, 1989; Donaldson, 1995a, 1995b; Dumond, 2000).

What are the effects of sexual assault/victimization? The Victimization Experience

The crisis of being a sexual assault victim is pervasive, devastating, and global - it affects the individual victim physically, emotionally, socially and spiritually. Sexual victimization causes a psychological disequilibrium from a situation which cannot be avoided, and for which a person cannot use their normal problem solving resources. Burgess and Holmstrom (1974a, 1974 b) developed the first working model to understand the physical and psychological annihilation of sexual assault. They identified the **"rape trauma syndrome,"** with its acute phase/disorganization, re-organization and resolution phases, which has since been adopted as a nursing diagnosis by the Fourth National Conference on the Classification of Nursing Diagnoses (Burgess, 1985; Mosby Year-Book, Inc., 1998). The sequella of sexual victimization has physical, cognitive, social, behavioral and psychological components, which in incarceration, has an additional upon victims. This model was an important adjunct to understanding the impact upon sexual assault victims and towards 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 *DSM-II* (1968), but was re-introduced as **"posttraumatic stress disorder (PTSD)"** to describe the reactions of individuals to a wide range of traumatic events, including war, combat, victimization, in *DSM-III* (1980). 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 rape trauma syndrome (RTS) being used by nursing professionals. Table II provides a comparison of rape trauma syndrome and posttraumatic stress disorder.

Insert Table II Here

As will be noted, each diagnosis provides aspects of the victimization experience which are essential to treating the problem. PTSD tends to focus on the cognitive and psychological

experiences which the victim may experience, while Rape Trauma Syndrome also includes a number of 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 & Wrigthsman, 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 & Leon, 1983).

For victims of any traumatic assault, there is always the lack of control, physical pain, suffering and threat of death/further harm which is concomitant with the assault. Victims often articulate shock and disbelief, panic and fright and the major task during the attack is **SURVIVAL**. A host of coping strategies can be employed by victims. While these may aid in some cases, they may equally exacerbate the situation. Understanding the victim's coping strategies is invaluable to treatment, because it can improve the recovery time of the rape survivor (Lennox & Gannon, 1983). Table III outlines some of the strategies often employed by victims in response to their sexual victimization.

Insert Table III Here

It is important to understand the range of strategies that victims may employ, because to the external world what a victim appears to do may in no way reflect their actual intention or motivation. These are critical factors in educating staff regarding the victimization experience, 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. In addition to the wide range of profound effects, victimization in incarcerated settings has additional components which increase the impact upon victims. In situations of captivity, the perpetrator(s) often becomes the most important person in the life of the victim. Ironically, as noted by Mariner (2001), sexual victims may be coerced, threatened and intimated 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. Hans Toch (1992c) identified the "double bind" facing inmates: while an inmate who fights earns respect from other inmates and staff, it has the negative consequence of the inmate being seen as a troublemaker, and it may also affect his parole. These pressures produce confusion, disorientation, and discomfort especially in potential victim.

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 upon all inmates, especially those new to prisoners (Jones & Schmid, 1989). The worry and constant alert to being assaulted (and being victimized) can result in a whole host of psychophysiological conditions which can lead to asthma, ulcers, colitis and hypertension (Davidson & Neale, 1990; McCorkle, 1993a,b). For youth in prisons, in particular, daily survival and avoiding victimization becomes the predominant activities in the prison jungle (Eisikovits & Baizerman, 1982; Rideau, 1992; Maitland & Sluder, 1996).

Groth, Burgess & Holmstrom (1977) identify the three major methods used to assault victims: entrapment, intimidation and physical force. These tactics have been described more extensively by Struckman-Johnson et al. (1996) and Struckman-Johnson & Struckman-Johnson, (2000a, 2000b) 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. In their research, most inmate targets of sexual coercion in their research reported the use of at least one force tactic (Struckman-Johnson et al., 1996; Struckman-Johnson & Struckman Johnson, 1999, 2000a, 2000b).

Perpetrators also utilize five (5) major psychological components to engage victims: 1) conquest & control; 2) revenge & retaliation; 3) sadism & denigration; 4) conflict & counteraction; 5) status & affiliation (Groth, Burgess & 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.

Unfortunately, the impact of sexual assault while incarcerated portends very severe consequences. In fact, in comparison to sexual assault victims in the community, incarcerated rape victims face issues which exponentially complicate and exacerbate their recovery. (Cotton & Groth, 1982; Wooden & Parker, 1982). In order to successfully intervene with inmates, correctional staff must understand the additional burdens experienced by inmate victims, as identified in Table IV:

Insert Table IV Here

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 (9) key studies which examined the impact of sexual victimization upon males in particular. The vast majority of these studies were conducted in prison/incarceration settings, since 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 (1974, 1975), with its concurrent features of posttraumatic stress disorder (PTSD), but also a number of other issues which exacerbate the victimization experience (Anderson, 1981; Calderwood, 1987; Mezey & King, 1989).

The "rape trauma syndrome" identified that rape victims can manifest **two (2) response styles: "expressive"** and **"controlled"** (Burgess and Holmstrom, 1974a, 1974b). Kaufman, Divasto, Jackson, Voorhees & Christy (1980) noted that 79% of the men sexually assaulted in the community 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 (Wooden & Parker, 1982; Donaldson, 1993).

There are some differences which exist in the experience of men and women and sexual assault. To be sure, the devastation of sexual assault is profound and life changing for both men and women. However, men face some additional challenges which need to be identified and addressed. Table V provides an overview of the key issues specifically identified for male sexual assault victims.

Insert Table V Here

With younger male victims, there may also be considerable confusion regarding their sexual identity. One of the strategies which 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 & Burgess (1980) have demonstrated that men can by physiologically sexually aroused by a variety of emotions including pain, fear and anger. When this occurs, as noted by Groth, Burgess & Holmstrom (1977) and Struckman-Johnson (1990), 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 (2) 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. (*American Journal of Preventative Medicine*, 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 which 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."

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% agreed that "society accepts prison rape as part of the price criminals pay for their wrongdoing". 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 which apparently continues to exist in incarcerated settings.

Struckman-Johnson et al. (1995, 1996) reported that of the target victims identified only 29% of the male inmates told at least one staff person in either an administrative or non-administrative position. (It is interesting to note that they further report 18% reported to counselor/clergy and 10% to medical staff). When asked to identify the reasons for their non-disclosure, 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; 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 the Struckman-Johnsons (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 institution and the conscious and/or conscious/unconscious projection of feelings of blame upon the victim. Cotton (1995) and Toch (1992b, 1992c) 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

Since there is a recognition of 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 sequella of brutal victimization, which include the following issues outlined in Table VI :

Insert Table VI Here

It must be recognized that each correctional institution has its own particular protocol in responding to medical emergencies which governs the action steps which will be taken. Large state prisons and jails, for example, may have well equipped and staffed medical facilities which

are able to respond to medical emergencies. Smaller prisons and jails, however, may be unable to provide the level of 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 and 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, since there is an inordinately high incidence of inmates attempting/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.

In general, medical and mental health treatment will be clustered in three (3) distinct phases: 1) immediately after the event/upon disclosure, 2) short-term interventions and 3) long-term interventions. In order to provide a more thorough presentation, Table VII outlines the key action steps to be undertaken by medical and mental health staff following identification and/or disclosure of inmate sexual victimization:

Insert Table VII Here

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.

Emergency room practitioners perform a comprehensive medical examination upon the inmate victims, and execute the appropriate treatment for injuries sustained as a result of the sexual assault. In addition, all sexual assault victims face medical risks which include sexually transmitted diseases, other communicable diseases, and HIV+/AIDS, while female inmates face risk of pregnancy (Cotton & Groth, 1984; Travis, 1993; Beers & Berkow, 1999). Female inmate victims should be carefully counseled about the potential risks of pregnancy, advised on the risks and benefits of pregnancy testing and use of the "morning after" pill, to be utilized if warranted and requested by the inmate victim.

Sexually Transmitted Diseases: Because inmates tend to have higher risk lifestyles and behaviors, preventative STD testing and treatment are vital (Widom & Hammett, 1996). Powelson & Flethcer (2000) note the variety of sexually transmitted diseases are present in incarcerated populations and identify some of the tests involved. For example, the Raid Plasma Reagent (RPR) test is a blood test used to detect syphilis, to which some inmates are reluctant to submit. However, the Ligase Chain Reaction (LCR) test used to test for gonorrhea and chlamydia is a urine test which is less invasive (Powelson & Flectcher, 2000).

However, other necessary procedures may themselves appear to be invasive. Cultures are generally collected from the vagina, urethra, anus and mouth of sexual assault victims (as

dictated by reported sites of sexual victimization). Cervical cultures involve the removal of cervical mucosa with a sterile, cotton swab, aided by the use of a vaginal speculum (Fischbach, 2000). Urethral cultures involve gentle scraping of the urethral mucosa, with similar procedures for the anal canal and orthopharyngeal culture (Fischbach, 2000). Henry (1984) advises that for each of the tests, the patient should be advised of the purpose of the test and the various aspects of the procedures to obtain the samples. Efforts should be made to making the patient comfortable and answering any questions that may be required. Appropriate prophylactic treatment for STDs, such as azithromicin for gonorrhea/chlamydia with compazine, and metronidazole for bacterial vaginosis, should be initiated as soon as possible (Mawn, 1999). However, it is also to be noted that treatment may need to be continued over a period of time, and should be continued and evaluated by the correctional institution to which the inmate victim will return. Repeat tests for gonorrhea, chlamydia, and syphilis should be performed within 6 weeks, and tests for syphilis at 6 months (Beers & Berkow, 1999).

Other Communicable Diseases: Unfortunately, other communicable diseases abound in prison, including tuberculosis (TB) (MacIntyre et al., 1999) and Hepatitis B (*AIDS Weekly Plus*, 1999; DeNoon, 1999). 90-95% of primary TB infections go unrecognized (Beers & Berkow, 1999). This appears especially true in correctional settings as well (MacIntyre et al., 1999). Consequently chemoprophylaxis is strongly indicated, especially if the assailant is known to be affected with TB, or the victim is HIV+. Establish a regimen of isoniazid for 6 - 9 months, or other appropriate medication, if patient is resistant (Beers & Berkow, 1999). Continue to monitor potential contamination. If assailant is known to be Hepatitis B+, administer Hepatitis B - immune globulin IM. If assailant Hepatitis B status is not known, consider Hepatitis vaccine (Mawn, 1999). Hepatitis C virus (HCV) has also been identified as a major public health risk, with 30-40% of the 1.8 million inmates potentially 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.

Human Immunodeficiency Virus (HIV) and Auto Immune Deficiency Syndrome (AIDS):

HIV and AIDS continues to represent a deadly threat to inmate sexual assault victims. DeGroot, Hammett & Scheib (1996) note that the HIV serepositivity rate is 10-fold 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% of all female State prison inmates were HIV+, compared to 2.2% 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 indicates that there were 25,483 U.S. State and Federal prisoners who were HIV-positive in 1998 (Cusac, 2000).

In 1999, AIDS accounted for 10.1% (324) of all the inmate deaths in adult State and Federal prisons (Camp & 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

("Breaking the Silence," 1995). The potential for an "unadjudicated death sentence" ("Breaking the Silence:" 14) as a result is an extremely troubling and disturbing consequence.

Due to legal and ethical requirements, medically responding to the potential risk of HIV+/AIDS requires the inmate victim's consent to test for the disease, and to provide treatment. Medical staff should carefully advise and inform the patient of his/her 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 90 and 180 days later (Beers & Berkow, 1999; Huffman, 2000).

Several medical researchers (Haufman, 2000; Myles, Hirozawa, Katz, Kimmerling & Bamberger, 2000; Wiebe, 2000) have supported the use of HIV postexposure prophylaxes (PEP) to address the risk of HIV+ exposure, especially in high risk populations. Myles, Herzowa, Katz, Kimmerling & Bamberger (2000) have proposed the use of zidovudine (300 mg, twice daily) and lamivudine (150 mg, twice daily) in a combination pill for 10 days, followed by an assessment, and then continued for an additional 18 days. They also note that male victims of anal rape are at the highest risk of HIV+ exposure, and strongly support the use of this procedure. If the assailant is known to be HIV+, or there is a known high risk (such as in incarcerated settings) and no serology is available, treat with AZT, 3TC, & indinavir, draw a basline, with follow up antiretroviral therapy for 4-6 weeks (Mawn,1999).
Sexual Assault Nurse Examiners (SANE) Initiative/Forensic Evidence Collection: 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 (SANE)** initiative was initiated nearly 30 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 (SAEC) 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 (Nacci & Kane, 1984b; Cotton & Groth, 1982, 1984; Fagan, Wennerstrom & Miller, 1996). 90% of the city, county, state and federal law enforcement agencies, crime laboratories and hospital personnel use sexual assault evidence collection (SAEC) kits manufactured by Tri-Tech, Inc. of Southport, NC, which has greatly increased standardization and reliability of sampling and evidence collection, according to the company's president, Jay W. Walker, Jr. (2001).

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 (see P-57 Sexual Assault, pp. 72-73 and P-68 Forensic Evidence, pp. 84-85). 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.. They suggest 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).

Since 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 have not been identified, and the inmate victim has been untreated. Careful attention must be paid to counterbalancing the need for on-going 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 insure 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 on-going safety of the victim upon return to the institution, and this is an issue which 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) which city/county/state correctional departments may wish to examine. [See website: www.ncjrs.org/txtfiles1/176344.txt]. The Massachusetts Department of Correction (2001) has also established a comprehensive strategy to address these issues, which may also be valuable to consider. *103 DOC 520 Inmate Sexual Assault Response Plan* is a carefully designed protocol which 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, the Beth Israel Deaconess Medical Facility, Boston, MA.

Additionally, on-going dialogue has been established to resolve difficulties which 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, etc.

Mental Health Intervention - A Myriad of Issues to Confront

There are several major mental health issues which follow inmate sexual assault: 1) **suicide**,

2) **PTSD**, and 3) other psychiatric disturbances, including exacerbation of existing mental illnesses and dissociative disorders. Each of these 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, Stephen & 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 & Camp, 2001). Toch & 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 American prisons and jails. The Task Force Report of the American Psychiatric Association notes that upward of 700,000 who enter the criminal justice system each year have active symptoms of serious mental disorders, with 75% of these individuals having co-occurring drug abuse disorders (Weinstein, Burnes, Newkirk, Zil, Dvoskin & Steadman, 2000). In fact, Sigurdson (2000) notes that the there are more mentally ill men and women in prisons and jails in the United States than in all of the State hospitals combined. Torrey (1999) argues that it is those severely mentally ill who cannot recognize their need for medication who often end up in jails and prison. Confinement institutions of all types (lockups, jails and prisons), as suggested by Harrington (1999), 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 (Lockwood, 1980; Tucker, 1982; Wooden & Parker, 1982; Wiggs, 1989; Bland, Newman, Dyck & Orn, 1990; Dooley, 1990; Haycock, 1991). Recent research conducted by Struckman-Johnson et al. (1995, 1996) and the Struckman-Johnsons (1999, 2000a, 2000b) in Mid-Western 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 he/she 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 of suicide until seen and evaluated by mental health (Donaldson, 1993). Throughout the intervention, the mental health practitioners should carefully assess and inquire about suicidal ideation in inmate victims in each and every interaction, since the full impact of the sexual victimization may not be manifest until some later period.

(2) Posttraumatic stress disorder/rape trauma syndrome: Many sexual assault victims experience the debilitating effects of posttraumatic stress disorder/rape trauma syndrome as a direct result of their victimization. In fact, about 1/3 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 (Kilpatrick, Edmunds & Seymour, 1992; Kilpatrick, Resnick, Saunders and Best, 1998). Even though this data describes

female victims, there is ample evidence that male rape victims experience similar degrees of PTSD (Lockwood, 1978; Groth & Burgess, 1980; Kaufman et al., 1980; Anderson, 1981; Cotton & Groth, 1982, 1984; Calderwood, 1987; and Mezey, 1989). Donaldson (1993) 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 upon inmates. Anecdotally, several victims have reported that when they have consulted correctional mental health practitioners, many of these individuals 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 rape trauma syndrome 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 (Lenox & Gannon,1983; Marton, 1988) Consequently clinicians should utilize an educational approaches in their therapeutic interventions, tangibly helping inmate victims to master sensible and manageable coping strategies and understanding 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 & Rothbaum (1997) and Rothbaun (2000). Clinicians are encouraged to become employ these important innovations.

Finally, since PTSD symptomology can be global and devastating, conjoint therapeutic interventions may be the most effective. The efforts of the Posttraumatic Stress Disorder Alliance has established concrete protocols which show great promise and which are valid especially in correctional settings (Beyzarov, 2000). Foa, Davidson & Frances (1999) recently promulgated expert consensus guidelines on the treatment of PTSD, which included psychotherapeutic as well as psychopharmacological interventions. Particularly important was the recognition of the vital role which can be played by selective serotonin reuptake inhibitors (SSRIs), most notably sertraline (Zoloft), which can also play a role in mediating depression. Other antidepressants, such as trazadone and nefazadone, can assist in reversing the insomnia often experienced when taking SSRIs (Beyzarov, 2000). Especially beneficial is the recognition that these medications can replace benzodiapines, which have been widely prescribed for PTSD and other anxiety disorders, but whose use is contraindicated with patients with comorbid substance abuse and in prison, because of their significant abuse potential (Foa et al., 1999).

(3) Other psychiatric disorders. As previously noted, there are a growing number of inmates in American corrections 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% in state prisons and jails, and over 7% in federal prisons. Chelala (1999) reported a total of 283,800 inmates in American 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 the number of inmates reporting incidents of prior abuse (physical and sexual). Harlow (1999) has documented the relatively

large number of inmates (18.7% state prison, 16.4% jail and 9.5% federal) reporting abuse prior to their incarceration, including between 7 - 16% 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 & Holmstrom, 1974a, 1974b, 1985). The most important aspects of mental health treatment are included in Table VIII

Insert Table VIII Here

Many inmate victims may have personal characteristics and/or have committed crimes which have made them less sympathetic and credible. Without even realizing it, correctional mental health practitioners may not adequately confront their own transference/ counter-transference issues, and may exacerbate the psychological injury to inmate victims. (Donaldson, 1993). Consequently, all correctional mental health practitioners must be well versed in the impact of sexual victimization upon 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 insure the basic safety needs of their patients (Dumond, 1992).

Furthermore, if inmate victims will be moved from one incarcerated setting to another, it is critical that there be on-going continuity of care which will be engaged. This can sometimes be difficult in institutional settings which may not always notify mental health in a timely fashion. Strategies must be initiated to include mental health in the classification process and the transition to new institutional settings to insure 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, re-victimization in incarceration may exacerbate and re-initiate the feelings of helplessness, hopelessness and increase suicidal ideation. Herman (1992) notes that survivors often develop an even more complex deformation of identity, with the self being experienced as "malignant.... contaminated, guilty and evil." 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 reexperience symptomology (Burgess & Holmstrom, 1974a, 1974b). Clinicians should carefully monitor patient behavior, affect and feeling states, and be aware of symptoms of acute decompensation, and treat patients accordingly.

This may also be manifest in victims who have experienced repeated, on-going victimization, either with the same perpetrator or with additional perpetrators. To survive, victims may anesthetize themselves with substances, 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 which often exceeds the traditional “fifty minute hour” session.

Anticipatory preparation, and behavioral rehearsal are key ingredients to the healing which incarcerated victims require. All sexual assault victims experience symptomology which 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 re-victimization. Utilization of strategies such as those identified in the manual and tapes of the *Prisoner Rape Education Project* (Donaldson, 1993, 1997) are important adjuncts to therapeutic intervention.

Additional issues are a recognition of the status of the inmate victim in regards to their sentence structure. 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 re-integrate 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 upon the individual circumstances of the inmate victim, there may need to be extended mental health intervention, continued emotional "processing". Should the tragic experience of HIV+/AIDS transmission be experienced, there may even be the need for hospice work (Dubler, 1998).

Need for 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 & Groth, 1982, 1984; Dumond, 1992; Donaldson, 1993; Fagan et al, 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 IX 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.

Insert Table IX Here

Correctional staff must participate in pursuing prosecution (when appropriate) and in ensuring the on-going safety and security of inmate victims. Each staff is key to the process. Since corrections is a holistic environment, no one part can adequately respond to the problems faced by inmate sexual assault victims. Everyone, from administrator (warden/superintendent) to correctional officer plays a key role in mediating the often destructive impact of inmate sexual assault. It is only with 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, which, due to the complex and changing nature of corrections, 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 among inmates, 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 American correctional settings remains unknown. More recent research, however, because of the large sample sizes and global surveying of state correctional systems, may actually be providing a reasonable and sound assessment of the incidence. The effects of inmate sexual assault is 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, posttraumatic stress disorder (PTSD), rape trauma syndrome symptoms, 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. It is hoped that the preceding chapter will contribute to improving correctional response to this most complex of institutional problems.

Resources

There are several resources which may be vital to improving correctional response. They

include:

* Cotton, D.J. & Groth, A.N. (1984). Sexual assault in correctional institutions: Prevention and intervention. In I.R. Stuart (Ed.). *Victims of sexual aggression: Treatment of children, women and men.* New York: Van Nostrand Reinhold. [Comprehensive analysis of how correctional systems should respond, including the presentation of the model protocol of the San Francisco Jail].

* Donaldson, S. (1997). Prisoner rape education project: Manual/overview for jail/prison administrators and staff, 2nd edition. Brandon, VT: The Safer Society Press. [A series of audio tapes and manual designed to assist inmate sexual assault victims to better cope with their victimization and to help correctional staff (administrators, security, medical, mental health, clergy) to understand and more effectively manage inmate sexual assault. Manual also includes model protocols established for the San Francisco Jail and *PS 5324.02 Sexual Assault Prevention/ Intervention Programs, Inmate* currently in use within the Federal Bureau of Prisons].

* Dumond, R.W. (1992). The sexual assault of male inmates in incarcerated settings. *International Journal of the Sociology of Law*, **20**(2): 135-157. [A comprehensive article which outlines key research on epidemiology, male rape, prison stratification, and which offers concrete models of intervention.]

* Foa, E.B., Davidson, J.R.T. & Frances, A. (Eds.) (1999). Treatment of posttraumatic stress disorder. The expert consensus guidelines series.. *The Journal of Clinical Psychiatry*, **60**: Supplement 16. [A compilation of the latest psychotherapeutic and psychopharmacological interventions for posttraumatic stress disorder].

* Herman, J. L. (1992). Complex PTSD: A syndrome in survivors in prolonged and repeated trauma. Journal of Traumatic Stress, 5(3): 377-391. [An important, well documented presentation of the impact of complex PTSD on victims of torture, incarceration and captivity].

Mariner, J. (2001). *No escape: Male rape in U.S. prisons*. New York: Human Rights Watch. [Most recent and first national study of male rape in U.S. prisons, with legal & social policy recommendations to consider].

* *The Prison Journal*, Volume **80**, No. 4, December 2000. Special Issue devoted to Prison Sexuality. [Most recent exposition of current empirical knowledge on inmate sexual assault, with important contemporary research].

* Stop Prisoner Rape, *Amicus Curiae* brief in the U.S. Supreme Court, ***Farmer v. Brennan, No. 902-7247.*** New York: Stop Prisoner Rape, Inc. Can be accessed, along with many other articles and information, from the Stop Prisoner Rape website at **http:www.spr.org**. [Extremely well written and useful document which provides a historical and comprehensive examination of the problem of male inmate rape].

* Struckman-Johnson, C.J., Struckman-Johnson, D.L., Rucker, L., Bumby, K., & Donaldson, S. (1996) Sexual coercion reported by men and women in prison. *The Journal of Sex Research,* **33**(1): 67-76. [Recent large scale study of Nebraska prisons (male & female) documenting significant incidents of forced sexual abuse of inmates].

APPENDIX I

United States Department of Justice, Federal Bureau of Prisons
PS 5324.04 Sexual Abuse/Assault Prevention and Intervention Programs

United States Department of Justice, Federal Bureau of Prisons
Preventing Sexual Assault in Federal Prisons (Inmate Brochure given at Admission)

APPENDIX II

Cycles of Victimization in the Sexual Assault of Inmates

(From Dumond, R.W. (1992). The sexual assault of male inmates in incarcerated settings, *International Journal of the Sociology of Law*, 20(2): 135-157, Figure I, p. 145.)

Strategies for Intervention with Inmate Sexual Assault Victims

(From Dumond, R.W. (1992). The sexual assault of male inmates in incarcerated settings, *International Journal of the Sociology of Law*, 20(2): 135-157, Figure II, p. 149.)

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Table I
Key Research on Sexual Assault With Incidence Data in American Corrections

Researcher(s)	Year	Setting	Type	Major Findings
Alan J. Davis	1968 (Done June 1966-July 1968)	Philadelphia prison system	Face to face interview; Prison records review; Witness polygraph	* 3,304 inmates and 500 staff interviewed * 156 (4.7%) incidents of sexual assault verified * 149 incidents in prison, 7 in sheriff's vans * Sexual assaults included 82 incidents of anal sex (buggary); 19 incidents oral sex (fellatio), and 55 sexual assault attempts and coercive solicitations * Incidents involved 97 different victims and 176 aggressors * 96 were reported to prison authorities; 64 noted in records * 40/64 received disciplinary action; 26/64 reported to police * "disproportionate number of black aggressors and white victims" (Davis, 1968: 15): 56% black-on-white; 29% black-on-black and 15% white-on-white sexual assaults * "conservative estimate that the true number of assaults in the 26-month period was about 2,000." (Davis, 1968: 13)
David A. Jones	1976 (Done 1972-1973)	Tennessee Penitentiary	Inmate interviews	* 3/4 of prisoners recalled at least one (1) rape per month * Greater than 1/3 recalled one (1) rape per week * 30% reported more than one (1) rape per week * No personal victimization rate was identified - inmates were not asked about their own victimization experiences * Nearly all whites agreed aggressors were black inmates and the victims were white inmates
Dan A. Fuller & Thomas Orsagh	1977 (Done last qtr. 1975)	North Carolina prison	Inmate interviews; Staff interviews; Records review	* Stratified random sample of 400 inmates in 6 different North Carolina state prison institutions * Prison supervisors interviewed * Sample of records of disciplinary hearings in 10 different prisons for 126 assaultive events * Victimization rate from offense report documents noted as 6 inmates/1,000 per quarter year = 2.4% sexual assaults/year * Victimization rate varied by race, age & institution
Peter L. Nacci	1978	Federal prison	Technical report	* 5 of the 8 homicides at USP Lewisburg, PA between March 1974 and May 1976 were motivated by homosexual activity, including unrequited love, jealousy, and pressuring for sex * 3 out of every 10 inmates released from FCI Tallahassee in

Researcher(s)	Year	Setting	Type	Major Findings
				the early 1970s reported having been propositioned for sex * Not all propositions resulted in a forced sexual experience, but sexual 'pressure' in prison appeared to be pervasive * Prisons were environments of overcrowding, regimentation and boredom
C. Scott Moss, Roy E.Hosford, & William Anderson	1979	Federal prison	Records review of identified rapists	* Of 1,100 inmates, 12 inmates identified and segregated for having raped other inmates [7 African American, 5 Chicano] * Estimated annual rate of sexual assault between 0.5% - 3.0% * Variables most highly correlated with being a rapist were (1) age at time of commitment (younger more likely); (2) number of disciplinary reports (greater # more likely); (3) median or lower SAT scores more likely. * All rapists were minority; all but two victims were white; and all victims were a different race than offenders
Daniel Lockwood	1978; 1980 (Done 1974-1975)	New York state prisons	Inmate interviews (transcribed) and inmate historical data	* 89 randomly selected inmates interviewed * 107 inmates (28%) reported being targets of sexual aggression at least once; total of 152 incidents reported * "Sexual aggression" defined as physical abuse, threats or insults, or threatening propositions * At least 2 out of 10 inmates were targets of sexual assault * Only 1 inmate was "forced to participate in oral or anal sex" * Targets of sexual aggression described aggressors as 80% black, 14% Hispanic and 6% white * Targets tended to be young, white, slight build, non-violent * Most incidents took place w/n first 16 weeks of incarceration * Aggressors had statistically significant differences in age, ethnicity, violent disciplinary infractions and juvenile record * Severe effects on victims, including high rates of fear, anxiety, psychological disturbance and suicidal ideation
Wayne S. Wooden & Jay Parker	1982 (Done 1979-1980)	California medium security men's prison	Anonymous question-naires	* Random sample of 607; 200 anon. questionnaires completed * Sample represented 10% of the prison population * 65% experienced at least 1 sexual contact while in prison * 14% forced to participate in oral or anal sex * Sexual aggressors establish and increase their dominance and status in the prison hierarchy through sexual conquests * Some sexual aggressors use psychological victimization and gain gratification by observing victims suffer * "Sexual exploitation in prison in an actuality;" For many inmates, incarceration becomes "a criminal act itself." (p. 227)
Peter L. Nacci & Thomas R. Kane	1983, 1984a 1984b	Federal prisons within the United States Bureau of Prisons (BOP)	Anonymous surveys	* 330 male inmates from a stratified random sample from 17 federal prison institutions surveyed (avg. time served 20 mos.) * 500 correctional officers surveyed as well * 30% experienced homosexual experiences while incarcerated, 12% of these while in current institution * 29% of federal inmates reported being sexually propositioned while in prison * 11% reported being "targets of sexual aggression" * Sexual aggression narrowly defined by use of violence * 1 inmate of 330 reported being forcibly sodomized; 2 inmates forced to perform a sex act (either fellatio or other) * Estimated 2 sexual assaults per month in 1983 in system of 31,000 inmates * Racial conflict not seen as a major motivating factor * Identified factors affecting behavior include criminal history,

Researcher(s)	Year	Setting	Type	Major Findings
				prison staff and prisoners' families' taboos, prisoners own moral beliefs and peer influences
Clemens Bartollas & Christopher M. Sieverdes	1983a 1983b	Juvenile training schools in southeast United States	Self administered question-naires	*Original sample of 561 residents (age 7 - 17 yrs.), with 327 male and female residents of 6 training schools responding * 70% of respondents felt unsafe at some time in setting * 54% claim someone had taken advantage of them * 51 residents (9.1%) reported sexual victimization, with equal percentages of males, females, blacks and whites * Age and physical size not found not as important as correlates of sexual assault as length of current stay and cumulative time spent in correctional facilities * Black residents outnumbered white residents 2-to-1 * Higher incidence of sexual victimization of blacks noted * 1/3 of sexual victims admitted to exploiting other residents
Richard Tewksbury	1989 (Done 1988)	Lebanon Correctional Institution, Lebanon, Ohio	Anonymous question-naires	* 150 inmates surveyed, 137 surveys completed * 19.4% reported sexual contact with at least 1 inmate last year * 92.6% never approached with coercion or threats for sex * NO inmate of 137 surveyed reported being victim of rape * Despite findings, respondents estimated 14% inmates raped * Rate & frequency of homosexual activity lower than expected
Christine A. Saum, Hilary L. Surratt, James A. Inciardi & Richard E. Bennett	1995 (Done March -April 1994)	Medium security Delaware prison, (within Therapeautic Community)	Face-to-face interviews	* Sample of 106 inmates,101 face-to-face interviews conducted * Average age 29.6 years, average # of incarcerations - 3.6 * Sample 92% African American, 5% white, 3% Hispanic * 24.8% witnessed consensual sex at least 1 time in last year * 33.7% heard of rape and only 4% saw a rape in last year * 1 inmate reported completed rape in lifetime of incarceration * 5 inmates reported attempted rape, 2 within last year * Inmates, contrary to their direct experiences, estimated much higher rates of sexual victimization: 15.9% every day * Conclusion: most sexual activity in prison is not rape but consensual; inmates endorse "myth of pervasive sex."
Cindy Struckman-Johnson, David Struckman-Johnson, Lila Rucker, Kurt Bumby, & Stephen Donaldson	1996 (Done spring 1994)	Four (4) Nebraska prisons 3 men's facilities, (2 medium, 1 minimum), 1 women's facility (Done Spring 1994)	Anonymous surveys	* Total inmate population of 1,801 - 1,708 men and 93 women * 516 usable inmate surveys returned (30% return rate) * Total staff of 714 in the four settings; 264 returned surveys * 104 inmates (20%) pressured or forced at least 1 time to have sexual contact against their will while incarcerated * 50% of all targets had completed oral/genital intercourse * 29% of male targets victim of gang rape (2+ more offenders) * 75% targets reported at least one force tactic; for men, two most common were threat of harm and physical intimidation * Males: 33% restrained, 30% physically injured, 25% weapon * Females: less severe incidents (2 genital touching, 1 att. rape) * Sexual assault targets reported an average of 9 incidents * 18% of staff reported to be involved as sexual perpetrators * Majority of targeted inmates experienced profound negative reactions, including 56% depression, 36% suicidal ideation * Low rate (29%) of disclosure by sexual targets to prison staff
Cindy Struckman-Johnson & David	1999 (Done spring 1998)	Three (3) Midwestern women's prisons	Anonymous surveys	* Total population of 3 facilities - 468 female inmates; 130 staff * 263 usable inmate surveys and 43 staff surveys returned * Great diversity of sexual victimization reported in 3 settings, greater incidence in larger setting (J) vs. smaller settings (K,L) * In max-min setting (J) w. older population, greater racial and

Researcher(s)	Year	Setting	Type	Major Findings
Struckman-Johnson		1 max-min - J, 1 med-min - K, 1 max-med - L.		sexual diversity and larger population (295 inmates), 27% pressured/forced sexual incidents at any facility (19% current) * J prison: 26 sexual incidents noted, including 7 rapes (26%); 33% targets physically restrained & 11% physically harmed; 14 incidents (52%) involved 2 or more perpetrators; 50% cases inmate perpetrator, 45% staff perpetrator (male); Low reporting rate (30%)to prison officials; profound impact on targets, including 52% depression and 15% suicidal ideas * K,L prisons: 5 & 2 incidents of sexual touching, 0 rapes * Conclusions: sexual abuse does occur in women's prisons, but the rate is differential and is impacted by population size and racial diversity. Individual assessments of women's prisons are necessary. Sexual coercion of female inmates is done by inmates and prison staff, not staff alone. Increased security and accountability seen as solutions to problem.
Cindy Struckman-Johnson & David Struckman-Johnson	2000 (Done spring 1998)	Seven (7) Midwestern prisons in four (4) different state Department of Corrections (DOCs)	Anonymous surveys	* Total of 7,032 male inmates, with 1,788 responding (25%) * Total of 1,936 security staff, with 425 staff responding (25%) * 375 (21%) inmates reported at least 1 incident of "pressured or forced sex" while imprisoned, 285 (16%) in current setting * 131 (7%) incidents of rape (oral/genital) using force tactics * 67 (40%) rape incidents occurred between 1996-1998 * Inmates and staff generally agreed on level of protection at facility; larger men's prisons given low rating of protection * 20% of inmates from larger prisons stated a male or female staff had participated in the "worst-case sexual coercion" act * High sexual coercion rates correlated with 5 factors: 1) use of barracks housing, 2) racial conflicts, 3) lax security, 4) prison inmate population over 1,000 and 5) larger inmate population with crimes against persons.
Christopher L. Hensley	2000 (Done 1998-1999)	Three (3) Oklahoma correctional facilities 1 maximum, 1 medium, 1 minimum	Face-to-face interviews	* Total sample - 174 inmates questioned; 52 minimum security prison, 61 each in medium and maximum security prisons * 24 (13.8%) reported having "been sexually threatened" * Targets mostly white (58.3%) or African American (29.2%) * 1 victim threatened twice, 2 victims threatened 3 or more * 2 inmates (1.1%) reported having "sexually threatened someone" and 1 inmate (0.6%) having "raped someone" * Of 2 perpetrators, 1 inmate reported having threatened and assaulted a victim 35 times, and raping victim 12 times * Perpetrators 57.5% African American, 37.5% white * 2 inmates (1.1%) reported one (1) completed rape * Rape victims were small framed, white, bisexual (in general or in prison);1 rape occurred in maximum, 1 rape in medium * Both rape victims found "protectors" after the rape incident and became victims of "sexually extortion", providing sexual services for protection [protective pairing or "hooking-up"]

Table II
A Comparison of Posttraumatic Stress Disorder With Rape Trauma Syndrome

Diagnostic Criteria for 309.81 Posttraumatic Stress Disorder,[DSM-IV-TR], (APA, 2000: 467-468)	**Rape Trauma Syndrome** **Mosby's Medical Nursing, & Allied Health & Dictionary, Edition 5, 1998, p. 7656; Burgess & Holsmstrom, 1974, 1985**

Diagnostic Criteria for 309.81 Posttraumatic Stress Disorder,[DSM-IV-TR], (APA, 2000: 467-468)	**Rape Trauma Syndrome** **Mosby's Medical Nursing, & Allied Health & Dictionary, Edition 5, 1998, p. 7656**; **Burgess & Holsmstrom, 1974, 1985**
A. The person has been exposed to a traumatic event in which both of the following were present: (1) the person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others. (2) the person's response involved intense fear, helplessness, or horror. **Note**: In children, this may be expressed instead of disorganized or agitated behavior. **B. The traumatic event is persistently reexperienced in one (or more) of the following ways:** (1) recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions. **Note**: In young children, repetitive play may occur in which aspects of the trauma are expressed. (2) recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content. (3) acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening when intoxicated.) **Note**: In young children, truama-specific reenactment may occur. (4) intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. (5) physiological reactivity on exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event. **C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:** (1) efforts to avoid thoughts, feelings or conversations associated with the trauma (2) efforts to avoid activities, places, or people that arouse recollections of the trauma (3) inability to recall an important aspect of the trauma (4) markedly diminished interest or participation in significant activities (5) feeling of detachment or estrangement from others (6) restricted range of affect (e.g., unable to have loving feelings) (7) sense of foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span) **D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:** (1) difficulty falling or staying asleep (2) irritability or outbursts of anger (3) difficulty concentrating (4) hypervigilance (5) exaggerated startle response **E. Duration of the disturbance (symptoms in Criteria B, C, and D) is more than 1 month.** **F. The duration causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.** *Specify* if: **Acute**: if duration of symptoms is less than 3 months **Chronic**: if duration of symptoms is 3 months or more *Specify* if: **With Delayed Onset**: if onset of symptoms is at least 6 months after the stressor	A nursing diagnosis accepted by the Fourth National Conference of Nursing Diagnoses. The trauma syndrome that develops from being raped includes an acute phase of disorganization and a longer phase of reorganization in the victim's life. The defining characteristics are divided into three subcomponents: **rape trauma, compound reaction** and **silent reaction**. **(1) Rape Trauma:** **The acute phase**: period when the victim may experience major change & sense of disorganization to their normal lifestyle. ***The physical symptoms may include the following:*** -*Physical trauma*: soreness, bruising from the physical attack in various parts of the body where the attack took place (mouth, throat, vagina, anus, breasts, penis, arms, thighs, etc.) -*Skeletal muscle tension*: headaches, fatigue, sleep disturbance, weeping, edginess and jumpiness over minor incidents. -*Gastrointestinal irritability*, including stomach aches & pains, excessive nausea, appetite changes, a distaste for certain foods nor experienced before; changes in bowel habits; -*Genitourinary disturbance*, distress, oral and/or anal burning and/or itching; disturbances of the normal patterns of sleep, activity and rest.. For women, gynecological problems - bleeding, infections, pain and discomfort ***Emotional symptoms may include the following:*** - Fear of physical violence and death, humiliation; - Anger, guilt and embarrassment; - Revenge and wish for revenge; - Self-blame, self-hatred, self-doubt, and in some cases, self-mutilation and self injury. **The long-term re-organization phase:** this period is characterized by the victim's attempt to reorganize and alter their lifestyle. This will generally occur 2 to 3 weeks after the event, but will vary. Some of the symptoms which occur may include, but are not limited to: - Sudden change in friends; - Sudden change in family contacts; - Increased or decreased need to communicate with family; - Strong desire to move from home/residence/housing; - Frequent nightmares; - Prolonged sleep problems; - Development of new phobias/neuroses, e.g., fear of being alone, outdoor/indoors, groups, someone sneaking up behind; **(2) Compound reaction** is characterized by all of the defining characteristics of rape trauma and other symptoms (especially if victim previously experienced physical/sexual abuse): - Severe depression; - Suicide attempts; - Psychosomatic illnesses and complaints; - Increased sexual activity/promiscuousness; - Increased drug and/or alcohol abuse; overeating; - Psychotic behavior. **(3) Silent Reaction** may replace ***rape trauma or compound reaction***: -Abrupt change in usual sexual relationships; -An increase in nightmares; -Increasing anxiety during the interview about the rape incident; -Marked change in sexual behavior; avoidance of relationships; -Denial of the rape or refusal to discuss it;

Diagnostic Criteria for 309.81 Posttraumatic Stress Disorder,[DSM-IV-TR], (APA, 2000: 467-468)	**Rape Trauma Syndrome** **Mosby's Medical Nursing, & Allied Health & Dictionary, Edition 5, 1998, p. 7656**; **Burgess & Holsmstrom, 1974, 1985**
	-Sudden development of phobic reactions.

Table III

COPING STRATEGIES DURING AN ATTACK AND POSSIBLE OUTCOMES

(Groth, Burgess & Holmstrom, 1977; Cotton & Groth, 1982, 1984; Lockwood, 1980; Donaldson, 1993)

STRATEGY	POTENTIAL OUTCOME
1. FIGHTING BACK	This could dissuade an attacker, but it could also encourage more serious physical assault/violation.
2. BARGAINING	The victim may seek to minimize injuries by agreeing to perform some activity, such as fellatio, as opposed to sodomy.
3. FOCUSING ON RAPIST	The victim may memorize salient features/description of the offender to identify in future.
4. MENTAL ESCAPING	The victim may focus their mental attention on other activities - this may lead, however, to an inability to describe the event, and therefore, potentially be perceived by officers as the victim being untruthful.
5. COMPLIANCE	The victim may "give in" to the assault as a way of "getting it over with". This can be misused by assailants in defending their actions.
6. FROZEN FRIGHT	In extreme fear, the victim may "freeze", and, as a result, assailants can assert the victim's willingness.
7. STOCKHOLM SYNDROME	Victims may begin to identify with their aggressor, and, may appear to comply willingly.

TABLE IV

PRIMARY VICTIMIZATION ISSUES IN INCARCERATED SETTINGS

(Lockwood, 1980; Wooden & Parker, 1983; Cotton & Groth, 1982,1984; Dumond, 1992; Donaldoson, 1993)

1. Victims are **MORE LIKELY** to receive **PHYSICAL HARM/TRAUMA** .
2. Victims experience **FEAR OF REPRISAL AND CONTINUED ATTACKS**.
3. Victims experience a **LOSS OF SOCIAL STATUS** in the incarcerated community.
4. Victims, following victimization, are at risk of **INCREASED VULNERABILITY** within the community.
5. If the victim chooses **Protective Custody (P.C.),** they risk **FURTHER LABELING AND INCREASED STIGMATIZATION.**
6. Victims may choose **PROTECTIVE PAIRING ("hooking up")** to avoid further victimization by others, in a sense allowing coerced sex by one to avoid others.
7. Victims, if they remain in population, may be further **CONFRONTED BY THE OFFENDER(S).**

TABLE V

SUMMARY OF KEY ISSUES IN MALE SEXUAL VICTIMIZATION

1. Male victims experience higher rates of fear, anxiety (especially while incarcerated), suicidal thoughts, social disruption and attitudinal change. (Lockwood, 1980)

2. 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. (Kaufman et al., 1980)

3. Most male victims experience concern about their masculinity, and, in the prison community, fear of reprisal and loss of social status. (Groth & Burgess, 1980)

4. Male victims appear to suffer more dramatic victimization especially in incarcerated settings, in part because of the devaluation of the two (2) primary areas of male identity: sexuality and aggression. (Cotton & Groth, 1982)

5. Male victims appear to experience a devalued sense of their manhood, their sexuality, as well as competence and security. (Cotton & Groth, 1982)

6. 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. (Donnelly & Kenyon, 1996)

7. 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. (Washington, 1999)

TABLE VI

FIRST PRIORITY - TREATING THE PHYSICAL/MEDICAL ISSUES

1. Bleeding

2. Head trauma

3. Other assaults suffered during, the attack

4. Anal tears/fissures

5. Oral gagging/vomiting

6. Venereal disease(s)

7. HIV+/AIDS

8. Other communicable diseases
   (TB, Hepatitis B/C Viruses)

9. Pregnancy (if female)

10. Shock

11. Suicidality

Table VII
Key Medical/Psychological Interventions, Defined By Time
(Cotton & Groth, 1982, 1984; Wooden & Parker, 1982; Dumond, 1992; Toch, 1992, Donaldson, 1993; Travis, 1993, McGovern, 2000)

Time	**Key Responsibilities**
I. Immediately Upon Disclosure/ Following	* **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, any head trauma, treating ancillary injuries suffered

Time	**Key Responsibilities**
Sexual Assault (within 72 hours)	during the attack, including anal tears/fissures, vaginal tears/injuries, oral gagging, vomiting, shock and suicidality. Records should carefully document both general and genital trauma, objective clinical findings, subjective victim statements, as well as behavioral observations. Evaluation & prophylactic treatment for sexually transmitted (STDs), pregnancy (females) and HIV+/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. * **Complete sexual assault evidence collection (SAEC) kit**, including securing authorization, collection of foreign materials, undergarments, clothing, debris, pubic hair combings, pulled pubic hairs, vaginal swabs & smears, rectal swabs & smears, oral swabs & 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, 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 and preserve inmate safety at all times, especially upon return to setting. * If medically necessary, negotiate in-patient hospital admission, addressing security demands. * 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.
II. Short-Term Follow-Up	* **Provide on-going 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+ testing** and provide continued prophylaxis. Initiate supportive counseling and education to patient regarding STDs and HIV+/AIDS. * **Continue close mental health supervision**, including on-going crisis counseling to focus on self-identity, survival & coping skills, 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.
III. Long-Term Follow-Up	* **Continue monitoring** of medical issues, including STD evaluation and 6-month HIV+/AIDS testing up to 18 months following sexual assault. Continue appropriate medical treatments. * Continue mental health intervention, including on-going counseling and support, with attention to PTSD symptomology, mental status, sexual identity, coping skills and 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.

TABLE VIII

KEY MENTAL HEALTH CONSIDERATIONS FOR EFFECTIVE INTERVENTION

1. Mental health practitioners should understand the nature and breadth of sexual victimization upon inmates.

2. Mental health clinicians must approach their intervention with an inter-disciplinary focus - necessary medical, psychiatric and other strategies should be implemented when necessary.

3. Suicidality is a key risk to all sexual assault victims - careful attention needs to be paid to evaluate and treat victims.

4. Clinicians must comprehend the insidious nature of the incarcerated setting, and must be prepared to intercede with security, classification and administrative staff to effectively manage victim care.

5. Given the nature of incarcerated settings, on-going care and continuity of treatment as an inmate is transferred from one setting to another is critical.

6. Clinicians must prepare victims for the full range of symptoms which they may experience, which includes PTSD, depression, and exacerbation of existing/premorbid psychiatric illnesses. In doing so, they assist victims in better coping with the sequalae.

7. Clinicians should also provide adjunctive support to treatment, such as anticipatory preparation and behavioral rehearsal, in an attempt to empower inmate victims to cope with their victimization and minimize re-victimization.

8. Clinicians must differentiate between the needs of the inmate victim who will be released within a short period time, and those who will be incarcerated for an extended period, and plan their treatment strategies accordingly.

Table IX
Key Correctional/Classification Interventions, Defined By Time
(Cotton & Groth, 1982, 1984; Wooden & Parker, 1982; Nacci & Kane, 1984a,b; Dumond, 1992; Toch, 1992; Donaldson, 1993)

Time	Key Correctional/Investigative Reponsibilities	Key Responsibilities of Classification
I. Immediately Upon Disclosure/ Following Sexual Assault	* Identify the victim, initiate emergency first-aid if necessary, remove him/her 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 (cell 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 & staff) and document carefully. Mirandize alleged offenders and begin interrogation procedures.	* 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 insure 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, transferred to the hospital or another prison setting. * Assist victim in notifying family and/or friends for support and assistance; help in securing other institutional support from clergy, property, etc.
II. Short-Term Follow-Up	* Determine appropriate placement conjointly with for victim, attempting to not be punitive. victim input; negotiate protective custody if warranted, but also consider other options. * 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 on-going risks to inmate victim and promote environmental changes as necessary.	* Determine appropriate placement with with inmate victim, and assess options (i.e. protective custody, housing/setting transfer) and implications of placement. * Always ensure victim safety & 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.
III. Long-Term Follow-Up	* Continue to preserve inmate victim safety while incarcerated, especially through changes in jail/ prison institutions. * Facilitate involvement with prosecution through completion of the criminal court processing. * Develop long-term placement plans and negotiate safe environments for inmate victims upon release to community. * Make appropriate referrals to probation/parole.	* Monitor inmate placement throughout incarceration, with particular attention to maintaining inmate safety and continuing to address on-going medical, mental health and environmental needs. * Negotiate post incarceration placement and referrals to community medical & mental health agencies for victims upon release to address on-going treatment.